Concise Explanatory Statement

Rhode Island Government Register

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

AGENCY: Office of the Health Insurance Commissioner

DIVISION:

RULE IDENTIFIER: 230-RICR-20-30-4

REGULATION TITLE: Powers and Duties of the Office of the Health Insurance Commissioner

RULEMAKING ACTION: Amendment

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

The amendments were originally filed in proposed form with the Rhode Island Secretary of State on December 6, 2019 ("Proposed Amendments"). A public hearing on the Proposed Amendments was held on January 10, 2020. OHIC received oral comments on January 10, 2020 and written comments by January 24, 2020. The comments of interested parties can be found here. Along with the Proposed Amendments, OHIC published a paper titled *Revisions to the Affordability Standards* and a Regulatory & Cost-Benefit Analysis prepared pursuant to R.I. Gen. Laws § 42-35-2.9. The document *Revisions to the Affordability Standards* articulates the evidence and rationale supporting adoption of the Proposed Amendments. OHIC has not updated this document in light of the changes to the Proposed Amendments discussed below. Interested parties should read this Concise Explanatory Statement and *Revisions to the Affordability Standards* in tandem. Where differences in the description of a specific provision of the Adopted Regulation and the Proposed Amendments exist, the Concise Explanatory Statement supersedes any other published description of the provision. Within the Adopted Regulation attached hereto, post-public comment changes to the regulation have been made in track changes with yellow highlighting.

REASON FOR RULEMAKING:

The Office of the Health Insurance Commissioner (OHIC) is adopting amendments to 230-RICR-20-30-4 *Powers and Duties of the Office of the Health Insurance Commissioner*. The amendments include technical modifications to § 4.3 Definitions, § 4.9 Affordable Health Insurance – General, and § 4.10 Affordable Health Insurance – Affordability Standards. Non-technical modifications to grammar and form are found throughout the regulation. Finally, references to dated health insurer reporting requirements are deleted. Collectively, the amendments and retained provisions 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."

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 amendments to § 4.9 Affordable Health Insurance – General, add improved integrated behavioral health care and reduced provision of low-value care to the articulated goals of the regulation.

The amendments to § 4.10 Affordable Health Insurance – Affordability Standards amend the primary care transformation and payment reform components of the Affordability Standards. Amendments to § 4.10(C) provide for the continuation of health insurer payments to support advanced primary care through the patient-centered medical home (PCMH) and adopt a set of policies to support behavioral health integration into primary care by removing administrative encumbrances to integration.

The amendments, with respect to primary care practice transformation, require health insurers to fund primary care practices that have met the Commissioner's definition of PCMH using a payment model that complies with parameters set forth in the amendments in § 4.10(C)(1)(b)(1)-(4). The definition of PCMH, § 4.3(A)(16), has been amended to include the implementation of cost management strategies and clinical quality performance attainment and/or improvement as components of the PCMH.

The amendments, with respect to behavioral health integration, require that health insurers eliminate copayments for patients who have a behavioral health visit with an in-network behavioral health provider on the same day and in the same location as a primary care visit at a Qualifying Integrated Behavioral Health Primary Care Practice as defined in § 4.3(A)(19) of the regulation. The Commissioner will determine which primary care practices are deemed Qualifying Integrated Behavioral Health Primary Care Practices for the purposes of this provision. Furthermore, the proposed amendments require health insurers to adopt policies for Health and Behavior Assessment/Intervention (HABI) codes that are no more restrictive than current CPT Coding Guidelines for HABI codes and to 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.

OHIC deletes language pertaining to the Care Transformation Advisory Committee and replaces this important mechanism for stakeholder engagement with a new advisory committee to be convened pursuant to § 4.10(E)(1).

Amendments to § 4.10(D) relate to payment reform. New sections have been added and other sections from the previous version of Part 4 have been consolidated.

§ 4.10(D)(1) requires health insurers to achieve a target for the percentage of medical payments made through alternative payment models (APMs).

§ 4.10(D)(2) introduces standards governing three common parameters of risk-based contracts. Furthermore, § 4.10(D)(2) introduces two new requirements 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 the 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) requires health insurer development and implementation of prospectively paid APMs for primary care. Furthermore, the amendments set forth annual targets for insurers to meet with respect to the implementation of APMs for primary care.

§ 4.10(D)(4) requires health insurer development and implementation of APMs for specialists.

§ 4.10(D)(5), pertaining to measure alignment, is amended to incorporate components of OHIC guidance on the use of aligned measure sets issued since the adoption of the measure sets in 2017. Maternity care and outpatient behavioral health measure sets have been added to the list of extant measure sets.

§ 4.10(D)(6) of the amended regulation modifies the hospital contracting requirements in two ways. First, health insurers are granted flexibility to make prospective quality payments to hospitals without consideration of performance, provided that if the annual quality performance targets have not been achieved, the hospital shall be required to remit unearned prospective payments back to the health insurer. Second, the amendment provides certain hospitals a one-time opportunity to earn a value-based rate adjustment to mitigate the wide variation in commercial payments for inpatient services across Rhode Island's acute care hospitals. Eligibility for the rate adjustment depends on the hospital's reimbursement relative to the median across all hospitals in the insurer's network.

Language pertaining to population-based contracting targets from the 2015 amendments of the regulation have been deleted. Likewise, language pertaining to the Alternative Payment Methodology Advisory Committee has been deleted. Consistent with the treatment of the Care Transformation Advisory Committee, OHIC will continue this important mechanism for stakeholder engagement through a new consolidated advisory committee described in § 4.10(E)(1).

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

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

General Comments

1. BCBSRI expressed a general concern that some of the proposed amendments will "increase costs and some are untested and may prove to be ineffective." In light of the State's recently adopted Cost Growth Target, BCBSRI observed: "[a]chieving the target will require allocating investments carefully to achieve the greatest returns and reacting quickly to data and developments if initial investments do not have the expected outcomes." Moreover, BCBSRI asserted: "Dictating both the Cost Growth Target and the means by which payers should achieve this target, by requiring certain actions and removing levers carriers may otherwise have used to achieve the target, goes far beyond the efforts undertaken in other states in setting a target." BCBSRI urged "OHIC to include only those amendments that provide a high return in improvements to cost, quality, and access, and allow payers and providers flexibility to change course and innovate to achieve our shared goals."

   OHIC Response: OHIC appreciates BCBSRI's thoughtful comments and notable efforts to improve the performance of Rhode Island's health care system. Cost, quality and access are three of the key outcomes that OHIC's Affordability Standards are designed to influence. OHIC agrees that reform strategies and investments should be

formulated to generate improvements in health care system performance. OHIC believes the interventions and policies endorsed by the amendments will influence net positive outcomes along these three performance domains at the system level. The rationale and evidence supporting the Proposed Amendments was reviewed in the document titled *Revisions to the Affordability Standards* that accompanied the Notice of Proposed Rulemaking. OHIC is committed to ongoing discussions with payers and providers on the direction and substance of public policy and is open to future course corrections should they become warranted by experience.

2. The Rhode Island Health Center Association (RIHCA) commented that OHIC should seek "input from primary care practice[s], including FQHCs" as refinements to the cost management strategies and clinical quality performance requirements for patient-centered medical homes (PCMHs) are concluded.

   OHIC Response: FQHCs are an invaluable part of Rhode Island's health care delivery system and have participated in practice transformation efforts through the Care Transformation Collaborative of Rhode Island (CTC-RI) and with payer partners. OHIC has, and will continue, to include FQHCs and other primary care practices in discussions regarding the PCMH requirements.

3. The Rhode Island Parent Information Network (RIPIN) expressed fears that "the new payment models promoted in the Affordability Standards, like new payment models in Medicare and elsewhere, emphasize cost control with far stronger incentives than quality and outcome improvements." RIPIN suggested that OHIC reframe the Affordability Standards "to give equal priority to quality improvement as is given to cost savings."

   OHIC Response: OHIC has profound gratitude for RIPIN's work to assist consumers through the challenging, and sometimes intimidating, complexities of health insurance, as well has RIPIN's work to enhance the wellbeing of vulnerable populations. The Affordability Standards are multi-faceted. While cost savings is a key objective of the Standards, the Adopted Regulation provides significant support for delivery system models, such as advanced primary care, that promote high quality health care and improved patient experience. Furthermore, OHIC is the only state Department of Insurance that maintains a process to define aligned quality measure sets that are used in value-based contracts between providers and commercial insurers. OHIC agrees that more work needs to be done to develop, test, validate, and employ quality measures that assess patient outcomes as opposed to processes of care.

Specific Comments

§ 4.3(A)(17) – Definitions – Primary care practice

4. Dr. Peter Hollmann recommended adding Geriatrics to the list of primary care specialties in the definition of primary care practice.

OHIC Response: OHIC agrees with this suggestion and Geriatrics has been added to the Adopted Regulation. Other amendments change the section number to § 4.3(A)(18).

§ 4.3(A)(19) – Definitions – Qualifying Integrated Behavioral Health Primary Care Practice

5. BCBSRI recommends amending the definition of QIBHPCP to include the three-year time limit for being in transition. Including a "time limit would encourage providers to move more quickly towards an integrated model of care."

   OHIC Response: This suggestion is reasonable and OHIC has amended the language in section § 4.3(A)(19) of the Adopted Regulation.

§ 4.9(A)(5) – Low Value Care

6. BCBSRI recommends "instead of including this provision in the Standards, … that OHIC convene a work group of both payers and providers to focus in this area, with a potential initial focus on reduction of unnecessary pre-operative testing and more broad adoption of other Choosing Wisely campaigns."

   OHIC Response: OHIC appreciates BCBSRI's attention to the important issue of low value care and the efforts of payers, providers, and business groups to encourage greater efficiency through the identification and reduction of low value care. § 4.9(A) of the Adopted Regulation articulates important dimensions of health care system performance that furnish policy goals for OHIC and the Affordability Standards. The proposed inclusion of "reduced provision of low-value care" will remain in the Adopted Regulation because efforts to address low value care represent an opportunity to improve affordability and patient safety. Payers and providers should address low value care through payment and other contracting strategies. OHIC is aware of efforts being undertaken by the Care Transformation Collaborative of Rhode Island to measure and assess low value care and encourages those efforts to continue. OHIC will reserve the option to include low value care as a topic for consideration of the newly constituted Payment and Care Delivery Advisory Committee.

7. Dr. Peter Hollmann suggested adding a definition of "low value care" to § 4.3(A).

   OHIC Response: OHIC agrees with this comment and a definition of low-value care has been added as § 4.3(A)(13).

§ 4.9(C)(1)(e) – Comparison to Rhode Island's Cost Growth Target as a factor in rate review

8. America's Health Insurance Plans (AHIP), BCBSRI, Neighborhood Health Plan of Rhode Island (NHPRI), and Tufts Health Plan objected to OHIC's proposal to add "Comparison to Rhode Island's Cost Growth Target" to the list of trends that the Commissioner may consider when determining whether a health insurer's products or proposed rate increases

are affordable (§ 4.9(C)(1)(e)). Specific comments in opposition to the proposal fall into the following categories:

A. The assessment of health insurer performance relative to the Cost Growth Target and the development and review of proposed premiums reflect fundamentally different types of analyses, draw on different types of data and cover different populations. For example, BCBSRI commented that "the Cost Growth Target and the cost and utilization trends examined in connection with a rate review are not the same thing. The Cost Growth Target encompasses a payer's entire book of business, including commercial products, self-funded plans and Medicare Advantage products, where the cost and utilization trends used in calculating premium rates are for commercial products only, and in some cases may even vary even within different commercial markets."

