Public Comments
Advance Notice of Proposed Rulemaking
230-RICR-20-30-4

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TO: Office of the Health Insurance Commissioner

FROM: American Cancer Society Cancer Action Network

DATE: December 16, 2021

SUBJECT: **Next Generation Affordability Standards Recommendations**

The American Cancer Society Cancer Action Network (ACS CAN) is the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society. ACS CAN supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. On behalf of ACS CAN, I would like to thank the Office of the Health Insurance Commissioner (OHIC) and Commissioner Tigue for your dedication to improving the quality and affordability of health insurance in Rhode Island. We appreciate the opportunity for ACS CAN to provide input on the direction of the Affordability Standards.

While we don't have input specific to the requirements outlined in the concept paper, we did want to weigh in with related opportunities to improve affordability, access and experience for health insurance consumers in Rhode Island.

Require flat dollar copays in prescription drug benefits

Thanks to innovative new medicines, many diseases that were once fatal are now being treated as manageable chronic conditions, and for other diseases, new medicines have greatly increased average life expectancy. But today, under many health insurance plans, patients living with serious and life-threatening diseases must pay thousands of dollars in out-of-pocket costs to access the medicines their health care providers have prescribed. This is true for medications used to treat cancer, multiple sclerosis, arthritis, HIV/AIDS, and other debilitating and life-threatening diseases. When cost-sharing becomes a barrier to access, patients find themselves facing difficult decisions about whether to take medically-necessary treatments or to risk the family's financial stability.

Other states have implemented regulatory measures to help to alleviate these concerns. We recommend that health insurers be required to have a subset of their plans on the individual and small group market include a pre-deductible, flat-dollar copayment structure to the entire drug benefit, including all tiers. The flat-dollar copayment tier structure for prescription drugs offered should be graduated and proportionately related, with the highest possible copay set at one-twelfth of the individual maximum out out-of-pocket per plan year.

Rhode Island would not pioneer the implementation of these regulatory standards. In 2018, the Colorado Department of Insurance (DOI) adopted a regulation that required each insurer to offer at least 25% of their plans at each metal level with a copayment-only payment structure for all drug tiers, without applying a

deductible or coinsurance. The regulation limited the highest allowable copayment for the highest cost drug tier to no greater than 1/12th of the plan's individual annual out-of-pocket maximum. The regulation required carriers to meet the 25% requirements for plans offered on the exchange and outside of the exchange.[i]

I've included a letter from Colorado's DOI where they confirmed that (1) the premium differences between copay-only and non-copay products are small, (2) insurers continue to deliver a robust set of copay-only and non-copay product options across the state at the bronze, silver, and gold levels, and (3) this regulation has had no demonstrable impact on the health of the state's markets and the ability of insurers to develop products and negotiate with drug makers.

Standardized Benefit Designs

Notably, Rhode Island is one of only two states in New England that doesn't require standardized individual market health plans. ACS CAN supports the creation of standardized benefit designs, which can be beneficial to individuals as they shop for health insurance coverage. This standardization could allow individuals shopping for coverage to focus on the most important aspects of their health insurance plan such as plan provider networks, covered benefits, quality, and premiums.

Standardized benefit designs is a practical way to reduce consumer confusion and allow consumers to compare plans during enrollment periods. Standardized benefit designs also have potential to be used as a mechanism to reduce health disparities. In Colorado, standard plans must be designed to promote health equity. The state's process for determining the design will include stakeholder engagement – soliciting input from the communities on opportunities to reduce health disparities.[ii] The District of Columbia, similarly, is analyzing and acting on opportunities to reduce disparities through plan designs.[iii]

Thank you for the opportunity to provide comments on the direction of the Affordability Standards here in Rhode Island. We are encouraged to see OHIC's dedication to increasing affordability and access for consumers in Rhode Island and look forward to continuing to work with you on these efforts.

Please feel free to contact me at Cori.Chandler@cancer.org or (401) 352-6761 if any additional information is needed or if you have any questions.

