RHODE ISLAND HEALTH CARE COST GROWTH TARGET

AND

PRIMARY CARE SPEND OBLIGATION

IMPLEMENTATION MANUAL

August 1, 2023

Version History

Version Number	Release Date	Summary of Changes

8	August 1, 2022	• Added Thundermist as ACO/AE ID 108
		• Added Insurer Code 100 (Insurer Overall)
		• Updated primary care site of care definition
		• Made changes to primary care payment codes
		  ○ Added primary care telehealth codes (99421-99423), two office visit E&M codes (99417, G2212), and extended chronic care management visit code (99439)
		  ○ Removed two other codes (99444 and 98969)
		  ○ Updated description of office outpatient visit (99203 – 99205, 99211-215)
		• Revised tab names
		• Revised requirement to report standard deviation instead of variance
		• Added “Total Claims excluded because of Truncation” in ACO/AE tab
		• Clarified inclusion of medical pharmacy rebates in TME submission
		• Revised levels of reporting NCPHI

8.1	August 26, 2022	• Revised Standard Deviation instructions
9	August 1, 2023	• Added details on new “Data Validation” tab in data submission template • Added Appendix I, which describes OHIC’s methodology for risk adjusting TME using age/sex factors • Added new primary care procedure codes (99424 – 99427, 99437), revised description for primary care procedure code (99491)

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Overview

In 2018, the former Governor, the Executive Office of Health and Human Services (EOHHS) and the Office of the Health Insurance Commissioner (OHIC) convened the Rhode Island Health Care Cost Trends Steering Committee (Steering Committee) to develop an annual health care cost growth target (Target) for Rhode Island. The Steering Committee, comprised of a broad range of stakeholders, deliberated the methodology for setting a cost growth target and how to measure its performance, and formalized its recommendations through a voluntary compact signed by all Steering Committee members in December 2018. The former Governor affirmed the cost growth target and the administration's commitment to assessing and reporting on performance relative to the target in Executive Order 19-03, issued February 6, 2019.

Previous to that, OHIC implemented its Affordability Standards in 2010, part of which directs commercial insurers in the state to expand and improve investment in primary care. The Affordability Standards required commercial insurers to increase primary care spending as a percentage of total medical expenses by one percentage point per year from 2010 to 2014.[1] The most recent Affordability Standards, effective June 2020, direct commercial insurers to annually spend at least 10.7 percent of their total medical expenses on primary care.[2] OHIC updated its definition of primary care spending in 2021, which it will also use for its cost growth target, with input from its Patient-Centered Medical Home (PCMH) Work Group. This updated definition of primary care spending is reflected in the instructions contained in this manual.

This implementation manual contains the technical and operational steps for implementing the health care cost growth target and primary care spend obligation, including the technical specifications for data reporting.

[1] OHIC's Primary Care Spending in Rhode Island, published January 2014: http://www.ohic.ri.gov/documents/Primary-Care-Spending-generalprimary-care-Jan-2014.pdf.
[2] OHIC's 2020 Affordability Standards, effective June 25, 2020: https://risos-apa-production-public.s3.amazonaws.com/DBR/REG_10932_20200605100847.pdf.

Chapter 1:
Health Care Cost Growth Target Definition and Methodology

A. Definition

The health care cost growth target (the Target) is the targeted annual per capita growth rate for Rhode Island's total health care spending, expressed as the percentage growth from the prior year's per capita spending. The Target is set on a calendar year basis.

B. Methodology for Calculating the Health Care Cost Growth Target

Executive Order 19-03 sets the Target for 2019-2022 as 3.2%, which is equal to Rhode Island's per capita potential gross state product (PGSP). The formula for the forecasted growth in per capita PGSP is as follows:

> *Expected growth in national labor force productivity + expected growth in the state civilian labor force + expected national inflation – expected state population growth*

Table 1 lists the sources for each of the components of the PGSP formula as calculated for Executive Order 19-03.

Table 1. Data Sources for PGSP Inputs

Components	Source
Expected growth in national labor force productivity	The source is the most recently published Congressional Budget Office Budget and Economic Outlook Report.[3] The report contains a table of Key Inputs to the CBO's Projections of Real Potential GDP that includes the potential labor force productivity projected average annual growth from 2023–2028 (Page 13, Table 2 of the August 2018 report). In general, the figure used to calculate PGSP should be the value that is forecast for five through 10 years into the future.
Expected growth in the state civilian labor force	The source is the Rhode Island Office of Management and Budget purchased forecast from IHS Economics or another vendor.[4] Specifically, the figure can be found on the employment tab of the IHS Economics US Regional Service September 2018 Long Term workbook. Labor Force statistics are in row 65. In this case, the figure is the average growth in the Labor Force from the first quarter of 2023 through the fourth quarter of 2028.
Expected national inflation	The source is the most recently published Congressional Budget Office Budget and Economic Outlook Report.[5] Included within the report is a table of CBO's Economic Projections for Calendar Years 2018 to 2028 (Page 5, Table 1 of the August 2018 report). In general, the figure used to calculate PGSP should be the value of the "PCE price index" percentage change from year-to-year that is forecast for five through 10 years into the future.
Expected state population growth	The source is the Rhode Island Population Projections Summary Tables from the Division of Statewide Planning. In general, the figure used to calculate PGSP should be the percentage change from year-to-year that is forecast for five through 10 years into the future. In this case, because the Division of Statewide Planning provides forecasts in five-year bands, the calculation used the figures that were as close to five through 10 years into the future as feasible. Specifically, the figure used to calculate PGSP is the annualized growth rate between 2025 and 2030.

[3] As of July 8, 2021, the Congressional Budget Office published its Budget and Economic Outlook Reports available at: www.cbo.gov/about/products/major-recurring-reports#1.

[4] The IHS Economics Forecast purchased by the RI Office of Management and Budget was supplied to Bailit Health and Cory King by Matt McCabe in the Office of Regulatory Reform. Mr. McCabe reported in an email on October 3, 2018 that these data are also used for the Revenue Estimating Conference.

[5] As of July 8, 2021 the Congressional Budget Office published its Budget and Economic Outlook Reports available at: www.cbo.gov/about/products/major-recurring-reports#1.

For the development of the initial Target, the time period of 2023-2028 was consistent with the desired future forecast period of five to 10 years into the future (which is a common future period used in economic modeling).

Table 2 presents the values used to calculate and establish the Target (PGSP) in Executive Order 19-03 using the sources listed above.

Table 2. PGSP Calculation

Components	Value from Sources Listed in Table 1	Formula Component
Expected growth in national labor force productivity	1.4%	A
Expected growth in the state civilian labor force	0.0%	B
Expected national inflation	2.0%	C
Nominal potential gross state product	3.4%	D = A + B + C
Expected state population growth	0.2%	E
Potential per capita gross state product for Rhode Island	3.2%	D - E

Chapter 2: Methodology for Assessing Performance Against the Health Care Cost Growth Target

Executive Order 19-03 requires OHIC and EOHHS to annually report on performance relative to the Target at the state, health insurance market, individual payer, and accountable care organization levels. OHIC will lead the State's efforts to collect and analyze data on Target performance. This chapter contains the methodology for measuring the growth in health care spending at each level, including which data to collect and which calculations to perform.[6] This chapter is organized as follows:

C. Definitions of Key Terms

Accountable Care Organization (ACO): A provider organization contracted with one or more payers and held accountable for the of quality health care, outcomes and total cost of care of an attributed commercial or Medicare population.

Accountable Entity (AE): Rhode Island Medicaid's version of an Accountable Care Organization. A provider organization contracted with one or more Medicaid insurers and held accountable for the quality of health care, outcomes and total cost of care of an attributed Medicaid population. AEs are certified by EOHHS.

[6] These methodologies and reporting specifications are derived, in part, from materials published by the Massachusetts Center for Health Information and Analysis, and the Delaware Health Care Commission. These materials have been edited from previously published materials to reflect the Rhode Island model.

Allowed amount: The amount the payer paid a provider, plus any member cost sharing for a claim. Allowed amount is typically a dedicated data field in claims data. Allowed amount is the basis for measuring the claims component of total health care expenditures.

Health care cost growth target (Target): The Target is the value by which the Rhode Island Health Care Cost Trends Steering Committee has agreed to measure total health care expenditures and total medical expense against. It is the value of Rhode Island's Potential Gross State Product (PGSP). PGSP is the total value of goods produced and services provided in a state at a constant inflation rate and is 3.2%.

Insurer: A private health insurance company that offers one or more of the following: commercial insurance, benefit administration for self-insured employers, Medicare managed care organization (MCO) and/or are Medicaid MCO products.

Market: The highest levels of categorization of the health insurance market. For example, Medicare Fee-For-Service (i.e., Original Medicare) and Medicare MCO are collectively referred to as the "Medicare market." Medicaid Fee-for-Service and Medicaid MCO Managed Care are collectively referred to as the "Medicaid market." Individual, self-insured, small and large group markets and student health insurance are collectively referred to as the "commercial market."

Measurement year: The measurement year is the calendar year for which performance is measured against the prior calendar year for purposes of calculating the growth in health care costs.

Net cost of private health insurance (NCPHI): Measures the costs to Rhode Island residents associated with the administration of private health insurance (including Medicare Managed Care and Medicaid Managed Care). It is defined as the difference between health premiums earned and benefits incurred, and consists of insurers' costs of paying bills, advertising, sales commission and other administrative costs, premium taxes and profits (or contributions to reserves) or losses. NCPHI is reported as a component of THCE at the state level. NCPHI is not reported at the market, insurer, or ACO/AE levels.

Payer: A term used to refer collectively to both insurers and public programs that are submitting data to OHIC.

Payer recoveries: Funds distributed by a payer and then later recouped (either through an adjustment from current or future payments, or a cash transfer) due to a review, audit or investigation of funds distribution by the payer. Payment recoveries is a separate, reportable field in insurer total medical expense (TME) reporting.

Pharmacy rebates: Any rebates provided by pharmaceutical manufacturers to payers for prescription drugs with specified dates of fill corresponding to the reporting period, excluding

manufacturer-provided fair market value bona fide service fees.[7] This amount should include pharmacy benefit manager (PBM) rebate guarantee amounts and any additional rebate amounts transferred by the PBM. Pharmacy rebate data should exclude stand-alone prescription drug plans. The computation of THCE at the state, market and payer level is net of pharmacy rebates (i.e., other expenditures are reduced by the amount of the pharmacy rebates).[8]

- **Medical pharmacy rebates:** Any rebates provided by pharmaceutical manufacturers to payers specifically for prescription drugs administered by a health care provider. These drugs may be included in the professional claims category code with J codes or part of facilitate fees for drug infusions administered in the outpatient setting.
- **Retail pharmacy rebates:** Any rebates provided by pharmaceutical manufacturers to payers specifically for prescription drugs obtained by consumers in the retail setting (e.g., drugstore).

Provider: A term referring to an individual clinician, medical group, individual provider, Accountable Care Organization, Accountable Entity or similar entities.

Total health care expenditures (THCE): The total medical expense incurred by Rhode Island residents for all health care services for all payers reporting to OHIC, plus their net cost of private health insurance. Defining specifications of THCE are included in Section B of this chapter.

Total health care expenditures per member per year: Total health care expenditures (as defined above) divided by the members reported by Rhode Island's payers. The annual change in THCE per member per year is compared to the Target at the state level. THCE will not be reported at the market, insurer, or ACO/AE levels.[9]

Total medical expense (TME): The sum of the allowed amount of total claims and total non-claims spending paid to providers incurred by Rhode Island residents for all health care services. TME is reported at multiple levels: state, market, payer and provider level. TME is reported net of pharmacy rebates at the market, payer, and provider levels only. Payers report TME by market (i.e.,., commercial, Medicare, and Medicaid) and at the ACO/AE level

[7] Fair market value bona fide service fees are fees paid by a manufacturer to a third party (e.g., insurer, pharmacy benefit manager, etc.) that represent fair market value for a bona fide, itemized service actually performed on behalf of the manufacturer that the manufacturer would otherwise perform (or contract for) in the absence of the service arrangement (e.g., data service fees, distribution service fees, patient care management programs, etc.)
[8] CMS is unable to report pharmaceutical rebates for traditional Medicare beneficiaries (i.e., FFS Medicare). Therefore, in the computations of THCE at the state and Medicare market levels, spending will be gross of Medicare FFS pharmaceutical rebates.
[9] NCPHI, a component of THCE, is not reportable at the ACO level. Therefore, THCE is not reported at the ACO/AE level.

whenever possible. More detailed TME reporting specifications are contained in the Appendices of this manual.

D. Methodology for Measuring Total Health Care Expenditures and Total Medical Expense

To assess health care spending growth, OHIC will measure THCE and TME annually, in aggregate dollars and on a per member per year basis. The aggregate dollar figure will be for informational purposes only. The percentage change in THCE and/or TME on a per member per year basis between the measurement year and the prior calendar year will be used to assess performance against the Target applicable to the specific measurement year.

Performance against Rhode Island's health care cost growth target is measured and calculated at four different levels:

1. Statewide;
2. By market (Medicare, Medicaid, commercial);
3. By payer; and
4. By ACO/AE.

The following formulas will be used to calculate performance against the cost growth target at each level. Note that all TME in the following formulas for state, Market and Payer reported are net of pharmacy rebates. ACO/AE TME is gross of pharmacy rebates.

Statewide THCE

Statewide THCE (in aggregate) =

Commercial TME + Medicare Advantage TME + Medicare FFS TME + Medicaid MCO TME + RI EOHHS FFS TME + Insurer NCPHI

Statewide THCE (PMPY) =

$$\frac{\left(\textit{Commercial TME + Medicare Advantage TME + Medicare FFS TME + Medicaid MCO TME + RI EOHHS FFS TME + Insurer NCPHI}\right)}{\textit{Rhode Island members as reported in the TME data}}$$

Market Level TME

Medicare Market TME (in aggregate) =

Medicare Advantage TME + Medicare FFS TME

Medicare Market TME (PMPY) =

$$\frac{\textit{Medicare Advantagee TME + Medicare FFS TME}}{\textit{Population of Members Reported by CMS}^{10}}$$

Medicaid Market TME (in aggregate) =

Medicaid MCO TME + RI EOHHS FFS TME

Medicaid Market TME (PMPY) =

$$\frac{\textit{Medicaid MCO TME + RI EOHHS FFS TME}}{\textit{Population of Rhode Island residents enrolled in Medicaid, as reported by EOHHS}}$$

Commercial Market TME (in aggregate) =

Commercial TME

Commercial Market TME (PMPY) =

$$\frac{\textit{Commercial TME}}{\textit{Population of Members Reported}}$$

Duals Market TME (in aggregate) =

TME for Duals enrolled in the Financial Alignment Initiative[11]

[10] CMS reports total Medicare members enrolled in Original Medicare and Managed Medicare products to OHIC. Because OHIC has not requested data from stand-alone Part D Medicare payers, OHIC removes prescription drug spending from Medicare Managed Care TME at the market level and adds in CMS-reported total prescription drug spending to capture both Medicare Part C and Part D prescription drug spending. This allows OHIC to report a comprehensive measurement of spending for Medicare at the market level. This adjustment is not applied at the payer level, Medicare line of business.

[11] Rhode Island is participating in the CMS Financial Alignment Initiative which combines Medicare and Medicaid dollars into one funding stream to pay for the coverage of individuals dually enrolled in Medicaid and Medicare. This level of analysis does not apply to the population of dually eligible individuals separately covered through Original Medicare, Medicare Advantage or Medicaid FFS. OHIC is unable to report on those individuals separately because it cannot estimate a unique count of individual members.

Duals Market TME (PMPY) =

$$\frac{\textit{TME for Duals enrolled in the Financial Alignment Initiative}}{\textit{Population of Members Reported}}$$

Payer TME

Payer, by Market (PMPM) =

$$\frac{\textit{Risk-Adjusted TME net of Spending Above Established Thresholds for High-Cost Outliers}}{\textit{Population of Members Reported}}$$

ACO/AE TME

ACO/AE, by Market (PMPM) =

$$\frac{\textit{Risk-Adjusted TME net of Spending Above Established Thresholds for High-Cost Outliers}}{\textit{Population of Members Reported}}$$

Defining Specifications for THCE

The defining specifications for THCE are as follows:

- It represents spending incurred in or out-of-state on behalf of Rhode Island residents. Spending associated with people who are not state residents is excluded.
- It includes spending on health care services/benefits. It excludes non-medical spending, even if such spending is made by a payer (e.g., gym memberships).
- Vision and dental spending are generally excluded except when vision and dental services are covered as a health insurance benefit or are a covered benefit under Medicaid or Medicare (e.g., Rite Smiles dental coverage for children).
- It represents the total allowed amount, which includes amounts covered by payers, and individual out-of-pocket spending associated with insured medical expenditures (e.g., co-pays, co-insurance and deductibles). To avoid double counting expenditures, health care premium payments are not included. Also, because data are not available, other out-of-pocket expenditures recorded by providers, but not paid by insurers, are not included (e.g., "charity care" or medical care spending for Rhode Island residents who cannot afford to pay providers, or privately purchased health care services).
- It encompasses all insurance market segments, including public and private payers listed in this manual, fully and self-insured products, and student insurance with the following limited exceptions: US Department of Veterans Affairs, the TRICARE program

and health spending by the Rhode Island Department of Corrections that is not otherwise covered by Medicaid.

- The administrative costs and underwriting gain/loss of insurers, referred to as the NCPHI, are included (see **Section E** of this chapter for more detail).
- TME data are only collected from a payer when it is the primary payer for a claim. The primary payer will report on the allowed amount. If the secondary payer of the claim were to report, it would cause double counting a portion of the allowed amount by the primary payer.
- TME is adjusted to account for any pharmacy rebates received by the payer by subtracting the rebates (revenue) from the payer's total medical expense. The exception is Medicare FFS spending as CMS will not share this information at the state level.
- TME is risk-adjusted using age/sex factors applied uniformly by OHIC at the payer and ACO/AE levels, using data supplied by the payers.
- Spending above certain thresholds for high-cost outliers are removed from TME at the payer and ACO/AE levels. The Age-Sex Factors section of **Appendix A** lists the threshold values, which are specific to each market and were derived through analyses conducted by Rhode Island payers.
- Provider resources applied in the delivery of care for uninsured Rhode Islanders should not be included in calculations of health care spending because they are technically not "spending" as defined herein. Future reporting on spending relative to the Target should, however, indicate that while this spending is not captured in the measurement of total health care spending, they may be significant for certain providers.

E. Data Sources for THCE

Data for THCE come from several sources. Insurers need to report TME for all lines of business and, in some instances, insurers need to report other data for the State to calculate the NCPHI. Other data sources include the Centers for Medicare & Medicaid Services (CMS) and EOHHS.

Table 3 below outlines the data source by THCE category and the location of the detailed specification or collection process within this manual.

Table 3. Data Sources for THCE

THCE Category	Data Source	Location of Data Specification/Collection Process in Manual
Expenditures from Insurers		
Insurer full claim (comprehensive coverage with no carve-outs)	TME reported by insurers	Appendix A
Insurer partial claim (coverage with carve-outs, such as pharmacy) calculated values	TME reported by insurers, with actuarial estimates produced by insurers	Appendix A
Insurer non-claim payments	TME reported by insurers	Appendix A
Prescription drug spending for Medicare Managed Care Organization, for market-level reporting only (*For insurer-level reporting, the data source is in insurer-reported TME .)*[12]	CMS	Appendix C
Expenditures from Public Programs		
EOHHS claim (Medicaid FFS and other) calculated values	EOHHS	Appendix B
Medicare FFS claim (Parts A, B and D) calculated values	CMS	Appendix C
Net Cost of Private Health Insurance		
Fully insured and Medicaid Insurer NCPHI	Calculated from regulatory reports submitted by the insurers or obtained through public sources	Appendix D
Self-insured Insurer NCPHI	Insurers with self-insured populations	Appendix D
Pharmacy Rebates		
Insurers	Pharmacy rebate data filing by insurers	Appendix A
Medicaid Program	Pharmacy rebate data filing by EOHHS	Appendix B

[12] CMS will provide OHIC with allowed amounts for Medicare FFS beneficiaries with stand-alone prescription drug plans (PDP) and for Medicare managed care beneficiaries with stand-alone PDP and Medicare Advantage Prescription Drug Plans (MAPD) in aggregate. CMS should be the source of pharmacy expenditure data for market-level spending as it will include all stand-alone PDP spending, even by insurers not reporting TME to OHIC and insurers specifically excluding stand-alone PDP spending from TME. For reporting at the insurer-level, each individual insurer should be the source of spending. However, stand-alone PDP spending has been excluded from reporting at the insurer-level because doing so would compromise the integrity of the spending calculations.

F. Insurer TME Data

TME represents all payments for medical expenses for the Rhode Island resident population and will be reported by payers for all their members (including fully and self-insured members). TME is adjusted (reduced) to account for pharmacy rebates at the state, market and payer levels.

Annually, OHIC will direct applicable insurers to submit TME data using the specifications outlined in **Appendix A** and the template provided as **Attachment 1.** Specifications for public programs to submit their TME are included in **Appendices B-C.** **Table 4** below lists which insurers should report for their commercial, Medicare managed care, Medicaid/CHIP managed care, and Medicare-Medicaid dual eligible markets.[13]

Table 4. Insurers Requested to Report TME Data by Market

Insurer	Commercial Fully and Self-Insured	Medicare Managed Care	Medicaid Managed Care	Medicare and Medicaid Dual Eligibles
Blue Cross Blue Shield of RI	X	X		X
Neighborhood Health Plan of RI	X	X	X	X
Tufts Health Plan	X		X	
UnitedHealthcare[14]	X	X	X	X

G. NCPHI Data

NCPHI captures the costs to Rhode Island residents associated with administrative activities and underwriting gain/loss of insurers. It is the difference between health premiums earned and benefits incurred and includes all categories of administrative expenditures, net additions to reserves, rate credits and dividends, and profits and losses.

OHIC will calculate NCPHI for all Rhode Island residents whose insurers submit data to OHIC, using data obtained from insurers and other public sources. **Appendix A** lists the data requested from commercial insurers to calculate NCPHI, and **Appendix D** details the methodology that OHIC will use to calculate NCPHI.

[13] This table represents the largest insurers in the Rhode Island insurance market as of June 2022. Because the market may change, this table may need to be updated over time.

