Arkansas Primary Care
Payment Improvement Working Group

Inaugural Report

March 27, 2026

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See Appendix A for more details

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EXECUTIVE SUMMARY

The Arkansas primary care system sits at the center of a challenging health landscape. National scorecards consistently rank Arkansas near the bottom of states on overall health system performance and on measures closely tied to the strength of primary care, including access, workforce capacity, and preventable health outcomes. Decades of evidence demonstrate that primary care is the only part of the health system where greater investment is associated with better health outcomes, reduced utilization, and lower overall costs. Yet nationally, and in Arkansas, primary care remains critically underfunded relative to its role.

Act 483 of the 95th General Assembly established the Arkansas Primary Care Payment Improvement Working Group (Working Group) to evaluate the current primary care delivery system, measure spending on primary care across payers, and recommend a primary care spending target designed to achieve better health outcomes and decreased health care costs for Arkansans. Between October 2025 and March 2026, the Working Group convened primary care clinicians, payers, state agencies, and policy experts to a) adopt a definition of primary care suitable for measurement, b) collect claims and non-claims spending data from payers, and c) assess the adequacy of the primary care system with respect to workforce, access, quality, and outcomes.

Using its adopted definition, the Working Group analyzed 2022 and 2023 spending data from nine payers. When applying a weighted average by each payer's total medical spending, statewide primary care spending relative to total medical expenditures was **5.67% in 2022 and 5.36% in 2023**, well below levels associated with stronger health system performance and below the benchmarks emerging in other states.

Based on this assessment, the Working Group puts forth three recommendations:

1. **Adopt a 12 percent primary care spending target, to be reached through annual, one-percentage-point benchmark increases, alongside a minimum spending floor of 5 percent for all payers and specific accountability mechanisms**. This target is designed to move Arkansas toward levels of primary care investment associated with stronger performance in other states and peer nations while allowing time for thoughtful implementation and evaluation.
2. **Expand the scope, responsibilities, and capabilities of the Working Group,** including dedicated funding for ongoing data collection, analysis, and public reporting. Stable support would allow the Working Group to maintain a consistent definition and methodology, leverage the Arkansas All-Payer Claims Database (APCD), and develop an interactive primary care scorecard to track progress on access, quality, affordability, and investment over time.
3. **Leverage the federal Rural Health Transformation Program (RHTP) to strengthen primary care**, using Arkansas's multi-year award to bolster the primary care workforce pipeline, support adoption of advanced value-based payment models, and expand telehealth and data infrastructure in rural and underserved communities.

Together, these recommendations provide a roadmap for moving Arkansas from underinvestment and fragile capacity toward a primary care system that is adequately resourced, more equitable, and better positioned to improve the health of all Arkansans.

INTRODUCTION

Working Group Overview

Act 483 of the 95th General Assembly of the State of Arkansas established the Arkansas Primary Care Payment Improvement Working Group (Working Group) to evaluate the primary care delivery system, including spending on primary care relative to whole health system spending, and set a target for future investments in primary care.[1]

This legislation builds upon a years-long, coordinated effort by stakeholders across the state to support comprehensive, sustainable, and high-quality primary care for Arkansas patients through increased investment.

Specifically, the Working Group was tasked with:

1. Establishing a definition of primary care to be used for data collection;
2. Identifying any portion of the Arkansas Medicaid Program population that should not be included in the study due to the unique circumstances of the population;
3. Creating templates for data submission from commercial insurance carriers and the Arkansas Medicaid Program;
4. Conducting an evaluation of the current amount spent on primary care and other health care services;
5. Determining the adequacy of the primary care delivery system in Arkansas, including the effect this system has on the supply of primary care providers in the state; and
6. Identifying data collection and measurement systems as a basis for creation of a primary care spending target that includes a method by which to measure improvements made toward the target.

Members of the Working Group designated by the legislation included primary care clinicians and leaders, state agencies, and payers, including commercial plans and Medicaid. The Working Group convened between October 2025 to March 2026 for a total of seven meetings.

Meetings were held hybrid or virtually, open to the public, and attended by a quorum of voting members along with other participants from the Arkansas primary care community. Each meeting included discussions of national and state-level evidence, other state approaches to strengthening primary care and best practices for evaluating primary care spending and setting attainable targets. Focus areas included:

- Defining primary care
- Best practices for data collection and methodology
- National frameworks and state approaches to meaningfully increasing investment
- Investment targets and other policy levers for supporting primary care

This report synthesizes those discussions, recognizing that they represent an important initial step toward strengthening primary care payment in Arkansas.

[1]Arkansas, 95th General Assembly. (2025). Act 483.

National Primary Care Landscape

Primary care saves lives, improves population health and enables healthy, thriving communities.[2] Regular access to high-quality primary care has consistently been associated with improved population health and life expectancy, and primary care is the only part of the health system where greater investment is associated with better health outcomes, reduced utilization and lower costs.[3]

Despite its essential and demonstrated role in patient health, primary care remains critically underfunded in the United States. Nationally, primary care accounts for at least 35 percent of all health care visits, yet receives only four to six percent of health care spending.[4] Recent analyses have shown that this national spending figure is declining, with notable decreases between 2021 to 2023.[5] This chronic lack of investment contributes to access shortages, worse health outcomes for patients, and an overburdened clinical workforce whose demand outpaces supply.[2,3,4]

United States spending on primary care is considerably less than peer nations, with other high-income countries spending an approximated 12 to 14 percent of health care spending on primary care. Countries that invest more in primary care generally achieve better population health outcomes and lower per capita health care spending than the U.S.[6] While international and cross-state spending estimates vary because there is no single, standardized definition of primary care, many peer nations still devote a larger share of total health spending to services commonly associated with primary care. Further, the United States' underinvestment in primary care is regarded as a central driver of the poor performance of the U.S. health care system in comparison with other countries.[7]

Strain on the primary care workforce is an unfortunate consequence of this chronic underinvestment, with primary care clinicians regularly reporting high levels of administrative burden and burnout, shrinking time per visit, and difficulty recruiting and retaining staff, particularly in rural and underserved communities.[2] Demand for primary care continues to grow with aging populations and a rise in chronic disease prevalence, illustrating that stagnant and declining investment is increasingly misaligned with population health needs.[2]

Meanwhile, the presence of more primary care providers in communities contributes to better health outcomes and lower health system costs. A 2022 study found that an increase of one primary care physician per 10,000 people contributes to 5.5 percent fewer hospital visits, 11 percent fewer emergency department visits and 7 percent fewer surgeries.[8]

In addition to contributing to powerful health transformation for Arkansas communities, investing in primary care can be an economic development strategy. Primary care clinics are

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[2] National Academies of Science, Engineering and Medicine. (2021). Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care.
[3] Ibid.
[4] Primary Care Collaborative. (2020). Primary Care Spending: High Stakes, Low Investment.
[5] Milbank Memorial Fund. (2025). The Health of US Primary Care: 2025 Scorecard Report — The Cost of Neglect.
[6] The Commonwealth Fund. (2022). Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System.
[7] Ibid.
[8] Primary Care Development Corporation. (2022). Investing in Primary Care: The Pathway to Better Health and Equity in the United States.

often small businesses rooted in their communities, who hire locally and generate tax revenues that support schools, infrastructure, and other public services. An economic impact analysis commissioned by the American Medical Association found that, in 2015, primary care physicians in Arkansas supported 28,843 jobs, generated $387 million in total economic output, contributed $1.85 billion in wages and benefits, and produced an estimated $147 million in state and local tax revenues.[9]

As Arkansas competes to attract and retain employers, a strong, affordable primary care system is a critical asset. Employers increasingly factor health care costs, workforce health, and access to local clinicians into decisions about where to locate and expand. For Arkansas communities, a well-resourced primary care system contributes to stronger small-business ecosystems while also improving the health and longevity of residents.