B. The *Compact to Reduce the Growth in Health Care Costs and State Health Care Spending in Rhode Island* was signed on a voluntary basis with the expectation that failure to meet the Cost Growth Target would not provoke sanctions from the State. For example, Tufts Health Plan commented " [o]ur comfort in signing the Compact and supporting this work during initial data submissions was based on the assertion, both in the compact itself and during meetings of the Steering Committee, that the goal of the cost growth target was to provide the market with greater transparency around healthcare costs and provide insights into spending that could help inform public policy." AHIP echoed this interpretation of the Cost Growth Target's purpose.

C. OHIC does not have the authority to formalize the Cost Growth Target. NHPRI stated that the "purpose of the RI Health Care Cost Trend Project was the voluntary collection of information on global expenditures in RI. The workgroup has no formal standing in state law, as it does in Massachusetts, and efforts to formalize should go through the legislative process."

OHIC Response: OHIC appreciates the concerns regarding the proposed revision to § 4.9(C)(1). In retrospect, the rationale of the proposal to include the Cost Growth Target among the enumerated trends that the Commissioner may consider when judging whether a health insurer's premium request is affordable could have been more clearly articulated. It was not OHIC's intent to establish a firm premium growth cap modeled on the concept of the Cost Growth Target. Nor was it OHIC's intent that a health insurer's performance relative to the Cost Growth Target would be exclusively determinative of the Commissioner's decision to approve, modify or reject a rate filing. Rather, OHIC sought to create a closer collaboration between rate review, the Cost Growth Target *performance analysis*, and the concept of a Cost Growth Target based on projected economic growth. Rate review offers a natural venue for educating purchasers about the factors driving premiums, including most importantly, cost trends.

In an environment characterized by a statewide Cost Growth Target, premium payers will invariably ask how year-over-year changes in premiums compare to the Target. The objectives of the Cost Growth Target go beyond health care cost transparency and the analytic excavation of cost drivers to inform public policy. The Cost Growth Target is intended to promote accountability for cost performance. OHIC's intent was to facilitate consumer and employer education around the Cost Growth Target by publishing the Target alongside requested premium increases while utilizing information from the Cost Growth Target *performance analysis* and other public reporting. The latter inputs would convey information to consumers and employers about historical medical expense trends, medical loss ratios, administrative costs, and insurer efforts to improve affordability through compliance with the Affordability Standards. The proper disclosures of the limitations of comparison between requested premium changes and the Cost Growth Target *performance analysis* would be published.

Undoubtedly the commenters' observations about the difference between the underlying data, populations, and analytic timeframes of rate review compared to the Cost Growth Target *performance analysis* are correct. However, fundamentally the Cost Growth Target *itself* is an accountability mechanism that is based on the expectation of the state's long-run economic growth rate, Potential Gross State Product (PGSP). Fostering medical expenditure and premium trends into greater alignment with economic growth is a longstanding objective of the Affordability Standards.

OHIC's interpretation of the health insurers' core concern with the proposed amendment to § 4.9(C)(1) is that it places rate filings at risk for rejection based on performance relative to the Cost Growth Target. The discussion above should ease that concern. However, given OHIC's authority to review and approve premiums in the individual and group markets and OHIC's wide latitude to publish information collected from health insurers, the proposal to add the Cost Growth Target to § 4.9(C)(1) to create the intended collaboration between rate review and the Cost Growth Target is not essential. Therefore, OHIC has chosen to withdraw this proposed amendment.

§ 4.9(D)(2)(a) – Integrated Behavioral Health as an Affordability Strategy

9. BCBSRI objects to the inclusion of integrated behavioral health care within the enumeration of factors that the Commissioner may consider when determining whether a health insurer has implemented effective strategies to enhance the affordability of its products.

OHIC Response: § 4.9(D) enumerates factors that the Commissioner may consider in determining whether a health insurance carrier has implemented effective strategies to enhance the affordability of its products. One set of factors (§ 4.9(D)(2)) centers on "whether the health insurer offers products that address the underlying cost of health care by creating appropriate and effective incentives for consumers, employers,

providers and the insurer itself." Establishing incentives that create a focus on primary care and prevention and wellness is an important constituent part of these activities. OHIC respectfully disagrees with BCBSRI's comment. Product design can influence patient utilization of certain providers, through limited networks and variable cost sharing based on provider classifications. For example, BCBSRI has been a leader in using product design to encourage use of high value providers, such as patient-centered medical homes, through variable copays. Certainly, PCMHs occupy an important position in the community's effort to improve affordability through the more effective management of patients' health care needs. Studies cited in the document *Revisions to the Affordability Standards* show promise for the integrated behavioral health delivery model to improve cost performance and quality. The use of product design to encourage integrated behavioral health as a valuable resource to better manage patients' physical and behavioral health care needs is a logical extension of the existing Regulation.

§ 4.10(C)(1)(b)(3) – Minimum attribution thresholds

10. UnitedHealthcare commented "that a minimum attribution threshold of 200 lives is necessary for making care management per member per month (PMPM) or infrastructure payments to a PCMH. Thus, enabling UnitedHealthcare the ability to employ funds where they would be most impactful."

    OHIC Response: Adequate financial support for primary care practices to conduct care management and function as PCMHs is essential to meeting the objectives of the Affordability Standards. Allowance of a minimum attribution threshold would reduce funding for practices and attenuate the resources practices have available to serve their patients. Therefore, UnitedHealthcare's proposal to include a minimum attribution threshold for PCMH care management and infrastructure payment is rejected.

§ 4.10(C)(2) – Behavioral health integration

§ 4.10(C)(2) introduces behavioral health integration into primary care as an advanced primary care strategy to improve the efficiency, quality, and accessibility of behavioral health care in primary care settings. Behavioral health care is an important component of Rhode Island's health care system and refers to services for mental health and substance use treatment. The requirements articulated under § 4.10(C)(2) comprise a first step toward the creation 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. OHIC views active efforts to create such as delivery system as a necessary step toward fulfilling the mandate placed on OHIC by the General Assembly in 2018 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." OHIC received several comments on the proposed integrated behavioral health requirements.

11. NHPRI wrote in "support of efforts to create behavioral health care integration with primary care settings." However, NHPRI asserted that "the model put forward lacks a cohesive and comprehensive strategy to achieve this goal." NHPRI stated further, "the legislative process should drive comprehensive strategies for integration, versus defining single components within regulation" and that "policy in this area should be further clarified and driven by the legislature before any further regulatory action is taken."

    OHIC Response: OHIC agrees that the legislature has a fundamental role to play in policy formulation related to integrated behavioral health and welcomes opportunities to collaborate with stakeholders to develop recommendations for legislative consideration. However, OHIC disagrees that the policies included in the Proposed Regulation instantiate a derogation of legislative prerogative. In fact, the legislature has vested new authorities in OHIC, including 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" (RI Gen. Laws § 42-14.5-3(p)-(r)). OHIC's interpretation of these powers were discussed in the document *Revisions to the Affordability Standards*.

12. UnitedHealthcare recommended OHIC add the phrase "by doing the following" to § 4.10(C)(2)(a).

    OHIC Response: UnitedHealthcare's drafting advice is reasonable and the Adopted Regulation includes the requested revision.

§ 4.10(C)(2)(a)(1) – Financial barriers

§ 4.10(C)(2)(a)(1) requires health insurers to eliminate copayments for patients who have a behavioral health visit with an in-network behavioral health provider on the same day and in the same location as a primary care visit at a Qualifying Integrated Behavioral Health Primary Care Practice as defined in § 4.3(A)(19).

13. BCBSRI and UnitedHealthcare expressed concerns about the proposal to waive 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. BCBSRI reiterated its view that OHIC did not possess the authority to require copayment waivers. Both carriers expressed concerns with operational challenges to implement the policy.

    OHIC Response: OHIC believes the authority to require this policy change is grounded on a firm statutory basis and has nothing further to add than what was articulated in the document *Revisions to the Affordability Standards*.

§ 4.10(C)(2)(a)(2) – Billing and coding policies

14. BCBSRI recommended "that this section be amended to reflect that the use of the HABI codes be consistent with CPT guidelines and applicable to services rendered by behavioral

health care providers. The reference to CMS coding guidelines should be removed to the extent those are only applicable to psychologists."

OHIC Response: The Adopted Regulation has substituted reference to CPT for CMS guidelines.

§ 4.10(C)(2)(c) – Integrated behavioral health reporting

15. BCBSRI opposed the requirement that health insurers report strategies to advance integrated behavioral health to OHIC. Furthermore, BCBSRI objected to OHIC's plan to publicly disseminate the reports.

OHIC Response: The Adopted Regulation extends the timeframe for submission of the required reports. OHIC believes there is utility in health insurers submitting plans and promises to work with the health insurers to guarantee that confidential information is not disclosed.

§ 4.10(C)(2)(b) – Qualifying Integrated Behavioral Health Primary Care Practices

16. UnitedHealthcare asked that "the final criteria used in the determination of whether a practice qualifies as an integrated behavioral health primary care practice, be disclosed to all stakeholders, and at a minimum require the practice be a designated patient-centered medical home.

OHIC Response: OHIC agrees with this comment and § 4.3(A)(19) of the Adopted Regulation requires that QIBHPCPs have achieved recognition as a patient-centered medical home under § 4.3(A)(16).

§ 4.10(D)(1) – Alternative payment models

17. Dr. Peter Hollmann noted that the requirement for health insurers to have 50% of insured medical payments made through an alternative payment model (§ 4.10(D)(1)(b)) does not specify a year by which compliance should be achieved.

OHIC Response: OHIC appreciates this comment. OHIC has specified January 1, 2021 as the first date of compliance assessment in the Adopted Regulation.

18. RIPIN recommended that OHIC add a new § 4.10(D)(1)(b) before the existing subparagraph (b) in the Proposed Regulation that states: "Health insurers shall ensure that alternative payment models provide appropriate incentives for providers to pursue quality improvement as well as cost control, including by providing bonuses to providers who score above quality targets established by the Commissioner on designated outcome measures, regardless of their cost performance."

OHIC Response: OHIC respectfully disagrees with this proposal. Alternative payment models currently emphasize quality performance through improvement requirements or quality gates. OHIC's concern with this proposal centers on the requirement that insurers disburse bonuses to providers that score above quality targets on outcome

measures regardless of the provider's cost performance. This proposal adds an additional layer of complexity to value based contracting due to the concomitant need to define *outcome* measures over which the provider has a clear and quantifiable influence. Furthermore, the proposal may also be cost additive by increasing the size of the quality incentive pool, or conversely, health insurers may respond by spreading the budgeted network quality incentive pool more thinly across providers.

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

19. § 4.10(D)(2) introduces minimum downside risk requirements for risk-sharing contracts between health insurers and Integrated Systems of Care. NHPRI objected "to the inclusion of the constraints placed on risk-based payment model contracts by OHIC beyond current statutory authority." NHPRI went on to argue "these guarded measures add unnecessary restrictions on the flexibility of plans and providers to develop innovative solutions, either in financing or structure for risk-bearing provider contracts. This authority should continue to be pursued legislatively rather than through regulation, if this is the direction OHIC wishes to pursue."

