Concise Explanatory Statement

Rhode Island Government Register

In accordance with the Administrative Procedures Act, R.I. Gen. Laws § 42-35-2.6, following is a concise explanatory statement:

AGENCY:	Office of the Health Insurance Commissioner
RULE IDENTIFIER:	230-RICR-20-30-4
REGULATION TITLE:	Powers and Duties of the Office of the Health Insurance Commissioner
RULEMAKING ACTION:	Amendment, Full Rulemaking
PUBLIC COMMENT PERIOD:	October 11, 2024 through November 15, 2024

The Office of the Health Insurance Commissioner ("OHIC") hereby provides, in accordance with R.I. Gen. Laws § 42-35-2.6, a concise explanatory statement of the principal reasons for and against these amendments to 230-RICR-20-30-4 ("Adopted Regulation").

The amendments were originally filed in proposed form with the Rhode Island Secretary of State on October 11, 2024 ("Proposed Amendments"). A public hearing on the Proposed Amendments was held on November 4, 2024. The comments of interested parties can be found here. Along with the Proposed Amendments, OHIC published a Regulatory & Cost-Benefit Analysis prepared pursuant to R.I. Gen. Laws § 42-35-2.9. The Regulatory & Cost-Benefit Analysis articulates the evidence and rationale supporting adoption of the Proposed Amendments. OHIC has slightly updated the financial analysis in this document considering the changes to the Proposed Amendments discussed below. Where differences in the description of a specific provision of the Adopted Regulation and the Proposed Amendments exist, the Concise Explanatory Statement supersedes any other published description of the provision. Within the Adopted Regulation attached hereto, post-public comment changes to the regulation have been made in track changes with yellow highlighting.

OHIC received comments from America's Health Insurance Plans (AHIP), Blue Cross Blue Shield of Rhode Island (BCBSRI), Brown University Health, CharterCARE Provider Group of Rhode Island, Care Transformation Collaborative of Rhode Island (CTC-RI), Integra, Hospital Association of Rhode Island (HARI), Brown Medicine, Pharmaceutical Care Management Association (PCMA), Neighborhood Health Plan of Rhode Island (NHPRI), Harvard Pilgrim Health Care (HPHC), Rhode Island Primary Care Physicians Corporation (RIPCPC), MLPB, RIPIN, Rhode Island Medical Society (RIMS), Cigna Healthcare, and the Rhode Island Office of the Attorney General.

REASON FOR RULEMAKING:

The Office of the Health Insurance Commissioner (OHIC) is adopting amendments to 230-RICR-20-30-4 *Powers and Duties of the Office of the Health Insurance Commissioner*. When creating OHIC, the General Assembly enumerated a list of statutory purposes at R.I. Gen. Laws § 42-14.5-2 (the OHIC Purposes Statute). To meet the requirements established by the OHIC Purposes Statute, the OHIC developed this regulation, which is designed to:

1. Ensure effective regulatory oversight by the OHIC;

2. Provide guidance to the state's health insurers, health care providers, consumers of health insurance, consumers of health care services and the general public as to how the OHIC will interpret and implement its statutory obligations; and

3. Implement the intent of the General Assembly as expressed in the OHIC Purposes Statute.

This rulemaking follows two recent OHIC reports that recommended actions by the agency to strengthen Rhode Island's primary care system. First, OHIC's December 2023 report: Primary Care in Rhode Island: Current Status and Policy Recommendations. This report presented findings from OHIC's state and national research on primary care trends, offered an assessment of the current state of primary care in Rhode Island informed by interviews with local stakeholders, and provided recommendations for future actions to support and strengthen primary care in the state. Second, OHIC's June 2024 Administrative Simplification Taskforce report: Prior Authorization – Final Report of Recommendations. This report was mandated by the General Assembly through legislation that amended OHIC's powers and duties in 2023. Each of these reports are the product of significant stakeholder engagement which informed the substance of this rulemaking.

The adopted amendments lower the Affordability Standards accountability threshold for commercial health insurers from 10,000 covered lives to 5,000 covered lives, rebase and restructure OHIC's regulatory target for commercial health insurer primary care funding, address patient-centered medical home (PCMH) sustainability payments by decoupling them from total cost of care risk, and address health insurer prior authorization practices. The adopted amendments comprise technical modifications to § 4.3 Definitions, § 4.9 Affordable Health Insurance – General, § 4.10 Affordable Health Insurance – Affordability Standards, and § 4.11 Administrative Simplification. The regulation is further augmented by two new sections, § 4.13 Primary Care Specialty Provider Taxonomy Codes and § 4.14 Primary Care Payment Codes. The substance of the amendments and new sections of 230-RICR-20-30-4 are described in greater detail below. Collectively, the adopted amendments and retained provisions set forth regulatory standards for commercial health insurers to follow in their efforts to improve the affordability of their products and to promote accessible, high quality health care. OHIC developed these standards to meet its statutory mandate under R.I.G.L § 42-14.5-2, which states:

"With respect to health insurance as defined in § 42-14-5, the health insurance commissioner shall discharge the powers and duties of office to:

(1) Guard the solvency of health insurers;

(2) Protect the interests of consumers;

(3) Encourage fair treatment of health care providers;

(4) Encourage policies and developments that improve the quality and efficiency of health care service delivery and outcomes; and

(5) View the health care system as a comprehensive entity and encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access."

Primary Care Funding

The adopted amendments addressing primary care funding are codified in § 4.3, § 4.10(B), § 4.10(C), with related changes in other subsections of § 4.10, § 4.13, and § 4.14. The amendments embrace the following substantive areas:

1. The adopted amendments revise the definition of primary care expenditures to account for the development of consensus approaches to primary care expenditure measurement that have emerged in the 15 years since OHIC first established a primary care expenditure target. The studies that informed OHIC's selection of measurement methodology are listed in Table 2, page 9, of the Regulatory & Cost-Benefit Analysis prepared for this rulemaking. In place of existing guidance on primary care provider types and categories of procedure codes that determine claims-based expenditure measurement, OHIC is adopting specific primary care specialty provider taxonomy codes (§ 4.13) and procedure codes (§ 4.14) within the body of the regulation. Adopting a code-based specification of claims-based primary care expenditures will ensure consistency across health insurers and facilitate auditing and enforcement of commercial insurer funding obligations by OHIC.

2. In § 4.3 OHIC discontinues the distinction between direct and indirect primary care expenses and adopts one definition of primary care expenditures that identifies allowable claims-based and non-claims-based expenditures. Non-claims-based payments shall be specifically attributed to the fully insured market. OHIC also adds specific definitions of "primary care provider" and "total annual medical expenditures" in § 4.3. The definition of total annual medical expenditures aligns with existing definitions used to measure per capita health care spending and spending growth through OHIC's Health Spending Accountability and Transparency Program.

3. In § 4.10(B) the primary care expenditure target, which is defined as the ratio of primary care expenditures to total medical expenditures, is restructured to improve OHIC's oversight of primary care expenditures by commercial health insurers and to require increased financial support for primary care through service-based mechanisms, including reimbursement for primary care services delivered at an ambulatory primary care site of care and enhanced primary care capitation payments for attributed patients. OHIC is rebasing measured primary care expenditures and total medical expenditures to calendar year 2022 using the new methodologies and is adopting an overall target for primary care expenditures as a percentage of total medical expenditures of 10% to be achieved over a multi-year period beginning in 2025. In addition to an overall target, the adopted amendments set forth a sub-target of 8% of total medical expenditures to be made through claims-based payments and/or primary care capitation payments.

4. OHIC is modifying the total medical expenditures denominator of the primary care expenditure target. This change will capture a greater percentage of the true total cost of

care for fully insured Rhode Islanders by including payments to out-of-state providers. This is a material change from the previous measurement and target-setting approach which exclusively focused on payments to Rhode Island providers. This change to the denominator better aligns with primary care's role managing total cost of care.

5. § 4.10(C) of the regulation is amended to explicitly require that care management and infrastructure payments to primary care practices designated by OHIC as patient-centered medical homes (PCMHs) shall not be at risk for total cost of care performance but may be at risk for performance on quality measures. OHIC also will require reporting of practice payments for each PCMH to the agency for internal tracking and audit.

6. § 4.10(D)(2)(f) is amended to require that population-based total cost of care contract budgets shall be held harmless for mandated increases in primary care funding. In § 4.10(D)(2)(h) OHIC clarifies that health insurers and Integrated Systems of Care (alternatively referred to as "Accountable Care Organizations") may negotiate contractual mechanisms to mitigate risk from high-cost specialty drugs.

The amendments to the primary care definition and expenditure requirement will improve OHIC's ability to hold insurers accountable for appropriate financing of primary care that is necessary to ensure a high performing health care system and the provision of more affordable health insurance. The amendments will also improve OHIC's ability to ensure that primary care payments are directed to the timely support of primary care practices and clinicians while strengthening the primary care workforce over time.

Following promulgation of this final regulation, OHIC will publicly report primary care expenditure data by payer using the new definition and perform periodic market conduct examinations to audit compliance.

Administrative Simplification – Prior Authorization

The adopted amendments to § 4.11 provide for a new set of standards governing prior authorization practices by commercial health insurers. The standards comprise six areas.

1. In § 4.11(F)(2) OHIC mandates a 20% reduction in prior authorization volume compared to 2023 baseline volume, measured on a normalized per member per month basis. Further, OHIC directs health insurers to prioritize volume reductions involving services, treatments, procedures, or other items ordered by primary care providers.

2. In § 4.11(F)(3) OHIC articulates that health insurers may develop and implement programs involving selective prior authorization requirements, based on stratification of health care providers' performance and adherence to evidence-based medicine with the input of contracted health care providers and/or provider organizations.

3. The adopted amendments require health insurers to conduct a review of medical services, including behavioral health services, and prescription drugs, subject to prior authorization on at least an annual basis, with the input of contracted health care providers and/or provider organizations. Health insurers shall consider a number of factors, including administrative costs to providers, when deciding to add, maintain, or remove prior authorization requirements.

4. In § 4.11(F)(5) the adopted amendments require quarterly reporting on prior authorization requests and other relevant data.
5. In § 4.11(F)(6) the adopted amendments require submission of an annual attestation, including answers to a standard set of questions, regarding prior authorization processes and annual reviews of prior authorization requirements, in a form and manner determined by the Commissioner.
6. Pursuant to adopted section § 4.11(F)(7) OHIC will convene a statewide advisory committee on prior authorization that shall be a subcommittee of the Administrative Simplification Task Force. The advisory committee shall be comprised of representatives of health care providers and health insurers with relevant experience and expertise in prior authorization and other utilization management practices and processes. The advisory committee shall meet at least two times per year and is charged with reviewing prior authorization data submitted to OHIC, health insurer attestations, and making recommendations to improve prior authorization processes for medical services and prescription drugs over time.

Non-technical modifications to grammar and form are proposed throughout the regulation.

The amendments are supported by evidence and sound theory and are rationally related to the statutory purposes of OHIC. The remainder of the amendments are changes to grammar and form.

SUMMARY OF PUBLIC COMMENTS & CHANGES TO TEXT OF THE RULE:

General Comments

1. Commentors expressed general agreement that actions were needed to support a robust primary care workforce and better access to care.

   Provider organizations and other groups expressed strong support for the proposed amendments. Brown University Health noted the policy recommendations that were issued by OHIC in the December 2023 report, Primary Care in Rhode Island: Current Status and Policy Recommendations. Brown University Health continued: "Recognition is also afforded to OHIC for the speed within which it has acted from the Report's issuance in December 2023 to the proposal of the Amendment that we see as a reflection of OHIC's understanding of a very serious problem coupled with its desire to immediately address it." RIPIN expressed its support for "actions to increase investment in primary care within the state" and offered agreement with "the methodology OHIC has laid out for driving that increased investment." CharterCARE Provider Group of Rhode Island stated: "Increased primary care spending … will strengthen Rhode Island['s] challenged base of primary care providers, while directing investment to those who have the greatest opportunity to have a holistic impact on patient outcomes, utilization, and experience."

   Health insurers, while supportive of initiatives to improve the affordability of health care, cautioned that the proposed initiatives may have the opposite effect. Specific concerns focused on implementation timelines and prior authorization requirements contained in the proposed rule.

The Office of the Attorney General, the only government entity to comment, stated:

> "Increasing payments to primary care providers and decreasing the burden of prior authorization, as this regulation proposed, are two important elements in mitigating the deficiencies in the Rhode Island health care system. As such, this proposed regulatory update is an important first step in addressing two of the many challenges that burden the Rhode Island health care system. At the same time, the Attorney General encourages OHIC to be more aggressive in its proposal."

OHIC Response: OHIC appreciates the breadth of comments offered by interested parties, which were constructive and thoughtful. With any rulemaking of this magnitude OHIC must conciliate diverse, and at times, competing interests. Foremost among OHIC's objectives is the public interest in accessible, affordable health insurance. As documented in OHIC's December 2023 report Primary Care in Rhode Island: Current Status and Policy Recommendations, the evidence shows that accessible primary care supports better health and lower costs. The report also documented the significant headwinds facing the primary care system in Rhode Island. The Adopted Regulation builds on established regulatory approaches to increasing primary care investment in Rhode Island and advances a new regulatory regime governing prior authorization practices. These are important steps. OHIC recognizes that policy changes or course corrections may be necessary in the future. Such changes will be the result of collaboration with stakeholders and review of data.

Below OHIC outlines changes that were made to the proposal in response to specific comments.

Specific Comments

§ 4.3(A)(18) and § 4.3(A)(20) – Definitions – Primary care expenditures and providers

2. Several stakeholders commented on the classifications and definitions of primary care providers and expenditures proposed in § 4.3(A). Dr. Peter Hollmann (on behalf of Brown Medicine) submitted several technical comments which were endorsed by the Rhode Island Medical Society. Dr. Hollmann offered:

> "It is important that the definition of primary care expenditures retain concordance in all 3 attributes: paid **to** a primary care practice or larger entity, **for** a primary are service, **at** a primary care site of care." "… **BOTH** the service and practitioner taxonomies must be met.

Dr. Hollmann notes that specialty care providers, such as behavioral health providers, are not primary care providers. In these instances, "[t]here should be a distinction between payments to a practice as compared to the practitioner classification."

RIPCPC proposed that insurers share internal specialty designations established through the credentialing process to improve transparency. On the provider taxonomy codes, RIPCPC noted "[s]ome duals, functioning primarily as specialists, may be included in some of these taxonomy codes." "This is a specific concern in the advanced practitioner categories."

MLPB recommended adding Community Health Worker (CHW) Services as claims-based payments eligible to be included in primary care expenditures. MLPB notes that "Rhode Island's investment in the CHW workforce is impressive, and they are essential contributors to many health care teams. Creating reimbursement structures to encourage and integrate CHWs more fully beyond the Medicaid-Insured patient population is a win-win for the patients served and the rest of the provider team."

BCBSRI recommended allowing flexibility to update the primary care payment code list to reflect [Centers for Medicare and Medicaid Services] CMS and industry changes.

OHIC Response – No change to text of the rule: OHIC appreciates these comments. Regarding BCBSRI's recommendation to allow flexibility to update the primary care payment code list to reflect CMS and industry changes, OHIC will perform an annual review of HCPCS codes, seek public comment, and issue guidance to insurers to allow for coding changes between formal updates of the code set in regulation.

With respect to RIPCPC's proposal that insurers share internal specialty designations established through the credentialing process, OHIC has recently requested such data from health plans to support internal primary care analyses from the all-payer claims database (APCD). It is OHIC's expectation that insurers will leverage their internal specialty designations to appropriately assign patient care activities that constitute primary care activity to primary care expenditures, particularly for providers with an internal medicine specialty. OHIC will issue additional guidance on this point if necessary.

RIPCPC's proposal relates to Dr. Hollmann's comments on provider specialties. As Dr. Hollmann concludes, "[i]f the OHIC required reporting methodology is sufficiently strong, this is a non-issue, but rather than overcounting in a presumably small way, it may be better to risk slight under counting."

With respect to MLPB's recommendation to add CHW services to the primary care expenditure specifications, OHIC has elected not to add CHW services to the primary care claims-based payment specifications at present. However, OHIC will entertain crediting insurer funding for CHW services paid as non-claims-based payments to primary care practices if appropriated allocated to the fully insured commercial market.

§ 4.13 & § 4.14 – Primary care provider taxonomy codes and payment codes

Stakeholder comments on § 4.13 & § 4.14 are pertinent to consider with comments on § 4.3(A). § 4.13 lists a set of provider taxonomy codes from the National Uniform Claim Committee and §

4.14 lists a set of HCPCS payment codes. Used in conjunction, these code sets define the universe of claims-based primary care expenditures.

