REVISIONS TO THE AFFORDABILITY STANDARDS

230-RICR-20-30-4

Abstract

This paper has been prepared to facilitate the public's review of the proposed amendments to 230-RICR-20-30-4: Powers and Duties of the Office of the Health Insurance Commissioner, which includes the Affordability Standards.

Office of the Health Insurance Commissioner (OHIC) – Rhode Island

December 2019

Executive Summary

The Office of the Health Insurance Commissioner (OHIC) is proposing amendments to 230-RICR-20-30-4 *Powers and Duties of the Office of the Health Insurance Commissioner*. Chiefly, the proposed amendments modify § 4.10 Affordable Health Insurance – Affordability Standards. The provisions of § 4.10 set forth regulatory standards for insurers to follow in their efforts to improve the affordability of their products. OHIC developed these standards to meet its statutory mandate under R.I.G.L § 42-14.5-2, which states:

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

With the foregoing objects in mind, this paper outlines a series of policy proposals OHIC deems necessary to advance the public interest in affordable health insurance coverage, access, and high-quality care. The policies are supported by evidence and sound theory and are rationally related to the statutory purposes of OHIC.

Furthermore, in consideration of pressing behavioral health needs of the public, in 2018 the General Assembly enacted legislation that augmented OHIC's powers and duties under R.I.G.L § 42-14.5-3 with respect to the promotion of integrated behavioral health. These provisions direct OHIC:

> *(p) To work to ensure the health insurance coverage of behavioral health care under the same terms and conditions as other health care, and to integrate behavioral health parity requirements into the office of the health insurance commissioner insurance oversight and health care transformation efforts.*
>
> *(q) To work with other state agencies to seek delivery system improvements that enhance access to a continuum of mental-health and substance-use disorder treatment in the state; and integrate that treatment with primary and other medical care to the fullest extent possible.*
>
> *(r) To direct insurers toward policies and practices that address the behavioral health needs of the public and greater integration of physical and behavioral health care delivery.*

The Commissioner has interpreted these statutory enhancements as a grant of power and responsibility to take necessary actions authorized by Titles 27 and 42 to advance policies that address

the behavioral health needs of the public and facilitate greater integration of physical and behavioral health care delivery. These legislative objects are promoted through the development of a high-quality, well-functioning delivery system capable of serving the comprehensive physical and behavioral health care needs of the public and of improving affordability through the effective management of patients with physical and behavioral health comorbidities. Herein, OHIC proposes a set of policies targeted to behavioral health integration which are minimally necessary to create such a system. These policies will serve the goals of the General Assembly and the broader mission of OHIC.

As a whole, the proposed amendments build on OHIC's prior work around investment in primary care and embrace strategies to transform the health care delivery system and address provider economic incentives through payment reform.

Affordability Standards Background

The Affordability Standards were developed in 2008-2009 by OHIC in consultation with its legislatively created Health Insurance Advisory Council. The Affordability Standards are a core component of OHIC's efforts to meet its statutory mission to improve the health care system, to protect consumers, and to improve the affordability of health insurance. As part of the annual rate review process for health insurance premiums, health insurers are required to prove that the rates filed for approval by OHIC are consistent with the proper conduct of the health insurer's business and the public interest. Given the public's interest in affordable health insurance, OHIC developed the Affordability Standards to systematize regulatory requirements that insurers must follow to demonstrate their efforts to improve affordability.

Since 2010, the Affordability Standards have been modified from time to time. The present iteration of Affordability Standards, promulgated in 2015, comprises the following policies:

Standard One: Primary Care Spend Obligation

Requires insurers to dedicate at least 10.7% of annual medical spend to primary care, with 9.7% for Direct Primary Care Expenses. Indirect Primary Care Expenses must include at least a proportionate share for administrative expenses incurred to support and strengthen the capacity of a primary care practices to function as medical homes and to successfully manage risk-bearing contracts, and to support the Rhode Island's health information exchange.

Standard Two: Primary Care Practice Transformation

Requires that by 2019, 80% of insurers' contracts with primary care practices be with practices designated by OHIC as patient-centered medical homes (PCMHs). Pursuant to annual care transformation plans, the Commissioner has required insurers to make sustainability payments to practices which achieve PCMH status and are recognized based on practice transformation, cost management and quality improvement standards developed by OHIC.

Standard Three: Payment Reform

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

1. **Population-based Contracting**: Requires that by the end of 2015, at least 30% of insured covered lives are attributed to a Population-Based Contract that is a Shared Savings Contract, a Risk Sharing Contract, or a Global Capitation Contract; and by the end of 2016, at least 45% are attributed to such arrangements with at least 10% of covered lives attributed to a Risk-Sharing Contract or Global Capitation Contract.

2. **Alternative Payment Models:** Requires insurers annually to increase their use of nationally recognized, APMs for hospital, medical and surgical, and primary care services.

3. **Measure Alignment:** Requires insurers to use the OHIC Aligned Measure Sets for primary care, hospital, Accountable Care Organization, and other contracts as developed by the Commissioner.

4. **Hospital Contracts:**
    a. **Unit of Service Payments:** Insurers must use unit-of-service payment methodologies for both inpatient and outpatient services that provide incentives for efficient use of health services.
    b. **Quality Incentive Program:** Insurers must include payment for attaining or exceeding mutually agreed to, sufficiently challenging, performance levels for all Core measures within the Aligned Measure Set for hospitals.
    c. **Limit Rate Increases:** Insurers must limit annual rate increases, including quality incentive payments, to the U.S. All Urban Consumer All Items Less Food and Energy Consumer Price Index (CPI) percentage increase + 1%.
    d. **Administrative Efficiencies:** Insurers must include terms that improve greater administrative efficiencies.
    e. **Transparency:** Insurers must include terms that relinquish the right of either party to contest the public release of any or all of these five specific terms by state officials or the participating parties to the agreement.

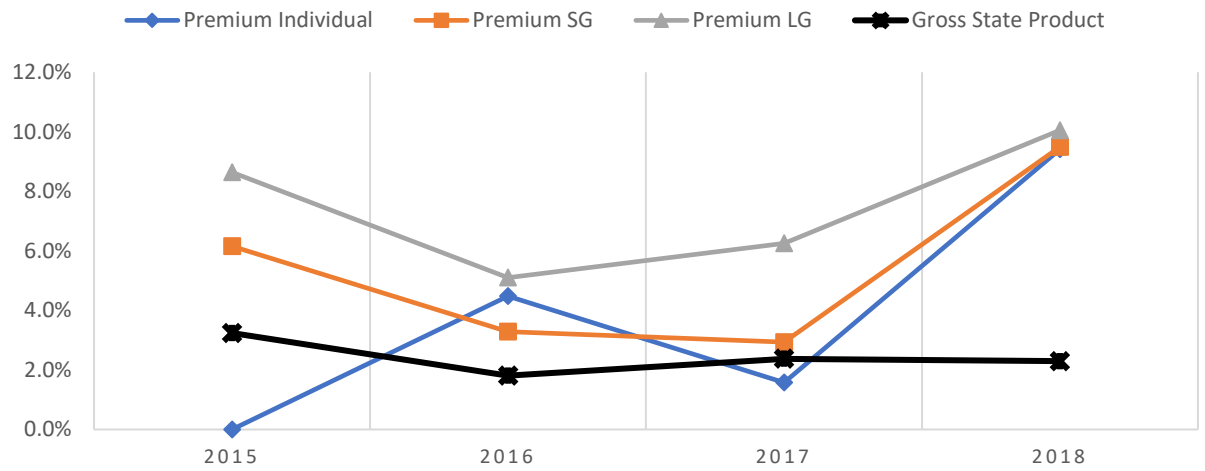
5. **Population-based Contracts:** Insurers must limit annual increases in budgets for Population-Based Contracts to the US All Urban Consumer All Items Less Food and Energy CPI + 3.5% in 2015, +3% in 2016, + 2.5% in 2017, + 2.0% in 2018, and + 1.5% after 2018.

Notwithstanding the progress made over the last few years through the implementation of the foregoing policies and other state and private sector initiatives, there remain significant opportunities to improve affordability and broader health care system performance in the years ahead.

Stakeholder Engagement on Revisions to the Standards

In late 2018, OHIC initiated a process to revise the Affordability Standards to meet the requirements of new OHIC statutory powers and duties and to satisfy continuing and emerging imperatives of public policy around affordability, access and quality. As shown in **Figure 1**, between 2015 and 2018 average premium increases in the small and large group markets exceeded the growth of Rhode Island's economic product. In two of the four years, average individual market premium increases outpaced economic growth. Increasing premiums, which are driven by increasing health care costs, pose a burden to Rhode Islanders. A principal goal of the Affordability Standards is to bring premium trends into closer alignment with economic growth.

FIGURE 1: AVERAGE PREMIUM INCREASES VS. ECONOMIC GROWTH



On May 9th, 2019, OHIC issued an Advance Notice of Proposed Rulemaking concerning potential modifications to the Affordability Standards. The Advance Notice identified seventeen areas for potential modification of the Standards, including the primary care spending, care transformation, and payment reform components. OHIC also solicited stakeholders for consideration of ideas beyond the seventeen proposals.

OHIC received public comments from fourteen entities.[1] The comments are posted on the OHIC website. Commenters were generally supportive of a continuance of efforts to address health care spending and quality through care transformation and payment reform. The following discussion

[1] Blue Cross Blue Shield of Rhode Island, Prospect/CharterCARE, Christopher Koller of the Milbank Memorial Fund, Care Transformation Collaborative of Rhode Island, The Hospital Association of Rhode Island, Integrated Healthcare Partners, Lifespan, Neighborhood Health Plan of Rhode Island, Coastal Medical, The Rhode Island Medical Society, Rhode Island Parent Information Network, Tufts Health Plan, UnitedHealthcare, and South County Health. OHIC also considered comments that were submitted by CharterCARE on September 28th, 2018, in response to a prior revision of the regulation. At the time, the CharterCARE's comments were not germane to OHIC's proposed amendments. However, OHIC promised to retain the comments for future consideration when 230-RICR-20-30-4 was to be comprehensively revised.

summarizes the stakeholder comments on the policy areas addressed in the Advance Notice and offers some commentary in response. Topics are taken up in the following order:

1. Primary Care Investment
2. Behavioral Health Integration
3. Alternative Payment Models & Risk-based Contracting
4. Hospital Contracting
5. Other Potential Actions

Primary Care Investment

Given the importance of primary care for overall health care system performance[2], OHIC's Affordability Standards comprise strategies to sustain and strengthen primary care in Rhode Island. The Advance Notice proposed two strategies relevant to investment in primary care:

1. An increase of the health insurer primary care spending requirement from 10.7% to 11% of total medical spending and a potential redefinition of primary care payments to align with spending specifications emerging from work in other states, and

2. Elimination of the requirement that insurers limit indirect primary care spending to 1% of total medical spending and require administrative investments in multi-payer primary care initiatives through an alternative mechanism.

The commenters were largely supportive of continued primary care investment. Lifespan supported "the continued requirement of insurers to meet a primary care spending target" and urged that "Rhode Island must continue to support the advancement of the primary care infrastructure in the State." However, while providers were supportive of increased investment in primary care, insurers voiced skepticism that an incremental investment in spending beyond 10.7% of total medical spending would produce a return on investment. Citing the need to justify investments in primary care to employer purchasers, Blue Cross Blue Shield of Rhode Island (BCBSRI) requested that OHIC "make available reports comparing RI to other states in terms of spending and results." UnitedHealthcare supported retention of a primary care spending target, but not an increase in required investment, citing the current success of care transformation at prevailing levels and a lack of evidence that marginal investment would yield marginal net benefits to consumers. Tufts Health Plan commented that increasing required investments in primary care may cause inflationary movement in medical spending at a time when the state and market entities are adopting a health care cost growth target.

The proposal to eliminate the requirement that insurers limit indirect primary care spending to 1% of total medical spending caused confusion of OHIC's intent among stakeholders. Some commenters expressed concern that the proposal would lead to diminished investment in the state's all-payer practice transformation initiative (Care Transformation Collaborative of Rhode Island, or CTC-RI) and the health information exchange (CurrentCare). The proposal was merely to discontinue the binary accounting framework between direct and indirect primary care spending to streamline

[2] Starfield, B., Shi, L., & Macinko, J. (2005). Contribution of Primary Care to Health Systems and Health. *The Milbank Quarterly, 83(3)*, 457-502. doi: 10.1111/j.1468-0009.2005.00409.x and Friedberg, M., Hussey, P., & Schneider, E. (2010). Primary Care: A Critical Review of the Evidence on Quality and Costs of Health Care. *Health Affairs, 29(5),* 766-772. https://doi.org/10.1377/hlthaff.2010.0025

reporting. Insurer investment in CTC-RI and CurrentCare would continue to count as primary care spending.

Finally, in recognition that OHIC's collaborative assessment with providers, payers and CTC-RI previously revealed a limited number of primary care practices in the state remaining as viable candidates for practice transformation, the Advance Notice proposed retiring the insurer practice transformation target but continuing to require insurer financial support for OHIC-recognized patient-centered medical homes (PCMHs). Many stakeholders agreed with OHIC's assessment that the number of viable candidates for first-time practice transformation was limited enough to support the discontinuation of the transformation target. However, no stakeholder contested the necessity of maintaining financial support for existing PCMHs. The Rhode Island Medical Society stated, "continued payment for advanced primary care is essential." Lifespan wrote in support of "the continued requirement of insurers to support OHIC-recognized PCMHs at no less than the current amounts or in a greater capacity." Furthermore, Lifespan expressed concern for "the potential erosion of these funds in the future – either by way of removing the guarantee to PCMHs and placing the funding at risk or by simply underfunding or removing the funding entirely." The insurers supported continued investment in PCMHs but qualified their support with appeals for flexibility. For example, NHPRI urged OHIC to commit to "the development of flexible standards that allow for discretion between providers and payers about how this investment should continue." UnitedHealthcare articulated its support for continued investment but encouraged the development of a plan "that allows the program to be self-sustaining and not a separate revenue stream."

OHIC Response:

There is evidence that investments and transformations in primary care delivery support cost control and improved quality.[3] The primary care spending requirement for insurers has reinforced the development and functioning of primary care delivery models that prioritize high-quality patient-centered care and cost management. A recent report by the Patient-Centered Primary Care Collaborative (PCPCC) evaluates the statistical association between spending on primary care and health care utilization metrics at the state level.[4] The researchers found a negative association between three indicators of health care utilization (ED visits, inpatient admissions, and inpatient admissions for ambulatory care-sensitive conditions) and primary care spending among the 29 states studied.[5] These findings are promising. However, the PCPCC report does not allow one to draw inferences about the marginal effect of increasing primary care spending on practice performance, and ultimately on outcomes (ex. ED visits). Therefore, in light of the need for continued research, OHIC will not propose an increase to, or otherwise amend, the primary care spending requirement under the Affordability Standards at this time. Furthermore, OHIC will maintain the distinction between direct and indirect primary care spending.

[3] Nielsen, M. Olayiwola, J.N., Grundy, P., Grumbach, K. (ed.) Shaljian, M. The Patient-Centered Medical Home's Impact on Cost & Quality: An Annual Update of the Evidence, 2012-2013. Patient-Centered Primary Care Collaborative (2014).