[14] UnitedHealthcare also does business as Oxford, Sierra Health and Life, UnitedHealthcare Insurance Company and UnitedHealthcare of New England, Inc.

H. Public Reporting of Cost Growth Target Performance

Table 5 outlines the minimum level at which OHIC will publicly report performance. When reporting TME, OHIC will report on a per member per year (PMPY) or per member per month (PMPM) basis.

Table 5. Levels at Which Public Reporting of Performance Against Target Should Occur

Level of Reporting	THCE/TME Components
State level	• Report TME net of rebates and including NCPHI components • Report aggregate and PMPY amounts • Compare PMPY rate of change against target
Medicare market	• Report TME net of rebates PMPY • Compare PMPY rate of change against target
Medicaid market	• Report TME net of rebates PMPY • Compare PMPY rate of change against target
Commercial market	• Report TME net of rebates PMPY • Compare PMPY rate of change against target
Financially Aligned Initiative for Medicare and Medicaid Duals market[15]	• Report TME net of rebates PMPY • Compare PMPY rate of change against target
Payer	• Compare TME (net of rebates) PMPM rate of change against target by market
ACO/AE	• Compare TME (gross of rebates) PMPM rate of change against target by market

Reporting TME by Service Category

The goal of TME data collection is to obtain summary-level payer data segmented into a manageable number of distinct service categories that all payers can consistently and accurately report. By analyzing service category spending, OHIC can understand the relative amount of TME spending going toward each individual service category and how much the spending growth in each service category contributes to the overall trend.

OHIC will report PMPY growth and contribution to growth for all or a subset of the following service categories:

- Hospital Inpatient
- Hospital Outpatient

[15] Rhode Island is participating in the CMS Financial Alignment Initiative which combines Medicare and Medicaid dollars into one funding stream to pay for the coverage of individuals dually enrolled in Medicaid and Medicare. This level of analysis does not apply to the population of dually eligible individuals separately covered through Original Medicare, Medicare Advantage or Medicaid FFS. OHIC is unable to report on those individuals separately because it cannot estimate a unique count of individual members.

- Professional, Primary Care
- Professional, Specialty Care
- Professional Other
- Retail Pharmacy (net of rebates)[16,17]
- Long-Term Care
- Other Claims
- Non-claims: Prospective payment models
- Non-claims: Performance incentive payments
- Non-claims: Population health and practice infrastructure payments
- Non-claims: Provider salaries
- Non-claims: Recoveries
- Non-claims: Other

Reporting TME by Insurer

OHIC will report performance against the target at the insurer level by Insurance Category Code which allows for a more granular analysis of market trends. In the commercial market, two Insurance Category Codes will be used to allow for separate reporting for: (a) members for whom the insurer holds the entire medical benefit; and (b) members whose employer contract carves-out certain benefits (e.g., pharmacy or behavioral health spend). Insurers must estimate spending on carved-out benefits using its own data and experience on a similar population, as requested in **Appendix A** to get a comprehensive view of the commercial market.

Reporting TME by ACO/AE and Members Unattributed to an ACO/AE

To measure and publicly report performance against the benchmark at the provider entity level, individual patients must be attributed or assigned to a primary care provider, and those primary care providers must be organized into provider entities large enough for their performance to be statistically valid. OHIC identifies the attribution logic that insurers must perform to assign members to an ACO/AE by market in **Appendix A** (see **Member Attribution**).

OHIC will report on Rhode Island ACO/AE performance in accordance with the Steering Committee's recommendations on the minimum number of attributed members required to report provider performance. Annually, OHIC will publicly report the age/sex-adjusted TME

[16] Insurers that have both Medicare Advantage and stand-alone PDP lines of business must exclude their stand-alone PDP data from their TME submission. Stand-alone PDP expenditure data will be obtained from CMS.
[17] When reporting trends in retail pharmacy spending, OHIC will subtract retail pharmacy rebates from this service category. It cannot do the same for medical pharmacy rebates as medical pharmacy data will be in multiple service categories, including hospital inpatient and hospital outpatient. Instead, the sum of medical and retail pharmacy rebates will be subtracted from TME.

of ACOs/AEs for the markets in which they have a minimum of 60,000 attributed member months.

Applying Adjustments to Insurer and ACO/AE Performance

OHIC requires insurers to submit non-adjusted TME data, but recognizes the need to account for the variability in individuals' health status, and for random variation in health care spending of small populations. For TME data, OHIC removes spending above certain thresholds for high-cost outliers, applying age/sex risk-adjustment factors, and performing statistical testing around each insurer and ACO/AE's cost growth. Each of these adjustments and how they are applied are described below.

Applying Truncation to Remove High-Cost Outlier Spending Above Specified Thresholds

To minimize the impact of high-cost outliers on insurer and provider cost growth, OHIC will truncate costs above certain dollar amounts. OHIC developed per member truncation points for each Insurance Category Code using Rhode Island payer analyses. Payers reported that members spending exceeding the truncation point accounts for between ~4-7% of total spending. The per member truncation points are specified in **Appendix A.**

OHIC will use insurer reported data to subtract the total spending above the truncation point from the aggregate spend at the insurer and ACO/AE levels, by market.

OHIC requests that truncation be applied to individuals' total spending, inclusive of all medical and pharmacy spending. **Appendix A** details how insurers should submit these data, including examples of how to calculate truncated spending in the context of carved-out populations and services.

Applying Age/Sex Risk-Adjustment Factors to Risk-Adjust Spending Data

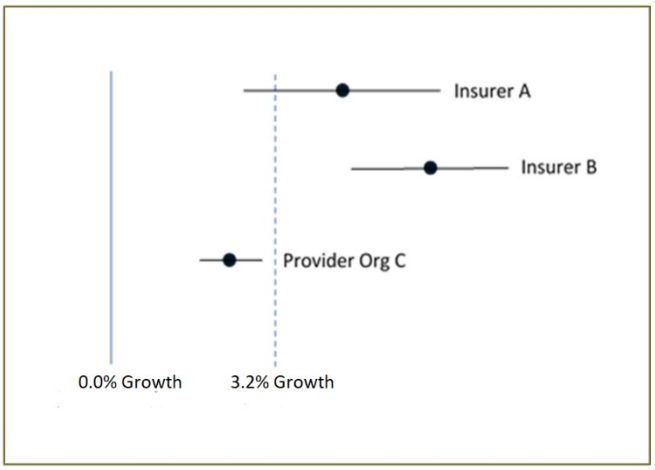
Analyses of early RI Cost Growth Target data (i.e., baseline analyses and first performance year analyses) showed that the use of diagnosis-based risk scores had a significant impact on some payers' and ACOs/AEs' performance, raising concerns about the increasing nature of the risk scores due to the practice of coding completeness. To better balance how risk-adjustment is applied at the ACO/AE level, OHIC will risk-adjust spending by age and sex to account for the changes in risk profile over a member's lifespan.

OHIC will collect data by age/sex bands (defined in **Appendix A**) and develop one set of factors that will be applied uniformly across all insurers and ACOs/AEs within each Insurance Category Code (Insurance Category Code 7, which refers to the Medicare/Medicaid Integrated Duals Product, will not be age/sex risk-adjusted since all members receive services through only one insurer).

Statistical Testing to Determine Performance Against the Benchmark

Given the small size of many Rhode Island ACOs/AEs, OHIC will conduct statistical significance testing to assess insurers' and ACOs/AEs' performance against the cost growth benchmark. This will involve developing confidence intervals around each insurer's and ACO/AE's cost growth, and determining whether the confidence interval intersects with the benchmark. OHIC will then categorize payers and providers as illustrated below:

- **Confidence interval intersects with benchmark –** under this circumstance, OHIC would be unable to determine whether an insurer or provider entity's performance did or did not meet the benchmark (Insurer A in the illustration below).
- **Lower confidence interval is over the benchmark –** this would indicate that the insurer or provider entity exceeded the benchmark (Insurer B in the illustration below).



Note: Figure is not to scale

- **Upper confidence interval is fully below the benchmark –** this would indicate that the insurer or provider has achieved the benchmark (Provider Org C in the illustration below).

To support the development of confidence intervals, OHIC asks insurers to provide standard deviation on non-risk-adjusted TME data after truncating spending for high-cost outliers. Insurers will need to provide standard deviation information for:

- Each market for the payer overall; and
- Each provider entity by market.

Since health care cost growth will be calculated using age/sex-adjusted claims spending, OHIC will also adjust the standard deviation used to calculate the confidence intervals. This will be done by applying same OHIC-calculated age/sex risk-adjustment factor used to risk-adjust TME. The formula for adjusting the variance will be as follows:

$$Adjusted\ Standard\ Deviation = \frac{Unadjusted\ Standard\ Deviation}{OHIC\ Calculated\ Risk\ Score^2}$$

Appendix H details how OHIC will calculate the confidence intervals.

I. Timeline for Measuring and Reporting the Cost Growth Target

OHIC will publish THCE and TME statistics annually, following a specific timeline to collect and report baseline data. Specifically, CY 2021 and CY 2022 performance data will be collected in fall 2023 and reported in spring 2024.

Due to the timing of ACO/AE settlements, insurers will need to annually submit two years' worth of data: (1) the performance year data (which is the calendar year immediately preceding the year in which TME data are reported) which will contain insurer estimates of ACO/AE settlements; and (2) the TME data for the calendar year prior to the performance year, which will be resubmitted to reflect final settlements that were estimated in prior year reporting.

Chapter 3: Methodology for Assessing Performance Against the Primary Care Spend Obligation

OHIC's Affordability Standards, per RICR-20-30-4, directs commercial insurers to annually spend at least 10.7 percent of their annual medical expenses for all fully insured lines of business on primary care, 9.7 percent of which shall be for direct primary care expenses. OHIC will annually lead the State's efforts to collect data from insurers and perform calculations on primary care spending. This chapter describes the methodology for assessing primary care spend for commercial insurers' fully insured lines of business, including which data to collect and which calculations to perform.[18] This chapter is organized as follows:

A. Definitions of Key Terms

Direct primary care expenses: The sum of all claims-based and non-claims-based primary care payments excluding HIE payments for CurrentCare and PCMH administration payments to support the operations of CTC-RI.

Indirect primary care expenses: The sum of all HIE payments for CurrentCare and PCMH administration payments.

[18] These methodologies and reporting specifications are derived, in part, from materials published by the New England States Consortium Systems Organization (NESCSO) primary care payments methodology (https://nescso.org/wp-content/uploads/2021/02/NESCSO-New-England-States-All-Payer-Report-on-Primary-Care-Payments-2020-12-22.pdf), the Milbank Memorial Fund's recommended definition for non-claims-based primary care spending (https://www.milbank.org/publications/measuring-non-claims-based-primary-care-spending/), and primary care spending target definitions utilized by other states (e.g., Connecticut, Delaware, Oregon).

Measurement year: The measurement year is the calendar year for which performance is measured against the prior calendar year for purposes of calculating the growth in health care costs.

Primary care spend obligation: The percentage of spending on total medical expenses, minus long-term care, that is allocated to primary care by commercial insurers for their fully insured lines of business in Rhode Island. Primary care spending is assessed on a calendar year basis. OHIC's Affordability Standards, per RICR-20-30-4,J directs commercial insurers to annually spend at least 10.7 percent of their annual medical expenses for all fully insured lines of business on primary care, 9.7 percent of which shall be for direct primary care expenses.

Provider: A term referring to an individual clinician, medical group, individual provider, Accountable Care Organization, Accountable Entity or similar entities.

Total medical expense (TME), less long-term care: The sum of the allowed amounts of total claims and total non-claims spending paid to providers incurred by Rhode Island residents for all health care services except for long-term care. This definition differs from that used for the health care cost growth target, which includes long-term care. TME, less long-term care, is reported net of pharmacy rebates. More detailed TME reporting specifications are contained in the Appendices of this manual.

B. Methodology for Measuring Primary Care Spending

To assess progress towards the primary care spending obligation, OHIC will calculate primary care spending as a proportion of TME, less long-term care for commercial insurers' fully insured lines of business.

TME, for assessing primary care spending, is consistent with TME for the RI Health Care Cost Growth Target but excludes spending for long-term care services. OHIC will measure primary care spending as a percentage of TME, less long-term care, at the insurer and commercial market levels.

The following formula will be used to calculate performance against the primary care spending obligation.

Primary care spending as a percentage of TME, less long-term care =

$$\frac{\textit{Commercial Primary Care Spending}}{\textit{Commercial TME-Commercial Long-term Care Spending}}$$

Defining Specifications for TME

The defining specifications for TME care are as follows:

- It represents spending incurred in or out-of-state on behalf of Rhode Island residents. Spending associated with people who are not state residents is excluded.
- It includes spending on health care services/benefits. It excludes non-medical spending, even if such spending is made by a payer (e.g., gym memberships).
- Vision and dental spending are excluded.
- It represents the total allowed amount, which includes amounts covered by payers, and individual out-of-pocket spending associated with insured medical expenditures (e.g., co-pays, co-insurance and deductibles). To avoid double counting expenditures, health care premium payments are not included. Also, because data are not available, other out-of-pocket expenditures recorded by providers, but not paid by insurers, are not included (e.g., "charity care" or medical care spending for Rhode Island residents who cannot afford to pay providers, or privately purchased health care services).
- TME data are only collected from a payer when it is the primary payer for a claim. The primary payer will report on the allowed amount. If the secondary payer of the claim were to report, it would cause double counting a portion of the Allowed Amount by the primary payer.
- TME is adjusted to account for any pharmacy rebates received by the payer by subtracting the rebates (revenue) from the payer's total medical expense.

These specifications are analogous with the TME specifications for the Health Care Cost Growth Target as outlined in **Chapter 2, Section B**, with the following exceptions:

- It includes only commercial lines of business subject to regulation by OHIC (i.e., for fully insured lines of business (LOBs) only and not self-insured LOBs).
- It excludes spending associated with Medicaid and Medicare members. It also excludes spending for any subcontractors hired to provide services for members (e.g., Landmark's Complexivist services).
- It does not include costs associated with NCPHI.

C. Data Sources and Specifications for Primary Care Spending and TME

Annually, OHIC will direct applicable insurers to submit primary care spending and TME, less long-term care, data using the specifications outlined in **Appendix E** and the template provided as **Attachment 2**. Table 6 below lists which insurers should report for their commercial fully insured LOBs.[19]

Table 6. Insurers Requested to Report Primary Care Spending and TME, Less Long-Term Care, by Market

Insurer	Commercial Fully Insured
Blue Cross Blue Shield of RI	X
Neighborhood Health Plan of RI	X
Tufts Health Plan	X
UnitedHealthcare	X

OHIC requests insurers to report the following individual services categories, using the definitions found in **Appendix E**:

- Member months
- Claims: Professional, Primary Care
- Non-claims: HIE Payments for CurrentCare
- Non-claims: PCMH Administration Payments
- Non-claims: Professional, Primary Care
- Claims: TME, less Long-term Care
- Non-claims: TME, less Long-term Care

OHIC will use the above service categories to calculate and report primary care spending as a percentage of TME, less long-term care, and to calculate direct primary care payments (i.e., the sum of all claims-based and non-claims-based primary care payments excluding HIE payments for CurrentCare and PCMH administration payments to support the operations of CTC-RI), and indirect primary care payments (i.e., the sum of HIE payments for CurrentCare and PCMH administration).

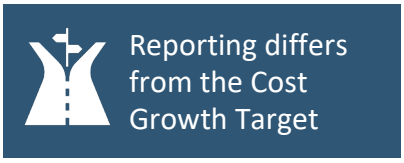
OHIC requests that insurers submit primary care spending and TME data for their fully insured LOB in aggregate. Insurers ***do not*** need to report spending by ACO/AE. In addition, unlike reporting for the Cost Growth Target, insurers ***do not*** need to apply any adjustments to the data

[19] This table represents the largest commercial insurers in the Rhode Island insurance market as of June 2021. Because the market may change, this table may need to be updated over time.

(i.e., they do not need to remove high cost outliers, apply age/sex risk-adjustment factors or perform statistical testing to develop confidence intervals).

D. Public Reporting of Primary Care Spending

OHIC will assess primary care spending as a percentage of TME, less long-term care for each commercial insurer. It will also aggregate data across insurers to report spending at the commercial market level.



E. Timeline for Measuring and Reporting Primary Care Spending

For reporting 2022 performance in 2023, insurers shall submit one report by September 29, 2023 with final data for January 1, 2022 – December 31, 2022.

For future years, OHIC shall assess primary care spending two times a year based on two insurer-submitted reports with data for the prior calendar year. The first report shall be submitted by the first business day in April and shall include preliminary data on performance for the prior calendar year (e.g., the April 3, 2023 report shall include preliminary data for the January 1, 2022 – December 31, 2022 reporting period). The second report shall be submitted as part of the insurer's cost growth target data submission with final data for the prior calendar year (e.g., the September 29, 2023 report shall include final data for the January 1, 2022 – December 31, 2022 reporting period).

F. Alignment between the Primary Care Spending Definition and Cost Growth Target Definition

While the methodology for the primary care spending calculation is mostly aligned with the Cost Growth Target methodology, there are some differences between the two. **Table 7** provides a comparison between the two calculations.

Table 7. Comparison of the Primary Care Spending and Cost Growth Target Definitions

Category	Primary Care Spending Definition	Cost Growth Target Definition	Different or Same
Payers required to report	Commercial payers for fully-insured lives only	All payers for all covered lives (i.e., fully and self-insured commercial, Medicaid, Medicare and dual-eligible members)	
Type of spending	Allowed amounts	Allowed amounts	Same
Secondary payer payments	Excluded	Excluded	Same
Non-claims payment timeframe	Incurred[20]	Incurred	Same
Member residence	Rhode Island residents only	Rhode Island residents only	Same
Provider residence	All providers, regardless of location	All providers, regardless of location	Same
Definition of primary care	Claims-level definition of primary care spending and taxonomy codes to define a primary care provider	Claims-level definition of primary care spending and taxonomy codes to define a primary care provider	Same
Definition of total medical expenses	Includes spending for prescription drugs, behavioral health, laboratory and imaging services. Excludes spending for dental, vision and long-term care services[21] (beyond those covered by a medical benefit)	Includes spending for prescription drugs, behavioral health, laboratory, imaging and **long-term care services**. Excludes spending for dental and vision services (beyond those covered by a medical benefit)	

[20] If payouts have not been made by the report submission date, insurers should apply reasonable and appropriate estimations of non-claims liability to provider organizations that are expected to be reconciled after the 180-day "run-out" period

[21] Exclusion of long-term care services differs from the cost growth target definition, but is a reasonable divergence given that long-term care spending is primarily attributed to Medicaid. OHIC will still align reporting for the primary care spend obligation and cost growth target because long-term care is reported as an individual spending category. Therefore, OHIC can subtract long-term care from total medical expenses reported for the cost growth target to obtain "Total Medical Payments" for the primary care spend obligation.

Category	Primary Care Spending Definition	Cost Growth Target Definition	Different or Same
Reported claims-based spending categories	• Professional, Primary Care • TME, less Long-term Care	• Hospital Inpatient • Hospital Outpatient • Professional, Primary Care • Professional, Specialty Care • Professional Other • Retail Pharmacy • Long-term Care • Other	
Reported non-claims spending categories	• HIE Payments for CurrentCare • PCMH Administration Payments • Professional, Primary Care • TME, less Long-term Care	• Prospective Capitated, Prospective Global Budget, Prospective Case Rate, or Prospective Episode-Based Payments • Performance Incentive Payments • Payments to Support Population Health and Practice Infrastructure • Provider Salaries • Recoveries • Other	

Appendix A:
Insurer TME Data Specification

This insurer TME data specification provides technical details to assist insurers in reporting and filing data to enable OHIC to calculate TME. This appendix can serve as a stand-alone document to serve as a guide for TME data reporting.

A. Definition of Key Terms

Accountable Care Organization (ACO): A provider organization contracted with one or more payers and held accountable for the of quality health care, outcomes and total cost of care of an attributed commercial or Medicare population.

Accountable Entity (AE): Rhode Island Medicaid's version of an Accountable Care Organization. A provider organization contracted with one or more Medicaid insurers and held accountable for the quality of health care, outcomes and total cost of care of an attributed Medicaid population. AEs are certified by EOHHS.

Allowed amount: The amount the payer paid a provider, plus any member cost sharing for a claim. Allowed amount is typically a dedicated data field in claims data. Allowed amount is the basis for measuring the claims component of total health care expenditures.

Health care cost growth target (Target): The Target is the value by which the Rhode Island Health Care Cost Trends Steering Committee has agreed to measure Total Health Care Expenditures and Total Medical Expense against. It is the value of Rhode Island's Potential Gross State Product (PGSP). PGSP is the total value of goods produced and services provided in a state at a constant inflation rate and is 3.2%.

Insurer: A private health insurance company that offers one or more of the following: commercial insurance, benefit administration for self-insured employers, Medicare managed care organization (MCO) and/or are Medicaid MCO products.

Market: The highest levels of categorization of the health insurance market. For example, Medicare Fee-For-Service (i.e., Original Medicare) and Medicare MCO are collectively referred to as the "Medicare market." Medicaid Fee-for-Service and Medicaid MCO Managed Care are collectively referred to as the "Medicaid market." Individual, self-insured, small and large group markets and student health insurance are collectively referred to as the "Commercial market."

Measurement Year: The measurement year is the calendar year for which performance is measured against the prior calendar year for purposes of calculating the growth in health care costs.

Net cost of private health insurance (NCPHI): Measures the costs to Rhode Island residents associated with the administration of private health insurance (including Medicare Managed Care and Medicaid Managed Care). It is defined as the difference between health premiums earned and benefits incurred, and consists of insurers' costs of paying bills, advertising, sales commission and other administrative costs, premium taxes and profits (or contributions to reserves) or losses. NCPHI is reported as a component of THCE at the state level. NCPHI is not reported at the market, insurer, or ACO/AE levels.

Payer: A term used to refer collectively to both insurers and public programs that are submitting data to OHIC.

Payer recoveries: Funds distributed by a payer and then later recouped (either through an adjustment from current or future payments, or a cash transfer) due to a review, audit or investigation of funds distribution by the payer. Payer recoveries is a separate, reportable field in insurer total medical expense (TME) reporting.