3. RIPCPC recommended that the "list of acceptable CPT/HCPCS codes should include language that allows for adjustment of the list of codes outside the annual rulemaking process, since some changes will likely occur throughout the year."

   In a similar vein, Dr. Hollmann, on behalf of Brown Medicine, noted that some codes are no longer accurate or applicable, recommending an annual review process to update the list and suggested improving taxonomy codes to address misclassification issues and ensuring accurate calculations of primary care expenditures.

   OHIC Response – No change to text of the rule: In response to RIPCPC's and Brown Medicine's individual feedback on the necessity to update the primary care payment code set, which are similar to BCBSRI's recommendation to allow flexibility to update the primary care payment code list to reflect CMS and industry changes described earlier in this Concise Explanatory Statement, OHIC will perform an annual review of HCPCS codes, seek public comment, and issue guidance to insurers to allow for coding changes between formal updates of the code set in regulation. This will allow for maintenance of the code set over time. Additionally, as part of oversight of commercial insurer primary care expenditure target achievement, including retrospective audits, OHIC will maintain a record of code set changes with appropriate effective dates.

4. CTC-RI recommended adding payment codes to § 4.14 that are used for Collaborative Care (99492, 99493, 99494, G2214), CHW services (98966, 98967, 98968, G0019, G0022), and Health Risk Assessment and Care Management (99495, 99496).

   OHIC Response – Post comment change: OHIC agrees with CTC-RI's recommendation to add codes for Collaborative Care. Two states with public specifications for primary care expenditures, Massachusetts, and Oregon, include these codes in their primary care measurement. These codes also support the integration of behavioral health into primary care, which OHIC wants to encourage. For both these reasons, Collaborative Care (99492, 99493, 99494, G2214) have been added to § 4.14. Codes for Health Risk Assessment and Care Management (99495, 99496) are presently included in the code set issued for public comment; therefore, no further action is necessary. At present, OHIC elects not to add CHW service codes.

§ 4.3(A)(26) – Total annual medical expenditures definition

§ 4.3(A)(26) provides a definition of total annual medical expenditures. This definition is important because total annual medical expenditures form the denominator of the ratio-based commercial health insurer primary care expenditure target. A ratio-based target seeks to direct a greater percentage of the medical dollar toward primary care.

5. Brown Medicine noted some inconsistencies in the use of the terms "allowed" and "paid" in the primary care expenditures and total annual medical expenditures definitions. In the insurance industry these terms have very specific meanings.

   OHIC Response – Post comment change: OHIC has revised terminology used in § 4.3 in response to Brown Medicine's comments on use of the terms "allowed" and "paid." OHIC recognizes that the term "paid" has a specific meaning in the context of claims (i.e. the "paid" amount of a claim vs. the "allowed" amount of a claim). This distinct meaning can cause confusion when using the term paid to describe the act of paying, or dispersing monies, during an exchange between an insurer and a provider.

6. BCBSRI proposed a change to the accounting methodology, for purposes of primary care expenditure target measurement, that would exclude high-cost claimants from total annual medical expenditures. BCBSRI stated: "members with unpredictable non-recurring claims like neonatal intensive care unit stays or cell/gene therapies, which often exceed several million dollars, could materially impact the denominator of the primary care spend calculation. As these types of claims typically do not repeat year over year, including them in the denominator likely will skew the percentage of primary care spend, making it unpredictable for the insurers to implement a plan to meet the required primary care spend percentages."

   OHIC Response – No change to text of the rule: OHIC appreciates BCBSRI's thoughtful comments on high-cost claims truncation in the context of the proposed primary care expenditure obligation. Currently, OHIC is not ready to amend the definition of total medical expenditures in § 4.3(26) of the regulation and is moving forward with the proposal. Additional data collection and analysis is needed to understand which value to set a potential truncation point ($750,000, $1,000,000, etc.). Toward that end, OHIC will collect additional data on high-cost claimants in the 2025 data collection cycle.

§ 4.10(B)(1) – Primary care expenditure obligation

OHIC received several comments on the proposed commercial health insurer primary care expenditure targets and implementation timelines.

7. Integra and HARI noted that the proposed primary care expenditure target of 10% is 0.7% lower than the target (10.7%) maintained under the former standards. These parties sought clarification of OHIC's rationale for making this change.

   OHIC Response – No change to text of the rule: OHIC appreciates the opportunity to clarify the primary care expenditure target percentages under the previous version of 230-RICR-20-30-4 and this adopted version. Under the former regulatory provisions, the primary care expenditure target of 10.7% consisted of two parts: direct primary care spending, which was set at a minimum of 9.7% of total medical expenditures and indirect primary care spending, which was set at 1% of total medical expenditures. The

adopted amendments retire this distinction, drop funding for the state's health information exchange from the definition of primary care spending (it was previously indirect), and adopt a definition that more closely drives investment in primary care. The appropriate comparison should be 10% to 9.7%. Additionally, OHIC would like to reiterate a point that was provided in the Regulatory and Cost-Benefit Analysis published in October 2024 and updated in January 2025. Under the former regulatory provisions, the payments to providers in the numerator and denominator of the target calculation were limited to payments to Rhode Island providers. The adopted amendments expand the calculation to include payments to all providers, regardless of state. This increases the denominator of the calculation more on a percentage basis than the numerator due to observed patterns of care migration. OHIC estimated that denominator total medical expenditures are approximately $190 million greater under the new adopted calculation methodology compared to the legacy methodology. This methodology change will require a material increase in primary care investments by commercial insurers to meet the expenditure targets. This definition aligns with existing definitions used to measure per capita health care spending and spending growth through OHIC's Health Spending Accountability and Transparency Program.

8. The Office of the Attorney General (OAG) offered several comments and observations on the proposed amendments to the primary care expenditure requirement. The OAG stated: "there is no mechanism in the proposal to track whether these increased investments are likely to retain individual primary care providers." OAG continued: "[t]he Proposal lacks a mechanism to ensure that providers see a direct increase in their pay or improvements in their working conditions that would incentivize them to stay in Rhode Island."

   OHIC Response – No change to text of the rule: The proposed amendments, and the Adopted Regulation, are intended to support affordable health insurance by improving the economic and professional conditions of primary care in Rhode Island, which is a fundamental factor in an efficient, high quality health care system. Chief among the measures of success is whether Rhode Island can maintain a primary care workforce that supports timely access to primary care services. OHIC expects to work with interested parties, including the primary care community, insurers, and state agencies, to monitor the primary care system in Rhode Island, including using longitudinal measures of primary care supply.

   Regarding OAG's comment that the proposed amendments lack "a mechanism to ensure that providers see a direct increase in their pay or improvements in their working conditions that would incentivize them to stay in Rhode Island," OHIC does not contest this limitation. For many providers, notably those who are employed by a health system, compensation and working conditions are shaped by their corporate employer. The Adopted Regulation drives insurance-based funding to primary care through established contractual mechanisms, and OHIC will be able to perform oversight that funding is adhering to the adopted definition of primary care expenditures. However, if a health system employs primary care physicians, the compensation model developed by the organization is opaque, confidential, and/or not subject to oversight by OHIC.

OHIC is hopeful that health systems will compete to provide appropriate primary care provider compensation and working conditions.

9. NHPRI asked OHIC to clarify two matters. First, NHPRI sought clarification of OHIC's interpretation of the phrase "all insured lines of business" believing that it may implicate government-funded business, such as Medicaid. NHPRI stated: [i]n the absence of increased funding for its government products, Neighborhood is concerned in its ability to meet the regulation as currently written. If the regulation does not apply to non-commercial products, the regulation should be clarified as such." Second, NHPRI requested that "OHIC clarify in the regulation that targets are based on the insurers' individual expenditures and not on market average."

   OHIC Response – No change to text of the rule: OHIC does not regulate government plans, such as Medicaid. OHIC does not believe this specific clarification is needed in the text of the Adopted Regulation. To NHPRI's comment concerning whether targets are based on individual insurer expenditures or a market average, the Adopted Regulation sets binding primary care investment targets for commercial health insurers to be achieved relative to that specific insurer's experience and baseline starting point.

10. BCBSRI and NHPRI commented on the implementation timeline, including the start date and duration of the multi-year phase-in of the primary care expenditure target. BCBSRI recommended beginning the new target implementation and phase-in in 2026, rather than 2025. BCBSRI reasoned that 2025 premiums have been approved and brought to market. NHPRI recommended extending the completion date for achievement of the ultimate 10% target to 2032. Related to the schedule of target implementation, Integra recommended a more aggressive 2025 target, 2% of total annual medical expenditures above baseline, as compared to the proposed 0.5%.

    OHIC Response – No change to text of the rule: OHIC believes that increased investment in primary care should occur as quickly as reasonably possible. This urgency is based on findings from OHIC's December 2023 report: Primary Care in Rhode Island: Current Status and Policy Recommendations. In drafting the regulations OHIC sought to balance considerations of health care finance, such as the fixed nature of premiums in the short-run, the at-times arduous and slow provider contracting process, and the documented need to begin boosting resources for primary care to address provider capacity and access. For these reasons OHIC proposed an initial 2025 implementation target of 0.5% of total medical expenditures, above 2022 baselines. Future year implementation targets were proposed of at least 1% of total medical expenditures. OHIC believes the proposed targets are attainable. Insurers may request a prior period adjustment in future rate filings to correct for additional patient care expenditures related to implementation of the requirement in 2025.

§ 4.10(C) – Primary care practice transformation

11. Brown Medicine commented that placing patient-centered medical home (PCMH) infrastructure and care management payments at risk for quality performance should be coupled with an OHIC defined quality performance rate. RIPCPC commented that OHIC should impose a minimum value for PCMH payments instead of leaving this to the contracting parties.

    OHIC Response – No change to text of the rule: OHIC does not presently specify performance targets for quality payment programs or define minimum acceptable PCMH payments. OHIC is not prepared to change policy at this time. To ensure consistency of PCMH payments and greater insight into insurer practices, OHIC will require that insurers report data to OHIC on total attributed patients and PMPM payments to PCMHs pursuant to § 4.10(C)(1)(b)(5) of the Adopted Regulation.

12. BCBSRI recommended eliminating the PMPM requirement for PCMHs in 2026 to allow for greater flexibility in supporting OHIC-recognized PCMHs. BCBSRI stated: "As primary care spending increases, it also will be important to ensure that the increased spend is directed in a way that provides the most impact to access and quality for Rhode Island residents. [….] While the certainty of fixed payments was important in the early stages of the PCMH practice transformation, it is important to ensure that those significant payments are being used wisely."

    OHIC Response – No change to text of the rule: § 4.10(C)(1)(b) sets forth requirements that commercial health insurers pay for PCMH infrastructure and care management according to specific guidelines. This requirement was promulgated in 2015 in response to the uncertainty of future funding following the transition of PCMHs from the common contract under the CTC-RI program to insurer-specific contracting. Historically, PMPM payments (which occur outside of the FFS billing system) have been paid to PCMH practices or to Accountable Care Organizations on behalf of their PCMH practices. PMPMs have the advantage of not requiring providers collect member cost-sharing for associated services, including care management, minimizing administrative burden, and for their steadiness and predictability. OHIC agrees that accountability for funds is important, and health insurers should find ways to ensure that PCMH funding is being put to optimal use. While FFS billing for care management services may provide a mechanism for tracking care management activity and better holding provider organizations accountable for use of funds, OHIC did not propose changes to § 4.10(C)(1)(b) such that elimination of the PMPM requirement would be acceptable in the context of this rulemaking. OHIC is committed to continuing discussion on the mechanisms, funding levels, and accountability standards for PCMH support. However, no additional changes to § 4.10(C)(1)(b) will be made at this time.

§ 4.10(D) – Payment reform

Several commentors provided feedback on payment reform provisions within § 4.10(D), particularly in relation to the treatment of drug expenditures in risk-based contracts.

13. Brown Medicine noted "[h]igh cost drugs are creating budget issues for employers, plans, and integrated systems. It may be reasonable to allow them to be carved out, provide an example of a mitigation strategy or provide sub-regulatory guidance on acceptable risk-mitigation strategies." HARI and Integra commented that OHIC should clarify whether high-cost specialty drugs may be excluded from total-cost of care budgets or to specify acceptable contractual mechanisms to mitigate the associated financial risks. RIPCPC stated: "[g]iven the continued, and at time unpredictable increase in specialty drugs, leniency should be provided for inclusion of Rx costs in contracts. At a minimum, trend-based contracts should account for new drugs to market and/or new therapeutic uses for existing drugs, which might turn a trend-based model upside down."

    OHIC Response – Post comment change: § 4.10(D)(2)(h) pertains to population-based contracts and prohibits health insurers from excluding behavioral health and prescription drug claims experience from the provider budget. This provision was adopted several years ago to ensure that population-based total cost of care contracts were comprehensive and accounted for whole-person care, inclusive of behavioral health. OHIC proposed amending this provision to allow for health insurers and providers to "negotiate contractual mechanisms to mitigate risk from high-cost specialty drugs." While it is customary for risk-based contracts to include high-cost claims truncation, risk corridors, and risk exposure caps as mechanisms to mitigate excessive financial risk it has become apparent from recent experience that drug expenditures are a key driver of volatility in provider performance under these contracts. In response to the public comments OHIC has revised § 4.10(D)(2)(h) of the Adopted Regulation to clarify that specialty drugs may be excluded from total cost of care budgets at the mutual agreement of the contracting parties.

§ 4.10(A) – Affordability Standards compliance threshold

14. Point32Health expressed concern with OHIC's proposal to lower the covered lives threshold for compliance with the delivery system and payment reform strategies from 10,000 to 5,000.

    OHIC Response – No change to text of the rule: OHIC appreciates Point32Health's comments on the compliance threshold. The compliance threshold was lowered to ensure fairness across regulated insurers. Certain requirements, including funding for primary care and PCMH sustainability payments, can be implemented without consideration of size. In other instances, supported by factual analysis and good cause, insurers may petition the Commissioner for a waiver pursuant to § 4.10(F).

§ 4.11 – Administrative Simplification

The proposed amendments included a new subsection (F) of § 4.11 which addresses prior authorization. The adopted amendments are designed to reduce provider administrative burden due to prior authorization and to establish guidelines for health insurers to streamline, continuously improve, and monitor improvements in prior authorization processes over time. OHIC received

robust comments on the proposed amendments from a range of stakeholders, including providers, health insurers, and the Office of the Attorney General.

15. Some stakeholders provided broad or supportive feedback regarding the overall proposed framework for administrative simplification. RIMS emphasized the need to standardize and automate prior authorization processes to reduce variability and improve transparency. Brown University Health and CharterCARE Provider Group of Rhode Island expressed general support for the proposed amendments without suggesting revisions. The Office of the Attorney General agreed "that a reduction in prior authorization volume is a necessary step to relieve the excessive administrative burdens faced by primary care providers. However, the proposed regulations lack the necessary support, enforcement options, and public accountability to provide the benefit Rhode Island providers deserve." The Office of the Attorney General further requested the basis for the targeted 20% reduction in prior authorization volume.

    OHIC Response – No change to text of the rule: The proposed amendments followed from OHIC's recommendations concerning reductions in administrative burden for primary care providers in December 2023 and the completion of OHIC's legislatively mandated Report of the Administrative Simplification Taskforce in June 2024. The amendments proposed, and those ultimately adopted, represent a starting point for more effective, strategic oversight of prior authorization practices. This includes improved data collection and monitoring of prior authorization volume across health insurers, better transparency into the factors that health insurers weigh when developing prior authorization rules, and an initial reduction in prior authorization volumes. The reduction target of 20% was developed in consultation with interested parties through two working group processes: the CTC-RI steering committee on prior authorization and the OHIC Administrative Simplification Task Force. These efforts are described in the June 2024 Report.

    OHIC believes there are opportunities for the Rhode Island General Assembly to pass additional laws governing prior authorization in the coming years. Furthermore, OHIC believes there are opportunities for health care-focused employers, such as health systems and hospitals, which account for a large percentage of Rhode Island employment, to work with their health plan administrators to reduce provider administrative burdens, starting with their employee health benefit plans.

    To provide public accountability, the Adopted Regulation § 4.11(F)(5)-(7) introduce new quarterly data collection, require insurer attestation, including answers to a standard set of questions, regarding prior authorization processes and annual reviews of prior authorization requirements, and outline a new OHIC-convened statewide advisory committee on prior authorization which will conduct public meetings. OHIC will perform these activities with existing resources.

    Regarding enforcement, OHIC has ample enforcement options.

