

RHODE ISLAND
HEALTH CARE COST
GROWTH TARGET

IMPLEMENTATION
MANUAL

July 27, 2020

Version 6.1

Version History

Version Number	Release Date	Summary of Changes
6	June 18, 2020	CY2018 and estimated CY2019 reporting.
6.1	July 27, 2020	<ul style="list-style-type: none">• Removed language requiring minimum attributed member thresholds from Appendix A.• Clarified that attribution of Medicaid members should be done using EOHHS's performance year 3 methodology in Appendix A.• Clarified that insurers should only report data by ACOs for which it is contracted with in Appendix A.

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Overview

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

This implementation manual contains the technical and operational steps that the State will need to take to implement the health care cost growth target. This manual contains the methodology the Steering Committee used to set the health care cost growth target, and the methodologies for calculating performance against the target. It also contains the technical specifications for data reporting and collection.

The document is outlined as follows:

Section 1. Health Care Cost Growth Target and Methodology

Section 2. Methodology for Assessing Performance Against the Target

Appendix A. Insurer TME Data Specification

Appendix B. RI EOHHS TME Data Specification

Appendix C. Medicare Fee-For-Service TME Data Collection Process

Appendix D. Net Cost of Private Health Insurance Data Specifications

Appendix E. Rhode Island Total Population Statistics

Appendix F. Insurer Attestation

Attachment 1. Timeline for Reporting

Attachment 2. Total Health Care Expenditures Databook

Attachment 3. Medicare Expenditure and Enrollment Request Template

Attachment 4. Cost Growth Target Performance Submission Template

I. Health Care Cost Growth Target Definition and Methodology

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

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

$$\text{expected growth in national labor force productivity} + \text{expected growth in the state civilian labor force} + \text{expected national inflation} - \text{expected state population growth}$$

As directed by Executive Order 19-03, during 2022, the methodology of the Target is to be reassessed and maintained, or replaced with a new target for 2023 and beyond. To assist in the reassessment, the sources for each of the components of the PGSP formula as calculated for Executive Order 19-03 are included below in Table 1.

Table 1. Sources for PGSP Formula

Components	Source
<p>Expected growth in national labor force productivity</p>	<p>The source is the most recently published <u>Congressional Budget Office Budget and Economic Outlook Report</u>.¹ Included within the report is a table of Key Inputs in the CBO’s Projections of Real Potential GDP that includes the potential labor force productivity projected average annual growth from 2023–2028 (Page 13, Table 2 of the August 2018 report).</p> <p>In general, the figure used to calculate PGSP should be the value that is forecast for five through 10 years into the future.</p>
<p>Expected growth in the state civilian labor force</p>	<p>The source is the Rhode Island Office of Management and Budget purchased forecast from IHS Economics or another vendor.²</p> <p>Specifically, the figure can be found on the employment tab of the IHS Economics US Regional Service September 2018 Long</p>

¹ As of April 7, 2020, the Congressional Budget Office published its Budget and Economic Outlook Reports here: www.cbo.gov/about/products/major-recurring-reports#1.

² The IHS Economics Forecast purchased by the RI Office of Management and Budget was supplied to Bailit Health and Cory King by Matt McCabe in the Office of Regulatory Reform. Mr. McCabe reported in an email on October 3, 2018 that these data are also used at the Revenue Estimating Conference.

	<p>Term workbook. Labor Force statistics are in row 65. In this case, the figure is the average growth in the Labor Force from the first quarter of 2023 through the fourth quarter of 2028.</p>
Expected national inflation	<p>The source is the most recently published <u>Congressional Budget Office Budget and Economic Outlook Report</u>.³ Included within the report is a table of CBO’s Economic Projections for Calendar Years 2018 to 2028 (Page 5, Table 1 of the August 2018 report).</p> <p>In general, the figure used to calculate PGSP should be the value of the “PCE price index” percentage change from year-to-year that is forecast for five through 10 years into the future.</p>
Expected state population growth	<p>The source is the Rhode Island Population Projections Summary Tables from the Division of Statewide Planning.</p> <p>In general, the figure used to calculate PGSP should be the percentage change from year-to-year that is forecast for five through 10 years into the future.</p> <p>In this case, because the Division of Statewide Planning provides forecasts in five-year bands, the calculation used the figures that were as close to five through 10 years into the future as feasible. Specifically, the figure used to calculate PGSP is the annualized growth rate between 2025 and 2030.</p>

For the development of the initial Target, the time period of 2023-2028 was consistent with the desired future forecast period of five to 10 years into the future (which is a common future period used in economic modeling). When reviewing the Target in 2022, should PGSP remain the target, a commensurate future time period for calculating the Target will need to be used.

Using the sources listed above, the value calculated to establish the Target (PGSP) in Executive Order 19-03 is presented in Table 2.

³ As of April 7, 2020 the Congressional Budget Office published its Budget and Economic Outlook Reports here: www.cbo.gov/about/products/major-recurring-reports#1.

Table 2. PGSP Calculation

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

II. Methodology for Assessing Performance Against the Health Care Cost Growth Target

Executive Order 19-03 requires OHIC and EOHHS to report annually during the fourth quarter on performance relative to the Target during the prior calendar year at the state, health insurance market, individual payer, and accountable care organization level for entities of a sufficient size, using clinical risk-adjustment methodologies. To do so, OHIC will lead the state efforts to perform a series of data collection activities and calculations. This chapter contains the methodology for measuring the growth in health care spending at each level, including which data are necessary to collect and which calculations need to be performed.⁴ This chapter is organized as follows:

- A. Definitions of Key Terms
- B. Methodology for Measuring Total Health Care Expenditures (THCE)
- C. Data Sources for THCE
- D. Public Reporting of Cost Growth Target Performance
- E. Timeline for Measuring and Reporting the Health Care Cost Growth Target

A. Definitions of Key Terms

- **Accountable Care Organization (ACO):** A provider organization contracted with one or more payers and held accountable for the quality health care, outcomes and total cost of care of an attributed commercial or Medicare population.
- **Accountable Entity (AE):** Rhode Island Medicaid's version of an Accountable Care Organization. A provider organization contracted with one or more Medicaid insurers and held accountable for the quality health care, outcomes and total cost of care of an attributed Medicaid population. AEs are certified by EOHHS.
- **Allowed Amount:** The amount the payer paid a provider, plus any member cost sharing for a claim. Allowed amount is typically a dedicated data field in claims data. Allowed amount is the basis for measuring the claims component of Total Health Care Expenditures.
- **Health Care Cost Growth Target (Target):** The Target is the value by which the Rhode Island Health Care Cost Trends Steering Committee has agreed to measure Total Health Care Expenditures and Total Medical Expense against. It is the value of Rhode Island's

⁴ These methodologies and reporting specifications are derived, in part, from materials published by the Massachusetts Center for Health Information and Analysis, and the Delaware Health Care Commission. These materials have been edited from previously published materials to reflect the Rhode Island model.

Potential Gross State Product (PGSP). PGSP is the total value of goods produced and services provided in a state at a constant inflation rate and is 3.2%.

