

HEALTH SPENDING ACCOUNTABILITY AND TRANSPARENCY PROGRAM

DATA SUBMISSION GUIDE: COST GROWTH TARGET AND PRIMARY CARE EXPENDITURE OBLIGATION

August 11, 2026



STATE OF RHODE ISLAND

Office of The Health Insurance Commissioner

Department of Business Regulation

Version History

Version Number	Release Date	Summary of Changes
8	August 1, 2022	- Added Thundermist as ACO/AE ID 108. - Added Insurer Code 100 (Insurer Overall). - Updated primary care site of care definition. - Made changes to primary care payment codes: - Added primary care telehealth codes (99421-99423), two office visit E&M codes (99417, G2212), and extended chronic care management visit code (99439) - Removed two other codes (99444 and 98969) - Updated description of office outpatient visit (99203 – 99205, 99211-215) - Revised tab names. - Revised requirement to report standard deviation instead of variance. - Added “Total Claims excluded because of Truncation” in ACO/AE tab. - Clarified inclusion of medical pharmacy rebates in TME submission. - Revised levels of reporting NCPHI.
8.1	August 26, 2022	Revised Standard Deviation instructions.
9	August 1, 2023	- Added details on new “Data Validation” tab in data submission template. - Added Appendix I, which describes OHIC’s methodology for risk adjusting TME using age/sex factors. - Added new primary care procedure codes (99424 – 99427, 99437), revised description for primary care procedure code (99491).
10	August 22, 2024	- Added details on methodology for deriving cost growth target values for 2023-2027. - Updated the ‘Definitions of Key Terms’ for the following: - removing terms that were duplicative in the Appendices, - clarifying the definition of “Member Month (annual)” for comprehensive health plans to not duplicate member months for members with both medical and pharmacy benefits, and - clarifying other definitions. - Updated the information to be reported under the “Doing Business As” filed in the HD-TME tabs to include all subsidiaries, by market, for which the insurer is reporting spending. - Added “reinsurance policy (recoveries and premiums)” and “specific disease policy” to the list of excluded policies. - Added specifications for payers to estimate pharmacy rebates (both retail and medical) for Commercial: Partial Claims. - Updated primary care procedure codes: - Deleted codes 99241, 99339, 99340, and 99343

		○ Updated descriptions of 99242, 99243, 99244, 99245, 99341, 99341, 99344, 99345, 99347, 99348, 99350, 99359, and 99417
11	August 14, 2025	• Updated primary care procedure codes. • Removed all references to clinical risk adjustment. • Incorporated looking at non-claims PMPMs by category. • Added PMPM comparison with last year's data. • Added four primary care codes (99492 – 99494, G2214) for behavioral health integration. • Added guidance for insurers to only report primary care spending in the “Claims: Professional, Primary Care” category for both the Total Medical Expense request and Primary Care Expenditure Obligation for clinicians that the plan credentialed as a primary care provided for the given performance year. • Updated the non-claims spending definitions to align with Peterson-Milbank’s Consensus Administrative Specifications for Health Care Cost Growth Target Programs. Key changes include: ○ Renamed “Non-Claims: Capitated, Prospective Hospital Global Budget Prospective Case Rate, or Prospective Episode-Based Payments” to “Non-Claims: Capitation and Full Risk Payments.” ○ Revised “Non-Claims: Performance Incentive Payments” into two categories: ▪ Non-Claims: Performance Payments, and ▪ Non-Claims: Shared Savings and Shared Risk Settlements. ○ Removed “Non-Claims: Provider Salaries” as a distinct category and added guidance that this category should be included under “Non-Claims: Other.” ○ Removed “Non-Claims: Recoveries” as a distinct category and added guidance that claims spending should be net of recoveries. • Added a tab to collect primary care non-claims spending for the entire commercial market (i.e., including the self-insured line of business). • Added primary care place of service codes to the primary care definition. • Broadened the definition of entities subject to assessment against the cost growth target from ACO/AE to “Large Provider Entities.” ○ Added named provider entities: Brown University Health, RIPCCP, and Southcoast Health. • Standard Deviation tab: Revised instructions for submitters to report using “market codes.”
12	August 11, 2026	• Added Aetna and Cigna Healthcare as insurers required to report TME data • Updated primary care non-claims tab of TME template to collect spending for all lines of business

		• Updated truncation points • Updated the code-level definition of Claims: Professional, Primary Care as follows: ○ Added the following CPT codes: G2211; G0556-G0558; 98000-98016 ○ Added descriptions for four codes: 99492 – 99494; G2214
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Overview

Cost Growth Target

In 2018, the former Governor, the Executive Office of Health and Human Services (EOHHS) and the Office of the Health Insurance Commissioner (OHIC) convened the Rhode Island Health Care Cost Trends Steering Committee (Steering Committee) to develop an annual health care cost growth target (Target) for Rhode Island. The Steering Committee, comprised of a broad range of stakeholders, deliberated on the methodology for setting a cost growth target and how to measure performance against it, and formalized its recommendations through a voluntary compact signed by all Steering Committee members in December 2018.

The former Governor affirmed the cost growth target and the administration's commitment to assessing and reporting on performance relative to the target in Executive Order 19-03, issued February 6, 2019. This Executive Order committed its signatories to "revisit the target's methodology in 2022 and advise the State on whether to keep the target or establish a new target for 2023 and beyond." The Steering Committee did so and in 2023 members signed the Compact to Reduce the Growth in Health Care Costs while Improving Health Care Access, Equity, and Quality in Rhode Island.¹ This renewed Compact established targets for five years (2023 through 2027) and included a new commitment to advancing public health and improving health equity.

The Rhode Island General Assembly's FY2027 budget formally codified the state's health care cost growth target program, granting the OHIC statutory authority to set and enforce annual spending benchmarks for payers and large provider entities.² OHIC intends to release draft regulations for public comment in response to the new statutory authority.

Primary Care Spending

OHIC implemented its Affordability Standards in 2010, part of which directed commercial insurers in the state to expand investment in primary care. Specifically, the Affordability Standards required commercial insurers to increase primary care spending as a percentage of total medical expenses by one percentage point per year from 2010 to 2014.³ The most recently updated Affordability Standards, effective March 2025, direct commercial insurers to

¹ *Compact to Reduce the Growth in Health Care Costs while Improving Health Care Access, Equity, Patient Experience, and Quality in Rhode Island*. Rhode Island Health Care Cost Trends Steering Committee. 2023. <https://ohic.ri.gov/sites/g/files/xkgbur736/files/2023-07/RI%20Health%20Care%20Cost%20Growth%20Target%20Compact%20final%20signed%202023%2004-14.pdf>

² Article 12 – Relating to Health Care. Rhode Island General Assembly. 2026. <https://webserver.rilegislature.gov/BillText26/HouseText26/Article-012-SUB-A-as-amended.pdf>

³ OHIC's Primary Care Spending in Rhode Island, published January 2014: <http://www.ohic.ri.gov/documents/Primary-Care-Spending-generalprimary-care-Jan-2014.pdf>.

annually spend at least 10 percent of their total medical expenses on primary care, with 8 percent through claims-based and capitation payments, phased in beginning in 2025, rebased to 2022 data.⁴ With this update, OHIC aligned the definition of primary care used to evaluate insurers' spending against the Primary Care Expenditure Obligation with that which is used for its cost growth target.

The Rhode Island General Assembly's FY2027 budget additionally granting the OHIC statutory authority to set annual all-payer primary care investment targets.⁵

This Data Submission Guide contains the technical and operational steps for implementing the health care cost growth target and primary care expenditure obligation, including the technical specifications for data reporting.

⁴ OHIC's 2020 Affordability Standards, effective March 20, 2025: <https://ohic.ri.gov/sites/g/files/xkgbur736/files/2025-03/230-RICR-20-30-4%20effective%203-20-2-2025.pdf>.

⁵ <https://webserver.rilegislature.gov/BillText26/HouseText26/Article-012-SUB-A-as-amended.pdf>

Chapter 1:

Health Care Cost Growth Target Definition and Methodology

A. Definition

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

B. Methodology for Calculating the Health Care Cost Growth Target

Rhode Island's Targets for 2023-2027 represent a 75/25 blend of the State's potential gross state product (PGSP) values and forecasted median household income growth. The Targets for 2023-2027 are shown below in **Table 1**, with information on the methodology used to calculate these values that follows.

Table 1. Target Values for 2023-2027

Calendar Year	Target Value
2023	6.0%
2024	5.1%
2025	3.6%
2026	3.3%
2027	3.3%

The formula for the forecasted growth in per capita PGSP is as follows:

$$(Growth\ in\ national\ labor\ force\ productivity + growth\ in\ the\ state\ civilian\ labor\ force + forecasted\ inflation^6) - state\ population\ growth$$

⁶ The Steering Committee, in its deliberations about the cost growth target, recommended the target values make an allowance for the sharp rise in general inflation that occurred in 2022. Economic analyses examining the relationship between inflation and health care spending have shown that general inflation has a delayed impact on health care spending growth. For more information, see: 1) *Health Spending Growth: The Effects of the Great Recession* (2015) The Brookings Institution, and 2) *The Growth of Health Spending in the USA: 1776-2026* (2017) Thomas Getzen, Temple University.

Table 2 lists the sources for each of the components of the PGSP formula.

Table 2. Data Sources for PGSP Inputs

Components	Source
Growth in Potential Labor Force Productivity (national figure)	The source was the May 2022 <u>Congressional Budget Office Budget and Economic Outlook Report</u>.⁷ The report contains a table of Key Inputs to the CBO's Projections of Real Potential GDP that includes the potential labor force productivity projected average annual growth from 2027–2032 (Page 48, Table 2-3 of the May 2022 report). The figure used to calculate PGSP should be the value that is forecast for five through 10 years into the future.
Potential Labor Force Growth (state figure)	The source was the Rhode Island Office of Management and Budget's purchased forecast from S&P Global (formerly IHS Economics).⁸ Specifically, the value was sourced from the Employment tab of the S&P Global July 2022 Long Term Annual workbook. Labor Force statistics were in row 65. The value represents the forecasted average growth in Rhode Island's labor force from the first quarter of 2027 through the fourth quarter of 2032.
Expected national inflation	The source was the May 2022 <u>Congressional Budget Office Budget and Economic Outlook Report</u>.⁹ Included within the report is a table of CBO's Economic Projections for Calendar Years 2022 to 2032 (Page 29, Table 2-1 of the May 2022 report). The figure used to calculate PGSP should be the value of the "PCE price index" percentage change from year-to-year that is forecast for five through 10 years into the future. To account for the two-year lagged impact of inflation on health care costs in the Target, this input was adjusted with inflation experience on a two-year lagged basis for 2023–25 (i.e., 2023 used the actual value for 2021, 2024 used the value for 2022, 2025 used the value for 2023). This input used the long-term forecast of inflation for 2026 and 2027, without adjustment (i.e., both 2026 and 2027 used the forecasted annual average for 2027–2032).
State population growth (state figure)	The source was the Rhode Island Office of Management and Budget's purchased forecast from S&P Global July 2022 Long Term manual workbook. Specifically, the value used to calculate PGSP is the forecasted average annual growth in Rhode Island's population between 2027 and 2032.

⁷ The Congressional Budget Office publishes its Budget and Economic Outlook Reports at: www.cbo.gov/about/products/major-recurring-reports#1.

⁸ The S&P Global Forecast purchased by the Rhode Island Office of Management and Budget was supplied to Bailit Health and Cory King of OHIC by Brian Shreck in the Office of Management and Budget.

⁹ The Congressional Budget Office publishes its Budget and Economic Outlook Reports at: www.cbo.gov/about/products/major-recurring-reports#1.

For the development of the Target, the period of 2027-2032 was consistent with the desired future forecast period of five to 10 years into the future (which is a common future period used in economic modeling).

Table 3 presents the values used to calculate and PGSP for each year using the sources listed above.

Table 3. PGSP Calculation

Year	Growth in Potential Labor Force Productivity (A)	Potential Labor Force Growth (B)	Forecasted Inflation (C)	State Population (D)	Calculation (E) E = (A + B + C) - D
2023	1.4%	0.1%	5.5%	0.3%	6.7%
2024			4.0%		5.2%
2025			2.3%		3.5%
2026			2.0%		3.2%
2027			2.0%		3.2%

As mentioned above, the Target also incorporates median household income into its calculation. The source was the Income tab of the S&P Global Long Term Annual Workbook, forecasted as of July 2022. Specifically, the figures used were the current forecasted annual growth in the Median Household Income metric (row 87) of the July 2022 annual forecast for 2023-25, and the long-term (five-through-ten-year) forecast for 2026-2027 (i.e., the forecasted growth from 2022-23 was used for the 2023 value, 2023-24 was used for 2024, and 2024-25 was used for 2025).

The median household inputs for each year are shown in **Table 4** below.

Table 4. Forecasted annual median household income growth (2023-2027)

	2023	2024	2025	2026	2027
Forecasted annual median household income growth	4.0%	4.6%	4.0%	3.7%	3.7%

Chapter 2:

Methodology for Assessing Performance Against the Health Care Cost Growth Target

Article 12 – Relating to Health Care (2026) requires OHIC and EOHHS to annually report on performance relative to the Target at the state, health insurance market, individual payer, and accountable care organization levels. This chapter contains OHIC’s methodology for measuring the growth in health care spending at each level, including which data to collect and which calculations to perform. This chapter is organized as follows:

- A. [Definitions of Key Terms](#)
- B. [Methodology for Measuring Total Health Care Expenditures \(THCE\) and Total Medical Expense \(TME\)](#)
- C. [Data Sources for THCE](#)
- D. [Insurer Total Medical Expense \(TME\) Data](#)
- E. [Net Cost of Private Health Insurance \(NCPHI\) Data](#)
- F. [Public Reporting of Cost Growth Target Performance](#)
- G. [Timeline for Measuring and Reporting the Health Care Cost Growth Target](#)

A. Definitions of Key Terms

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

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

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

Health care cost growth target (Target): The Target is the value against which the Rhode Island Health Care Cost Trends Steering Committee agreed to measure and assess total health care expenditures and total medical expense growth. For 2023-2027, the values represent a

75/25 blend of Rhode Island's Potential Gross State Product (PGSP) and forecast median household income growth. See **Table 1** for the Target values.

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

Large Provider Entity (LPE): A provider organization contracted with one or more payers that, at a minimum, includes primary care providers, and that collectively, during any given calendar year, has enough attributed lives to participate in total cost of care contracts, even if it is not engaged in a total cost of care contract as an ACO or AE.

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

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

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

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

Pharmacy rebates: Any rebates provided by pharmaceutical manufacturers to payers for prescription drugs with specified dates of fill corresponding to the reporting period, excluding manufacturer-provided fair market value bona fide service fees.¹⁰ This amount should include pharmacy benefit manager (PBM) rebate guarantee amounts and any additional rebate amounts transferred by the PBM. Pharmacy rebate data should exclude stand-alone prescription drug

¹⁰ Fair market value bona fide service fees are fees paid by a manufacturer to a third party (e.g., insurer, pharmacy benefit manager, etc.) that represent fair market value for a bona fide, itemized service actually performed on behalf of the manufacturer that the manufacturer would otherwise perform (or contract for) in the absence of the service arrangement (e.g., data service fees, distribution service fees, patient care management programs, etc.).

plans. The computation of TCHE at the state, market and payer level is net of pharmacy rebates (i.e., other expenditures are reduced by the amount of the pharmacy rebates).¹¹

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

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

Risk-adjusted total medical expense: A term that refers to an entity's risk-adjusted, truncated claims spending plus its non-claims spending. OHIC risk-adjusts claims spending using risk scores developed using payer-submitted age/sex spending data. Risk-adjusted TME is used to assess performance against the Target at the insurer and LPE levels.

