PROPOSED AMENDMENTS TO 230-RICR-20-30-4

Regulatory & Cost-Benefit Analysis

Abstract

This regulatory and cost-benefit analysis of the proposed amendments to 230-RICR-20-30-4 is published pursuant to the Administrative Procedures Act, R.I. Gen. Laws 42-35-2.9 and Executive Order 15-07.

Office of the Health Insurance Commissioner

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Introduction

The Office of the Health Insurance Commissioner (OHIC) was created by the Rhode Island General Assembly in 2004. The agency is charged with protecting consumers, ensuring fair treatment of health care providers, guarding the solvency of insurers, and improving the health care system as a whole.[1] OHIC has played a leading role in efforts to improve the affordability and quality of health care in Rhode Island. 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."*

In light of pressing behavioral health needs of the public, during the 2018 session of the General Assembly, legislation was enacted modifying 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 to:

> *(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 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.

[1] See RIGL 42-14.5-2 http://webserver.rilin.state.ri.us/Statutes/TITLE42/42-14.5/42-14.5-2.HTM

Background of the Affordability Standards

The Affordability Standards were developed in 2008-9 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 ensure that total medical payments made to primary care are at least 10.7 percent of annual medical spend, with 9.7 percent 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 practice to function as a medical home and to successfully manage risk-bearing contracts, and to support the health information exchange.

Standard Two: Primary Care Practice Transformation

Requires that by 2019, 80 percent of insurers' contracts with primary care practices be with practices designated by OHIC as Patient-Centered Medical Homes (PCMHs).

Standard Three: Payment Reform

OHIC's payment reform strategy includes the following key components: promoting population-based contracting, adoption of alternative payment models, 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 percent 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 percent 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, alternative payment models 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, and Accountable Care Organization contracts.
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 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 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.

Summary of the Proposed Amendments

The proposed rule modifies the payment reform and primary care transformation provisions of the Affordability Standards and makes other non-technical changes to the regulation. 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 alternative payment models (APMs) with their provider networks;
2. Minimum standards for risk assumption under population-based total cost of care contracts;
3. The development and implementation of alternative payment models for primary care;
4. The development and implementation of alternative payment models for specialists;
5. Changes to the hospital rate regulation to address price disparities across hospitals.

The care transformation amendments are articulated in §4.10(C) of the regulation. The amendments embrace two substantive areas:

1. Incorporation of the existing insurer funding obligation for PCMHs;
2. Required insurer actions to reduce barriers to the integration of behavioral health into primary care. These actions touch on financial barriers to patient access, billing and coding policies, and out-of-pocket costs for behavioral health screenings.

Some of the proposed amendments codify existing policies and therefore do not generate marginal costs or benefits relative to the status quo. The proposed policies which reflect a departure from the status quo and fall within the scope of this analysis are listed in the left-hand column of Table 1. These policy changes are itemized as A. – E. and this is the order in which they will be discussed in the Cost-Benefit Analysis section below.

Table 1: Policy Changes Subject to Cost-Benefit Analysis

Changes Status Quo	Does Not Change Status Quo
A. Changes to the hospital rate regulation to address price disparities across hospitals. **B.** Minimum standards for risk assumption under population-based total cost of care contracts. **C.** The development and implementation of alternative payment models for primary care. **D.** The development and implementation of alternative payment models for specialists. **E.** Required insurer actions to reduce barriers to the integration of behavioral health into primary care.	• Insurer obligations with respect to the implementation of alternative payment models with their provider networks. • Incorporation of the existing insurer funding obligation for PCMHs.

Stakeholder Analysis

For this analysis we distinguish between two major stakeholder groups: 1. Private market purchasers of health insurance and health care services; and 2. Health care providers. Rhode Island residents represent the basic entities with standing in this analysis. Individuals assume multiple economic roles, depending on the activities in which they engage. For example, a single individual may be a consumer, health care worker, and tax payer. The proposed regulation influences costs and outcomes for Rhode Island residents who obtain insurance coverage through their employer or who purchase it directly from a Rhode Island insurer. The economic impacts of the proposed regulation are not confined to this group. Health care providers are

a significant stakeholder group whose interests will be affected by the proposed regulation. To the extent that economic impacts that accrue to providers are distributed to Rhode Island resident workers and owners of capital, the universe of individuals with standing will be broader than private market purchasers. It can be assumed that standing is co-extensive with the Rhode Island population.

The purchaser stakeholder group reflects Rhode Island's businesses, large and small, and government entities, which either purchase a group insurance product from one of Rhode Island's major health insurers, or which use one of the major health insurers as a third-party administrator. The purchaser group also includes non-group, individual market consumers. Table 2 lists the major subgroups of purchasers and their relative sizes. The figures reflect Rhode Island resident enrollment in April 2019. The Medicaid and Medicare markets may experience spillover effects, but those spillovers are not assessed due to their indeterminant character.

Table 2: Purchasers

Purchaser Group	Group Size
Insured – Individual Market	44,777
Insured – Small Group Market	41,779
Insured – Large Group Market	76,395
Self-Insured – Private Business	88,675
Self-Insured – State of Rhode Island	34,000
Self-Insured – Municipal Group Purchaser	69,000
Total	**354,626**

R.I. Gen. Laws §42-35-2.9 requires administrative agencies to conduct a regulatory analysis for proposed rules. The regulatory analysis must include an assessment of the benefits and costs of a "reasonable range of regulatory alternatives" reflecting the scope of the agency's discretion. The proposed amendments reflect the product of considerable research and stakeholder engagement by OHIC. Prior to drafting the proposed rule OHIC issued an Advance Notice of Proposed Rulemaking on May 9th. 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 ideas beyond the seventeen proposals for consideration. OHIC received public comments from fourteen entities. The comments are posted on the OHIC website. During the months of June through September OHIC staff reviewed the comments and drafted the proposed amendments.

Cost-Benefit Analysis

Introduction

The following analysis attempts to catalog and quantify the benefits, costs, and monetary transfers accruing to Rhode Island residents from the proposed amendments to 230-RICR-20-30-4. Each policy proposal is assessed in isolation, without consideration of feedback effects and other interactions between proposals.

A. Changes to the hospital rate regulation to address price disparities across hospitals.

Proposed Policy Change

§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. Eligibility for the one-time rate increase is based on whether the hospital's average case-mix adjusted inpatient discharge rate is less than the median among hospitals in the insurer's network. 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."