- **Insurer:** A private health insurance company that offers one or more of the following: commercial insurance, benefit administration for self-insured employers, Medicare managed care organization (MCO) and/or are Medicaid MCO products.
- **Market:** The highest levels of categorization of the health insurance market. For example, Medicare and Medicare MCO are collectively referred to as the “Medicare Market.” Medicaid Fee-for-Service and Medicaid MCO Managed Care are collectively referred to as the “Medicaid Market.” Individual, self-insured, small and large group markets and student health insurance are collectively referred to as the “Commercial Market.”
- **Measurement Year:** The Measurement Year is the calendar year for which performance is measured against the prior calendar year for purposes of calculating the growth in health care costs.
- **Net Cost of Private Health Insurance (NCPHI):** Measures the costs to Rhode Island residents associated with the administration of private health insurance (including Medicare Managed Care and Medicaid Managed Care). It is defined as the difference between health premiums earned and benefits incurred, and consists of insurers’ costs of paying bills, advertising, sales commission and other administrative costs, premium taxes and profits (or contributions to reserves) or losses. NCPHI is reported as a component of THCE at the state, market and insurer levels. NCPHI is not reported at the Accountable Care Organization level.
- **Payer:** A term used to refer collectively to both insurers and public programs that are submitting data to OHIC.
- **Payer Recoveries:** Funds distributed by a payer and then later recouped (either through an adjustment from current or future payments, or a cash transfer) due to a review, audit or investigation of funds distribution by the payer. Payment recoveries is a separate, reportable field in insurer total medical expense (TME) reporting.
- **Pharmacy Rebates:** Any rebates provided by pharmaceutical manufacturers to payers for prescription drugs, excluding manufacturer-provided fair market value bona fide service fees.⁵ The computation of TCHE at the state, market and payer level is net of pharmacy rebates (i.e., other expenditures are reduced by the amount of the pharmacy rebates).⁶

⁵ Fair market value bona fide service fees are fees paid by a manufacturer to a third party (e.g., insurer, pharmacy benefit manager, etc.) that represent fair market value for a bona fide, itemized service actually performed on behalf of the manufacturer that the manufacturer would otherwise perform (or contract for) in the absence of the service arrangement (e.g., data service fees, distribution service fees, patient care management programs, etc.)

⁶ CMS is unable to report pharmaceutical rebates for traditional Medicare beneficiaries (i.e., FFS Medicare). Therefore, in the computations of THCE at the state and Medicare market levels, spending will be gross of Medicare FFS pharmaceutical rebates.

- **Provider:** A term referring to an individual clinician, medical group, individual provider, Accountable Care Organization or similar entities.
- **Public Program:** A term used to refer to payers that are not insurers. This includes Medicare Fee-For-Service, Medicaid Fee-for-Service and similar programs.
- **Total Health Care Expenditures (THCE):** The total medical expense incurred by Rhode Island residents for all health care services for all payers reporting to OHIC, plus the insurers' Net Cost of Private Health Insurance. Defining specifications of THCE are included in Section B of this chapter.
- **Total Health Care Expenditures Per Capita:** Total Health Care Expenditures (as defined above) divided by Rhode Island's total state population. The annual change in THCE per capita is compared to the Target at the state, market and insurer levels. THCE will not be reported at the ACO/AE level.⁷
- **Total Medical Expense (TME):** The sum of the Allowed Amount of total claims and total non-claims spending paid to providers incurred by Rhode Island residents for all health care services. TME is reported at multiple levels: state, market, payer and provider level. TME is reported net of Pharmacy Rebates at the state, market and payer levels only. Payers report TME by line of business (e.g., individual, self-insured, large group, small group, Medicare, Medicaid, Medicare/Medicaid dually eligible) and at the ACO/AE level whenever possible. More detailed TME reporting specifications are contained in the Appendices of this manual.

B. Methodology for Measuring Total Health Care Expenditures

To assess changes in the amount of health care spending, OHIC will need to calculate THCE annually. OHIC should measure THCE on an aggregate dollar and per capita basis. The aggregate dollar figure will be for informational purposes only. The change in THCE on a per capita basis will be used to assess performance against the Target.

THCE (in aggregate) =

$$\text{Commercial TME} + \text{Medicare Managed Care TME} + \text{Medicare FFS TME} + \\ \text{Medicaid MCO TME} + \text{RI EOHHS FFS TME} + \text{Insurer NCPHI}$$

THCE (per capita) =

$$\frac{\left(\text{Commercial TME} + \text{Medicare Managed Care TME} + \text{Medicare FFS TME} + \right. \\ \left. \text{Medicaid MCO TME} + \text{Medicaid FFS TME} + \text{Insurer NCPHI} \right)}{\text{Rhode Island Population}}$$

⁷ NCPHI, a component of THCE, is not reportable at the ACO level. Therefore, THCE is not reported at the ACO/AE level.

The percentage change in THCE per capita between the Measurement Year and the prior calendar year will be used to assess performance against the Target applicable to the specific measurement year.

The defining specifications of THCE are:

- It represents spending by or on behalf of Rhode Island residents in and out-of-state. Spending associated with people who live out-of-state is excluded.
- It includes spending on health care services/benefits. It excludes non-medical spending, even if such spending is made by a payer (e.g., gym memberships).
- Vision and dental spending are generally excluded except in instances where vision and dental services are covered as a health insurance benefit or are a covered benefit under Medicaid and Medicare.
- It represents the total Allowed Amount, which is inclusive both of amounts covered by payers and out-of-pocket spending associated with insured medical expenditures (e.g., copays and deductibles). In order to avoid double counting expenditures, health care premium payments are not included. Also, due to the lack of available data, other out-of-pocket expenditures recorded by providers, but not by insurers, are not included (e.g., “charity care” or spending for medical care by residents of Rhode Island who cannot afford to pay providers, privately purchased health care services).
- It includes all insurance market segments, including public and private payers listed in this manual, fully and self-insured, and student insurance with the following limited exceptions: US Department of Veterans Affairs, the TRICARE program and health spending by the Rhode Island Department of Corrections that is not otherwise covered by Medicaid.
- The administrative costs and underwriting gain/loss of insurers, referred to as the NCPHI, are included (see Section C of this chapter for more detail).
- TME data is only collected from a payer when it is the primary payer for a claim. The primary payer will report on the allowed amount. If the secondary payer of the claim were to report, it would cause double counting of a portion of the Allowed Amount by the primary payer.
- TME is adjusted to account for any pharmacy rebates received by the payer, by subtracting the rebates (revenue) from the payer’s total medical expense.

- Provider resources applied in the delivery of care for uninsured Rhode Islanders should not be included in calculations of health care spending because they are technically not “spending” as defined herein. Future reporting on spending relative to the Target should, however, indicate that while these resource applications are not captured in the measurement of total health care spending, they may be significant for certain providers.

C. Data Sources for THCE

Data for THCE comes from several sources. Insurers need to report TME for all lines of business and, in some instances, insurers need to report data for the State to calculate the NCPHI. Other data sources include the Centers for Medicare and Medicaid Services (CMS) and EOHHS. Table 3, below, outlines the data source by THCE category and the location of the detailed specification or collection process within this manual.