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

Total health care expenditures per member per year: Total health care expenditures (as defined above) divided by Rhode Island's covered population as reported in the TME data. The annual change in THCE per member per year is compared to the Target at the state level. THCE is not reported at the market, insurer, or provider levels.¹²

Total medical expense (TME): The sum of the allowed amount of total claims and total non-claims spending paid to providers incurred by Rhode Island residents for all health care services (also known as the total cost of care). TME is reported at multiple levels: state, market, payer and provider. TME is reported net of pharmacy rebates at the market, payer, and provider levels only. Payers report TME by market (i.e., commercial, Medicare, and Medicaid) and at the LPE level. More detailed TME reporting specifications are contained in the Appendices of this manual.

¹¹ CMS is unable to report pharmaceutical rebates for traditional Medicare beneficiaries (i.e., FFS Medicare). Therefore, in the computations of THCE at the state and Medicare market levels, spending are gross of Medicare FFS pharmaceutical rebates.

¹² NCPHI, a component of THCE, is not reportable at the provider level. Therefore, THCE is not reported at the provider level.

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

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

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

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

The following formulas are used to calculate performance against the cost growth target at each level. Note that all TME in the following formulas for state, market and payer are to be reported net of pharmacy rebates. LPE TME is gross of pharmacy rebates.

Statewide THCE

Statewide THCE (in aggregate) =

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

Statewide THCE (PMPY) =

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

Market Level TME

Medicare Market TME (in aggregate) =

Medicare Advantage TME + Medicare FFS TME

Medicare Market TME (PMPY) =

$$\frac{\text{Medicare Advantage (MA) TME} + \text{Medicare FFS TME}^{13}}{\text{Population of FFS Members (Parts A and B) Reported by CMS} + \text{Population of MA Members Reported by Insurers}}$$

Medicaid Market TME (in aggregate) =

$$\text{Medicaid MCO TME} + \text{RI EOHHS FFS TME}$$

Medicaid Market TME (PMPY) =

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

Commercial Market TME (in aggregate) =

$$\text{Commercial TME}$$

Commercial Market TME (PMPY) =

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

Duals Market TME (in aggregate) =

$$\text{TME for Duals enrolled in the Financial Alignment Initiative}^{14}$$

Duals Market TME (PMPY) =

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

Payer TME

Payer, by Market (PMPM) =

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

¹³ CMS reports total Medicare members enrolled in Original Medicare. Because OHIC has not requested data from stand-alone Part D Medicare payers, OHIC removes prescription drug spending from Medicare Managed Care TME at the market level and adds in CMS-reported total prescription drug spending to capture both Medicare Part C and Part D prescription drug spending. This allows OHIC to report a comprehensive measurement of spending for Medicare at the market level. This adjustment is not applied at the payer level, Medicare line of business.

¹⁴ Rhode Island participated in the CMS Financial Alignment Initiative which combined Medicare and Medicaid dollars into one funding stream to pay for the coverage of individuals dually enrolled in Medicaid and Medicare. The demonstration program ended on December 31, 2025. This level of analysis does not apply to the population of dually eligible individuals separately covered through Original Medicare, Medicare Advantage or Medicaid FFS. OHIC is unable to report on those individuals separately because it cannot estimate a unique count of individual members.

Large Provider Entity TME

LPE, by Market (PMPM) =

Risk-Adjusted TME Net of Spending Above Established Thresholds for High - Cost Outliers
Population of Members Reported

Defining Specifications for THCE

The defining specifications for THCE are as follows:

- It represents spending incurred in or out-of-state on behalf of Rhode Island residents who are insured by Medicare, Medicaid, or commercial insurers, as well as residents who obtain coverage from self-insured employers. Spending associated with people who are not state residents is excluded (i.e., THCE excludes spending for out-of-state residents receiving care from in-state providers).
- It includes spending on health care services/benefits. It excludes non-medical spending, even if such spending is made by a payer (e.g., gym memberships).
- Vision and dental spending are generally excluded except when vision and dental services are covered as a health insurance benefit or are a covered benefit under Medicaid or Medicare (e.g., RItE Smiles dental coverage for children).
- It represents the total allowed amount, which includes amounts covered by payers, and individual out-of-pocket spending associated with insured medical expenditures (e.g., co-pays, co-insurance and deductibles). To avoid double counting expenditures, health care premium payments are not included. Also, because data are not available, other out-of-pocket expenditures recorded by providers, but not paid by insurers, are not included (e.g., “charity care” or medical care delivered to Rhode Island residents who cannot afford to pay providers, or privately purchased health care services).
- It encompasses all insurance market segments, including public and private payers listed in this manual, fully and self-insured products, and student insurance, with the following limited exceptions: US Department of Veterans Affairs, the TRICARE program and health spending by the Rhode Island Department of Corrections that is not otherwise covered by Medicaid.
- The administrative costs and underwriting gain/loss of insurers, referred to as the NCPHI, are included (see [Section E](#) of this chapter for more detail).
- TME data are only collected from a payer when it is the primary payer for a claim. The primary payer will report on the allowed amount. If the secondary payer of the claim were to report, it would cause double counting a portion of the allowed amount by the primary payer.

- TME is adjusted to account for any pharmacy rebates received by the payer by subtracting the rebates (revenue) from the payer’s total medical expense. The exception is Medicare FFS spending as CMS will not share this information at the state level.
- TME is risk-adjusted using age/sex factors applied uniformly by OHIC at the payer and provider levels, using data supplied by the payers.
- Spending above certain thresholds for high-cost outliers is removed from TME at the payer and provider levels. Table 19 in [Appendix A](#) lists the threshold values, which are specific to each market and were derived using data from Rhode Island’s All-Payer Claims Database.
- Provider resources applied in the delivery of care for uninsured Rhode Islanders should not be included in calculations of health care spending because they are technically not “spending” as defined herein.

C. Data Sources for THCE

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

Table 5 below outlines the data source by THCE category and the location of the detailed specification or collection process within this data submission guide.

Table 5. Data Sources for THCE

THCE Category	Data Source	Location of Data Specification/Collection Process in DSG
Expenditures from Insurers		
Insurer full claim (comprehensive coverage with no carve-outs)	TME reported by insurers	Appendix A
Insurer partial claim (coverage with carve-outs, such as pharmacy) calculated values	TME reported by insurers, with actuarial estimates produced by insurers	Appendix A
Insurer non-claim payments	TME reported by insurers	Appendix A
Prescription drug spending for Medicare Managed Care Organization, for market-level reporting only (<i>For insurer-level</i>	CMS	Appendix C

THCE Category	Data Source	Location of Data Specification/Collection Process in DSG
<i>reporting, the data source is in insurer-reported TME.)¹⁵</i>		
Expenditures from Public Programs		
EOHHS claim (Medicaid FFS and other) calculated values	EOHHS	Appendix B
Medicare FFS claim (Parts A, B and D) calculated values	CMS	Appendix C
Net Cost of Private Health Insurance		
Fully insured and Medicaid Insurer NCPHI	Calculated from regulatory reports submitted by the insurers or obtained through public sources	Appendix D
Self-insured Insurer NCPHI	Insurers with self-insured populations	Appendix D
Pharmacy Rebates		
Insurers	Pharmacy rebate data filing by insurers	Appendix A
Medicaid Program	Pharmacy rebate data filing by EOHHS	Appendix B

D. Insurer TME Data

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

Annually, OHIC directs applicable insurers to submit TME data using the specifications outlined in [Appendix A](#) and the template provided as **Attachment 1**. Specifications for public programs to submit their TME are included in **Appendices B-C**. **Table 6** below lists which insurers should report for their commercial, Medicare managed care, Medicaid/CHIP managed care, and Medicare-Medicaid dual eligible markets.

¹⁵ CMS provides OHIC with allowed amounts for Medicare FFS beneficiaries with stand-alone prescription drug plans (PDP) and for Medicare managed care beneficiaries with stand-alone PDP and Medicare Advantage Prescription Drug Plans (MAPD) in aggregate. CMS is the source of pharmacy expenditure data for market-level spending as it includes all stand-alone PDP spending, even by insurers not reporting TME to OHIC and insurers specifically excluding stand-alone PDP spending from TME. For reporting at the insurer-level, each individual insurer is the source of spending. However, stand-alone PDP spending has been excluded from reporting at the insurer-level because doing so would compromise the integrity of the spending calculations.

Table 6. Insurers Required to Report TME Data by Market

Insurer	Commercial Fully and Self-Insured	Medicare Managed Care	Medicaid Managed Care	Medicare and Medicaid Dual Eligibles
Aetna	X	X ¹⁶		
Cigna Healthcare	X			
Blue Cross Blue Shield of RI	X	X		X
Neighborhood Health Plan of RI	X		X	X
Point32Health	X ¹⁷		X ¹⁸	
UnitedHealthcare ¹⁹	X	X	X ²⁰	X

E. NCPHI Data

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

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

F. Public Reporting of Cost Growth Target Performance

Table 7 outlines the minimum level at which OHIC publicly reports performance. When reporting TME, OHIC reports on a per member per year (PMPY) or per member per month (PMPM) basis.

¹⁶ Aetna's Medicare business operates as Aetna Medicare.

¹⁷ Point32Health's commercial business operates as Harvard Pilgrim Health Care.

¹⁸ Point32Health's Medicaid business operates as Tufts Health Plan.

¹⁹ UnitedHealthcare also does business as Oxford; UnitedHealthcare Services, Inc.; UnitedHealthcare Services, LLC; UnitedHealthcare Insurance Company; UnitedHealthcare of New England, Inc; UnitedHealthcare Insurance Company of New York, and Oxford Health Insurance.

²⁰ UnitedHealthcare's Medicaid business operates as UnitedHealthcare Community Plans.

Table 7. Levels at Which Public Reporting of Performance Against Target Occurs

Level of Reporting	THCE/TME Components
State level	• Report THCE net of rebates and including NCPHI components • Report aggregate and PMPY amounts • Compare PMPY rate of change against target
Medicare market	• Report TME net of rebates PMPY • Compare PMPY rate of change against target • Report NCPHI for the Medicare market
Medicaid market	• Report TME net of rebates PMPY • Compare PMPY rate of change against target • Report NCPHI for the Medicaid market
Commercial market	• Report TME net of rebates PMPY • Compare PMPY rate of change against target • Report NCPHI for the commercial market
Financially Aligned Initiative for Medicare and Medicaid Duals market	• Report TME net of rebates PMPY • Compare PMPY rate of change against target • Report NCPHI for Duals
Insurer	• Compare TME (net of rebates) PMPM rate of change against target by market • Report NCPHI by payer
Large Provider Entity	• Compare TME (gross of rebates) PMPM rate of change against target by market

Reporting TME by Service Category

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

OHIC requests that insurers report spending on the following service categories, using the definitions provided in the appendices of this data submission guide:

- Hospital Inpatient
- Hospital Outpatient
- Professional, Primary Care
- Professional, Specialty Care
- Professional Other

- Retail Pharmacy (net of rebates)^{21,22}
- Long-Term Care
- Other Claims
- Non-claims: Capitation and Full Risk Payments
- Non-claims: Performance Payments
- Non-claims: Shared Savings and Shared Risk Settlements
- Non-claims: Population Health and Practice Infrastructure Payments
- Non-claims: Other

Reporting TME by Insurer

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

Reporting TME by LPE and Members Unattributed to an LPE

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

OHIC reports on Rhode Island LPE performance in accordance with the Steering Committee's recommendations on the minimum number of attributed members required to report provider performance. Annually, OHIC publicly reports the age/sex-adjusted TME of LPE for the markets in which they have a minimum of 60,000 attributed member months.

Applying Adjustments to Insurer and LPE Performance

OHIC requires insurers to submit non-adjusted TME data but recognizes the need to account for the variability in individuals' health status, and for random variation in health care spending of small populations. For TME data, OHIC removes spending above certain thresholds for high-

²¹ Insurers that have both Medicare Advantage and stand-alone PDP lines of business must exclude their stand-alone PDP data from their TME submission. Stand-alone PDP expenditure data are obtained from CMS.

²² When reporting trends in retail pharmacy spending, OHIC will subtract retail pharmacy rebates from this service category. It cannot do the same for medical pharmacy rebates as medical pharmacy data are in multiple service categories, including hospital inpatient and hospital outpatient. Instead, the sum of medical and retail pharmacy rebates is subtracted from TME.

cost outliers, applies age/sex risk-adjustment factors, and performs statistical testing around each insurer and LPE's cost growth. Each of these adjustments and how they are applied are described below.

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

To minimize the impact of high-cost outliers on insurer and provider cost growth, OHIC truncates spending above certain dollar amounts. OHIC performed a spline regression analysis using Rhode Island's All-Payer Claims Database to determine appropriate per member truncation points for each market based on their respective spending distributions. The per member truncation points are specified in [Appendix A](#).

OHIC uses insurer-reported data to subtract the total spending above the truncation point from the aggregate spend at the insurer and LPE levels, by market.

Truncation should be applied to individuals' total spending, inclusive of all medical and pharmacy spending. [Appendix A](#) details how insurers should submit these data, including examples of how to calculate truncated spending in the context of carved-out populations and services.

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

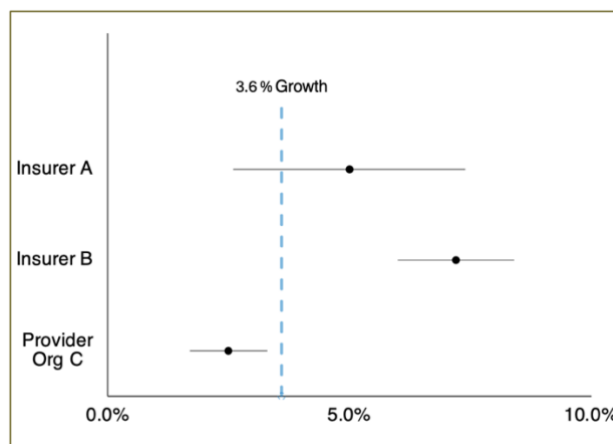
Analyses of Rhode Island cost growth target data showed that the use of diagnosis-based risk scores had a significant impact on some payers' and providers' performance, raising concerns about the distorting nature of the risk scores due to changes and variation in claim coding completeness. To better balance how risk-adjustment is applied at the provider level, OHIC risk-adjusts spending by age and sex to account for the changes in risk profile over a member's lifespan.

OHIC collects data by age/sex bands (defined in [Appendix A](#)) and develops one set of factors that are applied uniformly across all insurers and LPEs within each Insurance Category Code.

Statistical Testing to Determine Performance Against the Target

Given the statistically small population size of some insurers and many Rhode Island providers, OHIC conducts statistical significance testing to assess insurers' and LPEs' performance against the cost growth target. This involves developing confidence intervals around each insurer's and LPE's cost growth and determining whether the confidence interval intersects with the Target. OHIC then categorizes insurers and providers as illustrated below:

- **Confidence interval intersects with Target** – under this circumstance, OHIC is unable to determine whether an insurer or provider entity’s performance did or did not meet the Target (Insurer A in the illustration to the right).
- **Lower confidence interval is over the Target** – this indicates that the insurer or provider entity exceeded the Target (Insurer B in the illustration to the right).
- **Upper confidence interval is fully below the Target** – this indicates that the insurer or provider has achieved the Target (Provider Org C in the illustration above).