In order for eligible hospitals to retain the one-time increase they 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.

OHIC bears responsibility for guarding the consumer interest in affordable health insurance and high-quality care. OHIC believes that the final proposal, which ties eligibility for the one-time rate increase to the median, balances affordability with the need for some hospitals in Rhode Island to improve their financial standing.

Data and Methods

We estimate the impact of modifying the hospital rate regulation over a five-year period, 2020-2024. The analysis makes the following assumptions regarding implementation:

A.1. Regulation caps the annual hospital price increase at percentage changes in the CPI-U Less Food and Energy. In negotiations with insurers each eligible hospital is assumed to negotiate the maximum allowable price increase over the life of the contract in addition to the one-time rate adjustment authorized by the regulation.
A.2. Regulation requires that at least 50% of a hospital's annual rate increase be contingent on quality performance. All hospitals are assumed to meet contractual quality targets specified by the incentive program with the insurer and, by consequence, earn 100% of the quality component of the price increase.
A.3. All hospitals satisfy the quality performance targets for retention of the one-time rate adjustment described in §4.10(D)(6)(f)(1) of the proposed regulation.

Given these assumptions, the quantitative analysis presented below should be interpreted as an estimate of maximum impact.

The analysis also assumes some fixed parameters relating to the non-unit cost factors influencing inpatient spending and insurance market structure:

P.1 Utilization, service mix, and technology are held constant throughout the analysis period.
P.2 The size of the private commercial market is fixed over time.
P.3 The membership mix between insurers is fixed overtime.
P.4 The mix of insurance plan designs (and patient out of pocket burden) is fixed over time.[2]

In accordance with the proposed amendments only select hospitals will be eligible for a rate increase. To determine which hospitals may be eligible and to estimate the maximum rate increase for eligible hospitals we analyzed data from the 2012 Hospital Payment Study. The 2012 Study reported average commercial payment per inpatient stay, for each hospital, adjusted for case-mix. The present distribution of average reimbursement rates across Rhode Island's hospitals may differ from the 2012 Study. To avoid setting an expectation in future contract negotiations that certain hospitals are entitled to a given rate increase based on their identification in the analysis, we do not identify the hospitals or expected rate increases we employed in this analysis. This information will be provided confidentially to the Office of Regulatory Reform (ORR).

[2] Below we describe the methodology and data sources used to assess the impact of modifying the hospital rate regulation. For certain reasons described below, we chose to rely on 2015 claims data from the APCD, trended to 2018. Therefore, the insurance market structure parameters P.2 – P.4 will reference 2015. This assumption is not satisfying, but it is necessary due to the limitations in our data.

Commercial insurer payments to select hospitals for inpatient services form the basis of this part of the analysis. Claims are paid based on an allowed amount that represents the contractually negotiated payment amount for a service.[3] Hospital inpatient allowed claims were sourced from the Rhode Island All Payer Claims Database (APCD) for the four major commercial insurers: Blue Cross Blue Shield of Rhode Island, Neighborhood Health Plan of Rhode Island, Tufts Health Plan, and UnitedHealthcare.

Ideally, we would use the most recent complete year of claims data (2018) to project claims costs through the time horizon of the analysis.[4] Unfortunately, the APCD is missing a significant percentage of claims for Rhode Islanders whose insurance is self-funded by an employer. The missing data is due to the effects of the Supreme Court's ruling in Gobeille v. Liberty Mutual in March 2016. The Gobeille decision held that self-funded employers could not be compelled to submit their claims data under state APCD statutes.[5] As a result, some third-party administrators have ceased reporting claims data for self-insured groups to the APCD. This has resulted in a drop of about 88,192 enrollees from the APCD.[6]

Three methods to overcome the missing data issue were considered. Ultimately, we decided to rely on 2015 claims data, which is the most recent complete year prior to the Gobeille decision, and project those claims to our base year (2018) at an annual rate of 3%. The 3% is treated as price inflation, while other factors influencing total claims, such as utilization and shifts in service mix, are assumed to remain constant over the projection period.

Forecasts of the Consumer Price Index for all Urban Consumers (CPI-U) Less Food and Energy were obtained from Moody's Analytics through 2024. Price inflation factors for 2019 and 2020 are the actual rate caps established by OHIC for those years. The Moody's forecasts supply the price inflation factors for 2021 – 2024.

Limitations

This analysis faces key limitations which create uncertainty around the estimates of impact presented below. The principal limitations of this analysis are as follows:

1. The analysis assumes that all insurer contracts with hospitals incorporate the terms of the modified rule on January 1, 2020. In reality, the timing of contract renewals may spread the one-time rate adjustments across the five-year period. We chose to model the impact in the first year as a way of estimating maximum impact. To the extent that the one-time rate adjustments are carried out in years two through five of our analysis period, the overall impact will be less due to a shorter period.

2. To the extent that any of the assumptions or fixed parameters stated above are invalid, the estimates of impact presented below will be less valid.

[3] The allowed amount may differ from what is paid by the insurer to the hospital depending on whether or not the patient bears some financial responsibility for payment of a portion of this contractual allowance. For example, if a patient experiences an inpatient stay and the contractual allowance is $2,000, and the patient has a $500 unmet deductible, then the allowance is $2,000 but the amount paid by the health insurer to the hospital is $1,500 and the amount paid to the hospital by the patient is $500. Given the focus on contractual allowance in our data, consumer out of pocket costs (such as deductibles, copayments, and coinsurance) are not exclusively examined. These cost shares are embedded in the contractual allowance. This is a limitation of the analysis because providers occasionally do not collect the consumer out of pocket cost shares and write these off as unpaid bad debts. Still, allowed claims represent the total payment for the service.

[4] This analysis employs a five-year time horizon 2020 – 2024. The base year for our hospital claims analysis is 2018. 2018 is the most recent year of complete claims. 2018 claims are projected into 2019, then 2019 claims are projected into the period 2020 – 2024.