[4] Jabbarpour, Y, et al. Investing in Primary Care: A State-Level Analysis. Patient-Centered Primary Care Collaborative (2019).

[5] Rhode Island was not among the states studied due to small sample limitations in the underlying data.

With respect to continued funding for PCMHs, OHIC believes that investments in advanced primary care are among the most important health care investments the health insurers and the State has made. The proposed amendments solidify the existing support for PCMHs by extending the insurer obligation to fund OHIC-recognized PCMHs. The amendments also allow flexibility to providers and payers to tailor investments to specific goals and outcomes.

Behavioral Health Integration

Behavioral health integration into primary care garnered widespread support among stakeholders, though disagreements over the policies necessary to promote integration were manifest from the public comments. Some commenters, specifically health insurers, stressed that rulemaking in support of integration should not embrace a rigidity that constrains flexibility or innovation. Other commenters urged aggressive action by OHIC to remove barriers to integration, some of which were discussed in OHIC's Integrated Behavioral Health (IBH) Work Group, held concurrently with the Affordability Standards revision process.[6] Informed by actions under consideration by the Work Group, the Advance Notice cited four strategies to promote behavioral health integration into primary care.

1. Eliminating two co-pays for same-day primary care and behavioral health services provided in the same location.
2. Requiring the reimbursement of Collaborative Care codes, or other codes that are paid for by Medicare and/or Medicaid (to be fully defined by the IBH Work Group, but might also include health and behavior assessments, screening, warm hand-offs, etc.).
3. Credentialing requirements that support providers practicing in an integrated environment.
4. Defining the foundational elements of an integrated behavioral health practice and requiring insurers to financially support practices that achieve the foundational elements for non-reimbursed costs supportive of integrated care, e.g., warm hand-offs, health behavior groups. The PCMH PRIME Certification program developed by NCQA for Massachusetts could serve as a starting point for practice expectations.

The Rhode Island Medical Society wrote: "[Integrated behavioral health] is an important next step in advanced primary care. It is important that payers have clear and reasonable standards for allowing specific types of payment. Psychiatric Collaborative Care Management Services should be recognized. Elimination of two co-pays is desirable." BCBSRI strongly encouraged OHIC to articulate the foundational elements of integrated behavioral health practices. These foundational elements would then guide investment and policy. BCBSRI further commented that OHIC should consider linkages between the care transformation policy agenda—behavioral health integration specifically—and payment reform, stating "any strategy item requiring specific payments should be well supported in

[6] To gain an understanding of the barriers facing integrated practice sites, in early 2018 OHIC sponsored interviews with a group of practices that were participating in CTC-RI's IBH pilot. These interviews helped OHIC identify the most salient barriers facing IBH practices. In early 2019, the Commissioner convened a work group to review the barriers brought to light by the practice interviews and sought input on potential strategies for their redress. The deliberations of the Integrated Behavioral Health Work Group informed the proposed amendments.

terms of the potential return in improved cost and quality, and provide for flexibility to support alternative payment methods including capitation."

The proposal to eliminate two copayments for same-day primary care and behavioral health services provided in the same location elicited the most specific comments from stakeholders. United argued that "[e]limination of co-pays would require a benefit change that employer groups would have to support. Without 100% cooperation, this would add confusion and disparity." Alternatively, United stated its willingness to look for other solutions "such as global payment for other services when provided as integrated." BCBSRI asserted that OHIC lacks statutory authority to prescribe elements of plan design. In addition to the Rhode Island Medical Society, Integrated Healthcare Partners expressed support for the proposal.

OHIC Response:

Over the years the State has documented significant behavioral health needs within the Rhode Island population. A comprehensive assessment of behavioral health risk-factors and disease prevalence conducted by Truven Health Analytics in 2015 found that Rhode Island had a higher prevalence of some behavioral health disorders and higher utilization of services for mental health and substance use treatment when compared to the other New England states. The Truven report also found that Rhode Island dedicated 1.6% of its gross state product to treatment of behavioral health disorders, compared to the national average of 1.2%.[7] More recent data point to Rhode Island as a potential national outlier in terms of our population's behavioral health needs.[8]

To address the state's behavioral health needs, the Commissioner believes that nothing less than the creation of a high-quality well-functioning delivery system capable of meeting the comprehensive physical and behavioral health care needs of the public will answer this objective. This vision accords with OHIC's statutory charge to view the health care system as a comprehensive entity and to discharge the powers of the Office in a manner that improves the efficiency and quality of health care services and outcomes. As a first step the Commissioner believes that behavioral health integration into primary care is a necessary strategy to achieve the objects set forth by the legislature in OHIC's governing statute. While policies supportive of behavioral health integration into primary care constitute a good starting point, OHIC recognizes that the exigencies of our continuum of care for behavioral health will require a broader set of initiatives, interventions, and investments. Provision of the necessary investments and initiatives in behavioral health will form a core component of OHIC's policy agenda in the coming years.

[7] Rhode Island Behavioral Health Project: Final Report by Truven Health Analytics. The Truven report contains specific in-depth component reports on behavioral health care demand, supply, and cost. http://www.bhddh.ri.gov/mh/truven.php

[8] Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Rhode Island, Volume 5: Indicators as measured through the 2017 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services. HHS Publication No. SMA-19-Baro-17-RI. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2019. https://store.samhsa.gov/system/files/rhode_island-bh-barometervolume5-sma19-baro-17-us.pdf

OHIC appreciates the consensus among stakeholders that integrated behavioral health care is a model worth pursuing, as it may improve population health, the efficiency of health care delivery, and affordability. The Care Transformation Collaborative of Rhode Island and its partner organizations have laid a solid groundwork for integration. However, behavioral health integration will not become a formative and sustainable model if provider practices and patients face administrative headwinds from insurer payment and coverage policies.

OHIC agrees with BCBSRI that "any strategy item requiring specific payments should be we supported in terms of the potential return in improved cost and quality, and provide for flexibility to support alternative payment methods including capitation." OHIC believes that APMs, and capitation more specifically, can support behavioral health integration. OHIC is committed to working closely with stakeholders to monitor the effectiveness of proposals to support greater integration of behavioral health into primary care and to work collaboratively to further define the foundational elements of an integrated practice.

Regarding the double copayment issue, BCBSRI asserted that OHIC lacks statutory authority to dictate the components of plan design. OHIC respectfully disagrees with BCBSRI in relation to components of plan design that affect behavioral health integration and access to behavioral health services at integrated sites of care.

In 2018, the General Assembly augmented OHIC's powers and duties to embrace the following:

> *"To work to ensure the health insurance coverage of behavioral health care under the same terms and conditions as other health care, and to integrate behavioral health parity requirements into the office of the health insurance commissioner insurance oversight and health care transformation efforts."*
>
> *"To work with other state agencies to seek delivery system improvements that enhance access to a continuum of mental-health and substance-use disorder treatment in the state; and integrate that treatment with primary and other medical care to the fullest extent possible."*
>
> *"To direct insurers toward policies and practices that address the behavioral health needs of the public and greater integration of physical and behavioral health care delivery."*

It is well-known that the Commissioner enjoys "sole and exclusive jurisdiction over enforcement of those statutes with respect to all matters relating to health insurance."[9] Moreover, the Commissioner "may promulgate such rules and regulations as are necessary and proper to carry out the duties assigned to him or her by this title or any other provision of law."[10]

Under a broad public interest standard, the Commissioner may approve or reject a health insurer's plan policy forms. Specifically, the Rhode Island General Laws vest the review and approval of all health plan policy forms with the Commissioner under §§ 27-18-8(a) and 27-41-29.2(a), which state: "If the commissioner finds from an examination of any form that it is

[9] R.I.G.L § 42-14-5(d).

[10] R.I.G.L § 42-14-17. Under this provision the term "director of the department of business regulation" should be read "health insurance commissioner." The powers and responsibilities entrusted to the Commissioner with respect to health insurance are codified under Titles 27 and 42.

contrary to the public interest, or the requirements of this code or duly promulgated regulations, he or she shall forbid its use, and shall notify the company in writing as provided in § 27-18-8.2."

The Commissioner has a duty to "direct insurers toward policies and practices that address the behavioral health needs of the public and greater integration of physical and behavioral health care delivery." In light of the documented prevalence of behavioral health disorders in the state, and the General Assembly's recent action to augment OHIC's powers and duties to incorporate a specific focus on behavioral health integration, it is reasonable and appropriate for OHIC to ascribe access to integrated behavioral health care as a constituent part of the public interest. Therefore, the Commissioner is well within the powers of her office to promulgate a regulatory standard governing copayment at integrated sites and to oversee adherence to this standard through the rate and form review process to ensure that the public interest is served.

Alternative Payment Models (APMs) and Risk-based Contracting

OHIC believes that payment reform can support transformation of the delivery system and yield cost savings and quality improvement. The Advance Notice proposed several actions relating to payment reform. Among these were the establishment of an Alternative Payment Model (APM) adoption floor consistent with existing OHIC policies, the promulgation of standards for risk assumption under risk-based contracts, and the development of APMs designed for primary care providers. Commenters expressed general support for payment reform. However, stakeholders channeled a host of concerns and policy suggestions related to various aspects of payment through their comment letters. Those are summarized here:

APM Targets & Risk-Based Contracting:

Lifespan expressed support for continued APM and risk-based contracting targets. The Rhode Island Medical Society stated that APM targets should be continuously refined. CharterCARE called for more aggressive movement toward global capitation payment models and expressed frustration at the slow pace of change in the market. In contrast to the enthusiasm of CharterCARE, The Rhode Island Parent Information Network (RIPIN) expressed concern over the transition to risk-based contracting, citing the natural volatility in the total cost of care (TCOC) within small populations. RIPIN's concern is that consumer access to care may be harmed if providers assume downside risk and experience significant losses which they are not financially prepared to manage. RIPIN recommended "that risk-based contracting not be encouraged before the proper oversight [of risk-bearing entities] is in place, and never be encouraged for contracts with fewer than about 50,000 lives." RIPIN also requested that OHIC consider ways to encourage more balanced incentives between cost reduction and improvement of patient outcomes within the framework of APMs.

Coastal Medical offered detailed comments on APMs, specifically risk-based contracts, arguing for the need to account for "investment risk" within regulatory standards for risk. The Rhode Island Medical Society echoed Coastal Medical's call to account for "investment risk." Coastal Medical defines "investment risk" as "incremental spending on population health management" which is "additive to any contractual downside risk in the business model for each organization that is actively pursuing care transformation and payment reform, and as such should be included in assessments of the

amount of risk to be taken by any given SOC (System of Care)." Christopher F. Koller, President of the Milbank Memorial Fund, cited evidence from the *New England Journal of Medicine* that physician-group ACOs outperformed hospital-integrated ACOs in the Medicare Shared Savings Program. Mr. Koller asked whether OHIC can use regulation to leverage physician-based ACO success.

The health insurers' comments reinforced their collective commitment to payment reform. However, specific concerns pertaining to the nature of OHIC's regulatory framework were articulated. BCBSRI stated "by setting a model and targets, OHIC is creating a degree of rigidity preventing innovations and flexibility. Most importantly, and contrary to OHIC's policy goal, the target creates a ceiling; providers are unwilling to take on more risk than OHIC's defined minimums." UnitedHealthcare pointed to risk-sharing as the next evolution in payment reform but said "we continue to find resistance and concern on the part of providers. Insurers cannot force providers to enter into APMs." UnitedHealthcare further asked "what actions are being taken to allay the concerns of providers?" Noting that insurance oversight poses an asymmetric burden of accountability for compliance on insurers, United asked: "What are the ramifications to providers for not entering into such agreements? Perhaps a negative incentive, such as a reduction on FFS payments, needs to be introduced."

OHIC Response:

OHIC believes that payment reform is a vitally important innovation for improving affordability and system performance more broadly. Stakeholder comments on the Advance Notice, and those offered in various public forums convened by OHIC, impart a sophistication and level of commitment to payment reform that is a credit to our community. OHIC has invested in a stakeholder-driven model of policy development through the Alternative Payment Methodology Advisory Committee and intends to maintain a similar course for engaging stakeholders under the proposed regulations. OHIC believes that it is in the interest of Rhode Island consumers for health insurers and providers to continue to collaborate on APMs that align provider financial incentives with the efficient use of health care resources, promote transformation of the delivery system, and encourage the proactive management of the health care needs of their patient populations.

Central to OHIC's role promoting payment reform is the action of setting policy targets and enforcing regulatory standards. Targets and regulatory standards encourage collective action and ensure accountability, both of which are important for the progress of payment reform. Collective action is necessary due to the reliance of meaningful APM financial incentives on the achievement of critical mass in attributed patients and payments. Critical mass engenders scalable clinical transformations and provider behavioral responses intended by the incentives. BCBSRI contends that such targets effectively create a "ceiling" and that "providers are unwilling to take on more risk than OHIC's defined minimums." In response, OHIC believes provision must be made for targets and standards that increase over time. The proposed amendments described in the sections that follow will establish a global minimum APM adoption target and specify risk-based contracting standards which increase levels of risk assumption over time.

OHIC takes seriously the concerns of various stakeholders over the evolution of APMs to downside risk. RIPIN raises valid points regarding the effective oversight of the capability of providers to assume downside risk. Presently, the state lacks an agency for conducting oversight of risk-bearing provider organizations (RBPOs). However, OHIC and the Medicaid Program have entered into a Memorandum of Understanding to delegate the review of RBPOs bearing Medicaid risk to OHIC staff. This is a first step toward creating an oversight capability in the State. Furthermore, an existing provision of OHIC regulation requires that commercial payers exercise due diligence when contracting with providers for downside risk. OHIC believes RIPIN's proposal that risk-based contracts "never be encouraged for contracts with fewer than about 50,000 lives" is too stringent a standard.

Coastal Medical's proposal that risk-based contracts account for "investment risk" deserves further study. We will note that ACOs, such as Coastal Medical, receive substantial infrastructure payments from commercial health insurers. These infrastructure payments, coupled with the relatively low levels of risk assumption called for in the proposed amendments, militate against consideration of "investment risk" at this time. However, OHIC may refer this issue to the consideration of a public body in the future to ensure that it is thoughtfully considered by interested parties.

Finally, UnitedHealthcare noted the risk of compliance with the proposed regulations is borne exclusively by health insurers and asks for consideration of other measures, such as a "negative incentive" or, "a reduction on FFS payments," to encourage provider engagement with risk-based contracting. United's observation calls to mind the words of OHIC's first Commissioner:

> "government, consumers, employers, providers and health insurers all have a role to play in 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 advancing the welfare of the public through overall efficiency, improved health care quality, and appropriate access."[11]

These words remain as relevant to OHIC's mission today as they did in July 2006 when they formed a key premise of OHIC's interpretation of its governing statutes. Based on our observations, providers have acted in good faith in their interactions with insurers on payment reform. Time will tell whether regulatory measures, like those advocated by United, will be necessary.

Primary Care APMs:

OHIC has a long-standing commitment to primary care transformation and believes that payment models for primary care must evolve to support that transformation. Stakeholders commented

[11] Health Insurance Bulletin 2006-2. Guidance as to how the Office of the Health Insurance Commissioner will interpret and implement the Office's purposes statute, set out at R.I. Gen. Laws §42-14.5-2. Dated July 25, 2006.

extensively on OHIC's proposal to require insurer adoption of primary care APMs for their provider networks.