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

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

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

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

[Appendix H](#) details how OHIC calculates the confidence intervals.

G. Timeline for Measuring and Reporting the Cost Growth Target

OHIC publishes THCE and TME statistics annually, following a specific timeline to collect and report data. CY 2024 and CY 2025 performance data will be collected in fall 2025 and reported in spring 2027.

Due to the timing of provider settlements, insurers need to annually submit two years’ worth of data: (1) the performance year data (which is the calendar year immediately preceding the year in which TME data are submitted), which should contain insurer estimates of provider settlements; and (2) the TME data for the calendar year prior to the performance year, which is resubmitted to reflect final settlements that were estimated in the prior year’s data submission.

Chapter 3:

Methodology for Assessing Performance Against the Primary Care Expenditure Obligation

OHIC's Affordability Standards, per 230-RICR-20-30-4, directs commercial insurers to annually spend at least 10 percent of their annual medical expenses for all fully insured lines of business on primary care (8 percent through claims-based and capitation payments), phased in starting in 2025, rebased to 2022 data. This chapter describes the methodology for assessing primary care spending for commercial insurers' fully insured lines of business, including which data insurers are required to report and which calculations to perform. This chapter is organized as follows:

- A. Definitions of Key Terms
- B. Methodology for Measuring Primary Care Spending
- C. Data Sources and Specifications for Primary Care Spending and TME
- D. Public Reporting of Primary Care Spending
- E. Timeline for Measuring and Reporting Primary Care Spending
Alignment between the Primary Care Spending Definition and Cost Growth Target Definition

A. Definitions of Key Terms

Claims-based payments: Payments by health insurers to providers based on services provided to a beneficiary. Included services are defined using the primary care payment code list in Appendix F (i.e., for care management; care planning; consultation services; health risk assessments, screening and health behavior counseling; home visits; hospice and home health services; immunization administrations; and office visits and preventive medicine visits).

Measurement year: The measurement year is the calendar year for which performance is measured against the primary care expenditure obligation.

Non-claims-based payments: Payments by health insurers to providers not tied to fee-for-service claims. These include primary care-specific capitated payments, the primary care portion of prospective global budget payments, primary care prospective case rates; primary care prospective episode-based payments; primary care incentive payments made by the health insurer; and payments to support population health management and primary care practice infrastructure at the primary care site of care..

Primary care expenditure obligation: The percentage of spending on total medical expenses, minus long-term care, that is allocated to primary care by commercial insurers for their fully insured lines of business in Rhode Island. Primary care spending is assessed on a calendar year basis. OHIC's Affordability Standards, per 230-RICR-20-30-4, sets a 10 percent target for primary care expenditures (8 percent through claims-based and capitation payments), phased in starting in 2025, rebased to 2022 data.

- In 2025, each health insurer shall increase its annual primary care expenditures as a percentage of its total annual medical expenditures for all insured lines of business by at least one-half of one percentage point above the baseline ratio determined by 2022 data.
- In 2026, and years thereafter, each health insurer shall increase its annual primary care expenditures as a percentage of its total annual medical expenditures for all insured lines of business by at least an additional one percentage point per year such that by the end of 2028, or earlier, each health insurer's total annual primary care expenditures shall be at least an amount calculated as 10.0% of its total annual medical expenditures for all insured lines of business.
- By the end of 2028, or earlier, at least 8% of each health insurer's total annual medical expenditures shall be paid as claims-based payments for primary care services and/or service-based primary care payments under a primary care alternative payment model as defined by OHIC.

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

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

B. Methodology for Measuring Primary Care Spending

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



The following formula is used to calculate performance against the primary care expenditure obligation.

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

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

Defining Specifications for TME

The defining specifications for TME care are as follows:

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

These specifications for the Primary Care Expenditure Obligation are analogous with the TME specifications for the health care cost growth target as outlined in [Chapter 2, Section B](#), with the following exceptions:

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

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

Annually, OHIC directs applicable insurers to submit primary care spending and TME data, less long-term care, using the specifications outlined in [Appendix E](#) and the template provided as **Attachment 2. Table 8** below lists which insurers should report for their commercial fully insured LOBs.

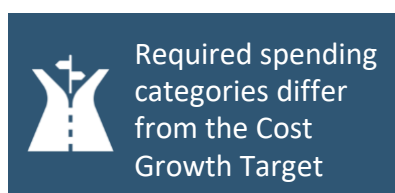


Table 8. Insurers Required to Report Primary Care Spending and TME, Less Long-Term Care, by Market

Insurer	Commercial Fully Insured
Blue Cross Blue Shield of RI	X
Neighborhood Health Plan of RI	X
Harvard Pilgrim Health Care	X
UnitedHealthcare	X
Aetna	
Cigna Healthcare	

OHIC requests insurers to report the following individual services categories, using the definitions found in [Appendix E](#):

- Member Months
- Claims: Professional, Primary Care
- Non-claims: Capitation and Full Risk Payments
- Non-claims: Primary Care Performance Payments
- Non-claims: Primary Care Shared Savings and Shared Risk Settlements
- Non-claims: Payments to Support Population Health and Practice Infrastructure
- Non-claims: Other
- Non-claims: Professional, Primary Care
- Claims: TME, less Long-term Care
- Non-claims: TME, less Long-term Care



OHIC uses the above service categories to calculate and report primary care spending as a percentage of TME, less long-term care, and to calculate claims-based primary care payments and non-claims-based primary care payments.

OHIC requests that insurers submit primary care spending and TME data for their fully insured LOB in aggregate. Insurers **do not** need to report claims-based spending by LPE. In addition, unlike reporting for the cost growth target, insurers **do not** need to apply any adjustments to the

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

D. Public Reporting of Primary Care Spending

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

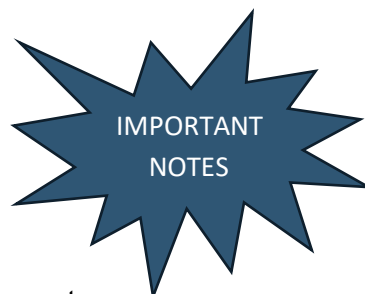


Reporting differs from the Cost Growth Target

E. Timeline for Measuring and Reporting Primary Care Spending

For fall 2025, insurers submitted three reports; one each for each of the following calendar years: January 1, 2022 – December 31, 2022, January 1, 2023 – December 31, 2023, and January 1, 2024 – December 31, 2024.

Beginning in fall 2026, insurers shall submit two primary care expenditure reports each year. **By September 30, 2026, insurers shall submit data for CY 2024 (January 1 – December 31, 2024) and CY 2025 (January 1 – December 31, 2025).**



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

While the methodology for the primary care spending calculation is mostly aligned with the cost growth target methodology, there are some differences between the two. **Table 9** provides a comparison between the two calculations.

Table 9. Comparison of the Primary Care Spending and Cost Growth Target Definitions

Category	Primary Care Expenditure Obligation Definition	Cost Growth Target Definition	Different or Same
Payers expected to report	Commercial payers for fully insured lives only	All payers for all covered lives (i.e., fully and self-insured commercial, Medicaid, Medicare and dual-eligible members)	
Type of spending	Allowed amounts	Allowed amounts	Same

Category	Primary Care Expenditure Obligation Definition	Cost Growth Target Definition	Different or Same
Minimum required lives for reporting	5,000 covered lives (60,000 member months)	5,000 covered lives (60,000 member months)	Same
Secondary payer payments	Excluded	Excluded	Same
Non-claims payment timeframe	Incurred ²³	Incurred	Same
Member residence	Rhode Island residents only	Rhode Island residents only	Same
Provider residence	All providers, regardless of location	All providers, regardless of location	Same
Definition of primary care	Claims-level definition of primary care spending and taxonomy codes to define a primary care provider	Claims-level definition of primary care spending and taxonomy codes to define a primary care provider	Same
Definition of total medical expenses	Includes spending for prescription drugs, behavioral health, laboratory and imaging services. Excludes spending on dental and vision services (beyond those covered by a medical benefit) and long-term care services. ²⁴	Includes spending for prescription drugs, behavioral health, laboratory, imaging, and long-term care services . Excludes spending on dental and vision services (beyond those covered by a medical benefit)	
Reported claims-based spending categories	- Professional, Primary Care - TME, less Long-term Care	- Hospital Inpatient - Hospital Outpatient - Professional, Primary Care - Professional, Specialty Care - Professional Other - Retail Pharmacy - Long-term Care - Other	

²³ If payouts have not been made by the report submission date, insurers should apply reasonable and appropriate estimations of non-claims liability to provider organizations that are expected to be reconciled after the 180-day “run-out” period.

²⁴ Exclusion of long-term care services differs from the cost growth target definition, but is a reasonable divergence given that long-term care spending is primarily attributed to Medicaid. OHIC will still align reporting for the primary care expenditure obligation and cost growth target because long-term care is reported as an individual spending category. Therefore, OHIC can subtract long-term care from total medical expenses reported for the cost growth target to obtain “Total Medical Payments” for the primary care expenditure obligation.

Category	Primary Care Expenditure Obligation Definition	Cost Growth Target Definition	Different or Same
Reported non-claims spending categories	• Capitation and Full Risk Payments • Performance Payments • Shared Savings and Shared Risk Settlements • Payments to Support Population Health and Practice Infrastructure • Other	• Capitation and Full Risk Payments • Performance Payments • Shared Savings and Shared Risk Settlements • Payments to Support Population Health and Practice Infrastructure • Other	Same

Appendix A:

Insurer TME Data Specification

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

A. Definition of Key Terms

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

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

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

Health care cost growth target (Target): The Target is the value by which the Rhode Island Health Care Cost Trends Steering Committee agreed to measure and assess total health care expenditures and total medical expense growth. For 2023-2027, the values represent a 75/25 blend of Rhode Island's Potential Gross State Product (PGSP) and forecast median household income growth. See **Table 1** for the Target values.

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

Large Provider Entity (LPE): A provider organization contracted with one or more payers that, at a minimum, includes primary care providers, and that collectively, during any given calendar year, has enough attributed lives to participate in total cost of care contracts, even if it is not engaged in a total cost of care contract as an ACO or AE.

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

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

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

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

Pharmacy rebates: Any rebates provided by pharmaceutical manufacturers to payers for prescription drugs with specified dates of fill corresponding to the reporting period, excluding manufacturer-provided fair market value bona fide service fees.²⁵ This amount should include pharmacy benefit manager (PBM) rebate guarantee amounts and any additional rebate amounts transferred by the PBM. Pharmacy rebate data should exclude stand-alone prescription drug plans. The computation of TCHE at the state, market and payer level is net of pharmacy rebates (i.e., other expenditures are reduced by the amount of the pharmacy rebates).²⁶

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

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

Risk-adjusted total medical expense: A term that refers to an entity's risk-adjusted, truncated claims spending plus its non-claims spending. OHIC risk-adjusts claims spending using risk

²⁵ Fair market value bona fide service fees are fees paid by a manufacturer to a third party (e.g., insurer, pharmacy benefit manager, etc.) that represent fair market value for a bona fide, itemized service actually performed on behalf of the manufacturer that the manufacturer would otherwise perform (or contract for) in the absence of the service arrangement (e.g., data service fees, distribution service fees, patient care management programs, etc.).

²⁶ CMS is unable to report pharmaceutical rebates for traditional Medicare beneficiaries (i.e., FFS Medicare). Therefore, in the computations of THCE at the state and Medicare market levels, spending is gross of Medicare FFS pharmaceutical rebates.

scores developed using payer-submitted age/sex spending data. Risk-adjusted TME is used to assess performance against the Target at the insurer and LPE levels.

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

Total health care expenditures per member per year: Total health care expenditures (as defined above) divided by the members reported by Rhode Island's payers. The annual change in THCE per member per year is compared to the Target at the state level. THCE is not reported at the market, insurer, or provider levels.²⁷

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

B. TME Submission Schedule

OHIC annually requests TME data file(s) with dates of service during the prior calendar year, and other past years. Insurers will submit TME data using Excel templates provided by OHIC according to the schedule outlined in [Table 10](#) below.

After insurers submit their data according to the filing schedule, they must actively engage with OHIC as it validates the data to ensure such data were submitted using the specifications outlined in this Data Submission Guide. OHIC will engage the insurers one-on-one to discuss the validation of submitted data, an initial analysis of data, and once again to review final data before they are published. Additionally, OHIC requests that insurers engage in data sharing with provider groups to resolve any discrepancies in performance between reported TME and total cost of care or other value-based payment contract data.

Table 10. Insurers' TME Filing Schedule

Date	Files Due
September 30, 2026	CY 2024 and CY 2025
September 30, 2027	CY 2025 and CY 2026
September 29, 2028	CY 2026 and CY 2027

²⁷ NCPHI, a component of THCE, is not reportable at the LPE level. Therefore, THCE is not reported at the LPE level.

C. TME Data Specifications

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

Insurers must include only information pertaining to members:

- who are residents of Rhode Island,
- who, at a minimum, have medical benefits²⁸, and
- for which the insurer is primary on a claim (i.e., exclude any paid claims for which it was the secondary or tertiary insurer, however, do not exclude a member solely because they have additional coverage).

Table 11 below details the policies that insurer include and exclude in their TME reports.

Table 11. Included and Excluded Policies for TME Data Reporting

Included Policies	Excluded policies
Commercial market: • self-insured plans • short-term health plans • student health plans • fully insured individual and group (small and large) plans • the Federal Employee Health Benefits Program (FEHBP)	• accident policy • disability policy • hospital indemnity policy • long-term care insurance • Medicare supplemental insurance (AKA Medigap) • reinsurance policy (recoveries and premiums) • stand-alone prescription drug plans • specific disease policy • stop-loss plans • supplemental insurance that pays deductibles, copays, or coinsurance • vision-only insurance • workers compensation • dental-only insurance
Medicare market: • Medicare Advantage Health Maintenance Organization (HMO) • Preferred Provider Organization (PPO) • HMO Point of Service (HMOPOS) • Medicare Medical Savings Account (MSA) • Private Fee-for-Service (PFFS) • Special Needs Plans (SNPs)	
Medicaid contracts: • Medicaid and CHIP managed care contracts with Rhode Island Medicaid	

²⁸ Members who only have a non-medical benefit should be excluded. Insurers who hold the medical benefit for those members should make estimates of TME for medical benefits and excluding non-medical benefit members would reduce the chance of duplicating the spending of those members.

Member Attribution

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

1. Medicaid:
 - a. Medicaid members who were attributed during the measurement year to an LPE, including AEs.
 - (1) If the member is attributed to an LPE that is a contracted AE, the insurer should use the attribution rules established by EOHHS for the measurement year (MCOs shall submit to AEs and to EOHHS electronic lists of attributed members on a monthly basis).²⁹
 - A. If an insurer is not participating in the AE program, but has a total cost of care contract with an LPE operating as an AE, the insurer should attribute members to the AE.
 - (2) If the member is attributed to a provider in an LPE that is **not** in a risk contract with the insurer, the insurer should use its own primary care attribution methodology to attribute patients to an LPE primary care provider.
 - b. Medicaid members not attributed to an LPE (reported in aggregate).
2. Commercial and Medicare:
 - a. Commercial and Medicare managed care members who were attributed during the measurement year, pursuant to a contract between the insurer and an ACO for financial and quality performance assessment purposes. Members can be attributed monthly, quarterly, annually, or at another frequency, so long as the attribution timing is consistent with the insurer contract.