[5] "The Consequences Of Gobeille v. Liberty Mutual For Health Care Cost Control, " Health Affairs Blog, March 10, 2016. DOI: 10.1377/hblog20160310.053837

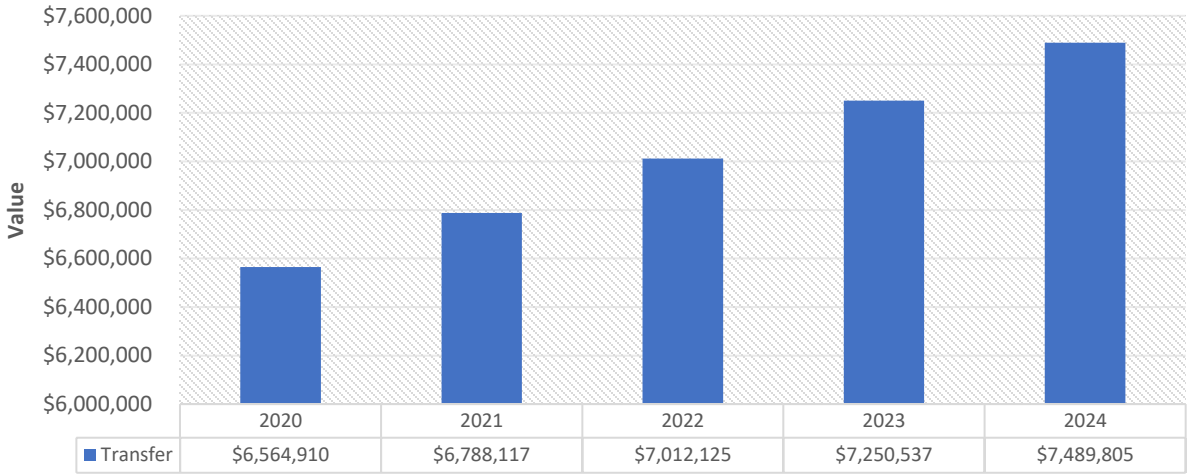
[6] This figure was computed by researchers at the Brown University School of Public Health as part of their analysis of health care cost drivers and presented at a conference on May 14th, 2019.

Schedule of Benefits, Costs and Transfers

The impact of the one-time rate increase is considered to be a monetary transfer from purchasers of inpatient services to providers of those services. A monetary transfer does not reflect an increase or decrease of real economic resources available to society. In the context of this analysis, dollars are transferred from the purchasers of services to providers and ultimately distributed to labor and capital in the form of wages and rents.[7] The transfer will occur through increased patient service revenue for providers funded by increases in claims costs and out-of-pocket expenses for insured groups and their members. Fully insured premiums will increase due to the increase in claims costs, all else equal. Self-insured groups, which do not have premiums, will experience an increase in claims costs. The fiscal impact on government purchasers, such as the state employee and municipal group purchasing entities, have been estimated and included on fiscal notes submitted to ORR.

The proposed one-time rate adjustment is estimated to yield a total transfer from purchasers to hospitals of **$ 35,105,493** over the five-year period 2020 – 2024, other things equal. **Figure 1** shows the annual transfer schedule. This translates into an annual transfer of $18.51 per member in year one, which increases to $21.12 per member by year five.

Figure 1:
Transfer Schedule



	2020	2021	2022	2023	2024
Transfer	$6,564,910	$6,788,117	$7,012,125	$7,250,537	$7,489,805

The regulation identifies benchmarks for three quality measures hospitals must satisfy in order to retain the one-time rate increase. These benchmarks, which reflect two hospital acquired infection measures and hospital wide readmissions, measure important dimensions of hospital quality. To the extent that hospitals improve their performance, or maintain high performance relative to their peers nationally, the policy may support hospitals' ability to avoid Medicare fee schedule reductions under the Hospital Value-Based Purchasing program. Given that standing in this analysis is coextensive with Rhode Island's population, any federal Medicare dollars accruing to hospitals from improved performance, discounted by Rhode Island's percentage contribution to the Medicare budget, would constitute a benefit. Furthermore, any reductions in Clostridium difficile (C. diff) intestinal infections, Central line-associated bloodstream infections (CLABSI), and the rate of readmission after discharge from hospital (hospital-wide) would

[7] This is an overly simplistic view. In fact, for some for-profit entities some of these dollars may be distributed to shareholders and ownership in other states. This would likely constitute a cost from the RI perspective.

constitute benefits in the form resource savings. We describe these savings as benefits, instead of transfers, because these outcomes and associated treatment should be avoidable.

In 2016, The Agency for Healthcare Research and Quality (AHRQ) estimated the average cost of a readmission to be $14,400.[8] If readmissions are decreased by 100 compared to the baseline rate, this will generate $1.44 million in savings. Reductions in hospital acquired infections will likewise reduce total costs within episodes of care. Furthermore, health is a form of human capital, and as such, any increases in the health of the population due to improved clinical quality reflect an increase in resources available to society and are appropriate to record as benefits.

Beyond the potential impacts on quality, the proposed one-time rate adjustment may improve the financial standing of some hospitals and ensure competition in the market.

Alternative 1: OHIC considered alternatives to the final proposal articulated above, including granting hospitals below a defined threshold of the rate distribution the benefit of a higher rate cap. A higher rate cap would not guarantee the opportunity for higher reimbursement rates because the rate cap is merely an upper bound on annual price inflation, which is subject to negotiation within the rate cap. It is not a guarantee of price inflation equivalent to the rate cap. As such, there is a meaningful risk that this methodology would be ineffective in achieving the intended outcome at a lower cost than the proposed.

Alternative 2: Another alternative was proposed by CharterCARE Health Partners in responses to the Advance Notice of Proposed Rulemaking. CharterCARE proposed establishing a rate floor for hospitals reimbursed at less than 90% of the average commercial payments to all Rhode Island acute care hospitals for inpatient and outpatient services. While OHIC's final proposal applies solely to inpatient services, thus departing from CharterCARE's proposal, OHIC did consider 90% of the statewide average as a potential threshold for eligibility. Based on data from the 2012 hospital payment study, adoption of 90% of the average as the relevant benchmark for eligibility would generate a higher rate increase across hospitals and confer eligibility to all but three of the state's hospitals. This is due to the sensitivity of the average to the highest reimbursed hospitals: Women & Infants, Kent, and Rhode Island Hospital. As such, using a mean approach is an unreliable metric to determine the true difference in reimbursement rates between a given hospital and its statewide counterparts. Furthermore, this methodology would have led to rate increases for more hospitals than necessary under the presumption that the proposed rule is to help some hospitals catch up rather than increase rates for most hospitals. Therefore, this alternative would have ineffectively balanced the need of affordability for Rhode Island residents with improving the financial standing of the lowest reimbursed hospitals.

