

ANNUAL REPORT

# Primary Care Spending and Utilization in Rhode Island

2026



STATE OF RHODE ISLAND

Office of The Health Insurance Commissioner

Department of Business Regulation

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# EXECUTIVE SUMMARY

**The Rhode Island Office of the Health Insurance Commissioner (OHIC)** has long recognized the central role of primary care in keeping residents healthy and health care affordable. Since establishing its Affordability Standards in 2010, OHIC has used its regulatory authority and oversight over commercial health insurers to require increased investment in primary care. Most recently, in March 2025, OHIC updated its primary care expenditure obligation to 10 percent of total medical spending by 2028 to more accurately capture direct spending on primary care and ensure primary care providers are paid at sustainable levels.

OHIC's December 2023 report, *Primary Care in Rhode Island*, underscored the urgency of the challenge and recommended increased transparency around primary care spending.<sup>1</sup> This report delivers on that recommendation by presenting the most recent data on primary care access, spending, utilization, and use of well-care services in Rhode Island. Subject to ongoing legislative appropriations, OHIC will produce this report annually to ensure transparency and accountability for building a primary care system that works for Rhode Islanders. The following four central questions guided OHIC's analysis, and generated the listed key findings:

## I. Do Rhode Islanders Have Adequate Access to Primary Care?

**KEY FINDING: Access to primary care is uneven and limited for many Rhode Islanders.**

- Brown University research shows Rhode Island does not have enough primary care providers to serve the population.
- Data from a state-administered survey reveal that too many Rhode Islanders lack a usual source of care, with the burden falling disproportionately on lower-income residents and communities of color.
- State surveys confirm growing difficulty in securing timely primary care appointments.

## II. Does Rhode Island Spend Enough on Primary Care to Ensure Adequate Access?

**KEY FINDING: Rhode Island payers have invested too little in primary care to secure an adequate workforce and meet the current and future needs of residents.**

- Massachusetts primary care providers practicing near the Rhode Island border are reimbursed 30 percent more for common primary care services than Rhode Island primary care providers based on 2024 claims data.
- Across commercial, Medicare, and Medicaid markets, primary care spending has stagnated through 2024.
- Commercial insurers' current investment levels remain far below OHIC's newly revised primary care expenditure obligation of 10 percent to be achieved by 2028.

<sup>1</sup> Rhode Island Office of the Health Insurance Commissioner (2023). Primary Care in Rhode Island: Current Status and Policy Recommendations. <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>

### III. How Do Rhode Islanders Receive Primary Care?

**KEY FINDING:** Rhode Islanders access primary care services in multiple settings, but primary-care office-based care remains the backbone.

- Most services are provided in traditional primary care offices, with some care delivered in urgent care clinics and, inappropriately, in emergency departments.
- Urgent care centers account for a small but growing share of visits, while telehealth use – after spiking during the COVID-19 pandemic – has declined.

### IV. Do Rhode Islanders Utilize Enough Well-Care Visits?

**KEY FINDING:** Too many Rhode Islanders are missing important preventive care.

- Only 48 percent of Medicaid members had a well-care visit in 2024, with rates particularly low for adults (33 percent).
- In 2024, only 66 percent of children on Medicaid received a well-care visit in 2024. This rate has been declining since at least 2019.
- Men have a very low rate of well-care visits. Only 46 percent of commercially insured men and 24 percent of men with Medicaid coverage had a visit in 2024.

OHIC has prioritized strengthening the state’s primary care foundation. Primary care is at the center of OHIC’s charge “to 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 2023, OHIC published *Primary Care in Rhode Island* with policy recommendations for advancing this goal. In 2024, the Commissioner joined other state health policy leaders and clinicians in developing systemwide efforts, including initiatives for primary care, through the Health System Planning Cabinet.<sup>2</sup>

In early 2025, OHIC promulgated new regulations to implement several of its recommendations from the December 2023 report. The updated regulation requires health insurers to:

- Reduce the administrative burdens put on providers due to prior authorization, and
- Increase investment in primary care by meeting OHIC’s investment targets by:
  - raising reimbursement for primary care services,
  - increasing primary care capitation rates where applicable, and
  - expanding support for primary care practice-based population health management resources.

<sup>2</sup> Rhode Island Executive Office of Health and Human Services. *Rhode Island Health Care System Planning Summary Report – 2024*. <https://eohhs.ecms.ri.gov/sites/g/files/xkgbur226/files/2025-01/Final%20-%20Health%20Care%20System%20Planning%20Summary%20Report%20-%20December%202024.pdf>

In June 2025, Governor McKee and the Executive Office of Health and Human Services (EOHHS) awarded \$6.7 million in grants to primary care practices to bolster the workforce and support access to care.<sup>3</sup> In July 2025, the General Assembly enacted legislation to ease administrative burdens on primary care by eliminating prior authorizations and directed EOHHS to increase Medicaid reimbursement rates to 100 percent of the Medicare fee schedule in Fiscal Year 2026. Additionally, OHIC was required to conduct a rate review for primary care services that is due September 1, 2026.

These changes are designed to rebalance the health care system by redirecting necessary resources to an area in critical need of support. OHIC is committed to transparency and ongoing reporting of data on all-payer primary care expenditures and access to primary care.

Primary care is the foundation of a high-performing health system: it improves outcomes, enhances quality of life, and lowers costs. Through strengthened regulatory standards and transparent reporting, OHIC is committed to ensuring every resident can access affordable, high-quality primary care, and live healthy lives.

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<sup>3</sup> Rhode Island Office of the Governor. (2025 June 18). *Governor McKee Awards \$6.7 Million in Grants to Bolster Rhode Island's Primary Care Community*. <https://governor.ri.gov/press-releases/governor-mckee-awards-67-million-grants-bolster-rhode-islands-primary-care-community>

# INTRODUCTION

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**Primary care** is the cornerstone of a strong and effective health care system. For most patients, it serves as the entry point to care; they rely on trusted relationships with primary care clinicians for preventive services, chronic condition management, and referrals to specialists when needed. Timely access to high-quality primary care is crucial to the health and productivity of Rhode Islanders.

Evidence shows that greater investment in primary care results in higher-quality care, long-term cost savings, and a stronger health care system overall.<sup>1</sup> Recent research suggests that health plans and provider organizations that dedicate more resources to primary care achieve better results on clinical quality, patient experience, utilization, and total cost of care.<sup>2</sup>

Despite its proven value, primary care is under strain across Rhode Island and the United States as a whole. Chronic underinvestment has contributed to workforce shortages as many primary care physicians reach retirement and too few medical graduates choose to practice primary care. High burnout rates for primary care clinicians and limited time with patients further undermine care delivery. Collectively, these challenges threaten the sustainability of primary care. Policymakers are responding with actions to stabilize and strengthen this critical part of the health care system.

This report presents OHIC's latest analysis of spending trends, drawing data from both health insurers (as part of OHIC's cost growth target request) and the All-Payer Claims Database (APCD). Future reports will expand upon these analyses.

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1 Shi L. (2012). The impact of primary care: a focused review. *Scientifica*, 2012, 432892. <https://doi.org/10.6064/2012/432892>

2 Yanagihara, D., & Hwang, A. (2022). *Investing in primary care: Why it matters for Californians with commercial coverage*. California Health Care Foundation. <https://www.chcf.org/wp-content/uploads/2022/04/InvestingPrimaryCareWhyItMattersCommercialCoverage.pdf>

# CHAPTER 1

## Do Rhode Islanders Have Adequate Access to Primary Care?

Primary care is often patients' first point of contact with the health care system. It is how they receive preventive services, manage chronic conditions, and obtain referrals to specialists for follow-up care, if needed. Without adequate access to high-quality and reliable primary care, people are more likely to forgo preventive visits and experience worse health outcomes. Limited access also reduces opportunities to build long-term, trusting relationships with primary care providers, which are essential for the effective management of care.

**KEY FINDING: Access to primary care is uneven and limited for many Rhode Islanders.**

- Rhode Island does not have enough primary care providers to support its population.
- Many Rhode Islanders – particularly those with lower incomes and some racial minorities – do not have a usual source of care.
- The strain on the health care system is evident in the challenges for some residents to schedule timely primary care appointments.

This chapter uses data from multiple sources to provide an overview of the current state of primary care access in Rhode Island.

