AMENDMENTS TO 230-RICR-20-30-4

Regulatory & Cost-Benefit Analysis

Abstract

This regulatory and cost-benefit analysis of the amendments to 230-RICR-20-30-4 is published pursuant to the Administrative Procedures Act, R.I. Gen. Laws 42-35-2.9 and Executive Order 15-07.

Office of the Health Insurance Commissioner

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Version History

This January 2025 version of the Regulatory & Cost-Benefit Analysis updates the September 2024 version as follows:

- Four Collaborative Care codes (99492, 99493, 99494, G2214) were added to Appendix B to reflect their inclusion in the Adopted Regulation post-public comment.
- The comparative primary care reimbursement rate analysis was updated. OHIC re-ran the APCD analysis to remove some Internal Medicine providers. Table 3 and Table 4 have been updated. The discussion of these results has been updated on pages 12-15.
- OHIC discusses potential spill-over effects of the primary care expenditure requirement on behavioral health care reimbursement.

Introduction

The Office of the Health Insurance Commissioner (OHIC) was created by the Rhode Island General Assembly in 2004. The agency is charged with protecting consumers, ensuring fair treatment of health care providers, guarding the solvency of insurers, and improving the health care system as a whole.[1] OHIC has played a leading role in efforts to improve the affordability and quality of health care in Rhode Island.

OHIC is proposing amendments to 230-RICR-20-30-4 *Powers and Duties of the Office of the Health Insurance Commissioner*. Chiefly, the proposed amendments modify § 4.3 Definitions, § 4.10 Affordable Health Insurance – Affordability Standards, and § 4.11 Administrative Simplification. The proposed amendments were drafted following a strategic reevaluation of OHIC policy initiatives to support primary care in 2023. From a review of the literature, OHIC finds that primary care availability and effectiveness is a key strategy to improve the affordability of health care and health insurance. Health insurer contracting decisions and administrative policies, such as utilization review, impact the functioning and vitality of the primary care system.

The provisions of § 4.10 set forth regulatory standards for insurers to follow in their efforts to improve the affordability of their products. OHIC developed these standards to meet its statutory mandate under R.I.G.L § 42-14.5-2, which states:

> *"With respect to health insurance as defined in § 42-14-5, the health insurance commissioner shall discharge the powers and duties of office to:*
>
> *(1) Guard the solvency of health insurers;*
>
> *(2) Protect the interests of consumers;*
>
> *(3) Encourage fair treatment of health care providers;*
>
> *(4) Encourage policies and developments that improve the quality and efficiency of health care service delivery and outcomes; and*
>
> *(5) View the health care system as a comprehensive entity and encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access."*

In December 2023, OHIC completed its reevaluation and published, *Primary Care in Rhode Island: Current Status and Policy Recommendations* ("OHIC Primary Care Report").[2] The OHIC Primary Care Report presents findings from OHIC's state and national research on primary care trends, offers an assessment of the current state of primary care in Rhode Island, and provides recommendations for future actions to support and strengthen primary care in the state. These recommendations include committing OHIC to the following action:

- "OHIC will amend the agency's primary care expenditure target in 2024 to better align the agency's legacy measurement methodology with emerging consensus definitions of primary care

[1] See RIGL 42-14.5-2 http://webserver.rilin.state.ri.us/Statutes/TITLE42/42-14.5/42-14.5-2.HTM.
[2] Primary Care in Rhode Island: Current Status and Policy Recommendations. December 2023. Available at: https://ohic.ri.gov/sites/g/files/xkgbur736/files/2023-12/Primary%20Care%20in%20Rhode%20Island%20-%20Current%20Status%20and%20Policy%20Recommendations%20December%202023.pdf.

expenditures and establish new targets for commercial insurers that will support achievement of necessary increases in primary care."

The proposed amendments build on OHIC's prior work on primary care and take steps to further prioritize, support, and sustain the primary care workforce in Rhode Island. These actions will support the provision of affordable health insurance.

The provisions of § 4.11 prescribe standards for administrative simplification. The purpose of administrative simplification in the context of health insurance regulation is to streamline health care administration to be more cost-effective, and less time consuming, for hospitals, professional providers, consumers, and insurers. R.I.G.L § 42-14.5-3(h) calls for OHIC to convene "a workgroup representing healthcare providers and health insurers for the purpose of coordinating the development of processes, guidelines, and standards to streamline healthcare administration that are to be adopted by payors and providers of healthcare services operating in the state." OHIC meets this charge by convening the Administrative Simplification Task Force ("Task Force").

In 2023, the general assembly amended OHIC's enabling statute to direct OHIC and the Task Force to develop recommendations for improving prior authorization processes.[3] Prior authorization is the prospective assessment of a health care service prior to rendering the service. In June 2024, OHIC submitted the *Prior Authorization Final Report of Recommendations: Report of the Administrative Simplification Task Force* to the general assembly in compliance with the 2023 law.[4] The report drew upon the prior work of the Care Transformation Collaborative of Rhode Island (CTC-RI) Prior Authorization Steering Committee, which met six times from April to October 2023, and discussions over the course eight meetings of the Task Force, which took place between October 2023 and March 2024. The CTC-RI Prior Authorization Steering Committee produced recommendations across six areas:

1. Reduce prior authorization volume.
2. Improve data collection on prior authorization.
3. Create on-going statewide advisory committees.
4. Evaluate the feasibility and advisability of therapeutic substitution at the pharmacy.
5. Implement technologies that improve the prior authorization process.
6. Identify and reduce processes that are 'prior authorization-like."

Through this rulemaking, OHIC is proposing amendments to 230-RICR-20-30-4.11 that address the first three areas: prior authorization volume, data collection, and on-going advisory committees. The proposed amendments to improve the prior authorization process also address a major finding in the OHIC Primary Care Report. OHIC found:

- "Clinician burnout is a key concern facing the primary care workforce and is driving physicians and advanced practitioners to reduce or leave clinical practice. Burnout among clinicians also negatively affects patient care. Utilization review activities, notably prior authorizations, and the challenges of managing a patient panel under workforce constraints that range from doctors to front office staff, exacerbate burnout. OHIC's interviews with primary care providers and practice groups evidenced that the foregoing challenges are impacting the local primary care workforce."

In response to this finding, OHIC committed to:

- "Make significant reductions in the administrative burdens placed on primary care practices and providers more generally by insurer utilization review and administrative requirements.

[3] See P.L. 2023, ch. 253, § 1 at https://webserver.rilegislature.gov/PublicLaws/law23/law23253.htm
[4] Prior Authorization Final Report of Recommendations: Report of the Administrative Simplification Task Force. Available at: https://ohic.ri.gov/sites/g/files/xkgbur736/files/2024-06/OHIC%20Administrative%20Simplification%20Task%20Force%20Report%20June%2028%202024.pdf

a. …. The burden of prior authorization is significant and OHIC will take necessary actions to meaningfully reduce the volume of prior authorizations through building consensus and promulgating regulations.

b. OHIC will convene a structured forum with representation from the provider community and health insurers to engage in dialog about the implications of medical management practices and other administrative requirements."

Background of the Affordability Standards - § 4.10

The Affordability Standards were developed in 2008 by OHIC in consultation with its legislatively created Health Insurance Advisory Council. The Affordability Standards are a core component of OHIC's efforts to meet its statutory mission to improve the health care system, to protect consumers, and to improve the affordability of health insurance. As part of the annual rate review process for health insurance premiums, health insurers are required to prove that the rates filed for approval by OHIC are consistent with the proper conduct of the health insurer's business and the public interest. Given the public's interest in affordable health insurance, OHIC developed the Affordability Standards to systematize regulatory requirements that insurers must follow to demonstrate their efforts to improve affordability.

Since 2010, the Affordability Standards have been modified from time to time. The present iteration of Affordability Standards comprises the following policy areas. The description of *Standard One: Primary Care Spend Obligation* reflects the current regulation and associated guidance, which is subject to amendments pursuant to the Notice of Proposed Rulemaking, and this cost benefit analysis.