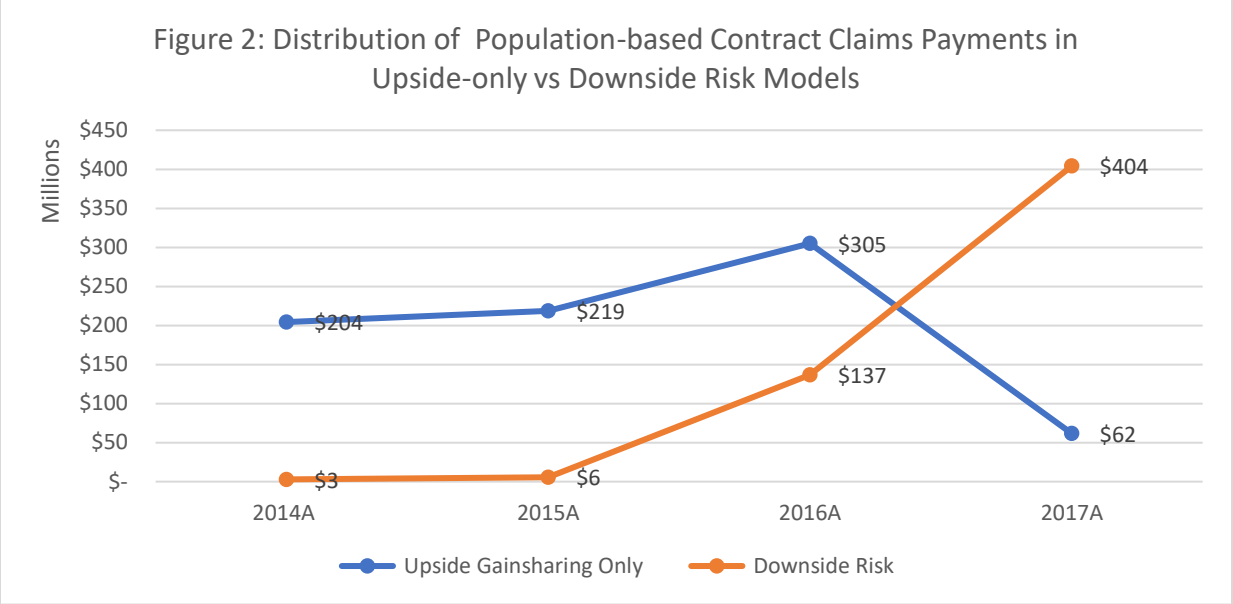
B. Minimum standards for risk assumption under population-based total cost of care contracts.

Population-based contracts, in which the provider assumes accountability for the clinical quality and total cost of care of an attributed population, accounted for over 90% of commercial APM payments in Rhode Island in 2018. Providers have organized as Accountable Care Organizations (ACOs) to manage patients under these contracts. Research has demonstrated that risk-based contracting has generated savings for commercially insured populations. A recent paper in *The New England Journal of Medicine* evaluated the performance of the Blue Cross Blue Shield of Massachusetts (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.[9]

[8] See https://hcup-us.ahrq.gov/reports/statbriefs/sb248-Hospital-Readmissions-2010-2016.jsp

[9] 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

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 fully insured[10] member claims were subject to downside risk incentives, while only $62 million were subject to upside gainsharing only (see **Figure 2**[11]).



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 should have been expected since many of the contracts reviewed reflected first efforts to develop population-based contracts in the local market. In 2017, OHIC established minimum downside risk standards for population-based contracts in an effort to nudge health systems toward levels of risk assumption 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, reflect low initial levels of risk assumption.

§4.10(D)(2) of the proposed rule 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 distinguished two types of ACOs: 1. ACOs which include hospital systems and 2. Physician-group based ACOs. This binary typology was developed in concert with the Alternative Payment Methodology Advisory Committee in 2017 and is based on the different financial capacities of provider organizations to cover losses in comparison 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.

Tables 3 and **4** present the downside risk requirements for ACOs which include hospital systems and physician group-based ACOs, respectively.

[10] OHIC tracks medical payments made under an APM for the fully insured population. Health insurers also include their self-insured clients on APM contracts with providers. We do not have data on self-insured member medical payments under APMs but expect the proportion of member claims under APMs to mirror the fully insured experience.

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

Table 3. Minimum Downside Risk Standards for ACOs Including Hospital Systems[12]

10,000-20,000 lives	2020 requirement	2021+ requirement
Risk exposure cap[13]	At least 5%	At least 6%
Minimum loss rate[14]	No more than 3%	No more than 3%
Risk sharing rate[15]	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%

Table 4: 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%

The discussion above shows that providers have begun to operate under risk-based contracts. The purpose of the proposed regulations is to increase level of risk in these contracts in order to generate outcomes similar to those observed in Massachusetts under the AQC. Lack of information of specific contract arrangements and baseline costs for the attributed member populations for each ACO precludes an in-depth analysis of this provision of the proposed rule. What follows is a discussion of categories of costs and benefits which may accrue from this proposal.

[12] A hospital-based ACO has ownership held in whole or in part by one or more hospitals.
[13] **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.
[14] **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.
[15] **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.

Costs: The principal effect of this proposal is to increase the amount of financial risk being borne by ACOs under population-based contracts. As previously noted, many ACOs in Rhode Island are already assuming risk. The costs which we may expect to materialize due to a marginal increase in risk exposure are as follows:

- Marginal costs associated with population health management, inclusive of expanded care teams, care management resources, data analytic staff and infrastructure needed to promote performance to avoid financial losses. ACOs fund these activities through contractual per member per month (PMPM) support payments from health insurers, patient service revenues, and reinvestment of incentive payments such as shared savings. Only marginal costs above what ACOs are currently investing would count as a cost in this analysis. For example, if the ACO is presently investing $5 PMPM for a total attributed population of 50,000 patients, then the baseline cost is $3 million. If the ACO assumes increased financial risk as a result of this regulation and invests an additional $1 PMPM to support population health management, then the marginal cost is $600,000.
- Marginal costs associated with risk management strategies; such as reserving, provider withholds, or purchase of stop loss coverage are another cost, etc. Risk management strategies are employed to protect the financial viability of the provider in the event that losses accrue under the contract. We assume that the provider will employ some combination of strategies to cover the potential maximum loss under their risk-based contracts. Marginal cost associated with the proposed policy would involve any combination of increased financial reserves, increased withhold percentages, and increasing stop loss coverage, just to name a few. In the case of increasing reserves to cover potential maximum losses, the opportunity cost of the marginal contribution to reserves would comprise a cost. If our hypothetical ACO with 50,000 attributed patients assumes incremental net risk of 1% of the total cost of care (assuming a $400 PMPM target) the potential incremental maximum loss would be $2.4 million.
- Taken together, this hypothetical example places the total cost at $3 million. This exercise was provided for purely descriptive purposes.