In recognition of primary care's fundamental role to the health care system, states have increasingly focused on primary care payment reform in recent years as a lever for improving health outcomes and affordability. With the creation of the Working Group and this inaugural report, Arkansas joins the growing national movement toward increasing state-level spending on primary care across payers.

More than 20 states have attempted a measure to meaningfully increase primary care investment.[10] Common strategies include legislating increased spending in accordance with a target benchmark, regularly reporting primary care spending as a proportion of total medical expenditures, and convening state-led task forces to study the issue and make recommendations.[11]

Early analyses of these efforts have found that states spending more on primary care tend to have lower rates of hospitalization and emergency department visits.[12] Increased primary care spending has also been associated with improved clinical quality and patient experience, and decreased utilization and costs.[13] And some states have seen direct correlation between increased primary care spending and lower costs to the health system. For example, when evaluating its Patient-Centered Primary Care Home program, Oregon found that every dollar invested in primary care resulted in $13 in savings for other health care services such as specialty care, emergency department services and inpatient care.[14]

Measurement and transparency are important components of meaningfully increasing primary care spending.[15] Multiple states have developed primary care scorecards to regularly monitor and report on primary care performance, access, workforce, and investment. These states include Massachusetts, Virginia, New York and, most recently announced, California.[16]

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[9] American Medical Association. (2018). The Economic Impact of Physicians in Arkansas.
[10] Primary Care Collaborative. State Primary Care Investment Initiatives.
[11] California Health Care Foundation. (2022). Investing in Primary Care: Lessons from State-Based Efforts.
[12] Primary Care Collaborative. (2019). Investing in Primary Care: A State-Level Analysis.
[13] CHCF. (2022). Investing in Primary Care: Why It Matters for Californians with Commercial Coverage.
[14] Oregon Health Authority. (2016). Implementation of Oregon's PCPH Program: Exemplary Practice and Program Findings.
[15] American Academy of Family Physicians (AAFP). (2022). AAFP Primary Care Investment Toolkit.
[16] California Department of Health Care Access and Information (HCAI). (2026). Introducing the HCAI Health of Primary Care in California Annual Snapshot.

Efforts to strengthen primary care investments are also increasingly incorporating alternative payment models, including non-claims, value-based payments, as a means of ensuring increased investments are directed toward the highest-quality care.[17]

By joining this national movement, Arkansas is emerging as an early leader among Southeast states. North Carolina convened a Primary Care Payment Reform Task Force to assess the performance of the primary care system in 2023, and Oklahoma established a primary care spending target for Medicaid in 2022.[18,19] Through this report, Arkansas will become the first Southeast state to evaluate primary care spending across payers and establish a multi-payer target.

The Working Group holds a vision for stronger primary care in Arkansas, supported by increased investments: better access to care and health outcomes for patients, a stronger primary care workforce enabled by provider choice for primary care practices, and an increased emphasis on and commitment to value-based contracting from payers.

ASSESSING THE ARKANSAS PRIMARY CARE DELIVERY SYSTEM

Arkansas approaches primary care payment reform from a challenging baseline. National scorecards consistently place Arkansas near the bottom on overall health system performance and on measures closely tied to the strength of primary care, including access, workforce capacity, and preventable health outcomes.[20] The experience of Arkansas clinicians, who are overburdened and under-resourced, and patients, who experience significant chronic disease burden and persistent access gaps, illustrate the consequences of underinvestment.

Table 1. Arkansas Health System Performance Compared to National Average

Category	Arkansas	National Average
Adults who went without care because of cost[21]	15.4%	12.4%
Uninsured adults[21]	13%	11.3%
Adults who are obese[21]	41.5%	34.3%
Adults reporting diabetes diagnosis[22]	15.3%	12.5%
Heart disease death rate per 100,000[23]	218.8	162.1

[17] Brown, S. et al. (2025). State Investments in Primary Care—5 Early Leaders of a Potential Policy Trend.
[18] North Carolina Department of Health and Human Services. (n.d.) Primary Care Payment Task Force.
[19] Foubister, V. Milbank Memorial Fund. (2025). Five States Leading Efforts to Increase Primary Care Spending.
[20] Lyon, J. (2026). Arkansas Center for Health Improvement. Arkansas Falls One Spot in 2025 America's Health Rankings.
[21] The Commonwealth Fund. (2025). Health System Data Center: Arkansas.
[22] Kaiser Family Foundation. (2024). State Health Facts: Adults Who Report Ever Being Told by a Doctor They Have Diabetes.
[23] Kaiser Family Foundation. (2023). State Health Facts: Total Heart Disease Deaths.

Access

Arkansas patients face greater barriers to accessing care than residents of many other states, with 13 percent of Arkansas adults being uninsured and 15.4 percent of Arkansas adults reporting going without needed care because of cost.[21]

When examining geographic and financial barriers, there are additional gaps — more than one-third of Arkansas residents live in health professional shortage areas, and in 2020 six Arkansas counties had only one full-time primary care physician. These shortages are closely associated with higher rates of preventable emergency department use and delays in diagnosis and treatment, particularly in rural areas.

There has been incremental progress in improving access to care for Arkansas patients across the past several years, with recent years seeing the share of adults going without care due to cost declining from 16 percent to 14 percent, and children without a medical preventive visit in the past year decreasing from 44 percent to 36 percent.[24] However, these improvements coexist with rising out-of-pocket costs for some populations and persistent gaps in preventive services.

Workforce

The Arkansas primary care workforce experiences challenges with supply, distribution and practice patterns, along with struggles to maintain a strong pipeline for new practitioners. In 2022, Arkansas had 2,816 active primary care physicians, or 9.4 per 10,000 residents.[25] Additionally, 26 percent of full-time primary care physicians were age 60 or older, raising concerns about near-term retirements and future supply to meet growing demand.[15]

Using a broader definition that includes nurse practitioners and physician assistants, in addition to physicians, Arkansas has 251.1 primary care providers per 100,000 population, compared to a national average of 291.4, placing Arkansas 43rd among states.[26] And particularly for independent primary care practices serving rural communities, recruiting and retaining these additional care team members is a challenge when those clinicians could be paid more in another specialty or other areas of the state.

The Working Group also identified several issues related to pipeline and retention of the Arkansas primary care workforce, including the need to recruit more medical students and residents into primary care, the importance of training in rural and community settings, and opportunities to better align payment models and practice supports with the longitudinal role of primary care.

This combination of aging full-time clinicians, difficulties staffing a comprehensive care team, and geographic maldistribution, create a fragile primary care infrastructure, particularly in rural communities.

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[24] Lyon, J. (2025). Arkansas Center for Health Improvement. Arkansas Ranks 48th in Health System Performance Scorecard.
[25] Arkansas Center for Health Improvement. (2025). Arkansas Primary Care Physician Workforce Dashboard.
[26] America's Health Rankings. (2025). Primary Care Providers in Arkansas.

Health Outcomes

Arkansas is consistently ranked near the bottom of all states in national health system evaluations, with most recent reports placing the state at 48th and 49th place.[26,27] Arkansas patients experience rates of diabetes, hypertension, and heart disease well above national metrics, and these poor health outcomes are strongly linked to primary care capacity and access.

These clinical patterns emerge in the delivery system as more frequent avoidable hospitalizations and emergency department visits, shorter life expectancy, and persistent gaps in outcomes between rural and urban communities and across population groups.

Primary care can play a central role in addressing these challenges, by providing comprehensive and coordinated care, managing chronic conditions and behavioral health needs, and supporting preventive care and early intervention, especially for high-need populations like those living in rural areas of the state. However, current data suggest that the primary care system in Arkansas needs stronger support in order to consistently prevent progressions of chronic disease, reduce avoidable utilization, or close long-standing equity gaps.

Value-Based Payment and Care Quality

Recognizing its health system constraints, Arkansas has made significant commitments to advancing value-based payment models designed to align payment for primary care services with quality of those services and health outcomes for patient populations served by participating providers.