## Access to a Usual Source of Care

Compared to the rest of the nation, Rhode Island touts a low percentage of adults who do not have a usual source of care (16.8 percent [United States] vs. 12.5 percent [Rhode Island] in 2024). However, performance has significantly declined in recent years and access is uneven across populations (see Figure 1 (a–c)):

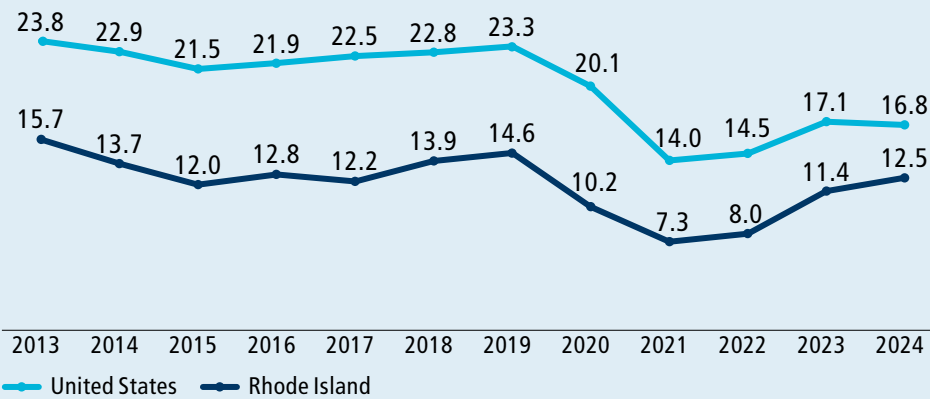
- Individuals with lower household income are more likely to lack a usual source of care than individuals with higher household income.
- One-third of Hispanic adults reported not having a usual source of care, a rate nearly six times higher than that of White, non-Hispanic adults.

This indicates a significant amount of unmet need in the state falls disproportionately on lower income residents and people of color.

## FIGURE 1: Percent of Rhode Island Adults without a Usual Source of Care

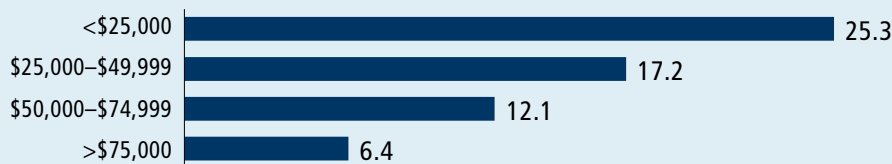
### a) Share (%) of Adults Who Report Not Having a Personal Doctor/Health Care Provider

Percent of adults age 18 and older who did not have one (or more) person they think of as their personal health care provider (For this measure, lower scores are better)

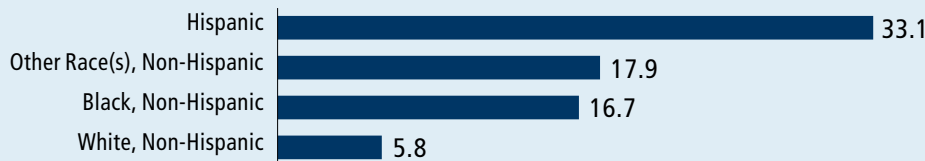


Source: Kaiser Family Foundation analysis of the Centers for Disease Control and Prevention (CDC)'s 2013-2024 Behavioral Risk Factor Surveillance System (BRFSS). <https://www.kff.org/state-health-policy-data/state-indicator/percent-of-adults-reporting-not-having-a-personal-doctor-by-sex/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>. Accessed April 17, 2026.

### b) Share (%) of Rhode Island Adults Without a Usual Source of Care by Household Income (2024)



### c) Share (%) of Rhode Island Adults Without a Usual Source of Care by Race and Ethnicity (2024)



Source (Figures 1b and 1c): Rhode Island Behavioral Health Risk Factor Surveillance System. <https://rhode-island-brfss-data-rihealth.hub.arcgis.com>. Accessed April 17, 2026.

Note: These data reflect responses to the question, "Do you have one person or a group of doctors that you think of as your personal health care provider?"

## Primary Care Workforce Shortages

Research from Brown University estimated that Rhode Island has about 700 primary care full-time equivalents (FTEs) to serve just over one million residents – roughly one clinician<sup>1</sup> FTE per 1,700 residents.<sup>2</sup> Even if each provider saw 1,200 patients annually, an estimated 343,000 residents would still be left without a provider. To meet demand, Rhode Island would need at least 300 more primary care FTEs.

<sup>1</sup> A primary care clinician is a physician (MD or DO), nurse practitioner, or physician assistant practicing primary care.

<sup>2</sup> Leslie, A. (2025, February 18). Hundreds more physicians needed to address RI primary care shortage, experts say. *WPRI*. <https://www.wpri.com/target-12/hundreds-more-physicians-needed-to-address-ri-primary-care-shortage-experts-say/#:~:text=They%20estimated%20there%20are%20nearly,still%20be%20without%20a%20provider>

This workforce shortage is compounded by the aging physician population. As of 2018, 44 percent of family physicians were over the age of 55 and nearing retirement age; coupled with the fact that the primary care workforce has not been replenished and low rates of graduating medical students choosing to practice primary care in the state, the numbers are surely to be similar or even higher now in 2026.<sup>3</sup> The primary care workforce shortage is projected to only become more severe in the future, as the gap between the demand and availability services continues to grow.<sup>4</sup>

## Barriers to Primary Care Access

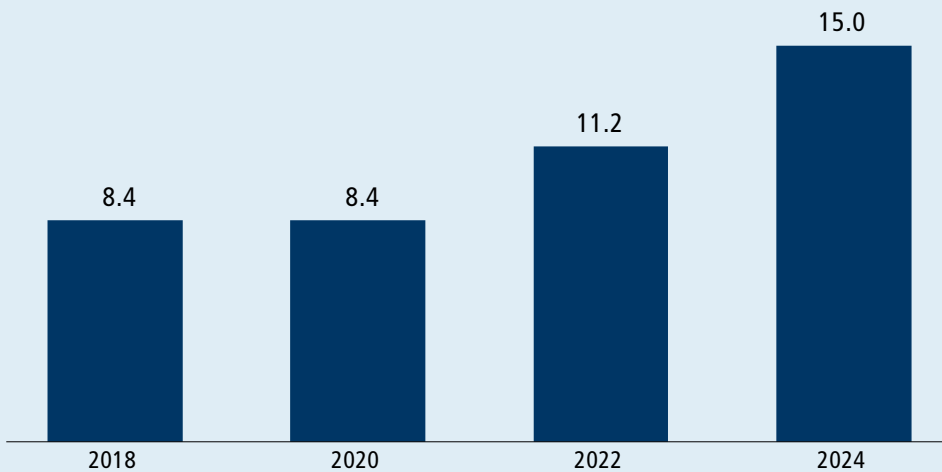
For many Rhode Islanders, simply getting in to see a primary care doctor has become increasingly difficult. The state’s biennial Health Information Survey shows that what was once a challenge for only a small share of residents is now a problem for a much larger portion of the population.

In 2018, fewer than 1 in 10 people struggled with getting a primary care appointment at a convenient time. By 2024, that share had risen to about 1 in 7 residents (see Figure 2). This upward trend was consistent across all income groups.

When asked about the type of care they did not receive or delayed due to difficulty finding a doctor, respondents most often cited services typically provided by primary care: routine or preventive medical care (35.1 percent) and medical care for an illness (21.8 percent).

**FIGURE 2: Share (%) of Rhode Island Survey Respondents Answering Yes to Question on Inability to Get Appointment with PCP**

Proportion of ‘Yes’ Answers to: During the past 12 months, were you unable to get an appointment with a primary care physician at a convenient time?



Source: HealthSource RI.

When care is delayed, problems can escalate, often requiring costly acute interventions. Over time, these delays not only harm patients’ health but also increase strain on the overall health care system.

<sup>3</sup> Robert Graham Center. (n.d). *The State of Primary Care Physician Workforce: Rhode Island*. <https://www.graham-center.org/content/dam/rgc/documents/maps-data-tools/state-collections/phys-workforce/Rhode-Island.pdf>  
<sup>4</sup> Association of American Medical Colleges (2024, March 21). *New AAMC report shows continuing projected physician shortage*. <https://www.aamc.org/news/press-releases/new-aamc-report-shows-continuing-projected-physician-shortage>

## **CHAPTER 2**

**Does Rhode  
Island Spend  
Enough on  
Primary Care to  
Ensure Adequate  
Access?**

Investing in primary care strengthens the foundation of a well-functioning health care system. It ensures there are enough clinicians to meet patients' needs and manage increasing demand. Adequate investment in these crucial services allows the state to expand capacity, support workforce stability in the form of higher payment and compensation, and ensure that patients can get timely and appropriate care. Overall, devoting more resources to the backbone of the health care system allows for a more sustainable, cost-effective system that allows residents to live the healthiest lives possible.

**KEY FINDING: Rhode Island payers have invested too little in primary care to secure an adequate workforce and meet the current and future needs of residents.**

- Spending on primary care services has remained largely flat for all insurance markets in recent years.
- Commercial insurers' contributions currently fall far below OHIC's stated 2028 target of at least 10 percent<sup>1</sup> of total claims spending.
- Reimbursement rates for common primary care services are 30 percent higher in Massachusetts than they are in Rhode Island based on 2024 claims data.

Rhode Island must prioritize and expand investment in primary care to ensure an adequate workforce and meet the current and future needs of residents. OHIC's analysis shows clear opportunities for greater investment in primary care. This chapter delves more deeply into each of these findings.

## Primary Care Investment Trends

Since 2020, claims-based spending on primary care services has fluctuated but remained modest across the three major insurance markets (see Table 1):

- **Commercial:** Spending increased slowly in 2021 and 2022, dipped in 2023, and increased slightly in 2024.
- **Medicare Advantage:** Spending on primary care services increased nearly \$4 in 2021 and by just over \$1 in 2022, then decreased by nearly \$7 in 2023 and remained nearly flat in 2024.
- **Medicaid:** Spending on primary care services increased about \$2.40 per person per month during this time.