Standard One: Primary Care Spend Obligation

Requires that health insurer total medical payments made to primary care are at least 10.7 percent of annual medical spend, with 9.7 percent for Direct Primary Care Expenses. Indirect Primary Care Expenses must include at least a proportionate share for administrative expenses incurred to support and strengthen the capacity of a primary care practice to function as a medical home and to successfully manage risk-bearing contracts, and to support the health information exchange. The methods for counting primary care expenditures, definition of the annual medical spend denominator, and definition of primary care providers were developed in 2008-09 and have not changed since that time. The focus of the primary care expenditure requirement was to drive increasing non-claim-based payments to primary care and to support the proliferation of the patient-centered medical home (PCMH) model through multi-payer initiatives, like the Care Transformation Collaborative of Rhode Island.

Standard Two: Primary Care Practice Transformation

Requires health insurers to support primary care practices that have achieved patient-centered medical home standards by providing ongoing payments to support care management. Furthermore, the standards support the integration of behavioral health care into the primary care practice.

Standard Three: Payment Reform

OHIC's payment reform strategy includes the following key components: promoting population-based contracting, adoption of alternative payment models in primary and specialty care, measure alignment in provider contracts, improved hospital contracting practices, and limiting cost increases associated with population-based contracts with Integrated Systems of Care (or, Accountable Care Organizations).

Summary of the Proposed Amendments

The proposed amendments chiefly modify the primary care expenditure definition and health insurer obligation provisions of the Affordability Standards and make other, related technical changes to the regulation. The amendments also address health insurer prior authorization practices.

The primary care amendments are articulated in § 4.3 and § 4.10(B) of the regulation, with related changes in other subsections of § 4.10. The amendments embrace the following substantive, related areas:

1. The definition of primary care expenditures will be revised to reflect substantive advances in consensus definitions of primary care in the 15 years since OHIC established the requirement.
2. The expenditure target is restructured to improve oversight of primary care expenditures and to incentivize increased financial support for primary care through service-based mechanisms.
3. The total medical expense (TME) denominator of the primary care expenditure target is also modified. As states have taken an interest in measuring primary care expenditures as a percentage of total medical expenditures, it has become more important to aligned denominator definitions to ensure comparability. The change in TME definition also better aligns with primary care's role managing total cost of care through risk-based contracts.
4. The regulation is amended to explicitly state that care management and infrastructure payments to primary care practices shall not be at risk for total cost of care performance but may be at risk for performance on quality measures.
5. Annual budget development for total cost of care contracts shall be held harmless for mandated increases in primary care funding.

The amendments to the primary care definition and expenditure requirement will improve OHIC's ability to hold insurers accountable for the appropriate financing of primary care that is necessary to ensure a high functioning health care system and provision of affordable health insurance. The amendments will also improve OHIC's ability to ensure that primary care payments are directed to the support of primary care practices and clinicians. OHIC will publicly report primary care expenditure data by payer using the new definition, once finalized, and perform periodic market conduct examinations to audit compliance.

OHIC also proposes adding a new subsection within § 4.11 – Administrative Simplification, concerning prior authorization. This new § 4.11(F) mandates a 20% reduction in the volume of prior authorization relative to 2023 data, encourages insurers to develop selective prior authorization requirements for providers based on performance and participation in risk-based contracts, and requires annual review of prior authorization requirements by health insurers, with the input of contracted providers and/or provider organizations. Further, the new subsection mandates new reporting requirements by health insurers and establishes a public body convened by OHIC to work toward improvements in prior authorization practices and processes over time.

To account for the secular decline in the size of the fully insured market, the threshold for compliance with the delivery system and payment reform strategies set forth in § 4.10 is lowered from 10,000 covered lives to 5,000. Where satisfaction of regulatory requirements, such as risk-based contracting, is not technically feasible without greater enrollment, insurers may seek a waiver under § 4.10(F)(2).

Stakeholder Analysis

OHIC is required to conduct a cost-benefit analysis of the proposed amendments. For this analysis we distinguish between two major stakeholder groups: 1. Private market purchasers of health insurance and health care services, which include consumers; and 2. Health care providers. Rhode Island residents represent the basic entities with standing in this analysis. Individuals assume multiple economic and social roles. For example, a single individual may be a consumer, health care worker, and taxpayer concurrently. The proposed amendments influence the allocation of economic resources in Rhode Island, with associated

transfers, benefits, and costs for Rhode Island residents who obtain insurance coverage through their employer or who purchase it directly from a Rhode Island insurer. The economic impacts of the proposed regulation are not confined to this group. Health care providers, particularly the primary care workforce, are a significant stakeholder group whose interests will be affected by the proposed amendments. It can be assumed that standing is co-extensive with the Rhode Island population based on guidance from the Rhode Island Office of Regulatory Reform.

The purchaser stakeholder group comprises Rhode Island employers who purchase a group insurance product from one of Rhode Island's major health insurers. The purchaser group also includes non-group, individual market consumers. Self-insured employers are another stakeholder group who may experience spillover effects. Table 1 lists the major subgroups of purchasers and their relative sizes. The figures reflect Rhode Island resident enrollment in March 2023. The Medicaid and Medicare markets, particularly those consumers who obtain insurance through these government-funded programs, may experience spillover effects, but those spillovers are not assessed due to their indeterminant character.

Table 1: Purchasers – Rhode Island Residents*

Purchaser Group	Group Size
Insured – Individual Market	40,906
Insured – Small Group Market	35,171
Insured – Large Group Market	60,551
Total Fully Insured	**136,628**
Self-Insured Group	171,081
Total Insured	**307,709**

*Data reported by RI's four largest insurers as of January 2024. These figures are based on Rhode Island residents whose insurance is issued in Rhode Island. Some Rhode Islanders work for employers in other states, where their insurance is issued. These Rhode Islanders are not included in the counts provided in Table 1.

The health care provider stakeholder group reflects Rhode Island's primary care providers and associated staff. According to CMS' National Plan and Provider Enumeration System, as of September 2023, Rhode Island had 301.5 active primary care providers per 100,000 population.[5] Of note, provider counts may over-represent the number of active primary care providers as some providers may practice part-time. OHIC has recently asked researchers at Brown University to utilize data from the all-payer claims database to provide alternative estimates of the primary care workforce based on billing information to assess true full-time equivalent (FTE) counts. OHIC expects this analysis to be complete in the fall of 2024.

R.I. Gen. Laws §42-35-2.9 requires administrative agencies to conduct a regulatory analysis for proposed rules. The regulatory analysis must include an assessment of the benefits and costs of a "reasonable range of regulatory alternatives" reflecting the scope of the agency's discretion. Toward that end, the proposed amendments reflect the product of considerable research and stakeholder engagement by OHIC.

In developing its Primary Care Report, OHIC conducted a series of semi-structured interviews with primary care providers, health insurers and patient advocates to inform OHIC's new vision for primary care in Rhode Island. During the interviews, OHIC asked interviewees to reflect on OHIC's prior primary care initiatives, share the biggest challenges to Rhode Island primary care from their perspectives, and recommend actions that OHIC should consider taking to support and sustain primary care in Rhode Island.

The themes that emerged from these interviews support the need for improved oversight of primary care expenditures by commercial insurers and increased investment in the primary care workforce in Rhode Island. Specifically, primary care providers noted workforce challenges as the chief concern, citing that primary care physician shortages result in at-risk patients being unable to access primary care and suffering adverse health consequences as a result. Providers additionally shared that pay for primary care is non-competitive, both compared to other medical specialties and to primary care pay in neighboring states.

[5] America's Health Rankings. Primary Care Providers in Rhode Island. Available at: https://www.americashealthrankings.org/explore/measures/PCP_NPPES/RI.