Pharmacy rebates: Any rebates provided by pharmaceutical manufacturers to payers for prescription drugs with specified dates of fill corresponding to the reporting period, excluding manufacturer-provided fair market value bona fide service fees.[22] This amount should include pharmacy benefit manager (PBM) rebate guarantee amounts and any additional rebate amounts transferred by the PBM. Pharmacy rebate data should exclude stand-alone prescription drug plans. The computation of TCHE at the state, market and payer level is net of pharmacy rebates (i.e., other expenditures are reduced by the amount of the pharmacy rebates).[23]

- **Medical pharmacy rebates:** Any rebates provided by pharmaceutical manufacturers to payers specifically for prescription drugs administered by a health care provider. These drugs may be included in the professional claims category code with J codes or part of facilitate fees for drug infusions administered in the outpatient setting.

- **Retail pharmacy rebates:** Any rebates provided by pharmaceutical manufacturers to payers specifically for prescription drugs obtained by consumers in the retail setting (e.g., drugstore).

[22] Fair market value bona fide service fees are fees paid by a manufacturer to a third party (e.g., insurer, pharmacy benefit manager, etc.) that represent fair market value for a bona fide, itemized service actually performed on behalf of the manufacturer that the manufacturer would otherwise perform (or contract for) in the absence of the service arrangement (e.g., data service fees, distribution service fees, patient care management programs, etc.)
[23] CMS is unable to report pharmaceutical rebates for traditional Medicare beneficiaries (i.e., FFS Medicare). Therefore, in the computations of THCE at the state and Medicare market levels, spending will be gross of Medicare FFS pharmaceutical rebates.

Provider: A term referring to an individual clinician, medical group, individual provider, Accountable Care Organization, Accountable Entity or similar entities.

Total health care expenditures (THCE): The total medical expense incurred by Rhode Island residents for all health care services for all payers reporting to OHIC, plus the insurers' net cost of private health insurance. Defining specifications of THCE are included in Chapter 2, Section B.

Total health care expenditures per member per year: Total health care expenditures (as defined above) divided by the members reported by Rhode Island's payers. The annual change in THCE per member per year is compared to the Target at the state level. THCE will not be reported at the market, insurer, or ACO/AE levels.[24]

Total medical expense (TME): The sum of the allowed amount of total claims and total non-claims spending paid to providers incurred by Rhode Island residents for all health care services. TME is reported at multiple levels: state, market, payer and provider level. TME is reported net of pharmacy rebates at the state, market and payer levels only. Payers report TME by line of business (e.g., individual, self-insured, large group, small group, Medicare, Medicaid, Medicare/Medicaid dually eligible) and at the ACO/AE level whenever possible. More detailed TME reporting specifications are contained in the other Appendices of this manual.

B. TME Submission Schedule

OHIC will annually request TME data file(s) with dates of service during the prior calendar year, and any other past years upon request. Insurers will submit TME data using Excel templates provided by OHIC according to the schedule outlined in **Table 8** below.

After insurers submit their data according to the filing schedule, they must actively engage with OHIC as it validates the data to ensure such data were submitted using the specifications outlined in this Implementation Manual. OHIC will engage the insurers one-on-one to discuss the validation of submitted data, an initial analysis of data, and once again to review final data before its published. Additionally, OHIC requests that insurers engage in data sharing with ACOs/AEs to describe any discrepancies in performance between TME and total cost of care or other value-based payment contracts.

[24] NCPHI, a component of THCE, is not reportable at the ACO level. Therefore, THCE is not reported at the ACO/AE level.

Table 8. Insurers' TME Filing Schedule

Date	Files Due
October 1, 2021	CY 2019 Final and CY 2020 Estimated TME
September 30, 2022	CY 2020 Final and CY 2021 Estimated TME
September 29, 2023	CY 2021 Final and CY 2022 Estimated TME

C. TME Data Specifications

Insurers must report TME data based on allowed amounts (i.e., the amount the insurer paid plus any member cost sharing).

Insurers must include only information pertaining to members:

- who are residents of Rhode Island,
- who, at a minimum, have medical benefits[25], and
- for which the insurer is primary on a claim (exclude any paid claims for which it was the secondary or tertiary insurer, however do not exclude a member solely because they have additional coverage).

Table 9 below details the policies that insurer include and exclude in their TME reports.

Table 9. Included and Excluded Policies for TME Data Reporting

Included Policies	Excluded policies
Commercial market: • self-insured plans • short-term health plans • student health plans • fully insured individual and group (small and large) plans • the Federal Employee Health Benefits Program (FEHBP) **Medicare market:** • Medicare Advantage Health Maintenance Organization (HMO) • Preferred Provider Organization (PPO)	• accident policy • disability policy • hospital indemnity policy • long-term care insurance • Medicare supplemental insurance (AKA Medigap) • stand-alone prescription drug plans • stop-loss plans • supplemental insurance that pays deductibles, copays, or coinsurance • vision-only insurance • workers compensation

[25] Members who only have a non-medical benefit should be excluded. Insurers who hold the medical benefit for those members will be making estimates of TME for medical benefits and excluding non-medical benefit members would reduce the chance of duplicating the spending of those members.

Included Policies	Excluded policies
• HMO Point of Service (HMOPOS) • Medicare Medical Savings Account (MSA) • Private Fee-for-Service (PFFS) • Special Needs Plans (SNPs) **Medicaid contracts:** • Medicaid and CHIP managed care contracts with Rhode Island Medicaid	• dental-only insurance

Member Attribution

Insurers must attribute members to an ACO according to the following categorization:

1. Medicaid:
    a. Medicaid members who were attributed during the measurement year to an AE using the attribution rules established by EOHHS for the AE program's performance year 4 (i.e., MCOs shall submit to AEs and to EOHHS electronic lists of attributed members on a monthly basis).[26] If a payer is not participating in the AE program, but has a total cost of care contract with an AE, members should be attributed to the AE.
    b. Medicaid members not attributed to an AE (reported in aggregate).

2. Commercial and Medicare:
    a. Commercial and Medicare managed care members who were attributed during the measurement year, pursuant to a contract between the insurer and ACO for financial and quality performance assessment purposes. Members can be attributed monthly, quarterly, annually, or at another frequency, so long as the attribution timing is consistent with the insurer contract.

Note: If a payer has a contract in place during the CY in which the data are reported, the payer should perform attribution consistent with its contract for the time period in which the data are requested. For example, if a Payer A had a contract with Provider X for CY 2023, but not CY 2021 or 2022, it should still attribute members and spending for CY 2021 and CY 2022 to Provider X utilizing the attribution rules established in CY 2023.

    b. Commercial and Medicare Advantage members not attributed to an ACO (reported in aggregate).

[26] See Attachment M: Accountable Entity - Attribution Guidance of the Rhode Island Accountable Entity Program. https://eohhs.ri.gov/initiatives/accountable-entities/resource-documents

3. Dual Eligible:
    a. Medicare and Medicaid dually eligible members should be attributed to an ACO or AE using the attribution rules above of the primary payer of their medical benefit.
    b. Medicare and Medicaid dually eligible members not attributed to an ACO/AE (to be reported in aggregate)

Insurers must report two categories of data, by Insurance Category Code:

1. TME data applicable to ACOs/AEs with attributed members, for which the insurer is contracted, reported by ACO/AE.
2. Member spending not attributable to an ACO/AE, reported in aggregate.

Insurers must include all allowed amounts for all TME data for members, regardless of whether services are provided by providers located in or out of Rhode Island, and regardless of the situs of the member's plan.[27]

The data reported for each ACO/AE must include all TME for all attributed members for each month a member was attributed, so long as the member was a resident at the time of attribution, even when care was provided by providers outside of or not affiliated with the respective ACO/AE entity. Insurers may choose whether residency is established as of the first of the month, last of the month, or another day of the month, consistent with their monthly attribution methodology.

Claims Run-Out Period Specifications

Insurers shall allow for a claims run-out period of at least 180 days after December 31 of the performance year. Insurers should apply reasonable and appropriate IBNR/IBNP completion factors to each respective TME service category and will be required to attest that they are reasonable and appropriate. Claims payments should be reported on an incurred basis, not paid basis.

Non-Claims Payment "Run-Out" Period Specifications

Insurers shall allow for a non-claims "run-out" period of at least 180 days after December 31 of the performance year to reconcile non-claims payments, including incentives, capitation and risk-settlements, or other non-claims-based payments. Insurers should apply reasonable and appropriate estimations of non-claims liability to each ACO/AE Organization ID (including payments expected to be made to organizations not separately identified for TME reporting

[27] If the insurer plays claims for another organization's members (e.g., Blue Card members in the Blue Cross Blue Shield network) those members should not be included in TME.

purposes) that are expected to be reconciled after the 180-day review period. Non-claims payments should be reported on an incurred basis, not paid basis.

ACO / AE Organization IDs

The following ACOs/AEs are to be reported on using the identification number for TME reporting listed in **Table 10**. The table also includes an identification number for reporting on the Insurer Overall, Organization ID 100. This list of ACOs/AEs may be updated from time to time as the ACO/AE market changes. The intent is for payers to report on all ACOs and certified AEs in Rhode Island.

Note: For insurers that did not have contracts with the ACOs/AEs listed in **Table 10** below during some or all of the reporting periods, but do so currently as of July 1, 2022, please report TME for past reporting periods using the primary care provider network within the ACO/AE contract signed closest to the date of the reporting period. For insurers reporting TME by ACO/AE for reporting periods that were not under contract, please indicate so in the comments box in the HD-TME tab of the reporting file.

Table 10. ACO/AE Organization Identification Numbers

ACO/AE Organization	ACO/AE or Insurer Overall Organizational Identification Number for TME Reporting
Insurer Overall	100
Blackstone Valley Community Health Care	101
Coastal Medical[28]	102
Integra Community Care Network	103
Integrated Healthcare Partners	104
Lifespan	105
Providence Community Health Centers	106
Prospect CharterCARE	107
Thundermist	108
Members Not Attributed to an ACO/AE	999

[28] Coastal merged with Lifespan in April 2021. Payers should continue to report Coastal separate from Lifespan so long as Coastal operates as an independent ACO.

D. TME File Specifications

Insurers will submit one Excel file using the template provided by OHIC that includes its TME data. This section describes the detailed information that payers must submit within the following tabs in the Excel file:

- Contents, which describes the Excel file
- Reference Tables
- Definitions
- HD-TME – 2021, which includes summary data and payer comments
- HD-TME – 2022, which includes summary data and payer comments
- ACO_AE – 2021, which includes TME by ACO/AE and insurance category
- ACO_AE – 2022, which includes TME by ACO/AE and insurance category
- Rx Rebates - 2021, which includes pharmacy rebates by insurance category
- Rx Rebates - 2022, which includes pharmacy rebates by insurance category
- LOB Enrollment, which includes detailed member month information for both 2021 and 2022 and request for total premiums earned on self-insured accounts (e.g., income from fees of uninsured plans)
- Standard Deviation – 2021, which includes standard deviation by ACO/AE and insurer
- Standard Deviation – 2022, which includes standard deviation by ACO/AE and insurer
- Age_Sex Factors 2021, which includes TME and truncated TME by age/sex brackets, insurance categories and ACOs/AEs
- Age_Sex Factors 2022, which includes TME and truncated TME by age/sex brackets, insurance categories and ACOs/AEs
- Mandatory Questions
- Validation by Market
- Validation by ACO_AE
- Data Validation

Contents Tab

This tab contains information regarding what the Excel file includes. Insurers do not need to submit information within this tab.

Reference Tables

This tab includes reference tables of key codes outlined herein for ease of reference. Insurers do not need to submit information within this tab.

Definitions

This tab includes definitions outlined herein for ease of reference. Insurers do not need to submit information within this tab.

HD-TME 2021 and HD-TME 2022 Tabs

Insurer Organization ID: The OHIC assigned organization ID as outlined in **Table 11** for the insurer submitting the file.[29]

Table 11. OHIC-assigned Insurer Organization ID

Insurer	Organizational ID
Blue Cross Blue Shield of RI	201
Neighborhood Health Plan of RI	202
Tufts Health Plan	203
UnitedHealthcare	204

Period Beginning and Ending Dates: The dates for the beginning and ending of the period represented by the reported data. These dates should always be January 1 and December 31, respectively, unless an insurer newly enters or exits the market during other parts of the year. All reporting is based on the date of service related to the TME data.

Insurer Comments: A field for insurers to submit any additional information about their submission.

Clinical Risk Adjustment Tool: The clinical risk-adjustment tool, software or product used to calculate the clinical risk score required in the TME file. While this will not be used to adjust spending, it remains a mandatory data element.

Clinical Risk Adjustment Version: The version number of the clinical risk-adjustment tool used to calculate the clinical risk-adjustment score required in the TME file. While this will not be used to adjust spending, it remains a mandatory data element.

Clinical Risk Adjustment Methodology: The underlying methodology used to adjust expenditures to account for patients' underlying clinical risk.

"Doing Business As:" Any Medicare Managed Care Organization must submit all names for which it is "doing business as" in the state of Rhode Island.

[29] This table may need to be updated from time to time as the insurer market in Rhode Island changes.

ACO_AE 2021 and ACO_AE 2022 Tabs

The ACO_AE tabs are the source of the insurer's expenditure data that will be used by OHIC to compute THCE. Insurers will report their permissible claims and non-claims payments in this file.

ACO/AE or Insurer Overall Organization ID: The OHIC Organization ID of the ACO/AE, as listed in **Table 9**. For TME data for members who are unattributed to an ACO/AE, their data are to be reported in aggregate as "Members Not Attributed to an ACO/AE (ACO/AE Identification Number 999)." The table also includes an identification number for reporting on the Insurer Overall, Organization ID 100.

Insurance Category Code: A number that indicates the insurance category that is being reported. All data reported by Insurance Category Code should be mutually exclusive. Commercial claims should be separated into two categories, as shown below. Commercial self-insured or fully insured data for large providers for which the insurer can collect information on all direct medical claims and any claims paid by a delegated entity should be reported in the "Full Claims" category. Commercial self-insured or fully insured data that does not include all medical and subcarrier claims should be reported in the "Partial Claims," category. An adjustment should be made to "Partial Claims" to allow for them to be comparable to full claims. Such an adjustment must be reviewed with OHIC before the adjustment is made.[30] The goal of the adjustment is to *estimate* what total spending might be for those members without having to collect claims data from carve-out vendors, such as PBMs or behavioral health vendors. For example, for those members for whom pharmacy benefits are carved out, the insurer might include its commercial market book of business average pharmacy spending per-member per-month for the same year, calculated on members who had pharmacy coverage, and applied to all member months for which the carve out applied.

If an insurer enrolls Medicare/Medicaid dual eligibles, OHIC requires the insurer to report Medicare-related expenditures under insurance category code 5 and Medicaid-related expenditures under Insurance Category Code 6. For example, if an insurer covers Medicare/Medicaid dual eligibles, but is only responsible for Medicaid services, expenditures for those dual eligibles are reported under Insurance Category Code 6.

Note: If an insurer provides both Medicare and Medicaid benefits to dually eligible beneficiaries through the CMS Financially Aligned Initiative, the insurer should use Insurance Category Code 7 to report applicable expenditures. Any payer with data in Insurance Category Code 7 will be required to submit a reasonable and appropriate estimate of the proportion of Medicare and Medicaid spending within each service category so that OHIC can allocate expenditures to the respective markets for the purposes of

[30] Email Cory.King@ohic.ri.gov with the insurer's proposed approach for making an actuarial sound adjustment to its Partial Claims.

analyses. This will allow OHIC to include the Medicare- or Medicaid-related expenditure for dual eligibles in the respective Market for reporting purposes. Insurers should detail the estimate in the comments field of Header Record tab.

Insurers shall report for all insurance categories for which they have business. For insurers reporting in the "Other" category, insurers should describe in the Comments field of the Header Record tab what is included in the "Other" category.

Table 12. Insurance Category Codes

Insurance Category Code	Definition
1	Medicare & Medicare Managed Care (excluding Medicare/Medicaid Dual Eligibles)
2	Medicaid & Medicaid Managed Care including CHIP (excluding Medicare/Medicaid Dual Eligibles)
3	Commercial — Full Claims
4	Commercial — Partial Claims, Adjusted
5	Medicare Expenditures for Medicare/Medicaid Dual Eligibles
6	Medicaid Expenditures and Medicare/Medicaid Dual Eligibles
7	Medicare/Medicaid Integrated Duals Product (as of CY 2019 this applies only to the NHP Integrity Product)
8	Other

Member Months (annual): The number of unique members participating in a plan each month with a medical benefit, regardless of whether the member has any paid claims. Member months should be calculated by summing the number of months each member was enrolled in a plan with a medical benefit for one calendar year.

Validation check: Beginning with the 2021-2022 reporting period, this tab includes a check to ensure that insurers' member months data submitted in the ACO_AE, Age/Sex, and Standard Deviation tabs align. This check links back to the Data Validation tab.

Clinical Risk Score: A value that measures a member's illness burden and predicted resource use based on differences in patient characteristics or other risk factors. Payers must disclose the health status adjustment tool and version number and calibration settings in the header record. **Note: This information will not be used to adjust payer data. OHIC will collect this information to compare results of payer-reported risk-adjustment with the results of age/sex risk-adjustment using the reported data in the Age/Sex Factors tabs.** Insurers must submit a clinical risk score that represents all members being reported by

Insurance Category Code and the three categories articulated under *TME Data Submission*. Insurers are permitted to use a clinical risk-adjustment tool and software of their own choosing, but must disclose the tool (e.g., ACG, DxCG, etc.) and the version in the comment fields of the TME data files. **TME data are not to be adjusted.**

Note: Clinical risk scores should be normalized for every annual data submission (regardless of how many calendar years of data are included in submission), to ensure accurate comparison of trend across years (e.g., when payers submit 2021-2022 data, clinical risk scores should be based on 2021).

Claims and Non-Claims Service Categories

Payers are to report TME data using the following claims and non-claims categories. To avoid double counting, all categories must be mutually exclusive.

Claims: Hospital Inpatient: The TME paid to hospitals for inpatient services generated from claims. Includes all room and board and ancillary payments. Includes all hospital types. Includes payments for emergency room services when the member is admitted to the hospital, in accordance with the specific payer's payment rules. Does not include payments made for observation services. Does not include payments made for physician services provided during an inpatient stay that have been billed directly by a physician group practice or an individual physician. Does not include inpatient services at non-hospital facilities.

Claims: Hospital Outpatient: The TME paid to hospitals for outpatient services generated from claims. Includes all hospital types and includes payments made for hospital-licensed satellite clinics. Includes emergency room services not resulting in admittance. Includes observation services. Does not include payments made for physician services provided on an outpatient basis that have been billed directly by a physician group practice or an individual physician.

Claims: Professional, Primary Care: The TME paid to primary care providers (i.e., family practice, geriatric, internal medicine and pediatric providers defined using taxonomy codes in **Appendix F**) delivering care at a primary care site of care (defined below) generated from claims using the following code-level definition found in **Appendix G**.

Primary care services include care management; care planning; consultation services; health risk assessments, screenings and counseling; home visits; hospice/home health services; immunization administrations; office visits and preventive medicine visits. They do not include prescription drugs (including those covered by both medical and pharmacy benefits), laboratory, x-ray and imaging services.

Payers should identify primary care providers first by searching for relevant provider taxonomy codes in the rendering provider field and then the billing provider field. If the carrier

does not utilize the provider taxonomy codes in **Appendix F**, it may apply its provider codes to match the description of the provider taxonomy codes included.

A primary care site of care is defined as a primary care outpatient setting (e.g., office, clinic or center), federally qualified health center (FQHC), school-based health center, or via telehealth delivered by a PCP that is part of a primary care outpatient setting, FQHC or school-based health center. It excludes primary care spending delivered at urgent care centers, retail pharmacy clinics and via stand-alone telehealth vendors, i.e., a third-party telehealth vendor that does not contract with a primary care outpatient setting, federally qualified health center or school-based health center to deliver services. Insurers should use the place of service and modifier codes in the primary care code list in **Appendix F** to identify primary care services delivered via telehealth.

Claims: Professional, Specialty Care: The TME paid to physicians or physician group practices generated from claims. Includes services provided by a doctors of medicine or osteopathy in clinical areas other than the family practice, geriatric, internal medicine and pediatric providers described above, not defined by the health plan as a PCP.

Claims: Professional Other: The TME paid from claims to health care providers for services provided by a licensed practitioner other than a physician or identified as a PCP. This includes, but is not limited to, licensed podiatrists, nurse practitioners, physician assistants, physical therapists, occupational therapists, speech therapists, psychologists, licensed clinical social workers, counselors, dieticians, dentists, chiropractors and any professional fees that do not fit other categories. It also includes services delivered through third-party telehealth vendors contracted directly through the health plan to offer a subset of services.

Claims: Retail Pharmacy: The TME paid from claims to health care providers for prescription drugs, biological products or vaccines as defined by the insurer's prescription drug benefit. *This category should not include claims paid for pharmaceuticals under the insurer's medical benefit.* Pharmacy spending provided under the medical benefit should be attributed to the location in which it was delivered (e.g., pharmaceuticals delivered in a hospital inpatient setting should be attributed to Claims: Hospital Inpatient). It does not include the cost of vaccines administered in the primary care setting. Medicare managed care, i.e., Medicare Advantage, insurers that offer stand-alone prescription drug plans (PDPs) should exclude stand-alone PDP data from their TME. Pharmacy data is to be reported gross of applicable rebates.

Claims: Long-Term Care: All TME data from claims to providers for: (1) nursing homes and skilled nursing facilities; (2) intermediate care facilities for individuals with intellectual disability (ICF/ID) and assisted living facilities; and (3) providers of home- and community-based services, including personal care (e.g., assistance with dressing, bathing, eating, etc.), homemaker and chore services, home-delivered meal programs, home health services, adult daycare, self-directed personal assistance services (e.g., assistance with grocery shopping, etc.), and programs designed to assist individuals with long-term care needs who receive care in their

home and community, such as PACE and Money Follows the Person. Does not include payments made for professional services rendered during a facility stay that have been billed directly by a physician group practice or an individual practitioner.