**TABLE 1: Rhode Island Statewide Averages of Per Member Per Month (PMPM) Spending on Claims-Based Primary Care by Market**

Insurance Market	Primary Care Claims PMPM				
	2020	2021	2022	2023	2024
Commercial	\$23.48	\$24.76	\$26.30	\$22.62	\$23.32
Medicare Advantage	\$32.74	\$36.66	\$37.73	\$30.80	\$30.60
Medicaid (MCO Only)	\$13.82	\$14.31	\$14.74	\$15.43	\$16.23

Source: OHIC analysis of cost growth target data from insurers.

Note: Data for the commercial market includes both the fully and self-insured market segments. PMPM values do not include non-claims payments. Non-claims make up a substantial portion of primary care spending. In fall 2025, OHIC collected data on primary care non-claims spending for the commercial market from health plans for 2022-2024. Per person spending on primary care was consistent between the fully insured market and the entirety of the commercial market.

<sup>1</sup> OHIC's updated definition more precisely identifies services captured under the expenditure obligation through the specification of procedure codes, taxonomy codes, and guidance for allocating non-claims-based expenditures. The definition of total medical expenditures was also updated to include payments to all providers, whereas the old definition was limited to Rhode Island providers only. Overall, OHIC's revised target more accurately captures the totality of spending on primary care for state residents.

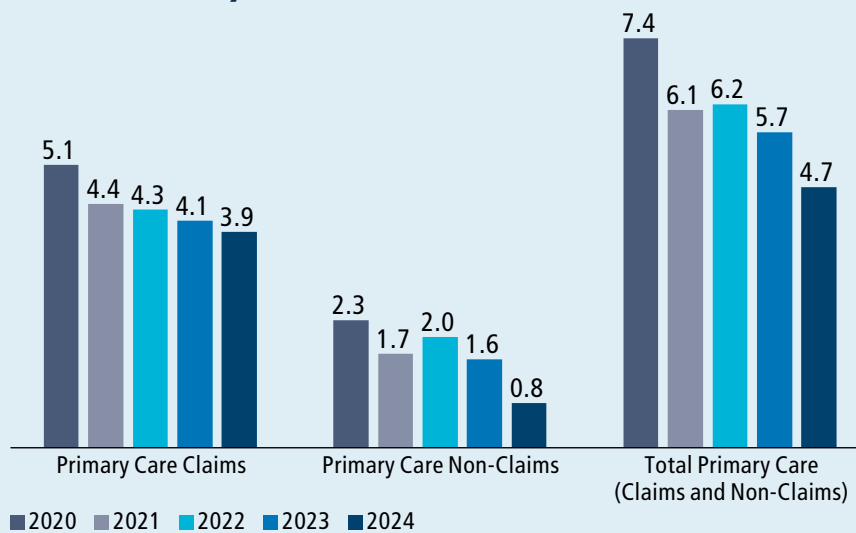
The data presented in Table 1 do not include non-claims spending on primary care. Non-claims comprise monthly payments to practices to support infrastructure and team-based care, care management services, and performance-based payments under value-based contracts. They also include capitated payments for covered services. Non-claims payments vary across payers and between years.

A closer look at the fully insured segment of the commercial market shows that in 2024, both primary care claims and non-claims<sup>2</sup> accounted for a smaller share of total health care spending in the state compared to 2023. This follows a downward trend from 2020 (see Figure 3). These data are collected to assess compliance with OHIC’s new Primary Care Expenditure Obligation; for more information, see the sidebar.

### OHIC’s Primary Care Expenditure Obligation

Under OHIC’s Affordability Standards (230-RICR-20-30-4), beginning in 2025, commercial insurers must incrementally increase their investment in primary care. By the end of 2028, OHIC expects that at least 10 percent of health plans’ annual total medical expenses for all fully insured lines of business goes towards primary care. The primary care spending data presented in this report, drawn from cost growth target data submissions, covers the entirety of the commercial market, not just the fully insured segment of the market to which the spending obligation applies. Therefore, the data in this report that come from cost growth target data submitted by health plans should not be used to assess health plans’ performance against the Primary Care Expenditure Obligation.

**FIGURE 3: Share (%) of Total Medical Expense Spent on Primary Care for the Fully Insured Market**



Source: OHIC analysis of primary care expenditure obligation data from insurers.

## Primary Care Payment Variation by State

A frequently cited concern is that primary care providers leave Rhode Island for higher-paying opportunities in other states, particularly Massachusetts. There is no data to assess net provider migration between Rhode Island and neighboring states and OHIC does not possess data on physician compensation or earnings. However, OHIC can assess payment differentials for primary care services. To examine this, OHIC analyzed 2019–2024 commercial claims data from Rhode Island’s APCD, focusing on primary care payment in Rhode Island and neighboring zip codes in Connecticut and Massachusetts.<sup>3</sup>

<sup>2</sup> Non-claims payments can be for many purposes, including capitation for covered services, performance incentives and practice infrastructure support.

<sup>3</sup> Some zip codes included in this analysis do not literally border Rhode Island; rather, some are just outside the border (i.e., one zip code removed from the state line). OHIC chose to examine payment rates for services by primary care providers in zip codes bordering and nearly bordering the state because they represent the most direct competition for Rhode Island primary care providers. Patients in Rhode Island who live close to the state line can, and do, elect to cross into Connecticut or Massachusetts for care. OHIC did not compare statewide averages across all the three states, recognizing that the metropolitan Boston area likely skews Massachusetts’ unit payment data upward significantly.

Analysis of commercial claims data confirms that primary care providers in Massachusetts receive higher payment rates from insurers than their counterparts in Rhode Island (see Table 2). In 2024, Rhode Island primary care provider payment rates lagged behind those in neighboring Massachusetts for all types of visits. The gap was largest for new patient well-care visits, followed by established patient well-care visits and established patient office visits. Payment rates for new patient office visits were closer, with Massachusetts slightly higher. The gap in payment between Rhode Island and Massachusetts has only widened through 2024.

Data for Connecticut are more limited, as fewer Rhode Islanders travel to Connecticut for primary care than to Massachusetts. Connecticut paid substantially more for well-care visits in 2024 (for both new and established patients), as well as for office visits for established patients (see Table 2).

Over the last four years, payment differences between the Rhode Island and Connecticut have fluctuated, largely due to the low volume of visits in Connecticut, which represented less than 1 percent of total visits (see Table 3).

**Table 2. 2024 Differences (%) in Commercial Payment Per Unit (PPU) for Primary Care Claims for Rhode Island vs. Massachusetts and Connecticut**

	Office Visit – New Patient	Office Visit – Est. Patient	Well-Care Visit – New Patient	Well-Care Visit – Est. Patient
MA (Border Zip Codes)	9.6%	33.9%	38.9%	36.7%
CT (Border Zip Codes)	3.3%	8.2%	31.1%	28.9%

Source: OHIC analysis of HealthFacts RI data.

Note: In this analysis, Rhode Island is the reference value. Therefore, values greater than 0 signal that the other state has the high value.

**Table 3. 2024 Primary Care Claims for Rhode Island Residents by Geography**

	Office Visit – New Patient	Office Visit – Est. Patient	Well-Care Visit – New Patient	Well-Care Visit – Est. Patient
RI	41,956	478,642	8,815	174,699
MA (Border Zip Codes)	2,000	18,481	360	6,415
CT (Border Zip Codes)	358	2,267	78	780

Source: OHIC analysis of HealthFacts RI data.

It is evident from this analysis that primary care providers receive higher reimbursement rates from commercial payers in neighboring states.<sup>4</sup> Increasing investment in Rhode Island’s primary care system will boost local capacity to meet patients’ needs. OHIC’s new primary care expenditure obligation aims to close these reimbursement gaps and strengthen care for Rhode Islanders.

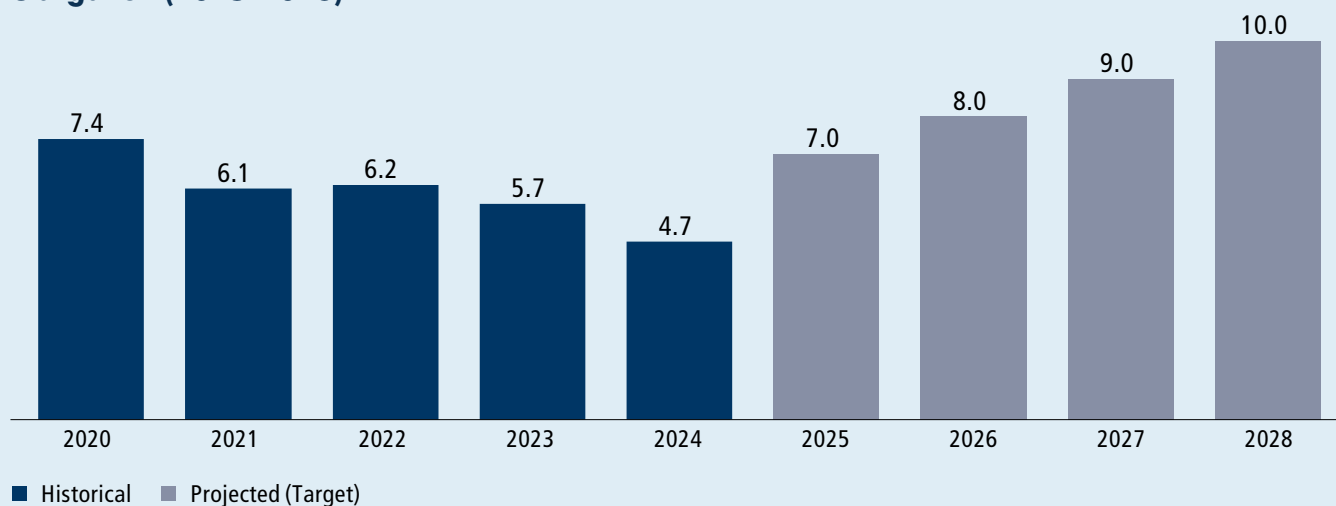
<sup>4</sup> Reimbursement rates are only one piece of primary care payment. This analysis does not include non-claims-based payments, or performance-based payments that support primary care practices.