Interviews with representatives from a consumer advocacy organization that serves a broad range of Rhode Islanders also cited that timely access to primary care is increasingly difficult for consumers.

The proposed amendments to § 4.11 – Administrative Simplification, are the product of analysis and lengthy public discussions among OHIC and members of the Administrative Simplification Task Force. The meeting materials from the Task Force are documented in Appendix B of Prior Authorization Final Report of Recommendations: Report of the Administrative Simplification Task Force.[6] Beyond the Task Force, at OHIC's request the Care Transformation Collaborative of Rhode Island (CTC-RI) convened a Prior Authorization Steering Committee, which included diverse representation from the provider community, including primary care, and the health insurers.

[6] Prior Authorization Final Report of Recommendations: Report of the Administrative Simplification Task Force. Available at: https://ohic.ri.gov/sites/g/files/xkgbur736/files/2024-06/OHIC%20Administrative%20Simplification%20Task%20Force%20Report%20June%2028%202024.pdf

Regulatory and Cost-Benefit Analysis

Introduction

The following analysis seeks to catalog and quantify the benefits, costs, and transfers from the proposed amendments to 230-RICR-20-30-4. While the primary care amendments cover two substantive areas – the definition of primary care expenditures and the level of the expenditure obligation – the following quantitative analysis assesses the impact of these proposals combined, given that the amendments work in conjunction to define the Rhode Island primary care expenditure obligation. The amendments concerning administrative simplification are evaluated separately.

Amendments to the Primary Care Expenditure Requirements

Amended Definition of Primary Care Expenditures

The proposed amendments revise the definition of primary care expenditures for the purpose of calculating payments that count towards the health insurer primary care expenditure obligation. Under the proposed revised definition, primary care expenditures are defined as all claims-based and non-claims-based payments by a health insurer directly to a primary care practice for primary care services delivered to Rhode Island residents at a primary care site of care.[7] The definition further includes payments to support the operations of the Care Transformation Collaborative of Rhode Island (CTC-RI).[8] The revised definition establishes the types of claims-based and non-claims-based payments that will count towards the primary care expenditure obligation, ensuring that health insurers use a common set of primary care payment codes to identify claim-based payments and common guidance to calculate non-claims-based payments.

The revised definition excludes certain categories of payments that were previously included in the methodology, such as Health Information Exchange Payments for CurrentCare, and shared savings and other incentive payments that are not directed to primary care providers.[9] In this way, the revised definition more accurately reflects commercial spending used to directly support Rhode Island primary care providers and infrastructure.

The methodology in the revised definition is more consistent with the New England States Consortium Systems Organization' (NESCSO) definition of primary care spending[10] and primary care spending target definitions utilized by other states (e.g., Connecticut, Delaware, Oregon). These states compute ratio measures of primary care spending to assess the proportion of total medical expenditures (TME) that are dedicated to primary care. OHIC has sought align denominator total medical expenditures with the Rhode Island Health Spending Accountability and Transparency Program as well.

The amended regulation also adopts a set of standard provider taxonomy codes from the National Uniform Claim Committee to identify primary care providers. This is an improvement over the legacy methodology.

The revised definition is more technically precise than the legacy definition, by virtue of its use of code-based specifications to define primary care services, sites of care and providers. It leverages a body of research that has been developed in the last seven years that aims to define primary care using code-

[7] 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 spending for services 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.

[8] The Care Transformation Collaborative of Rhode Island a non-profit that provides technical support to Rhode Island primary care practices. For more information, see https://ctc-ri.org/.

[9] The legacy definition counted 100% of shared savings and other performance-based distributions from primary care pay for performance arrangements.

[10] The New England States' All-Payer Report on Primary Care Payments. New England States Consortium Systems Organization (NESCSO); 2020. Available from: https://nescso.org/wp-content/uploads/2021/02/NESCSO-New-England-States-All-Payer-Report-on-Primary-Care-Payments-2020-12-22.pdf.

based specifications and estimate primary care spending by applying those specifications to administrative datasets. Moreover, the revised definition aligns more closely with the methodology for the primary care spending calculation under the Rhode Island Health Spending Accountability and Transparency Program.[11] Using consistent methodologies for that program and the primary care expenditure obligation will streamline health insurer reporting, as well as OHIC's data collection and analysis roles, under these two initiatives.

The primary care specialties provider taxonomy codes are listed in Appendix A. The primary care payment codes are listed in Appendix B. In response to public comments, OHIC added four Collaborative Care codes. These codes are not captured in the baseline data utilized in the financial analyses that follow. However, the total value of expenditures associated with these codes today is likely very small.

The research and policy literature that has informed this rulemaking is listed Table 2.

Table 2: Primary Care Definitions in the Literature

Year	Publication
2017	Bailit, et al., Standardizing the Measurement of Commercial Health Plan Primary Care Spending
2019	Jabbarpour, et al., Investing in Primary Care: A State-Level Analysis
2019	Reid, et al., Primary Care Spending in the Fee-for-Service Medicare Population
2020	Carmen, et al., Advancing the Development of a Framework to Capture Non–Fee-for-Service Health Care Spending for Primary Care
2020	NESCSO, The New England States' All-Payer Report on Primary Care Payments

Alternatives

OHIC considered broader definitions of primary care, including the identification of OB-GYN within the definition of primary care. OB-GYN is not included in the legacy primary care provider definition. OHIC surveyed other states with primary care expenditure targets and found that two states include OB-GYN (Colorado and Oregon) and two states exclude OB-GYN (Connecticut and Delaware).

Amended Primary Care Expenditure Obligation

The proposed amendments revise the level of the primary care expenditure obligation to at least 10% of a commercial insurer's Rhode Island resident annual medical expenses for all insured lines of business, excluding long-term care, and net of pharmacy rebates. In determining the level of the obligation, OHIC considered the implications of using a methodology with a narrower, or broader, definition of primary care spending, while also striving to further encourage necessary increases in primary care investment.

The numerical targets under the legacy expenditure obligation and the proposed one are similar. However, the numerator and denominator definitions are different. As discussed above, the numerator definition of primary care expenditures is more precisely defined through the specification of procedure codes, provider taxonomy codes, and guidance for allocating non-claims-based expenditures. The denominator definition of TME is materially different. The legacy expenditure target included only payments to Rhode Island providers in the calculation. While the preponderance of care for Rhode Island residents is delivered in Rhode Island, a meaningful percentage of expenditures on inpatient care is delivered outside of the state. This percentage has been stable over time. The inclusion of non-Rhode Island medical payments has a greater impact on the denominator than the numerator of the ratio. TME is greater in the new, proposed definition of the expenditure target, than it is under the legacy target, by about $187 million. Including all

[11] See Rhode Island Health Care Cost Growth Target and Primary Care Spend Obligation Implementation Manual. August 2023. Available at: https://ohic.ri.gov/sites/g/files/xkgbur736/files/2023-08/RI%20TME%20%26%20PC%20Spend%20Implementation%20Manual_CY21-22%202023%2008-01_v1.pdf.

provider payments, unrestricted by state, better aligns with the total cost of care management that is expected of primary care driven accountable care organizations.

To inform the revised spending obligation, OHIC considered the research findings from the OHIC Primary Care Report that documented trends in Rhode Island compared to other states for workforce, primary care spending, and access, as well as feedback from the report's stakeholder analysis described above. The following key research findings informed OHIC's consideration:

1. *Workforce*: As of September 2023, Rhode Island ranked as fourth out of all states in the U.S. in terms of number of active primary care providers per 100,000 population.[12] Despite this ranking, the report found that the primary care provider to population ratio has declined over the last two years. The numbers of providers are expected to further decline in the coming years due to factors such as the significant percentage of family physicians in Rhode Island nearing retirement age, and trends of newly state-trained physicians leaving to work in other states.[13] It is also of note that alternative ways to quantify the primary care workforce, based on analysis of the APCD, are also underway. These methods may demonstrate that the actual FTE counts of primary care providers fall below the counts suggested by the national data.
2. *Primary care spending*: When examining claims-based primary care spending as a percentage of total medical expense, the report found that Rhode Island ranked better than some, but not all, neighboring states. For example, according to the 2020 New England States Consortium Systems Organization (NESCSO) report, in 2018 Rhode Island ranked 3rd of the six New England states for commercial market primary care claims spending as a percentage of total medical spending.[14]
3. *Access:* According to 2021 data, Rhode Island had lower rates of adults and children without a usual source of care than the U.S. overall.[15] This is due, in part, to the high rate of insurance coverage in Rhode Island and strong system of federally qualified health centers. However, disparities exist among Rhode Island adults by race, ethnicity, education, and socioeconomic status in terms of access to a usual source of care,[16] suggesting that access to primary care is not equitably distributed within the state.