Cori Chandler

Cori Chandler
ACS CAN Rhode Island Government Relations Director

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[i] Colorado Department of Regulatory Agencies, Division of Insurance, Colorado Insurance Regulation 4-2-58. https://drive.google.com/file/d/1O5ahn2TLXaIEGZIoOADRoRCNposXytLq/view

[ii] Public Option Institute. "Summary of Standardized Benefit Plan Colorado Option" https://www.publicoptioninstitute.org/feed-co-legislation/summary-of-standardized-health-benefit-plan-colorado-option

[iii] DC Health Link. "DC Health Benefit Exchange Authority Takes Action to Achieve Social Justice and Equity in Health Insurance Coverage." https://dchealthlink.com/node/3569

COLORADO
Department of
Regulatory Agencies
Division of Insurance

February 22, 2021

Dana Bacon
Regional Director, Government Affairs
The Leukemia & Lymphoma Society
Office of Public Policy
10 G St. NE, Suite 400
Washington, DC 20002

Dear Mr. Bacon:

Thank you for your inquiry regarding the impact of Colorado Division of Insurance (DOI) regulation entitled "Non-discriminatory cost-sharing and tiering requirements for prescription drugs" (4-2-58).

DOI promulgated this regulation to prevent individual and small group ACA plans from using formulary designs to discriminate against Coloradans with certain health conditions. An estimated 780,000 Colorado adults under 65 (22%) have preexisting conditions, and many of these individuals require expensive medications to treat their conditions. In 2015, DOI implemented the policies that are now required by regulation 4-2-58. Among its provisions, this regulation requires 25% of a carrier's plans to have a copay-only payment structure for all drug tiers. It also allows no more than 50% of drugs that treat a particular condition from being placed in the highest cost tier.

Because of this regulation, consumers are more protected and have better choices in health insurance plans. Consumers are able to choose the plan that best balances their health care needs and personal financial situation. Coloradans are buying copay-only plans offered at the bronze, silver, and gold metal tiers statewide. Prices of these plans remain competitive relative to their non-copay counterparts. The number of consumer complaints DOI has received about prescription copay-only plans is comparable to those about other products offered on the market.

We see no evidence that this regulation has had negative impacts on the Colorado health insurance market. Colorado's individual health insurance market is as strong as ever. We have fewer counties with only one carrier offering plans on our state-based marketplace than at any time in the last five years. Consumers shopping in both rural and urban areas

across our state have dozens of plans available from which to choose. With insurance rates now declining in Colorado, there is no evidence that the business operations and negotiating leverage of Colorado health insurers has been impacted. The availability of prescription copay-only plans appears to have had no impact on the availability or affordability of health insurance products being sold on the individual and small-group markets here in Colorado.

We are committed to continuing to improve this regulation. The Division recently released a revised version that clarifies and strengthens our existing approach. It is available on our website.

Thank you again for your inquiry. Please let us know if you have any further questions.

Sincerely,

/s/ Kyle Brown /s/

Kyle Brown
Deputy Commissioner, Affordability Programs
Colorado Division of Insurance

Next Generation Affordability Standards: Concepts, Rationale, and Additional Information

Comments submitted by the Division of Behavioral Healthcare at the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals

The new requirements under consideration include:

1. A behavioral health investment/spending requirement;
2. A community investment requirement; and,
3. A professional services average annual price growth cap.

1. Behavioral health investment/spending requirement

Relevant sections quoted from the OHIC document:

The next generation Affordability Standards currently in development represent an effort to broaden insurer accountability for improving affordability by addressing:

Necessary investment in behavioral health services to ensure a well-functioning continuum of care for Rhode Islanders with behavioral health needs (from p.2 of OHIC document)

Rationale. *Legislation was enacted in 2018 that augmented OHIC's powers and duties under State of Rhode Island General Laws (RIGL) § 42-14.5-3 with respect to the promotion of integrated behavioral health. These provisions direct OHIC:*