BCBSRI articulated its support for the aim of primary care payment reform but discouraged OHIC from requiring insurers to implement primary care APMs or requiring adoption of a specific model. BCBSRI cited the administrative complexity of primary care APMs and the reliance on close collaboration with providers to justify insurer retention of flexibility instead of regulatory prescription. BCBSRI offered that "APM targets for primary care, may be the most workable" alternative and "a primary care APM target should be calculated in a manner that takes into account any other APM agreed to with a provider parent organization (ACO/System of Care (SoC)) that includes primary care providers." NHPRI declared its opposition to a primary care APM requirement, stating that "it would constrain how we engage and leverage our primary care relationships." Lifespan did not support a network-wide primary care APM requirement, arguing that "any APM adoption should be optional and mutually agreed to by the payor and the primary care practice."

The Rhode Island Medical Society stated that "primary care can be more flexible and effective with population-based payments. It is essential that such payments do not lock in inadequate payment for primary care and serve to promote continued progress in creating advanced primary care, such as integrated behavioral health." Coastal Medical expressed skepticism "that stand-alone primary care capitation will improve Triple Aim performance." Coastal Medical proposed "broadening the working definition of a primary care APM to include not only primary care capitation, but also primary care driven ACOs." Moreover, Coastal posited that "the challenge here is that the proposed regulation is trying to address PCP incentives which is really about PCP *compensation* models and not the payer-provider payment models which are regulated by OHIC but operate at the organizational level, not the individual provider level" (emphasis added by Coastal). Christopher F. Koller of the Milbank Memorial Fund, argued that "OHIC should facilitate alignment of commercial payers with [Center for Medicare and Medicaid Innovation] CMMI and Medicare strategy for primary care." These models include the Comprehensive Primary Care Plus model and the recently announced Primary Care First model.

OHIC Response:

Primary care payment reform presents an untapped opportunity to foster transformations in the delivery of primary care. Furthermore, primary care payment reform can be designed to facilitate the integration of behavioral health and to work synergistically with TCOC payment models. OHIC appreciates the stakeholder comments on the primary care APM proposal and has drafted proposed amendments to the regulation which require aggressive action by insurers to develop APMs for primary care while preserving flexibility for different approaches to contracting. Furthermore, OHIC has opted not to mandate a network-wide adoption of primary care APMs, but to specify annual targets which increase over time. The proposed amendments and their rationale are described in the sections that follow.

Hospital Contracting

The hospital contracting regulations impact hundreds of millions of dollars of hospital revenues and subject Rhode Island's acute care hospitals to rigorous cost discipline. A key component of the hospital contracting regulations is a cap on the annual inflation of hospital fee schedules, commonly

referred to as the hospital rate cap. The Advance Notice identified two approaches relative to the hospital rate cap. The first approach proposed maintaining the rate cap as presently configured in OHIC regulations. The second approach proposed granting a higher rate cap for hospitals with relatively lower base rates compared to their peers, contingent on quality performance. The latter approach was proposed in response to the concerns of some hospitals over disparities in payment rates relative to their competitors, and a higher rate cap was viewed as a means to decrease that variation.

The proposals garnered significant feedback. Insurers favored maintaining the rate cap as presently configured, while hospitals argued for relief from the rate cap in several ways. No commenters supported the second approach as drafted. Some commenters felt hospital rate differences were appropriate and did not warrant regulatory action, while others felt the proposal to close variation in hospital rates did not go far enough. Before proceeding to the summary below, readers are encouraged to review the comment letters submitted by CharterCARE Health Partners, the Hospital Association of Rhode Island (HARI), Lifespan, and South County Hospital for a full view of the hospital perspective. The letters can be found here.

Hospitals offered several perspectives on the effects of the rate cap. CharterCARE, South County Hospital and HARI argued that the rate cap, coupled with payments from Medicare and Medicaid that do not cover costs, has forced hospitals to confront acute fiscal and labor market burdens. According to the hospitals, these burdens manifest in terms of negative overall hospital operating margins and constraints recruiting and retaining human resources within a competitive regional labor market. The HARI and South County Hospital noted the recent elimination of the imputed rural floor, resulting in a 9.8% reduction in the Medicare hospital wage index, a federal regulatory change that will significantly reduce Medicare hospital revenues in the state.

The hospitals argue these factors combine to create an environment of fiscal austerity, with important ramifications for the financial and competitive regional standing of hospitals in Rhode Island. Words such as "unsustainable" and "destabilizing" were employed as descriptors of the rate cap's effects on hospitals. Specifically, South County Hospital warns of a weakening of hospitals in Rhode Island and a potential outflow of jobs and patients to neighboring, higher cost, states. "We believe OHIC policies can only (and unnecessarily) create harm for hospitals and health systems, while offering no potential benefit for those that share the goal of reducing cost and increasing value. Moreover, with no hospital in this state with a positive margin, we believe any policy that continues to reduce or limit hospital reimbursement is ultimately unsustainable and may contribute to destabilizing an already fragile Rhode Island healthcare delivery system," wrote South County Hospital. CharterCARE remarked that "the imposition of the rate limit in 2010 has protected the health insurers from the stronger bargaining positions of the larger hospital systems, it has also prohibited some community hospitals from realizing anything close to sustainable commercial rates. Rather, CharterCARE and other community hospitals have seen increasingly challenging payor mixes with most of their patients being covered by Medicare or Medicaid – at rates that historically fail to cover the total cost of providing services. The long-term impact of the annual rate increase limit is manifest in the receiverships of two community hospitals and the closure of another [and] will likely lead to similar outcomes if not corrected."

Beyond observations on the effects of the rate cap on balance sheets and human resource recruitment, hospitals also proffered comments on the design of the rate cap, specifically the economic index

OHIC uses to determine the value of the rate cap, and interactions between the hospital rate cap and the recently established Rhode Island Cost Growth Target.

With respect to the economic index, South County Hospital submitted lengthy and detailed observations on OHIC's decision to tether the rate cap to percentage changes in the Consumer Price Index (CPI-U) Less Food and Energy. Arguing that CPI bears no relationship to the increase in health care expenditures, and confers an inadequate annual revenue increase sufficient to keep up with the operational costs of running a hospital, South County proposed the following alternatives for OHIC's consideration:

1. "Allow each hospital to negotiate reimbursement of their highest payor by the OHIC Max, and other lower payers (excluding NHPRI) by the OHIC Max +2% (providing that the net impact cannot do more than bring the payment rates closer to the highest payer)."
2. "Allow NHPRI Commercial rates to increase by 10% annually until they are in line with other payers. Prohibit NHPRI from linking the commercial contract with the Medicaid and Medicare dual eligible products. These changes create the additional benefit of increasing the amount of federal subsidies that are brought into the state with no impact the subscribers that receive subsidies."
3. "Change the health expenditure benchmarks to utilization of the CMS National Health Expenditures. Discontinue utilization of the U.S. All Urban Consumer All Items Less Food and Energy CPI percentage increase + 1% that has no basis in health expenditures."
4. "Create a statewide Value Bonus Pool to reward systems that are investing in bending the cost curve. This could be achieved potentially by a mandatory pool established by commercial payers, potentially with a state match. This pool would then be distributed to those hospitals and health systems that achieve agreed upon cost goals while maintaining adequate quality and service (e.g. High Value Care). Average Medicare Spending per Beneficiary (MSpB) that is lower than the statewide average could be an effective benchmark. Given the lag in the MSpB metric, and the correlation between quality and episodic cost, the bonus could be payable to those hospitals that achieve the highest scores on the Medicare Hospital Valued Based Purchasing Factors."

With respect to the Rhode Island Cost Growth Target developed pursuant to the *Compact to Reduce the Growth in Health Care Costs and State Health Care Spending in Rhode Island* and Governor Raimondo's Executive Order 19-03 issued February 6th, 2019, HARI commented that the 3.2% Cost Growth Target is based on potential Gross State Product and it is an "aspirational target" which "is substantially different from the firm cap on hospitals." Lifespan observed that in light of the execution of the Cost Growth Target and the Governor's Executive Order, "the continuation of such a cap is an artificial barrier to providers being able to meet this newly-developed target."

CharterCARE offered comments on the variation in payment rates across hospitals in Rhode Island and submitted proposals for reducing rate variation. Because CharterCARE's core proposal does not bear directly on the current structure of the rare cap, we forbear discussion of that issue for the moment, but take it up in the space below. First, we respond to the issues raised in the review of comments above.

OHIC Response:

OHIC appreciates the perspectives conveyed by the hospitals and believes the comments are offered in a spirit of frankness and sincerity. Hospitals undoubtedly contribute significantly to the state's economy, therefore the concerns articulated in the comment letters deserve serious attention. The commenters argue that, considering pressures facing hospital balance sheets and ability to recruit and retain human resources, OHIC should reassess the rate cap in terms of its design elements and absolute value.

As the public knows, OHIC takes is statutory mandate to promote affordable health insurance coverage seriously. Hospital costs account for a significant percentage of premium. For example, 2018 large group market claims data show that hospital inpatient and outpatient paid claims accounted for between 43% and 45% of premium, depending on the insurer.[12] Rhode Island's hospital market is highly concentrated, and this concentration confers substantial market power to a few hospital systems.[13] Prior to the rate cap, hospitals with market power were known to avail themselves of significant price increases from commercial health insurers. The rate cap protects the consumer interest in affordable health insurance by foreclosing large hospital systems from the practice of negotiating excessive price increases from commercial payers. These price increases are ultimately passed on to consumers in the form of higher premiums and out-of-pocket medical expenses. The rate cap also promotes premium stability by effectively fixing an upper bound to components of premium rate factors based on the unit cost of hospital services.

The hospital rate cap enjoys a strong evidential claim as a key contributor to more affordable health insurance coverage in Rhode Island. A peer-reviewed article in the February 2019 issue of *Health Affairs* examined the impact of Rhode Island's Affordability Standards and found that "relative to quarterly fee-for-service (FFS) spending among the control group, quarterly FFS spending among the Rhode Island group decreased by $76 per enrollee after implementation of the policy, or a decline of 8.1 percent from 2009 spending." The researchers credit the rate cap and the concurrent shift of hospital inpatient commercial payments to Diagnosis Related Groups (DRGs) for the observed reduction in spending relative to the control group.[14]

As the Commissioner discharges the powers of her office to advance the public's interest in affordable health insurance, regulatory guardrails on provider contracting, such as the rate cap, are a necessary and proven means to promote this objective. However, in addition to the cost

[12] These figures are based on data from tab 1 of the large group rate filings for plan year 2020. 2018 inpatient hospital and outpatient hospital claims incurred and paid are divided by earned premium.

[13] In 2012, OHIC released a report on hospital payment variation, and among the factors believed to influence variation, was the concentrated structure of the Rhode Island market for hospital services. The Herfindahl-Hirschman Index (H-H index) is a commonly used measure of market concentration. The H-H index was calculated across a slate of hospital service domains. The index value was (2,559) for all inpatient stays, (3,236) for mental health stays, (6,689) for OB stays, (7,711) for pediatric care, (2,338) for outpatient visits, and (2,836) for orthopedic stays. A market bearing an H-H index value in excess of 2,500 is considered to be "highly concentrated" according to U.S. Department of Justice guidelines.

[14] Baum, A., Song, Z., Landon, B., Phillips, R., Bitton, A., Basu, S. (2019). Health Care Spending Slowed After Rhode Island Applied Affordability Standards to Commercial Insurers. *Health Affairs, 38(2)*, 237-245. https://doi.org/10.1377/hlthaff.2018.05164

considerations and dynamics of market structure cited above, OHIC recognizes that the needs of the local health care workforce, including hospitals, are salient factors that demand the awareness of policymakers.

OHIC does not contest that some hospitals face fiscal challenges. The pressures facing Rhode Island's hospitals are broader than the fiscal discipline imposed by commercial rate regulation. Many of the factors influencing hospital revenues are well known. These include competitive market pressure from freestanding ambulatory care facilities and secular changes in utilization patterns toward outpatient care, reduced patient volume stemming from payment reform, and state and federal budgetary decisions that impact what Medicaid and Medicare pay hospitals. OHIC recognizes that these fiscal pressures exist and many of them are ably articulated in the comment letters submitted by the hospitals. In the disposition of this issue, the question that confronts OHIC is whether the combination of these factors warrants restructuring or relaxing the rate cap to grant hospitals the opportunity for additional commercial revenues through the mechanism of higher allowable price inflation?

In responding to the fiscal needs of hospitals, OHIC must conciliate competing interests. Monies that would accrue to hospitals from relaxations of the rate cap translate into increased health care costs for Rhode Island's employers, workers and families. Increasing health care costs over time have led employers to transfer more of the burden of costs onto their employees through higher member cost sharing and premium co-shares. The question at hand cannot be addressed without reference to measures of the ability of Rhode Islanders to afford higher health care costs. This insight is provided by a host of measures that capture the absolute values and relative rates of change of health expenditures and premiums in relation to important economic metrics, such as economic growth and incomes.

First, the Leonard Davis Institute of Health Economics at the University of Pennsylvania has published an analysis of family premiums as a share of household income at the state level. This metric forms a "cost burden index." In 2016, Rhode Island average family premiums for employer-sponsored insurance represented 29.2% of median household income. This was slightly lower than the national average, but higher than Connecticut, Massachusetts, and New Hampshire.[15]

Second, keeping with past experience, health care expenditures are expected to increase faster than economic growth and incomes. According to the Office of the Actuary in the Centers for Medicare & Medicaid Services, national health expenditures are projected to grow at an average annual rate of 5.5% through 2027, with private health insurance and out-of-pocket spending growth averaging 4.8%.[16] Even if Rhode Island's health care expenditures grow at a slower rate than the national average, it is very likely they will outpace growth in incomes and

[15] The Burden of Health Care Costs for Working Families: A State-Level Analysis. Leonard Davis Institute of Health Economics, University of Pennsylvania and United States of Care (2019). https://ldi.upenn.edu/sites/default/files/pdf/Penn%20LDI%20and%20US%20of%20Care%20Cost%20Burden%20Brief_Final.pdf

[16] See Press Release: CMS Office of the Actuary Releases 2018-2027 Projections of National Health Expenditures. https://www.cms.gov/newsroom/press-releases/cms-office-actuary-releases-2018-2027-projections-national-health-expenditures

state economic product.[17] From 2002 to 2018, median household income in Rhode Island grew at an average annual rate of 2.3% and is expected to grow at an average annual rate of 3.2% through 2027. Per capita personal income is expected to grow at an average annual rate of 3.8% through 2027. Gross state product is expected to grow at an average annual rate of 3.8% through 2027.[18] In other words, health care expenditure growth is expected to outpace the growth of incomes and gross state product. Historical and projected growth rates for these metrics are presented in **Table 1.**