Benefits: The purpose of risk-based contracting is to incentivize providers to reduce waste in the health care system. The principal benefit accruing from this policy change is cost savings. Cost savings may accrue from the following sources:

- Due to the reduction of avoidable or unnecessary services. These services include low-value care, ambulatory care sensitive emergency department visits and inpatient admissions, hospital readmissions.
- Due to more cost-effective referrals and use of imaging and lab services.
- Savings may also accrue from improve provision of preventive care.

Alternative: The proposal described above relies on an existing minimum downside risk framework that is built in to the status quo and which took a considerable amount of time to develop with stakeholders in recent years. The framework distinguishes between two types of ACOs and identifies three common parameters of risk-based contracting. The range of alternative approaches necessary to consider in this analysis therefore centers on the numerical values attached to the three common parameters of risk-based contracting. OHIC could have established more aggressive standards, such as higher minimum risk exposure caps and risk sharing rates. However, in consideration of provider concerns over risk assumption that have been articulated in various forums, OHIC decided not to propose more aggressive standards. More aggressive risk standards may have exposed providers to levels of risk which they are not yet capable of managing. Less aggressive risk standards might have been ineffectual in achieving savings since they would have been less binding for providers, mitigating any incentive to change behavior. As such, the proposed minimum downside risk standards strike a balance between the financial exposure of providers and the need for cost reduction. Moreover, the proposed standards do not apply to risk-based contracts with fewer than 10,000 attributed members and do not preclude contracts with greater degrees of risk

assumption, such as global capitation. Therefore, health insurers and providers retain a high degree of latitude to negotiate risk-based contracting terms.

C. The development and implementation of alternative payment models for primary care.

The proposed amendments require health insurers to 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 percent of insured Rhode Island resident covered lives shall be attributed.
January 1, 2022	At least 40 percent of insured Rhode Island resident covered lives shall be attributed.
January 1, 2023	At least 60 percent of insured Rhode Island resident covered lives shall be attributed.

Researchers at Harvard University have found through simulation 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.[16] This analysis informed the selection annual targets because primary care APMs are meant to promote clinical transformations in primary care. Attributed members are admittedly different than payments, but there should be a close correlation between percent of members attributed to a given payment models and percent of payment made under that model.

As a form of primary care APM, primary care capitation has proven effective in producing cost savings 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 saw a $17.11 PMPM reduction in total cost of care in 2014, or $20.7 million in annual savings.[17]

[16] 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

[17] 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. 19.6M of savings from 2012-2015. Over the same period, performance on quality measures improved at higher rates than non-participating practices. See Capital District Physicians' Health Plan. Enhanced Primary Care Initiative. www.cdphp.com/-/media/files/providers/epc/enhanced-primary-care-summary.pdf?la=en. Also 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.

Table 6: 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 Accountable Care Organizations (ACOs) to improve total cost of care 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.

Capitation essentially reconfigures existing fee-for-service payments into a prospective payment. Capitation can be implemented without necessarily increasing spending. Given that the proposed regulation grants significant discretion to health insurers to design their primary care APM it will be difficult to conduct an informed analysis of costs and benefits. A narrative description of potential costs and benefits are described below.

Costs: The development and implementation of primary care APMs will likely generate increased operational costs for insurers and providers as they adjust to the new payment model.

Benefits: As the experience of CDPHP shows, primary care APMs, notably capitation, can be associated with cost savings. Given multiple concurrent payment reforms in the market, include risk-based contracting linked to total cost of care, it can be challenging to disentangle outcomes. This will be particularly true when primary care APMs are nested within total cost of care contracts. Beyond the potential for cost savings, primary care APMs can generate substantial benefits in the form of time savings for patients and improved access to care. Capitation confers greater flexibility on providers to allocate practice resources across their patient panels. Under fee-for-service payments, providers are held to time-based visits as the basic unit care delivery and reimbursement. Capitation allows providers to spend more time with high risk patients and employ alternative treatment modalities, like e-visits, for healthier patients. Patients may not need to travel to the provider's office and wait in the lobby. Substantial time savings can accrue from this innovation. Finally, under capitation, revenue maximization is no longer a function of the number of office visits. Instead, providers will increase their revenue by growing their patient panels. The opening of practice panels may alleviate access issues for patients who do not currently have a primary care provider.

Alternative 1: Alternatives to the final proposal were considered. One approach would have been for OHIC to mandate the development of a specific payment model and to prescribe the components of that model. Instead, OHIC has proposed a policy which reserves flexibility for health insurers and providers to develop prospectively paid models which satisfy the intent of the regulation but are not required to follow a prescribed approach.

Alternative 2: Another alternative to the proposed policy would have been to require network-wide adoption of primary care APMs. Instead, OHIC has established a target schedule which promotes adoption of primary care APMs at levels less than network-wide adoption. It will take time to transition systems and contracts to handle increased usage of primary care APMs and mandating a network-wide adoption may have been too aggressive given the lack of insurer and provider experience managing prospective payment in Rhode Island. While the proposed rule does include a ramp-up, the multi-year timeline ensures that network

members will have sufficient time to work towards the ultimate goal at a feasible pace, balancing the need for lower health care costs without putting unnecessary burden on network members.

D. The development and implementation of alternative payment models for specialists.

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 alternative payment model contracts, and/or expand existing alternative payment model contracts with clinical professionals in the following specialties:

(1) Orthopedics;

(2) Gastroenterology;

(3) Cardiology;

(4) Behavioral health;

(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.

For the same reasons discussed in the assessment of risk-based contracting standards and primary care APMs, the costs and benefits of this proposal is difficult to assess with precision. 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 is exist opportunities to achieve cost savings by improving provider performance and closing variation in outcomes. **Table 7** below was provided by Altarum and shows the potential savings from ten 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 $50 million could be saved.