Independent of the Primary Care Report, OHIC considered benchmarks of reimbursement and per member per month (PMPM) funding for primary care among neighboring states. It is generally accepted that primary care is an under resourced component of the health care system nationally. Therefore, benchmarks may be of limited value when determining ultimate primary care investment goals.

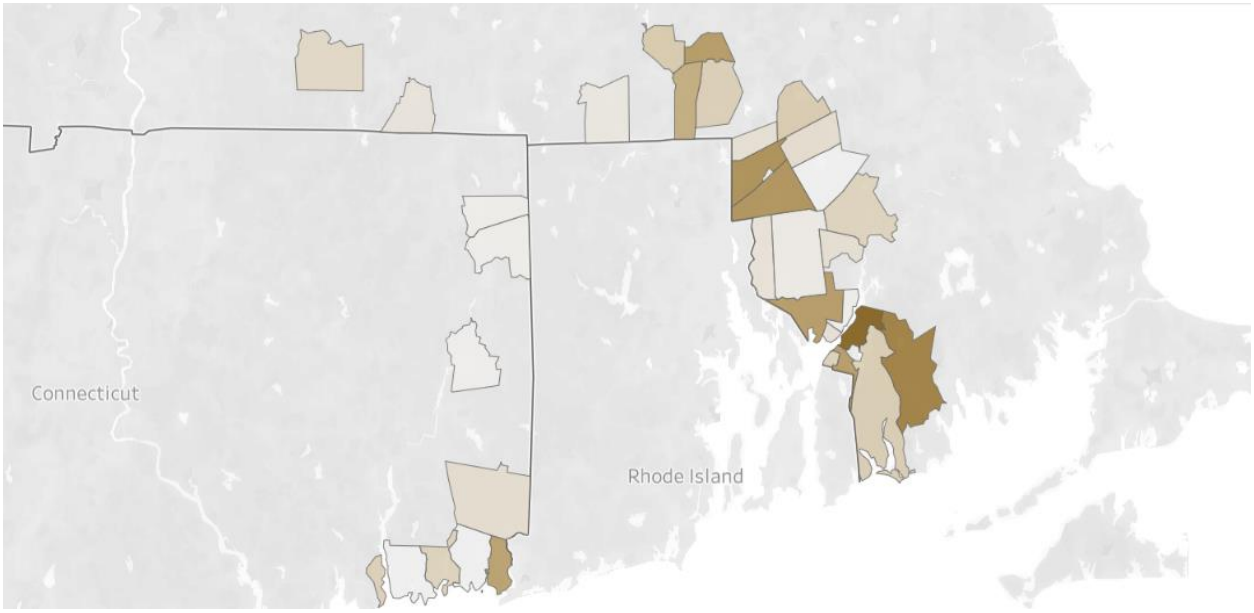
In 2024 OHIC conduced an analysis of 2018 - 2022 claims data from the APCD to assess primary care reimbursement. This analysis showed that Rhode Island primary care provider payment rates are below the payment rates for Massachusetts primary care providers in towns/zip codes bordering Rhode Island. OHIC mapped all the Rhode Island resident commercial primary care claims in the APCD to the zip codes where the services were delivered in Rhode Island, Massachusetts, and Connecticut. Given the geography of Rhode Island, primary care offices in bordering towns of Massachusetts and Connecticut may be closer to Rhode Island residents, or more accessible, than offices elsewhere in the state. Next, OHIC calculated the payment per unit for all primary care visits, and separate classes of visits (new patient[17] and established

[12] America's Health Rankings. Primary Care Providers in Rhode Island. Available at: https://www.americashealthrankings.org/explore/measures/PCP_NPPES/RI.
[13] Petterson S, Wilkinson E, Kessler AC, Stone C, Bazemore A. The State of Primary Care Physician Workforce. The Robert Graham Center. 2018. Available at: https://www.graham-center.org/content/dam/rgc/documents/maps-data-tools/state-collections/phys-workforce/Rhode-Island.pdf.
[14] The New England States' All-Payer Report on Primary Care Payments. New England States Consortium Systems Organization (NESCSO); 2020. Available from: https://nescso.org/wp-content/uploads/2021/02/NESCSO-New-England-States-All-Payer-Report-on-Primary-Care-Payments-2020-12-22.pdf. The NESCSO report did not systematically account for non-claims-based spending, which accounts for a significant percentage of primary care spending in Rhode Island.
[15] The Commonwealth Fund. Adults with a usual source of care. Available from: https://www.commonwealthfund.org/datacenter/adults-usual-source-care.
[16] Rhode Island Foundation, Health in Rhode Island. Adults without a usual source of care. Available from: https://healthinri.com/data/adults-without-a-usual-source-of-care.
[17] New Patient Visits were defined as (CPT 99202-99205, 99381-99387, G0466).

patient[18]), to calculate a measure of average commercial reimbursement. Payment per unit includes the insurer paid amount and consumer out-of-pocket payments.

OHIC examined the statewide average payment and the average payment in "border zip codes."[19] The defined border zip codes are shown in Figure 1.[20]

Figure 1: Bordering Zip Codes for Comparative Payment Analysis



OHIC found that average commercial payment for all primary care visits is 28.8% higher in bordering Massachusetts zip codes than in Rhode Island. There is a much smaller difference in average payment for new patient visits (4.4%), but a larger difference for established patient visits (32.3%). See Table 3. The data on average payment for Massachusetts statewide is also provided in Table 3 and consistent with these observations. Observed differences between Rhode Island reimbursement and Connecticut reimbursement were smaller. However, the Connecticut data are more limited. Of the 707,431 primary care service claims for the Rhode Island population in the APCD in 2022, 93.5% were incurred in Rhode Island, 5.9% were incurred in Massachusetts, and less than 1% were incurred in Connecticut. The claims count by geography is provided in Table 4.

It should be noted that reimbursement rates are only one piece of primary care payment. This analysis does not reflect non-claims-based payments, such as performance bonuses or shared savings, that also figure into primary care payment, and ultimately into provider compensation. Nor does this analysis capture health system subsidies that support primary care practices, such as hospital inpatient or hospital outpatient operating profits.

[18] Established Patient Visits were defined as (CPT 99211-99215, G0467)
[19] Massachusetts zip codes included (01106, 01010, 01566, 01550, 01570, 01516, 01569, 02019, 01756, 02038, 02093, 02762, 02035, 02048, 02760, 02703, 02766, 02771, 02769, 02780, 02764, 02777, 02726, 02725, 02724, 02721, 02790, 02747, 02720, 01757, 02053). Connecticut zip codes included (06260, 06241, 06239, 06354, 06374, 06359, 06379, 06378, 06355, 06340, 06320).
[20] Zip codes with fewer than 11 claims are suppressed.