Note: If a payer has a contract in place during the CY in which the data are reported, the payer should perform attribution consistent with its contract for the time period in which the data are requested. For example, if a Payer A had a contract with Provider X for CY 2025, but not CY 2024, it should still attribute members and spending for CY 2024 to Provider X utilizing the attribution rules established for CY 2025.

- b. Commercial and Medicare managed care members who were attributed during the measurement year to an LPE without an insurer ACO contract. If a member is attributed to a provider in an LPE that is not in a risk contract with an insurer, the insurer should use its own primary care attribution methodology to attribute patients to a primary care provider.
- c. Commercial and Medicare Advantage members not attributed to an LPE (reported in aggregate).

²⁹ See Attachment M: Accountable Entity - Attribution Guidance of the Rhode Island Accountable Entity Program.
<https://eohhs.ri.gov/initiatives/accountable-entities/resource-documents>

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

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

1. TME data applicable to LPEs with attributed members, for which the insurer is contracted, reported by LPE.
2. Member spending not attributable to an LPE, reported in aggregate.

Insurers must include all allowed amounts for all TME data for members, regardless of whether services are provided by providers located in or out of Rhode Island, and regardless of the situs of the member's plan.³⁰

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

Claims Run-Out Period Specifications

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

Non-Claims Payment “Run-Out” Period Specifications

Insurers shall allow for a non-claims “run-out” period of at least 180 days after December 31 of the performance year to reconcile non-claims payments, including incentives, capitation and risk-settlements, or other non-claims-based payments. Insurers should apply reasonable and appropriate estimations of non-claims liability to each LPE Organization ID (including payments expected to be made to organizations not separately identified for TME reporting purposes) that are expected to be reconciled after the 180-day review period. Non-claims payments should be reported on an incurred basis, not paid basis.

³⁰ If the insurer plays claims for another organization's members (e.g., Blue Card members in the Blue Cross Blue Shield network) those members should not be included in TME.

LPE Organization IDs

The following LPEs are to be reported on using the identification number for TME reporting listed in **Table 12**. The table also includes an identification number for reporting on the Insurer Overall, Organization ID 100. This list of LPEs may be updated from time to time as the LPE market changes. The intent is for payers to report on all LPEs (including ACOs and certified AEs) in Rhode Island.



Note: For insurers that did not have contracts with the LPEs listed in **Table 12** below during some or all of the reporting periods, but do so currently as of July 1, 2026, please report TME for past reporting periods using the primary care provider network within the provider contract signed closest to the date of the reporting period. For insurers reporting TME by LPE for reporting periods that were not under contract, please indicate so in the comments box in the HD-TME tab of the reporting file.

Table 12. LPE Identification Numbers

Large Provider Entity	LPE or Insurer Overall Organizational Identification Number for TME Reporting
Insurer Overall	100
Blackstone Valley Community Health Care	101
Integra Community Care Network	103
Integrated Healthcare Partners	104
Providence Community Health Centers	106
Astrana Health ³¹	107
Thundermist Health Center	108
Brown University Health	109
Rhode Island Primary Care Physicians Corporation	110
Southcoast Health	111
Members Not Attributed to an LPE	999

D. TME File Specifications

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

- Contents, which describes the Excel file
- Reference Tables

³¹ Prospect Health was acquired by Astrana Health, Inc. on July 1, 2025. Beginning with the CY2024-2025 data collection cycle, CharterCARE Provider Group of Rhode Island will be reported as Astrana Health.

- Definitions
- HD-TME – 2024, which includes summary data and payer comments
- HD-TME – 2025, which includes summary data and payer comments
- Large Provider Entity – 2024, which includes TME by LPE and insurance category
- Large Provider Entity – 2025, which includes TME by LPE and insurance category
- Primary Care Non-Claims which includes primary care non-claims payments for all lines of business
- Rx Rebates - 2024, which includes pharmacy rebates by insurance category
- Rx Rebates - 2025, which includes pharmacy rebates by insurance category
- LOB Enrollment, which includes detailed member month information for both 2024 and 2025 and request for total premiums earned on self-insured accounts (e.g., income from fees of uninsured plans)
- Standard Deviation – 2024, which includes standard deviation by Large Provider Entity and insurer
- Standard Deviation – 2025, which includes standard deviation by Large Provider Entity and insurer
- Age_Sex Factors 2024, which includes TME and truncated TME by age/sex brackets, insurance categories and Large Provider Entities
- Age_Sex Factors 2025, which includes TME and truncated TME by age/sex brackets, insurance categories and Large Provider Entities
- Mandatory Questions
- Validation by Market
- Validation by Large Provider Entity
- Data Validation

Contents Tab

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

Reference Tables

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

Note: This tab includes a crosswalk of the Non-Claims categories (i.e., original names used for the performance years CY2020 through CY2023 data collection cycles, cross-walked to the revised names).

Definitions

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

HD-TME 2024 and HD-TME 2025 Tabs

Insurer Organization ID: The OHIC-assigned organization ID as outlined in **Table 13** for the insurer submitting the file.³²

Table 13. OHIC-assigned Insurer Organization ID

Insurer	Organizational ID
Blue Cross Blue Shield of RI	201
Neighborhood Health Plan of RI	202
Harvard Pilgrim Health Care (commercial) Tufts Health Public Plans (Medicaid)	203
UnitedHealthcare (commercial and Medicare Advantage) UnitedHealthcare Community Plans (Medicaid)	204
Aetna (commercial) Aetna Medicare (Medicare Advantage)	205
Cigna Healthcare	206

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

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

“Doing Business As:” Insurers must submit all names for which it is “doing business as” in the state of Rhode Island, across all markets.

Large Provider Entity 2024 and Large Provider Entity 2025 Tabs

The Large Provider Entity tabs are the source of the insurer’s expenditure data that is used by OHIC to compute THCE. Insurers will report their permissible claims and non-claims payments in this file.

LPE or Insurer Overall Organization ID: The OHIC Organization ID of the LPE, as listed in **Table 12**. For TME data for members who are unattributed to an LPE, their data are to be reported in aggregate as “Members Not Attributed to an LPE (LPE Identification Number 999).” The table also includes an identification number for reporting on the Insurer Overall, Organization ID 100.

³² This table may need to be updated from time to time as the insurer market in Rhode Island changes.

Insurance Category Code: A number that indicates the insurance category that is being reported, as listed in **Table 14**. All data reported by Insurance Category Code should be mutually exclusive. Commercial claims should be separated into two categories, as shown below. Commercial self-insured or fully insured data for large providers for which the insurer can collect information on all direct medical claims and any claims paid by a delegated entity should be reported in the “Full Claims” category. Commercial self-insured or fully insured data that does not include all medical and subcarrier claims should be reported in the “Partial Claims,” category. An adjustment should be made to “Partial Claims” to allow for them to be comparable to full claims. Such an adjustment must be reviewed with OHIC before the adjustment is made.³³ The goal of the adjustment is to *estimate* what total spending might be for those members without having to collect claims data from carve-out vendors, such as PBMs or behavioral health vendors. For example, for those members for whom pharmacy benefits are carved out, the insurer might include its commercial market book of business average pharmacy spending per-member per-month for the same year, calculated on members who had pharmacy coverage, and applied to all member months for which the carve out applied.

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



Note: If an insurer provides both Medicare and Medicaid benefits to dually eligible beneficiaries through the CMS Financially Aligned Initiative, the insurer should use Insurance Category Code 7 to report applicable expenditures. Any payer with data in Insurance Category Code 7 will submit a reasonable and appropriate estimate of the proportion of Medicare and Medicaid spending within each service category so that OHIC can allocate expenditures to the respective markets for the purposes of analyses. This will allow OHIC to include the Medicare- or Medicaid-related expenditure for dual eligibles in the respective Market for reporting purposes. Insurers should detail the estimate in the comments field of Header Record tab.

Insurers shall report for all insurance categories for which they have business.

³³ Email Charles.Estabrook@ohic.ri.gov with the insurer’s proposed approach for making an actuarial sound adjustment to its Partial Claims.

Table 14. Insurance Category Codes

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

Member Months (annual): The number of unique members participating in a plan each month with a medical benefit, regardless of whether the member has any paid claims. **Member months for members with comprehensive health plans should be non-duplicative between medical benefits and pharmacy benefits.**

Validation check: This tab includes a check to ensure that insurers' member months data submitted in the LPE, Age/Sex, and Standard Deviation tabs align. This check links back to the Data Validation tab.

Claims and Non-Claims Service Categories

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

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

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

Claims: Professional, Primary Care: The TME paid to primary care providers (i.e., family practice, geriatric, internal medicine and pediatric providers defined using taxonomy codes in [Appendix F](#)) delivering care at a primary care site of care (defined below) generated from claims using the following code-level definition found in [Appendix G](#). Insurers should only report primary care spending for clinicians that the plan credentialed as a primary care provider for the given performance year.

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

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. Insurers should use the place of service and modifier codes in the primary care code list in [Appendix F](#) to identify primary care services delivered via telehealth.

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

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

Claims: Retail Pharmacy: The TME paid from claims to health care providers for prescription drugs, biological products and vaccines as defined by the insurer's prescription drug benefit. *This category should **not** include claims paid for pharmaceuticals under the insurer's medical benefit.* Pharmacy spending provided under the medical benefit should be attributed to the location in which it was delivered (e.g., pharmaceuticals delivered in a hospital inpatient setting should be attributed to Claims: Hospital Inpatient). It does not include the cost of vaccines administered in the primary care setting. Medicare managed care, i.e., Medicare Advantage,

insurers that offer stand-alone prescription drug plans (PDPs) should exclude stand-alone PDP data from their TME. Pharmacy data should be reported gross of applicable rebates.

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

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

Non-Claims: Capitation and Full Risk Payments: All non-claims based payments for services delivered under the following payment arrangements: (1) capitation payments, i.e., single payments to providers to provide health care services over a defined period of time;³⁴ (2) global budget payments, i.e., prospective payments made to providers for a comprehensive set of services for a defined patient population or a more narrowly defined set of services where certain benefits (e.g., behavioral health, pharmacy) are carved out;³⁵ (3) case rate payments, i.e., prospective payments made to providers in a given provider organization for a patient receiving a defined set of services for a specific period of time and (4) prospective episode-based payments, i.e., payments received by providers (which can span multiple provider organizations)

³⁴ If the arrangement includes payments for care management, integrated behavioral health, or any other category reported below, include spending for such services within this category.

³⁵ Services typically include primary care services, specialty care services, inpatient hospital services and outpatient hospital services at a minimum. Hospitals and health systems are typically the provider types that would operate under a global budget, although this practice is not widespread.

for a patient receiving a defined set of services for a specific condition across a continuum of care, or care for a specific condition over a specific time period.

Non-Claims: Performance Payments: All payments to reward providers for achieving quality or cost-savings goals. Includes pay-for-performance, i.e., payments to reward providers for achieving a set target (absolute, relative or improvement-based) for quality or efficiency metrics, and pay-for-reporting, i.e., payments to providers for reporting on a set of quality or efficiency metrics, usually to build capacity for pay-for-performance, payments.

Non-Claims: Shared Savings and Shared Risk Settlements: All payments to providers that may be reduced if costs exceed a defined, pre-determined, risk-adjusted target. Includes shared savings distributions, i.e., payments received by providers if costs of services are below a pre-determined, risk-adjusted target, and shared risk recoupments, i.e., payments providers must repay if costs of services are above a pre-determined, risk-adjusted target.

Non-Claims: Payments to Support Population Health and Practice Infrastructure: All payments made to develop provider capacity and practice infrastructure to help coordinate care, improve quality and control costs. Includes, but is not limited to payments that support care management, care coordination and population health;³⁶ electronic health record (EHR)/health information technology (HIT) infrastructure payments and other data analytics payments;³⁷ patient-centered medical home (PCMH) administration payments;³⁸ PCMH recognition payments³⁹ and behavioral health integration, *all of which are not reimbursed through claims.*⁴⁰

Non-Claims: Other: All other payments made pursuant to the insurer's contract with a provider not made on the basis of a claim for health care benefits/services and cannot be properly classified elsewhere. This may include governmental payer shortfall payments, grants or other surplus payments. FQHC wrap payments should be included in this category. Includes all payments for salaries of providers who provide health care services not otherwise included in

³⁶ Includes payments to fund care managers, care coordinators, or other traditionally non-billing practice team members (e.g., practice coaches, patient educators, community health workers, patient navigators) who help providers organize clinics to function better and help patients take charge of their health. It can also include payments to fund the cost of a pharmacist to help practices with medication reconciliation for poly-pharmacy patients.

³⁷ Includes payments to help providers adopt and utilize health information technology, such as electronic medical records and health information exchanges, software that enables primary care practices to analyze quality and / or costs outside of the EHR (e.g., software to track patient costs in near-to-real time) and / or the cost of a data analyst to support practices.

³⁸ Includes payments to support the operations of the Care Transformation Collaborative of Rhode Island (CTC-RI).

³⁹ Includes payments to primary care practices recognized as PCMHs by OHIC to support PCMH transformation and ongoing PCMH-related operations, as described on OHIC's "PCMH Definition and Requirements" website.

⁴⁰ Includes payments that promote the appropriate integration of primary care and behavioral health care that are not reimbursable through claims (e.g., funding behavioral health services not traditionally covered with a discrete payment when provided in a primary care setting, such as a) substance abuse or depression screening, b) performing assessment, referral, and warm hand-off to a behavioral health clinician, and/or c) supporting health behavior change, such as diet and exercise for managing pre-diabetes risk). This category excludes payments for mental health or substance use counseling.

other claims and non-claims categories (typically only applicable to closed delivery systems). Only payments made to providers are to be reported; insurer administrative expenditures (including corporate allocations) are not included in TME.

Total Claims Excluded Because of Truncation: The total claims-based spending truncated using the truncation points listed in Error! Reference source not found. below. This variable is collected by Insurance Category Code for each LPE and for the Insurer Overall.



Table 15. Truncation Points by Insurance Category Codes

Insurance Category Code	Definition	Per Member Truncation Point
1	Medicare & Medicare Managed Care (excluding Medicare/Medicaid Dual Eligibles)	\$185,000
2	Medicaid & Medicaid Managed Care including CHIP (excluding Medicare/Medicaid Dual Eligibles)	\$190,000
3	Commercial — Full Claims	\$170,000
4	Commercial — Partial Claims, Adjusted	\$170,000
5	Medicare Expenditures for Medicare/Medicaid Dual Eligibles	\$185,000
6	Medicaid Expenditures for Medicaid Dual Eligibles	\$190,000
7	Medicare/Medicaid Integrated Duals Product (as of CY 2019 this applies only to the NHPRI Integrity Product)	\$190,000

Count of Members with Claims Truncated: The number of members whose spending was above the truncation threshold. This variable is collected by Insurance Category Code for each LPE and for the Insurer Overall.

Validation Check: This tab includes a calculation of the average truncated claims per member.

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

Validation Check: This tab includes a check to ensure that insurers' truncated and non-truncated spending submitted in the LPE, Age/Sex, and Standard Deviation tabs align. This check links back to the Data Validation tab.