Table 7: Savings Opportunity Across Select Episodes of Care

	High Performing Providers			All Other Providers			Total Savings/Reduction	
	Number of Providers	Total $	PAC Rate	Number of Providers	Total $	PAC Rate	Total $	PAC Rate
Commercial							**$ 48,748,764**	
Gall Bladder Surgery	4	$ 10,267	29%	10	$ 11,877	37%	$ 1,193,394	-21%
Knee Replacement	3	$ 27,674	19%	7	$ 31,172	26%	$ 2,441,710	-26%
Hysterectomy	1	$ 9,619	23%	8	$ 15,326	48%	$ 3,652,501	-52%
Vaginal Delivery	2	$ 9,312	26%	10	$ 11,276	34%	$ 5,585,549	-25%
Asthma	62	$ 1,641	22%	83	$ 2,367	35%	$ 3,373,150	-36%
CAD	10	$ 2,908	23%	16	$ 5,121	34%	$ 1,387,714	-32%
Hypertension	216	$ 1,283	18%	279	$ 1,819	28%	$ 13,082,991	-35%
GERD	98	$ 1,237	11%	117	$ 1,894	20%	$ 5,479,886	-44%
Low Back Pain	60	$ 1,083	13%	94	$ 2,128	20%	$ 4,777,613	-37%
Diabetes	62	$ 4,035	36%	95	$ 5,780	53%	$ 7,774,256	-32%

APMs for specialists can generate benefits in the form of cost savings and reduction in potentially avoidable complications. It should be noted that the episodes of care listed in **Table 7** comprise a mix of procedural-based episodes and chronic conditions. In general, the specialist APMs most likely to be implemented will

be procedural-based, such as knee replacement or gall bladder surgery. The management of chronic conditions, such as asthma and diabetes, are generally left to ACOs and present cost savings more likely to be obtain under population-based contracts.

E. Required insurer actions to reduce barriers to the integration of behavioral health into primary care.

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 more efficient use of health care resources that will encourage providers to coordinate the behavioral and physical health needs of their patient populations. 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 substance use and mental health disorders, compared to residents of other states.[18] For example, in Commonwealth Fund's 2019 health ranking, Rhode Island ranked #41 in drug poisoning deaths.[19] 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%.[20] Individuals in Rhode Island Medicaid's Accountable Entity Program with a complex behavioral health diagnosis had per member per month (PMPM) costs that were nine times higher than those without a behavioral health diagnosis.[21] 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. A recent Milliman report estimates that 9% to 17% of this total additional spending across all payers may be saved through effective integration of medical and behavioral care.[22] Clinical effectiveness research also show that integrated care can improve depression and anxiety outcomes, patient quality of life, and satisfaction of care.[23]

Rhode Island spends more on direct and indirect behavioral health care than most other states. Overall, Rhode Island devoted $853 million to behavioral health treatment in 2013, which was approximately 1.6% of its gross state product, significantly above the national average of 1.2%.[24] Individuals in Rhode Island are more likely to report unmet need for behavioral health care services than adults in any other New England State: [25]

[18]Rhode Island Behavioral Health Project: Final Report, Truven Health Analytics, September 15, 2015. http://www.bhddh.ri.gov/mh/truven.php

[19] Commonwealth Fund Scorecard on State Health System Performance, 2019. https://scorecard.commonwealthfund.org/files/Rhode_Island.pdf

[20] 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-barometer volume5-sma19-baro-17-us.pdf.

[21] AE Advisory Committee, 2019. Complex BH diagnosis is defined as those with serious and persistent mental illness or enrollees in IHH, ACT and Opioid Health Home. Non-complex is defined as any BH diagnosis excluding those defined in complex. Includes ICD-10 F01-F99.

[22] Melek SP et al., Potential economic impact of integrated medical-behavioral healthcare: Updated projections for 2017, 12 February 2018. https://www.milliman.com/uploadedFiles/insight/2018/Potential-Economic-Impact-Integrated-Healthcare.pdf

[23] Integrating Behavioral Health into Primary Care, ICER Institute for Clinical and Economic Review, Final Report June 2, 2015. https://icer-review.org/wp-content/uploads/2016/02/BHI_Final_Report_060215.pdf

[24] Rhode Island Behavioral Health Project: Final Report, Truven Health Analytics, September 15, 2015. http://www.bhddh.ri.gov/mh/truven.php

[25] Ibid.

- Rhode Island adults die more frequently from narcotics overdose than adults in other New England states;

- Rhode Island is spending more in total on behavioral health care services primarily because of relatively greater expenditures on inpatient care and prescription medications;

- Adults in Rhode Island had the highest rate of psychiatric general hospital admissions among New England states and nationally; and

- One in five Rhode Island Medicaid beneficiaries hospitalized for a mental illness had no follow-up mental health treatment 30 days after discharge.[26]

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 and proper 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.

Proposed Policy Changes

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. In order to reach the goal of a well-integrated 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, on behalf of OHIC, 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 its 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 aforementioned 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 types of administrative barriers which the proposed amendments seek to address:

1. Financial barriers

2. Billing and coding policies

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

Data and Methods

We estimate the impact of the proposed policy changes over a five-year period, 2020-2024. The analysis makes the following assumptions regarding implementation:

[26] Ibid.

E.1. OHIC's regulations apply only to fully-insured commercial members, so the costs and benefits are estimated for this market segment only. Given this assumption, the quantitative analysis presented below should be interpreted as an estimate of maximum impact to the fully insured market only. There may be some spillover effects to other markets, i.e. the self-insured, but those costs and benefits are not reflected in this analysis.

E.2. APCD data represents claims for the time period 10/1/2017–9/30/2018 ("study period"). The five-year estimates below assume that this data is similar to the claims data that will be submitted in years 2020–2024.

E.3. This analysis assumes all fully-insured data is complete and accurately represented in the APCD.

E.4. In order to develop a cost estimate for IBH organizational costs, this analysis assumes that practices are not yet integrated. Given that some practices are already integrated, our calculations will overestimate these startup costs.