Claims: Other: All TME paid from claims to health care providers for medical services not otherwise included in other categories. Includes, but is not limited to durable medical equipment, freestanding fees of community health center services, free standing ambulatory surgical center services, hospice facility, freestanding diagnostic facility services, hospice, hearing aid services and optical services. It also includes the cost of vaccines administered in the primary care setting. Payments made to members for direct reimbursement of health care benefits/services may be reported in "Claims: Other" if the insurer is unable to classify the service. If this is the case, the insurer should consult with OHIC about the appropriate placement of the service prior to categorizing it as "Claims: Other." However, TME data for non-health care benefits/services, such as fitness club reimbursements, are not to be reported in any category. Payments for fitness club membership discounts whether given to the provider or given in the form of a capitated payment to an organization that assists the insurer with enrolling members in gyms is not a valid payment to include.

Non-Claims: Capitated, Prospective Global Budget, Prospective Case Rate, or Prospective Episode-Based Payments: All non-claims based payments for services delivered under the following payment arrangements: (1) capitation payments, i.e., single payments to providers to provide healthcare services over a defined period of time;[31] (2) global budget payments, i.e., prospective payments made to providers for a comprehensive set of services for a designated patient population or a more narrowly defined set of services where certain benefits (e.g., behavioral health, pharmacy) are carved out;[32] (3) case rate payments, i.e., prospective payments made to providers in a given provider organization for a patient receiving a defined set of services for a specific period of time and (4) prospective episode-based payments, i.e., payments received by providers (which can span multiple provider organizations) for a patient receiving a defined set of services for a specific condition across a continuum of care, or care for a specific condition over a specific time period.

Non-Claims: Performance Incentive Payments: All payments to reward providers for achieving quality or cost-savings goals, or payments received by providers that may be reduced if costs exceed a defined pre-determined, risk-adjusted target. Includes pay-for-performance, i.e., payments to reward providers for achieving a set target (absolute, relative or improvement-based) for quality or efficiency metrics, and pay-for-reporting, i.e., payments to providers for reporting on a set of quality or efficiency metrics, usually to build capacity for pay-for-

[31] If the arrangement includes payments for care management, integrated behavioral health, or any other category reported below, include spending for such services within this category.
[32] Services typically include primary care services, specialty care services, inpatient hospital services and outpatient hospital services at a minimum. Hospitals and health systems are typically the provider types that would operate under a global budget, though this is not widespread.

performance, payments. Includes shared savings distributions, i.e., payments received by providers if costs of services are below a pre-determined, risk-adjusted target, and shared risk recoupments, i.e., payments providers must recoup if costs of services are above a pre-determined, risk-adjusted target.

Non-Claims: Payments to Support Population Health and Practice Infrastructure: All payments made to develop provider capacity and practice infrastructure to help coordinate care, improve quality and control costs. Includes, but is not limited to payments that support care management, care coordination and population health; [33] EHR/HIT infrastructure payments and other data analytics payments[34]; HIE payments[35]; patient-centered medical home (PCMH) administration payments[36]; PCMH recognition payments[37] and behavioral health integration *that are not reimbursable through claims*.[38]

Non-Claims: Provider Salaries: All payments for salaries of providers who provide health care services not otherwise included in other claims and non-claims categories. This category is typically only applicable to closed delivery systems.

Non-Claims: Recoveries: All payments received from a provider, member/beneficiary or other payer, which were distributed by a payer and then later recouped due to a review, audit or investigation. This field should be reported as a **negative number**. Only report data in this category not otherwise included elsewhere (e.g., if Inpatient Hospital is reported net of Recoveries, do not separately report the same Recoveries amount in this category).

Non-Claims: Other: All other payments made pursuant to the insurer's contract with a provider not made on the basis of a claim for health care benefits/services and cannot be

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[33] Includes payments to fund care managers, care coordinators, or other traditionally non-billing practice team members (e.g., practice coaches, patient educators, community health workers, patient navigators) who help providers organize clinics to function better and help patients take charge of their health. It can also include payments to fund the cost of a pharmacist to help practices with medication reconciliation for poly-pharmacy patients.

[34] Includes payments to help providers adopt and utilize health information technology, such as electronic medical records and health information exchanges, software that enables primary care practices to analyze quality and / or costs outside of the EHR (e.g., software to track patient costs in near-to-real time) and / or the cost of a data analyst to support practices.

[35] Includes payments for CurrentCare, the state health information exchange, or to help practices link to CurrentCare established by RI Gen. Laws Chapter 5-37.7.

[36] Includes payments to support the operations of the Care Transformation Collaborative of Rhode Island (CTC-RI).

[37] Includes payments to primary care practices recognized as PCMHs by OHIC to support PCMH transformation and ongoing PCMH-related operations, as described on OHIC's "PCMH Definition and Requirements" website.

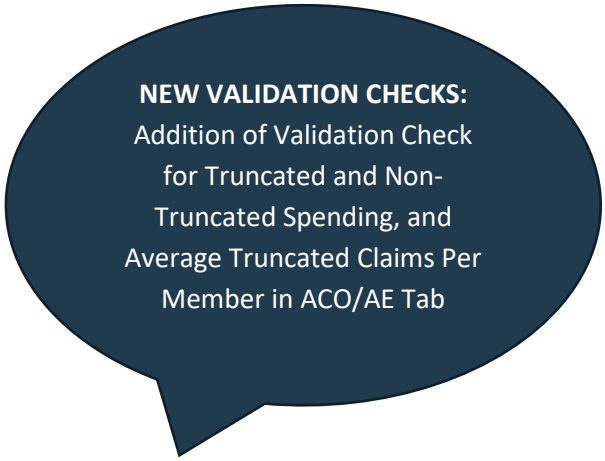
[38] Includes payments that promote the appropriate integration of primary care and behavioral health care that are not reimbursable through claims (e.g., funding behavioral health services not traditionally covered with a discrete payment when provided in a primary care setting, such as a) substance abuse or depression screening, b) performing assessment, referral, and warm hand-off to a behavioral health clinician, and/or c) supporting health behavior change, such as diet and exercise for managing pre-diabetes risk). This category excludes payments for mental health or substance use counseling.

properly classified elsewhere. This may include governmental payer shortfall payments, grants or other surplus payments. FQHC wrap payments should be included in this category. Only payments made to providers are to be reported; insurer administrative expenditures (including corporate allocations) are not included in TME.

Total Claims Excluded Because of Truncation: The total claims-based spending truncated using the truncation points listed in **Table 13** below. This variable is collected by Insurance Category Code for each ACO/AE and for the Insurer Overall.

Validation Check: Beginning with the 2021-2022 reporting period, this tab includes a calculation of the average truncated claims per member.

While OHIC recognizes that some insurers separately truncate medical and pharmacy spending in their total cost of care contracts, OHIC requests that truncation be applied to individuals' total spending, inclusive of all medical and pharmacy spending.



Validation Check: Beginning with the 2021-2022 reporting period, this tab includes a check to ensure that insurers' truncated and non-truncated spending submitted in the ACO_AE, Age/Sex, and Standard Deviation tabs align. This check links back to the Data Validation tab.

Rx Rebates 2021 and Rx Rebates 2022 Tabs

The pharmacy rebate tab will be the source of the insurer's pharmacy rebate and will be used by OHIC to compute THCE and TME. In reporting trend of service category spending, OHIC will report the retail pharmacy service category net of retail pharmacy rebates. Since medical pharmacy is spread among different service categories, medical pharmacy rebates will only be net from TME. Insurers will report their rebate data in this tab.

Insurance Category Code: A number that indicates the insurance category that pharmacy rebates are being reported on. Use the applicable Insurance Category Code as defined previously in the ACO/AE Record File (not all Insurance Category Codes may be applicable to pharmacy rebates).

Retail Pharmacy Rebates: The estimated value of rebates attributed to Rhode Island resident members provided by pharmaceutical manufacturers for prescription drugs with specified

dates of fill, corresponding to the reporting period excluding manufacturer-provided fair market value bona fide service fees for retail prescription drugs.[39]

This amount shall include pharmacy benefit manager (PBM) rebate guarantee amounts and any additional rebate amounts transferred by the PBM.

Medical Pharmacy Rebates: The estimated value of rebates attributed to Rhode Island resident members provided by pharmaceutical manufacturers for prescription drugs with specified dates of fill corresponding with the reporting period, excluding manufacturer-provided fair maker value bona fide service fees for pharmaceuticals that are paid for under the member's medical benefit. These drugs may be included in the professional claims category with J codes or part of facility feeds for drug infusions administered in the outpatient setting.

This amount shall include pharmacy benefit manager (PBM) rebate guarantee amounts and any additional rebate amounts transferred by the PBM.

If data submitters are unable to separate out retail and medical pharmacy rebates for reporting, all pharmacy rebates should be reported in aggregate in the Total Pharmacy Rebate field.

Total rebates should be reported without regard to how they are paid to the insurer (e.g., through regular aggregate payments, on a claims-by-claim basis, etc.) or whether they are passed on to an employer. The only exception is for Medicaid managed care payers who should not report pharmacy rebates that are passed to the state. They should only report those rebates above and beyond the state negotiated rebates.

Payers should apply IBNR factors to preliminary prescription drug rebate data to estimate total anticipated rebates related to fill dates in the calendar year for which reporting will be done. If insurers are unable to report rebates specifically for Rhode Island residents, insurers should report estimated rebates attributed to Rhode Island resident members in a proportion equal to the proportion of pharmacy spending for Rhode Island resident members compared to pharmacy spending for total members, by line of business. For example, if Rhode Island resident commercial member spending represent 10% of an insurer's total commercial members, then 10% of the total pharmacy rebates for its commercial book of business should be reported. If the insurer is unable to identify the percentage of pharmacy spending for Rhode Island resident members, then the insurer should calculate the pharmacy rebates attributable to Rhode Island resident members using percentage of membership. This value should always be reported as a **negative number.**

Total Pharmacy Rebates: The sum of retail pharmacy rebates and medical pharmacy rebates.

[39] Fair market value bona fide service fees are fees paid by a manufacturer to a third party (e.g., insurers, PBMs, etc.) that represent fair market value for a bona fide, itemized service actually performed on behalf of the manufacturer that the manufacturer would otherwise perform (or contract for) in the absence of the service arrangement (e.g., data service fees, distribution service fees, patient care management programs, etc.).

Line of Business Enrollment Tab

The Line of Business (LOB) tab will be the source of the insurer's member months by market OHIC will use to compute NCPHI. Insurers will report 1) their member months by market, and 2) spending to calculate NCPHI for self-insured plans in this tab.

Line of Business Enrollment Category Code: The code corresponding to the line of business for plans categorized by the insurer as individual, large group – fully insured, small group – fully insured, self-insured, student market, Medicare managed care, and Medicaid/CHIP managed care and Medicare/Medicaid duals. These market enrollment category codes are listed **in Table 13.**

Table 13. Line of Business Enrollment Category Codes

Line of Business Enrollment Category Code	Definition
901	Individual
902	Large group, fully insured
903	Small group, fully insured
904	Self-insured
905	Student market
906	Medicare managed care
907	Medicaid/CHIP managed care
908	Medicare/Medicaid duals

Member Months (annual): The number of unique Rhode Island resident members participating in a plan each month with at least a medical benefit, regardless of whether the member has any paid claims. Insurers will submit information for both 2021 and 2022 in this tab. Member months should be calculated by summing the number of months each member was enrolled in a plan with a medical benefit for one calendar year. The total member months reported in this tab should equal the total number of members whose TME is being reported.

Income from Fees of Uninsured Plans: OHIC requests insurance carriers to report aggregate information on the premiums earned from their self-insured accounts (e.g., "fees from uninsured plans"). Insurers should follow the instructions for Part 1, Line 12 on the NAIC SCHE for their Rhode Island situs self-insured accounts. Insurers must report this for self-insured plans since this is not typically reported in the SHCE filed with OHIC. Insurers will submit data for both 2021 and 2022.

Standard Deviation 2021 and Standard Deviation 2022 Tabs

The standard deviation information file will be the source of each provider entity and insurance carrier's standard deviation information for the purposes of conducting statistical testing and developing confidence intervals around cost growth rates. Carriers will report standard deviation data for:

- each market; and
- each provider entity by market (see below for definition of market).

ACO/AE or Insurer Carrier Organization ID: The OHIC-assigned organizational ID of the ACO/AE or insurance carrier submitting the file, as outlined in **Table 10 and Table 11,** respectively. For TME data for members who are unattributed to an ACO/AE, their data are to be reported in aggregate as "Members Not Attributed to an ACO/AE (ACO/AE Organization ID Number 999)."

Market: Refers to the Medicare and commercial markets, and combines Insurance Category Codes. Insurance Category Codes should be mapped to market as follows:

- **Medicare:** includes Medicare Managed Care and Medicare Expenditures for Medicare/Medicaid Dual Eligibles (i.e., ICC 1 and ICC 5)
- **Medicaid:** includes Medicaid Managed Care and Medicaid Expenditures Medicare/Medicaid Dual Eligibles (i.e., ICC2 and ICC6)
- **Commercial:** includes Commercial – Full Claims and Commercial – Partial Claims (for the commercial partial population, standard deviation should be calculated based on adjusted data for the partial population) (i.e., ICC 3 and ICC 4)

Member Months: The number of unique members participating in a plan each month with a medical benefit, regardless of whether the member has any paid claims. Member months should be calculated by taking the number of members with a medical benefit and multiplying that sum by the number of months in the member's policy.

Total Truncated Spending: The total claims-based spending after truncation attributed to each member participating in a plan each month with a medical benefit consistent with the general cost growth target specifications on how to calculate claims-based spending. The spending in these cells should be after member-level truncation is applied using the truncation points listed in **Table** 16 below. Do not include any non-claims spending categories.

Some insurers will attribute members to an Accountable Care Organization/Accountable Entity on a monthly basis. If a member is attributed to more than one ACO/AE during the year, the **payer should "reset the clock" by calculating total spending attributed to the ACO/AE for all** ACO/AEs to which the member was reported and identify the total spending above the truncation point by each ACO/AE (see the inset for an example calculation).

Validation Check: Beginning with the 2021-2022 reporting period, this tab includes a check to ensure that insurers' truncated spending submitted in the ACO_AE and Standard Deviation tabs align. This check links back to the Data Validation tab.

Standard Deviation PMPM: The calculated standard deviation for all members for the applicable market and ACO/AE, reported as a per-member-per-month (PMPM) value. Insurers should include all members attributed to an ACO/AE, including members with no utilization. Standard deviation should be based on PMPM spending. Insurance carriers should calculate the standard deviation PMPM after partial claims adjustments. Non-claims expenditures should be excluded from the calculation.

The following steps detail how insurers can calculate standard deviation values for the data submission:

Step 1: Attribute members to the appropriate ACO/AE for a specific market. Insurers should include all members attributed to an ACO/AE, including members with no utilization.

Step 2: For each market, for each ACO/AE, the insurance carrier must calculate the average monthly spending amount of each member using claims-based allowed amounts (in the Example spreadsheet, the result is in the column, "Average Per Member Month Amount After Applying Truncation"). Insurers should calculate the average claims-based allowed amount after partial claims adjustments and after truncation of member level spending (Claims: Annual Total After Applying Truncation). Non-claims expenditures should be excluded from this average.
Note: The unit of analysis is member months, not individual members. This ensures that the weight of monthly spending for each member is accurately reflected in the average.

Step 3: For each market, for each ACO/AE, sum "Average Per Member Month Amount After Applying Truncation" (result from Step 2) and divide by total member months (across all members) to produce a per member per dollar amount that is specific to that given market and ACO/AE.

Step 4: With the average claims expenses value for each ACO/AE, insurers can now calculate the standard deviation.

$$SD = \sqrt{\frac{\sum_i (X_i - \bar{X})^2}{N}}$$

Where:

s^2 = sample variance

x_i = value of the one observation
$\bar{x}$ = the mean value of all observations
n = the number of observations

Validation check: Using the Excel function STDEV.P() or other standard deviation commands in any other statistical software program, insurers can calculate the standard deviation of the PMPM costs for a given market.

Note that when calculating standard deviation, insurers should use the formula for population standard deviation (divided by N). Insurers should NOT use the formula for sample standard deviation (divided by N-1).

Step 5: Report the standard deviation values in the data submission template in the Standard Deviation tabs. Each row should correspond to an ACO/AE for a specific market or for the insurer overall (using Insurer Overall ID, 100) for that market.

Age_Sex Factors 2021 and Age_Sex Factors 2022 Tabs

The age/sex risk-adjustment tabs (Age_Sex Factors) are where insurers should report spending categorized by age/sex bands and for data on member level truncation. Information in these tabs will be used to calculate risk-adjustment scores that will be applied at the payer and ACO/AE level and to truncate high-cost outliers from the TME data. Field definitions are listed below.

Age Band Code: The code associated with the age band of the members whose spending is being reported. See **Table 14** below.

Table 14. Age Band Codes

Age Band Code	Description
1	0 to 1 year old
2	2 to 18 years old
3	19 to 39 years old
4	40 to 54 years old
5	55 to 64 years old
6	65 to 74 years old
7	75 to 84 years old
8	85 + years old

Sex Band Code: The code associated with the sex of the members whose spending is being reported. See **Table 15** below.

Table 15. Sex Band Codes

Sex Code	Description
1	Female
2	Male

How to Handle Members Without Recorded Sex Information

For members that have no recorded sex information, insurers should use their own predetermined rules for assigning the unreported member to a specific sex group (an insurer's predetermined rule could be based on the demographic distribution of the overall population or any other relevant factor).

If an insurer does not have a predetermined rule for categorizing unassigned members, it should use one of the following options to assign the member:

- Attribute the member to the larger group: In this approach, the member with unreported sex information would be assigned to the sex group (male or female) that has the largest representation in the submission/ICC code as measured by member months.
- Impute missing sex data: This approach involves using statistical methods to estimate the missing sex data based on other available information for the insurance member. Techniques such as regression imputation, nearest neighbor imputation, or multiple imputation could be used.

Total Member Months by Age/Sex Band: The number of unique Rhode Island resident members for the age/sex cell participating in a plan each month with a medical benefit, regardless of whether the member has any paid claims. Member months should be calculated by summing the number of months each member was enrolled in a plan with a medical benefit for one calendar year. The age of the member should be determined as of January 1st of the calendar year.

Total Spending Before Truncation is Applied: The annual total claims-based spending attributed to each member participating in a plan each month with a medical benefit consistent with aforementioned specifications on how to calculate claims-based spending. The spending in these cells should be before member-level truncation is applied. **Do not include any non-claims spending categories.** *Validation check: The sum of all age/sex bands for this variable within one Insurance Category Code should equal the sum of Total Unadjusted Claims Expenses for all ACOs/AE IDs in the ACO_AE tab.*

Count of Members Whose Spending was Truncated: Report the number of members whose spending was above the truncation threshold applicable to the Insurance Category Code and ACO/AE to which the member was attributed. This variable is not needed at the age/sex level, just the total level for each ICC and ACO/AE.

Total Spending After Applying Truncation at the Member Level: The total claims-based spending after truncation attributed to each member participating in a plan each month with a medical benefit consistent with the general cost growth target specifications on how to calculate claims-based spending. The spending in these cells should be *after* member-level truncation is applied using the truncation points listed in **Table** 16 below. **Do not include any non-claims spending categories.** *Validation check: the sum of all age/sex bands for this variable across all ACO/AE IDs within one Insurance Category Code will not necessarily equal the sum of the reported truncated spending reported in the Age_Sex_ICC tab because truncation is applied at a per-member level and "reset" for members who are attributed to more than one ACO/AE during the calendar year. (See below for more information.*

Some insurers will attribute members to ACOs/AEs on a monthly basis. If a member is attributed to more than one ACO/AE during the year, the payer should "reset the clock" by calculating total spending attributed to the ACO/AE for all ACO/AEs to which the member was reported and identify the total spending above the truncation point by each ACO/AE. *(See inset for example calculation).*

How to Handle When Members Can Be Attributed to More than One ACO/AE During the CY.

Example with a $150,000 truncation point:

- Member in Insurance Category Code 3 was attributed to ACO X for 8 months with $200,000 in claims.
- Member is then attributed to ACO Y for 4 months with $175,000 in claims.
- ACO X's spending above the truncation would be $50,000 while ACO's Y spending above the truncation would be $25,000.
- Since the member cost the payer $375,000 in total, the total dollars above the truncation point for the payer would be $225,000.

Table 16. Truncation Points by Insurance Category Codes

Insurance Category Code	Definition	Per Member Truncation Point
1	Medicare & Medicare Managed Care (excluding Medicare/Medicaid Dual Eligibles)	$100,000
2	Medicaid & Medicaid Managed Care including CHIP (excluding Medicare/Medicaid Dual Eligibles)	$250,000
3	Commercial — Full Claims	$150,000
4	Commercial — Partial Claims, Adjusted	$150,000

Insurance Category Code	Definition	Per Member Truncation Point
5	Medicare Expenditures for Medicare/Medicaid Dual Eligibles	$100,000
6	Medicaid Expenditures for Medicaid Dual Eligibles	$250,000
7	Medicare/Medicaid Integrated Duals Product (as of CY 2019 this applies only to the NHPRI Integrity Product)	$250,000
8	Other	Consult with OHIC

For insurers reporting in Insurance Category Code 4 (Partial Claims, Adjusted), the member level truncation should be applied *after* estimates of carve-out spending have been made, so that truncation is being applied to an estimate of individual members' total claims spending. *(See inset below for example calculation.)*

How to Apply Truncation to Insurance Category Code 4 (Partial Claims, Adjusted)

- An insurer reporting Insurance Category Code 4 (Partial Claims, Adjusted) data has carved-out its pharmacy benefit to a PBM and does not have access to claims level spending.
- The Insurer would develop an estimate for what Insurance Category Code 4's PMPM spending on pharmacy would have been using its Insurance Category Code 3 (Full Claims) population experience as a benchmark. The table below provides one suggested approach.

Calculate Rx PMPM for Insurance Category 4

[A]	Insurance Category 3 Rx PMPM	$100	
[B]	Insurance Category 3 Risk Score	1.23	
[C]	Insurance Category 4 Risk Score	1.44	
[D]	Insurance Category 4 Rx PMPM	**$117**	[A] ÷ [B] X [C]

- The Insurer would add this PMPM estimate to member level spending by multiplying the estimated Insurance Category 4 Rx PMPM by the number of member months within each age/sex band.
- The Insurer would then apply the per-member truncation to Insurance Category Code 4. column.

Total Dollars Excluded from Spending After Applying Truncation at the Member Level: The sum of all dollars that were removed from total spending after applying truncation at the member level. *Validation check: the sum of all age/sex bands for this variable within one Insurance Category Code should equal the difference between Total Spending before Truncation is Applied and Total Spending After Applying Truncation at the Member Level.*

Mandatory Questions Tab

Insurers must answer questions about their data submission to ensure the submission is in alignment with the specifications outlined herein.