Primary Care Non-Claims Tab

Payers should report primary care non-claims spending data for CY 2024 and CY 2025 using the following categories for all lines of business:



UPDATED REPORTING
REQUIREMENT
BEGINNING WITH
CY2024-CY2025

1. **Capitation and Full Risk Payments:** All non-claims-based payments for services delivered under the following payment arrangements: (1) capitation payments, i.e., single payments to providers to provide health care services over a defined period of time; (2) global budget payments, i.e., prospective payments made to providers for a comprehensive set of services for a defined patient population or a more narrowly defined set of services where certain benefits (e.g., behavioral health, pharmacy) are carved out; (3) case rate payments, i.e., prospective payments made to providers in a given provider organization for a patient receiving a defined set of services for a specific period of time and (4) prospective episode-based payments, i.e., payments received by providers (which can span multiple provider organizations) for a patient receiving a defined set of services for a specific condition across a continuum of care, or care for a specific condition over a specific time period.
2. **Performance Payments:** All payments to reward providers for achieving quality or cost-savings goals, or payments received by providers that may be reduced if costs exceed a defined pre-determined, risk-adjusted target. Includes pay-for-performance, i.e., payments to reward providers for achieving a set target (absolute, relative or improvement-based) for quality or efficiency metrics, and pay-for-reporting, i.e., payments to providers for reporting on a set of quality or efficiency metrics, usually to build capacity for pay-for-performance payments.
3. **Shared Savings and Shared Risk Settlements:** Includes shared savings distributions, i.e., payments received by providers if costs of services are below a pre-determined, risk-adjusted target, and shared risk recoupments, i.e., payments providers must repay if costs of services are above a pre-determined, risk-adjusted target.
4. **Payments to Support Population Health and Practice Infrastructure:** All payments made to develop provider capacity and practice infrastructure to help coordinate care, improve quality and control costs. Includes, but is not limited to payments that support care management, care coordination and population health;⁴¹ patient-centered medical

⁴¹ Includes payments to fund care managers, care coordinators, or other traditionally non-billing practice team members (e.g., practice coaches, patient educators, community health workers, patient navigators) who help providers organize clinics to function better and help patients take charge of their health. It can also include payments to fund the cost of a pharmacist to help practices with medication reconciliation for poly-pharmacy patients.

home (PCMH) administration payments;⁴² PCMH recognition payments⁴³ and behavioral health integration *that are not reimbursable through claims*.⁴⁴

5. **Other:** All other payments made pursuant to the insurer's contract with a provider not made on the basis of a claim for health care benefits/services and cannot be properly classified elsewhere. Only payments made to providers are to be reported; insurer administrative expenditures (including corporate allocations) are not included in TME.

IMPORTANT
NOTE

Insurers should only report payments to provider groups that are exclusively for primary care activities.

Validation check: Total non-claims reported in this tab should be less than or equal to total non-claims reported in the LPE tabs for the respective populations.

Rx Rebates 2024 and Rx Rebates 2025 Tabs

The pharmacy rebate tab is the source of the insurer's pharmacy rebate and is used by OHIC to compute THCE and TME. In reporting trend of service category spending, OHIC reports the retail pharmacy service category net of total pharmacy rebates. Insurers should report their rebate data in this tab.

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

Retail Pharmacy Rebates: The estimated value of rebates attributed to Rhode Island resident members provided by pharmaceutical manufacturers for prescription drugs with specified dates of fill, corresponding to the reporting period excluding manufacturer-provided fair market value bona fide service fees for retail prescription drugs.⁴⁵

⁴² Includes payments to support the operations of the Care Transformation Collaborative of Rhode Island (CTC-RI).

⁴³ Includes payments to primary care practices recognized as PCMHs by OHIC to support PCMH transformation and ongoing PCMH-related operations, as described on OHIC's "PCMH Definition and Requirements" website.

⁴⁴ Includes payments that promote the appropriate integration of primary care and behavioral health care that are not reimbursable through claims (e.g., funding behavioral health services not traditionally covered with a discrete payment when provided in a primary care setting, such as a) substance abuse or depression screening, b) performing assessment, referral, and warm hand-off to a behavioral health clinician, and/or c) supporting health behavior change, such as diet and exercise for managing pre-diabetes risk). This category excludes payments for mental health or substance use counseling.

⁴⁵ Fair market value bona fide service fees are fees paid by a manufacturer to a third party (e.g., insurers, PBMs, etc.) that represent fair market value for a bona fide, itemized service actually performed on behalf of the manufacturer that the manufacturer would otherwise perform (or contract for) in the absence of the service arrangement (e.g., data service fees, distribution service fees, patient care management programs, etc.).

This amount shall include pharmacy benefit manager (PBM) rebate guarantee amounts and any additional rebate amounts transferred by the PBM. Pharmacy rebate data should exclude stand-alone prescription drug plans.

When retail pharmacy rebate data are not available for Insurance Category Code 4 (Commercial Partial Claims), insurers should estimate the rebates using data from Insurance Category Code 3 (Commercial Full Claims). OHIC recommends applying the pharmacy-rebates-to-pharmacy-spending ratio observed in Insurance Category Code 3. Insurers can then apply this ratio to the pharmacy spending within Insurance Category Code 4.

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

When medical pharmacy rebate data are not available for Insurance Category Code 4 (Commercial Partial Claims), insurers should estimate the rebates using data from Insurance Category Code 3 (Commercial Full Claims). OHIC recommends applying the pharmacy-rebates-to-pharmacy-spending ratio observed in Insurance Category Code 3. Insurers can then apply this ratio to the pharmacy spending within Insurance Category Code 4.

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

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

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

Insurers should apply IBNR factors to preliminary prescription drug rebate data to estimate total anticipated rebates related to fill dates in the calendar year for which reporting will be done. If insurers are unable to report rebates specifically for Rhode Island residents, insurers should report estimated rebates attributed to Rhode Island resident members in a proportion equal to the proportion of pharmacy spending for Rhode Island resident members compared to pharmacy spending for total members, by line of business. For example, if Rhode Island resident commercial member spending represent 10% of an insurer's total commercial members, then 10% of the total pharmacy rebates for its commercial book of business should

be reported. If the insurer is unable to identify the percentage of pharmacy spending for Rhode Island resident members, then the insurer should calculate the pharmacy rebates attributable to Rhode Island resident members using percentage of membership. This value should always be reported as a **negative number**.

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

Line of Business Enrollment Tab

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

Line of Business Enrollment Category Code: The code corresponding to the line of business for plans categorized by the insurer as individual, large group – fully insured, small group – fully insured, self-insured, student market, Medicare managed care, and Medicaid/CHIP managed care and Medicare/Medicaid duals. These market enrollment category codes are listed in **Table 16**.

Table 16. Line of Business Enrollment Category Codes

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

Member Months (annual): The number of unique Rhode Island resident members participating in a plan each month with at least a medical benefit, regardless of whether the member has any paid claims. Insurers will submit information for both 2024 and 2025 in this tab. Member months should be calculated by summing the number of months each member was enrolled in a plan with a medical benefit for one calendar year. The total member months reported in this tab should equal the total number of members whose TME is being reported.

Income from Fees of Uninsured Plans: Insurance carriers should report aggregate information on the premiums earned from their self-insured accounts (e.g., “fees from uninsured plans”). Insurers should follow the instructions for Part 1, Line 12 on the NAIC SHCE for their Rhode Island situs self-insured accounts. Insurers must report this for self-insured plans since this is

not typically reported in the SHCE filed with OHIC. Insurers should submit data for both 2024 and 2025.

Standard Deviation 2023 and Standard Deviation 2025 Tabs

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

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

LPE or Insurance Carrier Organization ID: The OHIC-assigned organizational ID of the LPE or insurance carrier submitting the file, as outlined in **Table 12** and **Table 13**, respectively. For TME data for members who are unattributed to an LPE, their data are to be reported in aggregate as "Members Not Attributed to an LPE (LPE Organization ID Number 999)."

Market Code: Codes referring to the Medicare, Medicaid and commercial markets, and combined Insurance Category Codes, as listed in **Table 17** below.

Table 17. Market Codes

Market Code	Description
1	Medicare (Insurance Category Codes 1 and 5)
2	Medicaid (Insurance Category Codes 2 and 6)
3	Commercial (Insurance Category Codes 3 and 4)

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

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

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

Validation Check: This tab includes a check to ensure that insurers' truncated spending submitted in the LPE and Standard Deviation tabs align. This check links back to the Data Validation tab.

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

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

Step 1: Attribute members to the appropriate Large Provider Entity for a specific market. Insurers should include all members attributed to a Large Provider Entity, including members with no utilization.

Step 2: For each market, for each LPE, the insurance carrier must calculate the average monthly spending amount of each member using claims-based allowed amounts (in the Example spreadsheet, the result is in the column, "Average Per Member Month Amount After Applying Truncation"). Insurers should calculate the average claims-based allowed amount after partial claims adjustments and after truncation of member level spending (Claims: Annual Total After Applying Truncation). Non-claims expenditures should be excluded from this average.

Note: The unit of analysis is member months, not individual members. This ensures that the weight of monthly spending for each member is accurately reflected in the average.

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

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

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

Where:

s^2 = sample variance

x_i = value of the one observation

$\bar{x}$ = the mean value of all observations

n = the number of observations (count of member months, not individual members)

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

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

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

Age_Sex Factors 2023 and Age_Sex Factors 2025 Tabs

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

Age Band Code: The code associated with the age band of the members whose spending is being reported. See **Table 18** below.

Table 18. Age Band Codes

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

Sex Band Code: The code associated with the sex of the members whose spending is being reported. See **Table 19** below, as well as guidance for how to handle members without recorded sex information.

Table 19. Sex Band Codes

Sex Code	Description
1	Female
2	Male

How to Handle Members Without Recorded Sex Information

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

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

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

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

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

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

Total Spending After Applying Truncation at the Member Level: The total claims-based spending after truncation attributed to each member participating in a plan each month with a medical benefit consistent with the general cost growth target specifications on how to calculate claims-based spending. The spending in these cells should be *after* member-level truncation is applied using the truncation points listed in Error! Reference source not found above. **Do not**

include any non-claims spending categories. *Validation check: the sum of all age/sex bands for this variable across all LPE IDs within one Insurance Category Code will not necessarily equal the sum of the reported truncated spending reported in the Age_Sex_ICC tab because truncation is applied at a per-member level and “reset” for members who are attributed to more than one LPE during the calendar year. See below for more information.*

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

How to Handle When Members Can Be Attributed to More than One LPE During the CY.

Example with a \$170,000 truncation point:

- Member in Insurance Category Code 3 was attributed to LPE X for 8 months with \$200,000 in claims.
- Member is then attributed to LPE Y for 4 months with \$185,000 in claims.
- LPE X’s spending above the truncation would be \$30,000 while LPE’s Y spending above the truncation would be \$15,000.
- Since the member cost the payer \$385,000 in total, the total dollars above the truncation point for the payer would be \$215,000.

For insurers reporting in Insurance Category Code 4 (Partial Claims, Adjusted), the member-level truncation should be applied *after* estimates of carve-out spending have been made, so

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

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

Calculate Rx PMPM for Insurance Category 4

[A]	Insurance Category 3 Rx PMPM	\$100	
[B]	Insurance Category 3 Risk Score	1.23	
[C]	Insurance Category 4 Risk Score	1.44	
[D]	Insurance Category 4 Rx PMPM	\$117	$[A] \div [B] \times [C]$

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

that truncation is being applied to an estimate of individual members' total claims spending.
(See inset below for example calculation.)

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

Mandatory Questions Tab

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

Validation by Market Tab

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

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

Validation by LPE Tab

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

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

Data Validation Tab

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

Insurers do not need to input any data in this tab but must review them prior to submitting and either correct or explain any areas of misalignment in the data.

File Submission

Naming Conventions

Data submissions should follow the following naming conventions:

Insurer Name_TME_YYYY_Version.xls

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

Version is optional and indicates the insurer's submission number.

The file extension must be .xls or .xlsx.

Below are examples of valid file names:

TME_2025_01.xlsx or TME_2025_1.xlsx or TME_2025.xlsx.

Submitting Files to OHIC

Electronic files are to be submitted to Charles.Estabrook@ohic.ri.gov.

Appendix B:

EOHHS TME Data Specification

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

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

Much of the data should come from the MMIS system managed by Gainwell Technologies, however, some of the data should come from internal EOHHS reports such as the Medicaid Expenditure report. The table below identifies the source of data. To begin the process of collecting EOHHS FFS data, contact Kimberly Pelland Kimberly.Pelland@ohhs.ri.gov, Deputy Director of Medicaid Finance and Policy and Dezeree Hodish, Associate Director of Financial Management.

Table 20 outlines types of spending for EOHHS to include in its TME data submission.

Table 20. TME Data to Include in EOHHS' Data Submission

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

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

EOHHS data submission should not include:

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

OHIC may periodically update and revise these data specifications in subsequent versions of this Data Submission Guide.

TME File Submission Instructions and Schedule

EOHHS should submit Excel files of its data using the templates provided by OHIC. **Table 21** outlines the schedule for EOHHS to submit TME information on an annual basis.

Table 21. EOHHS' TME Filing Schedule

Date	Files Due
September 30, 2026	CY 2024 and CY 2025
September 30, 2027	CY 2025 and CY 2026
September 29, 2028	CY 2026 and CY 2027

TME Data Submission

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

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

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

Claims Run-Out Period Specifications

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

TME Data File Field Definitions

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

Header Tab Field Definitions

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

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

Spending by Program Code Record File Field Definitions

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

Program Code/Aid Eligibility Code: A code that indicates the program or nature of EOHHS TME data that are being reported, as listed in **Table 22**.

Table 22. EOHHS Program Codes / Aid Eligible Codes

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

Member Months (annual): The number of members for which EOHHS is reporting TME data, expressed in member months. EOHHS should report member months with two values: 1) total Medicaid enrollment (includes fee-for-service beneficiaries, managed care members, and full duals members), and 2) a count of full duals members only. OHIC should remove the count of full duals from the total count in its analyses.

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

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

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

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

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

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

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

Claims: Professional Other: The TME paid from claims to health care providers for services provided by a licensed practitioner other than a physician or identified as a primary care provider. This includes, but is not limited to, licensed podiatrists, nurse practitioners, physician assistants, physical therapists, occupational therapists, speech therapists, psychologists, licensed clinical social workers, counselors, dietitians, dentists, chiropractors and any professional fees that do not fit other categories. It also includes services delivered through

third-party telehealth vendors contracted directly through the insurer to offer a subset of services.

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

Claims: Long-Term Care: All TME data from claims to providers for: (1) nursing homes and skilled nursing facilities; (2) intermediate care facilities for individuals with intellectual disability (ICF/ID) and assisted living facilities; and (3) providers of home- and community-based services, including personal care (e.g., assistance with dressing, bathing, eating, etc.), homemaker and chore services, home-delivered meal programs, home health services, adult daycare, self-directed personal assistance services (e.g., assistance with grocery shopping, etc.), and programs designed to assist individuals with long-term care needs who receive care in their home and community, such as PACE and Money Follows the Person. Does not include payments made for professional services rendered during a facility stay that have been billed directly by a physician group practice or an individual practitioner. EOHHS should classify the following "type" codes listed in **Table 23** as long-term care and include spending associated with those codes in this category.