Table 3: Commercial Payment Per Unit (PPU) for Primary Care Claims – 2022 – Updated January 2025

	All PC Claims	New Patient	Established Patient
MA/RI - Border MA zip codes	28.8%	4.4%	32.3%
MA/RI – Statewide	31.6%	4.8%	40.2%
CT/RI – Border CT zip codes	1.0%	-4.1%	0.0%
CT/RI – Statewide	-2.4%	-10.1%	-3.2%

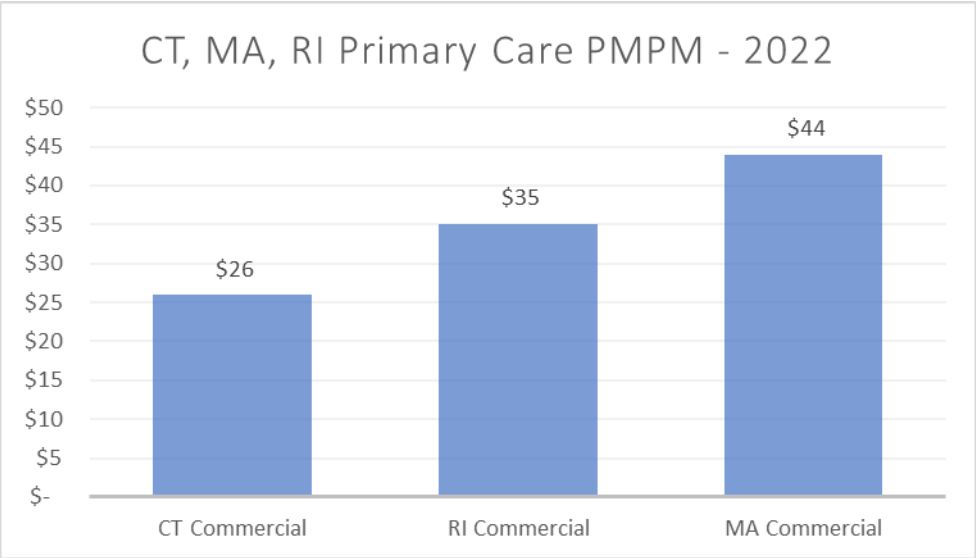
Table 4: Commercial Primary Care Claims for Rhode Island Residents by Geography – 2022 – Updated January 2025

State (Geography)	All PC Claims	New Patient	Established Patient
Rhode Island	661,126	51,590	447,462
Connecticut	4,882	135	3,437
Connecticut - Border zip codes	*3,614*	*74*	*2,593*
Massachusetts	41,423	3,736	31,329
Massachusetts - Border zip codes	*23,599*	*1,336*	*17,203*

Since reimbursement rates form only a part of total funding to primary care OHIC also analyzed primary care expenditures on a per member per month (PMPM) basis, inclusive of claims-based and non-claims-based expenditures. Drawing from recent reports by state agencies in Connecticut and Massachusetts, OHIC compared 2022 PMPM commercial payer expenditures.[21] The Rhode Island data used for this PMPM analysis is based on the primary care definition incorporated in this rulemaking. There are some minor variations in primary care expenditure definitions among the three states compared. Notably, some OB-GYN services are included in the Massachusetts definition, but not in Connecticut or Rhode Island. The Rhode Island data presented below is limited to Rhode Island resident fully insured members.

[21] The Connecticut data come from, Primary Care Spend Target Initiative 2022 Performance. A Report Pursuant to C.G.S. 19a-754h, Connecticut Office of Health Strategy, June 11, 2024. The Massachusetts data come from, Massachusetts Primary Care and Behavioral Health Spending: 2021 and 2022, Center for Health Information and Analysis, August 2024.

Figure 2: Commercial Primary Care PMPM by State



This analysis shows that Rhode Island's fully insured PMPM payment for primary care is 34.6% higher than Connecticut's commercial PMPM, but 25.7% lower than Massachusetts' commercial PMPM. The data indicates that Rhode Island relies more heavily on non-claims-based payments for primary care than Connecticut or Massachusetts. It is possible that total commercial market primary care PMPM in RI is lower than $35 when you include self-insured employers. Presently, OHIC does not collect data on non-claims-based payments to primary care apportioned to the self-insured market. When examining the claims-based payment PMPM for the fully insured market segment and the total market (fully insured and self-insured), PMPMs in 2022 were $25.24 and $26.71, respectively. In the fully insured market, an additional $10 PMPM is paid to primary care through non-claims payments. If self-insured employers are not participating in patient centered medical home initiatives or accountable care contracts through their third-party administrators, then total market PMPM will be lower than fully insured PMPM.

The OHIC Primary Care Report's stakeholder input and research findings, and independent research on payment levels, document the need for significantly increased oversight of commercial payer funding for primary care and increased investment in the primary care workforce in to ensure access to an adequate supply of primary care providers in the years to come. With the aim of improving oversight of primary care funding and increasing investments, OHIC subsequently conducted quantitative analysis, as described in the following section, modeling the potential financial impact of the proposed amendments to inform the specific level of the revised obligation.

To summarize, OHIC proposes to amend the primary care expenditure obligation, such that 10% of TME shall be directed to primary care, to be achieved over a multi-year phase in. The 10% target is similar to the legacy target of 9.7% direct primary care spending and 1% indirect, for a total of 10.7%. However, while the numerical targets are similar, the proposed change in methodology to capture numerator primary care spending and denominator TME in the ratio-based target is meaningful and will require an increased investment in primary care spending to achieve the new target relative to baseline data. In addition to the change in methodology for counting primary care expenditures, and the aggregate target value of 10%, the proposed amendments create a sub-target of at least 8% to be met by service-based primary care expenditures, inclusive of claims payments, and capitation payments made in accordance with the definition of a primary care alternative payment model (APM) defined in § 4.3 of 230-RICR-20-30-4. The difference of up to 2% of TME will account for non-claims-based payments that are not associated with a primary care

APM, and other allowable payments. The proposed rule offers direction to health insurers to meet the new targets. Specifically, proposed § 4.10(B)(c) reads:

> *Health insurers shall meet these annual primary care expenditure requirements by:*
>
> *(1) Increasing reimbursement for primary care services. Priority shall be given to the procedure codes that account for the preponderance of primary care service volume, including evaluation and management services for new patient and established patient office visits;*
>
> *(2) Making enhanced service-based capitation payments, consistent with the definition of a primary care alternative payment model, to primary care providers;*
>
> *(3) Increasing funding for primary care practice-based population health management resources, including care management, integrated behavioral health, and staffing for team-based care.*

Alternatives

OHIC considered two alternatives. 1. Working from the legacy primary care expenditure methodology and amending it to meet the present needs identified by the OHIC Primary Care Report. 2. Developing a PMPM target, as opposed to a TME ratio-based target.

OHIC concluded that the legacy methodology was no longer aligned with consensus definitions of primary care which have emerged in recent years. The legacy methodology was also not structured in a way to primarily drive greater investment in primary care through service-based mechanisms, like office visits. It was structured to drive investment through a particular model of care delivery, the patient-centered medical home (PCMH), foster multi-payer participation in the PCMH model, and pay for improved quality. OHIC deemed it necessary to undertake a complete redevelopment of the methodology underlying the primary care expenditure target.

A PMPM target would be aligned with OHIC's recently promulgated expenditure target for child and adolescent behavioral health services (2023 rulemaking). However, OHIC chose not to deviate from the present construct of a TME ratio-based target for primary care. The present construct has been socialized in Rhode Island for over a decade and is the model that other states have adopted, following Rhode Island's lead. Furthermore, OHIC will be able to track PMPM expenditures on primary care and will public report this metric.

Data Modeling and Assumptions

OHIC utilized the following data source to model the impact of the insurer primary care expenditure obligation:

> Health care spending data submitted to OHIC pursuant to the Health Spending Accountability and Transparency Program. These are data submitted by health insurers to OHIC by line of business (commercial, Medicaid managed care, and Medicare Advantage). Insurers submit the data annually as part of a commitment they have made via a signed written compact with OHIC, provider organizations, and other stakeholders. Insurers submit the data to OHIC each fall for health care provider payments related to the preceding year's contractual period. Insurers segment the spending data by service type; one of those categories is "primary care." OHIC prescribes in an instruction manual specific service codes and provider types that qualify as "primary care spending", as well as non-claims-based payments that also qualify as "primary care spending." For modeling purposes, OHIC utilized data for the most recently available year (2022) to calculate the percentage of total health care expenditures (excluding payments for long-term care services) that were paid to primary care providers.