# Projected Impact of OHIC's New Primary Care Expenditure Requirements

Recognizing the urgency of addressing Rhode Island's lagging investment in primary care, OHIC promulgated new regulations in March 2025 that require commercial health insurers to progressively increase funding for primary care over the next four years. These new rules are designed to specifically boost reimbursement for primary care services and resources for population health management. The rules also tackle key stressors of administrative burden experienced by primary care providers by reducing the volume of prior authorization requests.<sup>5</sup>

At the time of the rulemaking, OHIC projected that increasing primary care spending as a percentage of total medical spending to 10 percent by the end of 2028 (see Figure 4) would double per capita primary care funding by commercial payers. This is expected to increase primary care funding by approximately \$40 million over four years. If self-insured employers partner with insurers to incorporate value-based payments and enriched reimbursements into their contracts, OHIC projects the new regulations to increase primary care funding by an additional \$60 million relative to baseline funding.<sup>6</sup>

**FIGURE 4: Proportion (%) of Total Medical Expense Spent on Primary Care for the Commercial Fully Insured Market (2020–2024) and Projected Investment per OHIC Primary Care Expenditure Obligation (2025–2028)**



Source: OHIC analysis of primary care expenditure obligation data submitted by insurers.

<sup>5</sup> After the March 2025 OHIC rulemaking the General Assembly enacted legislation that suspends prior authorization requirements “for any admission, item, service, treatment, or procedure ordered by a primary care provider in the normal course of providing primary care treatment.” The legislation substantially strengthens the OHIC regulations, which mandated a 20% reduction in prior authorization volume for all physicians, but with priority placed on prior authorizations ordered by primary care providers. See House Bill 5120A and Senate Bill 0168B.  
<sup>6</sup> See [Amendments to 230-RICR-20-30-4: Regulatory & Cost-Benefit Analysis, Rhode Island Office of the Health Insurance Commissioner, January 2025](#). OHIC’s projections rely on several assumptions, as described in the *Regulatory & Cost-Benefit Analysis*. These assumptions include total market enrollment, payer mix, and projected future growth of total medical expenditures. To the extent that actual experience deviates from these assumptions, the projected total impact of the primary care expenditure rules will vary from current projections.

Reimbursement rates from Medicare show much less variation between Rhode Island and neighboring states. While commercial reimbursement rates are negotiated between insurance companies and providers, it is customary for commercial reimbursement rates to be higher than Medicare for the same service. Medicare reimbursement is determined administratively by the Centers for Medicare and Medicaid Services (CMS) pursuant to laws enacted by Congress. CMS defines physician fee schedules for Rhode Island, Connecticut, the Boston Metro area, and the rest of Massachusetts. In 2025, Medicare reimbursement for office visits commonly performed and billed by primary care providers in Rhode Island was approximately 8 percent lower than the Metro Boston area, approximately 3 percent lower than Connecticut, and only approximately 0.5 percent lower than the rest of Massachusetts.

OHIC does not present data on Medicaid reimbursement rates for primary care providers in Rhode Island relative to neighboring states in this report. This analysis is under development and will be reported as part of the primary care rate review that is due by September 1, 2026.

## **CHAPTER 3**

# **How Do Rhode Islanders Receive Primary Care?**

Selecting the most appropriate care setting ensures efficient use of limited resources while adequately meeting patients' needs. When patients seek care in urgent care settings for non-urgent conditions that could be treated in a primary care office, they face much higher costs. This also strains urgent care capacity and limits availability for patients who require timely, same-day treatment. Aligning needs with the best setting supports better patient outcomes and lower costs. Patients may also seek care at emergency rooms. Unlike urgent care centers, emergency rooms are required to treat and stabilize patients in accordance with federal law.

**KEY FINDING: Rhode Islanders access primary care services in multiple settings, but primary-care office-based care remains the backbone.**

- **Most care occurs in traditional primary care offices, but residents also receive services in urgent care centers, obstetrician-gynecologist (OB/GYN) offices, and virtually through telehealth.**
- **Urgent care centers account for a small but growing share of visits, while telehealth use – after spiking during the COVID-19 Public Health Emergency – has declined.**

This chapter summarizes patterns in Rhode Island residents' use of primary care services.

## The Rise of Urgent Care in Rhode Island

Between 2018 and 2024, the way Rhode Islanders sought primary care began to shift. In percentage terms, traditional office visits grew at a slower rate – rising only 10 percent in the commercial market and 7 percent in the Medicaid market over seven years – while urgent care visits climbed sharply, up 55 percent in the commercial market and 22 percent in the Medicaid Market (see Table 4 and Table 5).<sup>1</sup> Even with that growth, urgent care still comprises a small share of care, moving from 5.5 percent of visits in 2018 to 7.6 percent in 2024 in the commercial market and 8.8 percent of visits in 2018 to 10.0 percent in 2024 in the Medicaid market.

The health care landscape was reshaped by the pandemic. Evaluating trends since 2021 shows that office visits grew by less than 1 percent in the commercial market, while urgent care visits climbed 26 percent. Medicaid utilization followed a similar pattern.

<sup>1</sup> OHIC is not reporting PMPM spending levels gleaned from this analysis because these figures do not tie out to what was reported in [Chapter 2: Does Rhode Island Spend Enough on Primary Care to Ensure Adequate Access?](#) using cost growth target data. This is reasonable because commercial market spending data in the APCD is less complete than it is for cost growth target data; the APCD includes data for commercial fully insured members and for self-insured employers who choose to opt in, while health plans report aggregated data for the entirety of the commercial market as part of the cost growth target data request.

**Table 4. Utilization and Average Unit Payment for Primary Care Visits in Offices and Urgent Care (Commercial)**

	Claims Per 1,000 Members		Average Unit Payment	
	PRIMARY CARE	URGENT CARE	PRIMARY CARE	URGENT CARE
2018	2,403	140	\$93	\$97
2019	2,496	179	\$93	\$98
2020	2,580	192	\$90	\$84
2021	2,621	171	\$93	\$89
2022	2,660	194	\$97	\$97
2023	2,608	197	\$104	\$100
2024	2,638	216	\$109	\$101

Source: OHIC analysis of HealthFacts RI data.

**Table 5. Utilization and Average Unit Payment for Primary Care Visits in Offices and Urgent Care (Medicaid)**

	Claims Per 1,000 Members		Average Unit Payment	
	Primary Care	Urgent Care	Primary Care	Urgent Care
2018	2,550	247	\$60	\$65
2019	2,659	234	\$62	\$64
2020	2,641	226	\$60	\$61
2021	2,681	229	\$62	\$66
2022	2,704	243	\$70	\$79
2023	2,619	327	\$78	\$84
2024	2,727	302	\$82	\$82

Source: OHIC analysis of HealthFacts RI data.

When comparing utilization patterns between the Medicaid and commercial markets, Rhode Island residents access primary care in primary care settings at similar rates. However, Medicaid members access primary care in urgent care settings at a much higher rate than individuals with commercial coverage (see Table 6).

**Table 6. Commercial vs. Medicaid Utilization of Primary Care in Different Settings**

Location	2018	2019	2020	2021	2022	2023	2024
Primary Care	6.1%	6.5%	2.4%	2.3%	1.7%	0.4%	-2.8%
Urgent Care	77.5%	32.2%	18.2%	34.5%	25.0%	65.9%	39.6%

Source: OHIC analysis of HealthFacts RI data.

Note: Commercial claims per 1,000 members is the reference value. Values greater than 0 signal that Medicaid claims per 1,000 members is higher. Values less than 0 signify that Medicaid claims per 1,000 members is lower.

The trend is unmistakable: urgent care is becoming a bigger part of how residents access primary care. Clinicians point to a few main reasons for this. First, urgent care centers expanded during this period, creating more opportunities for patients to walk in. Second, some patients see urgent care as faster and more convenient than trying to book an appointment at a doctor's office. That perception – whether accurate or not – appears to be influencing where people turn for care. Third, practices refer their patients to urgent care centers when they lack capacity for same-day sick visits.