Table 1

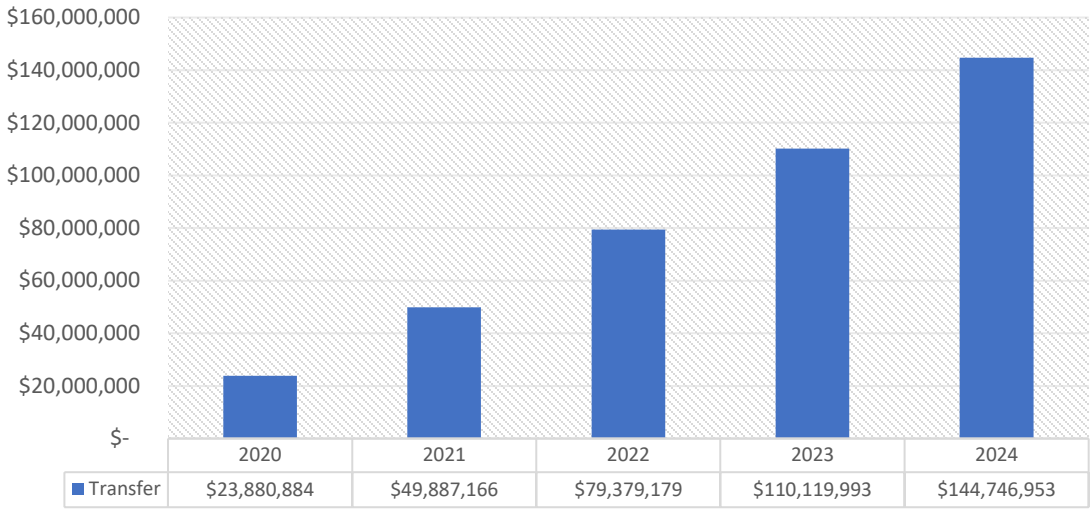
Measure	Average Annual Growth 2002 - 2018	Forecasted Average Annual Growth 2019 - 2027
Median Household Income	2.3%	3.2%
Per Capita Personal Income	3.3%	3.8%
Gross State Product	3.3%	3.8%

In this context it makes sense to discuss South County Hospital's proposal to restructure the rate cap. South County Hospital proposed a multi-part strategy for restructuring the rate cap which included substitution of the CMS National Health Expenditures for CPI-U Less Food and Energy + 1% as the basis for determining the annual value of the rate cap, add-on factors of + 2% for insurers that reimburse at less than the highest commercial payer, and the creation of a statewide quality pool. As stated above, according to the Office of the Actuary at CMS, national health expenditures are forecast to grow at an average annual rate of 5.5% through 2027, with private health insurance and out-of-pocket spending growth averaging 4.8%. The national health expenditures overall average annual growth rate exceeds forecasts of inflation, measured by the CPI-U Less Food and Energy, by 3.2 percentage points.[19] South County's proposal would allow hospital prices to increase at a rate up to 5.5% to 7.5% per year. This significantly exceeds the expected value of the OHIC rate cap, which is projected to average 3.3% per year.[20] A rough calculation of the potential maximum impact of South County's

[17] Based on data from IHS Markit, Personal Consumption Expenditures for Health Care Services in Rhode Island are expected to grow by an average of 5.1% per year through 2027. The trend of this Rhode Island specific measure is consistent with the national measures provided by the Office of the Actuary at CMS.
[18] IHS Markit data. All figures cited are nominal.
[19] According to Moody's Analytics forecasts purchased in August 2019, inflation as measured by the CPI-U Less Food and Energy is expected to increase at an average annual rate of 2.3% through 2027.
[20] The 3.3% expected rate cap is derived from the forecasted average inflation rate based on data from Moody's Analytics, see footnote 19, plus 1%. The actual rate cap will depend on the percentage change in the CPI-U Less Food and Energy as published by the Bureau of Labor Statistics. OHIC publishes this number on or around October 1 annually.

proposal yields a monetary transfer from health care purchasers to hospitals of $408,014,175 over a five-year period.[21] The annual transfer schedule is shown in **Figure 2**.

FIGURE 2:
ANNUAL TRANSFER SCHEDULE



The rate cap is designed to promote affordability by bringing hospital price trends into closer alignment with inflation. This serves the goal of bringing health care cost and premium trends into closer alignment with economic growth. In OHIC's view, South County Hospital's proposal to restructure the rate cap is liable to objection, not only because it significantly increases expenditures relative to the status quo, but through substitution of the CMS National Health Expenditures for CPI-U Less Food and Energy, it shuns an affordability-promoting design feature of the rate cap in preference of a self-fulfilling prophecy for cost inflation.

The recitation of facts above weigh against a modification of the rate cap. Therefore, the rate cap will not be modified at this time. OHIC's determination is not merely a preference for an incumbent measure. Whether through the mechanism of higher premiums, higher out-of-pocket payments at the point or service, or reduced wage growth due to higher employer health care costs, Rhode Island families will bear the cost of any modifications to the rate cap. The data suggests that Rhode Island's families are not positioned to bear these costs without increased burden. Moreover, OHIC's position considers recent actions to improve the financial position of hospitals in Rhode Island as well as proposed actions discussed below in the context of a new hospital contracting provision relative to value-based rate adjustments to mitigate price variation.

[21] OHIC used allowed claims data for hospital inpatient and hospital outpatient services from the fully insured rate filings, multiplied them by a factor of 2 to impute total private market claims (inclusive of the self-insured), and applied the expected value of the OHIC rate cap under existing policy (3.3%) and the expected 5.5% annual growth rate of national health expenditures as the alternative rate cap proposed by South County. Utilization was held constant. This estimate reflects maximum impact and assumes that hospitals negotiate the maximum rate increase and earn 100% of funding that is at risk for quality performance.

OHIC has not turned a deaf ear to the concerns of Rhode Island's hospitals. In light of fiscal concerns articulated by hospitals in 2016, OHIC modified the rate cap. The 2016 modification eliminated a scheduled reduction of the hospital rate cap to percentage changes in the CPI-U Less Food & Energy, instead maintaining a 1% add-on to CPI-U. OHIC estimated that the regulatory change would result in a maximum $137,671,147 transfer over five years from purchasers of health insurance to hospitals, paid in the form of higher premiums for insured groups and health care expenditures for self-funded entities. Furthermore, the policy change redounded to state and municipal budgets through increased health care costs for state and municipal employer health benefit plans. Therefore, payers of state and local taxes have standing in the disposition of this issue. Given the recency of the last modification, and the need to curb health care cost increases for Rhode Island consumers, OHIC has chosen not to revisit the core parameters of the rate cap at this time.

On the question of the rate cap's interaction with the recently developed Cost Growth Target, the answer is quite simple. The rate cap fixes an upper bound to the inflation of a key driver of health care spending and thereby supports achievement of the Cost Growth Target. OHIC disagrees with Lifespan's assertion that the "continuation of such a [rate] cap is an artificial barrier to providers being able to meet this newly-developed target."

Now we turn to the comments submitted by CharterCARE.[22] CharterCARE's principal concerns are threefold: 1. differences in reimbursement rates between its hospitals and the statewide average, 2. APM contract negotiations with health insurers, and 3. the standing of providers to request exemptions from OHIC rules from the Commissioner. In response to the Advance Notice, and prior instances of OHIC rulemaking on these issues, CharterCARE has proposed the following amendments for OHIC's consideration:

1. CharterCARE proposes that OHIC institute a rate floor, such that "[e]ach acute care hospital, who provides at least 30% of their total available inpatient occupancy in mental health services and has been paid by a Health Insurer at less than 90% of the average commercial payments made to all Rhode Island acute care hospitals in the Health Insurer's provider network, shall receive an increase in payment from such Health Insurer to an amount equal to or exceeding the 90% threshold for the 12-month period beginning October 1, 2019. In order to maintain continued eligibility for the rate floor in the years following the establishment of the floor, such hospitals must meet minimum quality standards established by OHIC in the Regulation."
2. CharterCARE has previously advocated for a "transitional APM incentive" through regulation and statute which would grant CharterCARE hospitals a rate increase in exchange for satisfying APM adoption targets through capitated payment models. In a letter dated September 28th, 2018, in response to a previous OHIC rule change, CharterCARE advocated for amendments to OHIC's Powers and Duties Regulation that would ask the Commissioner to assume a formal role in provider-payer contract negotiations.[23]

[22] CharterCARE's response to the Advance Notice dated May 30, 2019 focuses primarily on the means of reducing hospital rate disparities. CharterCARE reiterated positions advocated in prior correspondence with OHIC, namely, correspondence from Jeffrey F. Chase-Lubitz dated September 18, 2018 and correspondence from Jeffrey H. Leibman, dated January 28, 2019.

[23] CharterCARE proposed the following regulatory language in an attachment to its letter from Jeffrey F. Chase-Lubitz to Cory King, dated September 28, 2018:

3. Finally, CharterCARE has proposed amendments for adoption by OHIC, which would grant formal standing to provider entities to "request and obtain determinations or other actions from the Commissioner on any matter that may impact the health care provider and which relate to carrying out the purposes of the laws or regulations administered by the Office, including, without limitation, making requests for waiver or modification of laws and regulations administered by the Office as provided in [regulation]."

OHIC Response:

OHIC appreciates CharterCARE's comments. The claim that there is significant variation in commercial payment rates across Rhode Island's acute care hospitals is supported by the 2012 study Variation in Payment for Hospital Care in Rhode Island, commissioned by OHIC and the Executive Office of Health & Human Services. Among the study's findings, the ratio of the average case mix-adjusted commercial payment per stay to the median among hospitals

---

"Consistent with the purposes of this section as stated in § 4.10(D)(2)(a) of this Part, the Commissioner shall require that Health Insurers and provider organizations adhere to the following process:

Within 30 days of the receipt by the Health Insurer of a provider organization's desired form of alternative payment methodology, the Health Insurer will respond to the provider organization their willingness to enter negotiations on that form of alternative payment methodology, including but not limited to an advanced, delegated, population-based payment methodology such as global capitation. If the Health Insurer is unwilling to negotiate with the provider organization on the provider organization's preferred form of alternative payment methodology, the Health Insurer's written response must include: 1) an explanation of the reason it declines to negotiate on the provider organization's preferred alternative payment methodology and 2) a detailed substitute proposal regarding the alternative payment methodology it will be willing to negotiate. A copy of both the provider organization's proposal letter and the Health Insurer's response must also be provided to the Commissioner by the respective parties at the time of issuance.

The provider organization may accept the Health Insurer's substitute alternative payment methodology method or appeal in writing to the Commissioner, describing the reasons the provider organization does not accept the Health Insurer's refusal to negotiate with the provider organization on its preferred alternative payment methodology model or its offer of a substitute alternative payment methodology model. The Commissioner will accept written responses from both parties supporting their position and make a determination within 30 days as to the appeal and notify the Health Insurer and provider organization of the determination.

If the provider organization has reason to believe, at any time during the communication or negotiations that the Health Insurer is not negotiating in good faith toward the agreed upon alternative payment methodology, the provider organization may appeal to the Commissioner with the reason it believes that the Health Insurer is not negotiating in good faith.

The Commissioner will review the appeal within 30 days and provide the determination to both the Health Insurer and the provider organization, along with instructions on further negotiations.

In the event the Health Insurer and provider organization jointly agree upon an alternative payment methodology, including but not limited to an advance, delegated, population-based payment methodology such as global capitation, and for which the parties can demonstrate sufficient financial and administrative capability, and that requires the approval of the Commissioner for implementing such payment methodology, the Commissioner shall exercise best efforts to provide such approval to further the stated purpose of this § 4.10(D)(2)."

was 1.82 for the highest paid hospital and 0.87 for the lowest paid hospital. OHIC agrees that there should be an opportunity for hospitals to reduce rate disparities that do not appear to be justified based on patient case-mix and other reasonable factors, such as quality. However, OHIC does not concur with certain components of the methodology proposed by CharterCARE to effectuate such rate adjustments. The core components of CharterCARE's proposal are:

1. CharterCARE proposes a rate floor tied to 90% of the average payment to Rhode Island acute care hospitals.
2. CharterCARE proposes as a condition of eligibility for the rate floor that hospitals must provide "at least 30% of their total available inpatient occupancy in mental health services."
3. CharterCARE proposes that "hospitals must meet minimum quality standards established by OHIC in Regulation" to maintain eligibility for the rate floor. This is consistent with OHIC's proposal to require quality performance in the Advance Notice.

OHIC disagrees that a rate floor should be promulgated under 230-RICR-20-30-4.[24] A rate floor (or minimum payment level) would generate ongoing automatic adjustments to some hospital fee schedules as the distribution of payments changes across hospitals. Specifically, as fee schedules increase for the highest reimbursed hospitals, lower reimbursed hospitals may accrue a potential windfall. The value to Rhode Island consumers and employer purchasers from such a structural source of cost inflation is unsupported and the previous review of projected economic indicators for Rhode Island convey doubt that Rhode Islanders can bear escalating health care costs without increasing burden. However, OHIC believes that a policy change is warranted to address rate variation. Therefore, the proposed amendments structure a one-time opportunity for certain eligible hospitals to earn a rate adjustment to mitigate existing disparities in payment, without locking in a potential driver of ongoing cost inflation.

OHIC's proposal applies exclusively to inpatient services, not to the broader set of outpatient services offered by hospitals and is contingent on quality performance. The proposal benchmarks the potential rate increase for eligible hospitals to the median. The median was selected because averages are more sensitive to outliers and data from the 2012 hospital payment study showed that some Rhode Island hospitals are reimbursed at significantly higher rates than their peers, thus skewing the average. Based on data from the 2012 study, the median is less than 90% of the average, and reference to the median will, in OHIC's view, better guard the consumer interest in affordability, while conferring a meaningful opportunity for relatively lower-reimbursed hospitals to benefit from increased fee schedules and potentially higher revenue while supporting quality.

OHIC deliberated on whether to require the one-time rate adjustment to be executed in a cost neutral manner. This would mean that increased revenues accruing to hospitals eligible for the

[24] Interested readers are encouraged to review the proposed amendments and discussion of proposed amendments on pages 37 – 39 of this paper before proceeding.

one-time rate adjustment would be offset by decreased revenues to hospitals which are compensated above the median. In its public comments, Tufts Health Plan advocated for cost neutrality. Cost neutrality would certainly support the consumer interest in affordability. However, as noted previously, the interests of health care providers possess standing in the development of OHIC's regulations. The comments from the hospitals, discussed in the preceding pages, weighed heavily on the disposition of this issue. Ultimately, OHIC decided not to require cost neutrality. Furthermore, OHIC believes the efforts undertaken by eligible hospitals to improve or maintain quality performance may reduce costs over time.

OHIC applauds CharterCARE's commitment to preserving access to inpatient mental health services. The proposed amendments do not set forth a targeted percentage of inpatient capacity for mental health services as a condition of eligibility for the rate adjustment. OHIC does not regulate hospitals and the active supervision necessary to monitor such a provision is not within OHIC's power.

CharterCARE has proposed that the Commissioner assume a greater role in negotiations between health insurers and providers and grant providers formal standing to request modifications and waivers of OHIC regulations. These proposals exceed the purview of the Commissioner. The Commissioner's responsibility is to regulate the business of health insurance and set forth reasonable policies that promote the statutory objectives vested in the Office. In most cases, absent specific statutory authority, the Commissioner should not assume the role of arbiter in contract negotiations between health insurers and providers. However, OHIC is willing to clarify the meaning of specific regulatory requirements which govern how insurers contract with providers. Finally, health insurers confront the risk of compliance with laws and regulations pertaining to the business of health insurance. Therefore, health insurers are the only entities that can seek waivers or modifications of these obligations. OHIC recognizes the impact of its regulations on providers and welcomes feedback from all parties impacted by these policies. OHIC is interested in maintaining an open dialog and appreciates the time which the hospitals have invested rendering thoughtful comments and suggestions.