    OHIC Response: NHPRI asserts that OHIC lacks the statutory authority to support the establishment of standards for risk-sharing contracts, such as minimum risk exposure caps and risk sharing rates. OHIC enjoys broad authority under the Rhode Island General Laws to prescribe health insurer payment and delivery system strategies that logically support affordability and satisfy the public interest criterion for the approval of health insurer rate filings. To provide a cogent example, OHIC exercises authority over the terms of hospital contracts to cap annual fee schedule inflation and require quality performance programs. With the advent of population-based contracting, OHIC logically extended requirements to that space. The minimum downside risk standards articulated in § 4.10(D)(2) are not intended to constrain risk-based contracting. On the contrary, the purpose of the standards is to accelerate meaningful risk assumption to promote more efficient care delivery.

    NHPRI may have confused the proposed downside risk requirements with a separate body of work related to risk-based contracts. Presently, OHIC conducts reviews of risk-bearing provider organization capacity to assume downside risk under Medicaid contracts pursuant to an MOU with the Rhode Island Medicaid Program. OHIC sought authority to conduct similar reviews for commercial contracts during the 2019 legislative session, but S577 and H5582 did not obtain concurrent passage in the legislature. If NHPRI's gloss on the proposed minimum downside risk requirements alleges that OHIC is endeavoring to employ regulation as a vehicle to effectuate oversight of risk-bearing provider organizations of the form contemplated by S577 and H5582, then a closer reading of the Proposed Regulation will correct this error.

20. RIPIN expressed reservations about the progression of provider contracts toward greater downside risk due to the potential for year-over-year volatility in cost performance under contracts with small numbers of attributed lives. RIPIN also expressed concern with the

risk-based contracting parameters in the Proposed Regulation in general. RIPIN suggested revising § 4.10(D)(2)(d)(5) to read:

> "(5) The Minimum Downside Risk requirements above are not applicable to risk-sharing contracts with fewer than 10,000 attributed commercial lives, and due to the decreased statistical certainty with attributed populations less than 10,000, while health insurers and providers may enter into risk-sharing contracts including downside risk with fewer than 10,000 attributed lives, such contracts shall not count towards the 30% target to be achieved under 4.10(D)(2)(c) above."

OHIC Response: RIPIN's comments are extremely thoughtful and convey a sophisticated knowledge of risk-based contracting and the statistical implications of population size. OHIC respectfully disagrees with RIPIN's proposal. While it is correct that contracts with fewer than 10,000 attributed lives may exhibit greater volatility in cost from one performance period to the next, experience in the Rhode Island market has demonstrated that these contracts are viable. Furthermore, health insurers and providers can take meaningful actions to mitigate risk through reinsurance, reserving, minimum loss rates, and other mechanisms.

21. Contrary to RIPIN's concern, Tufts Health Plan (THP) commented that "downside risk agreements are still appropriate and beneficial even with patient volume beneath the 10,000-patient threshold" and requested "OHIC to include language … allowing for flexibility and acknowledging that contracting for downside risk with fewer attributed lives than the thresholds can be appropriate." In a related vein, AHIP encouraged OHIC "to revise the proposed standards for risk-based contracts … to make them less prescriptive."

    OHIC Response: OHIC agrees that risk-based contracting with fewer than 10,000 attributed lives can be appropriate and effective. OHIC believes §4.10(D)(2)(d)(5) already address's THP's concern. OHIC disagrees with AHIP that the standards are too prescriptive. For contracts with fewer than 10,000 attributed lives, health insurers retain significant latitude to specify risk-based contracting parameters. Moreover, OHIC invites health insurers and providers to develop innovative proposals that move beyond the minimum requirements set forth in to § 4.10(D)(2). While OHIC appreciates the perspective of AHIP, their proposal was not adopted.

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

    OHIC Response: CharterCARE's suggestion is reasonable and this language has been included in the Adopted Regulation under § 4.10(D)(2)(d)(6). OHIC still encourages health insurers to exercise due diligence when defining risk terms for risk-sharing contracts with fewer than 10,000 attributed lives.

§ 4.10(D)(2)(d)(1)-(2) – Minimum downside risk requirements for population-based contracts including hospital systems.

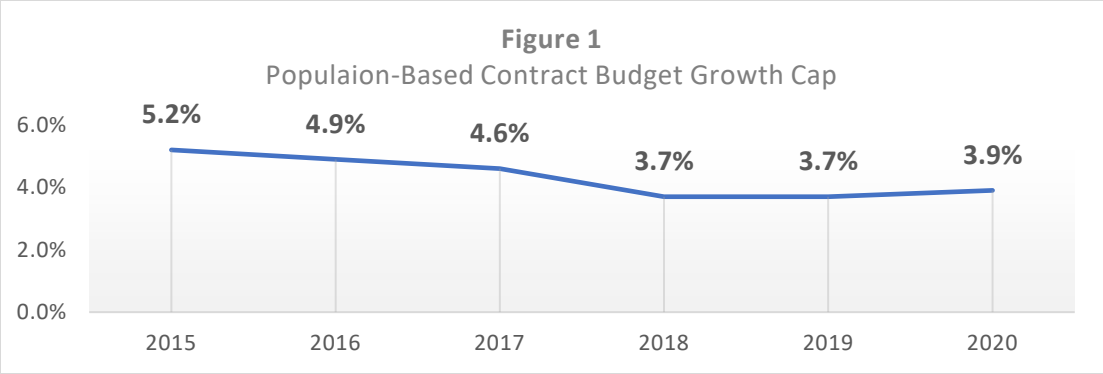
23. Lifespan proposed substituting the words "no more than" for "at least" in reference to the values of the risk-exposure caps in risk-sharing contracts between health insurers and Integrated Systems of Care involving hospital systems.

    OHIC Response: OHIC respectfully rejects Lifespan's proposed revisions. Subsections (1) – (4) of § 4.10(D)(2)(d) are designed as minimum downside risk requirements for risk-sharing contracts. The purpose of the minimum downside risk requirements is not to retard, but rather, to accelerate risk-sharing contracts along the continuum toward greater risk assumption.

§ 4.10(D)(2)(g) – Upward budget adjustments for Accountable Care Organizations (ACOs), otherwise known as Integrated Systems of Care

24. § 4.10(D)(2)(g) grants health insurers discretion to increase population-based contract budgets for providers with risk-adjusted spending that is significantly below the insured network average. BCBSRI wrote in opposition to the proposal. In BCBSRI's words: "the proposal creates a mechanism under which payers give extra payments to providers for reducing costs – negating the savings achievements. BCBSRI estimates the cost as being approximately $1 million annually, with no commensurate return for spending. Like other new provisions in the Standards, this increase in payments is inconsistent with the Cost Growth Target, and threatens payers' ability to meet the target. While the provision is purportedly at the payer's discretion, providers will expect these increases, and it will create an additional challenge for payers in negotiating contracts with providers that align with the goals of the Cost Growth Target. It is also counter to OHIC's goal of migrating providers to more sophisticate payment models."

    OHIC Response: BCBSRI raises several concerns about the proposal. As stated in the document *Revisions to the Affordability Standards*, the intent of § 4.10(D)(2)(g) is to preserve the participation of efficient providers in accountable care by further recognizing their achievement in efficiency and the comparatively diminished potential they have for further cost reduction relative to higher cost providers. OHIC views this provision as an adjunct to the budget growth cap applied to population-based contracts under § 4.10(D)(2)(f). At the inception of the budget growth cap in 2015, OHIC applied an additive factor of 3.5% to the percentage change in the Consumer Price Index (CPI) to derive the value of the cap. Each year thereafter the additive factor was reduced by 0.5% until the growth cap converged to percentage changes in CPI plus 1.5%. By design the budget growth cap has diminished over time (see Figure 1). This supports cost containment and affordability. However, given that all ACOs are held to this standard, it may prove too exacting for ACOs with lower risk-adjusted spending compared to the network as a whole. The Adopted Regulation retains § 4.10(D)(2)(f).



However, in response to BCBSRI's assertion that § 4.10(D)(2)(f) is "counter to OHIC's goal of migrating providers to more sophisticated payment models" OHIC has modified the provision to condition the opportunity for ACOs to receive the upward budget adjustment on the ACO's agreement to participate in a risk-sharing contract.

25. Coastal Medical questioned the OHIC-directed methodology health insurers should use to assess whether a provider's performance relative to the network is statistically significant. "We respectfully suggest that the language in section § 4.10(D)(2)(g) relative to statistical significance of cost performance that is favorable relative to the network be considered for revision, possibly in consultation with an actuary. We are uncertain as to whether the proposed p value of <.05 is meant to refer to performance in each of the three prior years or to the aggregate performance over three years. The former would appear to impose an unreasonably exacting standard."

OHIC Response: OHIC agrees that the statistical calculation methodology requires further clarification. In the Adopted Regulation OHIC has clarified the test of statistical significance should be applied to an average of three years of data, as opposed to three separate years.

§ 4.10(D)(2)(h) – Prohibition of carve outs for behavioral health and prescription drug claims from population-based contracts

26. § 4.10(D)(2)(h) provides that population-based contracts shall not carve out behavioral health or prescription drug claims experience from the provider budget. Lifespan requested that OHIC remove prescription drug claims experience from the carve out prohibition due to the "uncertainty associated with the price of drugs.' Lifespan went on to remark: "while pharmaceutical efforts to inform patients of lower drug cost alternatives is on-going and important, there is little a provider organization can do to impact pharmacy cost control when a new life saving therapeutic or expensive chemotherapeutic regimen is the best treatment."

OHIC Response: OHIC appreciates and is sympathetic to Lifespan's comment regarding the uncertainty associated with the price of prescription drugs and that "State or federal intervention tackling drug pricing controls or value based agreements with drug manufacturers" are desirable. OHIC believes that Integrated Systems of Care should manage the cost of the full range of covered goods and services received by the

attributed population. Therefore, OHIC is unable to accept Lifespan's proposed revision. However, health insurers and providers may negotiate contract structures that limit provider exposure to high cost prescription drugs, such as stop loss arrangements or truncation of high cost episodes of care or member claims above a certain value.

27. Due to self-insured group purchasing arrangements in which services, such as behavioral health and pharmacy, can be contracted through other third party administrators, BCBSRI requested that OHIC modify § 4.10(D)(2)(h) "to allow a population-based contract to include a methodology to reflect the member-months for which the payer covers pharmacy and/or behavioral health claims."

    OHIC Response: OHIC agrees with BCBSRI and the Adopted Regulation reflects the requested flexibility.

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

OHIC received several comments on the proposed requirement that commercial health insurers develop and implement prospectively paid primary care APMs with their provider networks. The rationale for OHIC's proposal to require primary care APMs is articulated in the document *Revisions to the Affordability Standards*. None of the comments called into question the rationale supporting OHIC's proposal to move the delivery system toward prospective primary care payment. The comments focused on potential unintended consequences due to the change in provider economic incentives produced by prospective payment and the readiness of the delivery system to adopt these models of payment.

28. Coastal Medical expressed concerns about "potential unintended consequences of stand-alone primary care capitation and recommend[ed] that OHIC attempt to collect before and after data to understand if there is any reduction in the availability of same day sick visits and after hours and weekend visits with PCP's under a capitated model that offers a financial incentive to expand patient panels while removing any financial incentive to maintain or increase the availability of such visits." Furthermore, Coastal Medical suggested that OHIC collect data to facilitate a comparative analysis of "performance of stand-alone primary capitation versus performance of primary care capitation nested within a total cost of care based risk model versus performance of total cost of care based risk models that do not include primary care capitation."