In terms of cost, office and urgent care visits for primary care services appear comparable for both the commercial and Medicaid markets. However, the numbers

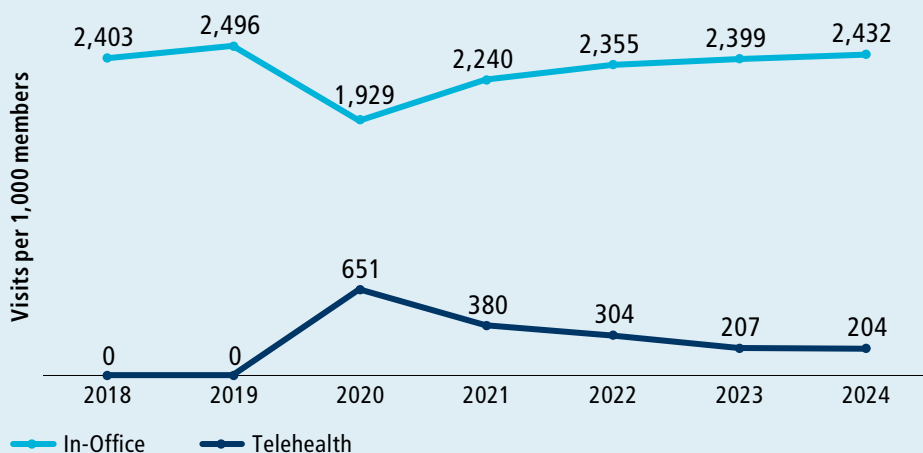
may understate the true cost of care in both settings. If this analysis was conducted at the claim line level (i.e., capturing all ancillary services billed separately in each setting), the total cost of care would be higher, with urgent care encounters being more expensive on average.

It is likely that some Rhode Islanders rely on emergency departments for conditions that could be treated in primary care or urgent care settings. National studies suggest that between 14 and 27 percent of emergency department visits could be treated in less intensive settings.<sup>2</sup>

## Trends by Modality: Office vs. Telehealth

The pandemic reshaped how residents accessed care. In 2020, telehealth use increased significantly while in-office visits declined, but as restrictions lifted, in-office visits rebounded and telehealth use declined (see Figure 5). Still, telehealth has not disappeared. Evidence suggests that some people continue to value its convenience.<sup>3</sup> Importantly, OHIC requires insurers to reimburse telehealth and in-office primary care visits at the same rate, ensuring that primary care providers are not penalized for offering virtual care.<sup>4</sup>

**FIGURE 5: Trend in Utilization of Telehealth and In-Office Visits for the Commercial Market in Rhode Island (2018–2024)**



Source: OHIC analysis of HealthFacts RI data.

Rhode Islanders access primary care in a variety of settings and modalities. Care delivery in Rhode Island remains mostly office-based, even as urgent care and telehealth play a growing, but limited, role. Ultimately, residents will choose the care setting that is most convenient and affordable for them. It is up to Rhode Island stakeholders to ensure that those choices support the continuity of care, rather than reliance on costly emergency departments for minor health needs. It is critical for the health of all Rhode Islanders that people can get the necessary care in the most appropriate setting.

<sup>2</sup> Weinick RM, Burns RM, Mehrotra A. Many emergency department visits could be managed at urgent care centers and retail clinics. *Health Aff (Millwood)*. 2010;29(9):1630-1636. doi:10.1377/hlthaff.2009.0748

<sup>3</sup> Razi T, Ramot N, Wolff Sagy Y, Arbel R, Shani M, Menashe I. Patient Satisfaction with Telehealth Services in Primary Care. *Telemed J E Health*. 2024 Nov;30(11):2704-2711. doi: 10.1089/tmj.2024.0363. Epub 2024 Jul 5. PMID: 38966964. <https://pubmed.ncbi.nlm.nih.gov/38966964>

<sup>4</sup> Office of the Health Insurance Commissioner. (n.d). *Advancing the Statewide Expansion of Telehealth Services*. <https://ohic.ri.gov/node/371>

# CHAPTER 4

## Do Rhode Islanders Utilize Enough Well- Care Visits?

Routine medical appointments, or well-care visits, are visits in which a primary care provider conducts a holistic examination of a patient’s overall health to catch potential health issues early. These visits typically occur annually and serve as periodic health checks, making them important for maintaining long-term health and preventing acute care episodes. Without these regular check-ups, health problems might go undetected and later require more intensive care to treat.

**KEY FINDING: Too many Rhode Islanders are missing important preventive care.**

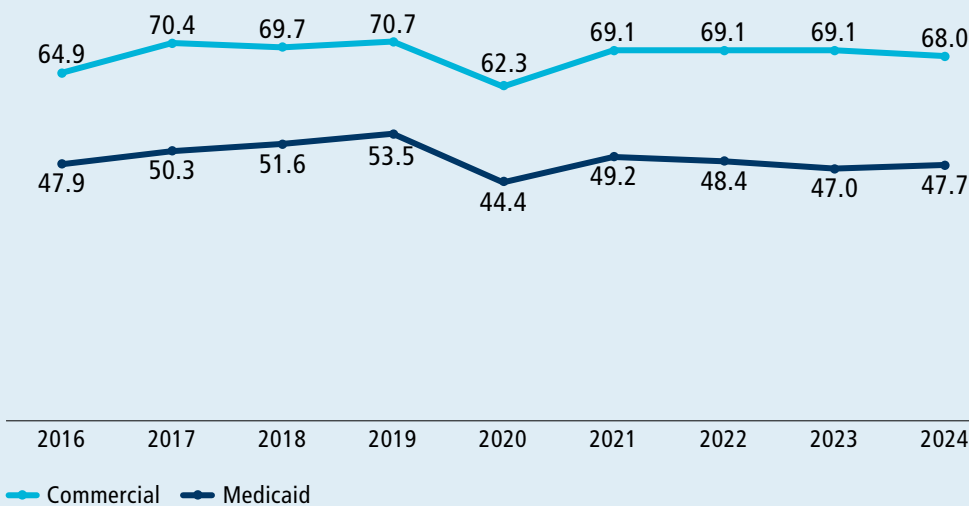
- Since 2016, less than half of people covered by Medicaid have reported a well-care visit each year; in fact, the rate has been declining, especially for children.
- Well-care utilization is also very low among men in both the commercial and Medicaid (managed care organization [MCO] only) markets.

This chapter presents data on the rates of well-care visits in the state from 2016 to 2024.

## Rates of Well-Care Visits by Market and Age

The proportion of Rhode Islanders with a well-care visit is much higher for those with commercial insurance than those with Medicaid. In 2024, nearly 70 percent of people with commercial insurance accessed a well-care visit; the rates have been hovering around this level since 2017 (2020 is an exception – people were not accessing preventive care during the COVID-19 pandemic due to stay-at-home orders). On the other hand, approximately only 48 percent of Medicaid members had such a visit in 2024; this rate has dropped over time and is still noticeably lower than it was pre-COVID-19 pandemic (see Figure 6).

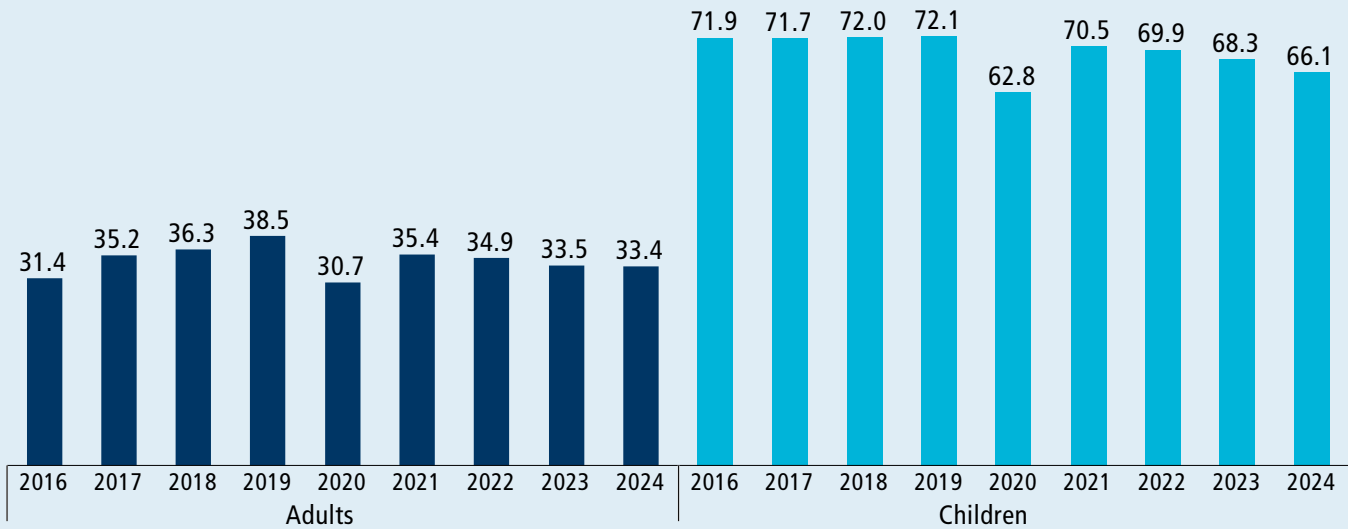
**FIGURE 6: Rates (%) of Well-Care Visits for Commercial and Medicaid (MCO) Members (2016–2024)**



Source: OHIC analysis of HealthFacts RI data.  
 Note: This analysis includes members of all ages and all genders. Medicaid members are those enrolled in managed care with full benefits.