In 2012, Arkansas was selected as one of the seven regions to participate in the Centers for Medicare and Medicaid Services Comprehensive Primary Care (CPC) model and in 2016 it became one of 14 regions for the CPC Plus (CPC+) model.[28] The original CPC program brought an estimated $50 million to support 69 Arkansas practices, which documented reductions in hospitalizations and net savings for Medicare beneficiaries.[29]

CPC+ expanded this work and by 2018, 182 Arkansas practices and 689 primary care clinicians were participating, serving almost 750,000 patients statewide. It is estimated that roughly $90 million in CPC+ payments, which include care management fees, performance-based initiatives, and comprehensive primary care payments, were made to Arkansas providers in 2017 and 2018 alone.[29,30]

These models supported practice-wide adoption of team-based care models and population health management, and were consistently associated with reductions in acute care spending and emergency department use. Arkansas clinicians participating in these models have described using such resources to hire care managers, enhance transitions-of-care, improve chronic disease management and preventive care in their practices, and spend more time with

[27] America's Health Rankings. (2026). 2025 Annual Report.
[28] Motley, M. (2017). Arkansas Center for Health Improvement. Comprehensive Primary Care Plus (CPC+) Fact Sheet.
[29] Ibid.
[30] Motley, M. (2019). Arkansas Center for Health Improvement. Report: Arkansas Health Care Payment Improvement Initiative Improving Quality, Efficiency.

patients. Both models were time-bound, federal demonstrations that are no longer active, but the lessons from these successful demonstrations continue to be incorporated into approaches for payment reform.

Arkansas' history with these and other models, such as the Patient-Centered Medical Home program, demonstrate that when primary care is supported through stable, value-based payments, primary care clinics can deliver more accessible, coordinated, and data-driven care. Alternative payment models can be an effective lever for strengthening investments in primary care,[31] and as such were a central theme of Working Group discussion.

EVALUATING ARKANSAS PRIMARY CARE SPENDING

Definition of Primary Care

When exploring its preliminary task of establishing a primary care definition as a basis for measuring and reporting spending, the Working Group looked to national frameworks and best practices. Conceptually, the Working Group sought to align with the four fundamental pillars (or four C's) of primary care practice as established by national researcher and pediatrician Barbara Starfield in 1992.[32] This seminal model of primary care delivery includes care that is first-contact, continuous, comprehensive, and coordinated.

To translate this foundational concept into measurable definitions, national leaders have established a broad and narrow definition framework across provider specialties, places of service, and service types.[33] The Working Group consulted this framework, which has been repeatedly used by national and state-level stakeholders to define, measure, and report primary care spending, when creating the Arkansas definition. The Working Group also considered several existing state definitions of primary care, most notably the one proposed by the North Carolina Primary Care Payment Reform Task Force in 2024.[34]

Working Group members adopted a definition that incorporated both broader elements, such as including Nurse Practitioners and Physician Assistants, and narrow elements, like excluding obstetrics and gynecology (OBGYN) providers. See Appendices 2 and 3 for a comprehensive list of provider taxonomy and service codes adopted by the Working Group.

Table 2. Arkansas Primary Care Definition Summary

Provider Type	Service Type
• General Medicine • Family Medicine • Internal Medicine • Pediatric Medicine • Geriatric Medicine • Nurse Practitioner • Physician Assistant	• Preventive care services, including vaccine administration • Evaluation and Management (E&M) services • Telehealth and remote services • Chronic disease and care management services • Others, including behavioral health services

[31] Mostashari, F. Milbank Memorial Fund. (2025). The Pathway to Primary Care Investment is Bolstered by Accountable Care.
[32] Starfield, B. (1992). Primary Care: Concept, Evaluation, and Policy.
[33] Milbank Memorial Fund. (2017). Standardizing the Measurement of Commercial Health Plan Primary Care Spending.
[34] North Carolina Department of Health and Human Services. Primary Care Payment Reform Task Force. (2024). https://webservices.ncleg.gov/ViewDocSiteFile/87160

Primary Care Spending

The Working Group applied its adopted definition of primary care to collect claims and non-claims data on primary care spending as a proportion of total medical expenditures.

These data represent an important baseline for understanding primary care investment in Arkansas. Analysis found that current statewide averages are well below the levels that many states and international peers are already achieving, with the Arkansas primary care system accounting for only a modest share of overall health care expenditures despite being the front door to the health system and the central point of most patient interactions.

Methodology

The Arkansas Insurance Department (AID) issued a standardized data request to insurance companies via a publicly available bulletin to collect claims and non-claims spending data for 2022 and 2023, in alignment with service and provider taxonomy codes in the adopted primary care definition. Submissions were received from nine payers. Primary care spending estimates are based on self-reported data submitted by these payers through a common template.

Reported data were analyzed to calculate the total primary care spend and total medical spend for each payer. A weighted average was applied, based on total medical spend, to determine the average percentage of primary care spending in Arkansas.

Self-Reported Data

The Working Group opted to rely on self-reported data collected by AID instead of data via the Arkansas All-Payer Claims Database (APCD) for three central reasons. First, the APCD currently captures claims data only and does not yet systematically capture the full range of non-claims payments that are central to innovative primary care financing. Because the Working Group wanted a comprehensive view of both claims and non-claims investment in primary care, direct reporting from payers was necessary. Second, using payer self-reports allowed the Working Group to align definitions and methods in real time and to resolve questions about how payment arrangements should be classified. Third, turning raw data from the APCD into digestible information requires time and analytical capacity not presently available to the Working Group. In the future, additional resources to support more comprehensive analysis would be beneficial.

The expectation for the APCD in the future is that it will continue to evolve to incorporate non-claims payment fields and more robust data submission requirements, consistent with national best practices for measuring primary care investment. Active efforts are in progress to update the capabilities of the APCD to report on non-claims data and as these enhancements are implemented, the state will be able to validate and refine the self-reported figures in this report using APCD-derived measures and, over time, transition toward a more fully APCD-based approach while preserving the ability to measure non-claims investments.