    OHIC Response: OHIC agrees with Coastal Medical that evaluation of the outcomes of prospectively paid primary care APMs is necessary to ensure effective oversight of the transition to these payment models and guard against unintended consequences. OHIC encourages health insurers to conduct this analysis as part of their customary review of provider performance results. Furthermore, OHIC will commit to assess the feasibility of a state-based evaluation of provider performance under primary care APMs, subject to available data and resources. The Adopted Regulation retains the provision under § 4.10(D)(3)(e) that the Commissioner shall convene a working group to assess patient, provider, and health insurer experience under primary care APMs. This forum will offer an opportunity to publicly discuss the issues raised by Coastal

Medical and others that are sure to arise. OHIC has elected to move the date for first convening this working group from April 2021 to October 2021 to grant interested parties more time to reflect on early experience under prospective payment.

29. Lifespan requested that OHIC withdraw the proposed targets for 2022 and 2023 and recast the 2021 target as a "goal." Two of the four major health insurers commented on the primary care APM proposal. UnitedHealthcare expressed gratefulness "to OHIC for flexibility around the structure of primary care APMs" and went on to write: "as previously stated, [UnitedHealthcare] agrees with OHIC on the overall benefit of these arrangements. UnitedHealthcare will continue to promote these models with its provider partners but, …, we cannot force the providers to adopt these models." BCBSRI identified the lack of local payer and provider experience under prospective payment as a reason to claim that OHIC's proposal was "premature." BCBSRI wrote in opposition to the annual expansion targets set forth in under § 4.10(D)(3)(d). "Based on BCBSRI's experience, the capitation thresholds proposed are unrealistic. BCBSRI has initiated prospective arrangements with willing providers in 2020, but the regulation's capitation target of 20% in 2021 and ramping up to 60% in the third year is too aggressive and puts providers who do not yet have the capabilities to manage a payment budget at risk."

OHIC Response: OHIC does not agree with Lifespan's proposal to describe the expansion of prospectively paid primary care APMs as a "goal" instead of a requirement. This would devitalize OHIC's proposal. OHIC interprets Lifespan's principle concern to be that of mandating network-wide adoption of prospective payment for primary care. OHIC has already conciliated this concern with the developed policy by proposing expansion targets as opposed to a uniform mandate governing contracting that would have operated similar to other requirements under the Affordability Standards, such as the hospital contracting requirements.

It is important that the state and market support the continued development of advanced primary care. Through present and past transformation efforts, Rhode Island has built a strong working foundation of primary care practices that have honed the competencies of team-based care, high risk patient identification and engagement, care management, and quality improvement. It is time to adopt a payment model for primary care that is conformable to the objectives of advanced primary care and that supports greater provider flexibility to address patient health care needs in the right setting at the right time. Furthermore, OHIC views the requirement as a necessary and proper means to support the integration of behavioral health into primary care through the requirement that prospective payment models for primary care practices recognized as Qualifying Integrated Behavioral Health Primary Care Practices compensate practices for the primary care *and* behavioral health services delivered by the site.

While expressing support for the expansion of primary care APMs generally, BCBSRI stated that it was "premature" to require that health insurers develop and implement primary care APMs. For three years OHIC has facilitated public discussion around primary care prospective payment and signaled through various means that this innovation was coming. OHIC credits BCBSRI for being first to market with a primary

care APM. However, it should hardly seem premature for OHIC to establish a requirement given the time already invested in the elevation of primary care payment reform on OHIC's policy agenda and the slow pace of some health insurers to implement these models without a mandate to do so.

OHIC understands that primary care APMs represent a novel innovation in our market and payers and providers will need time to garner lessons and perfect operations under these models. Recognition that primary care providers will exhibit variable short-term capacity and interest to transition to prospect payment, as well as health insurer operational considerations, informed the staging of regulatory targets over the multi-year time horizon (2021 – 2023) that were specified in § 4.10(D)(3)(d) of the Proposed Regulation. However, OHIC places authority in the cautionary representations of health insurers and providers about the time necessary to modify existing operations to implement prospective payments. Therefore, OHIC has modified the targets set forth in the Adopted Regulation. First, OHIC has expanded the timeframe for target expansion by one year. Second, OHIC has slackened the annual schedule of expansion targets. The proposed regulation called for 20% of insured Rhode Island resident covered lives for each insurer to be attributed to a prospectively paid primary care APM by January 1, 2021, with 40% attributed by January 1, 2022 and 60% by January 1, 2023. The Adopted Regulation requires 15% attributed by January 2021, 25% by January 2022, 40% by January 2023, and 60% by January 2024.

During the writing of these responses primary care providers were facing unprecedented challenges due to the fiscal and operational impacts of the novel coronavirus (COVID-19) pandemic. These challenges are likely to extend for some time and produce lasting effects on the primary care sector. OHIC has encouraged health insurers and providers to move quickly to adopt prospective payment in response to the impacts of the COVID-19 pandemic.

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

30. BCBSRI wrote in opposition to the new section requiring the implementation of specialist alternative payment models. While supportive of APMs for specialists, BCBSRI wrote that "compliance with these targets may result in higher specialist payments, as specialists will have little incentive to move from a fee-for-service model except for increased payments in an APM model." BCBSRI suggested as an alternative strategy to "focusing on alternate payment methodologies between specialists and payers, encouraging specialists to become part of [Systems of Care] might be a better strategy for achieving the desired result of cost and quality improvements." If OHIC chose to proceed with the proposed expansion of APMs to specialists, BCBSRI encouraged revisions to the policy to allow for greater flexibility in the selection of specialists, as opposed to the menu provided in the Proposed Regulation.

OHIC Response: OHIC is appreciative of the work BCBSRI has done to deploy value-based payments with specialists and wishes to accelerate the pace of specialist payment reform. Specialist payment reform has occupied the attention of OHIC and the

Alternative Payment Methodology Advisory Committee in recent years and represents an opportunity to improve quality and affordability. In response to BCBSRI's comment OHIC has revised the language in § 4.10(D)(4)(b)(5) of the Adopted Regulation to allow for selections of "other specialties" as opposed to "another specialty" for greater flexibly in choosing contracting partners. OHIC has also included more specific compliance dates in the Adopted Regulation. Though OHIC has liberalized the menu of specialties with which health insurers can execute or expand existing APMs to satisfy the requirement, OHIC believes the specifically enumerated specialties should warrant priority by the health insurers.

§ 4.10(D)(5) – Measure alignment

31. RIPIN recommended adding a new subparagraph § 4.10(D)(5)(2)(d) before subparagraphs (2) and (3) in the Proposed Regulation, to the following effect: "Whenever possible, prioritize measures that objectively track measurable healthcare outcomes over measures that track the performance of screenings or other processes."

    OHIC Response: OHIC agrees with RIPIN and the requested language is included in the Adopted Regulation.

§ 4.10(D)(6)(f) – Inpatient services rate adjustment to address price disparities

§ 4.10(D)(6)(f) of the proposed regulation introduces a new hospital contracting requirement designed to grant a one-time value-based rate increase for inpatient services for hospitals that are reimbursed at less than the network median reimbursement rate, adjusted for case-mix. The proposal provoked staunch opposition from the commercial health insurers and Lifespan and support from the Hospital Association of Rhode Island and CharterCARE Health Partners.

32. Health insurers viewed the proposal as cost additive while yielding dubious benefits in terms of improved quality. UnitedHealthcare expressed apprehension that "this regulation may be counter to the progress that has been made which encourages innovation and strives to reduce the total cost of care." Sounding concerns over the cost implications of the proposal, BCBSRI urged OHIC's deeper consideration of the complex factors that determine the present state of hospital reimbursement, including: "trade-offs, such as higher outpatient reimbursements in exchange for lower in-patient reimbursements"…failure of some hospitals to earn "the full quality payments for which they were eligible because they failed to meet the required quality standards"…and consideration of higher reimbursements paid to teaching hospitals and hospitals offering specialized services. Furthermore, BCBSRI observed: "increasing reimbursement rates discourages hospitals from addressing their cost structure and making necessary changes to control costs." Additionally, NHPRI and THP expressed concern with the cost implications of the proposed amendment. Each health insurer argued that the proposed amendment to correct hospital payment disparities was in conflict with the recently adopted Cost Growth Target.

    Lifespan, the only hospital system that wrote in opposition to the proposal, stated:

"we oppose the concept of addressing hospital rate variation and further believe that hospital rate variation is acceptable among hospitals with varying underlying cost structures such as level 1 trauma and teaching hospitals. OHIC's current proposal has further conditioned these disparity costs on benchmarks that pertain to metrics already part of state, federal or contractual requirements and of which defeat the overall purpose for implementing such a disparity correction system as it now becomes quality payments."

CharterCARE requested that OHIC clarify that the inpatient rate increases apply to inpatient behavioral health services and that the rate increases apply to all inpatient payments made by the health insurer. Furthermore, CharterCARE proposed an expansion of the scope of § 4.10(D)(6)(f) to include outpatient services among the payment rates subject to the one-time rate adjustment. CharterCARE wrote: "outpatient rates suffer the same disparity issues as inpatient rates and the problem has been exacerbated as more services transition from inpatient to outpatient. From a cost and public policy perspective, OHIC should want that shift from inpatient to outpatient to continue. Therefore, advantaging inpatient rates over outpatient rates will create an unfortunate and unintended incentive to resist the transition to outpatient services and make the healthcare system less efficient."

OHIC Response: OHIC agrees that the inpatient services rate adjustment should apply to inpatient behavioral health services and the Adopted Regulation makes that clear. OHIC also expects all commercial inpatient payments made by the health insurer to be subject to the requirements of § 4.10(D)(6)(f).

OHIC does not agree with CharterCARE's request to include outpatient services in the rate disparity adjustment. The rate disparity adjustment is designed to support the financial performance of lower reimbursed hospitals in the state, but the cost of this must be weighed against OHIC's mission to promote affordability. According to rate filing data, hospital outpatient claims accounted for an average of 57% of total hospital claims expenditures for the three-year period 2016-2018. Given the variance of the distribution of outpatient service prices across hospitals and the aggregate value of these claims, inclusion of outpatient services in § 4.10(D)(6)(f) at least double the cost of this policy to health care purchasers. OHIC understands CharterCARE's rationale for proposing to include outpatient services, but OHIC believes there are mitigating factors. For instance, CharterCARE argues that the change in relative prices between inpatient services and outpatient services will incent hospitals to substitute care in the inpatient setting for care in the outpatient setting. This may be a valid concern, but health insurer medical management policies and the prevailing incentives under risk-based contracts should counteract this incentive.

Arguments proffered by BCBSRI against the inpatient services rate adjustment pointed to interactions between local efforts to manage inpatient utilization, such as primary care investments and accountable care models, and the proposal to address price disparities among hospitals. BCBSRI made the observation that to "the extent that any of those efforts succeed in reducing inpatient utilization, this proposal defeats the

savings by increasing inpatient prices" (underline emphasis from BCBSRI). To broaden the rate adjustment to outpatient services would exacerbate the dynamic elucidated by this crucial point. Furthermore, several commenters identify an apparent inconsistency between the rate disparity adjustment for inpatient services and the recent adoption of a Cost Growth Target for Rhode Island. This observation provides further reason to limit the rate adjustment to inpatient services and decline to accept CharterCARE's proposal. OHIC believes the decision to limit the one-time rate adjustment to inpatient services effectively balances the concerns of certain hospitals with the interests of purchasers. Efforts to address health care spending in the United States over the last decade have largely emphasized utilization management, as opposed to price control. Yet, studies routinely point to price as the more important explanatory variable behind the comparatively higher per capita health care spending in the United States relative to other advanced industrial countries.[1] Balancing the needs of health care providers with the burdens of health care cost on Rhode Island's businesses and families, OHIC is compelled to exercise care when restructuring effective price-focused regulatory cost controls.