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

Comments:

a. A combination of all three bullets, above, would justify increasing access to behavioral health treatment for those who receive care through Medicaid Managed Care, by enforcing parity requirements for Medicaid to the same extent that OHIC enforces parity for the commercial insurers. If OHIC does not interpret its authority to extend to Medicaid, then it should use its influence to achieve the same end by implementing the third bullet, that appears in the quote within the text box, above, with the commercial insurers whose business includes Medicaid Managed Care.

b. BH Link, RI's only 24/7 Behavioral Health call-in/walk-in triage center, is used by some individuals who are covered by commercial insurance. According to BHDDH, 15.6% of all assessments in SFY21 at BH Link were paid by commercial insurance (this reflects visits--it does not indicate that 15.6% of all people seen at BH Link during the year were commercially insured, as one individual may have multiple visits). An investment in BH Link by commercial insurers would fulfill this proposed Affordability Standard by ensuring the financial stability of one of the critical services within a well-functioning continuum of care. It will also provide commercial insurers an attractive alternative for their insureds especially if the insurers provide a financial incentive to seek urgent care through BH Link, instead of through a traditional hospital emergency department.

c. Since OHIC wishes to develop a high-quality delivery system that can serve the physical and behavioral health needs of the public, BH Link could be funded to provide staff that would also rule-out (or rule-in) physical health concerns that may impact—or be the result of—acute behavioral health conditions, or to provide medical clearance to those who present with certain, defined symptoms.

   For example, a combination of supervising physicians, physician assistants, nurse practitioners, and possibly medical residents (through a cooperative agreement with the academic medical institutions in the state) could be available to those who seek care at BH Link. This would also fulfill OHIC's legislative mandate "to work with other state agencies [BHDDH] to enhance access to a continuum of mental health and substance use disorder treatment and integrate that treatment with primary and other medical care to the fullest extent possible." Another benefit could be the support of a second BH Link triage center in South County where there is a very high proportion of commercially insured individuals.

d. A full continuum of care for individuals with serious mental illness (SMI) and serious and persistent mental illness (SPMI) requires a robust array of services to support individuals who live in the community. The Truven Report (found here) concluded that,

> Rhode Island should shift financing and provision of services away from high-cost, intensive, and reactive services toward evidence-based services that facilitate patient-centered, *community-based*, recovery-oriented, coordinated care [emphasis added] … Rhode Island is spending more in total on behavioral healthcare services primarily because of relatively greater expenditures on inpatient care and prescription medications. P.4.

While the Truven Report was issued in 2015, many of its findings still hold true. Not only does Rhode Island require greater investments in the bricks and mortar of housing (see below) but the behavioral health system itself is not truly a "system" when the necessary options that would constitute a full continuum of care are lacking.

Patients in an inpatient setting should not be discharged to an inappropriate level of care because the appropriate level of care does not exist, nor should they remain hospitalized because the system does not offer the non-hospital level of care that they need; similarly, patients should not need to "board" in an emergency department of a hospital because inpatient psychiatric beds are full, in part due to the "gridlock" caused by the lack of appropriate options for those inpatients who are waiting for discharge.

e. This state desperately needs step-down and step-up units to serve individuals who do not require inpatient hospitalization, but whose clinical status requires more supervision and/or active treatment than what they can receive in their living situation. Once again, building this capacity in South County where the number of commercially insured individuals is very high would be a great benefit to the system. This would allow for inpatient beds to be reserved for those who truly need an inpatient level of care. It would also be consistent with the U.S. Supreme Court landmark case, *Olmstead v. L.C.* (1999), found here.

f. The behavioral health system also needs to expand its *supportive* housing options so that individuals can live in the least restrictive setting that is appropriate to their needs. This ranges from 24-hour supervision, to lower levels of supervision such as supervision during daytime hours, or even less. The structure of the supervision should be such that as an individual's needs change, the level of supervision also can easily change. The nature of mental illness is that it waxes and wanes over time. The design of the system should include flexibility to "meet people where they are." The system must adapt to the clients in the system—not the other way around: person-centered.

g. It is imperative to compare funding for Federally Qualified Health Centers (FQHCs) with funding for Community Mental Health Centers (CMHCs) to comprehend the lack of parity that exists between the funding mechanism the two systems. A comparison of funding for FQHCs, which provide care for physical health, far exceeds funding available for CMHCs, which provide care for behavioral health (mental illness and substance use disorders).