Claims Payments

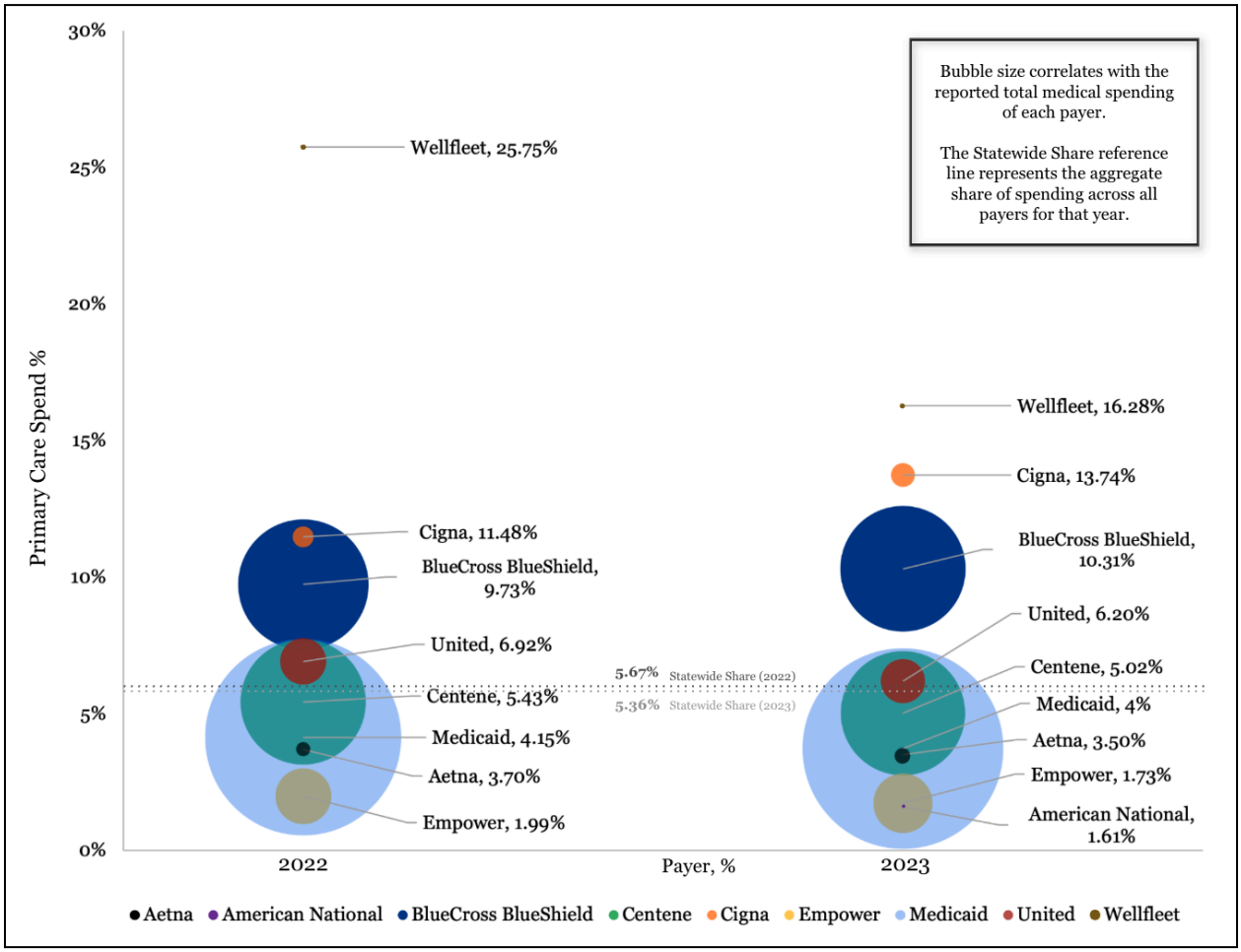
Using the adopted definition of primary care, The Working Group collected fee-for-service, or claims-based, payment data across more than 250 service codes defined by the identified list of

provider types (see Appendix B for the full list of provider taxonomy codes and Appendix C for the full list of service codes).

Non-Claims Payments

Recognizing the important role of non-claims payments in advancing high-quality care delivery, the Working Group also collected spending data on non-claims payments paid to primary care providers. These included primary care capitation payments, primary care incentive programs, care management payments for primary care, and net risk settlements to support primary care, compared to total spending for non-claims payments.

Chart 1. Reported Primary Care Spending as a Share of Total Medical Spending by Payer



Note: American National submitted no spending data for 2022.

Findings

Reported primary care spending ranged from 1.99 percent to 25.75 percent in 2022 and 1.61 percent to 16.28 percent in 2023. When applying a weighted average by each payer's total medical spending, the average spending on primary care was **5.67 percent in 2022** and **5.36 percent in 2023.** These figures are in alignment with national estimates of primary care spending in Arkansas.[35]

[35] The Commonwealth Fund. State Health Data Center: Arkansas.

Table 3. Reported Total Medical Expenditures and Primary Care Spending

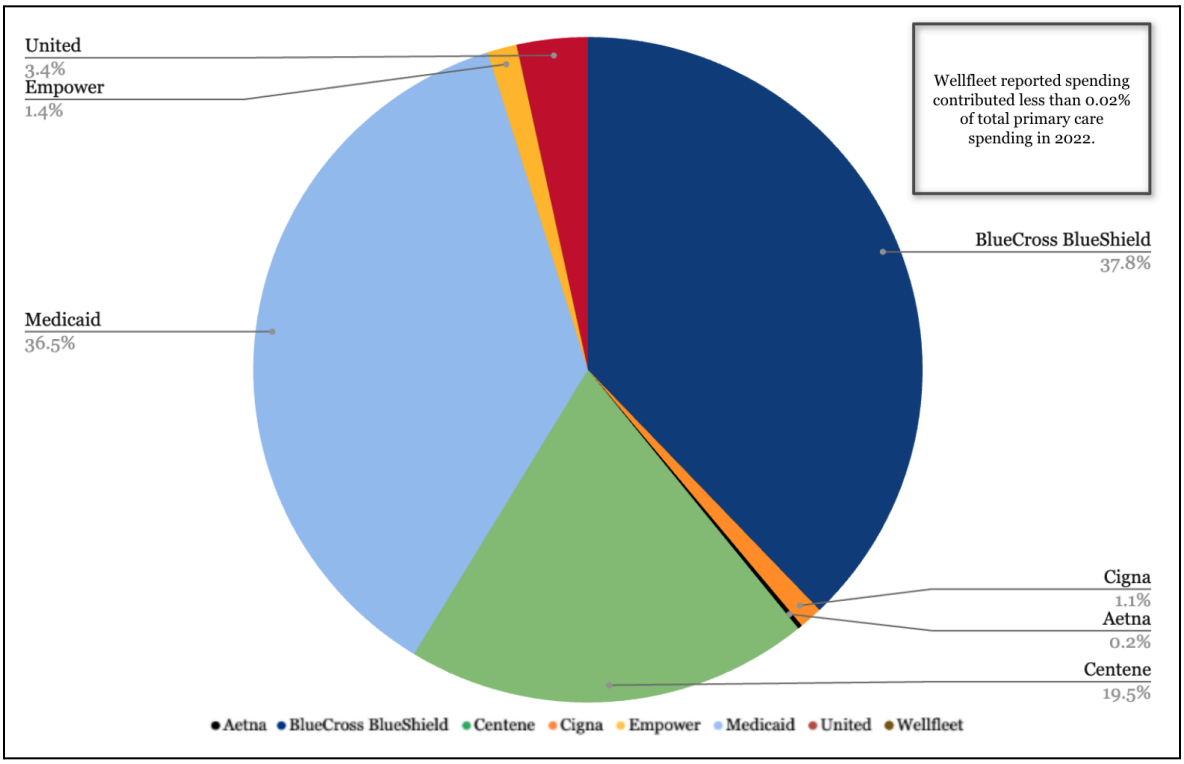
Payer	**Total Medical Expenditures (TME)**		**Primary Care Spending as Share of TME**	
	2022	**2023**	**2022**	**2023**
Aetna	$23,849,845	$26,230,017	3.70%	3.50%
American National	*Not reported*	$91,319	*Not reported*	1.61%
BlueCross BlueShield	$1,613,081,109	$1,495,357,076	9.73%	10.31%
Centene	$1,491,051,954	$1,476,258,407	5.43%	5.02%
Cigna	$40,828,757	$53,109,238	11.48%	13.74%
Empower	$295,977,824	$336,441,302	1.99%	1.73%
Medicaid	$3,649,867,895	$3,826,854,752	4.15%	4%
United	$204,684,542	$185,506,044	6.92%	6.20%
Wellfleet	$245,958	$428,737	25.75%	16.28%

Payers reported more than **$400 million in total spending on primary care in 2022** and over **$385 million in total spending on primary care in 2023**. When examining the total being spent each year on primary care in Arkansas, BlueCross BlueShield and Medicaid emerged as the greatest contributors to overall primary care spending, with Centene, United and other payers trailing considerably behind (see Charts 2 and 3).

The wide range across payers suggests significant variation in how payers contract for and support primary care. It also highlights several contextual factors that are important to consider. For example, Wellfleet, who reported the highest proportion of primary care spending (25.75% in 2022 and 16.28% in 2023), insures students in Arkansas, who generally receive most care from primary care providers and contribute little to total health care costs (less than 0.01%). Additionally, Medicaid, who reported lower percentages of primary care spend (4.15% in 2022 and 4% in 2023), supports many high-needs populations who rely significantly on primary care, but also on more costly downstream care that increases total overall expenditures.