Table 3. Data Sources for THCE

THCE Category	Data Source	Location of Data Specification/Collection Process in Manual
Expenditures from Insurers		
Insurer full claim (comprehensive coverage with no carve-outs)	TME reported by insurers	Appendix A
Insurer partial claim (coverage with carve-outs, such as pharmacy) calculated values	TME reported by insurers, with actuarial estimates produced by insurers	Appendix A
Insurer non-claim payments	TME reported by insurers	Appendix A
Prescription drug spending for Medicare Managed Care Organization, for market-level reporting only (For insurer-level reporting, the data source is in insurer-reported TME.)⁸	CMS	Appendix C

⁸ CMS will provide OHIC with allowed amounts for Medicare FFS beneficiaries with stand-alone prescription drug plans (PDP) and for Medicare managed care beneficiaries with stand-alone PDP and

Expenditures from Public Programs		
EOHHS claim (Medicaid FFS and other) calculated values	EOHHS	Appendix B
Medicare FFS claim (Parts A, B and D) calculated values	CMS	Appendix C
Net Cost of Private Health Insurance		
Insurer NCPHI	Calculated from regulatory reports submitted by the insurers or obtained through public sources	Appendix D
Pharmacy Rebates		
Insurers	Pharmacy rebate data filing by insurers	Appendix A
Medicaid Program	Pharmacy rebate data filing by EOHHS	Appendix G
Population Statistics		
Population of Rhode Island	Rhode Island Division of Statewide Planning	Appendix E

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

Insurer TME Data

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

Annually, OHIC will need to direct applicable insurers to submit TME data using the specifications outlined in **Appendix A** and the template provided as **Attachment 4**. Specifications for public programs to submit their TME are included in **Appendices B-C**, with the Medicare template provided as **Attachment 3**. Table 4, below, lists which insurers should report for their commercial, Medicare managed care, Medicaid/CHIP managed care markets and Medicare-Medicaid dual eligible market.⁹

Table 4. Insurers Requested to Report TME Data by Market

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

The TME data include claims and non-claims payments¹⁰ for a single calendar year. Payers should submit these data based on Allowed Amounts. Payers are expected to adjust expenditure data for a reasonable and appropriate estimate of unpaid claims liability (i.e., incurred but not reported (IBNR) or incurred but not paid (IBNP)) using actuarially sound principles, when claims run-out alone is not sufficient. TME spending is only reported by a payer when it is the primary insurer on the claim, as secondary coverage expenditures would generally double count a portion of the Allowed Amount by the primary insurer.

In some circumstances, insurers are only able to report claims payments for a subset of medical services due to benefit design in which the contracting employer may “carve out” some

⁹ This table represents the largest insurers in the Rhode Island insurance market as of June 2020. Because the market may change, this table may need to be updated over time.

¹⁰ Claims payments and payments to providers associated with a health care claim. Non-claims payments are payments to providers that are not associated with a claim and include capitation payments, pay-for-performance bonuses, risk settlements, care management payments, etc.

services, such as pharmacy or behavioral health. In other carve-out instances, however, insurers are unable to obtain the payment information and do not hold the insurance risk for the carved-out services. Thus, insurers will need to report this type of TME data separately in the partial-claim category (see **Appendix A** for more information). To estimate the full TME amount for the partial claim population, the insurer will need to make actuarial adjustments based on the reported partial-claim TME data. An actuarial adjustment will allow OHIC to estimate the full spending amount without having to collect data from carve-out vendors. For example, for those members for whom pharmacy benefits are carved out, the insurer might include its commercial market book-of-business average pharmacy spending per-member, per-month (PMPM) for the same year, calculated on members who had primary coverage, applied to all member months for which the carve-out applied. Before this adjustment is made, insurers should discuss appropriate methodologies with OHIC, recognizing there is no standard approach to performing this estimate, but that actuarially sound principles should be used.

Appendix A includes instructions for insurers to submit pharmacy rebate data so that OHIC can subtract pharmacy rebates from THCE and TME at the market and insurer levels. Payers will need to proportionally allocate total pharmacy rebates by line of business to Rhode Island resident members, unless rebates can be directly associated with a specific line of business.

NCPHI Data

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

OHIC will need to calculate NCPHI for all Rhode Island residents whose insurers are submitting data to OHIC, using data obtained from insurers and other public sources. NCPHI should exclude out-of-state residents covered under Rhode Island-based insurance plans. The methodology that OHIC will need to follow in order to calculate NCPHI is listed in **Appendix D**.

D. Public Reporting of Cost Growth Target Performance

To publicly report on performance against the Target and as directed in Executive Order 19-03, OHIC will report at the statewide level, with several “drill-down” analyses. The following specifications propose the minimal levels of public reporting that OHIC should undertake. The type of public reporting of performance relative to the Target will likely evolve over time. Therefore, this manual should be updated as the public reporting processes change.

Table 5 outlines the minimum level at which OHIC should publicly report performance. When reporting TME, OHIC should report on a per-member per year (PMPY) basis, which calculates the average amount of spending per member for a particular market segment.

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

Level	THCE	TME/NCPHI
State level	Aggregate and per capita Compare per capita rate of change against Target	Report TME and NCPHI components
Commercial market	Aggregate and PMPY Compare PMPY rate of change against Target	Report TME and NCPHI components
Medicare market	Aggregate and PMPY Compare PMPY rate of change against Target	Report TME only (NCPHI not applicable)
Medicaid market	Aggregate and PMPY	Report TME only (NCPHI not applicable)
Insurer Level	PMPY Compare PMPY rate of change against Target	Report TME and NCPHI components
ACO/AE Level	N/A	Report TME only, PMPY Compare PMPY rate of change against Target

Reporting should be done using both text and graphics that are engaging to the reader and easy to understand. For an example of how reporting can be done, please see Attachment 5 – Center for Health Information and Analysis’ Performance of the Massachusetts Health Care System Annual Report.

Reporting TME by Service Category

A goal with the collection of TME data is to obtain summary-level payer data segmented into a manageable number of distinct service categories that all payers can consistently and accurately report. By analyzing service category spending, OHIC is able to understand the scale of changes in individual service categories and the share of TME spending changes that are attributable to each service category. Ideally, payers would utilize a standardized list of claims codes by service category, but to create a list requires a time-intensive effort on behalf of the State to define the categories or an agreement to use a pre-defined list, like the one developed by the Health Care Cost Institute.¹¹ Payers would also have to undergo a resource-intensive effort to configure reports in the standardized format.

Instead, OHIC is requesting payers to report the following individual service categories using the definitions provided in the Appendices of this manual:

- Hospital Inpatient
- Hospital Outpatient
- Professional (Primary Care)
- Professional (Specialty Care)
- Professional Other
- Long-Term Care
- Retail Pharmacy¹²
- Pharmacy Rebates
- Other

More information on what specific types of services are included in each of the respective service categories is provided within the payer technical specification appendices. For the duration that these categories are not defined with specific codes, OHIC should acknowledge when analyzing and reporting these data publicly that there may be some limitations in consistent interpretation across payers. In future years, OHIC should consider facilitating a process whereby a pre-established claims code-level definition could be used consistently across payers. At that time, additional, more detailed categories of services could be added, such as lab and imaging, for example, to deepen OHIC analysis capabilities.