Although the Executive Office of Health and Human Services (EOHHS) and BHDDH have plans to create Certified Community Behavioral Health Clinics (CCBHs) to increase access to a comprehensive array of services, CCBHCs will not have access to the same level of funding as FQHCs. According to the Kaiser Family Foundation, section 330 of the Public Health Service Act created and authorized the health center program and permits the Health Resources and Services Administration (HRSA) to make grants to health centers. This source of funds is not available to CMHCs.

According to KFF, Medicaid only accounts for 44% of FQHC funding but in 2017 covered 79% of the costs of providing care (and in 2010 it covered 81%). FQHCs receive funding for infrastructure, including bricks and mortar. By comparison, for CMHCs, Medicaid accounts for

far more than 44% of their funding. They receive very little money for infrastructure. A survey of many of the buildings that CMHCs in Rhode Island use to provide services are old and crumbling.

Finally, a recent award to FQHCs in Rhode Island for American Rescue Plan Act (ARPA) totals $33,582,000 to support eight (8) health centers. Covid has made the need for access to quality behavioral healthcare services more important than ever. It is undeniable that to serve the needs of Rhode Islanders funding for CMHCs must be a priority.

RI's Opioid Treatment Programs (OTP) need to be able to be reimbursed by all insurers for all three medications in order to be able to offer the choice of best medication to treat individuals with an opioid use disorder. **Review of the existing rates for all services for behavioral health need to be explored, as true fidelity to models with positive outcomes will not be obtained without an investment in appropriate reimbursement for evidence-based and promising practices.**

2. <u>A community investment requirement</u>

Relevant sections quoted from the OHIC document:

Concept. *OHIC is exploring proposing a community investment requirement that will mitigate growth in health care costs while advancing health equity, addressing social determinants of health (SDOH), and improving population health. In this context, advancing health equity means "dismantling the systemic racism that underlies differences in the opportunity to be healthy, including addressing social and economic barriers to positive health outcomes [where] . . . progress toward the goal of health equity is often benchmarked by measuring reductions in health disparities."4 OHIC is interested in considering several forms that such a requirement could take including but not limited to:*

1. ***Community Benefit Activities:*** *Insurers would be required to use a defined amount of their excess surplus that is consistent with both the public interest and proper business conduct on an annual basis to fund community benefit activities that advance health equity, address SDOH, and improve population health. Excess surplus would be defined in a manner consistent with the notion that such a surplus level is one that would be able to withstand any probable drain from unexpected severity or incidence of claims. The defined amount of excess surplus would be utilized by the insurer to fund activities selected by the insurer and approved by OHIC in advance of providing the funding. Examples of the types of community benefit activities that would be consistent with the aims of this requirement could include addressing birth-related health disparities through support for programs that have demonstrated the ability to improve birth outcomes, the development of new housing units specifically designed for individuals and families who are homeless or at risk of becoming homeless, or the expansion and sustainability of community health teams. OHIC would notify the insurers annually on areas of suggested priority for community benefit activities informed by the solicitation of public input by OHIC.*

2. ***Community Investment Fund:*** *Insurers would be required to contribute a defined amount of their excess surplus that is consistent with both the public interest and proper business conduct on an annual basis towards community initiatives that advance health equity, address SDOH, and improve population health. Excess surplus would be defined in a manner consistent with the notion that such a surplus level is one that would be able to withstand any probable drain from unexpected severity or incidence of claims. The defined amount of excess surplus would be contributed to a community investment fund to be established and administered by a philanthropic organization in partnership with OHIC. The community investment fund would support a focus upstream to address underlying inequities and influencers of health disparities such as affordable housing and food security. Eligible community initiatives to be supported by the community investment fund would be specified on an annual basis by the philanthropic organization in consultation with OHIC and informed by input from an advisory group of stakeholders, including consumers and employers representing communities that disproportionately experience poor health care outcomes as well as technical experts.*