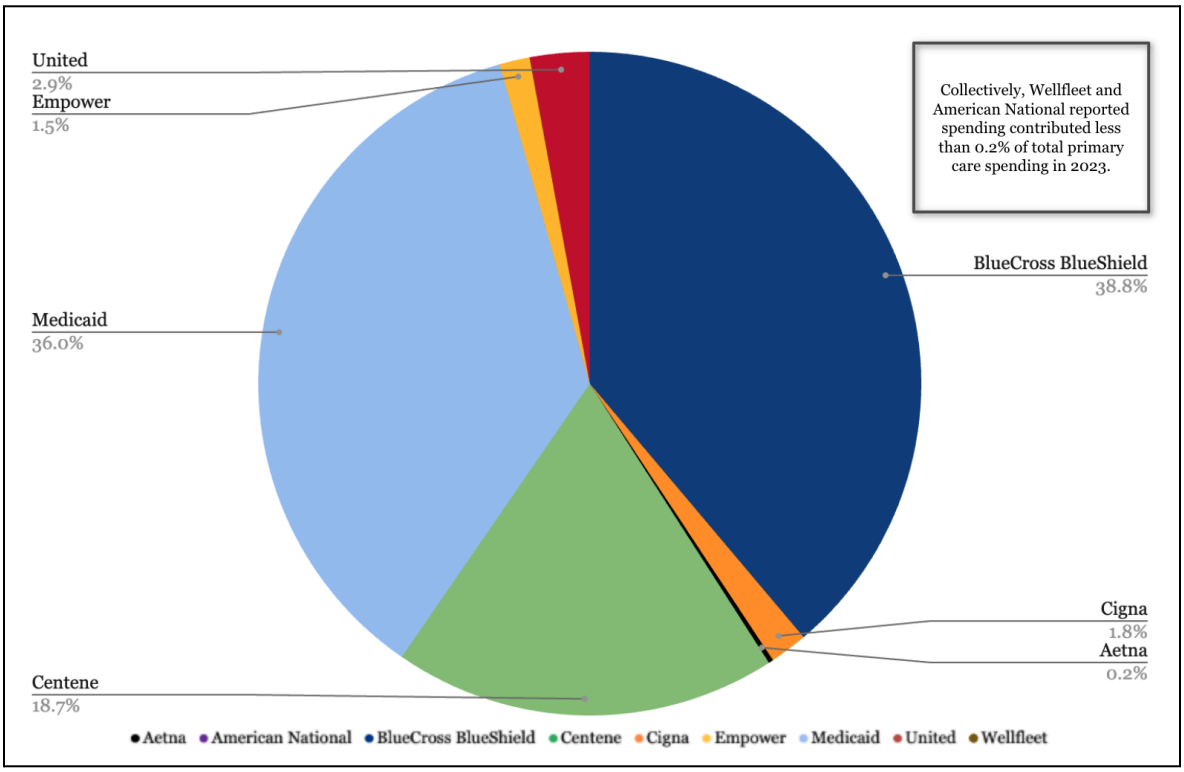
It is also important to interpret these findings in light of limitations. The analysis spans only two years across nine reporting payers, and one of these payers (American National) had no data to report in 2022. Additionally, while the Working Group standardized definitions, payers differ in how mature their reporting capabilities are, particularly for non-claims payments. These factors suggest that figures in this report should be considered best-available estimates and a strong baseline for ongoing refinement in methodology in data collection.

Chart 2. Share of Total Statewide Primary Care Spending by Payer, 2022



Note: American National submitted no spending data for 2022.

Chart 3. Share of Total Statewide Primary Care Spending by Payer, 2023



The Working Group also chose not to report per-member-per-month (PMPM) spending on primary care as there were inconsistencies with how member months were calculated and reported. Ability to access unified data systems, such as the Arkansas All-Payer Claims Database (APCD), would aid the Working Group in future reporting by ensuring consistent, reliable, and reportable data.

As non-claims payments become incorporated into the APCD, analyses using APCD data will allow Arkansas to independently verify spending patterns, better understand the drivers behind reported primary care shares, and distinguish any strategic contributions to primary care spending. These developments may also present the opportunity for the Working Group to utilize APCD data to understand not only primary care spending itself, but how this spending is connected to improved access to care, better health outcomes, reduced utilization, and lower health care costs for Arkansas patients.

The Working Group also anticipates that payers that are deeply engaged in well-designed value-based care and medical home programs, and therefore making significant care management and infrastructure investments in primary care, will be more likely to report higher primary care spending shares than payers that rely primarily on fee-for-service payments.

With future measurement and reporting on primary care spending in Arkansas, the Working Group will consider reporting the Provider-led Arkansas Shared Savings Entity (PASSE) program separately. The PASSE program plays a distinct role in both care delivery and health care spending for Medicaid beneficiaries with complex behavioral health needs and intellectual and developmental disabilities. PASSEs receive capitated payments that cover the full range of medical services, including primary care as well as specialty care, behavioral health, long-term services and supports, and care coordination.

Because of this payment structure, primary care spending for PASSE populations is not easily separable from other services at the payment level. In this analysis, two payers PASSE submitted data, Empower (a PASSE entity) and Medicaid (which included PASSE spending). In future reports, the Working Group may consider reporting PASSE data separately in order to ensure the most accurate and consistent picture of statewide primary care spending.

Despite limitations, the analysis clearly demonstrates that Arkansas invests too little of its health care dollars in primary care. The slight decline in the statewide spending share between 2022 and 2023, if sustained, would move the state farther away from the levels of primary care investment associated with stronger health system performance. This baseline therefore reinforces the importance of establishing a clear spending target, a minimum floor, enforcement mechanisms, and a sustainable measurement and reporting infrastructure to enable future increases in primary care investment to be monitored, evaluated, and linked to concrete improvements in the health of Arkansans.

RECOMMENDATIONS

Adopt a 12 percent primary care spending target, to be reached in annual one percent benchmark increases, and a minimum spending target of 5 percent across all payers.

Adopting a 12 percent primary care spending target more closely aligned with other states would move Arkansas significantly closer to levels of primary care investment associated with stronger health system performance, while recognizing the time and resources needed for payers to adjust. The Working Group recommends that this target be pursued through annual one percent increases in primary care's total share of medical expenditures, allowing for gradual implementation and ongoing evaluation of impact. Because there is such variety in reported primary care spending across payers, the Working Group also recommends establishing a minimum primary care spending floor of 5 percent for all payers. This will help payers that are currently reporting below 5 percent to reach that baseline before moving toward the 12 percent overall target.

When implementing these targets, the **Working Group recommends incorporating clear enforcement and accountability tools** to ensure consistent progress. Drawing on approaches used in other states,[36] the legislature could direct the Arkansas Insurance Department, in consultation with the Working Group, to:

- Tie target compliance to the annual rate review and approval process, making complete and accurate primary care spend reporting a condition of having rate filings deemed complete and eligible for approval.
- Require corrective action plans from carriers that fall below the target or fail to demonstrate reasonable year-over-year improvement, including concrete steps and timelines for increasing meaningful primary care investments. This builds upon the existing authority established in Act 483, which specifies that entities failing to meet targets recommended by the Working Group may be called upon to "appear before the Legislative Council" with updates on progress.
- Authorize administrative remedies for noncompliance, in the event of any insurers repeatedly failing to report and make progress toward the target benchmarks.

Expand the scope, responsibilities, and capabilities of the Working Group, including funding for ongoing, comprehensive data analysis.

To sustain progress beyond this inaugural report, the Working Group will require an ongoing mandate and dedicated resources. The Working Group recommends that the legislature formally extend and broaden its charge to include a) continued measurement and public reporting of primary care spending across payers, b) monitoring of progress toward the 12 percent target, and c) assessment of impact on increased primary care spending with primary care access, workforce, outcomes and health system costs.

[36] American Academy of Family Physicians. (2023). AAFP Primary Care Investment Toolkit.