16. Several stakeholders expressed concerns about the implementation timeline for the 20% prior authorization reduction and posed questions regarding data collection and measurement. BCBSRI recommended revising the implementation date for the 20% prior authorization reduction to the end of 2026 or phasing it in over 2025-2026 to allow insurers to adjust and mitigate medical expense increases. BCBSRI also requested "OHIC allow for some credit for actions taken before 2023 to reduce prior authorization burdens." NHPRI offered a similar concern and suggested measurement timelines align with the annual rate review process. Point32Health requested clarification on how the 20% reduction, based on a 2023 baseline, will be calculated, and enforced. AHIP and Cigna expressed concern with the 20% reduction target and requested either its removal or the addition of an exception process to account for varying starting points among insurers.

    OHIC Response – Post comment change: OHIC agrees that a phased-in approach is reasonable. OHIC has modified § 4.11(F)(2) in the Adopted Regulation to extend the timeframe for achievement of the 20% reduction target to the end of 2026. This additional time will allow health insurers and providers more time to collaborate on achieving strategic reductions in prior authorization volume in accordance with the direction articulated in the Adopted Regulation. Furthermore, to account for differences among insurer baselines due to actions to reduce prior authorization practices prior to 2023, language has been added to the Adopted Regulation to allow for this consideration in the development of baselines and target performance.

17. Proposed § 4.11(F)(3) would require health insurers to develop and implement "selective prior authorization requirements, based on stratification of health care providers' performance and adherence to evidence-based medicine." The proposed implementation of such programs, commonly referred to as "gold carding," elicited mixed reactions from stakeholders. AHIP and Cigna Healthcare expressed concerns with the proposal to require the development and implementation of "gold carding" programs. AHIP stated: "Broadly waiving PA [prior authorization] and mandating gold carding programs could lead to clinically inappropriate care, exposing patients to potential harm by using a service or drug where there is little to no evidence of clinical benefit, and could raise costs for all consumers and purchasers." NHPRI raised concerns regarding the "operational complexity" of implementing gold carding. BCBSRI encouraged OHIC to delay implementation of the gold carding requirement. Providers did not express strong support or opposition to the proposal to require gold carding.

    OHIC Response – Post comment change: Gold carding is only one mechanism that can be employed to mitigate provider administrative burden due to prior authorization while encouraging adherence to evidence-based care. OHIC appreciates the concerns raised by the insurers. In response to these concerns, OHIC has revised § 4.11(F)(3) of the Adopted Regulation to remove the requirement that health insurers develop gold carding programs. The proposed "shall" has been modified to "may." If health insurers develop and implement gold carding programs, the text of the Adopted Regulation retains requirements governing those programs.

18. NHPRI recommended excluding non-formulary drugs from the prior authorization reduction target.

    OHIC Response – Post comment change: OHIC agrees with NHPRI's recommendation. Consequently, § 4.11(F)(2) of the Adopted Regulation has been revised to exclude non-formulary drugs from the 20% reduction target.

19. RIPIN encouraged OHIC to "consider further action, including through the establishment of more particularized standards regarding the considerations enumerated at § 4.11(F)(4)(a)(1)-(5), such as prohibiting prior authorization for service lines with an average cost below a certain threshold and approval rates above a certain threshold; service lines identified as being particularly onerous for providers vis-à-vis their approval rate; and service lines where patient experience of and continuity of care are particularly implicated, such as within priority areas such as primary care or behavioral health."

    OHIC Response – No change to text of the rule: RIPIN has proposed ideas that are worthy of consideration. OHIC is not prepared to adopt more specific, quantitative standards, at this time. OHIC looks forward to collecting and reviewing data and health insurer attestations pursuant to the Adopted Regulation to inform future regulatory changes, or legislation.

REGULATORY ANALYSIS:

Pursuant to the Administrative Procedures Act, R.I. Gen. Laws § 42-35-2.9 and Executive Order 15-07 OHIC conducted a regulatory and cost-benefit analysis of the amendments. Interested parties are referred to the document Regulatory & Cost-Benefit Analysis for an assessment of the societal costs and benefits of the amendments. OHIC believes the amendments are likely to generate societal benefits that exceed the costs.

In the development of the amendments, consideration was given to: (1) alternative approaches; (2) overlap or duplication with other statutory and regulatory provisions; and (3) significant economic impact on small business. No alternative approach, duplication, or overlap was identified based upon available information.

I, Cory B. King, the Health Insurance Commissioner, hereby approve the attached final rule, 230-RICR-20-30-4 – Powers and Duties of the Office of the Health Insurance Commissioner.

Dated February 13, 2025

Cory B. King

230-RICR-20-30-4

TITLE 230 – DEPARTMENT OF BUSINESS REGULATION

CHAPTER 20 – INSURANCE

SUBCHAPTER 30 – HEALTH INSURANCE

PART 4 – POWERS AND DUTIES OF THE OFFICE OF THE HEALTH INSURANCE COMMISSIONER

4.1 Authority

A. This regulation is promulgated pursuant to R.I. Gen. Laws §§ 42-14.5-1 *et seq*., 42-14-5, and 42-14-17.

4.2 Purpose and Scope

A. When creating the Office of the Health Insurance Commissioner ("OHIC" or "Office"), the General Assembly created a list of statutory purposes for the OHIC at R.I. Gen. Laws § 42-14.5-2 (the OHIC Purposes Statute). In order to meet the requirements established by the OHIC Purposes Statute, the OHIC has developed this regulation, which is designed to:

1. Ensure effective regulatory oversight by the OHIC;

2. Provide guidance to the state's health insurers, health care providers, consumers of health insurance, consumers of health care services and the general public as to how the OHIC will interpret and implement its statutory obligations; and

3. Implement the intent of the General Assembly as expressed in the OHIC Purposes Statute.

4.3 Definitions

A. As used in this regulation:

1. "Affiliate" means the same as set out in the first sentence of R.I. Gen. Laws § 27-35-1(a). An "affiliate" of, or an entity or person "affiliated" with, a specific entity or person, is an entity or person who directly or indirectly through one or more intermediaries controls, or is controlled by, or is under common control with, the entity or person specified.

2. "Aligned measure set" means any set of quality measures adopted by the Commissioner pursuant to § 4.10(D)(5) of this Part. An Aligned Measure Set shall consist of measures designated as 'Core Measures' and/or

‘Menu Measures.’ Aligned Measure Sets are developed for specific provider contract types (e.g. primary care provider contracts, hospital contracts, Accountable Care Organization (ACO, or Integrated System of Care) contracts.

3. "Commissioner" means the Health Insurance Commissioner.

4. "Core measures" means quality measures in an Aligned Measure Set that have been designated for mandatory inclusion in applicable health care provider contracts that incorporate quality measures into the payment terms (e.g., primary care measures for primary care provider contracts).

5. “Demographic data” means self-reported data on race, ethnicity, preferred language, sex assigned at birth, gender identity, sexual orientation, and disability.

~~6. "Direct primary care expenses" means payments by the Health Insurer directly to a primary care practice for:~~

~~a. Providing health care services, including fee-for service payments, capitation payments, and payments under other alternative, non-fee-for-service methodologies designed to provide incentives for the efficient use of health services;~~

~~b. Achieving quality or cost performance goals, including pay-for-performance payments and shared savings distributions;~~

~~c. Infrastructure development payments within the primary care practice, which the practice cannot reasonably fund independently, in accordance with parameters and criteria issued by order of the Commissioner, or upon request by a Health Insurer and approval by the Commissioner:~~

~~(1) That are designed to transform the practice into, and maintain the practice as a Patient Centered Medical Home, and to prepare a practice to function within an Integrated System of Care. Examples of acceptable spending under this category include:~~

~~(AA) Making supplemental payments to fund a practice-based and practice-paid care manager;~~

~~(BB) Funding the provision of care management resources embedded in, but not paid for by, the primary care practice;~~

~~(CC) Funding the purchase by the practice of analytic software that enables primary care practices to~~

~~analyze patient quality and/or costs, such as software that tracks patient costs in near-to-real time;~~

~~(DD) Training of members of the primary care team in motivational interviewing or other patient activation techniques; and~~

~~(EE) Funding the cost of the practice to link to the health information exchange established by R.I. Gen. Laws Chapter 5-37.7;~~

~~(2) That promote the appropriate integration of primary care and behavioral health care; for example, funding behavioral health services not traditionally covered with a discrete payment when provided in a primary care setting, such as substance abuse or depression screening;~~

~~(3) For shared services among small and independent primary care practices to enable the practices to function as Patient-Centered Medical Homes. Acceptable spending under this category:~~

~~(AA) must directly enhance a Primary Care Practice's ability to support its patient population, and~~

~~(BB) must provide, reinforce or promote specific skills that Patient-Centered Medical Homes must have to effectively operate using Patient-Centered Medical Home principles and standards, or to participate in an Integrated System of Care that successfully manages risk-bearing contracts. Examples of acceptable spending under this category include:~~

~~(i) Funding the cost of a clinical care manager who rotates through the practices;~~

~~(ii) Funding the cost of a practice data analyst to provide data support and reports to the participating practices, and~~

~~(iii) Funding the costs of a pharmacist to help practices with medication reconciliation for poly-pharmacy patients;~~

~~(4) That promote community-based services to enable practices to function as Patient Centered Medical Homes. Acceptable spending under this category:~~

~~(AA) must directly enhance a Primary Care Practice's ability to support its patient population, and~~

~~(BB) must provide, reinforce or promote specific skills that the Patient-Centered Medical Homes must have to effectively operate using Patient-Centered Medical Home principles and standards, or to participate in an Integrated System of Care that successfully manages risk-bearing contracts. Acceptable spending under this category includes funding multi-disciplinary care management teams to support Primary Care Practice sites within a geographic region;~~

~~(5) Designed to increase the number of primary care physicians practicing in RI, and approved by the Commissioner, such as a medical school loan forgiveness program; and~~

~~(6) Any other direct primary care expense that meets the parameters and criteria established in a bulletin issued by the Commissioner, or that is requested by a Health Insurer and approved by the Commissioner.~~

6~~7~~. "Examination" means the same as set out in R.I. Gen. Laws § 27-13.1-1 *et seq*.

7~~8~~. "Health insurance" means "health insurance coverage," as defined in R.I. Gen. Laws §§ 27-18.5-2 and 27-18.6-2, "health benefit plan," as defined in R.I. Gen. Laws § 27-50-3 and a "medical supplement policy," as defined in R.I. Gen. Laws § 27-18.2-1 or coverage similar to a Medicare supplement policy that is issued to an employer to cover retirees.

8~~9~~. "Global capitation contract" means a Population-Based Contract with an Integrated System of Care that:

a. holds the Integrated System of Care responsible for providing or arranging for all, or substantially all of the covered services provided to the Health Insurer's defined group of members in return for a monthly payment that is inclusive of the total, or near total costs of such covered services based on a negotiated percentage of the Health Insurer's premium or based on a negotiated fixed per member per month payment, and

b. incorporates incentives and/or penalties for performance relative to quality targets.

9~~10~~. "Health insurer" means any entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the Commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for,

or reimburse any of the costs of health care services, including, without limitation, an insurance company offering accident and sickness insurance, a health maintenance organization, a non-profit hospital service corporation, a non-profit medical service corporation, a non-profit dental service corporation, a non-profit optometric service corporation, a domestic insurance company subject R.I. Gen. Laws Chapter 27-1 that offers or provides health insurance coverage in the state and a foreign insurance company subject to R.I. Gen. Laws Chapter 27-2 that offers or provides health insurance coverage in the state.

10~~11~~. "Holding company system" means the same as set out in R.I. Gen. Laws § 27-35-1 *et seq*.

~~12. "Indirect primary care expenses" means payments by the Health Insurer to support and strengthen the capacity of a primary care practice to function as a medical home, and to successfully manage risk-bearing contracts, but which do not qualify as Direct Primary Care Expenses. Indirect Primary Care Expenses may include a proper allocation, proportionate to the benefit accruing to the Primary Care Practice, of Health Insurer investments in data, analytics, and population-health and disease registries for Primary Care Practices without the foreseeable ability to make and manage such infrastructure investments, but which do not qualify as acceptable Direct Primary Care Spending, in accordance with parameters and criteria issued in a bulletin issued by the Commissioner, or upon request by a Health Insurer and approved by the Commissioner. Such payments shall include financial support, in an amount approved by the Commissioner, for the administrative expenses of the medical home initiative endorsed by R.I. Gen. Laws Chapter 42-14.6, and for the health information exchange established by R.I. Gen. Laws Chapter 5-37.7.~~

11~~13~~. "Integrated system of care", sometimes referred to as an Accountable Care Organization, means one or more business entities consisting of physicians, other clinicians, hospitals and/or other providers that together provide care and share accountability for the cost and quality of care for a population of patients, and that enters into a Population-Based Contract, such as a Shared Savings Contract or Risk Sharing Contract or Global Capitation Contract, with one or more Health Insurers to care for a defined group of patients.

12~~14~~. "Low-value care" most often refers to medical services, including tests and procedures, that should not be performed given their potential for harm or the existence of comparably effective and often less expensive alternatives.

13~~15~~. "Menu measures" means quality measures within an Aligned Measure Set that are included in applicable health care provider contracts that incorporate quality measures into the payment terms when such inclusion

occurs at the mutual agreement of the Health Insurer and contracted health care provider.

14~~16~~. "Minimum loss rate," means a defined percentage of the total cost of care, or annual provider revenue from the insurer under a population-based contract, which must be met or exceeded before actual losses are incurred by the provider. Losses may accrue on a "first dollar" basis once the "minimum loss rate" is breached.

15~~17~~. "Patient-centered medical home" means:

a. A Primary Care Practice recognized by the collaborative initiative endorsed by R.I. Gen. Laws Chapter 42-14.6, or

b. A Primary Care Practice recognized by a national accreditation body, or

c. A Primary Care Practice designated by contract between a Health Insurer and a primary care practice, or between a Health Insurer and an Integrated System of Care in which the Primary Care Practice is participating. A contractually designated Primary Care Practice must meet pre-determined quality and efficiency criteria and practice performance standards, which are approved by the Commissioner, for improved care management and coordination that are at least as rigorous as those of the collaborative initiative endorsed by R.I. Gen. Laws Chapter 42-14.6. For the purposes of this definition a primary care practice that participates in a primary care alternative payment model and participates in an integrated system of care will be deemed to have met the requirements of a patient-centered medical home, and

d. A Primary Care Practice which has demonstrated development and implementation of meaningful cost management strategies and clinical quality performance attainment and/or improvement. The requirements for meaningful cost management strategies and for clinical quality performance attainment and/or improvement, and the measures for assessing performance, shall be determined annually by the Commissioner.

16~~18~~. "Population-based contract" means a provider reimbursement contract with an Integrated System of Care that uses a reimbursement methodology that is inclusive of the total, or near total medical costs of an identified, covered-lives population. A Population-Based Contract may be a Shared Savings Contract, or a Risk Sharing Contract, or a Global Capitation Contract. A primary care or specialty service capitation reimbursement contract shall not be considered a Population-Based Contract for purposes of this Part. A Population-Based Contract may not

transfer insurance risk or any health insurance regulatory obligations. A Health Insurer may request clarification from the Commissioner as to whether its proposed contract constitutes the transfer of insurance risk.

17~~19~~. "Primary care alternative payment model" means a payment model that relies on prospective payment to a primary care practice or a primary care provider for a defined set of primary care services (including office evaluation and management services) in addition to any amounts paid to support care management and infrastructure of the primary care practice. It may also include a model that includes additional services in the alternative payment methodology, such as integrated behavioral health.

18. "Primary care expenditures" means all claims-based and non-claims-based payments by the health insurer directly to a Primary Care Practice or Integrated System of Care for primary care services delivered to Rhode Island residents at a primary care site of care, which shall include a primary care outpatient setting, federally qualified health center, school-based health center, or via telehealth, but shall not include a third-party telehealth vendor that does not contract with such sites of care to deliver services. A primary care site of care also does not include urgent care centers or retail pharmacy clinics. Primary care expenditures shall be limited to:

a. Claims-based payments for primary care services, based on allowed claims, defined using the primary care payment code list in § 4.14 of this Part, for:

(1) Care management;

(2) Care planning;

(3) Consultation services;

(4) Health risk assessments, screening and health behavior counseling;

(5) Home visits;

(6) Hospice and home health services;

(7) Immunization administrations; and

(8) Office visits and preventive medicine visits.

b. Non-claims-based payments, for:

(1) 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;

(2) Primary care provider incentive payments made by the health insurer, provided that shared savings and other forms of incentive payments to organizations that include, but are not solely comprised of, primary care providers shall only be allocated as primary care expenditures for the portion of payments directed to primary care providers as determined by an allocation methodology approved by the Commissioner;

(3) Payments to support population health management and primary care practice infrastructure at the primary care site of care;

(4) Primary care provider salaries; and

(5) Recoveries.

c. Payments for the administrative expenses of the medical home initiative endorsed by R.I. Gen. Laws Chapter 42-14.6, in an amount approved by the Commissioner.