Validation by Market Tab

This tab uses insurer-provided information from other tabs within the Excel workbook to calculate spend and trend by market and service category. These summary tables are intended to help insurers validate their own data prior to submission to OHIC.

Insurers are not required to input any data in this tab, but must review it prior to submitting to ensure the data are correct.

Validation by ACO_AE Tab

This tab uses insurer-provided information from other tabs within the Excel workbook to calculate spend and trend by ACO/AE and service category. These summary tables are intended to help insurers validate their own data prior to submission to OHIC.

Insurers are not required to input any data in this tab, but must review it prior to submitting to ensure the data are correct.

Data Validation Tab

This tab evaluates whether the member months and spending data the insurer submitted in the ACO_AE, Age-Sex Factors, and Standard Deviation tabs align. This tab contains validation checks at both the Insurer Overall and ACO/AE levels. This tab also compares submitted data to other publicly available data sources, such as CMS' Monthly Medicare Advantage Enrollment data and Supplemental Health Care Exhibit data.

Insurers are not required to input any data in this tab, but must review it prior to submitting and either correct or explain any areas of misalignment in the data.

File Submission

Naming Conventions

Data submissions should follow the following naming conventions:

Insurer Name_TME_YYYY_Version.xls

YYYY is the four-digit year of submission (which will generally be one year later than the year of the data reflected in the report).

Version is optional and indicates the submission number.

The file extension must be .xls or .xlsx.

Below are examples of valid file names:

TME_2021_01.xlsx or TME_2021_1.xlsx or TME_2021.xlsx.

Submitting Files to OHIC

Electronic files are to be submitted to Cory.King@ohic.ri.gov.

Appendix B:
EOHHS TME Data Specification

This EOHHS TME data specification provides technical details to assist EOHHS in reporting and filing data to enable OHIC to calculate TME. This appendix can serve as a stand-alone document to serve as a guide for EOHHS TME data reporting.

OHIC will annually request TME data files(s) from EOHHS with dates of service during the prior calendar year, and any other past years upon request.

Much of the data will come from the MMIS system managed by Gainwell Technologies, however, some of the data come from internal EOHHS reports such as the Medicaid Expenditure report. The table below identifies where the source of data will come from. To begin the process of collecting EOHHS FFS data, contact Charles Plungis Charles.Plungis@ohhs.ri.gov, Assistant Director of Finance for the Medicaid program.

Table 17 outlines types of spending for EOHHS to include in its TME data submission.

Table 17.TME Data to Include in EOHHS' Data Submission

Type of Spending	Source of Spending
• FFS claims expenditures for managed care enrollees, including any out-of-plan payments for dental, behavioral health, or services for persons with developmental disabilities.	• MMIS System
• FFS claims expenditures for individuals not eligible for managed care or in the "FFS waiting period." Expenditures should include data on individuals excluded from managed care, and data on managed care-eligible individuals during their "FFS waiting period" prior to enrollment in managed care. This will include claims for services for individuals who had been enrolled in Rhody Health Options or are enrolled in the Integrated Care Initiative when Medicaid is the primary payer (e.g., nursing home expenses, adult dental, etc.).	• MMIS System
• Other EOHHS FFS claims expenditures not included in any of the aforementioned categories such as FFS expenditures for populations or programs that are paid with State-only general funds (e.g., RI Pharmaceutical Program for the Elderly).	• MMIS System
• EOHHS' premium payments, capitation or lump sum payments to Rhode Island's Program for All-Inclusive Care for the Elderly (PACE) organization(s). PACE payments are considered non-claims payments. EOHHS should not include premium payments to managed care organizations, as the managed care organizations are reporting their spending and administrative expense separately.	• MMIS System

Type of Spending	Source of Spending
• EOHHS' payments to Eleanor Slater Hospital for acute and long term care services. These payments exist in the state's MMIS system and to the extent possible, acute spending should be included in hospital inpatient, long term care should be included in the long term care service category consistent with the definition listed below.	• MMIS System
• EOHHS' FQHC PPS Wrap payments made to FQHCs.	• MMIS System • Medicaid Expenditure Reports
• EOHHS' capitation payments to a vendor(s) for non-emergency medical transportation (NEMT). NEMT payments are considered non-claims payments. Data should be submitted on a program code basis.	• MMIS System
• EOHHS's other non-claims expenditures, including any incentive or HSTP payments made to providers, or AEs, as applicable. Any non-claims expenditures that EOHHS distributes to providers through the MCOs should not be reported by EOHHS. The MCOs will report this information in their non-claims-based payments category.	• Medicaid Expenditure Reports • Rhode Island's G/L -- RIFANS
• EOHHS's upper payment limit (UPL) payments made to hospitals to account for the difference between Medicaid and Medicare rates. These data should be included in non-claims-based payments at the aggregate Medicaid market level.	• Medicaid Expenditure Reports • Rhode Island's G/L -- RIFANS
• Federal and state supplemental pharmacy rebate collections. There is a separate file to report EOHHS pharmacy rebate data. See below for more details.	• MMIS System

EOHHS data submission should not include:

- Data related to spending for dual eligible populations when Medicaid is not the primary payer.
- Any expenditures made from or to EOHHS from or to Medicaid MCOs that are not considered claims (e.g., monthly capitation payments, maternity supplemental payments, risk mitigation payments, incentives/penalties). For example, EOHHS should not include capitation payments made to MCOs for managing the Rhody Health Options and Integrated Care Initiative populations. (However, FFS claims that were not covered under Rhody Health Options or Integrated Care Initiative should be reported in the FFS claims for non-managed care enrollees.)
- Any expenditures related to the Division of Elderly Affairs (DEA) Co-Pay Program. Including premium/copay assistance may duplicate spending in certain categories.

- Dual Medicare premium payments, including premium assistance for Qualified Medicare Beneficiary Program (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) premium assistance payments.
- Part D clawback payments.
- Nursing home interim payments and recoupments.

OHIC may periodically update and revise these data specifications in subsequent versions of this implementation manual.

TME File Submission Instructions and Schedule

EOHHS should submit Excel files of its data using the templates provided by OHIC. **Table 18** outlines the schedule for EOHHS to submit TME information on an annual basis.

Table 18. EOHHS' TME Filing Schedule

Date	Files Due
October 1, 2021	CY 2019 Final and CY 2020 Estimated TME
September 30, 2022	CY 2020 Final and CY 2021 Estimated TME
September 29, 2023	CY 2021 Final and CY 2022 Estimated TME

TME Data Submission

EOHHS must report TME data based on allowed amounts (i.e., the amount EOHHS paid plus any member cost sharing). EOHHS must include only information pertaining to members:

- who are residents of Rhode Island, regardless of whether services are provided by providers located in or out of Rhode Island, and
- for which EOHHS is primary on a claim (i.e., EOHHS should exclude any paid claims for which it was the secondary or tertiary payer).

EOHHS will not attribute its members to AEs or other providers. Instead, it will report all of its spending in aggregate.

Claims Run-Out Period Specifications

EOHHS shall allow for a claims run-out period of at least 180 days after December 31 of the performance year. EOHHS should apply reasonable and appropriate IBNR/IBNP completion factors to each respective TME service category. Claims payments should be reported on an incurred basis, not paid basis.

TME Data File Field Definitions

Each item below represents a column in the TME Data File Excel template that EOHHS will use to submit TME data to OHIC. There are four categories of tabs within the Excel template that EOHHS must submit: (1) validation tab; and two sets of the following tabs (one for each reporting year): (2) header tabs; (3) spending by program code tabs, and (4) pharmacy rebate tabs. Each tab data layout and field definitions are described below in more detail.

Header Tab Field Definitions

Period Beginning and Ending Dates: The beginning period of time represented by the reported data. These dates should always be January 1 and December 31, respectively. All reporting is based on the date of service related to the TME data.

Comments: EOHHS may use this field to provide any additional information or describe any data caveats for the TME submission.

Spending by Program Code Record File Field Definitions

The spending by program code record file will be the source of EOHHS's expenditure data that will be used by OHIC to compute THCE. EOHHS will report its applicable claims and non-claims payments in this file.

Program Code/Aid Eligibility Code: A code that indicates the program or nature of EOHHS TME data that are being reported.

Table 19. EOHHS Program Codes / Aid Eligible Codes

Program Code / Aid Eligibility Code	Definition
1	FFS claims expenditures for managed care enrollees
2	FFS claims expenditures for non-managed care enrollees
3	FFS claims expenditures for programs that are paid with state-only general funds
4	Non-claims-based payments for NEMT vendors
5	Non-claims payments for PACE vendors
6	Other non-claims based payments
7	Total EOHHS FFS spending for all programs/populations

Member Months (annual): The number of members for which EOHHS is reporting TME data over the specified period of time, expressed in member months. Member months reported for a) FFS claims expenditures for RIte Care enrollees and b) FFS claims expenditures for non-RIte Care enrollees should be mutually exclusive.

For program code 7 report the total number of unique member months for all populations EOHHS is reporting on (including any populations that were not already included in any previous program code). In this total, individuals can only be counted once for purposes of computing annual member months. Therefore, this figure cannot be a simple sum of the member months in the other program codes as this would double count some individuals.

Claims: Hospital Inpatient: The TME paid to hospitals for inpatient services generated from claims. Includes all room and board and ancillary payments. Includes all hospital types. Includes payments for emergency room services when the member is admitted to the hospital, in accordance with the specific payer's payment rules. Does not include payments made for observation services. Does not include payments made for physician services provided during an inpatient stay that have been billed directly by a physician group practice or an individual physician. Does not include inpatient services at non-hospital facilities.

Claims: Hospital Outpatient: The TME paid to hospitals for outpatient services generated from claims. Includes all hospital types and includes payments made for hospital-licensed satellite clinics. Includes emergency room services not resulting in admittance. Includes observation services. Does not include payments made for physician services provided on an outpatient basis that have been billed directly by a physician group practice or an individual physician.

Claims: Professional, Primary Care: The TME paid to primary care providers (i.e., family practice, geriatric, internal medicine and pediatric providers defined using taxonomy codes in **Appendix F**) delivering care at a primary care site of care (defined below) generated from claims using the following code-level definition found in **Appendix G.**

Primary care services include care management; care planning; consultation services; health risk assessments, screenings and counseling; home visits; hospice/home health services; immunization administrations; office visits and preventive medicine visits. They do not include prescription drugs (including those covered by both medical and pharmacy benefits), laboratory, x-ray and imaging services.

EOHHS should identify primary care providers first by searching for relevant provider taxonomy codes in the rendering provider field and then the billing provider field. If provider taxonomy matches then identify that provider as a primary care provider. If EOHHS does not utilize the provider taxonomy codes in **Appendix F**, it may apply its provider codes to match the description of the provider taxonomy codes included.

A primary care site of care is defined as a primary care outpatient setting (e.g., office, clinic or center), federally qualified health center (FQHC), school-based health center, or via telehealth delivered by a PCP that is part of a primary care outpatient setting, FQHC or school-based health center. It excludes primary care spending delivered at urgent care centers, retail pharmacy clinics and via stand-alone telehealth vendors, i.e., a third-party telehealth vendor that does not contract with a primary care outpatient setting, federally qualified health center or

school-based health center to deliver services. Insurers should use the place of service and modifier codes in the primary care code list in **Appendix F t**o identify primary care services delivered via telehealth.

Claims: Professional, Specialty Care: The TME paid to physicians or physician group practices generated from claims. Includes services provided by a doctors of medicine or osteopathy in clinical areas other than the family practice, geriatric, internal medicine and pediatric providers described above, not defined by the health plan as a PCP.

Claims: Professional Other: The TME paid from claims to health care providers for services provided by a licensed practitioner other than a physician or identified as a PCP. This includes, but is not limited to, licensed podiatrists, nurse practitioners, physician assistants, physical therapists, occupational therapists, speech therapists, psychologists, licensed clinical social workers, counselors, dieticians, dentists, chiropractors and any professional fees that do not fit other categories. It also includes services delivered through third-party telehealth vendors contracted directly through the health plan to offer a subset of services.

Claims: Retail Pharmacy: The TME paid from claims to health care providers for prescription drugs, biological products or vaccines as defined by the insurer's prescription drug benefit. *This category should not include claims paid for pharmaceuticals under the insurer's medical benefit.* Pharmacy spending provided under the medical benefit should be attributed to the location in which it was delivered (e.g., pharmaceuticals delivered in a hospital inpatient setting should be attributed to Claims: Hospital Inpatient). It does not include the cost of vaccines administered in the primary care setting. Medicare managed care, i.e., Medicare Advantage, insurers that offer stand-alone prescription drug plans (PDPs) should exclude stand-alone PDP data from their TME. Pharmacy data is to be reported gross of applicable rebates.

Claims: Long-Term Care: All TME data from claims to providers for: (1) nursing homes and skilled nursing facilities; (2) intermediate care facilities for individuals with intellectual disability (ICF/ID) and assisted living facilities; and (3) providers of home- and community-based services, including personal care (e.g., assistance with dressing, bathing, eating, etc.), homemaker and chore services, home-delivered meal programs, home health services, adult daycare, self-directed personal assistance services (e.g., assistance with grocery shopping, etc.), and programs designed to assist individuals with long-term care needs who receive care in their home and community, such as PACE and Money Follows the Person. Does not include payments made for professional services rendered during a facility stay that have been billed directly by a physician group practice or an individual practitioner. EOHHS should classify the following "type" codes listed in **Table 20** as long-term care and include spending associated with those codes in this category.

Table 20. Long-term Care Health Care Providers and Associated "Type Codes"

Skilled Nursing (010)	Nursing Home (021)	Rhode Island State Nursing Home (022)
RICLASS (026)	Assisted Living Facility (033)	ICF-MR Public Facility (028)
ICF-MR Private Facility (029)	Personal Care Aide/Assistant (072)	Case Management (044)
Adult Day Care (050)	Shared Living Agency (051)	Day Habilitation (055)
Waiver Case Manager-Other (057)	Severely Disabled Nursing Homecare (065)	BHDDH Behavioral Health Group (066)
Personal Care Choice/Hab Case Management (069)	Self Directed Community Services (071)	
Home Meal Delivery (077)	BHDDH DD Agencies (088)	

Claims: Other: All TME paid from claims to health care providers for medical services not otherwise included in other categories. Includes, but is not limited to durable medical equipment, freestanding fees of community health center services, free standing ambulatory surgical center services, hospice facility, freestanding diagnostic facility services, hospice, hearing aid services and optical services. It also includes the cost of vaccines administered in the primary care setting. Payments made to members for direct reimbursement of health care benefits/services may be reported in "Claims: Other" if the insurer is unable to classify the service. If this is the case, the insurer should consult with OHIC about the appropriate placement of the service prior to categorizing it as "Claims: Other." However, TME data for non-health care benefits/services, such as fitness club reimbursements, are not to be reported in any category. Payments for fitness club membership discounts whether given to the provider or given in the form of a capitated payment to an organization that assists the insurer with enrolling members in gyms is not a valid payment to include.

Non-Claims: Capitated, Prospective Global Budget, Prospective Case Rate, or Prospective Episode-Based Payments: All non-claims based payments for services delivered under the following payment arrangements: (1) capitation payments, i.e., single payments to providers to provide healthcare services over a defined period of time;[40] (2) global budget payments, i.e., prospective payments made to providers for a comprehensive set of services for a designated patient population or a more narrowly defined set of services where certain benefits (e.g., behavioral health, pharmacy) are carved out;[41] (3) case rate payments, i.e., prospective payments made to providers in a given provider organization for a patient receiving a defined

[40] If the arrangement includes payments for care management, integrated behavioral health, or any other category reported below, include spending for such services within this category.

[41] Services typically include primary care services, specialty care services, inpatient hospital services and outpatient hospital services at a minimum. Hospitals and health systems are typically the provider types that would operate under a global budget, though this is not widespread.

set of services for a specific period of time and (4) prospective episode-based payments, i.e., payments received by providers (which can span multiple provider organizations) for a patient receiving a defined set of services for a specific condition across a continuum of care, or care for a specific condition over a specific time period.

Non-Claims: Performance Incentive Payments: All payments to reward providers for achieving quality or cost-savings goals, or payments received by providers that may be reduced if costs exceed a defined pre-determined, risk-adjusted target. Includes pay-for-performance, i.e., payments to reward providers for achieving a set target (absolute, relative or improvement-based) for quality or efficiency metrics, and pay-for-reporting, i.e., payments to providers for reporting on a set of quality or efficiency metrics, usually to build capacity for pay-for-performance, payments. Includes shared savings distributions, i.e., payments received by providers if costs of services are below a pre-determined, risk-adjusted target, and shared risk recoupments, i.e., payments insurers must recoup from providers if costs of services are above a pre-determined, risk-adjusted target.

Non-Claims: Payments to Support Population Health and Practice Infrastructure: All payments made to develop provider capacity and practice infrastructure to help coordinate care, improve quality and control costs. Includes, but is not limited to payments that support care management, care coordination and population health; [42] EHR/HIT infrastructure payments and other data analytics payments[43]; HIE payments[44]; patient-centered medical home (PCMH) administration payments[45]; PCMH recognition payments[46] and behavioral health integration *that are not reimbursable through claims*.[47]

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[42] Includes payments to fund care managers, care coordinators, or other traditionally non-billing practice team members (e.g., practice coaches, patient educators, community health workers, patient navigators) who help providers organize clinics to function better and help patients take charge of their health. It can also include payments to fund the cost of a pharmacist to help practices with medication reconciliation for poly-pharmacy patients.

[43] Includes payments to help providers adopt and utilize health information technology, such as electronic medical records and health information exchanges, software that enables primary care practices to analyze quality and / or costs outside of the EHR (e.g., software to track patient costs in near-to-real time) and / or the cost of a data analyst to support practices.

[44] Includes payments for CurrentCare, the state health information exchange, or to help practices link to CurrentCare established by RI Gen. Laws Chapter 5-37.7.

[45] Includes payments to support the operations of the Care Transformation Collaborative of Rhode Island (CTC-RI).

[46] Includes payments to primary care practices recognized as PCMHs by OHIC to support PCMH transformation and ongoing PCMH-related operations, as described on OHIC's "PCMH Definition and Requirements" website.

[47] Includes payments that promote the appropriate integration of primary care and behavioral health care that are not reimbursable through claims (e.g., funding behavioral health services not traditionally covered with a discrete payment when provided in a primary care setting, such as a) substance abuse or depression screening, b) performing assessment, referral, and warm hand-off to a behavioral health clinician, and/or c) supporting health behavior change, such as diet and exercise for managing pre-diabetes risk). This category excludes payments for mental health or substance use counseling.

Non-Claims: Provider Salaries: All payments for salaries of providers who provide health care services not otherwise included in other claims and non-claims categories. This category is typically only applicable to closed delivery systems.

Non-Claims: Recoveries: All payments received from a provider, member/beneficiary or other payer, which were distributed by a payer and then later recouped due to a review, audit or investigation. This field should be reported as a **negative number**. Only report data in this category not otherwise included elsewhere (e.g., if Inpatient Hospital is reported net of Recovery, do not separately report the same Recovery amount in this category).

Non-Claims: Other: All other payments made pursuant to the insurer's contract with a provider not made on the basis of a claim for health care benefits/services and cannot be properly classified elsewhere. This may include governmental payer shortfall payments, grants or other surplus payments. FQHC wrap payments should be included in this category. Only payments made to providers are to be reported; insurer administrative expenditures (including corporate allocations) are not included in TME.

Pharmacy Rebate Tab

The pharmacy rebate file will be the source of Medicaid FFS and Medicaid MCO retail pharmacy rebate, and any other program or population for which EOHHS collects pharmacy rebates, including for facility-based pharmaceuticals.

Rebate Program Code: A code that indicates the source of the pharmacy claims data for which the pharmacy rebates are attributed, as outlined in **Table 21**.

Table 21. Pharmacy Rebate Program Codes

Rebate Program Code	Definition
1	Managed care pharmacy rebates
2	Fee-for-service pharmacy rebates
3	Managed care – J Code rebate[48]
4	Fee-For-Service – J Code rebate

Retail Pharmacy Rebates: The estimated or actual value of total federal and state supplemental rebates attributed to Rhode Island resident members provided by pharmaceutical manufacturers for prescription drugs with specified dates of fill, corresponding to the reporting

[48] A J-Code rebate is a pharmaceutical rebate the State receives for facility-based pharmaceuticals, and not for retail pharmacy. EOHHS typically credits J-Code rebates to hospital outpatient spending.

period excluding manufacturer-provided fair market value bona fide service fees for retail prescription drugs.[49]

This amount shall include pharmacy benefit manager (PBM) rebate guarantee amounts and any additional rebate amounts transferred by the PBM. These rebates should be reported without regard to how they are paid to EOHHS (e.g., through regular aggregate payments, on a claim-by-claim basis, etc.).

Medical Pharmacy Rebates: The estimated or actual value of total federal and state supplemental rebates attributed to Rhode Island resident members provided by pharmaceutical manufacturers for prescription drugs with specified dates of fill corresponding with the reporting period, excluding manufacturer-provided fair maker value bona fide service fees for pharmaceuticals that are paid for under the member's medical benefit. These drugs may be included in the professional claims category with J codes or part of facility feeds for drug infusions administered in the outpatient setting.

This amount shall include pharmacy benefit manager (PBM) rebate guarantee amounts and any additional rebate amounts transferred by the PBM.

If EOHHS is unable to separate out retail and medical pharmacy rebates for reporting, all pharmacy rebates should be reported in aggregate in the Total Pharmacy Rebate field.

Total rebates should be reported without regard to how they are paid to EOHHS (e.g., through regular aggregate payments, on a claims-by-claim basis, etc.) or whether they are passed on to an employer. The only exception is for Medicaid managed care payers who should not report pharmacy rebates that are passed to the state. They should only report those rebates above and beyond the state negotiated rebates.

EOHHS should apply IBNR factors to preliminary prescription drug rebate data to estimate total anticipated rebates related to fill dates in the calendar year for which data will be reported. This value should always be reported as a **negative number.**

Total Pharmacy Rebates: The sum of retail pharmacy rebates and medical pharmacy rebates.

Member Months (annual): The number of members for each Rebate Program Code expressed as member months.