3. ***Investment Portfolio Allocation:*** *Insurers would be required to allocate a portion of their investment portfolio that is consistent with both the public interest and proper business conduct to pooled investment vehicles that advance health equity, address SDOH, and improve population health. The allocation would take into account considerations such as "community, environmental and health benefits, as well as financial risks and returns, liquidity and geographic-related criteria."[5] OHIC would notify the insurers annually on areas of suggested priority for investment vehicles and approved by OHIC in advance of effectuating the allocation. This would be informed by the solicitation of public input by OHIC.*

- Comments:
  a. The OHIC document cites Community Catalyst, *Healthy Investments: Leveraging Health Plan Capital for Affordable Housing and Community Development* (Boston, MA: Community Catalyst, December 2019), 7, Healthy-Investments_final.pdf (communitycatalyst.org) , in which it is stated:

> *While the term "anchor institution" has typically been applied to hospitals, many health plans may also be viewed as anchor institutions, "rooted in their local communities by mission, invested capital, or relationships to customers, employees and vendors" and which "have the potential to bring crucial, and measurable, benefits to local children, families and communities." As such, they have an obligation to address the root causes of their members' health issues, including the lack of safe and affordable housing. This obligation has been cited, for example, by Kaiser Permanente – which is both a health care provider and a nonprofit health plan – when it announced three new initiatives to tackle housing insecurity. Similarly, UnitedHealthcare, pointed to the importance of "remov[ing] social barriers to better health for people in underserved communities" in announcing that its investments in affordable housing since 2011 have surpassed $400 million.*

  b. The number of individuals and families who experience housing instability in Rhode Island is rising, especially with the pandemic. It has always been the case that many of those who are homeless live with a serious mental illness and/or a substance use condition. For many who do

live with a behavioral health condition who often also have serious medical conditions, they may be housed, but not in the least restrictive setting. There are individuals who remain at a particular level of care beyond the time when they could be discharged to a lower level of care. The reason that there is no movement is because either the needed level of care has no openings, or the needed level does not exist. When people living with these behavioral and medical conditions live in precarious situation their conditions often go untreated and result in tragic outcomes.

c. AHIP (America's Health Insurance Plans, a health insurer association) cites data that approximately 30 percent of people who are homeless have a serious mental illness, and nearly 66 percent have a primary substance use disorder or other chronic health condition. Individuals with a mental health condition may also suffer from multiple chronic conditions, making it difficult to secure and maintain affordable housing. (Find AHIP Issue Brief here.).

   In Rhode Island, according to Crossroads-RI, each year approximately 4,000 men, women and children experience homelessness. Within Integrated Health Homes and Assertive Community Treatment, which are services provided to the SPMI population, 6% of these individuals experienced homelessness at some point during SFY 2021. This number is probably underreported as these are only the clients whom we know about who have been connected to treatment. The goal should be to improve access to services for all homeless individuals needing BH services.

d. The notion that health plans should invest in the development of housing is not novel. Most individuals with serious mental illness who are participants in the behavioral health system are on Medicaid, and most are under one of the managed care organizations. "Because these robust reserves are often the direct result of their participation in public programs like Medicaid, which are funded by taxpayers, health plans arguably have an increased responsibility to invest a portion of those reserves back into their communities" Community Catalyst, p. 4.