OHIC seeks to adopt multiple aspects of the Health Spending Accountability and Transparency Program's primary care expenditure definition, as it is more methodologically rigorous than the current regulatory measurement methodology. OHIC's first modeling step was to calculate 2022 primary care expenditures as a percentage of 2022 TME. This method yields a 2022 baseline primary care spending percentage of 6.4% for Rhode Island residents with fully insured coverage. This is lower than the current regulatory minimum for direct primary care expenditures (9.7%) that is tied to OHIC's legacy methodology for a few reasons.

- First, the denominator definitions of total medical expenditures are different. The legacy methodology relies on a narrower denominator definition of TME by imposing a restriction of payments to Rhode Island providers only (this is also true of numerator). While the preponderance of care, and associated expenditures, for Rhode Island residents is incurred in Rhode Island, a material percentage of expenditures for inpatient services is incurred in other states, primarily Massachusetts. For example, across the top ten major diagnostic categories of inpatient care, based on commercial spending, 78.2% of expenditures were incurred with Rhode Island providers.[22] Outpatient facility and professional expenditures are also incurred out of the state, though likely to a lesser degree than inpatient services where some complex care is delivered in Boston. A ratio-based primary care expenditure target, as opposed to an absolute fixed dollar target, will be sensitive to inclusion/exclusion of expenditures from the denominator.
- Second, the legacy methodology is limited to paid claims, which is the insurer proportion of overall spending, whereas the new methodology includes allowed claims, which is inclusive of the insurer paid amount and consumer cost sharing. The paid-to-allowed ratio for TME is 84%-85%, but varies across service categories, with higher paid to allowed ratios for inpatient services and lower ratios for professional services.
- Third, the numerator definition of primary care is more specifically defined in the new methodology compared to the legacy methodology. This is particularly true as it relates to non-claims-based payments. The legacy methodology granted credit to shared savings distributions in total, as opposed to applying a percentage allocation to shared savings earned by hospital-based accountable care organizations to estimate the proportion that is distributed only to primary care. Moreover, the legacy methodology allowed insurers to receive credit for care management payments made on behalf of Medicare Advantage and Medicaid Managed Care attributed membership. Credit for these expenditures was a product of policy decisions made in 2009-2010 to encourage multi-payer participation in primary care practice transformation initiatives, including the Care Transformation Collaborative of Rhode Island (CTC-RI).

When performing this modeling, OHIC made the following assumptions relating to TME and insurance market structure:

1. Commercial TME will grow at the rate of Rhode Island's cost growth target. The cost growth target values were used to impute TME for 2023[23] and 2024, and to project TME through 2029. The values of the cost growth target are as follows: 6.0% for 2023, 5.1% for 2024, 3.6% for 2025, and 3.3% for 2026 and beyond.
2. Utilization, service mix, site of care, and technology are held constant throughout the analysis period.
3. The size of the private commercial market is fixed over time. Additionally, the membership split between fully insured health plans and self-insured plans is fixed over time.
4. The membership mix between insurers is fixed over time.
5. The mix of insurance plan designs (and patient out of pocket burden) is fixed over time.

[22] Based on analysis of the Rhode Island APCD. See the OHIC Data Hub, Care Migration dashboard, table *MDC Comparison Drilldown*. https://ohic.ri.gov/data-reports/ohic-data-hub
[23] 2023 data was not available at the time this analysis was produced.

Limitations

The analysis has the following limitations.

1. Health Spending Accountability and Transparency Program reporting are not audited. While OHIC performs a validation check for reasonableness and queries insurers if data are surprising, some data reporting errors may exist.
2. To the extent that the analytic assumptions outlined above change, such as the trend of overall health care expenditure growth, mix of services, medical technology, and insurance market structure, the results of this analysis will be less accurate.
3. The data source used for these analyses do not include all commercial payments for primary care. Rhode Island primary care providers serve patients from neighboring states, particularly Massachusetts. Given that the data is inclusive of payments for Rhode Island residents only, primary care revenues garnered from out of state patients are not included. Additionally, some Rhode Island residents are covered through employer plans that are written in other states. For example, a Rhode Island resident who works in Massachusetts and whose employer has purchased a plan from a Massachusetts insurer (like BCBSMA) will not be included in this analysis.

Financial Impacts – Costs, Redistributions, and Transfers

OHIC has analyzed the potential financial impact of changing the primary care expenditure definitions and associated targets for commercial insurers. Ancillary proposed requirements that care management and infrastructure PMPMs not be placed a risk for total cost of care performance, and that ACO budgets be held harmless for the increased levels of primary care investment are assumed to be incorporated in this overall analysis of maximum impact. The proposed policy changes will impact the allocation of resources within the health care system, but the nature of the impacts considered within the context of overall commercial health care expenditures deserve extended discussion to properly identify them as a marginal cost, or a redistribution/transfer of future expected TME growth.

OHIC argues that the proposed changes to the primary care methodology and insurer obligation, designed to increase resources to primary care, should not be characterized as a cost. A primary care expenditure target, phased in over a multi-year period, is essentially a directive for commercial insurers to prioritize funding for primary care and find ways through contracting to drive financial resources to primary care. Health insurers can meet the higher primary care expenditure targets through a combination of means, including increased reimbursement for primary care, achieving higher utilization of primary care services, payments to support the broader primary care team through prospective arrangements, integrated behavioral health, and lowering TME trend.

OHIC began with baseline data from 2022 representing commercial health care expenditures for Rhode Island residents with fully insured health benefit plans. The 2022 data included primary care claims, primary care non-claims[24], total primary care (the sum of primary care claims and non-claims), total medical expenditures, and member months. Data for 2023 and complete data for 2024 were not available at the time this analysis was produced, therefore, the values for total medical expenditures for these two years were derived by inflating the 2022 data by the cost growth target value for each year. To project

[24] Non-claims expenditures include per member per month payments for care management, infrastructure payments, performance-based distributions, including shared savings, and other payments to primary care.

total medical expenditures for the five-year analysis period relevant to this rulemaking, the 2024 imputed data was trended forward by the annual cost growth target value.

Primary care expenditures for 2023 and 2024 were derived by applying the 2022 baseline percentage (6.4%) to the imputed 2023 and 2024 data, respectively. This assumes that the ratio of primary care spending to TME remains the same through 2024. Per the proposed amendments, in 2025, health insurers must increase primary care expenditures by at least 0.5 percentage point of TME relative to the baseline ratio calculated from 2022 data. In 2026, and years thereafter, health insurers must increase primary care expenditures by at least an additional 1 percentage point per year until the overall target of 10% of TME is met, and the 8% sub-target concerning service-based payments is met. Based on analysis of pooled market-wide data, OHIC expects these targets to be achieved by the end of 2028, though payments for services incurred in 2028 will continue to be disbursed into 2029.

OHIC applied a sequence of annual primary care expenditure to TME ratios based on the step-up schedule outlined in the proposed rule between 2025 and 2029 to the projected TME for each year. Table 4 shows these assumptions.

Table 4: Primary Care Increase Assumptions

	2022 (Baseline)	2025	2026	2027	2028	2029
Ratio	6.4%	6.9%	7.9%	8.9%	9.9%	10.0%
Increase	N/A	0.5	1	1	1	0.1

Table 5 shows the projected changes in primary care expenditures through 2029.