Other Potential Actions

The Advance Notice proposed a host of other potential actions. OHIC considered aligning the regulatory cap on annual increases under population-based contracts with the state's Cost Growth Target, requiring insurer acceptance of all-payer quality measures in value-based contracts, and a general proposal to require health insurers to reduce administrative burden. The proposal to link the cap on annual increases under population-based contracts with the Cost Growth Target met with resistance from some stakeholders who felt the proposal departed from the voluntary consensus to pursue performance relative to the Cost Growth Target without the threat of sanction. Given this concern, and in the interest of fidelity to the *Compact to Reduce the Growth in Health Care Costs and State Health Care Spending in Rhode Island*, OHIC will not propose linking the population-based contract cap with the Cost Growth Target. Finally, the other proposed measures were not sufficiently developed to justify their inclusion as amendments at this time.

Between June and September of 2019, OHIC staff reviewed the comments from the Advance Notice and drafted amendments to the OHIC Powers and Duties regulation, 230-RICR-20-30-4.

The Proposed Amendments

Rhode Island has a long track record of successful efforts to improve the health care system. Collaboration between industry and government has been a key to this success. In our discourse, the financing and structure of the health care system, and the relative responsibilities of health insurers and provider organizations for managing the state's health care expenditures, have formed the basis of longstanding questions and debates. In the context of OHIC's work specific questions come to the forefront:

- How should the delivery system be structured to achieve optimal system performance on cost, quality, and access?
- What is the appropriate balance of financial risk that should be shared between providers, health insurers, and employers?

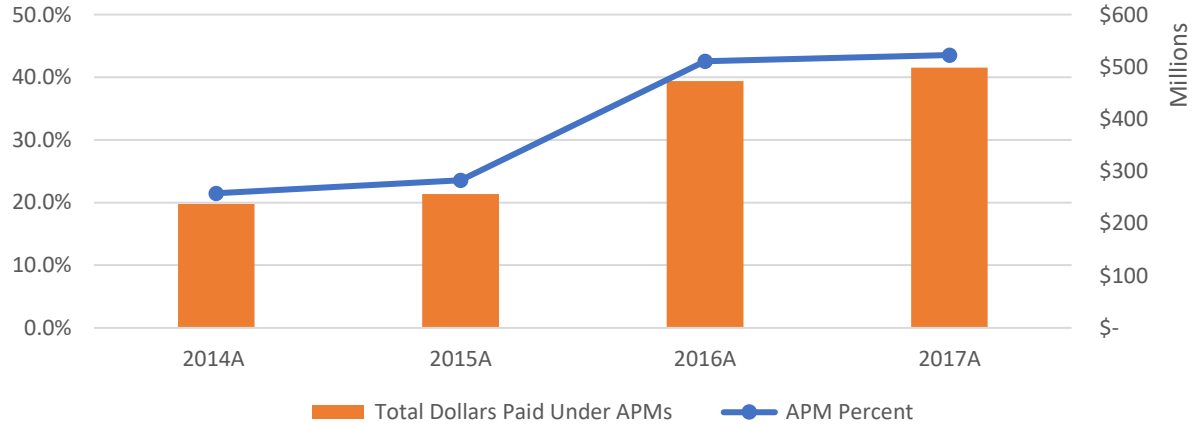
Those questions are not definitively answered here, but the proposed policies described herein point to strategies that carry us closer to answers. The Affordability Standards commence with the premise that systemic change in health care will require collective action and collaboration across the actors who comprise the health care system. Collective action on such a broad scale invokes a role for public policy.

The proposed amendments discussed in detail below reflect a deepening of OHIC's commitment to care transformation and payment reform as levers to drive improvements in health care system performance for Rhode Islanders. The amendments provide the fulcrum for coordinated action across payers to address provider economic incentives, support and sustain advanced primary care, and remove barriers which inhibit behavioral health integration into primary care. The amendments also require payment models and contracting strategies designed to expedite and support integration. OHIC believes that more must be done to facilitate the health care system toward optimal performance. As the rulemaking process continues, OHIC looks forward to ongoing dialogue with stakeholders.

Payment Reform

Opportunities for financial gain or loss can act as powerful motivators of human and organizational action. Naturally, economists, industry leaders, and policymakers have looked to reforms in the structure of health care payment as a mechanism to drive improvements in performance from the individual clinician up to the corporate entity. The sum of these improvements is measured in cost trends, quality measures, and patient access. Consistent with national trends, payment reform in Rhode Island has progressed significantly since 2015. As of the end of 2017, 43% of commercial health care payments were made under an APM. See **Figure 3**.

FIGURE 3: DOLLARS PAID UNDER APMS AND APM DOLLARS AS PERCENT OF TOTAL MEDICAL SPENDING 2014 - 2017



Furthermore, a significant percentage of commercial population-based APMs have transitioned to downside risk. During the same period, providers have executed APM contracts across other lines of business, including Medicare and Medicaid. For Rhode Island, and the nation, the last few years have borne an opportunity to experiment and learn from different payment reforms. The evidence on payment reform is a mix of peer-reviewed literature, government-funded program evaluation, and industry studies. Studies have employed numerous evaluation methods and yielded variable findings on key outcomes of interest: cost and quality.[25]

Despite mixed findings there is evidence in Rhode Island and nationally that APMs have led to health care cost savings through the more efficient delivery of health care and more active management of

[25] McClellan, Mark et al. "Evidence on Payment Reform: Where Are The Gaps?, " Health Affairs Blog, April 25, 2017. DOI: 10.1377/hblog20170425.059789 and Nichols, Len et al. "What Should We Conclude From 'Mixed' Results In Payment Reform Evaluations?, " Health Affairs Blog, August 14, 2017. DOI: 10.1377/hblog20170814.061537.

patient health care needs.[26] Evaluations of payment reforms, such as the commercial-based Blue Cross Blue Shield of Massachusetts Alternative Quality Contract (AQC), discussed below, have shown efficacy in terms of cost savings and quality performance. Experience under the Medicare Shared Savings Program (MSSP), notwithstanding its exclusivity to the Medicare population, points to the potential of population-based APMs to reduce health care costs, thereby improving affordability.[27]

OHIC views payment reform and care transformation as mutually necessary strategies to create a health care environment which supports affordable health insurance coverage, quality, and access to care. Evidence from recent payment reforms and the application of theory support continuing the work of payment reform and intensifying the scope of existing initiatives. Time and commitment are valuable resources because the transformations in care delivery that are necessary to support success under payment reform take time to fully mature. The proposed amendments seek to promote deeper transformation of health care delivery. The following observations informed OHIC's reasoning as the proposed amendments were developed:

1. Payment reform has proceeded upon a foundation of fee-for-service (FFS) payment. While the application of shared savings or shared risk incentives for defined patient populations has led to salutary changes in the structure and performance of the health care system, providers still confront clinical resource allocation decisions and economic incentives based on FFS payment.[28]
2. As a corollary to Observation 1, progress toward non-fee-for-service (non-FFS) payment models, such as capitation, has been slow. Despite OHIC's efforts to promote increased uptake, in 2018 only 3% of commercial medical payments were from non-FFS sources. Health Insurers have consistently struggled or failed to meet non-FFS payment targets. OHIC believes the clinical innovations that may arise from the application of non-FFS models remain an untapped opportunity to improve system performance on dimensions of cost, quality and access.
3. To fully leverage payment reform as a catalytic agent for system performance improvement, payment models must evolve along a continuum toward greater downside risk and prospective payment.
4. The state's significant investments in primary care have not been complemented with a payment model adequate to meet the needs of advanced primary care. Furthermore, there

[26] Rhode Island-based ACOs have achieved cost savings across one or more contracts. Based on data collected by OHIC and specific to the fully insured commercial market, Rhode Island's ACOs have generated over $60 million in shared savings and performance-based distributions since 2014.

[27] The MSSP and other federal payment reforms have been the subject of voluminous program evaluation reports. Evaluation of these programs yield valuable insights for the understanding of payment reform and delivery transformation in general. For example, see Lowell, K et al. (2018). *Next Generation Accountable Care Organization (NGACO) Model Evaluation. First Annual Report.* Retrieved from https://innovation.cms.gov/Files/reports/nextgenaco-firstannrpt.pdf. A host of evaluation reports can be found on the CMS.gov Innovation Models webpage.

[28] To prevent misconstruction of this observation, a further word of commentary is necessary. The transition to FFS-based APMs, such as population-based TCOC arrangements as they exist in Rhode Island, has had a salutary effect on the local health care system. These payment models, and concomitant investments in care management infrastructure, data analytics, and quality improvement, have supported the development of Accountable Care Organizations (ACOs) capable of managing the total cost of care. Several organizations in Rhode Island have been exemplary in their pursuit of cost and population health management through the care delivery structure of an ACO.

remain opportunities to leverage payment reform to promote the development of a high-quality delivery system capable of serving the comprehensive physical and behavioral health care needs of the public through increased integration of behavioral health into primary care.

5. A wide range of stakeholders have urged OHIC's attention to specialist engagement in value-based payment and care delivery. Based on analysis from Altarum there exist opportunities to reduce costs and improve patient outcomes through collaboration with specialists. The development of APMs for specialists has been slow. Other sectors of the delivery system have borne a greater share of the burden for improving affordability and quality.

The payment reform amendments are articulated in § 4.10(D) of the regulation. The amendments embrace five substantive areas:

1. Insurer obligations with respect to the implementation of APMs with their provider networks;
2. Minimum standards for risk assumption under population-based total cost of care TCOC contracts;
3. The development and implementation of APMs for primary care;
4. The development and implementation of APMs for specialists;
5. Changes to the hospital contracting regulations to address the price disparity across hospitals.

§ 4.10(D)(1) Alternative payment models

OHIC believes it is in the interest of Rhode Island consumers for health insurers and providers to continue to collaborate on APMs that align provider financial incentives with the efficient use of health care resources, promote transformation of the delivery system, and encourage the proactive management of the health care needs of their patient populations. § 4.10(D)(1) of the amended regulation provides that:

"Health insurers shall take such actions as necessary to have 50% of insured medical payments made through an alternative payment model.[29] The Commissioner shall issue a policy and guidelines manual annually that specifies the types of payments and payment models which may be credited toward the 50% target."

This requirement imposes a floor for health insurer payments tied to APMs. The 50% target is based on existing policy as codified in past versions of the Commissioner's Alternative Payment Methodology Plan. The target is also consistent with national goals for the Medicare program articulated during the Obama Administration. OHIC believes this is a reasonable minimal standard which preserves the progress of payment reform in the state. Moreover, health insurers retain latitude to develop different types of APMs under this requirement, including population-based shared savings and shared risk contracts, global capitation, bundled payments, and limited scope of service capitation payment models.

§ 4.10(D)(2) Population-based contracts

Population-based contracts, in which the provider assumes accountability for the clinical quality and TCOC of an attributed population, accounted for over 90% of commercial APM payments in Rhode

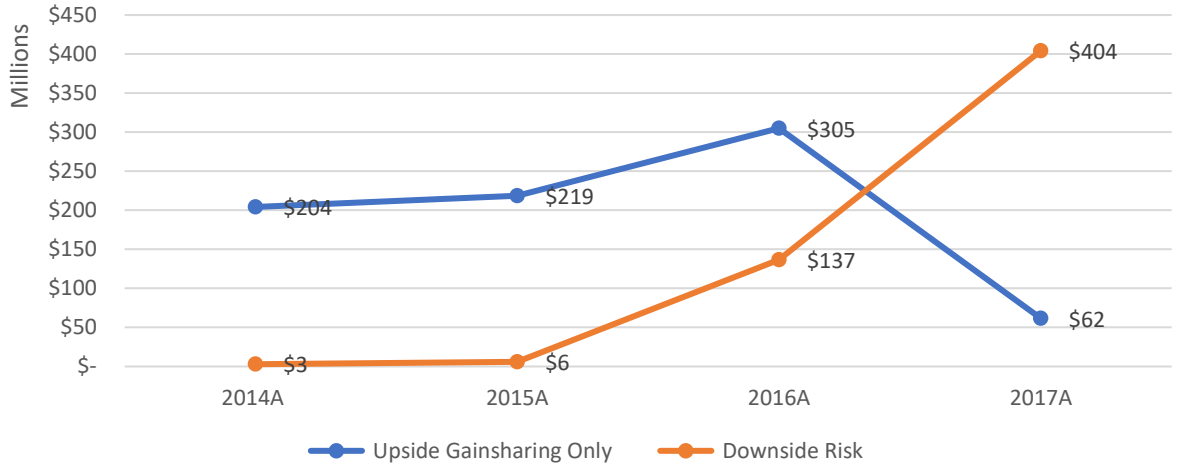
[29] See the 2019 Alternative Payment Methodology Plan for a definition of "alternative payment model" and the method of accounting for APM payments in the calculation of health insurer APM targets.

Island in 2018. As the most prevalent form of APM, these models represent a substantial lever for achieving the goals of the Affordability Standards.

Research has demonstrated that risk-based contracting can generate savings for commercially insured populations. A recent paper in *The New England Journal of Medicine* evaluated the performance of the BCBSMA Alternative Quality Contract (AQC) over an eight-year period (2009 – 2016). The AQC is a two-sided risk, population-based payment model. The researchers found that annual claims expenditures for attributed members was $461 lower per enrollee in organizations which entered the AQC in 2009 compared to the control group. Of note, risk-based incentives produced changes in provider behavior, including changes in referral patterns toward lower cost providers and settings of care, lower emergency department utilization, and lower utilization of laboratory tests and imaging services.[30]

In the Rhode Island commercial market there has been a shift from upside-only gainsharing arrangements to two-sided risk models since 2015. Between 2016 and 2017, most population-based contract payments shifted to two-sided risk models. In 2017, $404 million in attributed member claims were subject to downside risk incentives, while only $62 million were subject to upside gainsharing only (see **Figure 4**[31]).

FIGURE 4: DISTRIBUTION OF POPULATION-BASED CONTRACT CLAIMS PAYMENTS IN UPSIDE-ONLY VS DOWNSIDE RISK MODELS



Notwithstanding this encouraging development, an OHIC review of contracts in force up to July 2017 revealed that risk assumption under two-sided risk models was low. Moreover, the parameters of risk-based contracts varied widely, though variation is not surprising given that many of the contracts reviewed reflected first efforts to develop population-based contracts in the market. In 2017, OHIC established minimum downside risk standards for population-based contracts in an effort to nudge

[30] Song, Z., Ji, Y., Safran, D. G., & Chernew, M. E. (2019). Health Care Spending, Utilization, and Quality 8 Years into Global Payment. The New England Journal of Medicine, 381(3), 252–263. doi: 10.1056/NEJMsa1813621

[31] Payments include allowed claims for all members attributed to providers under population-based contracts and which are subject to the contractual budget target.

health systems toward levels of risk assumption that OHIC deemed necessary to induce changes in provider behavior similar to those observed under the BCBSMA AQC. The minimum downside risk standards, which have been modified over time, initially reflected low levels of risk assumption, with plans to increase risk over time.