With adequate resources, the Working Group could:

- Develop an interactive Arkansas Primary Care Scorecard, to be updated annually, that would track key indicators of access, quality, affordability, and investment. Securing capacity to analyze raw data from the Arkansas All-Payer Claims Database could support consistent and reliable data to report on an annual basis.
- Monitor progress toward the investment target across payers and report on how increased spending is correlated with care quality and health outcomes.
- Establish structures and reporting mechanisms to ensure increased investments are meaningfully distributed to primary care clinics across the state, in order to drive the most impact for population health and cost savings.

Leverage the Rural Health Transformation Program (RHTP) to strengthen primary care.

Through this program designed to improve statewide rural health care delivery, Arkansas was awarded $209 million in 2026 and will be awarded ongoing annual funding through September 2031. These funds could be used to:

- Strengthen the primary care clinician pipeline through loan repayment, scholarship, and residency programs targeted to primary care clinicians in rural, underserved areas.
- Support value-based payment model adoption by testing new, state-focused models that build on past success.
- Expand use of telehealth in primary care through supports for technological infrastructure and innovation, including broadband improvement.

Together, these recommendations provide a practical roadmap for strengthening primary care in Arkansas. By setting an ambitious but achievable spending target, ensuring the Working Group has the resources and scope to continue success, and leveraging federal and state policy opportunities to support workforce and delivery system transformation, Arkansas can move from a position of chronic underinvestment to becoming a primary care system that is adequately resourced, more resilient, and better able to improve health outcomes for all Arkansans. Continued collaboration among clinicians, payers, state agencies and community partners will be essential to realizing this vision and to ensuring that increased primary care investment translates into measurable improvements in health care access, affordability, and quality.

APPENDICES

Appendix A. Working Group Members

Role	Appointed by	Member
Practicing primary care physician*	President Pro Tempore of the Senate	Lonnie Robinson, MD, FAAFP ***Working Group Chair***
Practicing primary care physician	Speaker of the House of Representatives	Jason Merrick, MD
Pediatrician representative of the primary care community	Speaker of the House of Representatives	Tony Johnson, MD
Advanced practice registered nurse representative of the primary care community	President Pro Tempore of the Senate	Neil Langer, DNP, APRN
Primary care physician employed by or primary practicing in a federally qualified health center	President Pro Tempore of the Senate	Gary Berner, MD
Designee of the Department of Human Services (DHS)	DHS Secretary	Larry "David" Ballard
Designee of the Arkansas Insurance Department (AID)	Insurance Commissioner	Crystal Phelps, JD
Representative of the Arkansas Center for Health Improvement (ACHI)	ACHI	Craig Wilson, JD
Representative of the Arkansas community health insurance community from an Arkansas-based insurer (Cigna)	Speaker of the House of Representatives	Eric Moxley
Other meeting participants and invaluable contributors included the Arkansas Chapter of the American Academy of Family Physicians, the Arkansas Chapter of the American Academy of Pediatrics, Arkansas Blue Cross and Blue Shield, primary care clinicians and care team members from across the state, and Aledade.		

Appendix B. Primary Care Provider Taxonomy Codes as Established in Primary Care Definition

Code	Provider Type
1	General Practice
8	Family Practice
11	Internal Medicine
37	Pediatric Medicine
38	Geriatric Medicine
50	Nurse Practitioner
97	Physician Assistant

Appendix C. Primary Care Service Codes as Established in Primary Care Definition
Includes Healthcare Common Procedure Coding System (HCPCS) codes and Current Procedural Terminology (CPT) codes.

Code	Description
10060	I.D. Of Abscess, Simple Or Single
10061	I.D. Of Abscess, Complicated Or Multiple
10120	Removal Of Foreign Body, Other
11055	Paring Or Cutting, Single Corn Or Callus
11056	Paring Or Cutting, 2–4 Corns Or Callus
11300	Shave Biopsy Trunk <0.5 Cm
11301	Shave Biopsy Trunk 0.6–1 Cm
11302	Shave Biopsy Trunk 1.1–2 Cm
11303	Shave Biopsy Trunk >2 Cm
11306	Shave Biopsy Scalp, Neck, 0.6–1 Cm
11307	Shave Biopsy Scalp, Neck, 1.1–2 Cm
11308	Shave Biopsy Scalp, Neck, >2 Cm
11400	Excision Of Lesion Trunk <0.5 Cm
11401	Excision Of Lesion Trunk 0.6–1 Cm
11402	Excision Of Lesion Trunk 1–2 Cm
11403	Excision Of Lesion Trunk 2.1–3.0 Cm
11404	Excision Of Lesion Trunk 3.1–4.0 Cm
11406	Excision Of Lesion Trunk >4.0 Cm
11420	Excision Of Lesion H, F, N, Sp <0.5 Cm
11421	Excision Of Lesion H, F, N, Sp 0.6–1 Cm
11422	Excision Of Lesion H, F, N, Sp 1–2 Cm
11440	Excision Of Lesion Face <0.5 Cm
11441	Excision Of Lesion Face 0.6–1 Cm
11442	Excision Of Lesion Face 1–2 Cm
11719	Trim Nails
11730	Nail Avulsion
11750	Removal Of Nail Bed (Matrixectomy)
11981	Insertion Of Drug Delivery Implant
11982	Removal Of Drug Delivery Implant
11983	Removal And Re-Insertion Of Nexplanon
12001	Laceration Repair ≤2.5 Cm
12002	Laceration Repair 2.6–7.5 Cm

12004	Laceration Repair 7.6–12.5 Cm
12005	Laceration Repair 12.6–20 Cm
12006	Laceration Repair 20.1–30 Cm
12007	Laceration Repair >30 Cm
12011	Laceration Repair ≤2.5 Cm
12013	Laceration Repair 2.6–5.0 Cm
12014	Laceration Repair 5.1–7.5 Cm
12015	Laceration Repair 7.6–12.5 Cm
12016	Laceration Repair 12.6–20 Cm
12017	Laceration Repair 20.1–30 Cm
12018	Laceration Repair >30 Cm
15853	Removal Of Sutures Or Staples (Placed By Outside Provider)
15854	Removal Of Sutures And Staples (Placed By Outside Provider)
17000	Cryo Single Lesion
17003	Cryo Multiple Lesions (2–14)
20526	Carpal Tunnel Injection
20551	Tendon Injection
20552	Trigger Point Injection (1 Or 2)
20600	Drain Joint/Bursa
20600	Injection, Small Joint (E.G., Toes)
20605	Aspiration Of Joint
20610	Injection, Large Joint (E.G., Hip)
24600	Treatment Of Elbow Dislocation
24650	Treatment Of Shoulder Dislocation
30300	Removal Of Foreign Body, Nose
51701	In/Out Catheterization
51702	Insertion Of Foley Catheter (Indwelling)
57150	Vaginal Irrigation
57160	Pessary Fitting And Insertion
58300	Insertion Of Intrauterine Device (Iud)
58301	Removal Of Intrauterine Device (Iud)
65205	Removal Of Foreign Body, Eye
69200	Removal Of Foreign Body, Ear
69209	Ear Irrigation/Lavage (Unilateral Or Bilateral, No Instrumentation)
69210	Ear Wax Removal (Unilateral Or Bilateral, With Instrument)
90460	Immunization Administration Through 18 Years Of Age Via Any Route Of Administration, With Counseling By Physician Or Other Qualified Health Care Professional
90461	Each Additional Vaccine/Toxoid Component Administered
90465	Administration Of Initial/Single Vaccine Age < 8 Years
90466	Administration Of Additional Vaccine Age < 8 Years
90467	Administration Of Initial/Single Oral/Intranasal Vaccine < 8 Years
90468	Administration Of Oral/Intranasal Vaccine < 8 Years
90470	Administration Of H1n1 Vaccine
90471	Immunization Administration
90472	Immunization Administration
90473	Immunization Administration By Intranasal Or Oral Route
90474	Administration Of Nasal Or Oral Vaccine
90656	Vaccine For Influenza For Administration Into Muscle
90658	Vaccine For Influenza For Administration Into Muscle
90661	Vaccine For Influenza For Administration Into Muscle
90662	Vaccine For Influenza For Injection Into Muscle, Split Virus
90670	Pneumococcal Vaccine For Injection Into Muscle
90686	Vaccine For Influenza For Administration Into Muscle
90688	Vaccine For Influenza For Administration Into Muscle
90732	Vaccine For Pneumococcal Polysaccharide For Injection Beneath The Skin Or Into Muscle, Patient 2 Years Or Older
90750	Vaccine For Shingles For Injection Into Muscle
93000	Ecg Record And Interpret
93005	Ecg Record Only