The health insurers requested several modifications to the proposed inpatient services rate adjustment. The components of the proposal that health insures requested OHIC reconsider included: OHIC's decision to not require network-wide cost neutrality for the inpatient services rate adjustment, selection of the quality measures and performance targets for determining which eligible hospitals earn the rate adjustment, the methodology for calculating hospital eligibility for the rate adjustment, and the timing and frequency of recoupment payments for hospitals that fail to retain the rate adjustment. Each of these features are taken up in turn below.

Cost neutrality

33. BCBSRI, NHPRI, and THP requested that OHIC modify the proposal to require that any increases granted under § 4.10(D)(6)(f) be made in a manner that are cost neutral for the hospital network as a whole.

    OHIC Response: OHIC understands the rationale of cost neutrality. However, as OHIC observed in the document *Revisions to the Affordability Standards*, the comments from hospitals in response to the Advance Notice of Proposed Rulemaking conveyed the existence of material financial and operational challenges that confront hospitals in Rhode Island that are due to a mix of intra-state market pressures, regional competition, and public policy. These challenges have only been exacerbated by the novel coronavirus (COVID-19) pandemic. Therefore, OHIC will not require cost neutrality in the implementation of the provisions of § 4.10(D)(6)(f).

[1] Anderson GF, Hussey P, Petrosyan V. It's Still The Prices, Stupid: Why The US Spends So Much On Health Care, And A Tribute To Uwe Reinhardt. *Health Aff (Millwood)*. 2019;38(1):87-95. doi:10.1377/hlthaff.2018.05144 and Anderson GF, Reinhardt UE, Hussey PS, Petrosyan V. It's the prices, stupid: why the United States is so different from other countries. *Health Aff (Millwood)*. 2003;22(3):89-105. doi:10.1377/hlthaff.22.3.89

Quality measures & performance targets

34. Regarding OHIC's proposal to tie the one-time inpatient services rate increase to quality performance, BCBSRI wrote: "the quality metrics set out in the Standards are not meaningful. All but one hospital in Rhode Island already meets or exceeds the quality metrics included in the Standards, and the one hospital that does not meet them all, meets all but one. As a result, the proposal would do little to drive quality improvement at the hospitals eligible for the rate increases." Consequently, BCBSRI proposed:

    "revising the metrics to use the numeric quality scores on the Hospital Compare tool, and allowing carriers to use alternative or additional metrics as appropriate for the specific hospital and its mix of services."

    UnitedHealthcare proposed that OHIC amend the proposal to provide that all core hospital quality measures "sanctioned by OHIC, be at or better than the national benchmark."

    OHIC Response: OHIC recognizes the importance of quality improvement and appreciates BCBSRI's and UnitedHealthcare's thoughtful comments. When drafting § 4.10(D)(6)(f)(1) OHIC sought to create a meaningful opportunity for lower reimbursed hospitals to earn a value-based rate adjustment without imposing a standard for quality improvement that would set an impossibly high bar of achievement. Existing hospital contracting regulations already require that at least half of every hospital's annual commercial fee schedule increase be contingent on quality performance. OHIC believes that hospital management of rates of Clostridium difficile (C. diff) intestinal infections, Central-line associated bloodstream infections (CLABSI), and the rate of readmission after discharge are reasonable measures to judge hospital quality performance in exchange for the one-time inpatient services rate adjustment. However, to allow scope for alternative measures that meet the mutual goals of the contracting dyad, OHIC has modified § 4.10(D)(6)(f) to grant the parties flexibility in the selection of quality measures and performance targets. If an alternative arrangement cannot be met, then the parties are required to employ the quality measures and performance targets specified § 4.10(D)(6)(f)(1).

Methodology for calculating hospital eligibility for the rate adjustment

35. The proposed hospital contracting requirement employs a methodology to calculate hospital eligibility for the inpatient services rate adjustment that is based on the networkwide median payment adjusted for case mix. BCBSRI commented that the "calculation methodology based on the median rate is skewed by the comparatively higher payments made for hospitals paid on a daily case rate (per diem) basis and by payments for specialty hospitals and service lines (such as maternity)." BCBSRI recommended that OHIC modify the calculation methodology to remove "outlier" payments.

    OHIC Response: When developing the eligibility cutoff and target for the inpatient services rate adjustment OHIC considered two candidate measures of central tendency that describe features of the distribution of prices across hospitals: the arithmetical average and the median. Due to the concentration of expensive specialized services

among some hospitals, OHIC also considered excluding certain hospitals, such as Women & Infants, from the universe of payments as part of the required rate adjustment calculation methodology.

Each of these decisions relate to BCBSRI's concern about the influence of outlier payment methods and the inter-hospital mix of services on the cost of the proposed inpatient services rate adjustment. OHIC was aware of these influences and deliberately selected the median, as opposed to the arithmetical average, as the eligibility cutoff and target because the median is less sensitive to outliers than the arithmetical average. While the exclusion of Women & Infants hospital makes more sense if using the average, OHIC also modelled the impact of excluding Women & Infants hospital from the distribution when using the median. This exclusion resulted in a median payment rate that was 2% lower than the median payment rate when Women & Infants was included. The effect of excluding Women & Infants, or any hospital above the median, is to lower the median and attenuate the potential inpatient services rate adjustments available to eligible hospitals. OHIC sought to create a meaningful opportunity for some hospitals to receive an inpatient services rate adjustment, while limiting the cost impact to the overall market. Furthermore, contrary to constructs advocated by other parties, such as a price floor, OHIC further sought to limit the cost of the inpatient services rate adjustment by designing a one-time adjustment. OHIC believes the calculation methodology that was included in the proposed rule should be adopted without modification. Therefore, OHIC respectfully rejects BCBSRI's suggestion to modify the calculation methodology.

Timing & Frequency of Recoupment Payments

36. § 4.10(D)(6)(f) requires that contracts with hospitals eligible for the one-time inpatient services rate adjustment contain a provision for the recovery of monies paid to the hospital by the health insurer should the hospital fail to achieve the quality targets defined in § 4.10(D)(6)(f)(1). Furthermore, the provision would be subject to audit by the Commissioner. BCBSRI commented on the timing and frequency of recoveries. "BCBSRI recommends that the Standards be amended to allow payers to withhold some percentage of the payment increases, with full payment occurring upon attainment of the quality measures after the measurement period. An alternative would be to allow recoupment each year, rather than after an accumulation of three years of payments."

    OHIC Response: OHIC agrees that flexibilities around the timing and frequency of recoupments should be granted. The Adopted Regulation has been modified to allow for annual performance assessment and recoupments.

§ 4.10(E)(1)(a) – Payment and Care Delivery Advisory Committee

37. NHPRI wrote seeking clarity on the purpose of the Committee and "the authority it may have regarding developing recommendations for necessary actions by the Commissioner."

OHIC Response: OHIC chose to consolidate the extant Care Transformation Advisory Committee and the Alternative Payment Methodology Advisory Committee into a single advisory body. OHIC believes a unified structure will better allow for policy discussions that align delivery system transformation with payment models. The Committee will serve a similar function to the erstwhile two advisory committees from the 2015 iteration of the Affordability Standards.

§ 4.10(E)(1)(b) – Select representation on the Payment & Care Delivery Advisory Committee

38. The Mental Health Association of Rhode Island (MHARI) recommended that language be added to the list of members of the proposed Payment & Care Delivery Advisory Committee "to secure inclusion of mental health consumers, providers, or advocates, who can speak to the issues of parity violation and discrimination."

    OHIC Response: OHIC agrees with MARI's recommendation to include specific language to ensure inclusion of individuals or organizations with experience and expertise in behavioral health. § 4.10(E)(b)(5) of the Adopted Regulation has been revised to explicitly reference behavioral health providers. Furthermore, through the selection of committee members, OHIC will ensure representation of individuals and organizations capable of speaking to issues facing consumers with behavioral health needs and the needs of providers along the continuum of behavioral health care.

§ 4.10(E)(3) – Requests for waiver of requirements under § 4.10

39. CharterCARE expressed concern with § 4.10(E)(3) which allows for the Commissioner to grant modifications to and waivers from the requirements of § 4.10. CharterCARE sought the exclusion of the hospital inpatient services rate adjustment under § 4.10(D)(6)(f) from being waived.

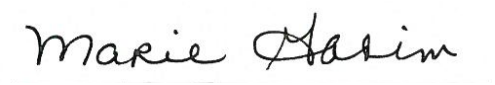
    OHIC Response: OHIC respectfully declines to revise the provision regarding waivers of the Affordability Standards to exclude § 4.10(D)(6)(f). OHIC expects health insurers to comply with § 4.10(D)(6)(f) but does not see the need to explicitly exclude it.

REGULATORY ANALYSIS:

Pursuant to the Administrative Procedures Act, R.I. Gen. Laws § 42-35-2.9 and Executive Order 15-07 OHIC conducted a regulatory and cost-benefit analysis of the amendments. Interested parties are referred to the document **Proposed Amendments to 230-RICR-20-30-4 Regulatory & Cost-Benefit Analysis** for an assessment of the societal costs and benefits of the proposed amendments. OHIC believes the amendments are likely to generate societal benefits that exceed the costs.

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

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



_____ Dated _____June 2nd, 2020_____

Marie Ganim, PhD.

230-RICR-20-30-4

TITLE 230 – DEPARTMENT OF BUSINESS REGULATION

CHAPTER 20 – INSURANCE

SUBCHAPTER 30 – HEALTH INSURANCE

PART 4 – Powers and Duties of the Office of the Health Insurance Commissioner

4.1 Authority

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

4.2 Purpose and Scope

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

1. Ensure effective regulatory oversight by the OHIC;

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

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

4.3 Definitions

A. As used in this regulation:

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

2. "Aligned measure set~~s~~" means any set of quality measures adopted by the Commissioner pursuant to § 4.10(D)(5~~3~~) of this Part. An Aligned Measure Set shall consist of measures designated as 'Core Measures' and/or 'Menu Measures.' Aligned Measure Sets are developed for specific

provider contract types (e.g. primary care provider contracts, hospital contracts, Accountable Care Organization (ACO, or Integrated System of Care) contracts.

3. "Commissioner" means the Health Insurance Commissioner.

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

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

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

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

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

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

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

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

            (CC) Funding the purchase by the practice of analytic software that enables primary care practices to analyze patient quality and/or costs, such as software that tracks patient costs in near-to-real time;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9. "Health insurer" means any entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the Commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including, without limitation, an insurance company offering accident and sickness insurance, a health maintenance organization, a non-profit hospital service

corporation, a non-profit medical service corporation, a non-profit dental service corporation, a non-profit optometric service corporation, a domestic insurance company subject R.I. Gen. Laws Chapter 27-1 that offers or provides health insurance coverage in the state and a foreign insurance company subject to R.I. Gen. Laws Chapter 27-2 that offers or provides health insurance coverage in the state.