Table 23. Long-term Care Health Care Providers and Associated "Type Codes"

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

Claims: Other: All TME paid from claims to health care providers for medical services not otherwise included in other categories. Includes, but is not limited to, durable medical equipment, freestanding fees of community health center services, free standing ambulatory surgical center services, hospice facility, freestanding diagnostic facility services, hospice,

hearing aid services and optical services. It also includes the cost of vaccines administered in the primary care setting. Payments made to members for direct reimbursement of health care benefits/services may be reported in “Claims: Other” if the insurer is unable to classify the service. If this is the case, the insurer should consult with OHIC about the appropriate placement of the service prior to categorizing it as “Claims: Other.” However, TME data for non-health care benefits/services, such as fitness club reimbursements, are not to be reported in any category. Payments for fitness club membership discounts whether given to the provider or given in the form of a capitated payment to an organization that assists the insurer with enrolling members in gyms is not a valid payment to include.

Non-Claims: Capitation and Full-Risk Payments: All non-claims based payments for services delivered under the following payment arrangements: (1) capitation payments, i.e., single payments to providers to provide health care services over a defined period of time;⁴⁶ (2) global budget payments, i.e., prospective payments made to providers for a comprehensive set of services for a defined patient population or a more narrowly defined set of services where certain benefits (e.g., behavioral health, pharmacy) are carved out;⁴⁷ (3) case rate payments, i.e., prospective payments made to providers in a given provider organization for a patient receiving a defined set of services for a specific period of time and (4) prospective episode-based payments, i.e., payments received by providers (which can span multiple provider organizations) for a patient receiving a defined set of services for a specific condition across a continuum of care, or care for a specific condition over a specific time period.

Non-Claims: Performance Incentive Payments: All payments to reward providers for achieving quality or cost-savings goals. Includes pay-for-performance, i.e., payments to reward providers for achieving a set target (absolute, relative or improvement-based) for quality or efficiency metrics, and pay-for-reporting, i.e., payments to providers for reporting on a set of quality or efficiency metrics, usually to build capacity for pay-for-performance, payments.

Non-Claims: Shared Savings and Shared Risk Settlements: All payments to providers that may be reduced if costs exceed a defined, pre-determined, risk-adjusted target. Includes shared savings distributions, i.e., payments received by providers if costs of services are below a pre-determined, risk-adjusted target, and shared risk recoupments, i.e., payments insurers must recoup from providers if costs of services are above a pre-determined, risk-adjusted target.

Non-Claims: Payments to Support Population Health and Practice Infrastructure: All payments made to develop provider capacity and practice infrastructure to help coordinate care, improve quality and control costs. Includes, but is not limited to payments that support

⁴⁶ If the arrangement includes payments for care management, integrated behavioral health, or any other category reported below, include spending for such services within this category.

⁴⁷ Services typically include primary care services, specialty care services, inpatient hospital services and outpatient hospital services at a minimum. Hospitals and health systems are typically the provider types that would operate under a global budget, though this is not widespread.

care management, care coordination and population health⁴⁸; EHR/HIT infrastructure payments and other data analytics payments;⁴⁹ patient-centered medical home (PCMH) administration payments;⁵⁰ PCMH recognition payments⁵¹ and behavioral health integration *that are not reimbursable through claims*.⁵²

Non-Claims: Other: All other payments made pursuant to the insurer’s contract with a provider not made on the basis of a claim for health care benefits/services and cannot be properly classified elsewhere. This may include governmental payer shortfall payments, grants or other surplus payments. FQHC wrap payments should be included in this category. The category also includes all payments for salaries of providers who provide health care services not otherwise included in other claims and non-claims categories (typically only applicable to closed delivery systems). Only payments made to providers are to be reported; EOHHS administrative expenditures (including corporate allocations) are not included in TME.

Pharmacy Rebate Tab

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

Rebate Program Code: A code that indicates the source of the pharmacy claims data for which the pharmacy rebates are attributed, as outlined in **Table 24**.

Table 24. Pharmacy Rebate Program Codes

Rebate Program Code	Definition
1	Managed care pharmacy rebates
2	Fee-for-service pharmacy rebates

⁴⁸ Includes payments to fund care managers, care coordinators, or other traditionally non-billing practice team members (e.g., practice coaches, patient educators, community health workers, patient navigators) who help providers organize clinics to function better and help patients take charge of their health. It can also include payments to fund the cost of a pharmacist to help practices with medication reconciliation for poly-pharmacy patients.

⁴⁹ Includes payments to help providers adopt and utilize health information technology, such as electronic medical records and health information exchanges, software that enables primary care practices to analyze quality and / or costs outside of the EHR (e.g., software to track patient costs in near-to-real time) and / or the cost of a data analyst to support practices.

⁵⁰ Includes payments to support the operations of the Care Transformation Collaborative of Rhode Island (CTC-RI).

⁵¹ Includes payments to primary care practices recognized as PCMHs by OHIC to support PCMH transformation and ongoing PCMH-related operations, as described on OHIC’s “PCMH Definition and Requirements” website.

⁵² Includes payments that promote the appropriate integration of primary care and behavioral health care that are not reimbursable through claims (e.g., funding behavioral health services not traditionally covered with a discrete payment when provided in a primary care setting, such as a) substance abuse or depression screening, b) performing assessment, referral, and warm hand-off to a behavioral health clinician, and/or c) supporting health behavior change, such as diet and exercise for managing pre-diabetes risk). This category excludes payments for mental health or substance use counseling.

Rebate Program Code	Definition
3	Managed care – J Code rebate ⁵³
4	Fee-For-Service – J Code rebate

Retail Pharmacy Rebates: The estimated or actual value of total federal and state supplemental rebates attributed to Rhode Island resident members provided by pharmaceutical manufacturers for prescription drugs with specified dates of fill, corresponding to the reporting period excluding manufacturer-provided fair market value bona fide service fees for retail prescription drugs.⁵⁴

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

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

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

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

Total rebates should be reported without regard to how they are paid to EOHHS (e.g., through regular aggregate payments, on a claims-by-claim basis, etc.).

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

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

⁵³ A J-Code rebate is a pharmaceutical rebate the State receives for facility-based pharmaceuticals, and not for retail pharmacy. EOHHS typically credits J-Code rebates to hospital outpatient spending.

⁵⁴ Fair market value bona fide service fees are fees paid by a manufacturer to a third party (e.g., insurers, PBMs, etc.) that represent fair market value for a bona fide, itemized service actually performed on behalf of the manufacturer that the manufacturer would otherwise perform (or contract for) in the absence of the service arrangement (e.g., data service fees, distribution service fees, patient care management programs, etc.).

Appendix C:

Medicare FFS TME Data Specification

OHIC receives TME and enrollment data from Medicare FFS annually by September 1 of the year following the measurement period (e.g., 2025 data will be available September 1, 2026). CMS believes that data are at least 90% complete by September 1.

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

- Hospital inpatient
- Hospital outpatient
- Non-hospital outpatient
- Home health agency
- Hospice
- Skilled nursing facility
- Physician
- Other professionals
- Durable medical equipment
- Other suppliers
- Part D⁵⁵

Table 25 maps CMS' service categories to the TME reporting categories.

Table 25. Mapping of CMS Medicare Service Categories to TME Service Mapping

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

⁵⁵ As part of the TME data received from CMS, CMS provides OHIC Part D data for individuals enrolled in FFS stand-alone PDPs as well as Medicare managed care enrollees in MAPD or MA-only plans.

Medicare Service Categories	TME Service Mapping
Other Suppliers	Other
Part D	Retail Pharmacy

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

To receive Medicare FFS TME data from CMS, EOHHS needs to make a formal request to the CMS IPAG Data Products Team (ipag_data_products@cms.hhs.gov). **Please note, CMS has specifically requested that Rhode Island staff (not a contractor) make the official request.**

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

Appendix D:

NCPHI Data Specification

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

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

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

The federal commercial medical loss ratio (MLR) reports is used to calculate NCPHI for the commercial fully insured market and are requested from insurers as part of their TME data submission, or obtained from CMS Center for Consumer Information and Oversight (CCIIO).⁵⁶ These reports become publicly available in the fall, but are requested from insurers when they submit their TME data in order to meet the reporting timeline. In an instance in which the MLR report submitted to OHIC on the TME deadline differs from the final submission an insurer makes to CCIIO, the insurer must notify OHIC in writing as soon as possible. To calculate NCPHI applicable for Rhode Island residents, OHIC calculates the NCPHI using situs-based information before applying it to Rhode Island residents. Doing so assumes that the cost of administering private health insurance is the same for Rhode Island residents as it is for providing it to employers whose employees are not Rhode Island residents. This calculation must be performed for each insurer. The data elements that are used in the calculation are detailed below:

⁵⁶ Available at: www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html.

Commercial Fully Insured NCPHI =

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

Situs-Based Commercial Fully Insured NCPHI PMPM =
$$\frac{\text{Commercial Fully-Insured NCPHI}}{\text{Member Months as reported on the MLR}}$$
RI Resident-Based Commercial Fully Insured NCPHI =

*Situs-based Commercial Fully Insured NCPHI PMPM * Member Months as reported on the Market Enrollment tab of the TME Data⁵⁷*

Medicare Advantage

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

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

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

Medicare Advantage NCPHI =

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

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

⁵⁷ OHIC does not use the member months that are reported on the MLR or SHCE forms as those forms are based on in situ information, whereas the cost growth target is intended to capture Rhode Island residents. By using member months reported by market segment within the TME data, OHIC assumes that the experience of the insurer across all of its Rhode Island business (regardless of whether it insures a member from another state) is the same experience as for Rhode Island residents.

Medicaid MCO Market

OHIC uses data obtained from EOHHS to derive NCPHI of the Medicaid MCO market for all Medicaid managed care products.⁵⁸ The formula is included below:

Medicaid MCO NCPHI =

Health Premiums Earned - Total Incurred Claims

Medicaid MCO NCPHI PMPM =

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

Self-Insured Market

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

Self-Insured NCPHI =

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

Situs-Based Self-Insured NCPHI PMPM =

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

⁵⁸ This formula is not applicable to NHPRI. For NHPRI, it is due to the inclusion of its Financial Aligned Initiative Medicare and Medicaid dual eligible product (Integrity). Data to calculate NCPHI for all of NHPRI's products must be obtained from the financial statements submitted to the Department of Business Regulation. These forms can be obtained by OHIC from Ted Hurley, Insurance Examiner-In-Charge (Ted.Hurley@dbr.ri.gov).

RI Resident-Based Self-Insured NCPHI =

*Situs-Based Self-Insured NCPHI PMPM * Member Months as reported on the LOB Enrollment tab of the TME Data⁵⁹*

Table 26 provides the columns associated with each line of business/market in the SHCE and the MLR reports.

Table 26. Columns Associated with each Line of Business in SHCE and MLR Reports

Line of Business	SHCE Column	MLR Column (Parts 1 and 2)	MLR Column (Part 3)
Individual	N/A	2	4
Small Group, Fully Insured	N/A	7	8
Large Group, Fully Insured	N/A	12	12
Student	N/A	36	36
Medicare Advantage and PDP	12	N/A	N/A
Medicaid MCO	N/A	N/A	N/A
Self-Insured	14	N/A	N/A

⁵⁹ OHIC does not use the member months that are reported on the MLR or SHCE forms as those forms are based on in situ information, whereas the cost growth target is intended to capture Rhode Island residents. By using member months reported by market segment within the TME data, OHIC assumes that the experience of the insurer across all of its Rhode Island business (regardless of whether it insures a member from another state) is the same experience as for Rhode Island residents.

Appendix E:

Insurer Primary Care Expenditure Obligation Data Specification

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

A. Definition of Key Terms

Claims-based payments: Payments by health insurers to providers based on services provided to a beneficiary. Included services are defined using the primary care payment code list in [Appendix F](#) (i.e., for care management; care planning; consultation services; health risk assessments, screening and health behavior counseling; home visits; hospice and home health services; immunization administrations; and office visits and preventive medicine visits).

Measurement year: The measurement year is the calendar year for which performance is measured against the primary care expenditure obligation.

Non-claims-based payments: Payments by health insurers to providers not tied to fee-for-service claims. These include primary care-specific capitated payments, the primary care portion of prospective global budget payments, primary care prospective case rates, or primary care prospective episode-based payments; primary care incentive payments made by the health insurer; payments to support population health management and primary care practice infrastructure at the primary care site of care; primary care provider salaries, and recoveries.

Primary care expenditure obligation: The percentage of spending on total medical expenses, minus long-term care, that is allocated to primary care by commercial insurers for their fully insured lines of business in Rhode Island. Primary care spending is assessed on a calendar year basis. OHIC's Affordability Standards, per 230-RICR-20-30-4, sets a 10 percent target for primary care expenditures (8 percent through claims-based and capitation payments), phased in starting in 2025, rebased to 2022 data.

- In 2025 each health insurer shall increase its annual primary care expenditures as a percentage of its total annual medical expenditures for all insured lines of business by at least one-half of one percentage point above the baseline ratio determined by 2022 data.
- In 2026, and years thereafter, each health insurer shall increase its annual primary care expenditures as a percentage of its total annual medical expenditures for all insured lines of business by at least an additional one percentage point per year such that by the end

of 2028, or earlier, each health insurer's total annual primary care expenditures shall be at least an amount calculated as 10.0% of its total annual medical expenditures for all insured lines of business.

- By the end of 2028, or earlier, at least 8% of each health insurer's total annual medical expenditures shall be paid as claims-based payments for primary care services and/or service-based primary care payments under a primary care alternative payment model as defined by OHIC.

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

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

B. Primary Care Expenditure Obligation Submission Schedule

Insurers will submit primary care spending and TME spending, less long-term care, using Excel templates (**Attachment 2**) provided by OHIC according to the schedule outlined below. **Table 27** outlines insurers' primary care spending filing schedule.

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

Table 27. Insurers' Primary Care Spending Filing Schedule

Date	Files Due
September 30, 2025	CY 2022, CY 2023, and CY 2024
September 30, 2026	CY 2024 and CY 2025
September 30, 2027	CY 2025 and CY 2026
September 29, 2028	CY 2026 and CY 2027

C. Primary Care Expenditure Obligation Data Specifications

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

Insurers must include only information pertaining to members:

- who are residents of Rhode Island,
- who, at a minimum, have medical benefits,⁶⁰ and
- for which the insurer is primary on a claim (exclude any paid claims for which it was the secondary or tertiary insurer), however do not exclude a member solely because they have additional coverage.

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

Insurers must include all allowed amounts for all TME data for members, regardless of whether services are provided by providers located in or out of Rhode Island, and regardless of the situs of the member's plan.⁶¹

Claims Run-Out Period Specifications

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

Non-Claims Payment “Run-Out” Period Specifications

Insurers shall allow for a non-claims “run-out” period of at least 180 days after December 31 of the performance year to reconcile non-claims payments, including incentives, capitation and risk-settlements, or other non-claims-based payments. Insurers should apply reasonable and appropriate estimations of non-claims liability to each LPE ID (including payments expected to

⁶⁰ Members who only have a non-medical benefit should be excluded. Insurers who hold the medical benefit for those members make estimates of TME for medical benefits and excluding non-medical benefit members would reduce the chance of duplicating the spending of those members.

⁶¹ If the insurer plays claims for another organization's members (e.g., Blue Card members in the Blue Cross Blue Shield network) those members should not be included in TME.