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

OHIC will request that insurers submit TME data at the ACO/AE level, by line of business, by applying an attribution methodology that will assign members to an ACO/AE as follows:

¹¹ See www.healthcostinstitute.org/images/pdfs/HCCI_2017_Methodology_public_v20.pdf

¹² Insurers that have both Medicare Advantage and stand-alone PDP lines of business must exclude their stand-alone PDP data from their TME submission. Stand-alone PDP expenditure data will be obtained from CMS.

1. Medicaid:
 - a. Medicaid members who were attributed during the measurement year to an AE using the attribution rules established by EOHHS.
 - b. Medicaid members not attributed to an AE (to be reported in aggregate).
2. Commercial and Medicare:
 - a. Commercial and Medicare managed care members who were attributed during the measurement year, pursuant to a contract between the insurer and ACO for financial or quality performance assessment purposes. Members can be attributed monthly, quarterly, annually, or at another frequency, so long as the attribution timing is consistent with the insurer contract.
 - b. Commercial and Medicare managed care members not attributed to an ACO (to be reported in aggregate).
3. Dual Eligible:
 - a. Medicare and Medicaid dually eligible members should be attributed to an ACO or AE using the attribution rules above of the primary payer of their medical benefit.
 - b. Medicare and Medicaid dually eligible members not attributed to an ACO/AE (to be reported in aggregate)

The data will be reported at the ACO/AE level by line of business for each payer, which is outlined in the TME specification in **Appendix A**. Data must include all TME for all attributed members, including when care was provided by providers outside of or not affiliated with the respective ACO/AE. Furthermore, for OHIC to calculate market performance, insurers must report spending in aggregate for members not attributed to an ACO/AE. The details of insurer attribution to an ACO/AE is included in the TME specification in **Appendix A**.

In order to publicly report on Rhode Island ACO/AE performance, the Health Care Cost Trends Steering Committee made recommendations on the minimum number of attributed members required to report provider performance. Annually, OHIC should publicly report, by line of business, on the clinical risk-adjusted TME for ACOs/AEs that meet the following criteria:

- A minimum of 120,000 attributed commercial or Medicaid member months
- A minimum of 60,000 attributed Medicare member months.

OHIC should require insurers to submit non-adjusted TME data. OHIC will adjust TME based on member clinical risk using insurer-reported clinical risk-adjustment scores. Because these tools used to create the clinical risk adjustment scores will likely vary from insurer to insurer, it is not possible to compare or combine clinical risk-adjusted TME data across insurers for public reporting purposes.

Given the small size of many Rhode Island ACOs/AEs, prior to reporting data on CY 2018-2019 trend, the State will develop guidelines for when to signify provider deviation from Target as

statistically meaningful (i.e., not at high risk of influence by random variation) in consultation with the Steering Committee or a successor stakeholder body. This might entail additional analysis of the APCD to develop performance confidence interval bands. These confidence interval bands should be applied to provider reporting.

E. Timeline for Measuring and Reporting the Cost Growth Target

Executive Order 19-03 calls for OHIC to publish THCE statistics in the fourth quarter of each calendar year following the respective reporting/data year. For example, CY 2019 performance will be reported in the fourth quarter of CY 2020. OHIC should anticipate that the first year of reporting may involve a longer timeline and higher start-up costs due to the time required to process questions, develop reporting templates, create data exhibits and resolve unanticipated issues.

Due to the timing of ACO/AE settlements, insurers will need to annually submit two years' worth of data: (1) the performance year data (which is the calendar year immediately preceding the year in which TME data are reported) which will contain insurer estimates of ACO/AE settlements, and (2) the TME data for the calendar year prior to the performance year, which will be resubmitted to reflect final settlements that had to be estimated in prior year reporting. The annual timeline for measuring and reporting on the Cost Growth Target is included as **Attachment 1**.

Appendix A

Insurer TME Data Specification

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

OHIC will annually request TME data file(s) with dates of service during the prior calendar year, and any other past years upon request. Files will contain different record types, including:

- Header, summary data, payer comments
- TME by ACOs/AEs

This insurer TME data specification appendix is directly based on Massachusetts’ and Delaware’s TME data collection specification, modified to meet the needs of Rhode Island. However, the file format is as close to identical to Massachusetts’ and Delaware’s as possible to aid insurers that operate in one or both of the other markets. OHIC may periodically update and revise these data specifications in subsequent versions.

TME File Submission Instructions and Schedule

TME file layouts for insurers are included in this appendix. Further file submission instructions will be available on OHIC’s website. Insurers will submit TME data using Excel templates provided by OHIC. Insurers will submit this information on an annual basis.

Insurers will submit TME data on the following schedule:

Insurers’ TME Filing Schedule	
Date	Files Due
September 1, 2020	CY 2018 Final and CY 2019 Estimated TME
August 2, 2021	CY 2019 Final and CY 2020 Estimated TME
August 1, 2022	CY 2020 Final and CY 2021 Estimated TME
August 1, 2023	CY 2021 Final and CY 2022 Estimated TME

TME Data Submission

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

Insurers must include only information pertaining to members:

- who are residents of Rhode Island,
- who, at a minimum, have medical benefits¹³, and
- for which the insurer is primary on a claim (exclude any paid claims for which it was the secondary or tertiary insurer).

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

1. Medicaid:
 - a. Medicaid members who were attributed during the measurement year to an AE using the attribution rules established by EOHHS for the AE program's performance Year 3.¹⁴
 - b. Medicaid members not attributed to an AE (reported in aggregate).
2. Commercial and Medicare:
 - a. Commercial and Medicare managed care members who were attributed during the measurement year, pursuant to a contract between the insurer and ACO for financial and quality performance assessment purposes. Members can be attributed monthly, quarterly, annually, or at another frequency, so long as the attribution timing is consistent with the insurer contract.
 - b. Commercial and Medicare Advantage members not attributed to an ACO (reported in aggregate).
3. Dual Eligible:
 - a. Medicare and Medicaid dually eligible members should be attributed to an ACO or AE using the attribution rules above of the primary payer of their medical benefit.
 - b. Medicare and Medicaid dually eligible members not attributed to an ACO/AE (to be reported in aggregate)

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

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

¹³ Members who only have a non-medical benefit should be excluded as insurers who hold the medical benefit for those members will be making estimates of TME for those non-medical benefits.

¹⁴ See Attachment M: Accountable Entity - Attribution Guidance of the Rhode Island Accountable Entity Program. <http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Attachment%20M%20-%20PY3%20Attribution%20Requirements%20.pdf>

Insurers must include all Allowed Amounts for all TME data for members, regardless of whether services are provided by providers located in or out of Rhode Island, and regardless of the situs of the member's plan.¹⁵

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

Claims Run-Out Period Specifications

Insurers shall allow for a claims run-out period of at least 120 days after December 31 of the performance year. Insurers should apply reasonable and appropriate IBNR/IBNP completion factors to each respective TME service category based on commonly accepted actuarial principles and will be required to attest that they are reasonable and appropriate.