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

11. "Indirect primary care expenses" means payments by the Health Insurer to support and strengthen the capacity of a primary care practice to function as a medical home, and to successfully manage risk-bearing contracts, but which do not qualify as Direct Primary Care Expenses. Indirect Primary Care Expenses may include a proper allocation, proportionate to the benefit accruing to the Primary Care Practice, of Health Insurer investments in data, analytics, and population-health and disease registries for Primary Care Practices without the foreseeable ability to make and manage such infrastructure investments, but which do not qualify as acceptable Direct Primary Care Spending, in accordance with parameters and criteria issued in a bulletin issued by the Commissioner, or upon request by a Health Insurer and approved by the Commissioner. Such payments shall include financial support, in an amount approved by the Commissioner, for the administrative expenses of the medical home initiative endorsed by R.I. Gen. Laws Chapter 42-14.6, and for the health information exchange established by R.I. Gen. Laws Chapter 5-37.7. ~~By May 1, 2016 the Commissioner shall reassess this obligation by Health Insurers to provide financial support for the health information exchange.~~

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

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

1~~3~~4. "Menu measures" means quality measures within an Aligned Measure Set that are included in applicable health care provider contracts that incorporate quality measures into the payment terms when such inclusion

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

15~~4~~. "Minimum loss rate," means a defined percentage of the total cost of care, or annual provider revenue from the insurer under a population-based contract, which must be met or exceeded before actual losses are incurred by the provider. Losses may accrue on a "first dollar" basis once the "minimum loss rate" is breached.

16~~54~~. "Patient-centered medical home" means:

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

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

c. ~~a~~ A Primary Care Practice designated by contract between a Health Insurer and a primary care practice, or between a Health Insurer and an Integrated System of Care in which the Primary Care Practice is participating. A contractually designated Primary Care Practice must meet pre-determined quality and efficiency criteria practice performance standards, which are approved by the Commissioner, for improved care management and coordination that are at least as rigorous as those of the collaborative initiative endorsed by R.I. Gen. Laws Chapter 42-14.6, and

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

17~~65~~. "Population-based contract" means a provider reimbursement contract with an Integrated System of Care that uses a reimbursement methodology that is inclusive of the total, or near total medical costs of an identified, covered-lives population. A Population-Based Contract may be a Shared Savings Contract, or a Risk Sharing Contract, or a Global Capitation Contract. A primary care or specialty service capitation reimbursement contract shall not be considered a Population-Based Contract for purposes of this Part. A Population-Based Contract may not transfer insurance risk or any health insurance regulatory obligations. A Health Insurer may request clarification from the Commissioner as to whether its proposed contract constitutes the transfer of insurance risk.

1876. "Primary care practice" means the practice of a physician, medical practice, or other medical provider considered by the insured subscriber or dependent to be his or her usual source of care. Designation of a primary care provider shall be limited to providers within the following practice type: Family Practice, Geriatrics, Internal Medicine and Pediatrics; and providers with the following professional credentials: Doctors of Medicine and Osteopathy, Nurse Practitioners, and Physicians' Assistants; except that specialty medical providers, including behavioral health providers, may be designated as a primary care provider if the specialist is paid for primary care services on a primary care provider fee schedule, and contractually agrees to accept the responsibilities of a primary care provider.

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

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

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

c. A patient centered-medical home practicePrimary Care Practice that completes a qualifying behavioral health integration self-assessment tool approved by the Commissioner and develops an action plan for improving its level of integration. Such practices must be recognized as an integrated behavioral health practice by a national accreditation body (such as NCQA) within three years.

2019. "Risk exposure cap" means a cap on the losses which may be incurred by the provider under the contract, expressed as a percentage of the total cost of care or the annual provider revenue from the insurer under the population-based contract.

21017. "Risk sharing contract" means a Population-Based Contract that:

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

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

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

2321~~8~~. "Shared savings contract" means a Population-Based Contract that:

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

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

4.4 Discharging Duties and Powers

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

1. Guard the solvency of health insurers;

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

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

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

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

4.5 Guarding the Solvency and Financial Condition of Health Insurers

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18. Whether the management of a health insurer has

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

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

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

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

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

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

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

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

4.6 Protecting the Interests of Consumers

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

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

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

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

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

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

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

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

1. The privacy and security of consumer health information;

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

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

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

3. The effectiveness of a health insurer's consumer appeal and complaint procedures. ~~for matters other than medical necessity and utilization review, which are within jurisdiction of the Department of Health~~;

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

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

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

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

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

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

4.7 Encouraging Fair Treatment of Health Care Providers

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

    a. Can be made in a manner that will

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

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

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

    b. Should include conditions when feasible that will

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

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

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

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

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

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

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

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

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

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

e. Prioritize the use of limited resources

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

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

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

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

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

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

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

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

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

a. Collaborating with state and local health planning officials;

b. Participating in the legislative and regulatory processes; and

c. Engaging the public in policy debates and discussions.

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

4.9 Affordable Health Insurance - General

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

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

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

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

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

5. Reduced provision of low-value care.

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

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

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

1. Trends, including:

a. Historical rates of trend for existing products;

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

c. Regional medical and health insurance trends; and

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

~~e. Comparison to Rhode Island's Cost Growth Target.~~

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

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

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

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

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

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

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

2. Whether the health insurer offers products that address the underlying cost of health care by creating appropriate and effective incentives for consumers, employers, providers and the insurer itself. Such incentives shall be designed to promote efficiency in the following areas:

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

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

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

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

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

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

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

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

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

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

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

3. Health insurer~~Health plan~~ solvency requirements.

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

4.10 Affordable Health Insurance – Affordability Standards

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

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

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

~~a. The Commissioner may reassess the primary care spending obligations set forth in § 4.10(B)(1)(A) of this Part in order to determine whether any adjustments would better achieve the purposes of supporting primary care as an affordability strategy. The reassessment may include a determination of whether the Health Insurer's obligation to provide financial support for the health information exchange established by R.I. Gen. Laws Chapter 5-37.7 should continue. Any adjustments proposed by the Commissioner shall be considered after soliciting comments from stakeholders, and in connection with the annual rate review process conducted by the Office. The reassessment may include a national survey of health care systems with a reputation for high performance and a commitment to primary care for the purposes of quantifying primary care spending in those systems~~

2. Direct Primary Care Expenses shall be accounted for as medical expenses on the ~~H~~health ~~i~~insurer's annual financial statements~~, and on its RI annual health supplemental statement~~. Indirect Primary Care Expenses shall be accounted for as administrative costs on the ~~H~~health ~~i~~insurer's annual financial statements~~, and on its RI annual health supplemental statement~~. Indirect Primary Care Expenses may be deducted from

theeach statement's administrative cost category as cost containment expenses, in accordance with federal Medical Loss Ratio calculation rules.

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

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

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

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

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

(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) of this Part, shall receive both infrastructure and care management per member per month (PMPM) payments. The care management PMPM payment shall support development and maintenance of a care management function within the practice site.

(2) Primary care practices with NCQA recognition and which have met the requirements in §4.3(A)(15) of this Part 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.

~~1. Each Health Insurer shall take such actions as are necessary so that, no later than December 31, 2019, 80 percent of the Primary Care Practices contracting with the Health Insurer are functioning as a Patient-Centered Medical Home, as defined in § 4.3(A)(14) of this Part. Such actions shall include but not be limited to contractual incentives for practices participating in a Patient-Centered Medical Home, and contractual disincentives for practices that are not participating in such care transformation practices.~~

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

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

(1) Financial barriers. By January 1, 2021 ~~H~~health insurers shall eliminate copayments for patients who have a behavioral health visit with an in-network behavioral health provider on the same day and in the same location as a

primary care visit at a Qualifying Integrated Behavioral Health Primary Care Practice as defined in § 4.3(A)(1918) of this Part.

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

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

b. The Commissioner shall determine which practices are Qualifying Integrated Behavioral Health Primary Care Practices beginning in the fall of by November 30, 2020, and annually thereafter. for Health Insurer administration beginning January 1, 2021, and by November 30 of each calendar year thereafter. The Commissioner shall issue guidelines on any time limitations for practices to qualify under §§ 4.3(A)(1918)(a) and (b) of this Part.

c. Health insurers shall submit a report to the Commissioner no later than OctoberJune 310, 2020, that delineates strategies, in addition to the requirements in § 4.10(D)(3)(c) of this Part, to facilitate and support the integration of behavioral health care into the primary care setting. The Commissioner shall issue documentation no later than Augustpril 1, 2020 that includes specific questions for the health insurers to respond to and any additional requirements for the report. The Commissioner shall post the completed reports on the OHIC website.

2. Care Transformation Advisory Committee

a. The Commissioner shall convene a Care Transformation Advisory Committee by February 28, 2015, by October 1, 2015, and by October 1 of each year thereafter. The Committee shall be charged with developing an annual care transformation plan designed to achieve the 80 percent requirement established in § 4.10(C)(1) of this Part.

b. The Commissioner shall designate as members of the Committee individuals or organizations that can bring value to the work of the Committee representing:

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

(2) Health Insurers;

(3) Hospital systems;

(4) Health care providers;

(5) Consumers;

(6) Businesses; and

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

c. The care transformation plan shall recommend, subject to approval by the Commissioner:

(1) annual care transformation targets prior to 2019,

(2) the specific Health Insurer activities, resources and financial supports needed by providers to achieve the targets, and

(3) common standards and procedures governing Health Insurer-primary care provider contractual agreements, such as, for alignment of performance measures and Health Insurer provision of information to practice. Such activities, resources, and financial support may include: the creation of community health teams to support small, independent practices with care management resources, and the deployment of practice coaches to provide technical assistance for primary care practices. The plan, together with any stakeholder comments, shall be submitted to the Commissioner on or before May 1, 2015 and before January 1 of each year thereafter. Health Insurers shall comply with the requirements of the plan approved by the Commissioner.

d. In the event that the Committee's stakeholders are unable to reach agreement on the plan, or in the event that the plan is inadequate for achieving the 80 percent requirement established in § 4.10(C)(1) of this Part, the Commissioner may adopt, and may

~~require compliance by Health Insurers with a suitable plan as a condition of approval of Health Insurers' rates.~~

~~3. Health Insurers shall fund the care transformation plan approved by the Commissioner in accordance with a formula established by the Commissioner that is based upon the Health Insurer's market share and other relevant considerations. In meeting its annual financial obligation, the Health Insurer's insured covered lives shall not bear a financial burden greater than their fair share of expenses that benefit both insured covered lives, and other covered lives whose health plans are administered by the Health Insurer. The Health Insurer's expenses in connection with the budget shall be accounted for as Direct or Indirect Primary Care Expenses, as applicable.~~

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

~~1. Population-based contracting. Health Insurers shall take such actions as are necessary to achieve the following population-based contracting targets:~~

~~a. By the end of calendar year 2015, at least 30 percent of insured covered lives shall be attributed to a Population-Based Contract that is a Shared Savings Contract, a Risk Sharing Contract, or a Global Capitation Contract.~~

~~b. By the end of calendar year 2016, at least 45 percent of insured covered lives shall be subject to a Population-Based Contract with at least 10 percent of insured covered lives attributed to a Population-Based Contract that is a Risk Sharing Contract, or a Global Capitation Contract.~~