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

D. Primary Care Expenditure Obligation File Specifications

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

- Contents, which describes the Excel file
- Definitions
- Reference Tables
- HD-PC Spend, which includes summary data and payer comments
- Primary Care Spending, which includes primary care spending and TME, less long-term care for the fully insured LOB
- Non-claims – LPE1, which includes tables for insurers to allocate non-claims-based spending to primary care for one LPE
- Non-claims – LPE2, which includes tables for insurers to allocate non-claims-based spending to primary care for a second LPE
- Non-claims – LPE3, which includes tables for insurers to allocate non-claims-based spending to primary care for a third LPE
- Non-claims – LPE4, which includes tables for insurers to allocate non-claims-based spending to primary care for a fourth LPE
- Non-claims – LPE5, which includes tables for insurers to allocate non-claims-based spending to primary care for a fifth LPE
- Non-claims – LPE6, which includes tables for insurers to allocate non-claims-based spending to primary care for a sixth LPE
- Non-claims – LPE7, which includes tables for insurers to allocate non-claims-based spending to primary care for a seventh LPE
- Non-claims – LPE8, which includes tables for insurers to allocate non-claims-based spending to primary care for an eighth LPE
- Non-claims – LPE9, which includes tables for insurers to allocate non-claims-based spending to primary care for a ninth LPE
- Non-claims – All Other, which includes tables for insurers to allocate non-claims-based spending to primary care for all other provider organizations
- Mandatory Questions

Contents Tab

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

Definitions

This tab includes definitions outlined herein for ease of reference.

Reference Tables

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

HD-PC Spending

Insurer Organization ID: The OHIC assigned organization ID for the insurers submitting the file, as outlined in **Table 28**.

Table 28. Insurers Required to Report Primary Care Expenditure Obligation for Fully Insured Business

Insurer	Organizational ID
Blue Cross Blue Shield of RI	201
Neighborhood Health Plan of RI	202
Harvard Pilgrim Health Care	203
UnitedHealthcare	204
Aetna	205
Cigna Healthcare	206

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

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

Primary Care Spending Tab

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

Insurer Organization ID: The OHIC-assigned organization ID for the insurer submitting the file, as outlined in **Table 28**.

Member months: The number of unique members participating in a plan each month with a medical benefit, regardless of whether the member has any paid claims. Member months

should be calculated by summing the number of months during the calendar year each member was enrolled in a plan with a medical benefit.

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



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

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

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

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

1. **Capitation and Full Risk Payments:** All non-claims based payments for services delivered under the following payment arrangements: (1) capitation payments, i.e., single payments to providers to provide health care services over a defined period of time; (2) global budget payments, i.e., prospective payments made to providers for a comprehensive set of services for a defined patient population or a more narrowly defined set of services where certain benefits (e.g., behavioral health, pharmacy) are carved out; (3) case rate payments, i.e., prospective payments made to providers in a given provider organization for a patient receiving a defined set of services for a specific

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

2. **Performance Payments:** All payments to reward providers for achieving quality or cost-savings goals, or payments received by providers that may be reduced if costs exceed a defined pre-determined, risk-adjusted target. Includes pay-for-performance, i.e., payments to reward providers for achieving a set target (absolute, relative or improvement-based) for quality or efficiency metrics, and pay-for-reporting, i.e., payments to providers for reporting on a set of quality or efficiency metrics, usually to build capacity for pay-for-performance, payments.
3. **Shared Savings and Shared Risk Settlements:** Includes shared savings distributions, i.e., payments received by providers if costs of services are below a pre-determined, risk-adjusted target, and shared risk recoupments, i.e., payments providers must repay if costs of services are above a pre-determined, risk-adjusted target.
4. **Payments to Support Population Health and Practice Infrastructure:** All payments made to develop provider capacity and practice infrastructure to help coordinate care, improve quality and control costs. Includes, but is not limited to payments that support care management, care coordination and population health,⁶² EHR/HIT infrastructure payments and other data analytics payments,⁶³ patient-centered medical home (PCMH) administration payments,⁶⁴ PCMH recognition payments⁶⁵ and behavioral health integration *that are not reimbursable through claims*.⁶⁶
5. **Other:** All other payments made pursuant to the insurer's contract with a provider not made on the basis of a claim for health care benefits/services and cannot be properly classified elsewhere. This may include governmental payer shortfall payments, grants or

⁶² Includes payments to fund care managers, care coordinators, or other traditionally non-billing practice team members (e.g., practice coaches, patient educators, community health workers, patient navigators) who help providers organize clinics to function better and help patients take charge of their health. It can also include payments to fund the cost of a pharmacist to help practices with medication reconciliation for poly-pharmacy patients.

⁶³ Includes payments to help providers adopt and utilize health information technology, such as electronic medical records and health information exchanges, software that enables primary care practices to analyze quality and / or costs outside of the EHR (e.g., software to track patient costs in near-to-real time) and / or the cost of a data analyst to support practices.

⁶⁴ Includes payments to support the operations of the Care Transformation Collaborative of Rhode Island (CTC-RI).

⁶⁵ Includes payments to primary care practices recognized as PCMHs by OHIC to support PCMH transformation and ongoing PCMH-related operations, as described on OHIC's "PCMH Definition and Requirements" website.

⁶⁶ Includes payments that promote the appropriate integration of primary care and behavioral health care that are not reimbursable through claims (e.g., funding behavioral health services not traditionally covered with a discrete payment when provided in a primary care setting, such as a) substance abuse or depression screening, b) performing assessment, referral, and warm hand-off to a behavioral health clinician, and/or c) supporting health behavior change, such as diet and exercise for managing pre-diabetes risk). This category excludes payments for mental health or substance use counseling.

other surplus payments. Only payments made to providers are to be reported; insurer administrative expenditures (including corporate allocations) are not included in TME.

Important Note: Insurers should only report payments to provider groups that are exclusively for primary care activities.

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

1. ***Hospital Inpatient:*** The TME paid to hospitals for inpatient services generated from claims. Includes all room and board and ancillary payments. Includes all hospital types. Includes payments for emergency room services when the member is admitted to the hospital, in accordance with the specific payer's payment rules. Does not include payments made for observation services. Does not include payments made for physician services provided during an inpatient stay that have been billed directly by a physician group practice or an individual physician. Does not include inpatient services at non-hospital facilities.
2. ***Hospital Outpatient:*** The TME paid to hospitals for outpatient services generated from claims. Includes all hospital types and includes payments made for hospital-licensed satellite clinics. Includes emergency room services not resulting in admittance. Includes observation services. Does not include payments made for physician services provided on an outpatient basis that have been billed directly by a physician group practice or an individual physician.
3. ***Professional, Primary Care:*** The TME paid to primary care providers delivering care at a primary care site of care generated from claims, as described in [Appendix A](#). Insurers should only report primary care spending for clinicians that the plan credentialed as a primary care provider for the given performance year.
4. ***Professional, Specialty Care:*** The TME paid to physicians or physician group practices generated from claims. Includes services provided by a doctors of medicine or osteopathy in clinical areas other than the family practice, geriatric, internal medicine and pediatric providers described above, who have not been defined by the insurer as a primary care provider for the given performance year.
5. ***Professional Other:*** The TME paid from claims to health care providers for services provided by a licensed practitioner other than a physician or identified as a primary care provider. This includes, but is not limited to, licensed podiatrists, nurse practitioners, physician assistants, physical therapists, occupational therapists, speech therapists, psychologists, licensed clinical social workers, counselors, dietitians, dentists, chiropractors and any professional fees that do not fit other categories. It also includes

services delivered through third-party telehealth vendors contracted directly through the insurer to offer a subset of services.

6. **Retail Pharmacy:** The TME paid from claims to health care providers for prescription drugs, biological products or vaccines as defined by the insurer's prescription drug benefit. *This category should not include claims paid for pharmaceuticals under the insurer's medical benefit.* Pharmacy spending provided under the medical benefit should be attributed to the location in which it was delivered (e.g., pharmaceuticals delivered in a hospital inpatient setting should be attributed to Claims: Hospital Inpatient). It does not include the cost of vaccines administered in the primary care setting. Medicare managed care, i.e., Medicare Advantage, insurers that offer stand-alone prescription drug plans (PDPs) should exclude stand-alone PDP data from their TME. Pharmacy data should be reported gross of applicable rebates.
7. **Other:** All TME paid from claims to health care providers for medical services not otherwise included in other categories. Includes, but is not limited to durable medical equipment, freestanding fees of community health center services, free standing ambulatory surgical center services, hospice facility, freestanding diagnostic facility services, hospice, hearing aid services and optical services. It also includes the cost of vaccines administered in the primary care setting. Payments made to members for direct reimbursement of health care benefits/services may be reported in "Claims: Other" if the insurer is unable to classify the service. If this is the case, the insurer should consult with OHIC about the appropriate placement of the service prior to categorizing it as "Claims: Other." However, TME data for non-health care benefits/services, such as fitness club reimbursements, are not to be reported in any category. Payments for fitness club membership discounts whether given to the provider or given in the form of a capitated payment to an organization that assists the insurer with enrolling members in gyms is not a valid payment to include.

Non-Claims: Total Medical Expenses, less Long-term Care: All non-claims-based payments, excluding non-claims payments made for long-term care. *This should be a sum of the total non-claims-based spending, less long-term care, reported in the individual LPE tabs.* It should include the following categories of non-claims-based spending, as described earlier: (1) Capitation and Full-Risk Payments, (2) Performance Payments, (3) Shared Savings and Shared Risk Settlements, (4) Payments to Support Population Health and Practice Infrastructure, and (5) Other. It also includes non-primary care, non-claims-based spending.

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

Medical Expenses, less Long-term Care” should be less than spending reported under the sum of all the “Non-Claims” categories for Insurance Category Codes 3 and 4 in the insurer’s TME submission.

Non-Claims – LPE Tabs

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



Reporting tab not found in the Cost Growth Target specifications

Insurers shall apply a default percentage to each non-claims-based payment subcategory to determine the primary care portion of non-claims-based payments to provider organizations that include primary care providers. To develop the default percentages, OHIC sent a survey to the major system of care organizations (that include primary care providers in part, but not in whole) in the state in 2025 to identify what percentage of non-claims-based payments are given to primary care providers. OHIC used these data to develop one set of statewide default percentages, as the major systems of care requested that these percentages remain confidential. Insurers can use the statewide default percentages to **estimate** their total primary care spending as a percentage of TME, less long-term care. OHIC will update the default percentages to align with the percentages submitted by each system of care in response to the survey to calculate a final, more accurate value of primary care spending for each insurer.

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

**IMPORTANT
NOTE**

- **For LPEs that exclusively include primary care providers (i.e., RIPCPC):** Report all non-claims-based spending as primary care non-claims-based spending in the orange-highlighted cells in column D of **Table 1** in **Attachment 2**.
- **For systems of care that include primary care providers in part, but not in whole (i.e., Astrana Health, Blackstone Valley Community Health Care, Brown University Health, Integra Community Care Network, Integrated Healthcare Partners,**

Providence Community Health Centers, Southcoast Health, and Thundermist Health Center): Report all non-claims-based spending as total non-claims-based spending in the orange-highlighted cells in column F of Table 2 in **Attachment 2**. The spreadsheet will then automatically calculate an **estimate** of primary care non-claims-based spending and non-primary care non-claims-based spending using the default percentages in column C. OHIC will update the percentages for each system of care after submission to calculate a final value of primary care spending for each insurer.

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

Mandatory Questions Tab

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

File Submission

Naming Conventions

Data submissions should follow the following naming conventions:

Insurer Name_TME_YYYY_Version.xls

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

Version is optional and indicates the insurer's submission number.

The file extension must be .xls or .xlsx.

Below are examples of valid file names:

PCSpend_2025_01.xlsx or PCSpend_2025_1.xlsx or PCSpend_2025.xlsx.

Submitting Files to OHIC

Electronic files are to be submitted to Charles.Estabrook@ohic.ri.gov.

Appendix F:

Primary Care Specialties Provider Taxonomy Codes and Place of Service Codes

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



Table 29. Primary Care Specialties Provider Taxonomy Codes

Taxonomy	Description	Notes or Restrictions
208D00000X	General Practice	
207Q00000X	Family Medicine	
207QA0000X	Family Medicine, Adolescent Medicine	
207QA0505X	Family Medicine, Adult Medicine	
207QG0300X	Family Medicine, Geriatric Medicine	
207QH0002X	Family Medicine, Hospice Palliative	Restrict to only home health and hospice procedure codes
208000000X	Pediatrics	
2080A0000X	Pediatrics, Adolescent Medicine	
2080H0002X	Pediatrics, Hospice and Palliative Medicine	Restrict to only home health and hospice procedure codes
207R00000X	Internal Medicine	
207RG0300X	Internal Medicine, Geriatric Medicine	
207RA0000X	Internal Medicine, Adolescent Medicine	
207RH0002X	Internal Medicine, Hospice and Palliative Medicine	Restrict to only home health and hospice procedure codes

Taxonomy	Description	Notes or Restrictions
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

Place of Service Codes

The codes below denote primary care sites of care.

Table 30. Primary Care Sites of Care

Place of Service Code	Place of Service 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

Excluded: third-party telehealth vendor that does not contract with the sites above to deliver services; urgent care or retail pharmacy clinics.

Modifier Codes

Modifier/POS Code	Description
95	Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system
GT	Via interactive audio and video telecommunication systems
2	Telehealth provided other than in patient's home
10	Telehealth provided in a patient's home

Appendix G:

Primary Care Payment Codes

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



Note: The procedure codes included in [Table 31](#) below align with codes included in 230-RICR-20-30-4.