19~~20~~. "Primary care practice" means the practice of a physician, medical practice, or other medical provider considered by the insured subscriber or dependent to be his or her usual source of care. Designation of a primary care provider shall be limited to providers within the following practice type: Family Medicine~~Practice~~, Geriatrics, Internal Medicine and Pediatrics, using a set of taxonomy codes from the National Uniform Claim Committee in § 4.13 of this Part; and providers with the following professional credentials: Doctors of Medicine and Osteopathy, Nurse Practitioners, and Physicians' Assistants; except that specialty medical providers, including behavioral health providers, may be designated as a primary care provider if the specialist is paid for primary care services on a primary care provider fee schedule, and contractually agrees to accept the responsibilities of a primary care provider.

20. "Primary care provider" means a provider within the practice types of Family Medicine, Geriatrics, Internal Medicine, and Pediatrics, defined using a set of taxonomy codes from the National Uniform Claim Committee in § 4.13 of this Part and providers with the following professional credentials: Doctors of Medicine and Osteopathy, Nurse Practitioners, and Physicians' Assistants; except that specialty medical providers, including behavioral health providers, may be designated as a primary care provider if the specialist is paid for primary care services on a

primary care provider fee schedule, and contractually agrees to accept the responsibilities of a primary care provider.

21. "Qualifying Integrated Behavioral Health Primary Care Practice" means:

    a. A patient-centered medical home practice that is recognized by a national accreditation body (such as NCQA) as an integrated behavioral health practice, or

    b. A patient-centered medical home practice that participated in and successfully completed, or is currently participating in, an integrated behavioral health program under the oversight of the collaborative initiative endorsed by R.I. Gen. Laws Chapter 42-14.6. Such practices must be recognized as an integrated behavioral health practice by a national accreditation body (such as NCQA) or meet integrated behavioral health standards developed by the Care Transformation Collaborative of Rhode Island, or

    c. A patient centered-medical home practice that completes a qualifying behavioral health integration self-assessment tool approved by the Commissioner and develops an action plan for improving its level of integration. Such practices must be recognized as an integrated behavioral health practice by a national accreditation body (such as NCQA) or meet integrated behavioral health standards developed by the Care Transformation Collaborative of Rhode Island.

22. "Risk exposure cap" means a cap on the losses which may be incurred by the provider under the contract, expressed as a percentage of the total cost of care or the annual provider revenue from the insurer under the population-based contract.

23. "Risk sharing contract" means a Population-Based Contract that:

    a. Holds the provider financially responsible for a negotiated portion of costs that exceed a predetermined population-based budget, in exchange for provider eligibility for a portion of any savings generated below the predetermined budget, and

    b. Incorporates incentives and/or penalties for performance relative to quality targets.

24. "Risk sharing rate" means the percentage of total losses shared by the provider with the insurer under the contract after the application of any minimum loss rate.

25. "Shared savings contract" means a Population-Based Contract that:

a. Allows the provider to share in a portion of any savings generated below a predetermined population-based budget, and

b. Incorporates incentives and/or penalties for performance relative to quality targets.

26. "Total annual medical expenditures" means 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, net of pharmacy rebates, and excluding long-term care expenditures.

4.4 Discharging Duties and Powers

A. The Commissioner shall discharge the powers and duties of the Office to:

1. Guard the solvency of health insurers;

2. Protect the interests of the consumers of health insurance;

3. Encourage fair treatment of health care providers by health insurers;

4. Encourage policies and developments that improve the quality and efficiency of health care service delivery and outcomes; and

5. View the health care system as a comprehensive entity and encourage and direct health insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access.

4.5 Guarding the Solvency and Financial Condition of Health Insurers

A. The solvency of health insurers must be guarded to protect the interests of insureds, health care providers, and the public generally.

B. Whenever the Commissioner determines that one of the circumstances in §§ 4.5(B)(1) through (4) of this Part exist, the Commissioner shall, in addition to exercising any duty or power authorized or required by R.I. Gen. Laws Titles 27 or 42 related specifically to the solvency or financial health of a health insurer, act to guard the solvency and financial condition of a health insurer when exercising any other power or duty of the Office, including, but not limited to, approving or denying any request or application; approving, denying or modifying any requested rate; approving or rejecting any forms, trend factors, or other filings; issuing any order, decision or ruling; initiating any proceeding, hearing, examination, or inquiry; or taking any other action authorized or required by statute or regulation.

1. The solvency or financial condition of any health insurer is in jeopardy or is likely to be in jeopardy;

2. Any action or inaction by a health insurer could adversely affect the solvency or financial condition of that health insurer;

3. The approval or denial of any regulatory request, application or filing by a health insurer could adversely affect the solvency or financial condition of that health insurer; or

4. Any other circumstances exist such that the solvency or financial condition of a health insurer may be at risk.

C. When making a determination as described in § 4.5(B) of this Part or when acting to guard the solvency of a health insurer, the Commissioner may consider and/or act upon the following solvency and financial factors, either singly or in combination of two or more:

1. Any appropriate financial and solvency standards for the health insurer, including those set out in R.I. Gen. Laws Title 27 and implementing regulations;

2. The investments, reserves, surplus and other assets and liabilities of a health insurer;

3. A health insurer's use of reinsurance, and the insurer's standards for ceding, reporting on, and allowing credit for such reinsurance;

4. A health insurer's transactions with affiliates, agents, vendors, and other third parties to the extent that such transactions adversely affect the financial condition of the health insurer;

5. Any audits of a health insurer by independent accountants, consultants or other experts;

6. The annual financial statement and any other report prepared by or on behalf of a health insurer related to its financial position or financial activities;

7. A health insurer's transactions within an insurance holding company system;

8. Whether the management of a health insurer, including its officers, directors, or any other person who directly or indirectly controls the operation of the health insurer, fails to possess and demonstrate the competence, fitness, and reputation deemed necessary to serve the insurer in the position;

9. The findings reported in any financial condition or market conduct examination report and financial analysis procedures;

10. The ratios of commission expense, general insurance expense, policy benefits and reserve increases as to annual premium and net investment income, which could lead to an impairment of capital and surplus;

11. Concerns that a health insurer's asset portfolio, when viewed in light of current economic conditions, is not of sufficient value, liquidity, or diversity to ensure the health insurer's ability to meet its outstanding obligations as such obligations mature;

12. The ability of an assuming reinsurer to perform and whether the health insurer's reinsurance program provides sufficient protection for the health insurer's remaining surplus after taking into account the health insurer's cash flow and the classes of business written and the financial condition of the assuming reinsurer;

13. The health insurer's operating loss in the last twelve--month period or any shorter period of time, including but not limited to net capital gain or loss, change in non-admitted assets, and cash dividends paid to shareholders, is greater than fifty percent (50%) of the health insurer's remaining surplus as regards policyholders in excess of the minimum required;

14. Whether any affiliate, subsidiary, or reinsurer of a health insurer is insolvent, threatened with insolvency, or delinquent in the payment of its monetary or other obligations;

15. Any contingent liabilities, pledges, or guaranties of a health insurer that either individually or collectively involve a total amount which in the opinion of the Commissioner may affect the solvency of the health insurer;

16. Whether any person, firm, association, or corporation who directly or indirectly has the power to direct or cause to be directed, the management, control, or activities of a health insurer, is delinquent in the transmitting to, or payment of, net premiums to the insurer;

17. The age and collectability of a health insurer's receivables;

18. Whether the management of a health insurer has

    a. Failed to respond to inquiries by the Commissioner, the Department of Business Regulation, the Department of Health, the Department of the Attorney General, any other state or federal agency relative to the financial condition of the health insurer;

    b. Furnished false and misleading information concerning an inquiry by the Commissioner, the Department of Business Regulation, the

Department of Health, the Department of the Attorney General, any other state or federal agency regarding the financial condition of the health insurer; or

c. Failed to make appropriate disclosures of financial information to the Commissioner, the Department of Business Regulation, the Department of Health, the Department of the Attorney General, any other state or federal agency, or the public.

19. Whether the management of a health insurer either has filed any false or misleading sworn financial statement, or has released a false or misleading financial statement to lending institutions or to the general public, or has made a false or misleading entry, or has omitted an entry of material amount in the books of the health insurer;

20. Whether a health insurer has grown so rapidly and to such an extent that it lacks adequate financial and administrative capacity to meet its obligations in a timely manner; and

21. Whether a health insurer has experienced or will experience in the foreseeable future cash flow and/or liquidity problems.

D. The factors enumerated in § 4.5(C) of this Part shall not be construed as limiting the Commissioner from making a finding that other factors not specifically enumerated in § 4.5(C) of this Part are necessary or desirable factors for the evaluation and maintenance of the sound financial condition and solvency of a health insurer.

4.6 Protecting the Interests of Consumers

A. The interests of the consumers of health insurance, including individuals, groups and employers, must be protected.

B. The provisions of this regulation do not require the Commissioner to act as an advocate on behalf of a particular health insurance consumer. Instead, while the Commissioner will endeavor to address individual consumer complaints as they arise, the OHIC Purposes Statute requires the OHIC to protect the interests of health insurance consumers, including individuals, groups and employers, on a system-wide basis.

C. Whenever the Commissioner determines that one of the circumstances in §§ 4.6(C)(1) through (3) of this Part exist, the Commissioner shall, in addition to exercising any duty or power authorized or required by R.I. Gen. Laws Titles 27 or 42 related specifically to the protection of the interests of the consumers of health insurance, act to protect the interests of consumers of health insurance when exercising any other power or duty of the Office, including, but not limited to, approving or denying any request or application; approving, denying or

modifying any requested rate; approving or rejecting any forms, trend factors, or other filings; issuing any order, decision or ruling; initiating any proceeding, hearing, examination, or inquiry; or taking any other action authorized or required by statute or regulation.

1. The interests of the state's health insurance consumers are, or are likely to be, adversely affected by any policy, practice, action or inaction of a health insurer;

2. The approval or denial by the Commissioner of any regulatory request, application or filing made by a health insurer could adversely affect the interests of the state's health insurance consumers; or

3. Any other circumstances exist such that the interests of the state's health insurance consumers may be adversely affected.

D. When making a determination as described in § 4.6(C) of this Part or when acting to protect the interests of the state's health insurance consumers, the Commissioner may consider and/or act upon the following consumer interest issues, either singly or in combination of two or more:

1. The privacy and security of consumer health information;

2. The efforts by a health insurer to ensure that consumers are able to

   a. Read and understand the terms and scope of the health insurance coverage documents issued or provided by the health insurer and

   b. Make fully informed choices about the health insurance coverage provided by the health insurer;

3. The effectiveness of a health insurer's consumer appeal and complaint procedures.;

4. The efforts by a health insurer to ensure that consumers have ready access to claims information;

5. The efforts by a health insurer to increase the effectiveness of its communications with its insureds, including, but not limited to, communications related to the insureds' financial responsibilities;

6. That the benefits in health insurance coverage documents issued or provided by a health insurer are consistent with state laws;

7. That the benefits delivered by a health insurer are consistent with those guaranteed by the health insurance coverage documents issued or provided by the health insurer; and

8. The steps taken by a health insurer to enhance the affordability of its products, as described in § 4.9 of this Part.

E. The factors enumerated in § 4.6(D) of this Part shall not be construed as limiting the Commissioner from making a finding that other consumer protection issues not specifically enumerated in § 4.6(D) of this Part are necessary or desirable factors upon which the Commissioner may act to protect the interests of consumers of health insurance.

4.7 Encouraging Fair Treatment of Health Care Providers

A. The Commissioner will act to encourage the fair treatment of health care providers by health insurers.

B. The provisions of this regulation do not require the Commissioner to act as an advocate for a particular health care provider or for a particular group of health care providers. Instead, while the Commissioner will endeavor to address individual health care provider complaints as they arise, the OHIC Purposes Statute requires the OHIC to act to enhance system-wide treatment of providers.

C. Whenever the Commissioner determines that any of the circumstances in §§ 4.7(C)(1) through (4) of this Part exist, the Commissioner shall, in addition to exercising any duty or power authorized or required by R.I. Gen. Laws Titles 27 or 42 related specifically to the fair treatment of health care providers, take the treatment of health care providers by a health insurer into consideration when exercising any other power or duty of the Office, including, but not limited to, approving or denying any request or application; approving, denying or modifying any requested rate; approving or rejecting any forms, trend factors, or other filings; issuing any order, decision or ruling; initiating any proceeding, hearing, examination, or inquiry; or taking any other action authorized or required by statute or regulation.

1. Health care providers are being treated unfairly by a health insurer;

2. The policies or procedures of a health insurer place an undue, inconsistent or disproportionate burden upon a class or providers;

3. The approval or denial by the Commissioner of any regulatory request, application or filing made by a health insurer will result in unfair treatment of a health care providers by a health insurer; or

4. Any other circumstances exist such that Commissioner is concerned that health care providers will be treated unfairly by a health insurer.

D. When making a determination as described in § 4.7(C) of this Part or when acting to encourage the fair treatment of providers, the Commissioner may consider and/or act upon the following issues, either singly or in combination of two or more:

1. The policies, procedures and practices employed by health insurers with respect to provider reimbursement, claims processing, dispute resolution and contracting processes;

2. A health insurer's provider rate schedules; and

3. The efforts undertaken by the health insurers to enhance communications with providers.

E. The factors enumerated in § 4.7(D) of this Part shall not be construed as limiting the Commissioner from making a finding that other factors related to the treatment of health care providers by a health insurer not specifically enumerated are necessary or desirable factors for the evaluation of whether health care providers are being treated fairly by a health insurer. The factors that may be considered by the Commissioner will not typically include those matters over which other agencies, such as the Department of Health, have jurisdiction.

4.8 Improving the Efficiency and Quality of Health Care Delivery and Increasing Access to Health Care Services

A. Consumers, providers, health insurers and the public generally have an interest in:

1. Improving the quality and efficiency of health care service delivery and outcomes in Rhode Island;

2. Viewing the health care system as a comprehensive entity; and

3. Encouraging and directing insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access.

B. The government, consumers, employers, providers and health insurers all have a role to play in increasing access to health care services and improving the quality and efficiency of health care service delivery and outcomes in Rhode Island. Nevertheless, the state's health insurers, because of their prominent role in the financing of health care services, bear a greater burden with respect to improving the quality and efficiency of health care service delivery and outcomes in Rhode Island, treating the health care system as a comprehensive entity, and advancing the welfare of the public through overall efficiency, improved health care quality, and appropriate access. Furthermore, a balance must be struck between competition among the health insurers, which can result in benefits such as innovation, and collaboration, which can promote consumer and provider benefits such as standardization and simplification.

C. Whenever the Commissioner determines that any of the circumstances listed in §§ 4.8(C)(1) or (2) of this Part exist, the Commissioner shall, in addition to

exercising any duty or power authorized or required by R.I. Gen. Laws Titles 27 or 42 related specifically to improving the efficiency and quality of health care delivery and increasing access to healthcare services, act to further the interests set out in § 4.8(C)(1)(a) of this Part when exercising any other power or duty of the Office, including, but not limited to, approving or denying any request or application; approving, denying or modifying any requested rate; approving or rejecting any forms, trend factors, or other filings; issuing any order, decision or ruling; initiating any proceeding, hearing, examination, or inquiry; or taking any other action authorized or required by statute or regulation.

1. The decision to approve or deny any regulatory request, application or filing made by a health insurer

    a. Can be made in a manner that will

        (1) Improve the quality and efficiency of health care service delivery and outcomes in Rhode Island;

        (2) View the health care system as a comprehensive entity; or

        (3) Encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access; or

    b. Should include conditions when feasible that will

        (1) Promote increased quality and efficiency of health care service delivery and outcomes in Rhode Island;

        (2) Incent health insurers to view the health care system as a comprehensive entity; or

        (3) Encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access; or

2. Any other circumstances exist such that regulatory action by the Commissioner with respect to a health insurer will likely improve the efficiency and quality of health care delivery and increase access to health care services.