[49] Fair market value bona fide service fees are fees paid by a manufacturer to a third party (e.g., insurers, PBMs, etc.) that represent fair market value for a bona fide, itemized service actually performed on behalf of the manufacturer that the manufacturer would otherwise perform (or contract for) in the absence of the service arrangement (e.g., data service fees, distribution service fees, patient care management programs, etc.).

Appendix C:
Medicare FFS TME Data Specification

OHIC will be able to receive TME and enrollment data from Medicare FFS annually by September 1 of the year following the measurement period (e.g., 2021 data will be available September 1, 2022). CMS believes that data will be at least 90% complete by September 1.

Specifically, CMS will share total program payments and cost sharing for the following services:

- Hospital inpatient
- Hospital outpatient
- Non-hospital outpatient
- Home health agency
- Hospice
- Skilled nursing facility
- Physician
- Other professionals
- Durable medical equipment
- Other suppliers
- Part D[50]

Table 22 maps CMS' service categories to the TME reporting categories.

Table 22. Mapping of CMS Medicare Service Categories to TME Service Mapping

Medicare Service Categories	TME Service Mapping
Hospital Inpatient	Hospital Inpatient
Hospital Outpatient	Hospital Outpatient
Non-Hospital Outpatient	Other
Home Health Agency	Long-Term Care
Hospice	Other
Skilled Nursing Facility	Long-Term Care
Physician	Professional, Primary Care and Professional, Specialty Care (must be combined when reporting service level category spending with CMS data)
Other Professionals	Other

[50] As part of the TME data received from CMS, CMS will be providing OHIC Part D data for individuals enrolled in FFS stand-alone PDPs as well as Medicare managed care enrollees in MAPD or MA-only plans.

Medicare Service Categories	TME Service Mapping
Durable Medical Equipment	Other
Other Suppliers	Other
Part D	Retail Pharmacy

CMS will also share enrollment figures for Medicare Parts A, B and D broken out between managed care and FFS. CMS reports beneficiaries based on the resident location as of the end of the calendar year.

To receive Medicare FFS TME data from CMS, EOHHS needs to make a formal request to Stephanie Bartee, Director of the Information Products and Analytics Group in the Office of Enterprise Data Analytics, (stephanie.bartee@cms.gov) and copying: ipag_data_products@cms.hhs.gov. **Please note, CMS has specifically requested that Rhode Island staff (not a contractor) make the official request.**

CMS is willing to share the data with OHIC by September 1 if the data request is made by June 1.

Appendix D:
NCPHI Data Specification

This element captures the costs to Rhode Island residents associated with the administration of private health insurance. It is defined as the difference between health premiums earned and benefits incurred and consists of insurers' costs of paying bills, advertising, sales commissions and other administrative costs, premium taxes and profits or losses. **NCPHI is reported as a component of THCE at the state level. NCPHI is not included in the calculation of cost growth at the market, payer, or provider level.**

Because of substantial differences among segments of the Rhode Island health insurance market, NCPHI will be calculated on a PMPM basis separately for the seven different market segments: (1) Individual Market; (2) Large Group, Fully Insured; (3) Small Group, Fully Insured; (4) Self-insured; (5) Student market; (6) Medicare Advantage; and (7) Medicaid/CHIP managed care. The methodology and data sources for the calculation of NCPHI for each market segment are described below.

Individual, Small Group, Fully Insured, Large Group, Fully Insured and Student Markets (collectively, the "commercial fully insured market")

The federal commercial medical loss ratio (MLR) reports will be used to calculate NCPHI for the commercial fully insured market and need to be requested from the insurers as part of their TME data submission, or obtained from CMS Center for Consumer Information and Oversight (CCIIO).[51] These reports become publicly available in the fall, but should be requested from insurers when they submit their TME data in order to meet the reporting timeline. In an instance in which the MLR report submitted to OHIC on the TME deadline differs from the final submission an insurer makes to CCIIO, the insurer must notify OHIC in writing as soon as possible. To get NCPHI applicable for RI residents, one must first calculate the NCPHI using situs-based information before applying it to RI residents. Doing so assumes that the cost of administering private health insurance is the same for Rhode Island residents is the same as for providing it to employers whose employees are not RI-residents. This calculation must be performed for each insurer. The data elements that will be used in the calculation are detailed below:

[51] Available at: www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html. July 19, 2021.

Commercial Fully-Insured NCPHI =

Premium as of March 31 (Part 1, Line 1.1) – Total Incurred Claims as of March 31 (Part 1, Line 2.1) + Advance Payments of Cost-Sharing Reductions (Part 2, Line 2.18) – MLR Rebates Current Year (Part 3, Line 5.4)

Situs-Based Commercial Fully-Insured NCPHI PMPM =

$$\frac{\textit{Commercial Fully-Insured NCPHI}}{\textit{Member Months as reported on the MLR}}$$

RI Resident-Based Commercial Fully-Insured NCPHI =

Situs-based Commercial Fully-Insured NCPHI PMPM X Member Months as reported on the Market Enrollment tab of the TME Data[52]

Medicare Advantage

The federal Medicare medical loss ratios (MLR) reports will be used to calculate NCPHI for the Medicare Advantage market and need to be requested from the insurers as part of their TME data submission or obtained from CMS Center for Consumer Information and Oversight (CCIIO). The Medicare Advantage reporting combines stand-alone prescription drug plans (PDP) and the Medicare Advantage plans with Part D inclusion (MAPDs). Therefore, insurers that offer both PDP and MAPD will need to separately report health premiums earned, total incurred claims, and members months for PDP and MAPD.

Insurers must also submit names for which they are "Doing Business As" for Medicare and Medicare Advantage on an annual basis.

The data elements that will be used in the calculation are detailed below.

Medicare Advantage NCPHI =

Premium as of March 31 (Part 1, Line 1.1) – Total Incurred Claims as of March 31 (Part 1, Line 2.1)

Medicare Advantage NCPHI PMPM =

$$\frac{\textit{Medicare Advantage NCPHI}}{\textit{Member Months as reported on the Market Enrollment Tab of the TME data}}$$

[52] OHIC should not use the member months that are reported on the MLR or SHCE forms as those forms are based on in situ information, whereas the spending benchmark is intended to capture Rhode Island residents. By using member months reported by market segment within the TME data, OHIC will be assuming that the experience of the insurer across all of its Rhode Island business (regardless of whether it insurers a member from another state) is the same experience as Rhode Island residents.

Medicaid MCO Market

OHIC will use data obtained from EOHHS to derive NCPHI of the Medicaid MCO Market for all Medicaid managed care products.[53] The formula is included below:

Medicaid MCO NCPHI =

Health Premiums Earned - Total Incurred Claims

Medicaid MCO NCPHI PMPM =

$$\frac{\textit{Medicaid MCO NCPHI}}{\textit{Member Months as reported on the Market Enrollment Tab of the TME data}}$$

Self-Insured Market

OHIC requests insurance carriers to report aggregate information on the premiums earned from their self-insured accounts (e.g., "fees from uninsured plans"). Carriers should follow the instructions for Part 1, Line 12 on the NAIC SHCE for their Rhode Island-situs self-insured accounts. This will be used to derive NCPHI of the self-insured market. To get NCPHI applicable for RI residents, one must first calculate the NCPHI using situs-based information before applying it to RI residents. Doing so assumes that the cost of administering private health insurance is the same for Rhode Island residents is the same as for providing it to employers whose employees are not RI-residents. This calculation must be performed for each insurer. The data elements that will be used in the calculation are detailed below:

Self-Insured NCPHI =

Carrier data reported pursuant to Part 1, Line 12 of the SHCE

Situs-Based Self-Insured NCPHI PMPM =

$$\frac{\textit{Self-Insured NCPHI}}{\textit{Member Months as reported by carriers pursuant to Part 1, Line 12 of the SHCE}}$$

[53] This formula is not applicable to NHPRI. For NHPRI, it is due to the inclusion of its Financial Aligned Initiative Medicare and Medicaid dual eligible product (Integrity). Data to calculate NCPHI for all of NHPRI's products must be obtained from the financial statements submitted to the Department of Business Regulation. These forms can be obtained by OHIC from Ted Hurley, Insurance Examiner-In-Charge (Ted.Hurley@dbr.ri.gov).

RI Resident-Based Self-Insured NCPHI =

*Situs-Based Self-Insured NCPHI PMPM * Member Months as reported on the LOB Enrollment tab of the TME Data*[54]

Table 23 provides the columns associated with each line of business/market in the SHCE and the MLR reports.

Table 23. Data Required to Calculate NCPHI

Line of Business	SHCE Column	MLR Column (Parts 1 and 2)	MLR Column (Part 3)
Individual	N/A	4	6
Small Group, Fully Insured	N/A	9	11
Large Group, Fully Insured	N/A	14	15
Student	N/A	49	39
Medicare Advantage and PDP	N/A	56	N/A
Medicaid MCO	N/A	N/A	N/A
Self-Insured	14	N/A	N/A

[54] OHIC should not use the member months that are reported on the MLR or SHCE forms as those forms are based on in situ information, whereas the spending benchmark is intended to capture Rhode Island residents. By using member months reported by market segment within the TME data, OHIC will be assuming that the experience of the insurer across all of its Rhode Island business (regardless of whether it insures a member from another state) is the same experience as Rhode Island residents.

Appendix E:
Insurer Primary Care Spending Data Specification

This insurer primary care spending data specification provides technical details to assist insurers in reporting and filing data to enable OHIC to primary care spending as a percentage of TME, less long-term care. This appendix can serve as a stand-alone document to serve as a guide for primary care spending data reporting.

A. Definition of Key Terms

Direct primary care expenses: The sum of all claims-based and non-claims-based primary care payments excluding HIE payments for CurrentCare and PCMH administration payments to support the operations of CTC-RI.

Indirect primary care expenses: The sum of all HIE payments for CurrentCare and PCMH administration payments.

Measurement year: The measurement year is the calendar year for which performance is measured against the prior calendar year for purposes of calculating the growth in primary care costs.

Primary care spend obligation: The percentage of spending on total medical expenses, minus long-term care, that is allocated to primary care by commercial insurers for their fully insured lines of business in Rhode Island. Primary care spending is assessed on a calendar year basis. OHIC's Affordability Standards, per RICR-20-30-4, directs commercial insurers to annually spend at least 10.7 percent of their annual medical expenses for all fully insured lines of business on primary care, 9.7 percent of which shall be for direct primary care expenses.

Provider: A term referring to an individual clinician, medical group, individual provider, Accountable Care Organization, Accountable Entity or similar entities.

Total medical expense (TME), less long-term care: The sum of the allowed amount of total claims and total non-claims spending paid to providers incurred by Rhode Island residents for all health care services except for long-term care. This definition differs from that used for the health care cost growth target, which includes long-term care. TME, less long-term care, is reported net of pharmacy rebates. More detailed TME reporting specifications are contained in the Appendices of this manual.

B. Primary Care Spend Obligation Submission Schedule

Insurers will submit primary care spending and TME spending, less primary care, using Excel templates **(Attachment 2)** provided by OHIC according to the schedule outlined below. Insurers will submit this information two times per year. **Table 24** outlines insurers' primary care spending filing schedule.

After insurers submit their data according to the filing schedule, they must actively engage with OHIC as it validates the data to ensure data were submitted using the specifications outlined in this Implementation Manual.

Table 24. Insurers' Primary Care Spending Filing Schedule

Date	Files Due
April 1, 2023	CY 2022 Estimated Primary Care Spending
September 29, 2023	CY 2022 Final Primary Care Spending

C. Primary Care Spend Obligation Data Specifications

Insurers must report primary care spending and TME, less long-term care, based on allowed amounts (i.e., the amount the insurer paid plus any member cost sharing).

Insurers must include only information pertaining to members:

- who are residents of Rhode Island,
- who, at a minimum, have medical benefits[55], and
- for which the insurer is primary on a claim (exclude any paid claims for which it was the secondary or tertiary insurer), however do not exclude a member solely because they have additional coverage.

Insurers should report one line of data that aggregates spending across their fully insured LOB in aggregate and not by ACO/AE. If insurers cannot separately identify lump-sum non-claims-based payment that are for fully insured vs. self-insured LOBs (i.e., payments are combined for insured and self-insured members), they may pro-rate the payment based on market share to identify the portion that is attributable to the fully insured LOB that should be reported to OHIC.

[55] Members who only have a non-medical benefit should be excluded. Insurers who hold the medical benefit for those members will be making estimates of TME for medical benefits and excluding non-medical benefit members would reduce the chance of duplicating the spending of those members.

Insurers must include all allowed amounts for all TME data for members, regardless of whether services are provided by providers located in or out of Rhode Island, and regardless of the situs of the member's plan.[56]

Claims Run-Out Period Specifications

For the spring submission, insurers shall report on claims-based primary care spending and TME, less long-term care, as of no earlier than 30 days before the submission of the report. For the fall submission, insurers shall allow for a claims run-out period of at least 180 days after December 31 of the performance year. Insurers should apply reasonable and appropriate IBNR/IBNP completion factors to each respective TME service category and will be required to attest that they are reasonable and appropriate. Claims payments should be reported on an incurred basis, not paid basis.

Non-Claims Payment "Run-Out" Period Specifications

For the spring submission, insurers shall report on non-claims-based primary care spending and TME, less long-term care, as of no earlier than 30 days before the submission of the report. For the fall submission, insurers shall allow for a non-claims "run-out" period of at least 180 days after December 31 of the performance year to reconcile non-claims payments, including incentives, capitation and risk-settlements, or other non-claims-based payments. Insurers should apply reasonable and appropriate estimations of non-claims liability to each ACO/AE Organization ID (including payments expected to be made to organizations not separately identified for TME reporting purposes) that are expected to be reconciled after the 180-day review period. Non-claims payments should be reported on an incurred basis, not paid basis.

D. Primary Care Spend Obligation File Specifications

Insurers must submit one Excel template provided by OHIC that includes its TME data. This section describes the detailed information that payers must submit within the following tabs in the Excel file:

- Contents, which describes the Excel file
- Definitions
- Reference Tables
- HD-PC Spend, which includes summary data and payer comments
- Primary Care Spending, which includes primary care spending and TME, less long-term care for the fully insured LOB

[56] If the insurer plays claims for another organization's members (e.g., Blue Card members in the Blue Cross Blue Shield network) those members should not be included in TME.

- Non-claims - ACO_AE1, which includes tables for insurers to allocate non-claims-based spending to primary care for one ACO/AE
- Non-claims - ACO_AE2, which includes tables for insurers to allocate non-claims-based spending to primary care for a second ACO/AE
- Non-claims - ACO_AE3, which includes tables for insurers to allocate non-claims-based spending to primary care for a third ACO/AE
- Non-claims - ACO_AE4, which includes tables for insurers to allocate non-claims-based spending to primary care for a fourth ACO/AE
- Non-claims - ACO_AE5, which includes tables for insurers to allocate non-claims-based spending to primary care for a fifth ACO/AE
- Non-claims – All Other, which includes tables for insurers to allocate non-claims-based spending to primary care for all other provider organizations
- Mandatory Questions

Contents Tab

This tab contains information regarding what the Excel file includes. Insurers do not need to submit information within this tab.

Definitions

This tab includes definitions outlined herein for ease of reference.

Reference Tables

This tab includes reference tables of key codes outlined herein for ease of reference.

HD-PC Spending

Insurer Organization ID: The OHIC assigned organization ID for the insurer submitting the file, as outlined in **Table 25**.

Table 25. Insurers Required to Report Primary Care Spend Obligation for Fully Insured Business

Insurer	Organizational ID
Blue Cross Blue Shield of RI	201
Neighborhood Health Plan of RI	202
Tufts Health Plan	203
UnitedHealthcare	204

Period beginning and ending dates: The beginning period of time represented by the reported data. These dates should always be January 1 and December 31, respectively, unless an insurer

newly enters or exits the market during other parts of the year. All reporting is based on the date of service related to the primary care spending and TME data.

Comments: A field for insurers to submit any additional information about their submission.

Primary Care Spending Tab

The Primary Care Spending tabs will be the source of the insurer's primary care and total medical expenditure data that OHIC will use to compute primary care spending as a percentage of TME, less long-term care. Insurers will report their permissible claims and non-claims payments in this file.

Insurer Organization ID: The OHIC assigned organization ID for the insurer submitting the file, as outlined in **Table 25**.

Member months: The number of unique members participating in a plan each month with a medical benefit, regardless of whether the member has any paid claims. Member months should be calculated by summing the number of months each member was enrolled in a plan with a medical benefit for one calendar year.

Claims: Professional, Primary Care: The TME paid to primary care providers (i.e., family practice, geriatric, internal medicine and pediatric providers defined using taxonomy codes in **Appendix F**) delivering care at a primary care site of care (defined below) generated from claims using the following code-level definition found in **Appendix G**.

Primary care services include care management; care planning; consultation services; health risk assessments, screenings and counseling; home visits; hospice/home health services; immunization administrations; office visits and preventive medicine visits. They do not include prescription drugs (including those covered by both medical and pharmacy benefits), laboratory, x-ray and imaging services.

Payers should identify primary care providers first by searching for relevant provider taxonomy codes in the rendering provider field and then the billing provider field. If the carrier does not utilize the provider taxonomy codes in **Appendix F**, it may apply its provider codes to match the description of the provider taxonomy codes included.

A primary care site of care is defined as a primary care outpatient setting (e.g., office, clinic or center), federally qualified health center (FQHC), school-based health center, or via telehealth delivered by a PCP that is part of a primary care outpatient setting, FQHC or school-based health center. It excludes primary care spending delivered at urgent care centers, retail pharmacy clinics and via stand-alone telehealth vendors, i.e., a third-party telehealth vendor

that does not contract with a primary care outpatient setting, federally qualified health center or school-based health center to deliver services. Insurers should use the place of service and modifier codes in the primary care code list in **Appendix F** to identify primary care services delivered via telehealth.

Non-Claims: HIE Payments for CurrentCare: All Payments for CurrentCare, the state health information exchange, or to help practices link to CurrentCare established by RI Gen. Laws Chapter 5-37.7. *This should be a sum of all the HIE payments for CurrentCare reported in the individual ACO/AE tabs.*

Non-Claims: PCMH Administration Payments: All payments to support the operations of the Care Transformation Collaborative of Rhode Island (CTC-RI). *This should be a sum of all PCMH administration payments reported in the individual ACO/AE tabs.*

Non-Claims: Professional, Primary Care: All non-claims-based payments for primary care services. *This should be a sum of all the non-claims-based primary care spending reported in the individual ACO/AE tabs.* It should include primary care-specific payments for the following categories of non-claims-based spending:

1. ***Capitated, Prospective Global Budget, Prospective Case Rate, or Prospective Episode-Based Payments***: All non-claims based payments for services delivered under the following payment arrangements: (1) capitation payments, i.e., single payments to providers to provide healthcare services over a defined period of time; (2) global budget payments, i.e., prospective payments made to providers for a comprehensive set of services for a designated patient population or a more narrowly defined set of services where certain benefits (e.g., behavioral health, pharmacy) are carved out; (3) case rate payments, i.e., prospective payments made to providers in a given provider organization for a patient receiving a defined set of services for a specific period of time and (4) prospective episode-based payments, i.e., payments received by providers (which can span multiple provider organizations) for a patient receiving a defined set of services for a specific condition across a continuum of care, or care for a specific condition over a specific time period.

2. ***Performance Incentive Payments***: All payments to reward providers for achieving quality or cost-savings goals, or payments received by providers that may be reduced if costs exceed a defined pre-determined, risk-adjusted target. Includes pay-for-performance, i.e., payments to reward providers for achieving a set target (absolute, relative or improvement-based) for quality or efficiency metrics, and pay-for-reporting, i.e., payments to providers for reporting on a set of quality or efficiency metrics, usually to build capacity for pay-for-performance, payments. Includes shared savings distributions, i.e., payments received by providers if costs of services are below a pre-determined, risk-adjusted target, and shared risk recoupments, i.e., payments providers must recoup if costs of services are above a pre-determined, risk-adjusted target.

3. ***Payments to Support Population Health and Practice Infrastructure***: All payments made to develop provider capacity and practice infrastructure to help coordinate care, improve quality and control costs. Includes, but is not limited to payments that support care management, care coordination and population health; [57] EHR/HIT infrastructure payments and other data analytics payments[58]; HIE payments[59]; patient-centered medical home (PCMH) administration payments[60]; PCMH recognition payments[61] and behavioral health integration *that are not reimbursable through claims*.[62]

4. ***Provider Salaries***: All payments for salaries of providers who provide health care services not otherwise included in other claims and non-claims categories. This category is typically only applicable to closed delivery systems.

5. ***Recoveries***: All payments received from a provider, member/beneficiary or other payer, which were distributed by a payer and then later recouped due to a review, audit or investigation. This can include infrastructure payments that are recouped under total cost of care arrangements if a provider does not generate savings. This field should be reported as a **negative number**. Only report data in this category not otherwise included elsewhere (e.g., if Inpatient Hospital is reported net of Recovery, do not separately report the same Recovery amount in this category).

6. ***Other***: All other payments made pursuant to the insurer's contract with a provider not made on the basis of a claim for health care benefits/services and cannot be properly classified elsewhere. This may include governmental payer shortfall payments, grants or other surplus payments. Only payments made to providers are to be reported;

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[57] Includes payments to fund care managers, care coordinators, or other traditionally non-billing practice team members (e.g., practice coaches, patient educators, community health workers, patient navigators) who help providers organize clinics to function better and help patients take charge of their health. It can also include payments to fund the cost of a pharmacist to help practices with medication reconciliation for poly-pharmacy patients.

[58] Includes payments to help providers adopt and utilize health information technology, such as electronic medical records and health information exchanges, software that enables primary care practices to analyze quality and / or costs outside of the EHR (e.g., software to track patient costs in near-to-real time) and / or the cost of a data analyst to support practices.

[59] Includes payments for CurrentCare, the state health information exchange, or to help practices link to CurrentCare established by RI Gen. Laws Chapter 5-37.7.

[60] Includes payments to support the operations of the Care Transformation Collaborative of Rhode Island (CTC-RI).

[61] Includes payments to primary care practices recognized as PCMHs by OHIC to support PCMH transformation and ongoing PCMH-related operations, as described on OHIC's "PCMH Definition and Requirements" website.