~~c. A Health Insurer shall not enter into a Risk Sharing Contract or a Global Capitation contract unless the Health Insurer has determined, in accordance with standard operating procedures filed and approved by the Commissioner, that the provider organization~~

~~entering into the contract has the operational and financial capacity and resources needed to assume clinical and financial responsibility for the provision of covered services to members attributable to the provider organization. At the reasonable request of the provider organization, the Health Insurer shall maintain the confidentiality of information which the Health Insurer requests to make its determination. The Health Insurer shall periodically review the provider organization's continuing ability to assume such responsibilities. The Health Insurer shall maintain contingency plans in the event the provider organization is unable to sustain its ability to manage its responsibilities. The foregoing shall not be construed to permit the transfer of insurance risk or the transfer of delegation of the Health Insurer's regulatory obligations.~~

~~2. Alternative payment methodologies~~

~~a. The purpose of this § 4.10(D)(2) of this Part is to significantly reduce the use of fee-for-service payment as a payment methodology, in order to mitigate fee-for-service volume incentives which unreasonably and unnecessarily increase the overall cost of care, and to replace fee-for-service payment with alternative payment methodologies that provide incentives for better quality and more efficient delivery of health services.~~

~~b. Health Insurers shall increase annually their use of nationally recognized, alternative payment methodology payments for hospital services, medical and surgical services, and primary care services in accordance with a schedule filed by the Health Insurer and approved or approved as modified by the Commissioner during the annual rate review process. A Health Insurer may request the Commissioner's approval of other effective alternative payment methodologies which have not been nationally recognized.~~

~~c. The Commissioner shall convene an Alternative Payment Methodology Committee by February 28, 2015, by October 1, 2015, and by October 1 each year thereafter. The Committee shall be charged with developing a target and a target date for increasing the use of alternative payment methodologies submitted for the Commissioner's approval by May 1, 2015, and by January 1 each year thereafter, and an annual alternative payment methodology plan for achieving the target. The Committee that convenes on October 1, 2015 shall be tasked with developing an alternative payment plan that specifically addresses medical and surgical specialty professional providers.~~

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

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

~~(2) Health Insurers;~~

~~(3) Hospital systems;~~

~~(4) Health care providers;~~

~~(5) Consumers;~~

~~(6) Businesses; and~~

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

~~e. The alternative payment methodology plan shall recommend subject to approval by the Commissioner:~~

~~(1) annual targets prior to achieving the ultimate target, and~~

~~(2) the type of payments that should be considered alternative methodology payments (such as bundled payments, prospective payments, and pay-for-performance payments). The plan, together with any stakeholder comments, shall be submitted to the Commissioner on or before May 1st of each year. Health Insurer shall comply with the requirements of the plan approved by the Commissioner.~~

~~f. In the event that the Committee's stakeholders are unable to reach agreement on the plan, or in the event that the plan is inadequate for implementing the schedule approved in § 4.10(D)(2)(b) of this Part, the Commissioner may require adoption of a suitable plan as a condition of approval of Health Insurers' rate~~

1. Alternative payment models

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

b. Health insurers shall take such actions as necessary to have 50% of insured medical payments made through an alternative payment

model by January 1, 2021, and annually thereafter. The Commissioner shall issue a policy and guidelines manual by January 1 of each year that specifies the types of payments and payment models which may be credited toward the 50% target.

2. Population-based contracts

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

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

c. 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.

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

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

at least 6% and a minimum loss rate of no more than 3% of the total cost of care.

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

(3) For contracts with Physician-based Integrated Systems of Care between 10,000 and 20,000 attributed commercial lives, health insurers shall employ a risk-sharing rate of at least 40%, and if applicable, a risk-exposure cap of at least 7% of provider revenue or at least 2% of the total cost of care and a minimum loss rate of no more than 3% of the total cost of care. For such contracts entered into, renewed, or amended on or after January 1, 2021, health insurers shall employ a risk-sharing rate of at least 50%, and if applicable, a risk-exposure cap of at least 8% of provider revenue or at least 3% of the total cost of care and a minimum loss rate of no more than 3% of the total cost of care.

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

(5) The Minimum Downside Risk requirements above, while not applicable to risk-sharing contracts with fewer than 10,000 attributed commercial lives, should not be construed to preclude or discourage health insurers and providers from entering into risk-sharing contracts with fewer than 10,000

attributed lives. OHIC recommends health insurer and provider caution when doing so, however, in order to account for the decreased statistical certainty with attributed populations less than 10,000.

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

e. A health insurer shall not enter into a Risk Sharing Contract or a Global Capitation contract unless the health insurer has determined, in accordance with standard operating procedures filed and approved by the Commissioner, that the provider organization entering into the contract has the operational and financial capacity and resources needed to assume clinical and financial responsibility for the provision of covered services to members attributable to the provider organization. At the reasonable request of the provider organization, the health insurer shall maintain the confidentiality of information which the health insurer requests to make its determination. The health insurer shall periodically review the provider organization's continuing ability to assume such responsibilities. The health insurer shall maintain contingency plans in the event the provider organization is unable to sustain its ability to manage its responsibilities. The foregoing shall not be construed to permit the transfer of insurance risk or the transfer of delegation of the health insurer's regulatory obligations.

f. Population-Based Contracts shall include a provision that agrees on a budget for each contract year. Review and prior approval by the Office of the Health Insurance Commissioner shall be required if any annual increase in the total cost of care for services reimbursed under the contract, after risk adjustment, exceeds the US All Urban Consumer All Items Less Food and Energy CPI ("CPI-Urban") percentage increase (determined by the Commissioner by October 1 of each year, based on the most recently published United States Department of Labor data). Such percentage increase shall be plus 1.5%.

g. Should any Integrated System of Care~~provider organization~~ have had three immediately prior years of average historical risk-adjusted total cost of care per capita spending for the provider's attributed patient population that was significantly below the health insurer's risk-adjusted commercially insured average (statistically significant at p <= .05 and excluding the provider from the calculated average), the health insurer may prospectively adjust

that provider's budget upward by up to, but not more than, 2% of the provider's unadjusted expected per capita spending. The adjusted budget shall never exceed the health insurer's projected risk-adjusted commercially insured average spending. Only Integration Systems of Care with risk-sharing contracts shall qualify for the upward budget adjustment.

h. Population-based Contracts shall not carve out behavioral health or prescription drug claims experience from the provider budget. Population-based Contracts may include a methodology to reflect the member-months for which the health insurer covers pharmacy and/or behavioral health claims.

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

3. Primary care alternative payment models

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

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

c. For primary care practices recognized as a Qualifying Integrated Behavioral Health Primary Care Practice under § 4.3(A)(18) of this Part, Health Insurers shall develop and implement a prospectively paid alternative payment model for primary care that compensates practices for the primary care and behavioral health services delivered by the site.

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

(1) By January 1, 2021, at least ~~20~~10% of insured Rhode Island resident covered lives shall be attributed to a prospectively paid primary care alternative payment model.

(2) By January 1, 2022, at least ~~40~~25% of insured Rhode Island resident covered lives shall be attributed to a prospectively paid primary care alternative payment model.

(3) By January 1, 2023, at least ~~60~~40% of insured Rhode Island resident covered lives shall be attributed to a prospectively paid primary care alternative payment model.

(4) By January 1, 2024, at least 60% of insured Rhode Island resident covered lives shall be attributed to a prospectively paid primary care alternative payment model.

e. No later than October ~~April~~ 2021, the Commissioner shall convene a working group to assess health insurer, provider and patient experience under these models.

4. Specialist alternative payment models

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

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

(1) Orthopedics;

(2) Gastroenterology;

(3) Cardiology;

(4) Behavioral health; and

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

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

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

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

53. Measure alignment

a. The purpose of this § 4.10(D)(53) of this Part is to ensure consistency in the use of quality measures in contracts between Hhealth iinsurers and health care providers in Rhode Island, to reduce the administrative burden placed on providers by the unaligned use of quality measures across health insurerspayers, to improve the quality of care by channeling clinical focus on core areas of health care delivery, to formally adopt Aligned Measure Sets to be used in contracts between Hhealth iinsurers and health care providers in Rhode Island, and to articulate a process for annually refining and updating the Aligned Measure Sets.

b. § 4.10(D)(53) of this Part applies to contracts between health care providers, including primary care providers, specialists, hospitals, and Integrated Systems of Care and a Hhealth iinsurer which incorporate quality measures into the payment terms of the contract and which are entered into, renewed, or amended on or after Julyanuary 1, 2020, or the effective date of this regulation, if earlierare entered into after July 1, 2017, or expire after July 1, 2017, or which would expire after July 1, 2017 but for the amendment or renewal of the contract (whether the renewal is effective pursuant to the terms of a previously executed contract, or otherwise).

c. Health iinsurers shall adopt the Aligned Measure Sets for primary care, hospitals, and Accountable Care Organizations (ACOs, otherwise known as Integrated Systems of Care as defined in § 4.3(A)(12) of this Part), maternity care, outpatient behavioral health

and any other Aligned Measure Set developed pursuant to this § 4.10(D)(5~~3~~) of this Part.

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

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

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

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

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

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

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

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

(3~~2~~) Propose~~s~~ measures as Core Measures and Menu Measures.

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

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

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

(2) Health ~~i~~insurers;

(3) Hospital systems;

(4) Health care providers;

(5) Consumers;

(6) Quality measure experts; and~~/or~~

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

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

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

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

64. Hospital contracts

a. Each ~~H~~health ~~i~~insurer shall include in its hospital contracts the terms required by § 4.10(D)(64) of this Part.

b. This § 4.10(D)(64) of this Part shall apply to contracts between a ~~H~~health ~~i~~insurer and a hospital licensed in Rhode Island which are entered into, renewed, or amended on or after July~~anuary~~ 1, 2020, or the effective date of this regulation, if earlier.~~, or which expire after January 1, 2020~~17, or which would expire but for the

~~amendment or renewal of the contract (whether the renewal is effective pursuant to the terms of a previously executed contract, or otherwise).~~ To ensure compliance with this subsection in the event of any hospital conversions pursuant to R.I. Gen. Laws Chapter 23-17.14, the ~~H~~health ~~i~~nsurer shall, in terms of contracting, treat the contract of the successor hospital or entity as a continuation of the contract of the predecessor hospital or entity with whom the ~~H~~health ~~i~~nsurer had contracted.

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

d. Hospital contracts shall include a quality incentive program.

(1) The quality incentive program shall include payment for attaining or exceeding mutually agreed-to, sufficiently challenging performance levels for all Core Measures within the Aligned Measure Set for hospitals. For measures beyond the Core Measures the ~~H~~health ~~i~~nsurer shall limit selection of measures to those listed as Menu Measures in the Aligned Measures Set for hospitals.

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

(3) Incentive payments will not be due and payable until the quality incentive measure targets have been met or otherwise achieved by the hospital. A ~~H~~health ~~i~~nsurer may m~~t~~ake interim payments in the event that interim quality performance targets have been met; provided that the interim payments ~~must be~~ are commensurate with the achievement of the interim targets; and provided further that if the annual quality performance targets have not been achieved, the hospital shall be required to remit unearned interim payments back to the ~~H~~health ~~i~~nsurer. A health insurer may also make prospective payments without consideration of performance, provided that if the annual quality performance targets have not been achieved, the hospital shall be required to remit unearned prospective payments back to the health insurer.