Non-Claims Payment "Run-Out" Period Specifications

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

ACO / AE Organization IDs

The following ACOs/AEs are to be reported on using the identification number for TME reporting listed in Table 6. This list of ACOs/AEs may be updated from time to time as the ACO/AE market changes. The intent is for payers to report on all ACOs and certified AEs in Rhode Island. For insurers that did not have contracts with the ACOs/AEs listed in Table 6 below during some or all of the reporting periods, but do so currently as of July 1, 2020, please report TME for past reporting periods using the primary care provider network within the ACO/AE contract signed closest to the date of the reporting period. For insurers reporting TME by ACO/AE for reporting periods that were not under contract, please indicate so in the comments box in the HD-TME tab of the reporting file.

¹⁵ If the insurer plays claims for another organization's members (e.g., Blue Card members in the Blue Cross Blue Shield network) those members should not be included in TME.

Table 6. ACO/AE Organization Identification Numbers

ACO/AE Organization	Identification Number for TME Reporting
Blackstone Valley Community Health Care	101
Coastal Medical	102
Integra Community Care Network	103
Integrated Healthcare Partners	104
Lifespan	105
Providence Community Health Centers	106
Prospect CharterCARE	107
Members Not Attributed to an ACO/AE	108

TME Data File Layouts and Field Definitions

Each item below represents a column in the TME Data File Layout that insurers will use to submit TME data to OHIC using an Excel template provided by OHIC. There are two TME data files that insurers must submit: a header record file and an ACO file. A pharmacy rebate data file will also be submitted. Each is described below in more detail:

Header Record File

Insurer Org ID: The OHIC assigned organization ID for the insurer submitting the file.¹⁶

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

¹⁶ This table may need to be updated from time to time as the insurer market in Rhode Island changes.

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

Clinical Risk Adjustment Tool: The clinical risk adjustment tool, software or product used to calculate the clinical risk score required in the TME file.

Clinical Risk Adjustment Version: The version number of the clinical risk adjustment tool used to calculate the clinical risk adjustment score required in the TME file.

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

ACO / AE Record File

The ACO/AE record file will be the source of the insurer’s expenditure data that will be used by OHIC to compute THCE. Insurers will report their permissible claims and non-claims payments in this file.

ACO/AE OrgID: The OHIC OrgID of the ACO/AE. For TME data for members who are unattributed to an ACO/AE, their data are to be reported in aggregate as “Members Not Attributed to an ACO/AE (ACO/AE Identification Number 108).”

Insurance Category Code: A number that indicates the insurance category that is being reported. All data reported by Insurance Category Code should be mutually exclusive. Commercial claims should be separated into two categories, as shown below. Commercial self-insured or fully insured data for large providers for which the insurer is able to collect information on all direct medical claims and any claims paid by a delegated entity should be reported in the “Full Claims” category. Commercial self-insured or fully insured data that does not include all medical and subcarrier claims should be reported in the “Partial Claims,” category. An actuarial adjustment should be made to “Partial Claims” to allow for them to be comparable to full claims. Such an adjustment must use actuarially sound principles and be reviewed with OHIC before the adjustment is made.¹⁷ The goal of the adjustment is to *estimate* what total spending might be for those members without having to collect claims data from carve-out vendors, such as PBMs or behavioral health vendors. For example, for those members for whom pharmacy benefits are carved out, the insurer might include its commercial market book of business average pharmacy spending per-member per-month for the same year, calculated on members who had pharmacy coverage, and applied to all member months for which the carve out applied.

¹⁷ Email Cory.King@ohic.ri.gov with the insurer’s proposed approach for making an actuarial sound adjustment to its Partial Claims.

If an insurer enrolls Medicare/Medicaid dual eligibles, OHIC requires the insurer to report Medicare-related expenditures under insurance category code 5 and Medicaid-related expenditures under insurance category code 6. For example, if an insurer covers Medicare/Medicaid dual eligibles, but is only responsible for Medicaid services, expenditures for those dual eligibles are reported under insurance category code 6. However, if an insurer is an integrated care entity providing both Medicare and Medicaid benefits to dual eligibles, the insurer should use both insurance category codes 5 and 6, respectively, to report applicable expenditures. If direct assignment of the expenditure cannot be made to code 5 or 6, the insurer should use reasonable and appropriate methods to allocate expenditures to the respective insurance category code. This will allow OHIC to include the Medicare- or Medicaid-related expenditure for dual eligibles in the respective Market for reporting purposes.

Insurers shall report for all insurance categories for which they have business. For insurers reporting in the “Other” category, insurers should describe in the Comments field (HD006) what is included in the “Other” category.

Insurance Category Code	Definition
1	Medicare & Medicare Managed Care (excluding Medicare/Medicaid Dual Eligibles)
2	Medicaid & Medicaid Managed Care including CHIP (excluding Medicare/Medicaid Dual Eligibles)
3	Commercial – Full Claims
4	Commercial – Partial Claims, Adjusted
5	Medicare Expenditures for Medicare/Medicaid Dual Eligibles
6	Medicaid Expenditures and Medicaid Dual Eligibles
7	Other

Member Months (annual): The number of unique members participating in a plan each month with a medical benefit. Member months should be calculated by taking the number of members with a medical benefit and multiplying that sum by the number of months in the member’s policy.

Clinical Risk Score: A value that measures a member’s illness burden and predicted resource use based on differences in patient characteristics or other risk factors. Payers must disclose the health status adjustment tool and version number and calibration settings in the header record.

Insurers must submit a clinical risk score that represents all members being reported by Insurance Category Code and the three categories articulated under *TME Data Submission*. Insurers are permitted to use a clinical risk adjustment tool and software of their own choosing, but must disclose the tool (e.g., ACG, DxCG, etc.) and the version in the comment fields of the TME data files. TME data are not to be adjusted. For the purposes of reporting, OHIC will make the necessary adjustments to TME data based on the insurer-submitted clinical risk score. It will do so by weighting the member months according to the value of the clinical risk score (i.e., the higher risk, the fewer member months) and will use the adjusted member months value to calculate the percentage change in TME year-over-year.

Where possible, payers must apply the following parameters in completing the clinical risk adjustment:

- The clinical risk adjustment tool used should correspond to the insurance category reported (i.e., Medicare, Medicaid, Commercial).
- The clinical risk score values should reflect only Rhode Island residents within the Insurance Category Code.
- The clinical risk scores should be un-weighted to allow for comparison of providers within one plan across years.
- Insurers must use concurrent modeling.
- The clinical risk adjustment tool must be all-encounter diagnosis-based (no cost inputs) and output total medical and pharmacy costs with no truncation.

Note: If an insurer changes its clinical risk adjustment method and software (including version updates), it must re-report at least one prior year of TME data using the modified clinical risk adjustment method in order to ensure comparability between years.

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

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

Claims: Professional, Primary Care: The TME paid to physicians or physician group practices generated from claims. Includes services provided by any care provider defined by the health plan as a PCP (including doctors of medicine or osteopathy in family medicine, internal medicine, general medicine or pediatric medicine, nurse practitioners, physicians assistants or others not explicitly listed here). The one exception is OB/GYNs may not be considered a PCP for this purpose.

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

Claims: Professional Other: The TME paid from claims to health care providers for services provided by a licensed practitioner other than a physician or identified as a PCP. This includes, but is not limited to, licensed podiatrists, nurse practitioners, physician assistants, physical therapists, occupational therapists, speech therapists, psychologists, licensed clinical social workers, counselors, dieticians, dentists, chiropractors and any fees that do not fit other categories, including facilities fees of community health center services and freestanding ambulatory surgical center services.