D. When making a determination as described in § 4.8(C) of this Part or when acting to further the interests set out in § 4.8(A) of this Part, the Commissioner may consider and/or act upon the following, either singly or in combination of two or more:

1. Efforts by health insurers to develop benefit design and payment policies that:

a. Enhance the affordability of their products, as described in § 4.9 of this Part;

b. Encourage more efficient use of the state's existing health care resources;

c. Promote appropriate and cost-effective acquisition of new health care technology and expansion of the existing health care infrastructure;

d. Advance the development and use of high quality health care services (e.g., centers of excellence); and

e. Prioritize the use of limited resources

2. Efforts by health insurers to promote the dissemination of information, increase consumer access to health care information, and encourage public policy dialog about increasing health care costs and solutions by:

a. Providing consumers' timely and user-friendly access to health care information related to the quality and cost of providers and health care services so that consumers can make well informed-decisions;

b. Encouraging public understanding, participation and dialog with respect to the rising costs of health care services, technologies, and pharmaceuticals; the role played by health insurance as both a financing mechanism for health care and as a hedge against financial risk for the consumers of health care; and potential solutions to the problems inherent in the health insurance market (e.g., market concentration, increasing costs, the growing population of uninsureds, market-driven changes to insurance products (such as the growth of high deductible plans) and segmentation of the insurance market due to state and federal laws); and

c. Providing consumers timely and user-friendly access to administrative information, including information related to benefits; eligibility; claim processing and payment; financial responsibility, including deductible, coinsurance and copayment information; and complaint and appeal procedures.

3. Efforts by health insurers to promote collaboration among the state's health insurers to promote standardization of administrative practices and policy priorities, including

a. Participation in administrative standardization activities to increase efficiency and simplify practices; and

b. Efforts to develop standardized measurement and provider payment processes to promote the goals set out in this regulation.

4. Directing resources, including financial contributions, toward system-wide improvements in the state's health care system related to quality, access and efficiency, including providing support to local collaboratives, organizations and initiatives that promote quality, access and efficiency.

5. Participating in the development and implementation of public policy issues related to health, including

   a. Collaborating with state and local health planning officials;

   b. Participating in the legislative and regulatory processes; and

   c. Engaging the public in policy debates and discussions.

E. The factors enumerated in § 4.8(D) of this Part shall not be construed as limiting the Commissioner from making a finding that other factors may be considered when acting to further the interests set out in § 4.8(A) of this Part.

4.9 Affordable Health Insurance - General

A. Consumers of health insurance have an interest in stable, predictable, affordable rates for high-quality, cost-efficient health insurance products. Achieving an economic environment in which health insurance is affordable will depend in part on improving the performance of the Rhode Island health care system as a whole, including but not limited to the following areas:

1. Improved primary care supply, measured by the total number of primary care providers, and by the percentage of physicians identified as primary care providers.

2. Improved integration of behavioral health services into the primary care delivery system to meet the physical and behavioral health needs of the public.

3. Reduced incidence of hospitalizations for ambulatory care-sensitive conditions, and of re-hospitalizations.

4. Reduced incidence of emergency room visits for ambulatory care-sensitive conditions.

5. Reduced provision of low-value care.

6. Reduced rates of premium increase for fully insured, commercial health insurance.

B. In discharging the duties of the Office, including but not limited to the Commissioner's decisions to approve, disapprove, modify or take any other action authorized by law with respect to a health insurer's filing of health insurance rates or rate formulas under the provisions of R.I. Gen. Laws Titles 27 or 42, the Commissioner may consider whether the health insurer's products are affordable, and whether the carrier has implemented effective strategies to enhance the affordability of its products.

C. In determining whether a carrier's health insurance products are affordable, the Commissioner may consider the following factors:

1. Trends, including:

a. Historical rates of trend for existing products;

b. National medical and health insurance trends (including Medicare trends);

c. Regional medical and health insurance trends; and

d. Inflation indices, such as the Consumer Price Index and the medical care component of the Consumer Price Index.

2. Price comparison to other market rates for similar products (including consideration of rate differentials, if any, between not-for-profit and for-profit insurers in other markets);

3. The ability of lower-income individuals to pay for health insurance;

4. Efforts of the health insurer to maintain close control over its administrative costs;

5. Implementation of effective strategies by the health insurer to enhance the affordability of its products; and

6. Any other relevant affordability factor, measurement or analysis determined by the Commissioner to be necessary or desirable to carry out the purposes of this Regulation.

D. In determining whether a health insurance carrier has implemented effective strategies to enhance the affordability of its products, the Commissioner may consider the following factors:

1. Whether the health insurer offers a spectrum of product choices to meet consumer needs.

2. Whether the health insurer offers products that address the underlying cost of health care by creating appropriate and effective incentives for

consumers, employers, providers and the insurer itself. Such incentives shall be designed to promote efficiency in the following areas:

a. Creating a focus on primary care, integrated behavioral health care, prevention and wellness.

b. Establishing active management procedures for the chronically ill population.

c. Encouraging use of the least cost, most appropriate settings; this goal is meant to apply in the aggregate. Use of some higher cost providers and settings may in some instances result in better outcomes and should not be discouraged; and

d. Promoting use of evidence-based, quality care.

3. Whether the insurer employs delivery system reform and payment reform strategies to enhance cost-~~-~~effective utilization of appropriate services. Such delivery system reform and payment reform strategies for insurers with greater than 5,000~~10,000~~ covered lives shall include, but not be limited to complying with the requirements of § 4.10 of this Part. Consideration may also be given to:

a. Whether the insurer supports product offerings with simple and cost-effective administrative processes for providers and consumers;

b. Whether the insurer addresses consumer need for cost information through increasing the availability of provider cost information and promoting public conversation on trade-offs and cost effects of medical choices; and

c. Whether the insurer allows for an appropriate contribution to surplus.

E. The following constraints on affordability efforts will be considered:

1. State and federal requirements (e.g., state mandates, federal laws).

2. Costs of medical services over which plans have limited control.

3. Health insurer solvency requirements.

4. The prevailing financing system in United States (i.e., the third-party payor system) and the resulting decrease in consumer price sensitivity.

4.10 Affordable Health Insurance – Affordability Standards

A. Health insurers with at least 5,000~~10,000~~ covered lives under a health insurance plan issued, delivered, or renewed in Rhode Island shall comply with the delivery system and payment reform strategy requirements set forth in this § 4.10 of this Part. For purposes of this § 4.10 of this Part only, a health insurer shall not include a non-profit dental service corporation, or a non-profit optometric service corporation.

B. Primary care and behavioral health care expenditure obligation. The purpose of § 4.10(B) of this Part is to ensure financial support for primary care providers and providers of behavioral health services in Rhode Island that will assist in achieving the goals of these Affordability Standards.

1. Primary care expenditures.

a. 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.

b. 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 in § 4.3(17) of this Part.

c. Health insurers shall meet these annual primary care expenditure requirements by:

(1) Increasing reimbursement for primary care services. Priority shall be given to the procedure codes that account for the preponderance of primary care service volume, including evaluation and management services for new patient and established patient office visits;

(2) Making enhanced service-based capitation payments, consistent with the definition of a primary care alternative payment model, to primary care providers;

(3) Increasing funding for primary care practice-based population health management resources, including care management, integrated behavioral health, and staffing for team-based care.

~~a. Each health insurer's annual, actual Primary Care Expenses, including both Direct and Indirect Primary Care Expenses, shall be at least an amount calculated as 10.7% of its annual medical expenses for all insured lines of business. Of the health insurer's annual Primary Care Expense financial obligation, at least 9.7% of the calculated amount shall be for Direct Primary Care Expenses. Each health insurer's Indirect Primary Care Expenses shall include at least its proportionate share for the administrative expenses of the medical home initiative endorsed by R.I. Gen. Laws Chapter 42-14.6, and for its proportionate share of the expenses of the health information exchange established by R.I. Gen Laws Chapter 5-37.7.~~

~~b. Direct Primary Care Expenses shall be accounted for as medical expenses on the health insurer's annual financial statements. Indirect Primary Care Expenses shall be accounted for as administrative costs on the health insurer's annual financial statements. Indirect Primary Care Expenses may be deducted from the statement's administrative cost category as cost containment expenses, in accordance with federal Medical Loss Ratio calculation rules.~~

dc. In meeting its annual primary care expenditure~~spending~~ obligations, a health insurer's fully insured covered lives shall not bear a financial burden greater than their fair share of expenses that benefit both fully insured covered lives, and self~~non~~-insured covered lives whose health plans are administered by the health insurer.

2. Behavioral health care expenditures.

a. Each health insurer shall report its annual, actual expenditures on behavioral health care in a form and manner determined by the Commissioner.

b. Behavioral health care expenditures shall be inclusive of claims-based expenditures where the claim includes a behavioral health condition as a principal diagnosis, inclusive of mental health and substance use disorder. Additionally, behavioral health care expenditures shall include non-claims-based expenditures, such as per member per month payments to support behavioral health care integration into primary care, pay for performance payments made

to behavioral health care providers, and grants designed to address the behavioral health care needs of insured members.

(1) Payments to support behavioral health care integration into primary care that are part of payments made to Integrated Systems of Care shall be allocated to behavioral health care based on a reasonable estimate of the portion of the payment that supports behavioral health care integration. Health insurers shall produce this estimate with guidance from their contracted Integrated Systems of Care, when necessary.

(2) Grants designed to address the behavioral health care needs of insured members may be reported in full, without need to apportion the value of the grant to an insured member population, with the prior approval of the Commissioner.

c. InBy January 1, 2025, each health insurer shall increase baseline per member per month expenditures on community-based behavioral health care for children and adolescents, age 0 – 18, to 200% of baseline expenditures and maintain the increase over time. Baseline expenditures shall be defined as payments incurred and paid in calendar year 2022.

d. After January 1, 20265, health insurers that have annual per member per month expenditures on community-based behavioral health care for children and adolescents, age 0 – 18, that fall below the market average shall increase per member per month expenditures by an amount necessary to equal the market average. The market average will be determined by OHIC through analysis of the behavioral health care expenditure reports.

C. Primary care practice transformation. The purpose of § 4.10(C) of this Part is to transform how primary care is delivered in Rhode Island and to ensure sustainable funding for advanced primary care, in order that the goals of these Affordability Standards can be achieved. While primary care practice transformation should not be considered an ultimate goal in itself, the Commissioner finds that it produces higher quality and potentially lower cost care and is a necessary foundation for the effective participation of practices in Integrated Systems of Care. One element of primary care transformation is the integration of behavioral health care into primary care practice. Integration is in the best interest of the public as it improves health status for those with behavioral health needs and may also result in more efficient use of health care resources. Further, behavioral health integration is a necessary and proper strategy to fulfill the Office's legislative mandate under R.I. Gen. Laws § 42-14.5-3, which directs insurers toward policies and practices that address the

behavioral health needs of the public and greater integration of physical and behavioral health care delivery.

1. Primary Care Practice Transformation & Patient Centered Medical Home Financial Support Model.

    a. Primary care practices which meet the requirements of a Patient-Centered Medical Home in § 4.3(A)(15~~7~~) of this Part shall be deemed eligible for practice support payments.

    b. Health insurers shall fund primary care practices which have met the requirements of a Patient-Centered Medical Home in § 4.3(A)(15~~7~~) of this Part in accordance with the following guidelines:

        (1) Primary care practices actively engaged in first-time transformation activity, or practices which have completed transformation activity, but which have not met the requirements outlined in § 4.3(A)(15~~7~~) of this Part, shall receive both infrastructure and care management per member per month (PMPM) payments. The care management PMPM payment shall support development and maintenance of a care management function within the practice site. The infrastructure and care management PMPM payments shall not be at-risk for total cost of care performance, but may be at-risk for quality performance.

        (2) Primary care practices that have completed transformation activity and which have met the requirements in § 4.3(A)(15~~7~~) of this Part shall receive a care management PMPM payment and have an opportunity to earn a performance bonus. The care management PMPM payments shall not be at risk for total cost of care performance, but may be at risk for quality performance.

        (3) Health insurers shall not impose a minimum attribution threshold for making care management PMPM or infrastructure payments to a Patient Centered Medical Home.

        (4) The monetary levels of practice support payments shall be independently determined by the health insurer and the primary care practices. If the primary care practice is part of an Integrated System of Care, the health insurer may make the PMPM payment to the Integrated System of Care, provided the Integrated System of Care is contractually obligated to use the PMPM payment to finance care

management services at the primary care practice earning the payment.

(5) Health insurers shall report data on total attributed patients and PMPM payments to primary care practices recognized as patient-centered medical home practices at least annually in a form and manner determined by the Commissioner.

2. Behavioral Health Care Integration. The goal of § 4.10(C)(2) of this Part is to improve the efficiency, quality, and accessibility of behavioral health care in primary care settings. Behavioral health care is an important dimension of Rhode Island's health care system and refers to services for mental health and substance use diagnosis and treatment. In order to reach the goal of affordability and access through a well-integrated health care delivery system, the Commissioner finds that specific health insurer actions are required to support the integration of behavioral health care into primary care settings.

a. Health insurers shall take such actions as necessary to decrease administrative barriers to patient access to integrated services in primary care practices by doing the following:

(1) Financial barriers. ~~By January 1, 2021, h~~Health insurers shall eliminate copayments for patients who have a behavioral health visit with an in-network behavioral health provider on the same day and in the same location as a primary care visit at a Qualifying Integrated Behavioral Health Primary Care Practice as defined in § 4.3(A)(21) of this Part.

(2) Billing and Coding Policies. Health insurers shall adopt policies for Health and Behavior Assessment/Intervention (HABI) codes that are no more restrictive than Current Procedural Terminology (CPT) Coding Guidelines for HABI codes.

(3) Out-of-pocket costs for Behavioral Health Screening. Health insurers shall adopt policies for the most common preventive behavioral health screenings in primary care that are no more restrictive than current applicable federal law and regulations for preventive services. For administrative simplification purposes, the Commissioner may issue interpretive guidance on strategies to align screening codes across health insurers and publish them, along with any supporting documentation, on the OHIC website.

b. The Commissioner shall determine which practices are Qualifying Integrated Behavioral Health Primary Care Practices by November 30, 2020, and annually thereafter. The Commissioner shall issue guidelines on any time limitations for practices to qualify under §§ 4.3(A)(21)(a) and (b) of this Part.

D. Payment reform. The purpose of § 4.10(D) of this Part is to improve the affordability and quality of health care through the implementation of alternative payment models. Alternative payment models are provider contracting practices that are designed to align provider financial incentives with the efficient use of health care resources and encourage the proactive management of the health needs of their patient populations. Furthermore, the Commissioner finds that provider contracting practices that incentivize the efficient use of health care resources and which invest in the capacity of health care providers to manage population health are essential to support the care transformation agenda articulated in § 4.10(C) of this Part and to meet OHIC's legislative mandate to direct health insurers toward policies and practices that address the behavioral health needs of the public and greater integration of physical and behavioral health care delivery.

1. Alternative payment models

a. It is in the interest of the public to significantly reduce the use of fee-for-service payment as a payment methodology, in order to mitigate fee-for-service volume incentives which unreasonably and unnecessarily increase the overall cost of care, and to replace fee-for-service payment with alternative payment models that provide incentives for better quality and more efficient delivery of health services.

b. Health insurers shall take such actions as necessary to have 50% of insured medical payments made through an alternative payment model by January 1, 2021, and annually thereafter. The Commissioner shall issue a policy and guidelines manual by January 1 of each year that specifies the types of payments and payment models which may be credited toward the 50% target.

2. Population-based contracts

a. It is in the interest of the public to encourage population-based contracting, and specifically, to direct the evolution of population-based contracts toward downside risk over time. Downside risk strengthens provider economic incentives to act as responsible stewards of scarce health care resources and to proactively manage the health needs of their patient populations. These practices are necessary to support the achievement of more affordable health insurance.

b. This § 4.10(D)(2) of this Part applies to Population-Based Contracts between an Integrated System of Care and a health insurer which are entered into, renewed, or amended on or after July 1, 2020, or the effective date of this regulation, if earlier. Each health insurer shall comply with the requirements of this § 4.10(D)(2) of this Part.

c. Health insurers shall take such actions as necessary to have 30% of Rhode Island resident commercial insured covered lives attributed to a risk-sharing contract or global capitation contract.

d. Risk-sharing contracts with 10,000 or more attributed lives shall meet the Minimum Downside Risk requirements of § 4.10(D)(2)(d) of this Part. For the purposes of §4.10(D)(2)(d), contracts with Physician-based Integrated Systems of Care may employ a risk exposure cap that is tied to the annual provider revenue from the health insurer under the contract or the total cost of care. Contracts with Integrated Systems of Care including Hospital Systems are to employ a total cost of care methodology.

(1) For contracts with Integrated Systems of Care including Hospital Systems between 10,000 and 20,000 attributed commercial lives, health insurers shall employ a risk-sharing rate of at least 40%, and if applicable, a risk-exposure cap of at least 5% of the total cost of care and a minimum loss rate of no more than 3% of the total cost of care. For such contracts entered into, renewed, or amended on or after January 1, 2021, health insurers shall employ a risk-sharing rate of at least 50%, and if applicable, a risk-exposure cap of at least 6% and a minimum loss rate of no more than 3% of the total cost of care.