Limitations:

- This analysis relies, in part, on enrollment data reported to OHIC by health insurers in 2019 and includes RI residents and RI business entities only. The APCD includes data from non-RI based companies for the time period 10/1/2017–9/30/2018. The APCD also allows individuals to opt-out of the system. Therefore, the calculations made comparing these two data sources will be approximations only.
- The evidence used in this analysis is primarily drawn from the Collaborative Care Model (CCM). RI primary care practices may utilize other models of IBH care. The variance in model type may yield costs and benefits that are different than the CCM evidence suggests.
- The APCD data for behavioral health (BH) screening used in this analysis is based only on CPT code 96127. If providers used other codes, those claims would not be captured in the data below and our calculations would overestimate the increase in costs.

Schedule of Benefits, Costs and Transfers - Overall Cost Savings from Integrating Behavioral Health (IBH) into Primary Care:

Milliman estimated that the portion of the elevated healthcare costs for patients with both medical and behavioral health care needs that may be controlled and impacted through IBH programs. Milliman estimated that $19.3–$38.6 billion could be saved by commercial payers nationally each year through effective integration of medical and behavioral services.[27] These projected healthcare cost savings represent 16%–28% of all spending for MH/SUD services. This is a significant opportunity that will likely continue to increase as medical costs increase, IBH programs become more effective, and more people in the country develop comorbid medical and behavioral disorders.

Using these national savings estimates and RI insurer enrollment data, RI payers could see estimated savings totaling $61.0–$106.8 million from investments in IBH over the five-year period. Among privately-insured state residents, health plans spent $76.3 million—an average of $468 annually per enrollee—for behavioral health disorders.[28]

[27] The total national expenditures for mental health and substance use services was estimated to be about $240 billion in 2017. Melek SP et al., Potential economic impact of integrated medical-behavioral healthcare: Updated projections for 2017, 12 February 2018. https://www.milliman.com/uploadedFiles/insight/2018/Potential-Economic-Impact-Integrated-Healthcare.pdf

[28] Rhode Island Behavioral Health Project: Final Report, Truven Health Analytics, September 15, 2015. http://www.bhddh.ri.gov/mh/truven.php

However, economic studies have shown with consistency that IBH increases organizational costs, at least in the short term.[29] A budget analysis study on Massachusetts Medicaid expenditures showed that the investment in IBH ranges from 0.3%-2.1% of annual expenditures depending on the underlying prevalence of depression.[30] Based on these estimates, RI providers would need to invest $1.1**–**$8.0 million over the five-year period, depending on the prevalence of depression in the IBH practices. **After accounting for the upfront organizational costs of integration, the potential five-year savings of IBH ranges from $53.0–$105.6 million (Table 8).**

Table 8: Estimated Savings from IBH Net of Organizational Costs

	ICER estimates of organizational costs	Milliman estimates for potential savings with IBH	
		16%	28%
Overall 5-year savings for IBH*		$ 61,008,854	$ 106,765,495
IBH savings minus organizational costs	**0.3%**	$ 59,864,938	$ 105,621,579
	2.1%	$ 53,001,442	$ 98,758,083

*based on average annual cost for BH services in RI @ $468 per fully-insured member

1) Financial barriers.

A) Under the proposed regulation health insurers shall eliminate copayments for patients who have a behavioral health visit with an in-network behavioral health provider on the same day and in the same location as a primary care visit at a "Qualifying Integrated Behavioral Health Primary Care Practice" (see "B" below) as defined in § 4.3(A)(18).

Costs: Payers submitted data during the IBH Work Group process indicating that 2%–6% of primary care patients had a behavioral health visit that same day. The providers in attendance agreed that these percentages reasonably reflected their experiences. The CDC estimates that nationally, 61.4% of the population has a primary care visit each year.[31] To give a conservative cost estimate, we assumed that 6% of fully-insured patients who had an annual primary care visit also had a behavioral health visit. Across payers, copays range from $0-$100 depending on the line of business. **Using two levels of copays ($10 and $25), waiving a same day behavioral health copay is estimated to cost commercial payers $300K–$750K over the five-year period.**

B) The Commissioner will determine which practices are "Qualifying Integrated Behavioral Health Primary Care Practices" beginning in the fall of 2020 for health insurer administration beginning January 1, 2021, and by November 30 of each calendar year thereafter. 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.[32]

[29] Integrating Behavioral Health into Primary Care, ICER Institute for Clinical and Economic Review, Final Report June 2, 2015. https://icer-review.org/wp-content/uploads/2016/02/BHI_Final_Report_060215.pdf
[30] Ibid.
[31] Centers for Disease Control, CDC/National Center for Health Statistics, https://www.cdc.gov/nchs/products/databriefs/db234.htm
[32] 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-

Costs: The initial cost to apply for the NCQA Behavioral Health Distinction (NBHD) is $500 per practice, then $150 per year to maintain the certification. As of this writing, there is only one practice in RI that has achieved the certification. To help promote behavioral health integration, OHIC is providing practices with alternative pathways to qualify as IBH practices for up to three years. Because these alternate pathways exist and due to the fact that the application process is burdensome and expensive, we are assuming that practices will be fairly slow to pursue the NBHD. There are approximately 152 PCMHs in RI who are familiar with NCQA's processes and we estimate a majority of them will apply for the NBHD by 2024. We assume that there will be an increase in the number of applications in year 4 when the alternate means of achieving "Qualifying Integrated Behavioral Health Primary Care Practices" expire. **The total cost to practices over 5 years is estimated to be approximately $54.0K (Table 9).**

Table 9: Practice Certification Costs

Year	Annual # Practices Seeking NCQA Certification	NCQA Fees		Total costs
		Initial ($500)	Annual ($150)	
1 (2021)	5	$2,500	$0	$2,500
2 (2022)	10	$5,000	$750	$5,750
3 (2023)	25	$12,500	$2250	$14,750
4 (2024)	50	$25,000	$6000	$31,000
Totals	**90**	**$45,000**	**$9000**	**$54,000**

Benefits: Eliminating the second copay for same day medical and behavioral health services in the same location eases the financial burden faced by patients receiving integrated behavioral health services. By removing this barrier to integrated care, patients are more likely to seek timely behavioral health care that will save money in the long-term through improved patient outcomes.

2) Billing and Coding Policies. Under the proposed regulation health insurers shall adopt policies for Health and Behavior Assessment/Intervention (HABI) codes that are no more restrictive than current Centers for Medicare and Medicaid Services (CMS) Coding Guidelines for HABI codes.