Claims: Pharmacy: The TME paid from claims to health care providers for prescription drugs, biological products or vaccines as defined by the insurer's prescription drug benefit. This category should not include claims paid for pharmaceuticals under the insurer's medical benefit. Medicare Advantage insurers that offer stand-alone PDPs should exclude stand-alone PDP data from their TME. Pharmacy data is to be reported gross of applicable rebates.

Claims: Long-Term Care: The TME paid from claims to health care providers for skilled or custodial nursing facility services, intermediate care facilities and services for persons with developmental disabilities, hospice, home health care services, home- and community-based services, and private duty/shift nursing services.

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

Non-Claims: Incentive Programs: All payments made to providers for achievement in specific predefined goals for quality, cost reduction or infrastructure development. Examples include, but are not limited to, pay-for-performance payments, performance bonuses and EMR/HIT adoption incentive payments.

Non-Claims: Capitation and Risk Settlements: All payments made to providers as a reconciliation of payments made (risk settlements) and payments made not on the basis of claims (capitated amount). Amounts reported as capitation and risk settlement should not include any incentive or performance bonuses.

Non-Claims: Care Management: All payments made to providers for providing care management, utilization review, and discharge planning.

Non-Claims: Recovery: All payments recouped during the performance year as the result of a prior review, audit or investigation, regardless of the time period of the initial payment. This field should be reported as a negative number, and be as of June 30th of the year in which data are reported. Only report data in this column that is not otherwise included elsewhere (e.g., if Inpatient Hospital is reported net of Recovery, do not separately report the same Recovery amount in this column).

Non-Claims: Other: All other payments made pursuant to the insurer's contract with a provider that were not made on the basis of a claim for health care benefits/services and that cannot be properly classified elsewhere. This may include governmental payer shortfall payments, grants or other surplus payments. It may also include HSTP payments made directly by insurers to providers. For CY 2020, this may also include funds made to providers to support clinical and business operations during the global COVID-19 pandemic. Only payments made to providers are to be reported; insurer administrative expenditures (including corporate allocations) are not included in TME.

Pharmacy Rebate Record File

The pharmacy rebate file will be the source of the insurer's pharmacy rebate and will be used by OHIC to compute THCE and TME. Insurers will report their rebate data in this file.

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

Pharmacy Rebates: The estimated value of rebates attributed to Rhode Island resident members provided by pharmaceutical manufacturers for prescription drugs with specified dates of fill, corresponding to the period beginning date through end date from the ACO/AE

file, excluding manufacturer-provided fair market value bona fide service fees.¹⁸ This amount shall include pharmacy benefit manager (PBM) rebate guarantee amounts and any additional rebate amounts transferred by the PBM. Total rebates should be reported without regard to how they are paid to the insurer (e.g., through regular aggregate payments, on a claims-by-claim basis, etc.). Payers should apply IBNR factors to preliminary prescription drug rebate data to estimate total anticipated rebates related to fill dates in the calendar year for which reporting will be done. If insurers are unable to report rebates specifically for Rhode Island residents, insurers should report estimated rebates attributed to Rhode Island resident members in a proportion equal to the proportion of pharmacy spending for Rhode Island resident members compared to pharmacy spending for total members, by line of business. For example, if Rhode Island resident commercial member spending represent 10% of an insurer’s total commercial members, then 10% of the total pharmacy rebates for its commercial book of business should be reported. If the insurer is unable to identify the percentage of pharmacy spending for Rhode Island resident members, then the insurer should calculate the pharmacy rebates attributable to Rhode Island resident members using percentage of membership. This value should always be reported as a negative number.

Market Enrollment File

The market enrollment file will be the source of the insurer’s member months by market in that it will be used by OHIC/EOHHS to compute NCPHI. Insurers will report their member months by market in this file.

Market Enrollment: The number of members participating in a plan categorized by the insurer as individual, large group – fully insured, small group – fully insured, self-insured, student market, Medicare managed care, and Medicaid/CHIP managed care and Medicare/Medicaid duals. Insurers should not include Medigap members, but should include D-SNP members. Insurers should report member months (see definition below) by market enrollment category listed below.

Market Enrollment Category Code	Definition
901	Individual
902	Large group, fully insured
903	Small group, fully insured

¹⁸ Fair market value bona fide service fees are fees paid by a manufacturer to a third party (e.g., insurers, PBMs, etc.) that represent fair market value for a bona fide, itemized service actually performed on behalf of the manufacturer that the manufacturer would otherwise perform (or contract for) in the absence of the service arrangement (e.g., data service fees, distribution service fees, patient care management programs, etc.).

904	Self-insured
905	Student market
906	Medicare managed care
907	Medicaid/CHIP managed care
908	Medicare/Medicaid duals

Member Months (annual): The number of unique members participating in a plan each month with at least a medical benefit. Member months should be calculated by taking the number of members with a medical benefit and multiplying that sum by the number of months in the member's policy.

File Submission Naming Conventions

Data submissions should follow the following naming conventions:

Insurer Name_TME_YYYY_Version.xls

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

Version is optional and indicates the submission number.

The file extension must be .xls or .xlsx

Below are examples of valid file names:

TME_2018_01.xlsx or TME_2018_1.xlsx or TME_2018.xlsx

Submitting Files to OHIC

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

Appendix B

EOHHS TME Data Specification

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

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

EOHHS data submission is to include TME data for the following categories:

- FFS claims expenditures for managed care enrollees, including any out-of-plan payments for behavioral health or services for persons with developmental disabilities.
- FFS claims expenditures for individuals not eligible for managed care or in the “FFS waiting period.” Expenditures should include data on individuals excluded from managed care, and data on managed care-eligible individuals during their “FFS waiting period” prior to enrollment in managed care. This will include claims for services for individuals who had been enrolled in Rhody Health Options or are enrolled in the Integrated Care Initiative when Medicaid is the primary payer (e.g., nursing home expenses, adult dental, etc.).
- Other EOHHS FFS claims expenditures not included in any of the aforementioned categories such as FFS expenditures for populations or programs that are paid with State-only general funds (e.g., RI Pharmaceutical Program for the Elderly).
- EOHHS’ premium payments, capitation or lump sum payments to Rhode Island’s Program for All-Inclusive Care for the Elderly (PACE) organization(s). PACE payments are considered non-claims payments. EOHHS should not include premium payments to managed care organizations, as the managed care organizations are reporting their spending and administrative expense separately.
- EOHHS’s capitation payments to a vendor(s) for non-emergency medical transportation (NEMT). NEMT payments are considered non-claims payments. Data should be submitted on a program code basis.
- EOHHS’s other non-claims expenditures, including any incentive or HSTP payments made to providers, or AEs, as applicable. This may also include payments made directly to providers to support clinical and business operations during the CY 2020 global COVID-19 pandemic. Any non-claims expenditures that EOHHS distributes to providers through the MCOs should not be reported by EOHHS. The MCOs will report this information in their non-claims-based payments category.
- Federal and state supplemental pharmacy rebate collections. There is a separate file to report EOHHS pharmacy rebate data. See below for more details.