§ 4.10(D)(2) incorporates minimum downside risk standards into the regulation and provides for a progression of the standards toward greater downside risk by 2021. The standards vary based on the type of ACO and the size of the population attributed to the ACO contract. OHIC differentiates two types of ACOs: ACOs that include hospital systems and Physician-group based ACOs. This binary typology was developed in consultation with the Alternative Payment Methodology Advisory Committee in 2017 and is based on the different financial capacities of provider organizations to cover losses in relation to their total operating revenue. The downside risk standards also account for the size of the population attributed to the ACO under contract. Population size is important due to the potential volatility in health care costs observed in small populations.

Table 2 and **Table 3** present the downside risk requirements for ACOs which include hospital systems and physician group-based ACOs, respectively.

Table 2. Minimum Downside Risk Standards for ACOs Including Hospital Systems[32]

10,000-20,000 lives	**2020 requirement**	**2021+ requirement**
Risk exposure cap[33]	At least 5%	At least 6%
Minimum loss rate[34]	No more than 3%	No more than 3%
Risk sharing rate[35]	At least 40%	At least 50%
20,000+ lives	**2020 requirement**	**2021+ requirement**
Risk exposure cap	At least 5%	At least 6%
Minimum loss rate	No more than 2%	No more than 2%
Risk sharing rate	At least 40%	At least 50%

[32] A hospital-based ACO has ownership held in whole or in part by one or more hospitals.
[33] **Risk exposure cap** is defined as a cap on the losses which may be incurred by the provider under the contract, expressed as a percentage of a) the total cost of care or b) the annual provider revenue from the insurer under the population-based contract.
[34] **Minimum loss rate** is defined as a 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.
[35] **Risk sharing rate** is defined as the percentage of total losses shared by the provider with the insurer under the contract after the application of any minimum loss rate.

Table 3: Minimum Downside Risk Standards for Physician-based ACOs

10,000-20,000 lives	**2020 requirement**	**2021+ requirement**
Risk exposure cap	At least 7% revenue, or 2% TCOC	At least 8% revenue, or 3% TCOC
Minimum loss rate	No more than 3%	No more than 3%
Risk sharing rate	At least 40%	At least 50%
20,000+ lives	**2020 requirement**	**2021+ requirement**
Risk exposure cap	At least 8% revenue, or 3% TCOC	At least 8% revenue, or 3% TCOC
Minimum loss rate	No more than 2%	No more than 2%
Risk sharing rate	At least 40%	At least 50%

As drafted, the downside risk requirements increase risk through the mechanism of higher minimum risk exposure caps and risk-sharing rates for 2021 compared to 2020. The potential for increased volatility of TCOC in contracts with fewer attributed lives is accounted for by larger allowable minimum loss rates for contracts less than 20,000 attributed lives compared to those 20,000 attributed lives or more.

§ 4.10(D)(2)(c) provides that:

"By January 2021, 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."

This target is drafted to ensure that a reasonable percentage of each insurer's members are attributed to risk-based contracts. Risk-based contracting, if successful, will promote affordable coverage through two mechanisms: lower claims trends, which serve as the basis for projections of insurer revenue requirements during the premium setting process, and slower growth in consumer out-of-pocket liability within the plans offered by the insurer. These outcomes rely on maximizing the percentage of insurer claims experience touched by risk-based contracting incentives.

The proposed amendments introduce two new provisions for population-based contracting. The first requires that population-based contracts not carve out behavioral health or prescription drug claims experience from the provider budget. Accountable care demands that providers coordinate patient care along the full continuum of health care goods and services. The second provision, in light of OHIC's cap on population-based contract budget growth, grants health insurers discretion to execute an upward adjustment to the population budget for providers with low-risk adjusted spending. The intent of such adjustments is to preserve the participation of efficient providers in accountable care

by recognizing their achievement in efficiency and the comparatively diminished potential they have for further cost reduction relative to higher cost providers.

Finally, § 4.10(D)(2) consolidates provisions related to ACO budget trend caps from § 4.10(D)(5) of the previous version of Part 4.

§ 4.10(D)(3) Primary care alternative payment models

It was observed above that progress toward non-fee-for-service payment models, such as capitation, has been slow. To fully leverage payment reform as a catalytic agent for system performance improvement, payment models must evolve along a continuum toward greater downside risk and prospective payment. This evolution should align incentives across provider types and conduce to the development of alternative approaches to care delivery.

OHIC has maintained that health insurer support of advanced primary care is a necessary strategy for improving affordability. Consistent with this approach, OHIC believes that health insurers should develop APMs for primary care to promote the transformation of primary care, the performance of ACOs, and the evolution of APMs toward prospective payment. Given the nature of OHIC's proposed amendments regarding primary care APMs, it is necessary to survey the travel of OHIC's promotion of primary care payment reform in some detail.

Rationale and Theory of Change

Research shows that strong primary care is a foundational element of a well-functioning health care system.[36] OHIC's early policy efforts focused on increasing investment in primary care and reforming models of care delivery along the dimensions of cost management, quality, and patient-centeredness. In 2009, OHIC co-convened a multi-payer patient-centered medical home (PCMH) project and in 2010, for a five-year period thereafter, mandated that commercial insurers increase the share of their overall medical spending that is directed to primary care by one percentage point per year. As a result, Rhode Island has a broad foundation of transformed primary care with 152 practice sites recognized by OHIC as PCMHs and another 21 in the process of transformation.[37] Many of these sites are part of Accountable Care Organizations (ACOs) that are focusing on improved integration of care and population health management with overarching TCOC incentives. This foundation of advanced primary care puts the state in a position to further leverage primary care to promote improved system performance. Given the centrality of primary care to system performance and recognizing that fee-for-service reimbursement is a poor fit for transformed primary care, in the spring of 2017 OHIC convened a work group to develop a multi-payer primary care APM.

OHIC's theory of change is that prospectively paid primary care APMs will allow providers to practice more flexibly, tailoring care to patient needs. Substitution of office visit-generated revenue with prospective fixed payments may lead to practice changes that support better access, care coordination, patient engagement, and quality, including:

[36] Starfield, B., Shi, L., & Macinko, J. (2005). Contribution of Primary Care to Health Systems and Health. The Milbank Quarterly, 83(3), 457-502. doi: 10.1111/j.1468-0009.2005.00409.x

[37] Based on 2018 OHIC PCMH recognition data.

1. PCPs spend more face-to-face time with at-risk patients (and less with low risk patients). Because visit volume no longer drives practice income, primary care providers (PCPs) can prioritize time with those patients who most need their time and attention. A complementary shared savings or shared risk program applied at the practice organization level amplifies the economic incentive to do so – as RI providers and payers have noted. In so doing, the PCP can:

    - learn more about his/her patients;
    - better help patients to manage their health, and
    - better coordinate the care patients receive, especially for those patients with complex problems and/or multiple specialist relationships

2. Practices make full use of the extended care team. Practices can expand access and see more patients by utilizing NPs, PAs, RNs, LPNs and MAs to serve patients who do not require physician-level care, including for prevention services. Nurse triage processes can aid many patients with self-management and skill-building in ways that may reduce the need for in-person visits. This is a core PCMH concept, but fee-for-service payment does not always support it. Capitation payments support this approach to the extent they allow a PCP to expand his/her panel size without increasing the time required from the physician him or herself.

3. Deliver services through non-office-visit-based modalities. Many patients prefer to not have to disrupt their busy day with an office visit, and primary care capitation no longer makes such visits an economic necessity for practices. Non-office visit service modalities include the following:

    - email via online portal;
    - text messaging;
    - telehealth (video or telephone);
    - remote monitoring, and
    - home visit.

What is unknown is whether these modalities are substitutes for office-based care, or whether they expand service utilization. A study suggests that telemedicine increases service utilization, in which case a switch to capitation alone (absent increased total payment) would not support the practices' costs for providing these new modalities.[38]

4. Deliver services not supported by fee-for-service payment. There are many services that primary care physicians have long complained are not reimbursed by fee-for-service payment; many broadly fit into the context of population health management and social determinants of health. While there are certainly limits on how many new services can be provided and to what

[38] Ashwood, J., Mehrotra, A., Cowling, D., & Uscher-Pines, L. (2017) Direct-To-Consumer Telehealth May Increase Access To Care But Does Not Decrease Spending. *Health Affairs 36(3)*, 485-491.

degree for a primary care APM to be financially sustainable for a practice, there are multiple new service possibilities. Some of these include:

- outreach to patients with identified gaps in recommended care;
- health education for patients with chronic conditions;
- facilitated patient peer support groups;
- social determinants of health, behavioral health, patient function and other health screenings;
- warm hand-offs;
- shared decision making;
- conversations between providers and patients that are informed by evidence-based recommendations, as promoted by the ABIM Foundation's Choosing Wisely initiative;
- care coordination to address social determinants of health, including accessing community resources and confirming successful linkage;
- management of care transitions;
- care team meetings with specialists, community resources (e.g., schools, public safety) and/or family members for care plan development and management, and
- high-risk care management.[39]

Like non-office-visit-based care, the cost to the practice of providing these services would only be covered in a capitation arrangement if the utilization of traditional care was reduced. In summary, providing a capitated payment for each member of the PCP's panel allows the primary care physician to make decisions about the allocation of resources across the patient panel, permitting flexibility to provide more or longer appointments to those with complex care needs[40] and allowing alternative service modes (e.g., telehealth services) to serve as substitutes for office visits when warranted.[41] These types of practices are consistent with those promoted by the Care Transformation Collaborative of Rhode Island (CTC-RI) through their patient-centered medical home model.[42] The likelihood of successful practice changes hinges on the attainment of critical mass in terms of the percentage of payments that fall under capitation. Researchers at Harvard University have found through simulation

[39] PCMHs and ACOs are often paid by RI insurers to provide this function.
[40] Capital District Physicians' Health Plan. Enhanced Primary Care Initiative. www.cdphp.com/-/media/files/providers/epc/enhanced-primary-care-summary.pdf?la=en. Accessed March 14, 2019.
[41] Berenson RA, Delbanco SF, Upadhyay DK, and Murray R. (2016, June 10). Payment Methods and Benefit Designs: How They Work and How They Work Together to Improve Health Care. Primary Care Capitation. Urban Institute. www.urban.org/policy-centers/health-policy-center/projects/payment-methods-and-benefit-designs
[42] For more information, see www.ctc-ri.org/.

analysis that levels of capitation, around 63% of total payments, are needed to put team-based care on sound financial footing and to allow practice changes to take root.[43]

Primary care capitation has proven effective at improving health care system performance in other markets. In Albany, New York, Capital District Physicians Health Plan (CDPHP) implemented primary care capitation with its provider network. According to an internal evaluation of CDPHP's Enhanced Primary Care program, the health plan observed a $17.11 PMPM reduction in total cost of care in 2014, or $20.7 million in annual savings.[44]

Table 4: PMPM Savings Associated with CDPHP's Enhanced Primary Care Model (2014)

PMPM	All Members	Healthiest 50%	Sickest 50%	Sickest 10%
All LOBs	$ 17.11	$ 3.81	$ 26.37	$ 49.34
Commercial	$ 15.81	$ 1.92	$ 33.07	$ 15.35
Medicaid	$ 22.30	$ 4.41	$ 15.79	$ 104.65
Medicare	$ 24.03	$ 10.64	$ 28.81	$ 146.30

Furthermore, CDPHP observed a shift in the allocation of office visits from healthier members to more high-risk, medically complex members. This shift is consistent with the theory behind capitation and may serve as a valuable lever for providers participating in ACOs to improve TCOC performance through deeper engagement with high-risk patients. Finally, under primary care capitation, the calculus for revenue maximization depends on expanding the patient panel. This could ameliorate access issues for new patients.

Discussions with Insurers

In August 2017, OHIC issued recommendations governing the development of primary care APMs in the state. The recommendations were formulated in consultation with a work group which met seven times between January 30th and June 22nd of 2017. Between April and July of 2018, OHIC reconvened the work group to discuss the design and implementation of a voluntary pilot program to test primary care capitation in the commercial market. OHIC envisioned a cohort of pilot practices beginning contracts on October 1st, 2018. During the work group meetings insurer representatives articulated concerns that the operational details of primary care capitation would require more time for design and development than the October 1st date afforded. Furthermore, some health insurers

[43] Basu, S., Phillips, R., Song, Z., Bitton, A., & Landon, B. (2017). High Levels of Capitation Payments Needed to Shift Primary Care Toward Proactive Team and Nonvisit Care. *Health Affairs, 36(9)*, 1599-1605. https://doi.org/10.1377/hlthaff.2017.0367

[44] The Capital District Physicians' Health Plan's Enhanced Primary Care Initiative generated $20.7 million in savings in 2014, with 60% from commercial patients, and 20% from the sickest 10% of Medicaid and Medicare patients. See Capital District Physicians' Health Plan. Enhanced Primary Care Initiative. www.cdphp.com/-/media/files/providers/epc/enhanced-primary-care-summary.pdf?la=en. For source of **Table 4** see Addendum to the Alternative Payment Model (APM) Framework White Paper. APM Framework and Progress Tracking (FPT) Work Group, Health Care Payment Learning & Action Network, CMS Alliance to Modernize Healthcare, January 12, 2016. https://hcp-lan.org/workproducts/apm-whitepaper-total.pdf

were reluctant to commit to collaborate over a common set of practices for the pilot; one payer cited anti-trust concerns. In August 2018, OHIC suspended the work group meetings to give insurers more time to develop primary care APMs.

In January 2019, the Commissioner sent letters to the Chief Executive Officers of each of the major health insurers asking them to commit to the implementation of a primary care APM pilot program. Beyond their commitment, each health insurer was asked to report to OHIC on a set of implementation milestones so the Office could track their progress. Two health insurers, Tufts Health Plan and UnitedHealthcare committed to participation in the pilot and agreed to report to OHIC on the attainment of the milestones. Blue Cross Blue Shield of Rhode Island, which has been a leading advocate for primary care transformation in the state, conveyed its ongoing efforts to develop primary care capitation, but declined to participate in a coordinated pilot or otherwise report according to OHIC's milestones. Citing operational concerns and its limited commercial market share, NHPRI declined to participate in the pilot. Given these responses, OHIC was unable to facilitate a viable primary care APM pilot program.

The Proposed Amendments

OHIC finds that the development and implementation of prospectively paid APMs for primary care providers is necessary to support continued primary care practice transformation and to improve health care system performance. The implementation of APMs for primary care also represent a necessary strategy to fulfill OHIC's legislative mandate to "direct insurers toward policies and practices that address the behavioral health needs of the public and greater integration of physical and behavioral health care delivery."

The proposed amendments require that health insurers develop and implement a prospectively paid APM for primary care by January 2021. It is recommended, though not required, that health insurers align their 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. Additionally, as a necessary support for primary care practices which have achieved designation as a Qualifying Integrated Behavioral Health Primary Care Practice under § 4.3(A)(18), health insurers are required to develop and implement a prospectively paid APM for primary care that compensates practices for the primary care and behavioral health services delivered by the site.

Furthermore, § 4.10(D)(3)(d) states that health insurers shall take necessary action to achieve targets for the percentage of their Rhode Island resident covered lives attributed to a prospectively paid primary care APM according to the following schedule:

Table 5: Primary Care APM Targets

Date	Target
January 1, 2021	At least 20% of insured Rhode Island resident covered lives shall be attributed.
January 1, 2022	At least 40% of insured Rhode Island resident covered lives shall be attributed.
January 1, 2023	At least 60% of insured Rhode Island resident covered lives shall be attributed.