[62] Includes payments that promote the appropriate integration of primary care and behavioral health care that are not reimbursable through claims (e.g., funding behavioral health services not traditionally covered with a discrete payment when provided in a primary care setting, such as a) substance abuse or depression screening, b) performing assessment, referral, and warm hand-off to a behavioral health clinician, and/or c) supporting health behavior change, such as diet and exercise for managing pre-diabetes risk). This category excludes payments for mental health or substance use counseling.

insurer administrative expenditures (including corporate allocations) are not included in TME.

Claims: Total Medical Expenses, less Long-term Care: All TME paid for providing the following categories of services. It should specifically ***exclude*** spending for long-term care services. It should be reported ***net of pharmacy rebates***.

1. ***Hospital Inpatient***: The TME paid to hospitals for inpatient services generated from claims. Includes all room and board and ancillary payments. Includes all hospital types. Includes payments for emergency room services when the member is admitted to the hospital, in accordance with the specific payer's payment rules. Does not include payments made for observation services. Does not include payments made for physician services provided during an inpatient stay that have been billed directly by a physician group practice or an individual physician. Does not include inpatient services at non-hospital facilities.

2. ***Hospital Outpatient***: The TME paid to hospitals for outpatient services generated from claims. Includes all hospital types and includes payments made for hospital-licensed satellite clinics. Includes emergency room services not resulting in admittance. Includes observation services. Does not include payments made for physician services provided on an outpatient basis that have been billed directly by a physician group practice or an individual physician.

3. ***Professional, Primary Care***: The TME paid to primary care providers delivering care at a primary care site of care generated from claims, as described earlier.

4. ***Professional, Specialty Care***: The TME paid to physicians or physician group practices generated from claims. Includes services provided by a doctors of medicine or osteopathy in clinical areas other than the family practice, geriatric, internal medicine and pediatric providers described above, not defined by the health plan as a PCP.

5. ***Professional Other***: The TME paid from claims to health care providers for services provided by a licensed practitioner other than a physician or identified as a PCP. This includes, but is not limited to, licensed podiatrists, nurse practitioners, physician assistants, physical therapists, occupational therapists, speech therapists, psychologists, licensed clinical social workers, counselors, dieticians, dentists, chiropractors and any professional fees that do not fit other categories. It also includes services delivered through third-party telehealth vendors contracted directly through the health plan to offer a subset of services.

6. ***Retail Pharmacy***: The TME paid from claims to health care providers for prescription drugs, biological products or vaccines as defined by the insurer's prescription drug benefit. *This category should not include claims paid for pharmaceuticals under the insurer's*

medical benefit. Pharmacy spending provided under the medical benefit should be attributed to the location in which it was delivered (e.g., pharmaceuticals delivered in a hospital inpatient setting should be attributed to Claims: Hospital Inpatient). It does not include the cost of vaccines administered in the primary care setting. Medicare managed care, i.e., Medicare Advantage, insurers that offer stand-alone prescription drug plans (PDPs) should exclude stand-alone PDP data from their TME. Pharmacy data is to be reported gross of applicable rebates.

7. ***Other***: All TME paid from claims to health care providers for medical services not otherwise included in other categories. Includes, but is not limited to durable medical equipment, freestanding fees of community health center services, free standing ambulatory surgical center services, hospice facility, freestanding diagnostic facility services, hospice, hearing aid services and optical services. It also includes the cost of vaccines administered in the primary care setting. Payments made to members for direct reimbursement of health care benefits/services may be reported in "Claims: Other" if the insurer is unable to classify the service. If this is the case, the insurer should consult with OHIC about the appropriate placement of the service prior to categorizing it as "Claims: Other." However, TME data for non-health care benefits/services, such as fitness club reimbursements, are not to be reported in any category. Payments for fitness club membership discounts whether given to the provider or given in the form of a capitated payment to an organization that assists the insurer with enrolling members in gyms is not a valid payment to include.

Non-Claims: Total Medical Expenses, less Long-term Care: All non-claims-based payments, excluding payments made for long-term care. *This should be a sum of the total non-claims-based spending less long-term care reported in the individual ACO/AE tabs.* It should include the following categories of non-claims-based spending, as described earlier: (1) Prospective Capitated, Prospective Global Budget, Prospective Case Rate, or Prospective Episode-Based Payments, (2) Performance Incentive Payments, (3) Payments to Support Population Health and Practice Infrastructure, (4) Provider Salaries, (5) Recoveries and (6) Other.

Validation checks to be performed: Spending reported under the "Claims: Professional, Primary Care" spending category should be less than spending reported under the same category for Insurance Category Codes 3 and 4 in the insurer's TME submission. Spending reported under the "Claims: Total Medical Expenses, less Long-term Care" category should be less than spending reported under the sum of all the "Claims" categories for Insurance Category Codes 3 and 4 in the insurer's TME submission. Finally, spending reported under "Non-Claims: Total Medical Expenses, less Long-term Care" should be less than spending reported under the sum of all the "Non-Claims" categories for Insurance Category Codes 3 and 4 in the insurer's TME submission.

Non-Claims – ACO_AE Tabs

These six Non-Claims tabs, five for each ACO/AE and one for all other provider organizations for which the insurer is submitting data, will be the source of the detailed calculations insurers use to calculate non-claims-based primary care spending. It is for insurers to allocate a percentage of non-claims-based spending made to systems of care that include primary care providers in part, but not in whole, to primary care providers.

Insurers shall apply a default percentage to each non-claims-based payment subcategory to determine the primary care portion of non-claims-based payments to provider organizations that include primary care providers. To develop the default percentages, OHIC sent a survey to the major system of care organizations (that include primary care providers in part, but not in whole) in the state in 2021 to identify what percentage of non-claims-based payments are given to primary care providers. OHIC used these data to develop one set of statewide default percentages, as the major systems of care requested that these percentages remain confidential. Insurers can use the statewide default percentages to ***estimate*** their total primary care spending as a percentage of TME, less long-term care. OHIC will update the default percentages to align with the percentages submitted by each system of care to calculate a final, more accurate value of primary care spending for each insurer.

Insurers must first select for which they are reporting performance in in the yellow box in column C. Then, they must report non-claims-based spending based on the composition of primary care providers for each system of care:

2021-2022 IMPORTANT NOTE

- **For systems of care that largely include primary care providers (e.g., Coastal Medical)**: Report all non-claims-based spending as primary care non-claims-based spending in the yellow-highlighted cells in column D of **Table 1** in **Attachment 2.**

- **For systems of care that include primary care providers in part, but not in whole (e.g., Integra Community Care Network, Lifespan, Prospect CharterCARE, Thundermist)**: Report all non-claims-based spending as total non-claims-based spending in the yellow-highlighted cells in column F of Table 2 in **Attachment 2**. The spreadsheet will then automatically calculate an ***estimate*** of primary care non-claims-based spending and non-primary care non-claims-based spending using the default percentages in column C. OHIC will update the percentages for each system of care after submission to calculate a final value of primary care spending for each insurer.

- **For systems of care that do not include primary care providers**: Report all non-claims-based spending as total non-claims-based spending in the yellow highlighted cell in column F of **Table 3** in **Attachment 2**.

Mandatory Questions Tab

Insurers must answer questions about their data submission to ensure the submission is in alignment with the specifications outlined herein.

File Submission

Naming Conventions

Data submissions should follow the following naming conventions:

Insurer Name_TME_YYYY_Version.xls

YYYY is the four-digit year of submission (which will generally be one year later than the year of the data reflected in the report).

Version is optional and indicates the submission number.

The file extension must be .xls or .xlsx.

Below are examples of valid file names:

PCSpend_2021_01.xlsx or PCSpend_2021_1.xlsx or PCSpend_2021.xlsx.

Submitting Files to OHIC

Electronic files are to be submitted to Cory.King@ohic.ri.gov.

Appendix F: Primary Care Specialties Provider Taxonomy Codes

The following table includes select provider taxonomy codes for four primary care specialties included in OHIC's definition of primary care providers (i.e., family practice, geriatrics, internal medicine and pediatrics) and certain provider organization taxonomy codes (e.g., federally qualified health centers). As a reminder, primary care providers must deliver care at a primary care site of care in order for spending to be included in OHIC's primary care spend obligation. Insurers shall only modify the taxonomy codes included in the table below if it is including (a) primary care spending for "dual" providers, as defined above, and/or (b) additional primary care provider organizations. If insurers are modifying the taxonomy codes in the table below, insurers shall provide written information to OHIC describing their changes.

Note: The taxonomy codes included in the table below are informed by the New England States Consortium Systems Organization' (NESCSO) 2020 definition of primary care spending. There were no changes made to the taxonomy codes in 2021 or 2022.

Table 26. Primary Care Specialties Provider Taxonomy Codes

Taxonomy	Description	Notes or Restrictions
208D00000X	General Practice	
207Q00000X	Family Medicine	
207QA0000X	Family Medicine, Adolescent Medicine	
207QA0505X	Family Medicine, Adult Medicine	
207QG0300X	Family Medicine, Geriatric Medicine	
207QH0002X	Family Medicine, Hospice Palliative	Restrict to only home health and hospice procedure codes
208000000X	Pediatrics	
2080A0000X	Pediatrics, Adolescent Medicine	
2080H0002X	Pediatrics, Hospice and Palliative Medicine	Restrict to only home health and hospice procedure codes
207R00000X	Internal Medicine	
207RG0300X	Internal Medicine, Geriatric Medicine	

Taxonomy	Description	Notes or Restrictions
207RA0000X	Internal Medicine, Adolescent Medicine	
207RH0002X	Internal Medicine, Hospice and Palliative Medicine	Restrict to only home health and hospice procedure codes
363A00000X	Physician Assistant	
363AM0700X	Physician Assistant, Medical	
363L00000X	Nurse Practitioner	
363LA2200X	Nurse Practitioner, Adult Health	
363LF0000X	Nurse Practitioner, Family	
363LG0600X	Nurse Practitioner, Gerontology	
363LP0200X	Nurse Practitioner, Pediatrics	
363LP2300X	Nurse Practitioner, Primary Care	
363LC1500X	Nurse Practitioner, Community Health	
363LS0200X	Nurse Practitioner, School	
261QF0400X	Federally Qualified Health Center (FQHC)	Restrict on revenue codes for clinic and professional services 0510, 0515, 0517, 0520, 0521, 0523, 0960, 0983

Appendix G:
Primary Care Payment Codes

Services must be performed by a primary care provider delivering care at a primary care site of care in order for spending to be included in OHIC's primary care spend obligation.

Note: The procedure codes included in the table below are informed by the New England States Consortium Systems Organization' (NESCSO) 2020 definition of primary care spending, updated to reflect any changes made to the procedure codes in 2021 and 2022. In addition, the codes were developed for use with payers across commercial, Medicaid and Medicare markets, and therefore it is likely that insurers will not use all codes for reporting performance for commercial members to OHIC.

Table 27. Primary Care Payment Codes

Procedure Code	Description	Reporting Procedure Category
99202	OFFICE OUTPATIENT NEW 20 MINUTES (Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.)	Office Visits
99203	OFFICE OUTPATIENT NEW 30 MINUTES (Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.)	Office Visits
99204	OFFICE OUTPATIENT NEW 45 MINUTES (Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.)	Office Visits

Procedure Code	Description	Reporting Procedure Category
99205	OFFICE OUTPATIENT NEW 60 MINUTES (Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter. (For services 75 minutes or longer, see Prolonged Services 99417))	Office Visits
99211	OFFICE OUTPATIENT VISIT 5 MINUTES (Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional).	Office Visits
99212	OFFICE OUTPATIENT VISIT 10 MINUTES (Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.)	Office Visits
99213	OFFICE OUTPATIENT VISIT 15 MINUTES (Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.)	Office Visits
99214	OFFICE OUTPATIENT VISIT 25 MINUTES (Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.)	Office Visits

Procedure Code	Description	Reporting Procedure Category
99215	OFFICE OUTPATIENT VISIT 40 MINUTES (Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter. (For services 55 minutes or longer, see Prolonged Services 99417).)	Office Visits
99381	INITIAL PREVENTIVE MEDICINE NEW PATIENT <1YEAR	Preventive Medicine Visits
99382	INITIAL PREVENTIVE MEDICINE NEW PT AGE 1-4 YRS	Preventive Medicine Visits
99383	INITIAL PREVENTIVE MEDICINE NEW PT AGE 5-11 YRS	Preventive Medicine Visits
99384	INITIAL PREVENTIVE MEDICINE NEW PT AGE 12-17 YR	Preventive Medicine Visits
99385	INITIAL PREVENTIVE MEDICINE NEW PT AGE 18-39YRS	Preventive Medicine Visits
99386	INITIAL PREVENTIVE MEDICINE NEW PATIENT 40-64YRS	Preventive Medicine Visits
99387	INITIAL PREVENTIVE MEDICINE NEW PATIENT 65YRS&>	Preventive Medicine Visits
99391	PERIODIC PREVENTIVE MED ESTABLISHED PATIENT <1Y	Preventive Medicine Visits
99392	PERIODIC PREVENTIVE MED EST PATIENT 1-4YRS	Preventive Medicine Visits
99393	PERIODIC PREVENTIVE MED EST PATIENT 5-11YRS	Preventive Medicine Visits
99394	PERIODIC PREVENTIVE MED EST PATIENT 12-17YRS	Preventive Medicine Visits
99395	PERIODIC PREVENTIVE MED EST PATIENT 18-39 YRS	Preventive Medicine Visits
99396	PERIODIC PREVENTIVE MED EST PATIENT 40-64YRS	Preventive Medicine Visits
99397	PERIODIC PREVENTIVE MED EST PATIENT 65YRS& OLDER	Preventive Medicine Visits
99241	OFFICE CONSULTATION NEW/ESTAB PATIENT 15 MIN	Consultation Services
99242	OFFICE CONSULTATION NEW/ESTAB PATIENT 30 MIN	Consultation Services
99243	OFFICE CONSULTATION NEW/ESTAB PATIENT 40 MIN	Consultation Services

Procedure Code	Description	Reporting Procedure Category
99244	OFFICE CONSULTATION NEW/ESTAB PATIENT 60 MIN	Consultation Services
99245	OFFICE CONSULTATION NEW/ESTAB PATIENT LEVEL 5	Consultation Services
99417	Prolonged office or other outpatient evaluation and management service(s) requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes	Office Visits
G2212	Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact	Office Visits
G0466	FEDERALLY QUALIFIED HEALTH CENTER VISIT NEW PT	HCPC Visit Codes
G0467	FEDERALLY QUALIFIED HEALTH CENTER VISIT ESTAB PT	HCPC Visit Codes
G0468	FEDERALLY QUALIFIED HEALTH CENTER VISIT IPPE/AWV	HCPC Visit Codes
T1015	CLINIC VISIT/ENCOUNTER ALL-INCLUSIVE	HCPC Visit Codes
S9117	BACK SCHOOL VISIT	HCPC Visit Codes
G0402	INIT PREV PE LTD NEW BENEF DUR 1ST 12 MOS MCR	HCPC Visit Codes
G0438	ANNUAL WELLNESS VISIT; PERSONALIZ PPS INIT VISIT	HCPC Visit Codes
G0439	ANNUAL WELLNESS VST; PERSONALIZED PPS SUBSQT VST	HCPC Visit Codes
G0463	HOSPITAL OUTPATIENT CLIN VISIT ASSESS & MGMT PT	HCPC Visit Codes
99401	PREVENT MED COUNSEL&/RISK FACTOR REDJ SPX 15 MIN	Preventive Medicine Services
99402	PREVENT MED COUNSEL&/RISK FACTOR REDJ SPX 30 MIN	Preventive Medicine Services
99403	PREVENT MED COUNSEL&/RISK FACTOR REDJ SPX 45 MIN	Preventive Medicine Services
99404	PREVENT MED COUNSEL&/RISK FACTOR REDJ SPX 60 MIN	Preventive Medicine Services

Procedure Code	Description	Reporting Procedure Category
99406	TOBACCO USE CESSATION INTERMEDIATE 3-10 MINUTES	Preventive Medicine Services
99407	TOBACCO USE CESSATION INTENSIVE >10 MINUTES	Preventive Medicine Services
99408	ALCOHOL/SUBSTANCE SCREEN & INTERVEN 15-30 MIN	Preventive Medicine Services
99409	ALCOHOL/SUBSTANCE SCREEN & INTERVENTION >30 MIN	Preventive Medicine Services
99411	PREV MED COUNSEL & RISK FACTOR REDJ GRP SPX 30 M	Preventive Medicine Services
99412	PREV MED COUNSEL & RISK FACTOR REDJ GRP SPX 60 M	Preventive Medicine Services
99420	ADMN & INTERPJ HEALTH RISK ASSESSMENT INSTRUMENT	Preventive Medicine Services
99429	UNLISTED PREVENTIVE MEDICINE SERVICE	Preventive Medicine Services
99341	HOME VISIT NEW PATIENT LOW SEVERITY 20 MINUTES	Home Visits
99342	HOME VISIT NEW PATIENT MOD SEVERITY 30 MINUTES	Home Visits
99343	HOME VST NEW PATIENT MOD-HI SEVERITY 45 MINUTES	Home Visits
99344	HOME VISIT NEW PATIENT HI SEVERITY 60 MINUTES	Home Visits
99345	HOME VISIT NEW PT UNSTABL/SIGNIF NEW PROB 75 MIN	Home Visits
99347	HOME VISIT EST PT SELF LIMITED/MINOR 15 MINUTES	Home Visits
99348	HOME VISIT EST PT LOW-MOD SEVERITY 25 MINUTES	Home Visits
99349	HOME VISIT EST PT MOD-HI SEVERITY 40 MINUTES	Home Visits
99350	HOME VST EST PT UNSTABLE/SIGNIF NEW PROB 60 MINS	Home Visits
99374	SUPVJ PT HOME HEALTH AGENCY MO 15-29 MINUTES	Hospice/Home Health Services
99375	SUPERVISION PT HOME HEALTH AGENCY MONTH 30 MIN/>	Hospice/Home Health Services
99376	CARE PLAN OVERSIGHT/OVER	Hospice/Home Health Services

Procedure Code	Description	Reporting Procedure Category
99377	SUPERVISION HOSPICE PATIENT/MONTH 15-29 MIN	Hospice/Home Health Services
99378	SUPERVISION HOSPICE PATIENT/MONTH 30 MINUTES/>	Hospice/Home Health Services
G0179	PHYS RE-CERT MCR-COVR HOM HLTH SRVC RE-CERT PRD	Hospice/Home Health Services
G0180	PHYS CERT MCR-COVR HOM HLTH SRVC PER CERT PRD	Hospice/Home Health Services
G0181	PHYS SUPV PT RECV MCR-COVR SRVC HOM HLTH AGCY	Hospice/Home Health Services
G0182	PHYS SUPV PT UNDER MEDICARE-APPROVED HOSPICE	Hospice/Home Health Services
99339	INDIV PHYS SUPVJ HOME/DOM/R-HOME MO 15-29 MIN	Domiciliary, Rest Home Multidisciplinary care Planning
99340	INDIV PHYS SUPVJ HOME/DOM/R-HOME MO 30 MIN/>	Domiciliary, Rest Home Multidisciplinary care Planning
99495	TRANSITIONAL CARE MANAGE SRVC 14 DAY DISCHARGE	Transitional Care Management Services
99496	TRANSITIONAL CARE MANAGE SRVC 7 DAY DISCHARGE	Transitional Care Management Services
99497	ADVANCE CARE PLANNING FIRST 30 MINS	Advance Care Planning Evaluation & Management Services
99498	ADVANCE CARE PLANNING EA ADDL 30 MINS	Advance Care Planning Evaluation & Management Services
99366	TEAM CONFERENCE FACE-TO-FACE NONPHYSICIAN	Case Management Services
99367	TEAM CONFERENCE NON-FACE-TO-FACE PHYSICIAN	Case Management Services
99368	TEAM CONFERENCE NON-FACE-TO-FACE NONPHYSICIAN	Case Management Services
99439	Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month	Chronic Care Management Services

Procedure Code	Description	Reporting Procedure Category
99424	Initial 30 minutes per calendar month of principal care management services, including creation of a disease-specific care plan by a physician or qualified health care provider.	Chronic Care Management Services
99425	Each additional 30 minutes per calendar month of principal care management services, as carried out by a physician or qualified health care professional.	Chronic Care Management Services
99426	Initial 30 minutes per calendar month of principal care management clinical staff time, as carried out by clinical staff (such as nursing professionals) under the direction and guidance of a physician or qualified health professional.	Chronic Care Management Services
99427	Each additional 30 minutes per calendar month of principal care management clinical staff time, as carried out by clinical staff (such as nursing professionals) under the direction and guidance of a physician or qualified health professional.	Chronic Care Management Services
99437	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; each 30 minutes by a physician or other qualified health care professional, per calendar month.	Chronic Care Management Services
99487	CMPLX CHRON CARE MGMT W/O PT VST 1ST HR PER MO	Chronic Care Management Services
99489	CMPLX CHRON CARE MGMT EA ADDL 30 MIN PER MONTH	Chronic Care Management Services
99490	CHRON CARE MANAGEMENT SRVC 20 MIN PER MONTH	Chronic Care Management Services
99491	CHRON CARE MANAGEMENT SRVC 1ST 30 MIN PER MONTH	Chronic Care Management Services
G0506	COMP ASMT OF & CARE PLNG PT RQR CC MGMT SRVC	Chronic Care Management Services
99358	PROLNG E/M SVC BEFORE&/AFTER DIR PT CARE 1ST HR	Prolonged Services
99359	PROLNG E/M BEFORE&/AFTER DIR CARE EA 30 MINUTES	Prolonged Services