Table 5: Analysis of Fully Insured Expenditures

Commercial (FI Only)	2022	2025	2026	2027	2028	2029
Primary Care Claims % TME	4.6%	5.1%	6.1%	7.1%	8.0%	8.0%
Primary Care Total % TME	6.4%	6.9%	7.9%	8.9%	9.9%	10.0%
Primary Care Claims	$ 42,962,881	$ 55,196,183.04	$ 68,197,589.85	$ 81,996,980.85	$ 95,439,866.16	$ 98,589,381.75
Primary Care Non-Claims	$ 16,798,745	$ 19,481,005.78	$ 20,123,878.97	$ 20,787,966.98	$ 22,666,968.21	$ 24,647,345.44
Primary Care Total	$ 59,761,626	$ 74,677,188.82	$ 88,321,468.82	$ 102,784,947.83	$ 118,106,834.38	$ 123,236,727.19
TME	$ 937,714,288	$ 1,082,278,098.89	$ 1,117,993,276.15	$ 1,154,887,054.27	$ 1,192,998,327.06	$ 1,232,367,271.85
Member Months	1,702,328	1,702,328	1,702,328	1,702,328	1,702,328	1,702,328
Baseline (6.4%)		$ 68,974,846.77	$ 71,251,016.71	$ 73,602,300.26	$ 76,031,176.17	$ 78,540,204.99
Annual Difference (Relative to Baseline Ratio)		$ 5,702,342.05	$ 17,070,452.10	$ 29,182,647.57	$ 42,075,658.21	$ 44,696,522.20

This analysis predicts that primary care expenditures, PMPM, would double from about $35 to about $70 through the end of the decade. Another way to look at the proposed primary care expenditure target of 10% is through a comparison of primary care expenditures in 2022 (the baseline year) to the counterfactual where 2022 expenditures represent 10% of TME. In 2022, primary care expenditures accounted for 6.4% of TME, or $35.11 PMPM. If primary care expenditures had accounted for 10% of TME in 2022, using the updated methodology, then PMPM expenditures would have been $55 PMPM, or 57% higher.

As explained above, OHIC views this marginal increase in primary care expenditures as a redistribution of future, expected health care spending growth, not as a net increase to total health care expenditures.

In public comments submitted by Blue Cross Blue Shield of Rhode Island on November 15th, 2024, the company observed that “increasing the fee schedule or other spending on primary care could trigger increased spending in other areas, like behavioral health services, in order to comply with state and federal mental health parity requirements. The mental health parity regulations require insurers to analyze payment rates for medical/surgical services and behavioral health services as part of their non-quantitative treatment limitation analyses. Increasing primary care reimbursement likely will require

corresponding increases for comparable behavioral health services, which may significantly increase the expected financial impact of the revised Standards." BCBSRI recommended that OHIC perform additional analyses on this point.

Laws mandating parity in coverage for mental health and substance use disorder (MH/SUD) compared to medical/surgical services require that health insurers satisfy several tests. Among the areas where parity is required is standards for provider admission to participate in a network, including reimbursement rates. For reimbursement rates, to comply with parity rules, "a plan or issuer must be able to demonstrate that it follows a comparable process in determining reimbursement rates for in-network and out-of-network providers for both medical/surgical and MH/SUD benefits. For example, if reimbursement rates for medical/surgical benefits are determined by reference to the Medicare Physician Fee Schedule, reimbursement rates for MH/SUD benefits must also be determined comparably and applied no more stringently by reference to the Medicare Physician Fee Schedule. Any variance in rates applied by the plan or issuer to account for factors such as the nature of the service, provider type, market dynamics, or market need or availability (demand) must be comparable and applied no more stringently to MH/SUD benefits than medical/surgical benefits."[25]

As of January 2025, OHIC is in the closing stages of a market conduct examination evaluating health insurer compliance with mental health parity requirements. Reimbursement is a component of this examination. While it is possible that compliance with the new primary care expenditure requirements may generate higher reimbursement for select professional behavioral health care clinicians, this is not known with certainly. The impact of any increases in reimbursement on the total cost of care should not be material.

Total Market Analysis (Including Self-Insured)

The previous analysis confined its focus to primary care expenditures and TME for Rhode Island residents with fully insured health benefit plans subject to state jurisdiction. These plans account for approximately 44% of total commercial market enrollment, and 36% of total employer-based commercial market enrollment.[26] Self-insured employers account for most Rhode Island residents who are insured through private insurance. Self-insured employers bear the insurance risk of paying claims for their employees and their dependents, however, they commonly rely on private health insurers for administrative services, such as provider contracting, claims processing, utilization review, and customer support. Health insurers occupy an important role as third party administrators for self-funded employers and tend to utilize common contracts and fee schedules with providers, that do not differentiate reimbursement rates based on whether care is provided for a member whose plan is fully insured or self-insured.

To the extent that health insurers meet the proposed primary care expenditure requirements through increased reimbursement rates for primary care services, or work with self-insured employers to equitably fund care management and other primary care practice infrastructure, the aggregate impact of the revised primary care expenditure obligation could be materially increased. Table 6 shows the projected increase in total market expenditures through the mechanism of the 8% sub-target.[27]

Table 6: Analysis of Total Market Expenditures (Including Self Insured)

[25] Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA), p. 20.
[26] These percentages are based on January 2024 Rhode Island resident enrollment data submitted to OHIC by the four largest commercial health insurers in Rhode Island: BCBSRI, UnitedHealthcare, Point32Health, and NHPRI.
[27] OHIC presently does not collect self-insured non-claims data at the primary care level.

Commercial (FI + SI)	2022	2025	2026	2027	2028	2029
Primary Care Claims % TME	4.6%	5.1%	6.1%	7.1%	8.0%	8.0%
Primary Care Claims	$117,790,918	$149,126,858	$184,253,544	$221,536,191	$257,855,646	$266,364,882
Primary Care Total (no data on non-claims)						
TME	$2,533,479,277	$2,924,056,048	$3,020,549,898	$3,120,228,044	$3,223,195,570	$3,329,561,024
Member Months	4,409,805	4,409,805	4,409,805	4,409,805	4,409,805	4,409,805
Baseline (4.6%)		$ 135,950,292	$ 140,436,651	$ 145,071,061	$ 149,858,406	$ 154,803,733
Annual Difference (Cumulative)		13,176,567	43,816,892	76,465,130	107,997,240	111,561,149

Under the scenario projected in Table 5, the primary care PMPM from claims-based expenditures would increase from $26.71 to $60.40 by 2029. Conversely, if primary care claims-based expenditures were 8% of TME today, instead of 4.6%, then expenditures would be $45.96 PMPM.

Benefits

Increasing the level of commercial market primary care spending for primary care services and infrastructure will help to shore up the primary care workforce in Rhode Island. In turn, a higher supply of primary care providers will help ensure equitable access for Rhode Island residents, and increased access to services will lead to better health outcomes and lower total health care costs.

Research shows that a higher per capita supply of primary care providers is associated with positive health outcomes, including improved mortality outcomes, increased life expectancy, increased receipt of preventive health services, and reduced low birth-weight rates.[28,29,30,31,32] Greater primary care availability in a community is also correlated with a decrease in utilization of more expensive types of health services, such as hospitalizations and emergency department visits.[33]

Ensuring access to primary care services will also lower total health care costs. Primary care clinicians use fewer tests, spend less money, and protect people from overtreatment more than the subspecialists from whom people seek routine care.[34] For example, a recent analysis found that addressing basic patient problems in the emergency room costs up to 12 times more than in primary care offices.[35]

Overall, increased investments to maintain and grow the supply of primary care providers will be central to the well-being of Rhode Islanders, the sustainability of the state's health care system, and the state's economic development.

Amendments to the Administrative Simplification Requirements

The amended 230-RICR-20-30-4 also includes a new subsection on prior authorization. The new subsection contains six key elements.

1. Health insurers are directed to reduce the volume of prior authorization requests by 20% relative to 2023 baseline data.