The targets above are informed by the simulation analysis conducted by Basu et al.[45] Given the innovative nature of primary care APMs, the Commissioner will convene a working group by April 2021 to assess health insurer, provider and patient experience under these models.

§ 4.10(D)(4) Specialist alternative payment models

Specialists play an important role within the health care system. Clinical decisions by specialists influence the use of other expensive health care resources, particularly inpatient hospital services, outpatient procedures, imaging and testing. For some of the most complex and expensive medical conditions, specialist physicians exercise significant influence over the total cost and outcomes of treatment. In recognition of these facts, payers across the country have developed and implemented APM contracts with a diverse range of specialist professionals focusing on episodes of care. These include bundled payments for common orthopedic procedures, maternity care, and coronary artery disease, just to name a few. Much of the focus of payment reform in Rhode Island has centered on primary care providers and hospitals, either as stand-alone components of the delivery system or as constituent parts of ACOs. Specialists should be subject to the same incentives to improve efficiency and quality.

The place of specialists in efforts to improve affordability and system performance has been a recurrent topic of discussion at OHIC's Alternative Payment Methodology Advisory Committee. In terms of payment reform, OHIC has done research to show that APMs designed for specialists, such as episode-based payment models, can exist alongside, or be nested within, TCOC contracts with ACOs. Furthermore, OHIC has engaged expert analysis of opportunities for improved cost performance and clinical outcomes within episodes of care. A 2018 analysis of Rhode Island commercial claims data from July 1, 2015 through June 30, 2017 by the firm Altarum produced metrics on episode costs, the prevalence of potentially avoidable complications (PACs), and variation in these outcomes across providers. This analysis revealed that there exist opportunities to achieve cost savings by improving provider performance and closing variation in outcomes. **Table 6** below was provided by Altarum and shows the potential savings from four high opportunity episodes of care that would accrue from raising the performance of all providers to the level of "high performing" providers in the state. According to this analysis, nearly $13 million could be saved.[46]

[45] Attributed members are admittedly different than payments, which is the focus of the simulation by Basu et al.; however, there should be a close correlation between percent of members attributed to a given payment model and percent of payment made under that model.

[46] The Altarum analysis identified other high opportunity episodes of care, some of which are primarily managed by primary care physicians. Across ten high opportunity episodes, inclusive of the four listed in **Table 6**, Altarum estimated a potential savings of $48 million from raising the performance of all providers to the level of "high performing" providers within each episode of care.

Table 6: Episode Savings and PAC Reductions – Improvement Opportunity

Episode	Total Savings/Reduction	
	Total $	**PAC Rate**
Commercial	**$ 12,873,154**	
Gall Bladder Surgery	$ 1,193,394	-21%
Knee Replacement	$ 2,441,710	-26%
Hysterectomy	$ 3,652,501	-52%
Vaginal Delivery	$ 5,585,549	-25%

High opportunity episodes of care are of high volume and high cost variability (average cost and/or total cost). They may also reflect episodes of care where reducing the prevalence or variation in PACs offers an opportunity to improve clinical outcomes.

OHIC believes that it is in the interest of the public to expand innovative APMs to specialist physician practices to encourage the more efficient use of health care resources, reduce unwarranted variation in episode treatment costs, and improve the quality of care through the reduction of PACs. The proposed amendments under § 4.10(D)(4) require that health insurers with at least 30,000 covered lives "shall develop and implement new specialist 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 another clinical specialty selected by the Health Insurer.

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. APMs qualifying under this provision include limited scope of service budget models, including both prospectively paid and retrospectively reconciled models and episode-based (bundled) payments. The regulation defines a schedule for health insurers to follow when sequencing specialist APM contracts: Health insurers shall cumulatively implement new or expand current APM contracts with two specialties in 2021, three specialties in 2022, four specialties in 2023, and five specialties in 2024.

§ 4.10(D)(6) Hospital Contracts

The hospital contracting requirements under the Affordability Standards form a core component of OHIC's efforts to improve affordability and system performance. As discussed previously, the cap on annual commercial hospital fee schedule increases, with the concurrent shift of commercial hospital payments to DRGs, is credited with slowing the rate of annual growth in commercial market health

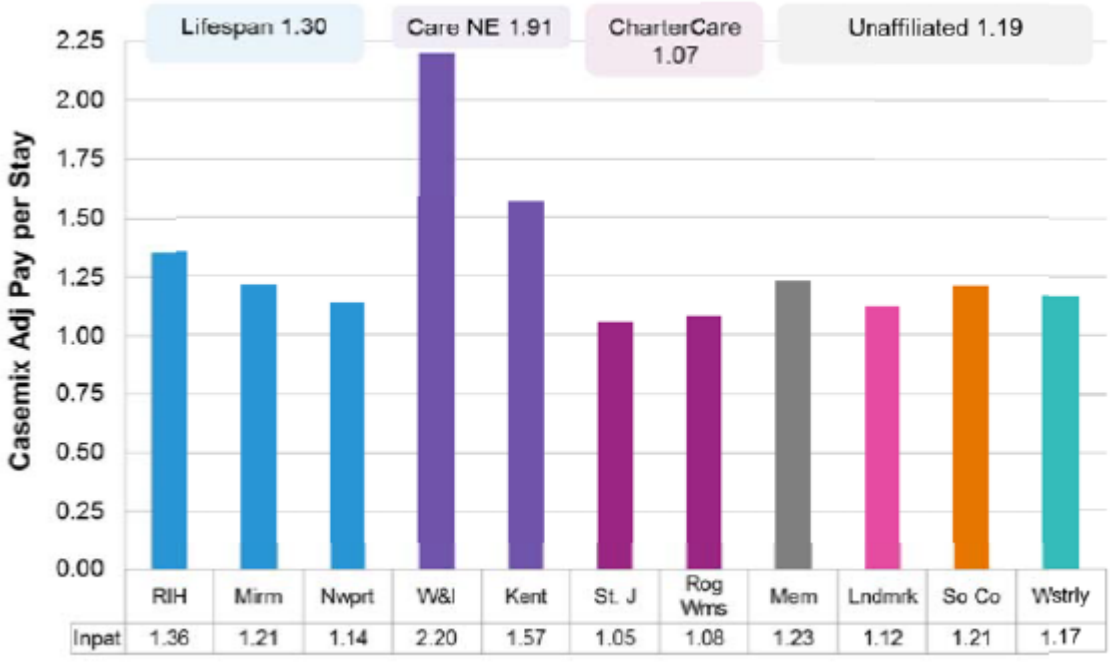
care expenditures. OHIC is proposing two amendments to the hospital contacting requirements under § 4.10(D)(6):

1. § 4.10(D)(6)(d)(3) is amended to allow health insurers to make prospective quality-based payments to hospitals without consideration of interim performance, provided that the hospital shall be contractually obligated to remit unearned prospective payments back to the health insurer if annual quality performance targets are not met. This proposed amendment creates more flexibility for health insurers and hospitals to structure the timing of incentive payments without sacrificing accountability for the quality of care.

2. § 4.10(D)(6)(f) provides for a one-time value-based rate adjustment for certain eligible hospitals, contingent on the hospitals meeting quality targets. This is an important policy change and so the rationale for this proposal is discussed at greater length below.

Prior to the promulgation of the hospital contracting regulations there was wide variation in case-mix adjusted payments per stay across Rhode Island's acute care hospitals. **Figure 5**, taken from the 2012 Hospital Payment Study, shows the variation in commercial case-mix adjusted inpatient payments relative to the statewide average from all payers. Among commercial payers only, the ratio of the case mix-adjusted payment per stay among hospitals to the median was 1.82 for the highest paid hospital and 0.87 for the lowest paid hospital. Some hospitals have argued that a systematic rate adjustment is necessary to rectify prevailing rate disparities. The current hospital contracting regulations do not provide latitude for reducing rate disparities that do not appear justified based on patient case mix and other reasonable factors.

Figure 5: Commercial Plan Payment for Inpatient Care
Adjusted for patient case mix using APR-DRGs



The hospital contracting regulations impact hundreds of millions of dollars of hospital revenues and subject Rhode Island's acute care hospitals to rigorous cost discipline and quality incentives. This policy benefits consumers and other purchasers of health care services through improved affordability, which has been demonstrated empirically. OHIC appreciates that the intensity and pacing of efforts to promote affordability and quality impact concerns beyond those which inhere among consumers and purchaser entities. OHIC recognizes that certain hospitals may be disadvantaged by a rate structure which reflects the historical bargaining position of different hospitals and insurers, instead of reflecting valid factors such as patient case-mix and quality. Therefore, OHIC is exercising its discretion to grant an opportunity for a one-time inpatient services base rate increase for certain eligible hospitals. The proposed language to § 4.10(D)(6)(f) reads:

"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 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, 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; and

(2) 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) should the hospital fail to achieve the quality targets defined in § 4.10(D)(6)(f)(1). Such provision shall be subject to audit by the Commissioner."

An extended commentary on the proposed amendments and how OHIC envisions health insurers operationalizing the requirements of this section follows.

Timing: The proposed amendments do not require health insurers to reopen existing hospital contracts. Rather, at the time of renewal, or upon the joint agreement of the parties to reopen negotiations pursuant to existing terms of the contract, the health insurer shall determine whether the hospital is eligible for the one-time rate adjustment.

Eligibility: A hospital's eligibility for the one-time rate adjustment depends on whether the hospital has been paid at less than the median commercial payments made to all Rhode Island acute care hospitals for inpatient services in the health insurer's provider network. The measure for determining eligibility is a case-mix-adjusted discharge payment rate for each hospital for inpatient services. 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. Consider the

following example. A health insurer contracts with five hospitals and the distribution of case-mix adjusted payment per discharge for each hospital is as follows:

Table 7: Illustration of Eligibility for One-Time Rate Adjustment

Hospital Name	Case-mix adjusted payment per discharge
Hospital A	$17,500
Hospital B	$14,000
Hospital C	$12,500 = median
Hospital D	$11,750
Hospital E	$11,000

In the example Hospital D and Hospital E would be eligible for the one-time rate adjustment because each hospital is paid below the median ($12,500).

Calculation of the Eligible Rate Increase: Computation of the eligible rate adjustment shall be made at a point in time and be in addition and anterior to any negotiated rate increase up to the hospital rate cap. Once the health insurer calculates the eligible rate adjustment, it shall be dispersed to the hospital in one fee schedule adjustment. Prepayment of the rate adjustment was determined necessary to ensure the hospitals have the resources needed to improve the quality of care.

Table 8: Illustration of Allowable One-Time Rate Adjustment

Hospital Name	Case-mix adjusted payment per discharge	Eligible Rate Adjustment
Hospital A	$17,500	Up to rate cap
Hospital B	$14,000	Up to rate cap
Hospital C	$12,500	Up to rate cap
Hospital D	$11,750	6.4% + Up to rate cap
Hospital E	$11,000	13.6% + Up to rate cap

The table above illustrates rate adjustments which Hospital D and Hospital E would be eligible for under this hypothetical example.

Contingent Eligibility: Retention of the rate adjustment is not guaranteed. At the conclusion of three years after the increase in payments, the Hospital must 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[47]. These are important measures of patient safety and outcomes and reflect hospital quality more widely. Failure to perform relative to these benchmarks will result in a loss of the rate adjustment. Finally, the proposed amendments require the health insurer and hospital to agree to terms that provide for the recovery of monies paid to the hospital under this provision, should the hospital fail to satisfy the quality requirements.

It deserves reiterating that this proposal does not institute a rate floor. A rate floor would attempt to control the statistical variance of the distribution of rates among hospitals indefinitely. A rate floor would tie rate adjustments to a benchmark in the distribution of payments (such as the median or average), such that ongoing adjustments to some hospitals' rates would be triggered if the value of the benchmark changes. Furthermore, if a hospital ceases to be eligible for retention of the rate adjustment due to its failure to satisfy the conditions above, the hospital will not be re-eligible for the one-time increase under the proposed provision.

[47] Medicare.gov Hospital Compare. https://www.medicare.gov/hospitalcompare/search.html?

Care Transformation

Rhode Island is well-resourced with reform-oriented individuals and organizations who have worked tirelessly to carry into effect transformations in the delivery of health care. These care transformations are designed to improve efficiency, quality, access, and health. Earlier it was observed that payment reform and care transformation are mutually necessary strategies to create a health care environment which supports affordable health insurance coverage and improved system performance. Strong primary care is a foundational component of a well-functioning health care system. The PCMH represents an evidence-based model of care delivery which instantiates strong primary care.

Under the heading of care transformation, this section describes two classes of proposed amendments to the Affordability Standards. Each endorses a model of care delivery that the Commissioner deems foundational to the achievement of the objects of the Affordability Standards. The first class reaffirms OHIC's commitment to advanced primary care through the PCMH. The second class removes administrative encumbrances to the integration of behavioral health into primary care.

§ 4.10(C) Primary Care Transformation

Evidence suggests that advanced primary care can reduce cost and improve quality.[48] For this reason, OHIC has an abiding commitment to strengthen primary care in Rhode Island. In 2015, OHIC convened the Care Transformation Advisory Committee to develop a three-part definition of PCMH against which Rhode Island primary care practices are evaluated. The three-part definition relies on external verification of practice transformation through NCQA, demonstration of practice initiatives to manage spending within their patient panels, and demonstration of performance on a set of clinical quality measures. In exchange for meeting the three-part definition of PCMH, practices are eligible for payments from health insurers to sustain the PCMH. The current definition of PCMH as described in the Commissioner's 2019's Care Transformation Plan is as follows:

> **1. Transformation Experience:**
>
> a. Practice is participating for the first time in a formal transformation initiative[49] (e.g., CTC-RI, PCMH-Kids, TCPI, or an OHIC-approved payer- or ACO-sponsored transformation program) with the expectation that the practice will obtain NCQA recognition within two years of entry into the transformation initiative; or

[48] This assertion is supported by previously cited reports from the Patient-Centered Primary Care Collaborative.

[49] Rhode Island Office of the Health Insurance Commissioner 2019 Care Transformation Plan, available at: http://www.ohic.ri.gov/documents/2019-Care-Transformation-Plan.pdf. A formal PCMH transformation initiative is a structured training program for primary care providers and support staff with a pre-defined curriculum and technical assistance based on an evidence-based PCMH transformation model and designed to systematically build the skills within the practice to function as a PCMH.

b. Practice holds current NCQA PCMH recognition status[50]. Practices meeting this requirement through achievement of NCQA recognition may do so independent of participating in a formal transformation initiative.

2. Cost Management:

This requirement places parameters around existing NCQA PCMH (2017 Edition) reporting requirements. In meeting NCQA Element QI 09, a practice must develop and implement a quality improvement strategy that addresses one menu item, from either the Care Coordination or Cost-Effective Use of Services categories, as outlined in the Commissioner's 2019's Care Transformation Plan:

Care Coordination:

- Care coordination between facilities (including safe and effective care transitions)
- Care coordination with specialists/other providers
- Care coordination with patient[51]

Cost-Effective Use of Services:

- Emergency Department (ED) utilization
- Inpatient hospital utilization
- Overuse/appropriateness of care (low-value care)
- Pharmaceutical costs (including volume and/or use of high-value pharmaceuticals)
- Specialist referral costs (including volume of referrals and/or referrals to high-value specialists)

Practices that are NCQA-recognized PCMHs using the 2017 NCQA standards will be evaluated on this requirement during their annual NCQA reporting. Practices will be expected to specify the measure of resource stewardship they will track to monitor performance improvement in the selected menu item. All other practices will be evaluated based on responses to an OHIC-administered survey.