EOHHS data submission should not include:

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

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

TME File Submission Instructions and Schedule

EOHHS should submit Excel files of its data using the templates provided on [OHIC's website](#). EOHHS should submit this information on an annual basis in accordance with the following schedule:

EOHHS' TME Filing Schedule	
Date	Files Due
September 1, 2020	CY 2018 Final and CY 2019 Estimated TME
August 2, 2021	CY 2019 Final and CY 2020 Estimated TME
August 1, 2022	CY 2020 Final and CY 2021 Estimated TME
August 1, 2023	CY 2021 Final and CY 2022 Estimated TME

TME Data Submission

EOHHS must report TME data based on Allowed Amounts (i.e., the amount EOHHS paid plus any member cost sharing).

EOHHS must include only information pertaining to members:

- who are residents of Rhode Island, regardless of whether services are provided by providers located in or out of Rhode Island, and

- for which EOHHS is primary on a claim (i.e., EOHHS should exclude any paid claims for which it was the secondary or tertiary payer).

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

Claims Run-Out Period Specifications

EOHHS shall allow for a claims run-out period of at least 120 days after December 31 of the performance year. EOHHS should apply reasonable and appropriate IBNR/IBNP completion factors to each respective TME service category based on commonly accepted actuarial principles.

TME Data File Field Definitions

Each item below represents a column in the TME Data File Excel template that EOHHS will use to submit TME data to OHIC. There are three data files that EOHHS must submit: (1) a header record file; (2) a spending by program code record file, and (3) a pharmacy rebate data file. Each data file layout and field definitions are described below in more detail:

1. Header Record File Field Definitions

Record Type: Must have “HD” inputted to indicate that this is a header record.

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

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

2. Spending by Program Code Record File Field Definitions

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

Record Type: Must have “SPC” in this field.

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

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

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

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

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

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

Claims: Professional, Primary Care: The TME paid to physicians or physician group practices generated from claims. Includes services provided by any care provider defined by EOHHS as a PCP (including doctors of medicine or osteopathy in family medicine, internal medicine, general medicine or pediatric medicine, nurse practitioners, physicians assistants or others not explicitly listed here). The one exception is OB/GYNs may not be considered a PCP for this purpose.

Claims: Professional, Specialty: The TME paid to physicians or physician group practices generated from claims. Includes services provided by a doctor of medicine or osteopathy in clinical areas other than family medicine, internal medicine, general medicine or pediatric medicine, not defined by EOHHS as a PCP.

Claims: Professional Other: The TME paid from claims to health care providers for services provided by a licensed practitioner other than a physician or identified as a PCP. This includes, but is not limited to, licensed podiatrists, nurse practitioners, physician assistants, physical therapists, occupational therapists, speech therapists, psychologists, licensed clinical social workers, counselors, dietitians, dentists, chiropractors and any fees that do not fit other categories, including facilities fees of community health center services and freestanding ambulatory surgical center services.

Claims: Pharmacy: The TME paid from claims to health care providers for prescription drugs, biological products or vaccines¹⁹ as defined by EOHHS’s prescription drug benefit. EOHHS should not include any pharmacy claims that are paid for under the medical benefit in this category. Pharmacy data is to be reported gross of applicable rebates.

Claims: Long-Term Care: The TME paid from claims to health care providers that are identified by EOHHS in the following table along with their “type code.”

Skilled Nursing(010)	Nursing Home (021)	Rhode Island State Nursing Home (022)
RICLASS (026)	Hospice (027)	ICF-MR Public Facility (028)
ICF-MR Private Facility (029)	Assisted Living Facility (033)	Case Management (044)
Adult Day Care (050)	Shared Living Agency (051)	Day Habilitation (055)
Waiver Case Manager-Other (057)	Severely Disabled Nursing Homecare (065)	BHDDH Behavioral Health Group (066)
Personal Care Choice/Hab Case Management (069)	Self Directed Community Services (071)	Personal Care Aide/ Assistant (072)

¹⁹ The Department of Health is reimbursed by the federal government for vaccines for children under 18, therefore, spending on vaccines is adult-only.

Home Meal Delivery (077)	BHDDH DD Agencies (088)	
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Claims: Other: All TME paid from claims to health care providers for medical services not otherwise included in other categories. Includes, but is not limited to freestanding diagnostic facility services, hearing aid services and optical services. Payments made to members for direct reimbursement of health care benefits/services may be reported in “Claims: Other” if EOHHS is unable to classify the service. However, TME data for non-health care benefits/services, such as fitness club reimbursements, are not to be reported in any category.

Non-Claims: Incentive Programs: All payments made to providers for achievement in specific predefined goals for quality, cost reduction or infrastructure development. Examples include, but are not limited to, pay-for-performance payments, performance bonuses and EMR/HIT adoption incentive payments. EOHHS should not report any incentive or HSTP payments made to Accountable Entities through the MCOs as the MCOs will report this information.

Non-Claims: Capitation and Risk Settlements: All payments made to providers as a reconciliation of payments made (risk settlements) and payments made not on the basis of claims (capitated amount). Amounts reported as capitation and risk settlement should not include any incentive or performance bonuses.

Non-Claims: Care Management: All payments made to providers for providing care management, utilization review, and discharge planning.

Non-Claims: Recovery: All payments recouped during the performance year as the result of a prior review, audit or investigation, regardless of the time period of the initial payment. This field should be reported as a negative number, and be as of June 30th of the year in which data are reported. Only report data in this column that is not otherwise included elsewhere (e.g., if Inpatient Hospital is reported net of Recovery, do not separately report the same Recovery amount in this column).

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

3. Pharmacy Rebate Record File

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

Record Type: Must have “RX” in this field.

Rebate Program Code: A code that indicates the source of the pharmacy claims data for which the pharmacy rebates are attributed:

Rebate Program Code	Definition
1	Managed care pharmacy rebates
2	Fee-for-service pharmacy rebates
3	Managed care - J Code rebate ²⁰
4	Fee-For-Service - J Code rebate

Pharmacy Rebates: The estimated or actual value of total federal and state supplemental rebates attributed to Rhode Island resident members provided by pharmaceutical manufactures for prescription drugs with specified dates of fill corresponding to the period beginning date through end date of the respective calendar year, excluding manufacturer-provided fair market value bona fide service fees.²¹ This amount shall include pharmacy benefit manager (PBM) rebate guarantee amounts and any additional rebate amounts transferred by the PBM. Total rebates should be reported without regard to how they are paid to EOHHS (e.g., through regular aggregate payments, on a claims-by-claim basis, etc.).

The source of the pharmacy rebates is Allison Shartrand, Public Assistance Business Manager (Allison.Shartrand@ohhs.ri.gov)

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

²⁰ A J-Code rebate is a pharmaceutical rebate the State receives for facility-based pharmaceuticals, and not for retail pharmacy.

²¹ Fair market value bona fide service fees are fees paid by a manufacturer to a third party (e.g., insurers, PBMs, etc.) that represent fair market value for a bona fide, itemized service actually performed on behalf of the manufacturer that the manufacturer would otherwise perform (or contract for) in the absence of the service arrangement (e.g., data service fees, distribution service fees, patient care management programs, etc.).