93010	Ecg Interpret Only
93225	Holter Monitor Hook Up (0–48 Hours)
93227	Holter Monitor Interpretation (0–48 Hours)
93242	Holter Monitor Hook Up (3–7 Days)
93244	Holter Monitor Interpretation (3–7 Days)
93246	Holter Monitor Hook Up (Greater Than 8 Days)
93248	Holter Monitor Interpretation (Greater Than 8 Days)
93270	Event Monitor Hook Up
93272	Event Monitor Interpretation
94010	Spirometry
94060	Spirometry (Pre And Post Bronchodilation)
94640	Nebulizer Treatment, Multiple
94640	Nebulizer Treatment, Single
96110	Developmental Screen W/ Scoring & Documentation
96127	Brief Emotional/Behavioral Assessment
96160	Administration And Interpretation Of Patient-Focused Health Risk Assessment
96161	Administration And Interpretation Of Caregiver-Focused Health Risk Assessment
96360	Iv Hydration (Initial 31 Min–1 Hr)
96361	Iv Hydration (Additional Hour)
96372	Injection Beneath The Skin Or Into Muscle For Therapy, Diagnosis, Or Prevention
96523	Port Flush
98008	Audio Only Visit
98009	Audio Only Visit
98010	Audio Only Visit
98011	Audio Only Visit
98012	Audio Only Visit
98013	Audio Only Visit
98014	Audio Only Visit
98015	Audio Only Visit
98016	Tech-Based Check In
98966	Telephone Assessment And Management Service, 5-10 Minutes Of Medical Discussion
98967	Telephone Assessment And Management Service, 11-20 Minutes Of Medical Discussion
98968	Telephone Assessment And Management Service, 21-30 Minutes Of Medical Discussion
98969	Internet Or Similar Electronic Online Patient Assessment And Management Service
99078	Physician Educational Services Provided In A Group Setting
99172	Visual Acuity
99173	Eye Chart Testing Of Visual Acuity Of Both Eyes
99202	New Patient Outpatient Visit, Total Time 15-29 Minutes
99203	New Patient Outpatient Visit, Total Time 30-44 Minutes
99204	New Patient Outpatient Visit, Total Time 45-59 Minutes
99205	New Patient Outpatient Visit, Total Time 60-74 Minutes
99211	Established Patient Outpatient Visit, Minimal Presenting Problem
99212	Established Patient Outpatient Visit, Total Time 10-19 Minutes
99213	Established Patient Outpatient Visit, Total Time 20-29 Minutes
99214	Established Patient Outpatient Visit, Total Time 30-39 Minutes
99215	Established Patient Outpatient Visit, Total Time 40-54 Minutes
99324	New Patient Assisted Living Visit, Typically 20 Minutes
99325	New Patient Assisted Living Visit, Typically 30 Minutes
99326	New Patient Assisted Living Visit, Typically 45 Minutes
99327	New Patient Assisted Living Visit, Typically 60 Minutes
99328	New Patient Assisted Living Visit, Typically 75 Minutes
99334	Established Patient Assisted Living Visit, Typically 15 Minutes
99335	Established Patient Assisted Living Visit, Typically 25 Minutes
99336	Established Patient Assisted Living Visit, Typically 40 Minutes
99337	Established Patient Assisted Living Visit, Typically 60 Minutes
99339	Physician Supervision Of Patient Care At Home Or Assisted Living Facility, 15-29 Minutes In One Month
99340	Physician Supervision Of Patient Care At Home Or Assisted Living Facility, 30 Minutes Or More In One Month
99341	New Patient Home Visit, Typically 20 Minutes

99342	New Patient Home Visit, Typically 30 Minutes
99343	New Patient Home Visit, Typically 45 Minutes
99344	New Patient Home Visit, Typically 60 Minutes
99345	New Patient Home Visit, Typically 75 Minutes
99347	Established Patient Home Visit, Typically 15 Minutes
99348	Established Patient Home Visit, Typically 25 Minutes
99349	Established Patient Home Visit, Typically 40 Minutes
99350	Established Patient Home Visit, Typically 60 Minutes
99354	Prolonged Outpatient Service, First Hour
99355	Prolonged Outpatient Service, Each Additional 30 Minutes
99358	Prolonged Patient Service Without Direct Patient Contact First Hour
99359	Prolonged Patient Service Without Direct Patient Contact Each 30 Minutes Beyond First Hour
99381	Initial New Patient Preventive Medicine Evaluation Infant Younger Than 1 Year
99382	Initial New Patient Preventive Medicine Evaluation, Age 1 Through 4 Years
99383	Initial New Patient Preventive Medicine Evaluation, Age 5 Through 11 Years
99384	Initial New Patient Preventive Medicine Evaluation, Age 12 Through 17 Years
99385	Initial New Patient Preventive Medicine Evaluation Age 18-39 Years
99386	Initial New Patient Preventive Medicine Evaluation Age 40-64 Years
99387	Initial New Patient Preventive Medicine Evaluation, Age 65 Years And Older
99391	Established Patient Periodic Preventive Medicine Examination Infant Younger Than 1 Year
99392	Established Patient Periodic Preventive Medicine Examination, Age 1 Through 4 Years
99393	Established Patient Periodic Preventive Medicine Examination, Age 5 Through 11 Years
99394	Established Patient Periodic Preventive Medicine Examination, Age 12 Through 17 Years
99395	Established Patient Periodic Preventive Medicine Examination Age 18-39 Years
99396	Established Patient Periodic Preventive Medicine Examination Age 40-64 Years
99397	Established Patient Periodic Preventive Medicine Examination, Age 65 Years And Older
99401	Preventive Medicine Counseling, Approximately 15 Minutes
99402	Preventive Medicine Counseling, Approximately 30 Minutes
99403	Preventive Medicine Counseling, Approximately 45 Minutes
99404	Preventive Medicine Counseling, Approximately 60 Minutes
99406	Smoking And Tobacco Use Intermediate Counseling, Greater Than 3 Minutes Up To 10 Minutes
99407	Smoking And Tobacco Use Intensive Counseling, Greater Than 10 Minutes
99408	Alcohol And/Or Substance Abuse Screening And Intervention, 15-30 Minutes
99409	Alcohol And/Or Substance Abuse Screening And Intervention, Greater Than 30 Minutes
99411	Group Preventive Medicine Counseling, Approximately 30 Minutes
99412	Group Preventive Medicine Counseling, Approximately 60 Minutes
99421	Online Digital Evaluation And Management Service, For An Established Patient, For Up To 7 Days, Cumulative Time During The 7 Days; 5-10 Minutes
99422	Online Digital Evaluation And Management Service, For An Established Patient, For Up To 7 Days, Cumulative Time During The 7 Days; 11-20 Minutes
99423	Online Digital Evaluation And Management Service, For An Established Patient, For Up To 7 Days, Cumulative Time During The 7 Days; 21 Or More Minutes
99429	Preventive Medicine Service
99439	Chronic Care Management Services
99441	Physician Telephone Patient Service, 5-10 Minutes Of Medical Discussion
99442	Physician Telephone Patient Service, 11-20 Minutes Of Medical Discussion
99443	Physician Telephone Patient Service, 21-30 Minutes Of Medical Discussion
99444	Physician Or Health Care Professional Evaluation And Management Of Patient Care By Internet (Email) Related To Visit Within Previous 7 Days
99446	Telephone Or Internet Assessment And Management Service Provided By Consultative Physician With Verbal And Written Report, 5-10 Minutes Of Medical Consultative Discussion And Review
99447	Telephone Or Internet Assessment And Management Service Provided By Consultative Physician With Verbal And Written Report, 11-20 Minutes Of Medical Consultative Discussion And Review
99448	Telephone Or Internet Assessment And Management Service Provided By Consultative Physician With Verbal And Written Report, 21-30 Minutes Of Medical Consultative Discussion And Review
99449	Telephone Or Internet Assessment And Management Service Provided By Consultative Physician, 31 Minutes Or More Of Medical Consultative Discussion And Review
99451	Telephone Or Internet Assessment And Management Service Provided By Consultative Physician With Written Report, 5 Minutes Or More Of Medical Consultative Discussion And Review