Digging into these Medicaid population patterns by age group reveals that only 33 percent of adults and 66 percent of children accessed well-care visits in 2024. For both age groups, the rates have been declining since 2019 (see Figure 7). This trend gives cause for concern, as those who do not access preventive care have an increased risk of late diagnoses for preventable conditions.

**FIGURE 7: Rates (%) of Well-Care Visits for Adults and Children in Medicaid (2016–2024)**



Source: OHIC analysis of HealthFacts RI data.

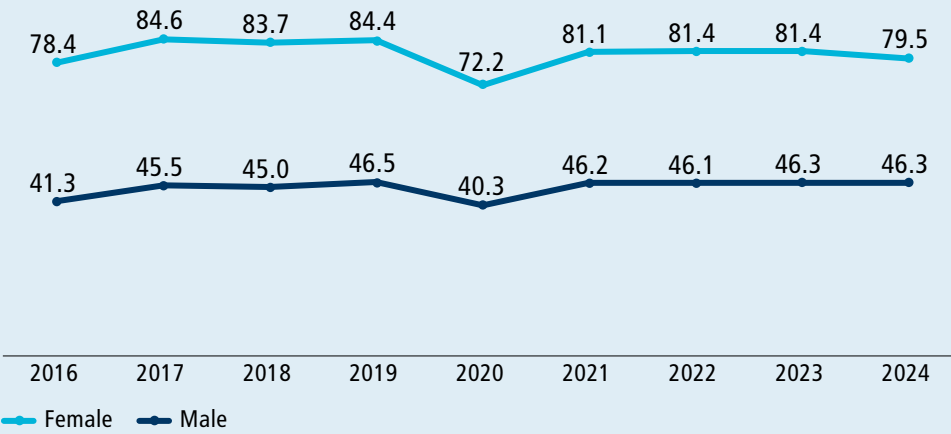
Note: The ages included in each grouping are as follows: children (1–17 years), and adults (18–64 years). Medicaid members are those enrolled in managed care with full benefits.

# Rates of Well-Care Visits by Gender

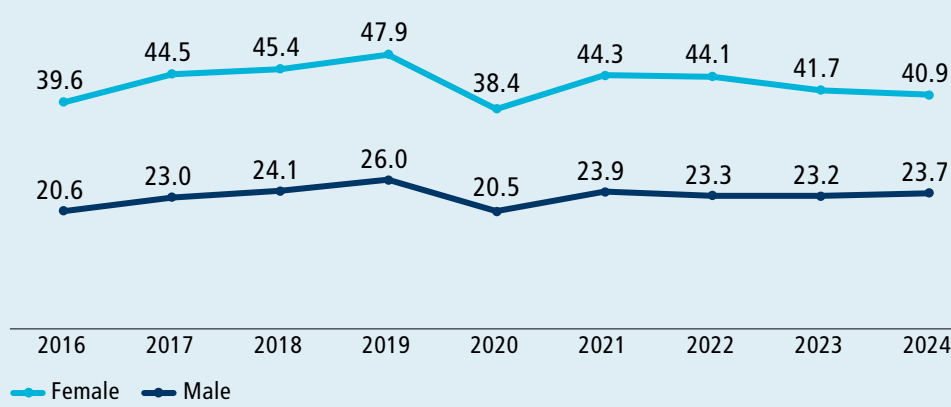
In both the Medicaid and commercial markets, the rates of preventive care visits for women were much higher than for men, although the rates for women have dipped since 2019 (see Figure 8).

**FIGURE 8: Rates (%) of Well-Care Visits for Female vs. Male Adults (2016–2024)**

**a) Commercial**



**b) Medicaid**



Source: OHIC analysis of HealthFacts RI data.  
 Note: The ages included in the adult grouping are: 18-64 years. Medicaid members are those enrolled in managed care with full benefits.

It is evident from the data that there are opportunities to improve preventive care engagement in Rhode Island, particularly among men and within the Medicaid population.

# CONCLUSION

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**Primary care** is the foundation of a high-performing health system: it improves outcomes, enhances quality of life, and lowers costs. Through strengthened regulatory standards and transparent reporting, OHIC is committed to ensuring every resident can access affordable, high-quality primary care, and live healthy lives.

Future annual reports will serve as OHIC's chief platform to communicate with the public and policymakers on matters that concern primary care funding, access, and utilization. These reports will document progress toward meeting the new OHIC-mandated primary care expenditure targets. OHIC will also offer policy recommendations and outline strategic actions to be undertaken by the office, as needed, to ensure continued progress. This will foster collective accountability between the public and private sectors for building and sustaining the foundation of our health care system.

Rhode Island has positioned itself to make headway in addressing the access and underfunding challenges outlined in this report. In April 2025, Governor McKee announced a series of strategic actions to address the primary care crisis. These actions include requiring commercial insurers to increase funding for primary care through 2028, accelerating a review of primary care reimbursement rates, easing prior authorization requirements, and distributing \$6.7 million in grants to primary care practices in June 2025.

## Actions on Medicaid Payment

In the Fiscal Year 2026 budget, the General Assembly appropriated funding to raise primary care reimbursement rates in the Medicaid program to the Medicare rate. In prior fiscal years the General Assembly had already appropriated funding to set Medicaid reimbursement for pediatrics at the Medicare rate. The General Assembly also appropriated additional funding for Federally Qualified Health Centers.

## Primary Care Rate Review

OHIC is conducting a one-time rate review for primary care services that is due by September 1, 2026. This rate review will produce recommendations on reimbursement rates and payment models, with consideration for Medicaid, Medicare, and commercial payments. To inform rate and payment model recommendations, OHIC is analyzing the cost of delivering advanced primary care.

These actions and a durable commitment to transparency will continuously center Rhode Islanders' interest in a robust system of primary care on the state's policy agenda.

# APPENDIX

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## Data Sources and Methodology

### Definition of Primary Care

In all analyses, OHIC defined primary care services using a combination of:

- Procedure codes
- Taxonomy codes
- Place of service codes.

The full code lists used in these analyses are provided below.

### Measures Used

Throughout this report, OHIC uses the following measures:

- **PMPM (per member per month):** Total spending for the year divided by the number of member months
- **PPU (payment per unit):** Average payment per unit, calculated as total spending amount divided by the number of service units
- **Units per 1,000 members:** Units divided by the number of members, multiplied by 1,000). In these analyses, a unit is a claim.

### Data Sources

For the state data contained in this report, OHIC draws on three primary sources: cost growth target data collected under its Health Spending Accountability and Transparency Program, primary care expenditure data collected pursuant to the Affordability Standards (230-RICR-20-30-4), and the state's All-Payer Claims Database (ACPD). The sections below describe OHIC's analytic methodologies for each of these sources.

#### Cost Growth Target

This report pulls in data from OHIC's annual cost growth target data collection. OHIC collects aggregate (i.e., not claim-level) health spending data directly from the health insurers in the state in accordance with its specifications.<sup>1</sup> OHIC used total primary care spending data submitted by health plans in the analyses in [Chapter 2](#).

#### Primary Care Expenditure

This report pulls in data from OHIC's annual primary care expenditure data collection. OHIC collects aggregate (i.e., not claim-level) primary care spending data directly from the commercial health insurers in the state for their fully insured lines of business in

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<sup>1</sup> For more information, see: Rhode Island Office of the Health Insurance Commissioner. Rhode Island Health Care Cost Growth Target and Primary Care Expenditure Obligation Data Submission Guide. August 14, 2025. [https://ohic.ri.gov/sites/g/files/xkgbur736/files/2025-08/RI%20TME%20%26%20PC%20DSG\\_CY23-24.pdf](https://ohic.ri.gov/sites/g/files/xkgbur736/files/2025-08/RI%20TME%20%26%20PC%20DSG_CY23-24.pdf)

accordance with its specifications.<sup>2</sup> OHIC used total claims and non-claims primary care spending data submitted by health plans in the analyses in [Chapter 2](#).

## All-Payer Claims Database

This report utilizes data from the state's APCD, HealthFacts RI. Insurers submit claim-level data to the APCD, allowing analysts to conduct deep-dive analyses that are not possible with the aggregate cost growth target data. The granular data available in the APCD provides OHIC with insight into utilization and average unit payments, helping identify specific policy areas for intervention. Several analyses in this report rely on data from the APCD. Each of their methodologies are described below.

**Note:** Data for this report were obtained through an approved request to the Rhode Island All-Payer Claims Database as administered by the Rhode Island Department of Health (RIDOH). Data were obtained for 2016–2024. RIDOH is not responsible for the author's analysis, opinions, or conclusions contained in this document.