Table 31. Primary Care Payment Codes

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

Procedure Code	Description	Reporting Procedure Category
99212	OFFICE OUTPATIENT VISIT 10 MINUTES (Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.)	Office Visits
99213	OFFICE OUTPATIENT VISIT 15 MINUTES (Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.)	Office Visits
99214	OFFICE OUTPATIENT VISIT 25 MINUTES (Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.)	Office Visits
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

Procedure Code	Description	Reporting Procedure Category
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
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
G2211	VISIT COMPLEXITY INHERENT TO E/M (add-on to 99202-99205; 99211-99215)	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 health care 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

Procedure Code	Description	Reporting Procedure Category
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
G0556	APCM LEVEL 1 (LOW COMPLEXITY)	Chronic Care Management Services
G0557	APCM LEVEL 2 (MODERATE COMPLEXITY, 2+ CHRONIC CONDITIONS)	Chronic Care Management Services
G0558	APCM LEVEL 3 (HIGH COMPLEXITY/QMB)	Chronic Care Management Services
98000	TELEMEDICINE NEW PT AUDIO-VIDEO STRAIGHTFORWARD	Telephone and Internet Services
98001	TELEMEDICINE NEW PT AUDIO-VIDEO LOW COMPLEXITY	Telephone and Internet Services
98002	TELEMEDICINE NEW PT AUDIO-VIDEO MODERATE COMPLEXITY	Telephone and Internet Services
98003	TELEMEDICINE NEW PT AUDIO-VIDEO HIGH COMPLEXITY	Telephone and Internet Services
98004	TELEMEDICINE EST PT AUDIO-VIDEO STRAIGHTFORWARD	Telephone and Internet Services
98005	TELEMEDICINE EST PT AUDIO-VIDEO LOW COMPLEXITY	Telephone and Internet Services
98006	TELEMEDICINE EST PT AUDIO-VIDEO MODERATE COMPLEXITY	Telephone and Internet Services
98007	TELEMEDICINE EST PT AUDIO-VIDEO HIGH COMPLEXITY	Telephone and Internet Services
98008	TELEMEDICINE NEW PT AUDIO-ONLY STRAIGHTFORWARD	Telephone and Internet Services
98009	TELEMEDICINE NEW PT AUDIO-ONLY LOW COMPLEXITY	Telephone and Internet Services
98010	TELEMEDICINE NEW PT AUDIO-ONLY MODERATE COMPLEXITY	Telephone and Internet Services
98011	TELEMEDICINE NEW PT AUDIO-ONLY HIGH COMPLEXITY	Telephone and Internet Services

Procedure Code	Description	Reporting Procedure Category
98012	TELEMEDICINE EST PT AUDIO-ONLY STRAIGHTFORWARD	Telephone and Internet Services
98013	TELEMEDICINE EST PT AUDIO-ONLY LOW COMPLEXITY	Telephone and Internet Services
98014	TELEMEDICINE EST PT AUDIO-ONLY MODERATE COMPLEXITY	Telephone and Internet Services
98015	TELEMEDICINE EST PT AUDIO-ONLY HIGH COMPLEXITY	Telephone and Internet Services
98016	BRIEF COMMUNICATION TECHNOLOGY-BASED SVC 5-10M	Telephone and Internet Services
99401	PREVENT MED COUNSEL&/RISK FACTOR REDJ SPX 15 MIN	Preventive Medicine Services
99402	PREVENT MED COUNSEL&/RISK FACTOR REDJ SPX 30 MIN	Preventive Medicine Services
99403	PREVENT MED COUNSEL&/RISK FACTOR REDJ SPX 45 MIN	Preventive Medicine Services
99404	PREVENT MED COUNSEL&/RISK FACTOR REDJ SPX 60 MIN	Preventive Medicine Services
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

Procedure Code	Description	Reporting Procedure Category
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
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

Procedure Code	Description	Reporting Procedure Category
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
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

Procedure Code	Description	Reporting Procedure Category
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
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

Procedure Code	Description	Reporting Procedure Category
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
90474	IM ADM INTRANSL/ORAL EA VACCINE	Immunization Administration for Vaccines/Toxoids
G0008	ADMINISTRATION OF INFLUENZA VIRUS VACCINE	Immunization Administration for Vaccines/Toxoids
G0009	ADMINISTRATION OF PNEUMOCOCCAL VACCINE	Immunization Administration for Vaccines/Toxoids

Procedure Code	Description	Reporting Procedure Category
G0010	ADMINISTRATION OF HEPATITIS B VACCINE	Immunization Administration for Vaccines/Toxoids
96160	PT-FOCUSED HLTH RISK ASSMT SCORE DOC STND INSTRM	Health Risk Assessment, Screenings, and Counseling
96161	CAREGIVER HLTH RISK ASSMT SCORE DOC STND INSTRM	Health Risk Assessment, Screenings, and Counseling
99078	PHYS/QHP EDUCATION SVCS RENDERED PTS GRP SETTING	Health Risk Assessment, Screenings, and Counseling
99483	ASSMT & CARE PLANNING PT W/COGNITIVE IMPAIRMENT	Health Risk Assessment, Screenings, and Counseling
G0396	ALCOHOL &/SUBSTANCE ABUSE ASSESSMENT 15-30 MIN	Health Risk Assessment, Screenings, and Counseling
G0397	ALCOHOL &/SUBSTANCE ABUSE ASSESSMENT >30 MIN	Health Risk Assessment, Screenings, and Counseling
G0442	ANNUAL ALCOHOL MISUSE SCREENING 15 MINUTES	Health Risk Assessment, Screenings, and Counseling
G0443	BRIEF FACE-FACE BEHAV CNSL ALCOHL MISUSE 15 MIN	Health Risk Assessment, Screenings, and Counseling
G0444	ANNUAL DEPRESSION SCREENING 15 MINUTES	Health Risk Assessment, Screenings, and Counseling

Procedure Code	Description	Reporting Procedure Category
G0505	COGN & FUNCT ASMT USING STD INST OFF/OTH OP/HOME	Health Risk Assessment, Screenings, and Counseling
99173	SCREENING TEST VISUAL ACUITY QUANTITATIVE BILAT	Preventive Medicine Services
G0102	PROS CANCER SCREENING; DIGTL RECTAL EXAMINATION	Preventive Medicine Services
G0436	SMOKE TOB CESSATION CNSL AS PT; INTRMED 3-10 MIN	Preventive Medicine Services
G0437	SMOKING & TOB CESS CNSL AS PT; INTENSIVE >10 MIN	Preventive Medicine Services
99492	INITIAL PSYCHIATRIC COLLABORATIVE CARE MODEL (CoCM)	Collaborative Care
99493	FOLLOW-UP PSYCHIATRIC CoCM	Collaborative Care
99494	ADD-ON FOR INITIAL & SUBSEQUENT PSYCHIATRIC CoCM	Collaborative Care
G2214	INITIAL & SUBSEQUENT PSYCHIATRIC CoCM	Collaborative Care

Appendix H:

Statistical Testing to Determine Performance Against the Target

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

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

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

Formulas for Calculating Confidence Intervals

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

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

The formula for pooling the variance is as follows:

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

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

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

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

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

Sample Calculations Using Mock Data

Each insurer shall submit payment data for LPEs stratified by market. To calculate the insurer's cost growth, OHIC uses a weighted value. OHIC also risk-adjusts the average PMPM spending by age and sex, and truncates costs over certain thresholds for high-cost outliers. Insurers shall also submit unadjusted variance data by market, and for each LPE by line of business.

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

Hypothetical Spending and Standard Deviation Data for Insurer A

For 2024	Paid entity	Market	Average PMPM Spending	Member Months	Standard Deviation
	LPE 1	Medicaid	\$416.67	240,000	\$166.67
	LPE 1	Commercial	\$666.67	660,000	\$250.00
	LPE 2	Medicaid	\$66.67	93,000	\$29.17
	LPE 2	Commercial	\$83.33	384,000	\$39.59
	Overall	Medicaid	\$318.92	333,000	\$211.93
	Overall	Commercial	\$452.11	1,044,000	\$292.32

For 2025	Paid entity	Market	Average PMPM Spending	Members Months	Standard Deviation
	LPE 1	Medicaid	\$458.33	204,000	\$165.71
	LPE 1	Commercial	\$650.00	720,000	\$375.00
	LPE 2	Medicaid	\$70.83	72,000	\$41.67
	LPE 2	Commercial	\$175.00	480,000	\$56.25
	Overall	Medicaid	\$357.24	276,000	\$223.47
	Overall	Commercial	\$460.00	1,200,000	\$426.63

Hypothetical Spending and Standard Deviation Data for Insurer B

For 2024	Paid entity	Market	Average PMPM Spending	Member Months	Standard Deviation
	LPE 1	Medicaid	\$398.22	125,000	\$128.79
	LPE 1	Commercial	\$635.13	300,000	\$224.08
	LPE 2	Medicaid	\$70.12	50,000	\$67.24
	LPE 2	Commercial	\$65.12	201,000	\$42.71
	Overall	Medicaid	\$304.48	175,000	\$233.08
	Overall	Commercial	\$406.44	501,000	\$274.83

For 2025	Paid entity	Market	Average PMPM Spending	Members Months	Standard Deviation
	LPE 1	Medicaid	\$415.24	105,000	\$174.78
	LPE 1	Commercial	\$640.51	380,000	\$387.83
	LPE 2	Medicaid	\$75.25	45,000	\$50.84
	LPE 2	Commercial	\$100.35	223,000	\$82.92
	Overall	Medicaid	\$313.24	150,000	\$230.74
	Overall	Commercial	\$440.75	603,000	\$396.03

From the insurer-submitted data, OHIC calculates weighted spending averages for each line of business in each year. The weighted spending averages are calculated by taking data for all providers in the line of business, multiplying the spending in each row by the number of member months, then summing the products, and then dividing the grand total by the total number of member months.

At the insurer level, OHIC reports growth in THCE, which includes TME and NCPHI. While insurers report aggregate spending and variance information for TME, OHIC calculates NCPHI separately using insurance filings. In assessing insurer performance, OHIC combines PMPM growth in NCPHI to the PMPM growth in TME and calculates the confidence interval around year over year growth of that total. For this example, OHIC calculated the following PMPM NCPHI amounts for Insurers A and B for 2024 and 2025:

Average PMPM NCPHI for Insurers A and B

Insurer	Market	2024 Average PMPM NCPHI	2025 Average PMPM NCPHI
Insurer A	Medicaid	\$33.33	\$41.66
Insurer A	Commercial	\$58.33	\$66.66
Insurer B	Medicaid	\$43.65	\$45.33
Insurer B	Commercial	\$65.34	\$66.71

Using the above data, where $\bar{X}$ is defined as the average PMPM THCE, the growth in the Insurer A's PMPM spending from 2024 to 2025 is calculated as follows:

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

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

Calculating Confidence Intervals for Each Insurer by Line of Business

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

Confidence Interval for Medicaid Growth:

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

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

Thus, Insurer A's Medicaid growth rate from 2023 to 2024 was 13.2% and the 95% confidence interval range is 12.9% and 13.5%. Therefore, we can say with 95% certainty that the Insurer A's Medicaid line of business did not meet the cost growth benchmark by growing more than 3.2%. This calculation would then be repeated for the insurer's commercial line of business.

Calculating Confidence Intervals for Each Provider Entity by Market

At the provider level, OHIC will calculate growth using only TME. Using the above data, the weighted average of LPE 1's Medicaid spending and pooled variance for 2024 and 2025 are calculated as follows:

LPE 1's weighted average PMPM spending for Medicaid:

$$\text{For 2024} = (\$416.67 \times 240,000 + \$398.22 \times 125,000) / (240,000 + 125,000) = \$410.35$$

$$\text{For 2025} = (\$458.33 \times 204,000 + \$415.24 \times 105,000) / (204,000 + 105,000) = \$443.69$$

Pooled variance for 2024 Medicaid:

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

$$\text{For 2024 Medicaid, first section: } \frac{(240,000 \times 166.67^2) + (125,000 \times 128.79)^2}{240,000 + 125,000}$$

$$\text{For 2024 Medicaid, second section: } \frac{240,000 \times 125,000 (416.67 - 398.22)^2}{(240,000 + 125,000)^2}$$

$$\text{For 2024 Medicaid, all sections combined: } 24,022.81$$

Pooled variance for 2025 Medicaid:

$$\text{For 2025 Medicaid, first section} = \frac{(204,000 \times 27,459.89) + (105,000 \times 174.78^2)}{204,000 + 105,000}$$

$$\text{For 2025 Medicaid, second section} = \frac{204,000 \times 105,000 (458.33 - 415.24)^2}{(204,000 + 105,000)^2}$$

$$\text{For 2025 Medicaid, all sections combined: } 28,925.95$$

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

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

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

Thus, the growth rate from 2024 to 2025 was 8.1% and the 95% confidence interval range is 8.0% and 8.3%. Therefore, we can say with 95% certainty that LPE 1's growth in Medicaid costs did not meet the cost growth benchmark by growing more than 3.2%. This calculation would then be repeated for LPE 1's commercial and Medicare Advantage spending.

References

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Appendix I:

Methodology for Risk-Adjusting Data by Age/Sex

A. Risk-Adjusting TME for Insurers and Large Provider Entities (LPE)

OHIC risk-adjusts total medical expenses (TME) data when evaluating performance against the Cost Growth Target at insurer and LPE levels. Risk-adjustment is done for age and sex by Insurance Category Code (see **Table 32** below for Insurance Category Code definitions), using standard weights developed by OHIC.

To develop the weights, OHIC collects TME data and member months data by age/sex bands (see **Table 33** below for age bands) at the insurer overall and LPE levels and calculates two set of weights for each Insurance Category Code (one set at the insurer level and one set at the LPE level).⁶⁷ These standard weights are applied uniformly across all Insurers and LPEs respectively within each Insurance Category Code.

This section outlines how OHIC calculates standard weights and develops insurer and LPE-specific age/sex risk scores.

B. Calculation of Standard Weights

For each Insurance Category Code, using base year data (for the 2024-2025 analysis, this would be 2024 data):

- OHIC calculates the statewide claims-based, truncated TME (see
- **Table 34** below for truncation points) and member months within each age/sex band by combining data across Insurer submissions. Non-claims-based spending is **NOT** included in this calculation.
- OHIC then calculates statewide per member per month (PMPM) spending for each age/sex band by taking the statewide claims-based, truncated TME and dividing it by the statewide member months.
- To calculate standard weights for each age-sex band, OHIC takes the PMPM spending for an age-sex band and divides by overall PMPM spending.

⁶⁷ OHIC calculates two sets of weights (one set at the insurer level and one set at the LPE level) because for members who are attributed to more than one LPE during the year, insurers “reset the clock” and calculate truncated spending for the member for each of the LPEs, and for the Insurer as a whole, which may result in different truncated spending amounts.

- This is conducted at the insurer and at the LPE level (note that spending data at the Insurer and LPE levels do not necessarily align due to the “reset the clock” approach for truncating claims).

C. Calculation of Insurer Risk Scores

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

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

D. Calculation of LPE Risk Scores

Within each insurer’s submission, OHIC calculates a risk score for each LPE being reported on, stratified by Insurance Category Code. To do this, within an insurer submission, for each Insurance Category Code:

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

E. Application of Insurer and LPE Risk Scores to Spending Data

To calculate the age/sex risk-adjusted spending for each insurer, OHIC divides the unadjusted, truncated claims spending for the insurer overall by Insurance Category Code by the insurer risk scores developed in **Section C** above and adds its respective non-claims spending. To calculate the age/sex risk-adjusted spending for each LPE, within each insurer’s submission for each Insurance Category Code, OHIC divides the unadjusted, truncated claims spending for each LPE by the LPE’s risk score developed in **Section D** above and adds its respective non-claims spending. OHIC does not sum risk-adjusted LPE level spending to derive risk-adjusted insurer level spending, as this approach does not take into account the “reset the clock” methodology for truncated spending.

Table 32. Insurance Category Code Definitions for TME Reporting

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

Table 33. Age Bands

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

Table 34. Truncation Points for Insurer and LPE Claims Expenses⁶⁸

Insurance Category Code	Definition	Per Member Truncation Point
1	Medicare Expenses for Non-Dual Eligible Members	\$185,000
2	Medicaid Expenses for Non-Dual Eligible Members	\$190,000
3	Commercial: Full Claims	\$170,000
4	Commercial: Partial Claims	\$170,000
5	Medicare Expenses for Medicare/Medicaid Dual Eligible	\$185,000
6	Medicaid Expenses for Medicare/Medicaid Dual Eligible	\$190,000

⁶⁸ For members who are attributed to more than one LPE during the year, insurance carriers are asked to “reset the clock” and calculate truncated spending for the member for each of the LPEs and for the insurer as a whole. This is done by first calculating the member’s total spending that is attributed to each LPE, and then separately applying truncation to the member’s spending that is attributed to each LPE.

Appendix J:

Insurer Attestation

Attestation of the Accuracy and Completeness of Reported Data

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

Insurer: _____

Performance Period Being Reported: _____

Pursuant to Rhode Island’s establishment, monitoring and implementation of annual Health Care Cost Growth Target under the Article 12 – Relating to Health Care and State-defined reporting guidelines, health insurers operating in the state of Rhode Island must annually submit certain data required to calculate insurer and provider performance relative to Rhode Island’s Target.

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

Signature

Date

Printed Name

Title