Procedure Code	Description	Reporting Procedure Category
99360	PHYS STANDBY SVC PROLNG PHYS ATTN EA 30 MINUTES	Prolonged Services
G0513	PRLNG PREV SRVC OFC/OTH O/P RQR DIR CTC;1ST 30 M	Prolonged Services
G0514	PRLNG PREV SRVC OFC/OTH O/P DIR CTC;EA ADD 30 M	Prolonged Services
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	Telephone and Internet Services
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	Telephone and Internet Services
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	Telephone and Internet Services
99441	PHYS/QHP TELEPHONE EVALUATION 5-10 MIN	Telephone and Internet Services
99442	PHYS/QHP TELEPHONE EVALUATION 11-20 MIN	Telephone and Internet Services
99443	PHYS/QHP TELEPHONE EVALUATION 21-30 MIN	Telephone and Internet Services
99446	NTRPROF PHONE/NTRNET/EHR ASSMT&MGMT 5-10 MIN	Telephone and Internet Services
99447	NTRPROF PHONE/NTRNET/EHR ASSMT&MGMT 11-20 MIN	Telephone and Internet Services
99448	NTRPROF PHONE/NTRNET/EHR ASSMT&MGMT 21-30 MIN	Telephone and Internet Services
99449	NTRPROF PHONE/NTRNET/EHR ASSMT&MGMT 31/> MIN	Telephone and Internet Services
99451	NTRPROF PHONE/NTRNET/EHR ASSMT&MGMT 5/> MIN	Telephone and Internet Services
99452	NTRPROF PHONE/NTRNET/EHR REFERRAL SVC 30 MIN	Telephone and Internet Services
98966	NONPHYSICIAN TELEPHONE ASSESSMENT 5-10 MIN	Telephone and Internet Services
98967	NONPHYSICIAN TELEPHONE ASSESSMENT 11-20 MIN	Telephone and Internet Services

Procedure Code	Description	Reporting Procedure Category
98968	NONPHYSICIAN TELEPHONE ASSESSMENT 21-30 MIN	Telephone and Internet Services
98970	Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes	Telephone and Internet services
98971	Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes	Telephone and Internet Services
98972	Qualified nonphysician health care professional 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	Telephone and Internet Services
90460	IM ADM THRU 18YR ANY RTE 1ST/ONLY COMPT VAC/TOX	Immunization Administration for Vaccines/Toxoids
90461	IM ADM THRU 18YR ANY RTE ADDL VAC/TOX COMPT	Immunization Administration for Vaccines/Toxoids
90471	IM ADM PRQ ID SUBQ/IM NJXS 1 VACCINE	Immunization Administration for Vaccines/Toxoids
90472	IM ADM PRQ ID SUBQ/IM NJXS EA VACCINE	Immunization Administration for Vaccines/Toxoids
90473	IM ADM INTRANSL/ORAL 1 VACCINE	Immunization Administration for Vaccines/Toxoids
90474	IM ADM INTRANSL/ORAL EA VACCINE	Immunization Administration for Vaccines/Toxoids
G0008	ADMINISTRATION OF INFLUENZA VIRUS VACCINE	Immunization Administration for Vaccines/Toxoids
G0009	ADMINISTRATION OF PNEUMOCOCCAL VACCINE	Immunization Administration for Vaccines/Toxoids

Procedure Code	Description	Reporting Procedure Category
G0010	ADMINISTRATION OF HEPATITIS B VACCINE	Immunization Administration for Vaccines/Toxoids
96160	PT-FOCUSED HLTH RISK ASSMT SCORE DOC STND INSTRM	Health Risk Assessment, Screenings, and Counseling
96161	CAREGIVER HLTH RISK ASSMT SCORE DOC STND INSTRM	Health Risk Assessment, Screenings, and Counseling
99078	PHYS/QHP EDUCATION SVCS RENDERED PTS GRP SETTING	Health Risk Assessment, Screenings, and Counseling
99483	ASSMT & CARE PLANNING PT W/COGNITIVE IMPAIRMENT	Health Risk Assessment, Screenings, and Counseling
G0396	ALCOHOL &/SUBSTANCE ABUSE ASSESSMENT 15-30 MIN	Health Risk Assessment, Screenings, and Counseling
G0397	ALCOHOL &/SUBSTANCE ABUSE ASSESSMENT >30 MIN	Health Risk Assessment, Screenings, and Counseling
G0442	ANNUAL ALCOHOL MISUSE SCREENING 15 MINUTES	Health Risk Assessment, Screenings, and Counseling
G0443	BRIEF FACE-FACE BEHAV CNSL ALCOHL MISUSE 15 MIN	Health Risk Assessment, Screenings, and Counseling
G0444	ANNUAL DEPRESSION SCREENING 15 MINUTES	Health Risk Assessment, Screenings, and Counseling
G0505	COGN & FUNCT ASMT USING STD INST OFF/OTH OP/HOME	Health Risk Assessment, Screenings, and Counseling
99173	SCREENING TEST VISUAL ACUITY QUANTITATIVE BILAT	Preventive Medicine Services
G0102	PROS CANCER SCREENING; DIGTL RECTAL EXAMINATION	Preventive Medicine Services
G0436	SMOKE TOB CESSATION CNSL AS PT; INTRMED 3-10 MIN	Preventive Medicine Services

Procedure Code	Description	Reporting Procedure Category
G0437	SMOKING & TOB CESS CNSL AS PT; INTENSIVE >10 MIN	Preventive Medicine Services

Appendix H: Statistical Testing to Determine Performance Against the Benchmark

To determine whether an insurer or provider entity met or did not meet the benchmark, OHIC will conduct hypothesis testing using confidence intervals. OHIC will first develop confidence intervals around each insurer and provider entity's performance. These confidence intervals indicate the range of reasonable estimates of actual healthcare cost growth. If the 95% percent confidence interval contains the benchmark value, then OHIC would not be able to determine that the insurer or provider entity's performance is significantly different from the benchmark. However, if the benchmark value lies outside of the 95% confidence interval, OHIC would be able to determine that the insurer or provider entity either met or exceeded the healthcare cost growth benchmark.

OHIC will use average TME PMPY, the number of attributed lives, and the standard deviation of TME PMPY costs to calculate the confidence intervals for the following:

- **Per member healthcare cost growth, by market, for each insurer.** Each insurer will report the variance by market, thus OHIC will not need to pool variances.
- **Per member healthcare growth, by insurance market, for a provider entity whose data is listed in multiple insurers' data submission.** OHIC will pool the variances (i.e., take a weighted average) for each provider entity by market such that commercial spending has a pooled variance, Medicaid spending has a pooled variance, and Medicare Advantage spending has a pooled variance. Then OHIC will pool the variances across multiple years within each market to calculate the confidence intervals of the provider entity's growth for that market. This would be repeated to calculate the confidence interval for the provider entity's growth in the other markets.

Formulas for Calculating Confidence Intervals

The following describes the formulas needed to pool variances and calculate confidence intervals.

Notation Table	
i	Year index, 1 = prior year, 2 = current year
df	Degrees of freedom
N_i	Population size for year i (or number of member months for year i)
V_i	Variance for year i
σ_i	Standard deviation (when squared it equals variance)
$\bar{X}_i$	Mean per member per month cost for year i (population-level mean)
ρ	Growth target ratio

The formula for pooling the variance is as follows:

$$V_{pool} = \frac{\sum_i N_{X_i} \sigma^2_{X_i}}{\sum_i N_{X_i}} + \frac{\sum_{i<j} N_{X_i} N_{X_j} \left(\bar{X}_i - \bar{X}_j\right)^2}{\left(\sum N_{X_i}\right)^2}$$

OHIC will use the following formula for calculating confidence intervals with unequal variances:

$$CI = \frac{\bar{X}_1 \bar{X}_2 \pm \sqrt{\bar{X}_1^2 \bar{X}_2^2 - \left(\bar{X}_1^2 - t^2_{\hat{df},\alpha} \frac{V_1}{n_1}\right)\left(\bar{X}_2^2 - t^2_{\hat{df},\alpha} \frac{V_2}{n_2}\right)}}{\bar{X}_1^2 - t^2_{\hat{df},\alpha} \frac{V_1}{n_1}}$$

Where $t_{\hat{df},\alpha}$ equals the t statistic given the degrees of freedom ($\hat{df}$) and the value of alpha (α). For 95% confidence, the alpha value is 0.05, which means:

$t_{\hat{df},0.05}$ = 1.644861 (when using a one-sided test)

Sample Calculations Using Mock Data

Each insurer will submit payment data for ACOs/AEs stratified by market. To calculate the insurer's cost growth, OHIC will use a weighted value. OHIC will also risk-adjust the average PMPM spending by age and sex, and truncate costs over certain thresholds for high-cost outliers. Insurers will also submit unadjusted variance data by market, and for each ACO/AE by line of business.

The following walks through examples of calculating growth rates and confidence intervals around the growth rates using the above formula with mock data. For this example, Insurers A and B submitted the following data to OHIC:

Hypothetical Spending and Standard Deviation Data for Insurer A

	Paid entity	Market	Average PMPM Spending	Member Months	Standard Deviation
For 2021	ACO/AE 1	Medicaid	$416.67	240,000	$166.67
	ACO/AE 1	Commercial	$666.67	660,000	$250.00
	ACO/AE 2	Medicaid	$66.67	93,000	$29.17
	ACO/AE 2	Commercial	$83.33	384,000	$39.59
	Overall	Medicaid	$318.92	333,000	$211.93
	Overall	Commercial	$452.11	1,044,000	$292.32

	Paid entity	Market	Average PMPM Spending	Members Months	Standard Deviation
For 2022	ACO/AE 1	Medicaid	$458.33	204,000	$165.71
	ACO/AE 1	Commercial	$650.00	720,000	$375.00
	ACO/AE 2	Medicaid	$70.83	72,000	$41.67
	ACO/AE 2	Commercial	$175.00	480,000	$56.25
	Overall	Medicaid	$357.24	276,000	$223.47
	Overall	Commercial	$460.00	1,200,000	$426.63

Hypothetical Spending and Standard Deviation Data for Insurer B

	Paid entity	Market	Average PMPM Spending	Member Months	Standard Deviation
For 2021	ACO/AE 1	Medicaid	$398.22	125,000	$128.79
	ACO/AE 1	Commercial	$635.13	300,000	$224.08
	ACO/AE 2	Medicaid	$70.12	50,000	$67.24
	ACO/AE 2	Commercial	$65.12	201,000	$42.71
	Overall	Medicaid	$304.48	175,000	$233.08
	Overall	Commercial	$406.44	501,000	$274.83

	Paid entity	Market	Average PMPM Spending	Members Months	Standard Deviation
For 2022	ACO/AE 1	Medicaid	$415.24	105,000	$174.78
	ACO/AE 1	Commercial	$640.51	380,000	$387.83
	ACO/AE 2	Medicaid	$75.25	45,000	$50.84
	ACO/AE 2	Commercial	$100.35	223,000	$82.92
	Overall	Medicaid	$313.24	150,000	$230.74
	Overall	Commercial	$440.75	603,000	$396.03

From the insurer-submitted data, OHIC can calculate weighted spending averages for each line of business in each year. The weighted spending averages are calculated by taking data for all

providers in the line of business, multiplying the spending in each row by the number of member months, then summing the products, and then dividing the grand total by the total number of member months.

At the insurer level, OHIC will report growth in THCE, which includes TME and NCPHI. While insurers report aggregate spending and variance information for TME, OHIC calculates NCPHI separately using insurance filings. In assessing insurer performance, OHIC will combine PMPM growth in NCPHI to the PMPM growth in TME and calculate the confidence interval around year over year growth of that total. For this example, OHIC calculated the following PMPM NCPHI amounts for Insurers A and B for 2021 and 2022:

Average PMPM NCPHI for Insurers A and B

Insurer	Market	2020 Average PMPM NCPHI	2021 Average PMPM NCPHI
Insurer A	Medicaid	$33.33	$41.66
Insurer A	Commercial	$58.33	$66.66
Insurer B	Medicaid	$43.65	$45.33
Insurer B	Commercial	$65.34	$66.71

Using the above data, where $\bar{X}$ *is defined as the average PMPM THCE*, the growth in the Insurer A's PMPM spending from 2020 to 2021 is calculated as follows:

Medicaid spending growth = ($357.25 + $41.66)/($318.92 + $33.33) - 1 = 13.2%

Commercial spending growth = ($460.00 + $66.66)/($452.11 + $58.33) - 1 = 1.3%

Calculating Confidence Intervals for Each Insurer by Line of Business

The confidence intervals for the insurer's PMPM growth in Medicaid spending is calculated as follows:

Confidence Interval for Medicaid Growth:

$$CI = \frac{\bar{X}_1\bar{X}_2 \pm \sqrt{\bar{X}_1^2\bar{X}_2^2 - \left(\bar{X}_1^2 - t^2_{df,\alpha}\frac{V_1}{n_1}\right)\left(\bar{X}_2^2 - t^2_{df,\alpha}\frac{V_2}{n_2}\right)}}{\bar{X}_1^2 - t^2_{df,\alpha}\frac{V_1}{n_1}}$$

$$= \frac{318.92 \times 357.25 \pm \sqrt{\left(318.92^2 \times 357.25^2\right) - \left(318.92^2 - 1.644861^2\frac{211.93^2}{333{,}000}\right)\left(357.25^2 - 1.644861^2\frac{223.47^2}{276{,}000}\right)}}{318.92^2 - 1.644861^2\frac{211.93^2}{333{,}000}}$$

Thus Insurer A's Medicaid growth rate from 2020 to 2021 was 13.2% and the 95% confidence interval range is 12.9% and 13.5%. Therefore, we can say with 95% certainty that the Insurer A's

Medicaid line of business did not meet the cost growth benchmark by growing more than 3.2%. This calculation would then be repeated for the insurer's commercial line of business.

Calculating Confidence Intervals for Each Provider Entity by Market

At the provider level, OHIC will calculate growth using only TME. Using the above data, the weighted average of ACO/AE 1's Medicaid spending and pooled variance for 2020 and 2021 are calculated as follows:

ACO/AE 1's weighted average PMPM spending for Medicaid:

For 2020 = ($416.67 x 240,000 + $398.22 x 125,000) / (240,000 + 125,000) = $410.35

For 2021 = ($458.33 x 204,000 + $415.24 x 105,000) / (204,000 + 105,000) = $443.69

Pooled variance for 2020 Medicaid:

First section Second Section

$$V_{pool}=\frac{\sum_i N_{X_i}\sigma^2_{X_i}}{\sum_i N_{X_i}}+\frac{\sum_{i<j} N_{X_i}N_{X_j}\left(\bar{X}_i-\bar{X}_j\right)^2}{\left(\sum N_{X_i}\right)^2}$$

For 2020 Medicaid, first section: $\frac{(240{,}000\times 166.67^2)+(125{,}000\times 128.79)^2}{240{,}000+125{,}000}$

For 2020 Medicaid, second section: $\frac{240{,}000\times 125{,}000\ (416.67-398.22)^2}{(240{,}000+125{,}000)^2}$

For 2020 Medicaid, all sections combined: 24,022.81

Pooled variance for 2021 Medicaid:

For 2021 Medicaid, first section= $\frac{(204{,}000\times 27{,}459.89)+(105{,}000\times 174.78^2)}{204{,}000+105{,}000}$

For 2021 Medicaid, second section= $\frac{204{,}000\times 105{,}000\ (458.33-415.24)^2}{(204{,}000+105{,}000)^2}$

For 2021 Medicaid, all sections combined: 28,925.95

Using the above formula for calculating confidence intervals, the confidence interval for ACO/AE 1's Medicaid cost growth is as follows:

$$= \frac{410.35 \times 443.69 \pm \sqrt{\left(410.35^2 \times 443.69^2\right) - \left(410.35^2 - 1.644861^2 \frac{24{,}022.81}{365{,}000}\right)\left(443.69^2 - 1.644861^2 \frac{28{,}925.95}{309{,}000}\right)}}{410.35^2 - 1.644861^2 \frac{24{,}022.81}{365{,}000}}$$

$$= \frac{182{,}068.19 \pm \sqrt{77{,}702.63}}{168{,}383.94} = 8.1 \text{ to } 8.3$$

Thus the growth rate from 2021 to 2022 was 8.1% and the 95% confidence interval range is 8.0% and 8.3%. Therefore, we can say with 95% certainty that ACO/AE 1's growth in Medicaid costs did not meet the cost growth benchmark by growing more than 3.2%. This calculation would then be repeated for ACO/AE 1's commercial and Medicare Advantage spending.

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Appendix I: Methodology for Risk-Adjusting Data by Age/Sex

A. Risk-Adjusting TME for Insurers and Accountable Care Organizations/Accountable Entities (ACO/AE)

OHIC risk-adjusts total medical expenses (TME) data when evaluating performance against the Cost Growth Target at Insurer and ACO/AE levels. Risk-adjustment is done for age and sex by Insurance Category Code (see **Table 1** below for Insurance Category Code definitions), using standard weights developed by OHIC.

To develop the weights, OHIC collects TME data and member months data by age/sex bands (see **Table 2** below for age bands) at the Insurer overall and ACO/AE levels and calculates two set of weights for each Insurance Category Code (one set at the Insurer level and one set at the ACO/AE level).[63] These standard weights are applied uniformly across all Insurers and ACO/AEs respectively within each Insurance Category Code.

This section outlines how OHIC calculates standard weights and develops Insurer and ACO/AE-specific age/sex risk scores.

B. Calculation of Standard Weights

For each Insurance Category Code, using base year data (for the 2021-22 analysis, this would be 2021 data):

- OHIC calculates the statewide claims-based, truncated TME (see **Table 3** below for truncation points) and member months within each age/sex band by combining data across Insurer submissions. Non-claims-based spending is **NOT** included in this calculation.
- OHIC then calculates statewide per member per month (PMPM) spending for each age/sex band by taking the statewide claims-based, truncated TME and dividing it by the statewide member months.
- To calculate standard weights for each age-sex band, OHIC takes the PMPM spending for an age-sex band and divides by overall PMPM spending.

[63] OHIC calculates two sets of weights (one set at the Insurer level and one set at the ACO/AE level) because for members who are attributed to more than one ACO/AE during the year, insurers "reset the clock" and calculate truncated spending for the member for each of the ACO/AEs, and for the Insurer as a whole, which may result in different truncated spending amounts.

- This is conducted at the Insurer and at the ACO/AE level (note that spending data at the Insurer and ACO/AE levels do not necessarily align due to the "reset the clock" approach for truncating claims).

C. Calculation of Insurer Risk Scores

OHIC calculates a risk score for each Insurer being reported on, stratified by Insurance Category Code. To do this, using Insurer level data for each Insurance Category Code:

- OHIC calculates the population distribution of attributed members across age/sex bands for each Insurer. This is done by taking the member months for each age/sex band and dividing it by the member months for the Insurer.
- OHIC then multiplies the standard Insurer weights for the age-sex band calculated in **Section A** above to the respective population distribution.
- OHIC then sums the values calculated above across age/sex bands for Insurer. This is the Insurer's risk score for the specific Insurance Category Code.

D. Calculation of ACO/AE Risk Scores

Within each Insurer's submission, OHIC calculates a risk score for each ACO/AE being reported on, stratified by Insurance Category Code. To do this, within an Insurer submission, for each Insurance Category Code:

- OHIC calculates the population distribution of attributed members across age/sex bands for the ACO/AE. This is done by taking the member months for each age/sex band and dividing it by the member months for the ACO/AE.
- OHIC then applies the standard ACO/AE weights for the age-sex band calculated in **Section A** above to the respective population distribution.
- OHIC then sums the values calculated above across age/sex bands for each ACO/AE. This will be the ACO/AE's risk score for the specific Insurance Category Code.

E. Application of Insurer and ACO/AE Risk Scores to Spending Data

To calculate the age/sex risk-adjusted spending for each Insurer, OHIC divides the unadjusted, truncated claims spending for the insurer overall by Insurance Category Code by the Insurer risk scores developed in **Section B** above and adds its respective non-claims spending. To calculate the age/sex risk-adjusted spending for each ACO/AE, within each Insurer's submission for each Insurance Category Code, OHIC divides the unadjusted, truncated claims spending for each ACO/AE by the ACO/AE's risk score developed in **Section C** above and adds its respective non-claims spending. OHIC does not sum risk-adjusted ACO/AE level

spending to derive risk-adjusted Insurer level spending, as this approach does not take into account the "reset the clock" methodology for truncated spending.

Table 28. Insurance Category Code Definitions for TME Reporting

	Definition
1	Medicare Managed Care (excluding Medicare/Medicaid Dual Eligibles)
2	Medicaid including CHIP (excluding Medicare/Medicaid Dual Eligibles)
3	Commercial — Full Claims
4	Commercial — Partial Claims
5	Medicare Expenditures for Medicare/Medicaid Dual Eligibles
6	Medicaid Expenditures for Medicare/Medicaid Dual Eligibles
7	Other

Table 29. Age Bands

Age Band Code	Description
1	0 to 1 year old
2	2 to 18 years old
3	19 to 39 years old
4	40 to 54 years old
5	55 to 64 years old
6	65 to 74 years old
7	75 to 84 years old
8	85 + years old

Table 30. Truncation Points for Insurer and ACO/AE Claims Expenses[64]

Insurance Category Code	Definition	Per Member Truncation Point

[64] For members who are attributed to more than one ACO/AE during the year, insurance carriers are asked to "reset the clock" and calculate truncated spending for the member for each of the ACO/AEs and

1	Medicare Expenses for Non-Dual Eligible Members	$150,000
2	Medicaid Expenses for Non-Dual Eligible Members	$250,000
3	Commercial: Full Claims	$150,000
4	Commercial: Partial Claims	$150,000
5	Medicare Expenses for Medicare/Medicaid Dual Eligible	$150,000
6	Medicaid Expenses for Medicare/Medicaid Dual Eligible	$250,000

for the Insurer as a whole. This is done by first calculating the member's total spending that is attributed to each ACO/AE, and then separately applying truncation to the member's spending that is attributed to each ACO/AE.

Appendix J:
Insurer Attestation

Attestation of the Accuracy and Completeness of Reported Data

Instructions: Please enter all requested information in the blank spaces provided below and have an authorized signatory sign the attestation. Insurers should submit one "Attestation of the Accuracy and Completeness of Reported Data" per performance period. Scanned copies of the signed attestations should be emailed to: Cory.King@ohic.ri.gov

Insurer: _____

Performance Period Being Reported: _____

Pursuant to Rhode Island's establishment, monitoring and implementation of annual Health Care Cost Growth Target under the former Governor's Executive Order 19-03 and State-defined reporting guidelines, certain health insurers operating in the state of Rhode Island must annually submit certain data requested to calculate insurer and provider performance relative to Rhode Island's Target.

I hereby attest that the information submitted in the reports herein is current, complete and accurate to the best of my knowledge. I understand that whoever knowingly and willfully makes or causes to be made a false statement or representation on the reports may be prosecuted under any applicable state laws. Failure to sign this Attestation of the Accuracy and Completeness of Reported Data will result in OHIC non acceptance of the attached reports.

Signature	Date
Printed Name	Title