### Analysis of Average Unit Payment and Comparison with Massachusetts and Connecticut

The state's APCD contains claims for Rhode Island residents. Some residents get care in bordering Connecticut and Massachusetts. OHIC was interested in examining the primary care payment rates and utilization for services residents received in bordering (or almost bordering [i.e., one or two towns removed from the border]) zip codes in Connecticut and Massachusetts. Below is the methodology used for the analysis contained in the [Primary Care Payment Variation by State](#) section in Chapter 2:

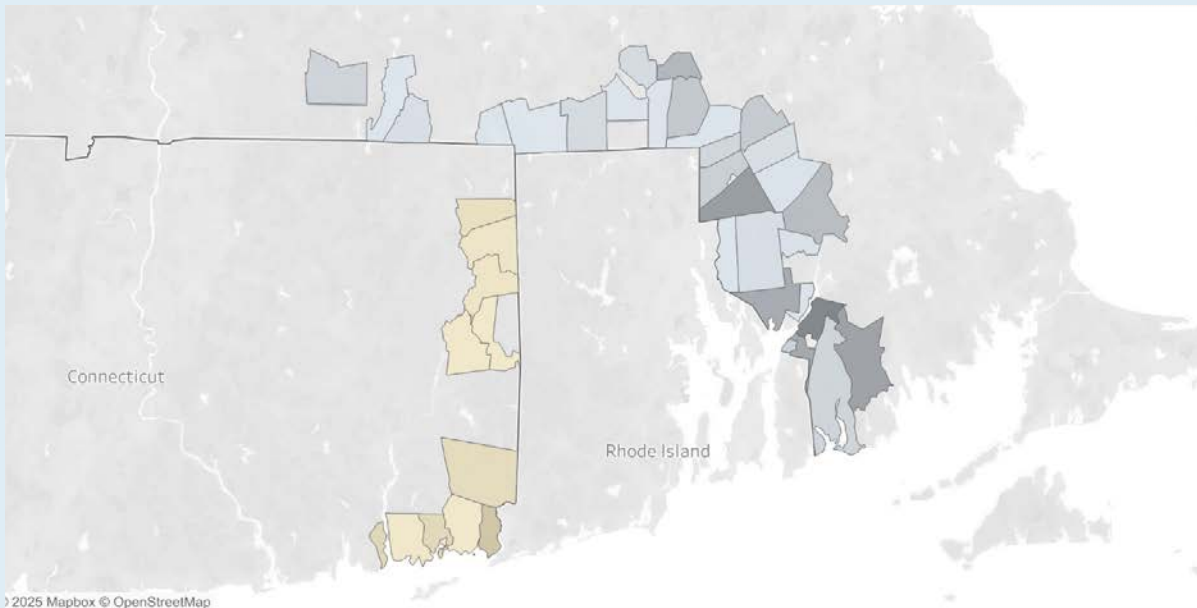
- Rhode Island residents' primary care claims were mapped to the zip codes where the services were delivered, including across state borders. Bordering zip codes were specifically examined because, given Rhode Island's geography, these locations may be closer or more convenient for residents than offices elsewhere in the state – making them the most likely cross-state destination for primary care.
- OHIC then calculated the payment per unit for all primary care visits (office and well-care visits), and within each type of visit, separated by patient types (new<sup>3</sup> and established patient<sup>4</sup>). Payment per unit reflects allowed amounts, which includes both the insurer paid amount and the consumer cost sharing payment obligation (includes deductible, copayments, and coinsurance amounts). OHIC examined the average payment in border zip codes in Connecticut and Massachusetts, and compared those values to Rhode Island's statewide average unit payment. The defined border zip codes are as follows, and shown in Figure 8:
  - **Connecticut:** 06260, 06241, 06239, 06354, 06374, 06359, 06379, 06378, 06355, 06340, 06320.
  - **Massachusetts:** 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.

<sup>2</sup> For more information, see: Rhode Island Office of the Health Insurance Commissioner. Rhode Island Health Care Cost Growth Target and Primary Care Expenditure Obligation Data Submission Guide. August 14, 2025. [https://ohic.ri.gov/sites/g/files/xkgbur736/files/2025-08/RI%20TME%20%26%20PC%20DSG\\_CY23-24.pdf](https://ohic.ri.gov/sites/g/files/xkgbur736/files/2025-08/RI%20TME%20%26%20PC%20DSG_CY23-24.pdf)

<sup>3</sup> The new patient codes included in this analysis were CPT codes 99202-99205 and G0466 for Office Visit – New Patient, and 99381-99387, G0438, and G0402 for Well-Care Visit – New Patient. OHIC selected these codes because they capture different types of services (both problem-oriented and preventive care) typically seen by primary care providers. Descriptions of each code are included in Table 9.

<sup>4</sup> The established patient codes included in this analysis were CPT codes 99211-99215, G0467, and G0468 for Office Visit – Established Patient, and 99391-99397 and G0439 for Well-Care Visit – Established Patient. As with new patient codes, OHIC selected these codes because they capture common primary care services for patients who have already established a care relationship with a provider. Descriptions of each code are included in Table 9.

**FIGURE 9: Bordering Zip Codes for Comparative Payment Analysis**



Source: OHIC analysis of HealthFacts RI data.

Note: Connecticut zip codes are in yellow, and Massachusetts zip codes are in blue. Darker coloring represents zip codes with comparatively more service units.

### ***Analysis of Primary Care Delivery by Setting***

Below are a few important analytic notes for Chapter 3, which summarize OHIC's analyses of primary care delivery by setting in the state:

- In this analysis, one unit is one claim.
- The analysis is limited to RI providers only.
- Spending under 'urgent care visits' includes primary care taxonomy codes (see Table 7), CPT and HCPCS codes identified as primary care services (see Table 9), and Place of Service Code 20 - Urgent Care Facility. Spending under 'urgent care visits' does not include any ancillary services (e.g., labs or x-rays).
- Telehealth visits are for primary care services only. Telehealth visits are identified based on meeting the following criteria:
  - Procedure code modifiers: GQ, GT, G0, FQ, 93, 95.
  - Place of Service (POS) codes: 02 – Inside Home, and 10 – Outside Home.

### ***Analysis of Well-Care Visits***

Below are a few important analytic notes for Chapter 4, which summarize OHIC's analyses of well-care visit rates in the state:

- In this analysis, one unit is one claim.
- The analysis is limited to RI providers only.
- This analysis includes well-care visits for both new and established patients. Specific codes are listed below.
- OB/GYNs are included as a primary care provider for the purpose of this analysis. A full list of the taxonomy codes used are listed below.

## Code Lists

### Taxonomy, Place of Service, and Procedure Codes

**TABLE 7: Primary Care Taxonomy Codes**

Taxonomy Code	Description
<b>CODES USED IN ALL ANALYSES*</b>	
208D00000X	General Practice
207Q00000X	Family Medicine
207QA0000X	Family Medicine, Adolescent Medicine
207QA0505X	Family Medicine, Adult Medicine
207QG0300X	Family Medicine, Geriatric Medicine
208000000X	Pediatrics
2080A0000X	Pediatrics, Adolescent Medicine
207R00000X	Internal Medicine
207RG0300X	Internal Medicine, Geriatric Medicine
207RA0000X	Internal Medicine, Adolescent Medicine
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)
<b>ADDITIONAL CODES USED ONLY IN ANALYSIS OF WELL-CARE VISITS**</b>	
207V00000X	Obstetrics and Gynecology
207VG0400X	Obstetrics and Gynecology, Gynecology
207QH0002X	Family Medicine, Hospice and Palliative Medicine
2080H0002X	Pediatrics, Hospice and Palliative Medicine
207RH0002X	Internal Medicine, Hospice and Palliative Medicine

\*OHIC employed this full set of taxonomy codes for analyses using cost growth target data and for those using APCD data.

\*\*OHIC does not include OB/GYNs in its regulatory definition of primary care. However, in its examination of well-care visits in the state, OHIC included OB/GYNs in its analysis, recognizing that a large portion of women seek care from these providers.

**TABLE 8: Primary Care Place of Service Codes**

Code	Description
02	Telehealth – Outside Home
03	School
10	Telehealth – Inside Home
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
19	Off Campus – Outpatient Hospital
22	On Campus – Outpatient Hospital
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
50	Federally qualified health center

Note: Place of Service Codes 19 and 22 relate to the professional portion of a visit in an outpatient facility.

### **Primary Care Services Procedure Codes**

Table 9 below shows the procedure codes used in each of the analyses included in this report.

- Analyses using Cost Growth Target data and Primary Care Expenditure data use codes from the Office Visits, Well-Care Visits, and All Other Services lists.
- Analyses using HealthFacts RI data use a mix of these codes:
  - The Primary Care Payment Variation by State analysis and the analyses examining how Rhode Islanders receive care use codes from the Office Visits, Well-Care Visits, and All Other Services lists.
  - The well-care visits analysis uses codes from the Well-Care Visits and Newborn Evaluation and Management (E&M) & Women’s Health Services lists.