(2) For contracts with Integrated Systems of Care including Hospital Systems with more than 20,000 attributed commercial lives, health insurers shall employ a risk-sharing rate of at least 40%, and if applicable, a risk-exposure cap of at least 5% of the total cost of care and a minimum loss rate of no more than 2% of the total cost of care. For such contracts entered into, renewed, or amended on or after January 1, 2021, health insurers shall employ a risk-sharing rate of at least 50%, and if applicable, a risk-exposure cap of at least 6% and a minimum loss rate of no more than 2% of the total cost of care.

(3) For contracts with Physician-based Integrated Systems of Care between 10,000 and 20,000 attributed commercial lives, health insurers shall employ a risk-sharing rate of at least 40%, and if applicable, a risk-exposure cap of at least

7% of provider revenue or at least 2% of the total cost of care and a minimum loss rate of no more than 3% of the total cost of care. For such contracts entered into, renewed, or amended on or after January 1, 2021, health insurers shall employ a risk-sharing rate of at least 50%, and if applicable, a risk-exposure cap of at least 8% of provider revenue or at least 3% of the total cost of care and a minimum loss rate of no more than 3% of the total cost of care.

(4) For contracts with Physician-based Integrated Systems of Care with more than 20,000 attributed commercial lives, health insurers shall employ a risk-sharing rate of at least 40%, and if applicable, a risk-exposure cap of at least 8% of provider revenue or at least 3% of the total cost of care and a minimum loss rate of no more than 2% of the total cost of care. For such contracts entered into, renewed, or amended on or after January 1, 2021, health insurers shall employ a risk-sharing rate of at least 50%, and if applicable, a risk-exposure cap of at least 8% of provider revenue or at least 3% of the total cost of care and a minimum loss rate of no more than 2% of the total cost of care.

(5) The Minimum Downside Risk requirements above, while not applicable to risk-sharing contracts with fewer than 10,000 attributed commercial lives, should not be construed to preclude or discourage health insurers and providers from entering into risk-sharing contracts with fewer than 10,000 attributed lives. OHIC recommends health insurer and provider caution when doing so, however, in order to account for the decreased statistical certainty with attributed populations less than 10,000.

(6) None of the requirements of this §4.10(D)(2)(d) of this Part shall be construed to preclude contracts with greater degrees of provider risk assumption with health insurers including fee for service, capitation and global capitation contracts.

e. A health insurer shall not enter into a Risk Sharing Contract or a Global Capitation contract unless the health insurer has determined, in accordance with standard operating procedures filed and approved by the Commissioner, that the provider organization entering into the contract has the operational and financial capacity and resources needed to assume clinical and financial responsibility for the provision of covered services to members attributable to the provider organization. At the reasonable request

of the provider organization, the health insurer shall maintain the confidentiality of information which the health insurer requests to make its determination. The health insurer shall periodically review the provider organization's continuing ability to assume such responsibilities. The health insurer shall maintain contingency plans in the event the provider organization is unable to sustain its ability to manage its responsibilities. The foregoing shall not be construed to permit the transfer of insurance risk or the transfer of delegation of the health insurer's regulatory obligations.

f. Population-Based Contracts shall include a provision that agrees on a budget for each contract year. Review and prior approval by the Office of the Health Insurance Commissioner shall be required if any annual increase in the total cost of care for services reimbursed under the contract, after risk adjustment, exceeds the US All Urban Consumer All Items Less Food and Energy CPI ("CPI-Urban") percentage increase (reported by the Commissioner by October 1 of each year, in accordance with the method set forth in § 4.10(D)(6)(i) of this Part). Such percentage increase shall be plus 1.5%.

(1) In the calculation of the annual increase of the total cost of care budget for each contract year, health insurers shall hold Integrated Systems of Care harmless for the mandated increase in primary care expenditures.

g. Should any Integrated System of Care have had three immediately prior years of average historical risk-adjusted total cost of care per capita spending for the provider's attributed patient population that was significantly below the health insurer's risk-adjusted commercially insured average (statistically significant at p <= .05 and excluding the provider from the calculated average), the health insurer may prospectively adjust that provider's budget upward by up to, but not more than, 2% of the provider's unadjusted expected per capita spending. The adjusted budget shall never exceed the health insurer's projected risk-adjusted commercially insured average spending. Only Integration Systems of Care with risk-sharing contracts shall qualify for the upward budget adjustment.

h. Population-based Contracts shall not carve out behavioral health or prescription drug claims experience from the provider budget, provided, however, that health insurers and Integrated Systems of Care may negotiate contractual mechanisms to mitigate risk from high-cost specialty drugs, including, but not limited to, carving out specialty drug claims expenses from the contract. Population-based Contracts may include a methodology to reflect the member-

months for which the health insurer covers pharmacy and/or behavioral health claims.

g. Population-Based Contracts shall include terms that relinquish the right of any party to contest the public release, by state officials or the parties to the contract, of the provisions of the contract demonstrating compliance with the requirements of § 4.10(D)(2) of this Part; provided that the health insurer or other affected party may request the Commissioner to maintain specific contract terms or portions thereof as confidential, if properly supported with legal and factual analysis justifying the claim of confidentiality.

3. Primary care alternative payment models

a. The development and implementation of alternative payment models for primary care providers is necessary to support primary care practice transformation. The implementation of alternative payment models for primary care also represents a necessary strategy to fulfill OHIC's legislative mandate to direct health insurers toward policies and practices that address the behavioral health needs of the public and greater integration of physical and behavioral health care delivery.

b. Health insurers shall develop and implement a prospectively paid alternative payment model for primary care. Health insurers are encouraged to align their primary care alternative payment model with the State of Rhode Island Office of the Health Insurance Commissioner Primary Care Alternative Payment Model Work Group Consensus Model published on August 9, 2017.

c. For primary care practices recognized as a Qualifying Integrated Behavioral Health Primary Care Practice under § 4.3(A)(21) of this Part, Health Insurers shall develop and implement a prospectively paid alternative payment model for primary care that compensates practices for the primary care and behavioral health services delivered by the site.

d. Health insurers shall take such actions as necessary to achieve the following primary care alternative payment model contracting targets.

(1) At least 20% of insured Rhode Island resident covered lives shall be attributed to a primary care alternative payment model by the end of 2024.

(2) At least 35% of insured Rhode Island resident covered lives shall be attributed to a primary care alternative payment model by the end of 2025.

(3) At least 45% of insured Rhode Island resident covered lives shall be attributed to a primary care alternative payment model by the end of 2026.

(4) At least 60% of insured Rhode Island resident covered lives shall be attributed to a primary care alternative payment model by the end of 2027.

e. The Commissioner shall periodically convene a working group to assess health insurer, provider and patient experience under these models.

4. Specialist alternative payment models

a. It is in the interest of the public to expand innovative alternative payment models to specialist physician practices to encourage more efficient use of health care resources, reduce unwarranted variation in episode treatment costs, and improve the quality of care through the reduction of potentially avoidable complications.

b. Health insurers with 30,000 or more covered lives shall develop and implement new specialist alternative payment model contracts, and/or expand existing alternative payment model contracts with clinical professionals in the following specialties:

(1) Orthopedics;

(2) Gastroenterology;

(3) Cardiology;

(4) Behavioral health; and

(5) Maternity, Endocrinology, or other clinical specialties selected by the health insurer.

c. For each specialty, the health insurer shall develop or expand at least two contracts. The term “expand existing alternative payment model contracts” includes, but is not limited to, an expansion of a health insurer’s existing contract such that more services (e.g., procedures, conditions) are included in the arrangement, or downside risk is introduced for the first time.

d. Qualifying alternative payment models include limited scope of service budget models, including both prospectively paid and retrospectively reconciled models, and episode-based (bundled) payments.

e. Health insurers shall meet this requirement according to the following schedule: by December 31, 2021: two specialties; by December 31, 2022: three specialties; by December 31, 2023: four specialties; by December 31, 2024: five specialties.

5. Measure alignment

a. The purpose of this § 4.10(D)(5) of this Part is to ensure consistency in the use of quality measures in contracts between health insurers and health care providers in Rhode Island, to reduce the administrative burden placed on providers by the unaligned use of quality measures across health insurers, to improve the quality of care by channeling clinical focus on core areas of health care delivery, to formally adopt Aligned Measure Sets to be used in contracts between health insurers and health care providers in Rhode Island, and to articulate a process for annually refining and updating the Aligned Measure Sets.

b. § 4.10(D)(5) of this Part applies to contracts between health care providers, including primary care providers, specialists, hospitals, and Integrated Systems of Care and a health insurer which incorporate quality measures into the payment terms of the contract and are entered into, renewed, or amended on or after July 1, 2020, or the effective date of this regulation, if earlier.

c. Health insurers shall adopt the Aligned Measure Sets for primary care, hospitals, Accountable Care Organizations (ACOs, otherwise known as Integrated Systems of Care as defined in § 4.3(A)(12) of this Part), maternity care, outpatient behavioral health and any other Aligned Measure Set developed pursuant to this § 4.10(D)(5) of this Part.

(1) Health care provider contracts which incorporate quality measures into the payment terms shall include all measures designated as Core Measures in an Aligned Measure Set.

(2) Health care provider contracts which incorporate quality measures into the payment terms shall not include measures beyond those designated as Core Measures in an Aligned Measure Set, with the exception of designated Menu Measures. Menu Measures may be incorporated into the payment terms of the contract at the mutual agreement of the health insurer and contracted health care provider.

(3) In the event than an Aligned Measure Set does not include any Core Measures, health insurers shall limit selection of measures to Menu Measures.

(4) Health insurers shall not incorporate a Core Measure into the terms of payment with a de minimis weight attached to the measure, such that performance on the Core Measure lacks meaningful financial implication for the provider.

(5) A health insurer may petition the Commissioner to modify or waive one or more of the requirements of § 4.10(D)(5) of this Part. Any request to modify or waive one or more of the requirements must articulate a clear rationale supporting the waiver request and must demonstrate how the health insurer's request will advance the quality, accessibility, and/or affordability of health care services in Rhode Island.

d. The Commissioner shall convene a Quality Measure Alignment and Review Committee (Committee) by August 1 each year. The Committee shall be charged with developing recommendations, for consideration by the Commissioner, that:

(1) Propose modifications, if necessary, to existing Aligned Measure Sets to be used in contracts between health insurers and health care providers in Rhode Island.

(2) When possible, prioritize measures that objectively track measurable health care outcomes over measures that track the performance of screenings or other processes.

(3) Propose measures as Core Measures and Menu Measures.

(4) Propose a work plan for the development of Aligned Measure Sets for additional professional health care provider specialties as determined necessary by the Commissioner.

e. The Commissioner shall designate as members of the Committee individuals or organizations representing:

(1) Relevant state agencies and programs, including the Office, the Medicaid program, the Rhode Island Department of Health, and the Department of Behavioral Health, Developmental Disabilities and Hospitals;

(2) Health insurers;

(3) Hospital systems;

(4) Health care providers;

(5) Consumers;

(6) Quality measure experts; and

(7) Any other individual or organization that the Commissioner determines can bring value to the work of the Committee.

f. OHIC will maintain a list of participating individuals or organizations with voting status. Each designated organization shall have one (1) vote and the designee must be present in order to vote.

g. The recommendations, together with any stakeholder comments, shall be submitted to the Commissioner on or before October 1 of each year. Health insurers shall comply with the requirements adopted by the Commissioner.

h. The Commissioner shall maintain the Aligned Measure Sets and publish them, along with any supporting documentation and interpretive guidance, on the OHIC website.

6. Hospital contracts

a. Each health insurer shall include in its hospital contracts the terms required by § 4.10(D)(6) of this Part.

b. This § 4.10(D)(6) of this Part shall apply to contracts between a health insurer and a hospital licensed in Rhode Island which are entered into, renewed, or amended on or after July 1, 2023, or the effective date of this regulation, if earlier. To ensure compliance with § 4.10(D)(6) in the event of any hospital conversions pursuant to R.I. Gen. Laws Chapter 23-17.14, the health insurer shall, in terms of contracting, treat the contract of the successor hospital or entity as a continuation of the contract of the predecessor hospital or entity with whom the health insurer had contracted.

c. Hospital contracts shall utilize unit-of-service payment methodologies for both inpatient and outpatient services that realign payment to provide incentives for efficient use of health services, and are derived from nationally utilized payment practices other than fee-for-service. Nothing in this requirement prevents contract terms that provide additional or stronger payment incentives toward quality and efficiency such as performance bonuses, bundled payments, global payments, or case rates.

d. Hospital contracts shall include a quality incentive program.

(1) The quality incentive program shall include payment for attaining or exceeding mutually agreed-to, sufficiently challenging performance levels for all Core Measures within the Aligned Measure Set for hospitals. For measures beyond

the Core Measures the health insurer shall limit selection of measures to those listed as Menu Measures in the Aligned Measures Set for hospitals.

(2) The measures, performance levels, payment levels, and payment mechanisms must be articulated in the contract.

(3) Quality incentive payments will not be due and payable until the quality incentive measure targets have been met or otherwise achieved by the hospital. A health insurer may make interim payments in the event that interim quality performance targets have been met; provided that the interim payments are commensurate with the achievement of the interim targets; and provided further that if the annual quality performance targets have not been achieved, the hospital shall be required to remit unearned interim payments back to the health insurer. A health insurer may also make prospective payments without consideration of performance, provided that if the annual quality performance targets have not been achieved, the hospital shall be required to remit unearned prospective payments back to the health insurer. Earned quality incentive payments shall become part of base payment rates.

e. Hospital contracts shall include a provision that agrees on rates, and quality incentive payments for each contract year, such that review and prior approval by the Office of the Health Insurance Commissioner shall be required if either:

(1) The average rate increase, including estimated quality incentive payments, is greater than the US All Urban Consumer All Items Less Food and Energy CPI ("CPI-Urban") percentage increase (reported by the Commissioner by October 1 each year, in accordance with the method set forth in § 4.10(D)(6)(i) of this Part). Such percentage increase shall be plus 1%, or

(2) Less than twenty-five percent (25%) of the average rate increase is for expected quality incentive payments.

f. Hospitals which have been paid by a health insurer at less than the median commercial payments made to all Rhode Island acute care hospitals for inpatient services, including inpatient behavioral health services, in the health insurer's provider network, as determined by the health insurer summing all of its inpatient payments (numerator) and dividing that by a sum of all DRG case weights (denominator) to provide a case-mix-adjusted discharge payment rate for each

hospital for inpatient services, shall receive an equal percentage increase in payment for each inpatient service until the hospital's average payment per case-mix-adjusted DRG for inpatient services is equal to the median. At the time of the calculation, the health insurer shall utilize the most recent 12-months of claims data for which the health insurer's Rhode Island hospital claim runout is at least 95% complete. The increase in payment rates shall not be construed as an ongoing price floor. The increase in payment rates shall be contractually contingent on the following:

(1) At the conclusion of three years after the first increase in payments, or at the mutual agreement of the health insurer and hospital to establish a shorter time period, the hospital shall attain performance no different or better than the national benchmark for Clostridium difficile (C. diff) intestinal infections, Central line-associated bloodstream infections (CLABSI), and the rate of readmission after discharge from hospital (hospital-wide) as published on the Medicare.gov Hospital Compare website;

(2) At the mutual agreement of the health insurer and hospital, alternative quality measures and performance targets may be employed as a substitute for the quality measures and performance targets specified in § 4.10(D)(6)(f)(1). If the parties cannot agree to an alternative set of quality measures, then the quality measures and performance targets in § 4.10(D)(6)(f)(1) shall be used.