HABI codes (96150-96154) 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. For example, these codes could support a behavioral health provider in teaching coping skills to a group of patients with diabetes, or to use behavioral health techniques to support a patient newly diagnosed with a chronic medical condition. These codes are not designed to treat behavioral health conditions as the primary diagnosis. Information collected for the IBH Work Group showed that there was variation in use of the HABI codes among integrated primary care practices, and variation in HABI code payer reimbursement policies.

Costs: There were only 714 total HABI claims in the APCD during the study period. During the Workgroup meetings, several practice representatives stated that they do not currently bill for HABI codes. The primary reasons given were: 1) that payer policies were overly complex and that pursuing payments for HABI services was not worth the time needed to submit the claims; and 2) since some payers do not reimburse

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.

for HABI codes, providers did not want to treat patients differently because of their insurance carrier. Therefore, there is reason to believe that the APCD data does not accurately represent the frequency of HABI services rendered. There are no published estimates of how many patients could potentially benefit from HABI code-related services. For this section, we assumed that 1% of people who had a preventive visit might possibly benefit from these services as a conservative estimate, using the average of the CMS rates currently paid for the five HABI codes.[33] Across the four major payers, this could cost an estimated **$460K over the five-year period.**

Benefits: Uniform HABI reimbursement policies across payers will benefit providers by allowing them to be reimbursed for services they are currently rendering. Patients will also benefit if this barrier to integrated care is removed because they will have greater access to behavioral health services. Greater access to timely behavioral health services will save money in the long-term through improved patient outcomes.

3) Out-of-pocket costs for Behavioral Health Screening. Health insurers shall adopt policies for the most common preventive behavioral health screenings in primary care that are no more restrictive than current applicable federal law and regulations for preventive services. For administrative simplification purposes, the Commissioner 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.

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 screening.[34] CPT code 96127 was created as part of the ACA's federal mandate to include mental health services as part of the essential health benefits package now required in all insurance plans.

Table 2 above shows that in 2019, there were 162,951 people in the fully-insured market and 191,675 in the self-insured market. As previously described on page 7, the Gobeille decision resulted in a loss of 89,000 enrollees from the APCD. Therefore, we adjusted the APCD claims data to reflect only the fully-insured segment of the market.[35] We estimated that approximately 28.7% of the claims in the APCD were from self-insured and adjusted the total claims for code 96127 accordingly, as seen in Table 9 below. Using the average CMS rate for this code, the cost of behavioral health screenings during the study period was approximately $153K.[36] **If all fully-insured patients are screened at their preventive visits, code 96127 claims would be an estimated $ 1.94 million dollars higher over the five-year period.**

[33] Centers for Medicare and Medicaid Services (CMS) Physician Fee Schedule, https://www.cms.gov/apps/physician-fee-schedule/overview.aspx

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

[35] Cost Trends Work Group numbers were used to estimate the number of self-insureds still in APCD during the study period. This figure was computed by researchers at the Brown University School of Public Health as part of their analysis of health care cost drivers and presented at a conference on May 14th, 2019.

[36] Centers for Medicare and Medicaid Services (CMS) Physician Fee Schedule, https://www.cms.gov/apps/physician-fee-schedule/overview.aspx

Table 10

Total 96127 Claims in APCD[a]	96127 Claims (Fully-Insured Only)	Average CMS Rate	Total $ For 96127 Claims in APCD[b]	Total Annual $ For BH Screening[c]	5-Year Cost for BH Screening[d]
46,056	**28,345**	**$ 5.41**	**$ 153,345**	**$ 541,281**	**$ 1,939,678**

[a] This total includes all submitted claims (fully-insured and self-insured) during the study period.

[b] This estimates the cost for fully-insured members' claims.

[c] According to the CDC, approximately 61.4% of people in U.S. have an annual preventive exam. [37] Estimate is for the cost of one annual screen (i.e. depression, anxiety, SUD) per person at their annual preventive visit.[38]

[d] The 5-year cost estimate includes the increased cost of screening everyone at their annual exam by subtracting the cost of those currently being screened as reported in the APCD database.

Summary

Rhode Islanders are disproportionately affected by substance use and mental health disorders, compared to residents of other states.[39] These projected health care cost savings represent 16%–28% of all spending for MH/SUD services. This is a significant opportunity that will likely continue to increase as medical costs increase, IBH programs become more effective, and more people in the country develop comorbid medical and behavioral disorders.

As shown in Table 10, Rhode Island commercial payers could see estimated savings **$ 50.1–$ 95.9 million** after accounting for the estimated costs of OHIC's proposed policy changes over the five-year period. In addition to these estimated cost savings, successful integration of care can also improve depression and anxiety outcomes, patient quality of life, and satisfaction of care.

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[37] Centers for Disease Control, CDC/National Center for Health Statistics, https://www.cdc.gov/nchs /products /databriefs/ db234.htm.

[38] CPT code 96127 (Brief emotional/behavioral assessment) has existed since early 2015. Code 96127 has been approved by the Center for Medicare & Medicaid Services (CMS) and is reimbursed by most major insurance companies. The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. https://www.uspreventiveservicestaskforce.org/Page/Document/ RecommendationStatementFinal/depression-in-adults-screening1#Pod1. The USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. https://www.usprev entiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/depression-in-children-and-adolescents-screening1. The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use. https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/unhealthy-alcohol-use-in-adolescents-and-adults-screening-and-behavioral-counseling-interventions
The USPSTF recommends screening for illicit drug use in adults age 18 years or older. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred. https:// www.uspreventiveservicestaskforce.org/Page/Document/draft-recommendation-statement/drug-use-in-adolescents-and-adults-including-pregnant-women-screening

[39] Rhode Island Behavioral Health Project: Final Report, Truven Health Analytics, September 15, 2015. http://www.bhddh.ri.gov/mh/truven.php

Table 11: IBH Net Savings with Proposed Policy Changes

IBH Net Savings (Table 7)		$ 53,001,442–$98,758,083
IBH Policy Change Costs	**No BH Copay**	$ 750,389
	NCQA	$ 54,000
	HABI codes	$ 119,134
	BH Screen no Copay	$ 1,939,678
	Total	**$ 2,863,202**
IBH Net Savings with Proposed Policy Changes		**$ 50,138,240–$ 95,894,881**

Based on the analysis above, we believe the proposed rule will yield significant net benefits to Rhode Island residents.