Appendix C

Medicare FFS TME Data Specification

OHIC will be able to receive TME and enrollment data from Medicare FFS annually by September 1 of the year following the measurement period (e.g., 2019 data will be available September 1, 2020). CMS believes that data will be at least 90% complete by September 1.

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

- Hospital inpatient
- Hospital outpatient
- Non-hospital outpatient
- Home health agency
- Hospice
- Skilled nursing facility
- Physician
- Other professionals
- Durable medical equipment
- Other suppliers
- Part D²²

These services are mapped to the TME reporting categories as follows:

Medicare Service Categories	TME Service Mapping
Hospital Inpatient	Hospital Inpatient
Hospital Outpatient	Hospital Outpatient
Non-Hospital Outpatient	Other
Home Health Agency	Long-Term Care
Hospice	Long-Term Care
Skilled Nursing Facility	Long-Term Care
Physician (Primary Care)	Professional Physician (Primary Care)

²² As part of the TME data received from CMS, CMS will be providing OHIC Part D data for individuals enrolled in FFS stand-alone PDPs as well as Medicare managed care enrollees in MAPD or MA-only plans.

Physician (Specialty Care)	Professional Physician (Specialty Care)
Other Professionals	Other
Durable Medical Equipment	Other
Other Suppliers	Other
Part D	Retail Pharmacy

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

To receive Medicare FFS TME data from CMS, EOHHS needs to make a formal request to CMS by emailing the attached Excel file (**Attachment 3**) to Stephanie Bartee, Director of the Information Products and Analytics Group in the Office of Enterprise Data Analytics, (stephanie.bartee@cms.gov) and copying: CMSProgramStatistics@cms.hhs.gov. **Please note, CMS has specifically requested that Rhode Island staff (not a contractor) make the official request.**

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

Appendix D

NCPHI Data Specification

$$THCE = \frac{\text{Commercial TME} + \text{Medicare Advantage TME} + \text{Medicare FFS TME} + \text{Medicaid MCO TME} + \text{RI EOHHS FFS TME} + \text{Insurer NCPHI}}{\text{Rhode Island Population}}$$

NET COST OF PRIVATE HEALTH INSURANCE

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

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

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

The federal commercial medical loss ratio (MLR) reports will be used to calculate NCPHI for the commercial fully insured market and need to be requested from the insurers as part of their TME data submission, or obtained from CMS Center for Consumer Information and Oversight (CCIIO).²³ These reports become publicly available in the fall, but should be requested from insurers when they submit their TME data in order to meet the reporting timeline. In an instance in which the MLR report submitted to OHIC on the TME deadline differs from the final submission an insurer makes to CCIIO, the insurer must notify OHIC in writing as soon as possible. The data elements that will be used in the calculation are detailed below:

NCPHI =

²³ Available at: www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html. April 7, 2020.

Premium as of March 31 (Part 1 Line 1.1) - [Total Incurred Claims as of March 31 (Part 1, Line 2.1) - Advance Payments of Cost Sharing Reductions (Part 2, Line 2.18)] - MLR Rebates Current Year (Part 3, Line 6.4)

$$\text{NCPHI PMPM} = \frac{\text{NCPHI}}{\text{Member Months as reported on the Market Enrollment tab of the TME data}}^{24}$$

Medicare Advantage

The Supplemental Health Care Exhibit (SHCE) from the National Association of Insurance Commissioners will be used to derive NCPHI of the Medicare Advantage market. The SHCE can be obtained from OHIC annually each April. The Medicare Advantage reporting combines stand-alone prescription drug plans (PDP) and the Medicare Advantage plans with Part D inclusion (MAPDs). Therefore, insurers that offer both PDP and MAPD will need to separately report health premiums earned, total incurred claims and members months for PDP and MAPD.

Insurers must also submit names for which they are d/b/a for Medicare and Medicare Advantage on an annual basis.

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

NCPHI =

Health Premiums Earned (Part 1, Line 1.1) - Total Incurred Claims (Part 1, Line 5.0)

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

Medicaid MCO Market

The Supplemental Health Care Exhibit (SHCE) from the National Association of Insurance Commissioners will be used to derive NCPHI of the Medicaid MCO Market. The SHCE can be obtained from OHIC annually each April. The data elements that will be used in the calculation should from column 10 "Government Business (Excluded by Statute)." The formula is included below:

NCPHI =

Health Premiums Earned (Part 1, Line 1.1) - Total Incurred Claims (Part 1, Line 5.0)

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

²⁴ OHIC should not use the member months that are reported on the MLR or SHCE forms as those forms are based on in situ information, whereas the spending benchmark is intended to capture Rhode Island residents. By using member months reported by market segment within the TME data, OHIC will be assuming that the experience of the insurer across all of its Rhode Island business (regardless of whether it insures a member from another state) is the same experience as Rhode Island residents.

Member Months as reported on the Market Enrollment tab of the TME data

Self-Insured Market

The SHCE will be used to derive NCPHI of the self-insured market. The formula will be:

$NCPHI =$

Income from fees of uninsured plans (Part 1, Line 12)

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

The table below provides the columns associated with each line of business/market in the SHCE and the MLR reports.

LINE OF BUSINESS/MARKET	SHCE COLUMN	MLR COLUMN (PARTS 1 AND 2)	MLR COLUMN (PART 3)
Individual	N/A	2	4
Small Group, Fully Insured	N/A	7	8
Large Group, Fully Insured	N/A	12	12
Student	N/A	36	36
Medicare Advantage and PDP	12	N/A	N/A
Medicaid MCO	10	N/A	N/A
Self-Insured	14	N/A	N/A

Aggregate NCPHI

Upon calculating each market segment NCPHI, OHIC will need to calculate the aggregate NCPHI. To do so, first commercial data need to be adjusted to use in situ information. Do so by calculating the average NCPHI PMPM by market segment by adding the total NCPHI by insurer within the segment and then dividing it by the total member months as reported in the MLR report. Next, take the newly calculated average NCPHI PMPM and multiply it by each insurer's market segment member months as reported within the TME submission to get NCPHI for each insurer within each market segment.

Now that data are comparable, each segment's PMPM amount should be multiplied by the Rhode Island resident market enrollment member months, in each segment, as reported within the TME submission.

Appendix E

Rhode Island Total Population Statistics

The denominator of the THCE per capita calculation is the Rhode Island state population count for the respective reporting period. The source of the Rhode Island population value is the [US Census Bureau](#) estimates. The most recently available census figures, which will be a snapshot in time figures (not full-year estimates) for the measurement year, should be used as the “Rhode Island Population” figure in the THCE per capita formula listed below.

THCE (per capita) =

$$\frac{\left(\begin{array}{l} \text{Commercial TME} + \text{Medicare Advantage TME} + \text{Medicare FFS TME} + \\ \text{Medicaid MCO TME} + \text{Medicaid FFS TME} + \text{Insurer NCPHI} \end{array} \right)}{\text{Rhode Island Population}}$$

Appendix F Insurer Attestation

Attestation of the Accuracy and Completeness of Reported Data

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

Insurer: _____

Performance Period Being Reported: _____

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

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

Signature

Date

Printed Name

Title