(3) The contract contains a provision for recovery of monies paid to the hospital by the health insurer pursuant to this § 4.10(D)(6)(f) of this Part should the hospital fail to achieve the quality targets defined in § 4.10(D)(6)(f)(1) of this Part. Such provision shall be subject to audit by the Commissioner.

g. Hospital contracts shall include terms that define the parties' mutual obligations for greater administrative efficiencies, such as improvements in claims and eligibility verification processes, and identify commitments on the part of each, and that require the parties to actively participate in the Commissioner's Administrative Simplification Work Group.

h. Hospital contracts shall include terms that relinquish the right of either party to contest the public release, by state officials or the parties to the contract of the provisions of the contract demonstrating compliance with the requirements of this § 4.10(D)(6) of this Part; provided that the health insurer or other

affected party may request the Commissioner to maintain specific contract terms or portions thereof as confidential, if properly supported with legal and factual analysis justifying the claim of confidentiality.

i. The US All Urban Consumer All Items Less Food and Energy CPI ("CPI-Urban") percentage increase to be reported according to the Standard Method by the Commissioner shall be equal to the 12-month percent change in the CPI-Urban published by the United States Bureau of Labor Statistics in September of each year. The September report will reference the 12-month percent change from August of the prior year to August of the report year. Due to significant epidemiological or macroeconomic events the Commissioner may elect to utilize a different method of determining the value of the CPI-Urban Should the Commissioner elect to utilize a different method than the Standard Method, the Commissioner shall announce his or her intention of doing so by August 1 and allow for thirty days of public comment on the proposed method prior to issuing a final decision. If the Commissioner ultimately elects to utilize a different method than the Standard Method, any entity that submitted a public comment and is aggrieved by the Commissioner's determination may challenge the determination through all available methods of appeal.

7. Nothing in § 4.10(D)(2) or (6) of this Part is intended to require that the health insurer must contract with all hospitals and providers licensed in Rhode Island. Consistent with statutes administered by OHIC, health insurers must demonstrate the adequacy of their hospital and provider network.

8. Professional provider contracts

a. The purpose of § 4.10(D)(8) of this Part is to ensure that health insurer contracts with professional providers include terms that allow for the release of contracts, in whole or in part, to OHIC for purposes of monitoring professional provider fee schedule increases, substantiating unit cost trend data filed as part of the health insurer's rate filing, or assessing compliance with state laws and regulations adopted pursuant to Titles 27 or 42 in which the Commissioner holds jurisdiction. This § 4.10(D)(8) of this Part shall apply to contracts between a health insurer and a professional provider or provider group in Rhode Island which are entered into, renewed, or amended on or after January 1, 2024.

b. Professional provider contracts shall include terms that relinquish the right of either party to contest the release of the contract, or parts thereof, to OHIC; provided that the health insurer or other

affected party may request that OHIC maintain specific contract terms or portions thereof as confidential, if properly supported with legal and factual analysis justifying the claim of confidentiality.

E. Health equity

1. By July 1, 2026, health insurers are required to obtain NCQA Health Equity Accreditation in support of making progress toward eliminating health disparities, improving health outcomes, and reducing overall health care cost growth.

2. Demographic data collection principles

   a. Health insurers are required to systematically collect, maintain, protect, and report on demographic data. When collecting, maintaining, and reporting demographic data, health insurers shall aim to align their practices with established national standards where possible.

   b. Health insurers are required to utilize industry-wide best practice for demographic data in terms of data collection strategies and survey language that has been consumer-tested and is widely recognized for increased accuracy and responsiveness.

   c. The disclosure of demographic data by prospective members and members to health insurers must always be voluntary and based on self-identification or disclosure and be accompanied by detailed reasoning for why demographic data is being requested and that it will support efforts to provide equitable care.

   d. To the extent that health insurers use staff to collect and/or analyze demographic data, health insurers shall develop and implement trainings on how to ask questions about the demographic data, including training on how to maintain privacy of this sensitive information.

3. Demographic data use principles

   a. Health insurers shall strictly adhere to any and all existing federal and/or state prohibitions or restrictions on the collection and/or reporting of demographic data.

   b. Health insurers shall apply Health Insurance Portability and Accountability Act of 1996 protections to demographic data and treat demographic data as protected health information.

c. Health insurers shall strictly adhere to any and all existing federal and/or state requirements governing analysis and information sharing of demographic data.

d. Legally and ethically acceptable use cases relative to the use of demographic data may include:

(1) Evaluating algorithms or population health or performance related analytics used to assess member needs, evaluate performance, or assess key performance indicators, to identify and mitigate disparate impact or bias;

(2) Analyzing claims, enrollment, and complaint data to better understand health care disparities or to evaluate the efficacy of programs intended to reduce health care disparities;

(3) Provider network development and performance and coordination of care;

(4) Service quality improvement; or

(5) Assessing or planning to meet the need for health-related social services and supports, including trauma-informed care, and outreach to populations that have been marginalized, among other uses.

4. Demographic data completeness goals

a. By January 1, 2025, health insurers should obtain demographic data for at least 80% of their members, as specified by the Commissioner.

F. Stakeholder input, waiver and modification

1. Stakeholder input plays a critical role in the formation of public policy. The transformation of the health care system, which is necessary to support improved system performance on cost and quality, is a dynamic task which relies on trust, collaboration, and open communication between stakeholders and policymakers.

a. The Commissioner may convene a Payment and Care Delivery Advisory Committee as needed to obtain input on policies related to the Affordability Standards. The Committee shall be charged with considering and developing recommendations for necessary actions by the Commissioner to advance health care system performance and affordability. The Commissioner shall solicit input from members of the Committee on topics to address during the meetings.

b. The Commissioner shall designate as members of the Committee individuals or organizations representing:

(1) Relevant state agencies and programs, such as the Office of the Health Insurance Commissioner, the Medicaid program, the Department of Health, and the state employees' health benefit plan;

(2) Health insurers;

(3) Integrated Systems of Care;

(4) Hospital systems;

(5) Health care providers, including behavioral health providers;

(6) Consumers; and

(7) Employer purchasers of health insurance and health care services.

c. In addition to topics concerning the improvement of health care system performance and affordability, the Commissioner shall solicit input on whether the Affordability Standards need to be modified:

(1) To create or maintain an effective incentive for provider organizations to participate in care transformation, population-based contracts and alternative payment models; or

(2) To account for unanticipated and profound macroeconomic events, or similarly significant changes in systemic utilization or costs that are beyond the ability of the health insurer to control, such that application of the any of the requirements of § 4.10 of this Part would be manifestly unfair.

2. The Commissioner, upon petition by a health insurer for good cause shown, or in his or her discretion as necessary to carry out the purposes of the laws and regulations administered by the Office, may modify or waive one or more of the requirements of § 4.10 of this Part. Any such modifications shall be considered and made during the formal process of the Commissioner's review and approval of health insurance rates filed by the health insurer.

3. A health insurer shall not be held accountable for a violation of the requirements of § 4.10 of this Part if the health insurer demonstrates to the satisfaction of the Commissioner that compliance with any of these

requirements was not possible, notwithstanding the health insurer's good faith and reasonable efforts. The health insurer shall notify the Commissioner and request a waiver under § 4.10(F)(2) of this Part, if desired, as soon as any such circumstances arise. Failure by the health insurer to establish that good faith and reasonable efforts were undertaken shall result in penalties consistent with the Commissioner's authority under R.I. Gen. Laws Titles 27 and 42.

G. Data collection and evaluation

1. Each health insurer shall submit to the Commissioner, in a format approved by the Commissioner, a Primary Care Spend Report, a Behavioral Health Care Spend Report, and a Payment Reform Report, including such data as is necessary to monitor and evaluate the provisions of § 4.10 of this Part.

2. On or before October 1 and annually thereafter, the Office shall present to the Health Insurance Advisory Council a monitoring report describing the status of progress in implementing the Affordability Standards.

3. Health insurers shall provide to the Office, in a timely manner and in the format requested by the Commissioner, such data as the Commissioner determines is necessary to evaluate the Affordability Standards and to monitor compliance with the Affordability Standards established in this § 4.10 of this Part. Such data may include any hospital or provider reimbursement contract, and any data relating to a hospital or provider's attainment of quality and other performance-based measures as specified in quality incentive programs referenced in §§ 4.10(D)(6)(d) and (e) of this Part.

4. To the extent possible, the Office shall use the All Payer Claims Database authorized by R.I. Gen. Laws Chapter 23-17.17 to collect data required by § 4.10(G) of this Part.

4.11 Administrative Simplification

A. Administrative Simplification Task Force

1. An Administrative Simplification Task Force is established to make recommendations to the Commissioner for streamlining health care administration so as to be more cost-effective, and less time-consuming for hospitals, providers, consumers, and insurers, and to carry out the purposes of R.I. Gen. Laws § 42-14.5-3(h). The Commissioner shall appoint as members of the Task Force representatives of hospitals, physician practices, community behavioral health organizations, each health insurer, consumers, businesses, and other affected entities, as necessary and relevant to the issues and work of the Task Force. The

Task force shall also include at least one designee each from the Rhode Island Medical Society, Rhode Island Council of Community Mental Health Organizations, the Rhode Island Health Center Association, and the Hospital Association of Rhode Island. The Chair or Co-Chairs of the Task Force shall be selected annually by its members.

2. At the discretion of, and as directed by the Commissioner, the Task Force shall convene to consider issues of streamlining health care administration. Members of the Task Force may propose and substantiate such issues for review and inclusion in a work plan, together with such data and analysis that demonstrates the need to address the issue. The Task Force will meet during September, October and November to make its recommendations to the Commissioner for resolving issues identified in the work plan no later than December 31 of each year. If the Task Force agrees on recommendations for resolving the identified issues, those recommendations will be submitted to the Commissioner for her or his consideration. If the Task Force cannot agree on recommendations, a report will be submitted to the Commissioner on the Task Force's activities, together with comments by members concerning the identified issues. The Commissioner shall consider the report of the Task Force, and may adopt such regulations as are necessary to carry out the purposes of § 4.11 of this Part, and the purposes of R.I. Gen. Laws § 42-14.5-3(h).

B. Retroactive terminations

1. The purpose of § 4.11(B) of this Part is to reduce administrative burdens as well as the associated costs in connection with the practice of retroactive terminations, create an incentive for efficiencies among stakeholders for timeliness of notices of termination, and establish an equitable balance of financial liability among health insurers, employers and enrollees in light of the unavailability of real time, accurate eligibility information.

2. Health Insurers shall cease the administrative process of seeking recoupment of payment from providers in the case of retroactive terminations of an enrollee, except when verified by the Health Insurer that the enrollee is covered by another Health Insurer for the service provided during the retroactivity period. For purposes of § 4.11(B) of this Part, the term Health Insurer includes state and federal government programs, a self-insured benefit plan, and an entity providing COBRA coverage.

3. Health insurers may include the reasonable cost of retroactive terminations into their filed rates. Health insurers shall establish reasonable policies and procedures for providers to conduct eligibility checks at the time services are provided. If the health issuer requires by administrative policy or provider contract that the eligibility check is a

prerequisite to the application of the provisions of § 4.11(B) of this Part, the Health Insurer must also provide an administratively simple mechanism, approved by the Commissioner, for the provider to document that eligibility was checked by the provider at the time of service. In addition, Health Insurers may include reasonable adjustments attributable to the Insurer's financial burden with respect to retroactive terminations with its employer groups, so long as the process does not include recoupment of payments from providers not permitted under this § 4.11(B) of this Part in the event of retroactive termination.

C. Coordination of benefits

1. The purpose of § 4.11(C) of this Part is to improve on the accuracy and timeliness of information when an enrollee is covered by more than one Health Insurer, and to communicate to affected parties which health insurer's coverage is primary.

2. Health Insurers shall:

a. Accept a common coordination of benefits ("COB") form approved by the Commissioner;

b. Submit to the Commissioner for approval a procedure to inform contracted providers of a manual and electronic use of the common COB form in provider settings;

c. Not alter the common COB form, except for use internally by the Insurer, or on the Insurer's website, and in these excepted instances only the Insurer's name and contact information may be added to the form;

d. Accept the common COB form submitted by the provider on behalf of patient; and

e. No later than January 1, 2016, include a flag within the insurance eligibility look-up section of its website indicating the most recent information available to the Insurer on additional coverage by another Health Insurer, the last update of an enrollee's COB information. Health Insurers may continue to use their own COB form as part of an annual member survey.

3. Health insurers shall participate in a centralized registry for coverage information designated by the Commissioner. If the Centers for Medicare and Medicaid Services designates a centralized registry, Health Insurers shall participate in the CMS-designated registry no later than one calendar year from the date of use of the designated registry by Medicare, unless such deadline is extended by the Commissioner.

4. Health insurers shall establish written standards and procedures to notify providers of all eligibility determinations electronically and telephonic at the time eligibility determination is requested by the provider.

D. Appeals of “timely filing” denials

1. This Subsection is intended to permit a provider to appeal the denial of a claim for failure to file the claim within the time period provided for in the participation agreement when the provider exercised due diligence in submitting the claim in a timely manner, or when the claim is filed late due to no fault of the provider.

2. Health insurers shall accept a provider appeal of a denial for failure to meet timely claim filing requirements so long as the claim is submitted to the correct Health Insurer within 180 days of the date of receipt by the provider of a denial from the initial, incorrect Health Insurer, provided that the initial claim was submitted to the incorrect Health Insurer within 180 days of the date of service.

3. Health Insurers shall not deny the appeal of a claim based on failure to meet timely filing requirements in the event that the provider submits all of the following documentation:

a. A copy of the timely filing denial;

b. Written documentation that the provider billed another Health Insurer or the patient within at least 180 days of the date of service;

c. If the provider billed another Health Insurer, an electronic remittance advice, explanation of benefits or other communication from the plan confirming the claim was denied and not paid, or inappropriate payment was returned;

d. If the provider billed the patient, acceptable documentation may include:

(1) Benefit determination documents from another carrier,

(2) A copy of provider’s billing system information documenting proof of an original carrier claim submission,

(3) A patient billing statement that includes initial claim send date and the date of service, or

(4) Documentation as to the exact date the provider was notified of member’s correct coverage, who notified the provider, how the provider was notified and a brief, reasonable statement as to why the provider did not initially know the

patient was not covered by carrier. Practice management and billing system information can be used as supportive documentation for these purposes.

4. Health Insurers shall notify providers that upon submission of the information required by § 4.11(D)(3) of this Part the Health Insurer shall not deny the appeal of a claim due to the failure to file the claim in a timely manner. Nothing in § 4.11(D) of this Part precludes the denial of a claim for other reasons unrelated to the timeliness of filing the claim.

   a. Health insurers shall utilize a standardized appeal checklist approved by the Commissioner when informing providers of a timely filing denial and what needs to be submitted to appeal that denial. The checklist and appeal submissions shall be made available for both manual and electronic processing.

   b. Health Insurers may implement the requirements of § 4.11(D) of this Part either by amendments to their claims processing system, or by amendments to their provider appeal policies and procedures.

E. Medical records management

1. The purpose of § 4.11(E) of this Part is to maintain the confidentiality of patient information during the process of transmittal of medical records between providers and health insurers, and to reduce the administrative burden of both the providers and carriers with regard to medical record submissions.

2. Health insurers shall comply with all state and federal laws and regulations relating to requests for written clinical and medical record information from patients or providers.

3. Health insurer requests for medical records shall specify:

   a. What medical record information is being requested;

   b. Why the medical record information being requested meets ‘need to know’ requirements under The Privacy and Individually Identifiable Health Information, 45 C.F.R. § 164.500-534 (2013); and

   c. Where the medical record is to be sent via mailing addresses, fax or electronically.

4. Health insurers shall establish a mechanism to provide for verification of the receipt of the medical records when a provider requests such verification.

5. Upon a provider's request, the Health Insurer disclose when a medical record was mis-sent or mis-addressed. In such events the Health Insurer shall destroy the mis-sent of mis-addressed records.

6. Upon a provider's request, Health Insurers shall provide:

   a. A clear listing of contact information (including mailing address, telephone number, fax number or email address) as to where medical records are to be sent,

   b. What specific records are to be sent, and

   c. Why the records are needed and permitted to be used in accordance with 45 C.F.R. § 164.500-534.

F. Prior Authorization

1. The purpose of § 4.11(F) of this Part is to reduce administrative burden due to prior authorization and to establish guidelines for health insurers to streamline, continuously improve, and monitor improvements in prior authorization processes over time.

2. By the end of 20265, health insurers shall reduce the volume of prior authorization requests by 20% relative to baseline 2023 requests on a normalized per member per month basis for all insured lines of business. In meeting the reduction target, health insurers shall prioritize items, services, treatments, or procedures ordered by primary care providers. The reduction target shall exclude non-formulary drugs. The Commissioner may consider health insurer actions to reduce prior authorization that were taken prior to 2023 in the establishment of baseline data and measurement of performance against the 20% reduction target.

3. Health insurers mayshall develop and implement the use of programs that implement selective prior authorization requirements, based on stratification of health care providers' performance and adherence to evidence-based medicine with the input of contracted health care providers and/or provider organizations. Such criteria shall be transparent and easily accessible to contracted providers. Such selective prior authorization programs shall be available when health care providers participate directly with the insurer in risk-based payment contracts and may be available to providers who do not participate in risk-based contracts.