**TABLE 9: Procedure Codes**

Procedure Code	Description
<b>OFFICE VISITS</b>	
99202	New patient, straightforward medical decision making, 15–29 minutes
99203	New patient, low level of medical decision making, 30–44 minutes
99204	New patient, moderate level of medical decision making, 45–59 minutes
99205	New patient, high level of medical decision making, 60–74 minutes
G0466	Used for FQHCs only; covers a comprehensive new patient visit
99211	Established patient, minimal or no medical decision making, 5–10 minutes (e.g., blood pressure check, brief nurse visit)
99212	Established patient, straightforward medical decision making, 10–19 minutes
99213	Established patient, low complexity, 20–20 minutes
99214	Established patient, moderate complexity, 30–39 minutes
99215	Established patient, high complexity, 40–54 minutes
G0467	Used for FQHCs only; covers a comprehensive preventive visit for an established patient (used only for Medicare beneficiaries)

Procedure Code	Description
G0468	Used for FQHCs only; covers an Initial Preventive Physical Examination (IPPE) (used only for Medicare beneficiaries)
<b>WELL-CARE VISITS</b>	
99381	Preventive visit for new patient (under 1 year)
99382	Preventive visit for new patient (1–4 years)
99383	Preventive visit for new patient (5–11 years)
99384	Preventive visit for new patient (12–17 years)
99385	Preventive visit for new patient (18–39 years)
99386	Preventive visit for new patient (40–64 years)
99387	Preventive visit for new patient (65+ years)
G0402	“Welcome to Medicare visit” (one-time preventive visit covered within 12 months of a patient’s first Medicare Part B enrollment).
G0438	The first annual wellness visit (AWV) under Medicare Part B (used only for Medicare beneficiaries)
99391	Preventive visit, established patient (under 1 year old)
99392	Preventive visit, established patient (1–4 years)
99393	Preventive visit, established patient (5–11 years)
99394	Preventive visit, established patient (12–17 years)
99395	Preventive visit, established patient (18–39 years)
99396	Preventive visit, established patient (40–64 years)
99397	Preventive visit, established patient (65+ years)
G0439	AWV after the first (used only for Medicare beneficiaries)
<b>NEWBORN E&amp;M &amp; WOMEN’S HEALTH SERVICES</b>	
99460	Initial hospital or birthing center care, per day, for evaluation and management of a normal newborn infant
99461	Initial care, per day, for evaluation and management of a normal newborn infant, seen in non-hospital or other birthing center setting
S0302	Documentation of completed OB history
S0610	Annual gynecological exam, new patient
S0612	Annual gynecological exam, established patient
S0613	Annual gynecological exam, established patient, with routine pelvic and breast exam
<b>ALL OTHER SERVICES (CONSULTATIONS, CHRONIC CARE MGMT, IMMUNIZATION ADMINISTRATION, ETC.)</b>	
99242	Office consultation new/estab patient 20 min
99243	Office consultation new/estab patient 30 min
99244	Office consultation new/estab patient 40 min
99245	Office consultation new/estab patient 55 min
99417	Prolonged office or other outpatient evaluation and management service(s) ; used in conjunction with other code
G2212	Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact
T1015	Clinic visit/encounter all-inclusive
S9117	Back school visit
G0463	Hospital outpatient clin visit assess & mgmt pt
99401	Prevent med counsel&/risk factor redj spx 15 min
99402	Prevent med counsel&/risk factor redj spx 30 min
99403	Prevent med counsel&/risk factor redj spx 45 min
99404	Prevent med counsel&/risk factor redj spx 60 min
99406	Tobacco use cessation intermediate 3–10 minutes
99407	Tobacco use cessation intensive >10 minutes

Procedure Code	Description
99408	Alcohol/substance screen & interven 15–30 min
99409	Alcohol/substance screen & intervention >30 min
99411	Prev med counsel & risk factor redj grp spx 30 m
99412	Prev med counsel & risk factor redj grp spx 60 m
99420	Admn & interpj health risk assessment instrument
99429	Unlisted preventive medicine service
99341	Home visit new patient straightforward 15 minutes
99342	Home visit new patient low severity 30 minutes
99344	Home visit new patient moderate severity 60 minutes
99345	Home visit new patient high severity 75 minutes
99347	Home visit est patient straightforward 20 minutes
99348	Home visit est patient low severity 30 minutes
99349	Home visit est patient moderate severity 40 minutes
99350	Home visit est patient high severity 60 minutes
99374	Supvj pt home health agency mo 15–29 minutes
99375	Supervision pt home health agency month 30 min/>
99376	Care plan oversight/over
99377	Supervision hospice patient/month 15–29 min
99378	Supervision hospice patient/month 30 minutes/>
G0179	Phys re-cert mcr-covr hom hlth svrc re-cert prd
G0180	Phys cert mcr-covr hom hlth svrc per cert prd
G0181	Phys supv pt recv mcr-covr svrc hom hlth agcy
G0182	Phys supv pt under medicare-approved hospice
99495	Transitional care manage svrc 14 day discharge
99496	Transitional care manage svrc 7 day discharge
99497	Advance care planning first 30 mins
99498	Advance care planning ea addl 30 mins
99366	Team conference face-to-face nonphysician
99367	Team conference non-face-to-face physician
99368	Team conference non-face-to-face nonphysician
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
99487	Cmplx chron care mgmt w/o pt vst 1st hr per mo
99489	Cmplx chron care mgmt ea addl 30 min per month
99490	Chron care management svrc 20 min per month
99491	Chron care management svrc 1st 30 min per month
G0506	Comp asmt of & care plng pt rqr cc mgmt svrc
99358	Prolng e/m svc before&/after dir pt care 1st hr
99359	PROLNG E/M BEFORE&/AFTER DIR CARE EA 30 MINUTES (use in conjunction with 99358)
99360	Phys standby svc prolng phys attn ea 30 minutes
G0513	Prlng prev svrc ofc/oth o/p rqr dir ctc;1st 30 m
G0514	Prlng prev svrc ofc/oth o/p dir ctc;ea add 30 m
99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes
99422	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11–20 minutes
99423	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes

Procedure Code	Description
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.
99425	Each additional 30 minutes per calendar month of principal care management services, as carried out by a physician or qualified health care professional.
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.
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.
99437	Chronic care management services with specific required elements; each 30 minutes by a physician or other qualified health care professional, per calendar month.
99441	Phys/qhp telephone evaluation 5–10 min
99442	Phys/qhp telephone evaluation 11–20 min
99443	Phys/qhp telephone evaluation 21–30 min
99446	Ntrprof phone/ntrnet/ehr assmt&mgmt 5–10 min
99447	Ntrprof phone/ntrnet/ehr assmt&mgmt 11–20 min
99448	Ntrprof phone/ntrnet/ehr assmt&mgmt 21–30 min
99449	Ntrprof phone/ntrnet/ehr assmt&mgmt 31/> min
99451	Ntrprof phone/ntrnet/ehr assmt&mgmt 5/> min
99452	Ntrprof phone/ntrnet/ehr referral svc 30 min
98966	Nonphysician telephone assessment 5–10 min
98967	Nonphysician telephone assessment 11–20 min
98968	Nonphysician telephone assessment 21–30 min
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
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
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
90460	Im adm thru 18yr any rte 1st/only compt vac/tox
90461	Im adm thru 18yr any rte addl vac/tox compt
90471	Im adm prq id subq/im njxs 1 vaccine
90472	Im adm prq id subq/im njxs ea vaccine
90473	Im adm intranl/oral 1 vaccine
90474	Im adm intranl/oral ea vaccine
G0008	Administration of influenza virus vaccine
G0009	Administration of pneumococcal vaccine
G0010	Administration of hepatitis b vaccine
96160	Pt-focused hlth risk assmt score doc stnd instrm
96161	Caregiver hlth risk assmt score doc stnd instrm
99078	Phys/qhp education svcs rendered pts grp setting
99483	Assmt & care planning pt w/cognitive impairment
G0396	Alcohol &/substance abuse assessment 15–30 min
G0397	Alcohol &/substance abuse assessment >30 min
G0442	Annual alcohol misuse screening 15 minutes
G0443	Brief face-face behav cnsl alchol misuse 15 min
G0444	Annual depression screening 15 minutes
G0505	Cogn & funct asmt using std inst off/oth op/home
99173	Screening test visual acuity quantitative bilat

Procedure Code	Description
G0102	Pros cancer screening; digtl rectal examination
G0436	Smoke tob cessation cnsl as pt; intrmed 3–10 min
G0437	Smoking & tob cess cnsl as pt; intensive >10 min
98968	Nonphysician telephone assessment 21–30 min
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
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
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
90460	Im adm thru 18yr any rte 1st/only compt vac/tox
90461	Im adm thru 18yr any rte addl vac/tox compt
90471	Im adm prq id subq/im njxs 1 vaccine
90472	Im adm prq id subq/im njxs ea vaccine
90473	Im adm intrasl/oral 1 vaccine
90474	Im adm intrasl/oral ea vaccine
G0008	Administration of influenza virus vaccine
G0009	Administration of pneumococcal vaccine
G0010	Administration of hepatitis b vaccine
96160	Pt-focused hlth risk assmt score doc stnd instrm
96161	Caregiver hlth risk assmt score doc stnd instrm
99078	Phys/qhp education svcs rendered pts grp setting
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G0396	Alcohol &/substance abuse assessment 15–30 min
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G0102	Pros cancer screening; digtl rectal examination
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