3. Meaningful Performance Improvement

[50] Rhode Island Office of the Health Insurance Commissioner 2019 Care Transformation Plan, available at: http://www.ohic.ri.gov/documents/2019-Care-Transformation-Plan.pdf. If NCQA recognition was obtained according to 2014 standards, then NCQA level 3 must be obtained to meet this requirement.

[51] Rhode Island Office of the Health Insurance Commissioner 2019 Care Transformation Plan, available at: http://www.ohic.ri.gov/documents/2019-Care-Transformation-Plan.pdf. Care coordination with patient refers to measures of successful coordination or communication between members of the care team and the patient. Examples can include, but are not limited to: follow up to ensure ordered lab or imaging tests were completed, follow up to ensure referral has been completed, follow up after patient receipt of abnormal test results, outreach to patients not recently seen that results in an appointment, discussion to reduce % of patients seeing multiple providers (3 or more), follow-up phone calls to check on the patient after an ER visit (or hospitalization), or following up on pediatric visits to after-hours care.

A practice must demonstrate meaningful clinical quality performance improvement. In 2018, 92% of practices met OHIC's target for meaningful performance requirement. The measures assessing performance and the definition of meaningful performance improvement are determined annually by the Commissioner.

In 2019, the measures for assessing performance are as follows:

Adult practices

- Colorectal Cancer Screening
- Comprehensive Diabetes Care: Eye Exam
- Comprehensive Diabetes Care: HbA1c Control (<8)
- Screening for Clinical Depression and Follow-up Plan
- Controlling High Blood Pressure[52]

Pediatric practices

- Adolescent Well-Care Visits
- Weight Assessment and Counseling for Nutrition and Physical Activity
- Developmental Screening in the First Three Years of Life

"Meaningful performance improvement" is defined as a 3-percentage point improvement over one or two years (if applicable); or performance at or above the performance benchmarks defined by the Commissioner.

Consistent with existing OHIC policy, § 4.3(A)(15) of the regulation adds the development and implementation of meaningful cost management strategies and clinical quality performance to the definition of PCMH. Under the amended regulation, OHIC will require health insurers to adopt the following payment model to sustain primary care transformation. The total dollars paid to providers under this model will be counted towards the health insurers' primary care spend obligation under § 4.10(B). Health insurers must minimally apply this model to practices that have met the OHIC definition of a PCMH under § 4.3(A)(15). To be eligible for support payments, primary care practices must meet the requirements of a PCMH under § 4.3(A)(15) of the amended regulation. The financial support model shall be structure as follows:

1. Primary care practices actively engaged in first-time transformation activity and without NCQA recognition, or practices with NCQA recognition, but which have not met the requirements outlined in § 4.3(A)(15)(d), shall receive both infrastructure and care management per member per month (PMPM) payments. The care management PMPM

[52] Rhode Island Office of the Health Insurance Commissioner 2019 Care Transformation Plan, available at: http://www.ohic.ri.gov/documents/2019-Care-Transformation-Plan.pdf. In 2019, Controlling High Blood Pressure (NCQA HEDIS, modified by CTC-RI) will be a report-only measure due to the significant changes in this measure's specifications.

payment shall support development and maintenance of a care management function within the practice site.

2. Primary care practices with NCQA recognition and which have met the requirements of § 4.3(A)(15) shall receive a care management PMPM payment and have an opportunity to earn a performance bonus.

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.

§ 4.10(C)(2) Behavioral Health Care Integration

Behavioral health care is an important dimension of Rhode Island's health care system. Behavioral health care refers to services for mental health and substance use treatment (MH/SUD). As a part of care transformation, the development and implementation of behavioral health integration into the primary care setting is in the interest of the public as a potentially more efficient use of health care resources that will encourage providers to coordinate the behavioral and physical health needs of their patients. Individuals with behavioral health diagnoses have higher spending and lowering their costs will contribute to overall lower health care spending.

Rhode Islanders are disproportionately affected by some substance use and mental health disorders, compared to residents of other states. For example, in Commonwealth Fund's 2019 health ranking, Rhode Island ranked #41 in drug poisoning deaths.[53] Among people aged 12 or older in Rhode Island, during 2015–2017, 9.3% had a substance use disorder in the past year, which is higher than the national average of 7.5%.[54] In 2012, behavioral health spending per private insurance enrollee in Rhode Island was higher than in any other New England state.[55] Nationally, overall costs for treating patients with chronic medical and comorbid behavioral health conditions are two to three times higher on average compared to the costs for those beneficiaries who don't have comorbid MH/SUD conditions. Milliman estimates that 9% to 17% of this total additional spending may be saved through effective

[53] Commonwealth Fund Scorecard on State Health System Performance, 2019, available at: https://score card . commonwealthfund.org/files/Rhode_Island.pdf

[54] Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Rhode Island, Volume 5: Indicators as measured through the 2017 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services. HHS Publication No. SMA-19-Baro-17-RI. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2019, available at: https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/Rhode%20Island-BH BarometerVolume5.pdf

[55] Rhode Island Behavioral Health Project: Cost Report, Truven Health Analytics, June 8, 2015, available at: http://www.bhddh.ri.gov/mh/pdf/Truven%20Behavioral%20Healthcare%20Cost.pdf

integration of medical and behavioral care.[56] Clinical effectiveness research also show that integrated care can improve depression and anxiety outcomes, patient quality of life, and satisfaction of care.[57]

In 2018, the General Assembly added new powers and duties to OHIC's charge to help address the behavioral health needs in our state. OHIC believes that behavioral health integration is a necessary strategy to fulfill the Office's legislative mandate. R.I.G.L 42-14.5-3 requires that OHIC "direct insurers toward policies and practices that address the behavioral health needs of the public and greater integration of physical and behavioral health care delivery." OHIC has made a priority of working with insurers, state agencies, and other stakeholders to improve the integration of physical, mental health, and unhealthy substance use care in the primary care setting.

The goal of the proposed amendments under § 4.10(C)(2) is to improve the efficiency, quality, and accessibility of behavioral health care in primary care settings. Primary care settings have become a gateway for many individuals with behavioral health care needs. In order to reach the goal of a well-integrated behavioral 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.

OHIC is working with insurers and other stakeholders to improve access to integrated behavioral health services. As a first step, OHIC sought to understand what administrative barriers existed to providing integrated behavioral health in the primary care setting. In May and June of 2018, Bailit Health interviewed individuals from six organizations selected by OHIC to identify any such administrative barriers. As a result of these interviews, and Bailit Health's review of CTC-RI's evaluation of its Integrated Behavioral Health Pilot program, OHIC identified several administrative barriers to behavioral health integration. In the 2019 Care Transformation Plan, OHIC established the Integrated Behavioral Health Work Group (Work Group) to identify potential solutions to these barriers.

In February 2019, OHIC convened the Work Group in order to identify potential solutions to the identified barriers to patient access to integrated services in primary care practices. A report was generated in August 2019 that provides a summary of the Work Group meetings and a set of recommendations to the Commissioner. In consideration of these recommendations, the Commissioner will require that health insurers take necessary actions to decrease administrative barriers to patient access to integrated services at qualifying practices. The work group identified three areas which the proposed amendments seek to address:

1. Financial barriers
2. Billing and coding policies
3. Out-of-pocket costs for Behavioral Health Screening

1. **Financial barriers**

[56] Melek SP et al., Potential economic impact of integrated medical-behavioral healthcare: Updated projections for 2017, 12 February 2018.

[57] Integrating Behavioral Health into Primary Care A Technology Assessment Final Report, June 2, 2015, Completed by: Institute for Clinical and Economic Review, https://icer-review.org/wp-content/uploads/2016/02/_BHI_Final_Report_060215.pdf.

The identified barrier was that some patients had refused services from behavioral health providers if they occurred on the same day as a primary care visit because it would trigger a copayment. In some instances, this would be the second copayment for a patient for what might be perceived as a continuation of the care the patient had been receiving at the primary care practice. The Work Group felt "payers should eliminate copayments for patients who have a behavioral health visit with a qualified in-network behavioral health provider on the same day and in the same location as a primary care visit at a qualifying primary care practice."

The Work Group felt this recommendation would remove the financial burden faced by patients receiving integrated behavioral health services on the same day as a primary care visit, and a barrier to integrated care. The Work Group also determined that practices should obtain some type of external recognition for behavioral health integration. The suggested implementation steps identified by the Work Group sought to make an immediate impact on patients receiving care from integrated practices, while also incentivizing more practices to work toward NCQA's Behavioral Health Distinction Program recognition and achieve evidence-based models of integration.

To identify which behavioral health providers are designated to waive copayments for qualified behavioral health visits, OHIC has added a limited set of questions regarding behavioral health integration to the OHIC annual PCMH survey. For 2019, the questions are for reporting purposes only and are as follows:

a. Has the practice received the NCQA Behavioral Health Distinction, or is the practice receiving facilitated assistance from a formal program designed to assist primary care practices in achieving the NCQA Behavioral Health Distinction?[58] *If yes, practice is eligible. Practices may only be designated eligible by virtue of receiving facilitated assistance for up to three years in order to encourage practices to work toward NCQA Behavioral Health Distinction.*

b. Does the practice currently, or did the practice participate in and successfully complete the CTC Integration Behavioral Health Program? *If yes, practice is eligible. Practices may only be designated eligible through this option for up to three years in order to encourage practices to work toward NCQA Behavioral Health Distinction.*

c. If option (a) or (b) are not applicable, has the practice completed a behavioral health integration self-assessment tool and developed an action plan for improving its level of integration? Self-assessment tools include, but are not limited to: Organizational Assessment Toolkit for Primary and Behavioral Health Care Integration, the PCBH Implementation Kit, and the Maine Health Access Foundation Site Self-Assessment. *If the practice has submitted an attestation indicating it has completed an assessment and developed an action plan, then the practice is eligible. Practices may only be designated eligible through this option for up to three years in order to encourage practices to work toward NCQA Behavioral Health Distinction.*

[58] Rhode Island Office of the Health Insurance Commissioner, Integrated Behavioral Health Work Group Final Report, August 7, 2019, available at: http://www.ohic.ri.gov/documents/August%202019/8-29/OHIC%20IBH%20 Work%20Group%20Final%20Report%202019%2008%2008.pdf. A formal program consists of a structured training or support program for primary care providers and/or behavioral health providers with a pre-defined curriculum and technical assistance and designed to systematically build the skills within the practice with a goal of pursuing and attaining NCQA Behavioral Health Distinction.

Practices must attest to having made demonstrable progress towards achieving NCQA Behavioral Health Distinction in their Year 2 and 3 attestations, if applicable.

The Commissioner will determine which practices are Qualifying Integrated Behavioral Health Primary Care Practices beginning in the fall of 2020 for health plan administration beginning January 1, 2021. The Commissioner will determine which practices are Qualifying Integrated Behavioral Health Primary Care Practices by November 30 of each calendar year. OHIC will communicate to the payers which practices are eligible to have their co-located behavioral health providers waive copayments for qualified behavioral health visits.[59] Practices may not qualify for waived copayments for qualified behavioral health visits that occur on the same day and in the same location using options (b) or (c) for more than three years in either option, or in total.

The codes that would be eligible to have no copayment are the most commonly used codes for behavioral health services integrated into the primary care setting identified by CTC-RI and approved by the Commissioner. The proposed amendments state:

"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 primary care practice as defined under § 4.3(A)(18)." Compliance with this requirement will be determined during the annual form review process.

2. **Billing and Coding Policies**

Health and Behavior Assessment/Intervention (HABI) codes are used for services that identify and manage the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health problems. These codes are used to reimburse behavioral health providers for providing behavioral health intervention techniques to help a patient manage a medical condition. The proposed amendments state:

"Health Insurers shall adopt policies for Health and Behavior Assessment/Intervention (HABI) codes that are no more restrictive than current CMS Coding Guidelines for HABI codes."

3. **Out-of-pocket costs for Behavioral Health Screening**

Primary care practices reported receiving complaints from patients with "surprise" coinsurance payments for behavioral health screenings conducted in the primary care setting. Work Group members noted that preventive services should be covered with no cost sharing requirements under the federal requirements. Specifically, Section 2713 of the Patient Protection and Affordable Care Act (ACA) requires insurers offering group or individual coverage to provide coverage for and not impose any cost sharing requirements for certain preventive health services, including developmental and behavioral health services, such as alcohol misuse screening and counseling, autism screening, developmental screenings, and surveillance, psychosocial / behavioral assessment and depression

[59] Rhode Island Office of the Health Insurance Commissioner, Integrated Behavioral Health Work Group Final Report, August 7, 2019, available at: http://www.ohic.ri.gov/documents/August%202019/8-29/OHIC%20IBH%20Work%20Group%20Final%20Report%202019%2008%2008.pdf. When a practice becomes eligible for same-day, same-location copayments to be waived, the behavioral health provider delivering the service is eligible regardless of whether the behavioral health provider is contracted or employed by or with the primary care practice.

screening.[60,61] In addition to the ACA requirements, the Work Group wanted to support the practice of universal screening of patients for common behavioral health conditions in the primary care setting (e.g., depression, anxiety, unhealthy substance use), because of the value and importance of screening. The Work Group also wanted to reduce the administrative burden of varying billing policies. The proposed amendments state:

"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 laws and regulations for preventive services."

For administrative simplification purposes, the Commissioner will issue interpretive guidance on strategies to align screening codes across health insurers and publish them, along with any supporting documentation, on the OHIC website.

The integration of behavioral health into primary care settings will need financial support beyond addressing the barriers described in parts 1 through 3 above. The Commissioner is requiring that health insurers propose strategies that will help support behavioral health integration. The proposed amendments state:

"The Health Insurers shall submit a report to the Commissioner no later than June 30, 2020 that delineates strategies, in addition to the requirements under § 4.10(D)(3)(c) ... to facilitate and support the integration of behavioral health care into the primary care setting."

The Commissioner will issue documentation no later than April 1, 2020 that includes specific questions for the health insurers to respond to and any additional requirements for the report. The Commissioner will consider the proposed strategies and issue guidance on approved criteria for improving the integration of the behavioral health care into primary care settings for health plan administration beginning January 1, 2021 and will post the completed reports on the OHIC website.

[60] 29 CFR § 2590.715-2713, The Patient Protection and Affordable Care Act, Sec 2713, Coverage of Preventive Services.
[61] Kaiser Family Foundation. "Preventive Services Covered by Private Health Plans under the Affordable Care Act." August 4, 2015, available at: https://www.kff.org/health-reform/fact-sheet/preventive-services-covered-by-private-health-plans/.

Other Proposed Amendments

The balance of the proposed amendments incorporates changes to the standards governing the aligned measure sets, modify definitions under § 4.3, and reflect revisions to grammar and form. The proposed amendments consolidate the former Care Transformation and Alternative Payment Methodology Advisory Committees into a single public body. This public body, the Payment and Care Delivery Advisory Committee, will comprise representatives from the organizations which have been vital to OHIC's policy development process. OHIC looks forward to continuing meaningful engagement with interested parties on this important work.

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Office of the Health Insurance Commissioner
1511 Pontiac Ave., Building 69-1
Cranston, RI 02920