4. Health insurers shall conduct a review of medical services, including behavioral health services, and prescription drugs, subject to prior authorization on at least an annual basis, with the input of contracted health care providers and/or provider organizations. Any changes to the

list of medical services, including behavioral health services, and prescription drugs requiring prior authorization, shall be shared via provider-accessible websites.

a. When determining whether to add, maintain, or remove prior authorization requirements, health insurers shall consider, when applicable, such factors as:

(1) volume and cost of services;

(2) approval rate of services subject to prior authorization;

(3) administrative costs to the health insurer;

(4) administrative costs to health care providers; and

(5) impact on the patient experience and continuity of care.

b. Health insurers shall document the evidentiary basis for adding prior authorization requirements, including but not limited to any peer-reviewed literature or other clinical research utilized to support new prior authorization requirements. Such documentation shall be made available to contracted health care providers upon request.

5. Health insurers shall submit a quarterly prior authorization report, in a form and manner determined by the Commissioner, that includes data on prior authorization requests, approval rates, and any other factors deemed relevant to the implementation and enforcement of this § 4.11(F) of this Part by the Commissioner.

6 Health insurers shall submit an annual attestation, including answers to a standard set of questions, regarding prior authorization processes and annual reviews of prior authorization requirements, in a form and manner determined by the Commissioner.

7. The Commissioner shall convene a statewide advisory committee on prior authorization that shall be a subcommittee of the Administrative Simplification Task Force. The advisory committee shall be comprised of representatives of health care providers and health insurers with relevant experience and expertise in prior authorization and other utilization management practices and processes. The advisory committee shall meet at least two times per year and will be charged with reviewing prior authorization data submitted to OHIC, health insurer attestations, and making recommendations to improve prior authorization processes for medical services and prescription drugs over time.

4.12 Price Disclosure

A. The purpose of this -§ 4.12 of this Part is to empower consumers who are enrollees in a health insurance plan to make cost effective decisions concerning their health care, and to enable providers to make cost-effective treatment decisions on behalf of their patients who are enrollees of a health insurance plan, including referral and care coordination decisions.

B. A health insurer shall not enforce a provision in any participating provider agreement which purports to obligate the health insurer or health care provider to keep confidential price information requested by a health care provider for the purpose of making cost-effective clinical referrals, and for the purpose of making other care coordination or treatment decisions on behalf of their patients who are enrollees in the health benefit plan of the health insurer.

C. At the request of a health care provider acting on behalf of an enrollee-patient, a health insurer shall disclose in a timely manner to the health care provider such price information as the provider determines is necessary to make cost-effective treatment decisions on behalf of their patients, including clinical referrals, care coordination, and other treatment decisions.

D. A health insurer may adopt reasonable policies and procedures designed to limit the disclosure of price information for unauthorized purposes.

4.13 Primary Care Specialty Provider Taxonomy Codes

A. The primary care specialty provider taxonomy codes to be used by health insurers to meet the primary care expenditure requirements defined in § 4.10(B)(1) of this Part shall be as follows.

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	

Taxonomy	Description	Notes or Restrictions
207QH0002X	Family Medicine, Hospice Palliative	Restrict to only home health and hospice procedure codes
208000000X	Pediatrics	
2080A0000X	Pediatrics, Adolescent Medicine	
2080H0002X	Pediatrics, Hospice and Palliative Medicine	Restrict to only home health and hospice procedure codes
207R00000X	Internal Medicine	
207RG0300X	Internal Medicine, Geriatric Medicine	
207RA0000X	Internal Medicine, Adolescent Medicine	
207RH0002X	Internal Medicine, Hospice and Palliative Medicine	Restrict to only home health and hospice procedure codes
363A00000X	Physician Assistant	
363AM0700X	Physician Assistant, Medical	
363L00000X	Nurse Practitioner	
363LA2200X	Nurse Practitioner, Adult Health	
363LF0000X	Nurse Practitioner, Family	
363LG0600X	Nurse Practitioner, Gerontology	
363LP0200X	Nurse Practitioner, Pediatrics	
363LP2300X	Nurse Practitioner, Primary Care	
363LC1500X	Nurse Practitioner, Community Health	
363LS0200X	Nurse Practitioner, School	

Taxonomy	Description	Notes or Restrictions
261QF0400X	Federally Qualified Health Center (FQHC)	Restrict on revenue codes for clinic and professional services 0510, 0515, 0517, 0520, 0521, 0523, 0960, 0983

4.14 Primary Care Payment Codes

A. The primary care payment codes to be used by health insurers to meet the primary care expenditure requirements defined in § 4.10(B)(1) of this Part shall be as follows.

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	Office Visits

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

Procedure Code	Description	Reporting Procedure Category
	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.)	
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

Procedure Code	Description	Reporting Procedure Category
99385	INITIAL PREVENTIVE MEDICINE NEW PT AGE 18-39YRS	Preventive Medicine Visits
99386	INITIAL PREVENTIVE MEDICINE NEW PATIENT 40-64YRS	Preventive Medicine Visits
99387	INITIAL PREVENTIVE MEDICINE NEW PATIENT 65YRS&>	Preventive Medicine Visits
99391	PERIODIC PREVENTIVE MED ESTABLISHED PATIENT <1Y	Preventive Medicine Visits
99392	PERIODIC PREVENTIVE MED EST PATIENT 1-4YRS	Preventive Medicine Visits
99393	PERIODIC PREVENTIVE MED EST PATIENT 5-11YRS	Preventive Medicine Visits
99394	PERIODIC PREVENTIVE MED EST PATIENT 12-17YRS	Preventive Medicine Visits
99395	PERIODIC PREVENTIVE MED EST PATIENT 18-39 YRS	Preventive Medicine Visits
99396	PERIODIC PREVENTIVE MED EST PATIENT 40-64YRS	Preventive Medicine Visits
99397	PERIODIC PREVENTIVE MED EST PATIENT 65YRS& OLDER	Preventive Medicine Visits
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

Procedure Code	Description	Reporting Procedure Category
99417	Prolonged office or other outpatient evaluation and management service(s) requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes (use 99417 in conjunction with 99205, 99215, 99245, 99345, 99350, 99483. Do not report 99417 on the same date of service as 90833, 90836, 90838, 99358, 99359, 99415, 99416)	Office Visits
G2212	Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact	Office Visits
G0466	FEDERALLY QUALIFIED HEALTH CENTER VISIT NEW PT	HCPC Visit Codes
G0467	FEDERALLY QUALIFIED HEALTH CENTER VISIT ESTAB PT	HCPC Visit Codes
G0468	FEDERALLY QUALIFIED HEALTH CENTER VISIT IPPE/AWV	HCPC Visit Codes
T1015	CLINIC VISIT/ENCOUNTER ALL-INCLUSIVE	HCPC Visit Codes
S9117	BACK SCHOOL VISIT	HCPC Visit Codes
G0402	INIT PREV PE LTD NEW BENEF DUR 1ST 12 MOS MCR	HCPC Visit Codes
G0438	ANNUAL WELLNESS VISIT; PERSONALIZ PPS INIT VISIT	HCPC Visit Codes

Procedure Code	Description	Reporting Procedure Category
G0439	ANNUAL WELLNESS VST; PERSONALIZED PPS SUBSQT VST	HCPC Visit Codes
G0463	HOSPITAL OUTPATIENT CLIN VISIT ASSESS & MGMT PT	HCPC Visit Codes
99401	PREVENT MED COUNSEL&/RISK FACTOR REDJ SPX 15 MIN	Preventive Medicine Services
99402	PREVENT MED COUNSEL&/RISK FACTOR REDJ SPX 30 MIN	Preventive Medicine Services
99403	PREVENT MED COUNSEL&/RISK FACTOR REDJ SPX 45 MIN	Preventive Medicine Services
99404	PREVENT MED COUNSEL&/RISK FACTOR REDJ SPX 60 MIN	Preventive Medicine Services
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

Procedure Code	Description	Reporting Procedure Category
99341	HOME VISIT NEW PATIENT STRAIGHTFORWARD 15 MINUTES	Home Visits
99342	HOME VISIT NEW PATIENT LOW SEVERITY 30 MINUTES	Home Visits
99344	HOME VISIT NEW PATIENT MODERATE SEVERITY 60 MINUTES	Home Visits
99345	HOME VISIT NEW PATIENT HIGH SEVERITY 75 MIN	Home Visits
99347	HOME VISIT EST PT STRAIGHTFORWARD20 MINUTES	Home Visits
99348	HOME VISIT EST PT LOW SEVERITY 30 MINUTES	Home Visits
99349	HOME VISIT EST PT MOD SEVERITY 40 MINUTES	Home Visits
99350	HOME VST EST PT HIGH SEVERITY 60 MINS	Home Visits
99374	SUPVJ PT HOME HEALTH AGENCY MO 15-29 MINUTES	Hospice/Home Health Services
99375	SUPERVISION PT HOME HEALTH AGENCY MONTH 30 MIN/>	Hospice/Home Health Services
99376	CARE PLAN OVERSIGHT/OVER	Hospice/Home Health Services
99377	SUPERVISION HOSPICE PATIENT/MONTH 15-29 MIN	Hospice/Home Health Services
99378	SUPERVISION HOSPICE PATIENT/MONTH 30 MINUTES/>	Hospice/Home Health Services
G0179	PHYS RE-CERT MCR-COVR HOM HLTH SRVC RE-CERT PRD	Hospice/Home Health Services

Procedure Code	Description	Reporting Procedure Category
G0180	PHYS CERT MCR-COVR HOM HLTH SRVC PER CERT PRD	Hospice/Home Health Services
G0181	PHYS SUPV PT RECV MCR-COVR SRVC HOM HLTH AGCY	Hospice/Home Health Services
G0182	PHYS SUPV PT UNDER MEDICARE-APPROVED HOSPICE	Hospice/Home Health Services
99495	TRANSITIONAL CARE MANAGE SRVC 14 DAY DISCHARGE	Transitional Care Management Services
99496	TRANSITIONAL CARE MANAGE SRVC 7 DAY DISCHARGE	Transitional Care Management Services
99497	ADVANCE CARE PLANNING FIRST 30 MINS	Advance Care Planning Evaluation & Management Services
99498	ADVANCE CARE PLANNING EA ADDL 30 MINS	Advance Care Planning Evaluation & Management Services
99366	TEAM CONFERENCE FACE-TO-FACE NONPHYSICIAN	Case Management Services
99367	TEAM CONFERENCE NON-FACE-TO-FACE PHYSICIAN	Case Management Services
99368	TEAM CONFERENCE NON-FACE-TO-FACE NONPHYSICIAN	Case Management Services
99439	Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month	Chronic Care Management Services
99424	Initial 30 minutes per calendar month of principal care management services, including creation of a disease-specific care	Chronic Care Management Services

Procedure Code	Description	Reporting Procedure Category
	plan by a physician or qualified health care provider.	
99425	Each additional 30 minutes per calendar month of principal care management services, as carried out by a physician or qualified health care professional.	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

Procedure Code	Description	Reporting Procedure Category
99489	CMPLX CHRON CARE MGMT EA ADDL 30 MIN PER MONTH	Chronic Care Management Services
99490	CHRON CARE MANAGEMENT SRVC 20 MIN PER MONTH	Chronic Care Management Services
99491	CHRON CARE MANAGEMENT SRVC 1ST 30 MIN PER MONTH	Chronic Care Management Services
G0506	COMP ASMT OF & CARE PLNG PT RQR CC MGMT SRVC	Chronic Care Management Services
99358	PROLNG E/M SVC BEFORE&/AFTER DIR PT CARE 1ST HR	Prolonged Services
99359	PROLNG E/M BEFORE&/AFTER DIR CARE EA 30 MINUTES (use in conjunction with 99358)	Prolonged Services
99360	PHYS STANDBY SVC PROLNG PHYS ATTN EA 30 MINUTES	Prolonged Services
G0513	PRLNG PREV SRVC OFC/OTH O/P RQR DIR CTC;1ST 30 M	Prolonged Services
G0514	PRLNG PREV SRVC OFC/OTH O/P DIR CTC;EA ADD 30 M	Prolonged Services
99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes	Telephone and Internet Services
99422	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes	Telephone and Internet Services
99423	Online digital evaluation and management service, for an established patient, for up to	Telephone and Internet Services

Procedure Code	Description	Reporting Procedure Category
	7 days, cumulative time during the 7 days; 21 or more minutes	
99441	PHYS/QHP TELEPHONE EVALUATION 5-10 MIN	Telephone and Internet Services
99442	PHYS/QHP TELEPHONE EVALUATION 11-20 MIN	Telephone and Internet Services
99443	PHYS/QHP TELEPHONE EVALUATION 21-30 MIN	Telephone and Internet Services
99446	NTRPROF PHONE/NTRNET/EHR ASSMT&MGMT 5-10 MIN	Telephone and Internet Services
99447	NTRPROF PHONE/NTRNET/EHR ASSMT&MGMT 11-20 MIN	Telephone and Internet Services
99448	NTRPROF PHONE/NTRNET/EHR ASSMT&MGMT 21-30 MIN	Telephone and Internet Services
99449	NTRPROF PHONE/NTRNET/EHR ASSMT&MGMT 31/> MIN	Telephone and Internet Services
99451	NTRPROF PHONE/NTRNET/EHR ASSMT&MGMT 5/> MIN	Telephone and Internet Services
99452	NTRPROF PHONE/NTRNET/EHR REFERRAL SVC 30 MIN	Telephone and Internet Services
98966	NONPHYSICIAN TELEPHONE ASSESSMENT 5-10 MIN	Telephone and Internet Services
98967	NONPHYSICIAN TELEPHONE ASSESSMENT 11-20 MIN	Telephone and Internet Services
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	Telephone and Internet services

Procedure Code	Description	Reporting Procedure Category
	patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes	
98971	Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes	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

Procedure Code	Description	Reporting Procedure Category
G0008	ADMINISTRATION OF INFLUENZA VIRUS VACCINE	Immunization Administration for Vaccines/Toxoids
G0009	ADMINISTRATION OF PNEUMOCOCCAL VACCINE	Immunization Administration for Vaccines/Toxoids
G0010	ADMINISTRATION OF HEPATITIS B VACCINE	Immunization Administration for Vaccines/Toxoids
96160	PT-FOCUSED HLTH RISK ASSMT SCORE DOC STND INSTRM	Health Risk Assessment, Screenings, and Counseling
96161	CAREGIVER HLTH RISK ASSMT SCORE DOC STND INSTRM	Health Risk Assessment, Screenings, and Counseling
99078	PHYS/QHP EDUCATION SVCS RENDERED PTS GRP SETTING	Health Risk Assessment, Screenings, and Counseling
99483	ASSMT & CARE PLANNING PT W/COGNITIVE IMPAIRMENT	Health Risk Assessment, Screenings, and Counseling
G0396	ALCOHOL &/SUBSTANCE ABUSE ASSESSMENT 15-30 MIN	Health Risk Assessment, Screenings, and Counseling
G0397	ALCOHOL &/SUBSTANCE ABUSE ASSESSMENT >30 MIN	Health Risk Assessment,

Procedure Code	Description	Reporting Procedure Category
		Screenings, and Counseling
G0442	ANNUAL ALCOHOL MISUSE SCREENING 15 MINUTES	Health Risk Assessment, Screenings, and Counseling
G0443	BRIEF FACE-FACE BEHAV CNSL ALCOHL MISUSE 15 MIN	Health Risk Assessment, Screenings, and Counseling
G0444	ANNUAL DEPRESSION SCREENING 15 MINUTES	Health Risk Assessment, Screenings, and Counseling
G0505	COGN & FUNCT ASMT USING STD INST OFF/OTH OP/HOME	Health Risk Assessment, Screenings, and Counseling
99173	SCREENING TEST VISUAL ACUITY QUANTITATIVE BILAT	Preventive Medicine Services
G0102	PROS CANCER SCREENING; DIGTL RECTAL EXAMINATION	Preventive Medicine Services
G0436	SMOKE TOB CESSATION CNSL AS PT; INTRMED 3-10 MIN	Preventive Medicine Services
G0437	SMOKING & TOB CESS CNSL AS PT; INTENSIVE >10 MIN	Preventive Medicine Services
99492		Collaborative Care
99493		Collaborative Care
99494		Collaborative Care

Procedure Code	Description	Reporting Procedure Category
G2214		Collaborative Care

4.153 Severability

A. If any section, term, or provision of this regulation is adjudged invalid for any reason, that judgment shall not affect, impair, or invalidate any remaining section, term, or provision, which shall remain in full force and effect.

4.164 Construction

A. This regulation shall be liberally construed to give full effect to the purposes stated in R.I. Gen. Laws § 42-14.5-2.

B. This regulation shall not be interpreted to limit the powers granted the Commissioner by other provisions of the law.