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

(1) The average rate increase, including estimated quality incentive payments, is greater than the US All Urban Consumer All Items Less Food and Energy CPI ("CPI-Urban") percentage increase (determined by the Commissioner by October 1 each year, based on the most recently published United States Department of Labor data). Such percentage increase shall be plus 1%, or

(2) Less than 50% of the average rate increase is for expected quality incentive payments.

f. Hospitals which have been paid by a health insurer at less than the median commercial payments made to all Rhode Island acute care hospitals for inpatient services, including inpatient behavioral health services, in the health insurer's provider network, as determined by the health insurer summing all of its inpatient payments (numerator) and dividing that by a sum of all DRG case weights (denominator) to provide a case-mix-adjusted discharge payment rate for each hospital for inpatient services, shall receive an equal percentage increase in payment for each inpatient service until the hospital's average payment per case-mix-adjusted DRG for inpatient services is equal to the median. At the time of the calculation, the health insurer shall utilize the most recent 12-months of claims data for which the health insurer's Rhode Island hospital claim runout is at least 95% complete. The increase in payment rates shall not be construed as an ongoing price floor. The increase in payment rates shall be contractually contingent on the following:

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

(2) At the mutual agreement of the health insurer and hospital, alternative quality measures and performance targets may be employed as a substitute for the quality measures and performance targets specified in § 4.10(D)(6)(f)(1). If the

parties cannot agree to an alternative set of quality measures, then the quality measures and performance targets in § 4.10(D)(6)(f)(1) shall be used.

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

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

hg. Hospital contracts shall include terms that relinquish the right of either party to contest the public release, by state officials or the parties to the contract of the provisions of the contract demonstrating compliance with the requirements of this § 4.10(D)(64) of this Part; provided that the Hhealth Iinsurer or other affected party may request the Commissioner to maintain specific contract terms or portions thereof as confidential, if properly supported with legal and factual analysis justifying the claim of confidentiality.

5. Population-based contracts

a. This § 4.10(D)(5) of this Part applies to Population-Based Contracts between an Integrated System of Care and a Health Insurer which are entered into after July 1, 2015, or expire after July 1, 2015, or which would expire after July 1, 2015 but for the amendment or renewal of the contract (whether the renewal is effective pursuant to the terms of a previously executed contract, or otherwise). Each Health Insurer shall comply with the requirements of this § 4.10(D)(5) of this Part.

b. Population-Based Contracts shall include a provision that agrees on a budget for each contract year, such that review and prior approval by the Office of the Health Insurance Commissioner shall be required if any annual increase in the total cost of care for services reimbursed under the contract, after risk adjustment, exceeds the US All Urban Consumer All Items Less Food and Energy CPI ("CPI-Urban") percentage increase (determined by the Commissioner as soon as practicable for calendar year 2015 and

~~by October 1 of each year, based on the most recently published United States Department of Labor data). Such percentage increase shall be plus 3.5% during calendar year 2015, plus 3.0% during calendar year 2016, plus 2.5% during calendar year 2017, plus 2.0% during calendar year 2018, and plus 1.5% after calendar year 2018.~~

~~c. Population-Based Contracts shall include terms that relinquish the right of any party to contest the public release, by state officials or the parties to the contract, of the provisions of the contract demonstrating compliance with the requirements of § 4.10(D)(5) of this Part; provided that the Health Insurer or other affected party may request the Commissioner to maintain specific contract terms or portions thereof as confidential, if properly supported with legal and factual analysis justifying the claim of confidentiality.~~

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

E. Stakeholder input, waiver and modification~~Waiver and modification~~

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

a. The Commissioner shall convene a Payment and Care Delivery Advisory Committee by October 1 each year. The Committee shall be charged with developing recommendations for necessary actions by the Commissioner to advance health care system performance and affordability. By July 1 of each year, the Commissioner shall solicit input from members of the Committee on topics to address during the Fall meetings.

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

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

(2) Health insurers;

(3) Integrated Systems of Care;

(4) Hospital systems;

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

(6) Consumers; and

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

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

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

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

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

32. ~~Comment and accountability~~ A health insurer shall not be held accountable for a violation of the requirements of § 4.10 of this Part if the health insurer demonstrates to the satisfaction of the Commissioner that compliance with any of these requirements was not possible, notwithstanding the health insurer's good faith and reasonable efforts. The health insurer shall notify the Commissioner and request a waiver under § 4.10(E)(2) of this Part, if desired, as soon as any such circumstances arise. Failure by the health insurer to establish that good faith and reasonable efforts were undertaken shall result in penalties consistent with the Commissioner's authority under R.I. Gen. Laws Titles 27 and 42.

~~a. On or before January 1 of each year the Commissioner shall solicit comments from stakeholders, and issue formal guidance~~

~~concerning whether the population-based contracting targets established in §§ 4.10(D)(1)(a) through (c) of this Part, the population-based contract budget limits established in § 4.10(D)(5)(b) of this Part, the care transformation requirements established in § 4.10(C)(1) of this Part, or the alternative payment requirements established in § 4.10(D)(2)(b) of this Part should be modified:~~

~~(1) To create or maintain an effective incentive for hospitals and providers to participate in care transformation, population-based contracts and alternative payment arrangements; or~~

~~(2) To account for unanticipated and profound macroeconomic events, or similarly significant changes in systemic utilization or costs that are beyond the ability of the Health Insurer to control, such that application of the budget limit would be manifestly unfair.~~

~~b. A Health Insurer shall not be held accountable for a violation of the population-based contracting targets established in §§ 4.10(D)(1)(a) through (c) of this Part, the population-based budget limit established in § 4.10(D)(5)(b) of this Part, the care transformation requirements established in § 4.10(C)(1) of this Part, or the alternative payment requirements established in § 4.10(D)(2)(b) of this Part if the Health Insurer demonstrates to the satisfaction of the Commissioner that compliance with any of these requirements was not possible, notwithstanding the Health Insurer's good faith and reasonable efforts. The Health Insurer shall notify the Commissioner and request a waiver under § 4.10(E)(1) of this Part, if desired, as soon as any such circumstances arise.~~

F. Data collection and evaluation

1. On or before 15 days following the end of each quarter, each ~~H~~health ~~i~~insurer shall submit to the Commissioner, in a format approved by the Commissioner, a Primary Care Spend Report, a Care Transformation Report, and a Payment Reform Report, including such data as is necessary to monitor and evaluate the provisions of this Section. The Care Transformation Report shall include data measuring the integration of behavioral health care into Patient-Centered Medical Homes and other provider practices, and measuring the impact of such integration on health care quality and cost.

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

3. ~~During calendar year 2018, the Office shall conduct a comprehensive evaluation of the Affordability Standards, together with recommendations for achieving the health care quality and affordability goals of the Office. Following completion of the comprehensive evaluation, the Commissioner shall request the Health Insurance Advisory Council to review the evaluation and make recommendations to the Commissioner for any revisions to the Affordability Standards.~~

~~4.~~ Health ~~i~~insurers shall provide to the Office, in a timely manner and in the format requested by the Commissioner, such data as the Commissioner determines is necessary to evaluate the Affordability Standards and~~,~~ to monitor compliance with the Affordability Standards established in this § 4.10 of this Part~~, and to evaluate and monitor the activities necessary to implement the State Innovation Models Grant, which has been awarded to Rhode Island by the federal Centers for Medicare and Medicaid Services~~. Such data may include any hospital or provider reimbursement contract, and any data relating to a hospital~~'s~~ or provider's attainment of quality and other performance-based measures as specified in quality incentive programs referenced in §§ 4.10(D)(64)(d) and (e) of this Part.

45. To the extent possible, the Office shall use the All Payer Claims Database authorized by R.I. Gen. Laws Chapter 23-17.17 to collect data required by this subsection.

4.11 Administrative Simplification

A. Administrative Simplification Task Force

1. An Administrative Simplification Task Force is established to make recommendations to the Commissioner for streamlining health care administration so as to be more cost-effective, and less time-consuming for hospitals, providers, consumers, and insurers, and to carry out the purposes of R.I. Gen. Laws § 42-14.5-3(h). The Commissioner shall appoint as members of the Task Force representatives of hospitals, physician practices, community behavioral health organizations, each health insurer, consumers, businesses, and other affected entities, as necessary and relevant to the issues and work of the Task Force. The Task force shall also include at least one designee each from the Rhode Island Medical Society, Rhode Island Council of Community Mental Health Organizations, the Rhode Island Health Center Association, and the Hospital Association of Rhode Island. The Chair or Co-Chairs of the Task Force shall be selected annually by its members.

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

B. Retroactive terminations

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

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

3. Health insurers may include the reasonable cost of retroactive terminations into their filed rates. Health insurers shall establish reasonable policies and procedures for providers to conduct eligibility checks at the time services are provided. If the health issuer requires by administrative policy or provider contract that the eligibility check is a prerequisite to the application of the provisions of this Subsection, the Health Insurer must also provide an administratively simple mechanism, approved by the Commissioner, for the provider to document that eligibility was checked by the provider at the time of service. In addition, Health Insurers may include reasonable adjustments attributable to the Insurer's financial burden with respect to retroactive terminations with its employer groups, so long as the process does not include recoupment of payments

from providers not permitted under this § 4.11(B) of this Part in the event of retroactive termination.

C. Coordination of benefits

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

2. Health Insurers shall:

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

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

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

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

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

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

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

D. Appeals of "timely filing" denials

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

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

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

    a. A copy of the timely filing denial;

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

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

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

        (1) ~~b~~Benefit determination documents from another carrier,

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

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

        (4) ~~d~~Documentation as to the exact date the provider was notified of member's correct coverage, who notified the provider, how the provider was notified and a brief, reasonable statement as to why the provider did not initially know the patient was not covered by carrier. Practice management and billing system information can be used as supportive documentation for these purposes.

4. Health Insurers shall notify providers that upon submission of the information required by § 4.11(D)(3) of this Part the Health Insurer shall

not deny the appeal of a claim due to the failure to file the claim in a timely manner. Nothing in this Subsection precludes the denial of a claim for other reasons unrelated to the timeliness of filing the claim.

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

b. Health Insurers may implement the requirements of this Subsection either by amendments to their claims processing system, or by amendments to their provider appeal policies and procedures.

E. Medical records management

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

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

3. Health insurer requests for medical records shall specify:

a. What medical record information is being requested;

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

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

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

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

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

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

b. wWhat specific records are to be sent, and

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

4.12 Price Disclosure

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

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

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

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

~~E. Each Health Insurer shall file for the Commissioner's approval its Comprehensive Price Transparency Plan. A Comprehensive Price Transparency Plan shall empower consumers and health care providers to make informed and cost-effective health care decisions with respect to the Health Insurer's network of participating providers, facilities and vendors. The Plan shall:~~

~~1. Identify the health care services, products and supplies subject to price disclosure under the Plan, including but not limited to hospital in-patient and out-patient services, physician services, other health care provider services, medical imaging services, laboratory services, prescription drug prices, durable medical equipment, and medical supplies;~~

~~2. Identify the health services, products and supplies, if any, that are not subject to price disclosure under the Plan, a reasonable basis for not~~

~~including those services, products and supplies within the Plan, and a time table for including those services, products and supplies in the Plan; and~~

~~3. Disclose price information with respect to services reimbursed on a fee-for service basis, as well as services reimbursed by alternative reimbursement mechanisms.~~

4.13 Severability

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

4.14 Construction

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

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