[28] Chang CH, Stukel TA, Flood AB, Goodman DC. Primary care physician workforce and Medicare beneficiaries' health outcomes. JAMA. 2011 May 25;305(20):2096-104. doi: 10.1001/jama.2011.665.
[29] Shi L. The Impact of Primary Care: A Focused Review. Scientifica (Cairo). Published online 2012. doi:10.6064/2012/432892
[30] Starfield B, Shi L, Macinko J. Contribution of Primary Care to Health Systems and Health. The Milbank Quarterly. 2005;83(3):457-502. doi:10.1111/j.1468-0009.2005.00409.x.
[31] Basu S, Berkowitz SA, Phillips RL, Bitton A, Landon BE, Phillips RS. Association of Primary Care Physician Supply With Population Mortality in the United States, 2005-2015. JAMA Internal Medicine. 2019;179(4):506-514. doi:10.1001/jamainternmed.2018.7624
[32] Yanagihara D, Hwang A. Investing in Primary Care: Why it Matters for Californians with Commercial Coverage. California Health Care Foundation. 2022. Available at: https://www.chcf.org/publication/investing-primary-care-why-matters-californians-commercial-coverage/.
[33] Kravet SJ, Shore AD, Miller R, Green GB, Kolodner K, Wright SM. Health care utilization and the proportion of primary care physicians. Am J Med. 2008;121(2):142-148. doi:10.1016/j.amjmed.2007.10.021.
[34] Phillips RL Jr, Bazemore AW. Primary Care And Why It Matters For U.S. Health System Reform. Health Affairs. May 2010;29(5): 876-880. doi:10.1377/hlthaff.2010.0020.
[35] UnitedHealth Group. 18 Million Avoidable Hospital Emergency Department Visits Add $32 Billion in Costs to the Health Care System Each Year. 2019. Available at: https://www.unitedhealthgroup.com/content/dam/UHG/PDF/2019/UHG-Avoidable-ED-Visits.pdf.

2. Health insurers are encouraged to develop and implement the use of programs that implement selective prior authorization requirements, based on stratification of health care providers' performance and adherence to evidence-based medicine with the input of contracted health care providers and/or provider organizations.
3. Health insurers are required to conduct a review of medical services, including behavioral health services, and prescription drugs, subject to prior authorization on at least an annual basis, with the input of contracted health care providers and/or provider organizations. The regulation enumerates a list of non-exhaustive factors that should be considered by health insurers during the annual review process, including the approval rate of prior authorizations at the service level.
4. OHIC will collect quarterly prior authorization reports from health insurers, at the enterprise level.
5. An annual attestation by health insurers, with responses to a standardized set of questions, will be implemented.
6. OHIC will convene a statewide advisory committee on prior authorization that will meet at least three times per year and will be charged with reviewing prior authorization data submitted to OHIC, health insurer attestations, and making recommendations to improve prior authorization processes for medical services and prescription drugs over time.

Alternatives

OHIC considered proposing specific quantitative guardrails on prior authorization. For example, one proposal would have required insurers to remove prior authorization from all services that are approved at least 90% of the time and have an average cost of $25,000 or below. This concept was discussed during the meetings of the Administrative Simplifications Task Force. Ultimately, OHIC chose to grant insurers flexibility and to require that insurers consider the approval rate of services, in addition to other factors, when determining whether to maintain prior authorization as part of the mandated annual review. Insurers will also be required to report this information publicly.

OHIC also considered taking no action through rulemaking. Health insurers have recently taken voluntary initiative to eliminate some services from their prior authorization lists. OHIC chose to undertake rulemaking for two reasons. 1. The General Assembly specifically amended OHIC's enabling statute in 2023 to direct the agency's focus on prior authorization after conferring with the Administrative Simplification Task Force. This implies that OHIC should utilize all reasonable actions to direct insurers toward administrative simplification in this space. Moreover, the proposed rules will create more transparency into health insurer administrative practices, which should further facilitate improvements in administrative simplification because providers and regulators will have greater insight into health insurers' justifications for prior authorization.

Analysis

The regulatory directive to reduce prior authorization requests by 20% formalizes an agreement among the health insurers and providers to reduce prior authorization volume by a targeted percentage. This agreement was made through the work of CTC-RI. The development of selective prior authorization programs and annual review of prior authorization processes are derived from OHIC's enabling statute. These two activities, and the new insurer reporting requirements, will necessitate health insurers to utilize existing administrative resources. OHIC does not envision a material marginal increase in operational costs for health insurers to comply with these requirements.

To oversee and enforce components 4 – 6, OHIC will rely on existing resources within the agency. Therefore, the marginal cost to the state is $0.

There is no evidence that removing prior authorization by 20% will substantially increase health care expenditures and premiums. In past instances when insurers have removed prior authorization, OHIC has not observed an increase in expenditures.

Benefits

The intended outcome of the proposed amendments to § 4.11 is to remove burdensome administrative processes that stem from wide use of prior authorization. These administrative burdens contribute to clinician burnout in primary care and other medical settings. Fewer administrative requirements will free up time for clinicians and office staff to serve more patients. The professional experience of practice is important and fewer administrative requirements should improve clinician experience. Provider and insurers may also be able to save on administrative expenses that have been incurred to manage prior authorization. These expenses could be reallocated toward other functions or constitute a savings to health care purchasers and providers.

Appendix A. 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). 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.

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 spending for services 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.

Taxonomy	Description	Notes or Restrictions
208D00000X	General Practice	
207Q00000X	Family Medicine	
207QA0000X	Family Medicine, Adolescent Medicine	

Taxonomy	Description	Notes or Restrictions
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	
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 B. Primary Care Payment Codes

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 2022 and 2023. 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.

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

Procedure Code	Description	Reporting Procedure Category
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
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

Procedure Code	Description	Reporting Procedure Category
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
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

Procedure Code	Description	Reporting Procedure Category
99242	OFFICE CONSULTATION NEW/ESTAB PATIENT 20 MIN	Consultation Services
99243	OFFICE CONSULTATION NEW/ESTAB PATIENT 30 MIN	Consultation Services
99244	OFFICE CONSULTATION NEW/ESTAB PATIENT 40 MIN	Consultation Services
99245	OFFICE CONSULTATION NEW/ESTAB PATIENT 55 MIN	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 (use 99417 in conjunction with 99205, 99215, 99245, 99345, 99350, 99483. Do not report 99417 on the same date of service as 90833, 90836, 90838, 99358, 99359, 99415, 99416)	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

Procedure Code	Description	Reporting Procedure Category
99404	PREVENT MED COUNSEL&/RISK FACTOR REDJ SPX 60 MIN	Preventive Medicine Services
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 STRAIGHTFORWARD 15 MINUTES	Home Visits
99342	HOME VISIT NEW PATIENT LOW SEVERITY 30 MINUTES	Home Visits
99344	HOME VISIT NEW PATIENT MODERATE SEVERITY 60 MINUTES	Home Visits
99345	HOME VISIT NEW PATIENT HIGH SEVERITY 75 MIN	Home Visits
99347	HOME VISIT EST PT STRAIGHTFORWARD20 MINUTES	Home Visits
99348	HOME VISIT EST PT LOW SEVERITY 30 MINUTES	Home Visits
99349	HOME VISIT EST PT MOD SEVERITY 40 MINUTES	Home Visits
99350	HOME VST EST PT HIGH SEVERITY 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
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

Procedure Code	Description	Reporting Procedure Category
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
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
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

Procedure Code	Description	Reporting Procedure Category
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 (use in conjunction with 99358)	Prolonged Services
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

Procedure Code	Description	Reporting Procedure Category
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
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

Procedure Code	Description	Reporting Procedure Category
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
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

Procedure Code	Description	Reporting Procedure Category
G0436	SMOKE TOB CESSATION CNSL AS PT; INTRMED 3-10 MIN	Preventive Medicine Services
G0437	SMOKING & TOB CESS CNSL AS PT; INTENSIVE >10 MIN	Preventive Medicine Services
99492		Collaborative Care
99493		Collaborative Care
99494		Collaborative Care
G2214		Collaborative Care