99452	Telephone Or Internet Referral Service, 30 Minutes
99453	Remote Monitoring Of Physiologic Parameters, Initial Set-Up And Patient Education On Use Of Equipment
99454	Remote Monitoring Of Physiologic Parameters, Initial Supply Of Devices With Daily Recordings Or Programmed Alerts Transmission, Each 30 Days
99457	Remote Physiologic Monitoring Treatment Management Services, Health Care Professional Time In A Calendar Month Requiring Interactive Communication With The Patient/Caregiver; First 20 Minutes
99458	Remote Physiologic Monitoring Treatment Management Services, Health Care Professional Time In A Calendar Month Requiring Interactive Communication With The Patient/Caregiver; Each Additional 20 Minute
99484	Care Management Services For Behavioral Health Conditions, At Least 20 Minutes Clinical Staff Time
99487	Complex Chronic Care Management Services, First 60 Minutes Clinical Staff Time Per Calendar Month
99489	Complex Chronic Care Management Services, Each Additional 60 Minutes Clinical Staff Time Per Calendar Month
99490	Chronic Care Management Services, First 20 Minutes Of Clinical Staff Time Per Calendar Month
99491	Chronic Care Management Services By Qualified Health Care Professional, 30 Minutes Or More Per Calendar Month
99492	Initial Psychiatric Collaborative Care Management, First 70 Minutes In The First Calendar Month
99493	Subsequent Psychiatric Collaborative Care Management, First 60 Minutes In Subsequent Month Of Behavioral Health Care Manager Activities
99494	Initial Or Subsequent Psychiatric Collaborative Care Management, Additional 30 Minutes In The First Calendar Month
99495	Transitional Care Management Services, Moderately Complexity, Requiring Face-To-Face Visits Within 14 Days Of Discharge
99496	Transitional Care Management Services, Highly Complexity, Requiring Face-To-Face Visits Within 7 Days Of Discharge
99497	Advance Care Planning By The Physician Or Other Qualified Health Care Professional, First 30 Minutes
99498	Advance Care Planning By The Physician Or Other Qualified Health Care Professional, Each Additional 30 Minutes
G0008	Administration Of Influenza Virus Vaccine
G0009	Administration Of Pneumococcal Vaccine
G0010	Administration Of Hepatitis B Vaccine
G0101	Cervical Or Vaginal Cancer Screening; Pelvic And Clinical Breast Examination
G0102	Prostate Cancer Screening; Digital Rectal Examination
G0123	Screening Cytopathology, Cervical Or Vaginal (Any Reporting System), Collected In Preservative Fluid, Automated Thin Layer Preparation, Screening By Cytotechnologist Under Physician Supervision
G0179	Physician Or Allowed Practitioner Re-Certification For Medicare-Covered Home Health Services Under A Home Health Plan Of Care (Patient Not Present), Including Contacts With Home Health Agency And Review Of Reports Of Patient Status Required By Physicians And Allowed Practitioners To Affirm The Initial Implementation Of The Plan Of Care
G0180	Physician Or Allowed Practitioner Certification For Medicare-Covered Home Health Services Under A Home Health Plan Of Care (Patient Not Present), Including Contacts With Home Health Agency And Review Of Reports Of Patient Status Required By Physicians And Allowed Practitioners To Affirm The Initial Implementation Of The Plan Of Care
G0181	Physician Or Allowed Practitioner Supervision Of A Patient Receiving Medicare-Covered Services Provided By A Participating Home Health Agency (Patient Not Present) Requiring Complex And Multidisciplinary Care Modalities Involving Regular Physician Or Allowed Practitioner Development And/Or Revision Of Care Plans
G0182	Physician Supervision Of A Patient Under A Medicare-Approved Hospice
G0396	Alcohol And/Or Substance (Other Than Tobacco) Misuse Structured Assessment, And Brief Intervention 15 To 30 Minutes
G0397	Alcohol And/Or Substance (Other Than Tobacco) Misuse Structured Assessment, And Intervention, Greater Than 30 Minutes
G0402	Initial Preventive Physical Examination; Face-To-Face Visit, Services Limited To New Beneficiary During The First 12 Months Of Medicare Enrollment
G0438	Annual Wellness Visit; Includes A Personalized Prevention Plan Of Service (PPS), Initial Visit
G0439	Annual Wellness Visit, Includes A Personalized Prevention Plan Of Service (PPS), Subsequent Visit
G0442	Annual Alcohol Misuse Screening, 15 Minutes
G0443	Brief Face-To-Face Behavioral Counseling For Alcohol Misuse, 15 Minutes
G0444	Annual Depression Screening, 15 Minutes

G0463	Hospital Outpatient Clinic Visit For Assessment And Management Of A Patient
G0466	Federally Qualified Health Center (Fqhc) Visit, New Patient
G0467	Federally Qualified Health Center (Fqhc) Visit, Established Patient
G0468	Federally Qualified Health Center (Fqhc) Visit, IPPE Or AWV
G0476	Infectious Agent Detection By Nucleic Acid (Dna Or Rna); Human Papillomavirus (Hpv), High-Risk Types For Cervical Cancer Screening, Must Be Performed In Addition To Pap Test
G0506	Comprehensive Assessment Of And Care Planning For Patients Requiring Chronic Care Management Services (List Separately In Addition To Primary Monthly Care Management Service)
G0511	Rural Health Clinic Or Federally Qualified Health Center (Rhc Or Fqhc) Only, General Care Management
G0512	Rural Health Clinic Or Federally Qualified Health Center (Rhc/Fqhc) Only, Psychiatric Collaborative Care Model
G0513	Prolonged Preventive Service(S) (Beyond The Typical Service Time Of The Primary Procedure), In The Office Or Other Outpatient Setting Requiring Direct Patient Contact Beyond The Usual Service; First 30 Minutes (List Separately In Addition To Code For Preventive Service)
G0514	Prolonged Preventive Service(S) (Beyond The Typical Service Time Of The Primary Procedure), In The Office Or Other Outpatient Setting Requiring Direct Patient Contact Beyond The Usual Service; Each Additional 30 Minutes
G2010	Remote Evaluation Of Recorded Video And/Or Images Submitted By An Established Patient
G2064	Comprehensive Care Management Services For A Single High-Risk Disease
G2065	Comprehensive Care Management For A Single High-Risk Disease Services
G2211	Visit Complexity Inherent To Evaluation And Management Associated With Medical Care Services
G8431	Screening For Caregiver Depression
G8482	Influenza Immunization Administered Or Previously Received
G8510	Screening For Caregiver Depression
J1642	Heparin Lock Flush
Q0091	Screening Papanicolaou Smear; Obtaining, Preparing And Conveyance Of Cervical Or Vaginal Smear To Laboratory
S0610	Annual Gynecological Examination, New Patient
S0612	Annual Gynecological Examination, Established Patient
S0613	Annual Gynecological Examination; Clinical Breast Examination Without Pelvic Evaluation
S4981	Insertion Of Levonorgestrel-Releasing Intrauterine System
S9117	Back School, Per Visit
T1015	Clinic Visit/Encounter, All-Inclusive