   For example, a person may be an inpatient at a psychiatric hospital or unit. Once that person's acute illness has stabilized such that a hospital level of care is no longer required, discharge to an appropriate setting should occur in a timely manner. In Rhode Island, there are Mental Health Psychiatric Rehabilitation Residences (MHPRRs):

   - Congregate licensed residential settings (commonly referred to as "group homes")
   - Specialized Mental Health Psychiatric Rehabilitative Residence (a group home for people who live with co-occurring substance use disorder and mental illness)
   - Supportive Mental Health Psychiatric Rehabilitative Residence Apartments (commonly referred to as "supervised")
   - On-Site Supportive Psychiatric Rehabilitative Apartments

e. This continuum of residential settings is lacking both in quantity and variety of levels of support to meet the needs of the population. The state requires a more robust continuum of care for individuals with behavioral health needs to enable them to live in the least restrictive, most integrated, most independent setting that is appropriate for their needs and is consistent with their choice. There is a need for step-down and step-up units to accommodate those whose

illness puts them in-between hospital level care and care in the community. Even more, there needs to be additional housing within the MHPRR system so that there is a flow from higher levels of care and support, to lower levels. These funds could be used to create these much-needed units and housing.

f. Not only do MCOs have a responsibility to invest in housing for those with serious mental illness for the reasons stated above, but it would be financially advantageous to reduce payment for hospital days when a lower level of care would meet the needs of the individual. It is well-known that the daily cost of hospitalization is at the top of the costs for psychiatric care. Transfer to a step-down unit or other appropriate level of care would not only reduce costs but would also comply with the *Olmstead* requirement for individuals to live in the least restrictive setting. To date, MCOs have not made the investment. The approach has been to save on spending and accept ESH as the hospital of last resort and not invest in the needed step-down services.

g. Because of the inadequacy of a full continuum of care, and because patients are often "stuck" in a higher level of care than is necessary, gridlock is created in the system. Those who remain in a setting that they no longer require prevent those who need that level of care from getting what they need. This is an untenable situation. While waiting to obtain the appropriate level of care, individuals either board in an emergency department or in another unsuitable setting. In the meantime, their needs are not met and, potentially, their mental status worsens. All emergency departments (EDs) should initiate and provide access to psychiatric treatment to improve a client's mental status while waiting placement. This does not occur in some hospitals as ED physicians believe treatment of mental illness lies outside the purview of an ED department and physician.

As noted above, the practice of health insurers investing in social determinants of health is not new:

- United Health Group announced in 2020 that it "will increase investments in affordable housing to $500 million to address social determinants of health as insurers intensify strategies to reduce costs and improve outcomes beyond covering traditional medical treatments" (Forbes).

- Similarly, in February 2021, Rhode Island-based CVS Health, owner of Aetna Insurance, announced that to "address housing insecurities and promote community health improvement in vulnerable populations, CVS Health (NYSE: CVS) invested over $114 million in affordable housing in 2020. The company's investments over the past year will lead to the construction and rehabilitation of more than 2,800 affordable housing units in 30 cities, across 12 states"(CVS Health Press Release).

  "Since 1997, the company, along with Aetna, have made more than $1 billion in affordable housing and community investments, which have supported the creation and renovation of more than 93,000 affordable homes. CVS acquired Aetna in 2018" Affordable Housing Finance.

- Kaiser Permanente, whose coverage is primarily in the west, with some presence in the mid-Atlantic states, writes:

In 2018, Kaiser Permanente established the $200 million Thriving Communities Fund to take on housing instability and homelessness, including creating or contributing to [several] funds. In 2021, we reached a critical milestone — the preservation and creation of 5,000 affordable housing units — just 3 years after launching the Thriving Communities Fund. Kaiser Permanente.

3. Professional Services Average Annual Price Growth Cap

Relevant quotes from the OHIC document

> ***Concept.*** *OHIC is exploring proposing the promulgation of a cap on average annual price growth for professional services (e.g., physician services or laboratory services). For over a decade, OHIC has capped average annual price growth for hospital inpatient and outpatient services through the regulation of insurer contracts. This regulatory construct has been effective at slowing health care cost growth in the Rhode Island market according to peer reviewed research published in the journal* ***Health Affairs****. Specifically, the researchers found that "relative to quarterly fee-for-service (FFS) spending among the control group, quarterly FFS spending among the Rhode Island group decreased by $76 per enrollee after implementation of the policy, or a decline of 8.1 percent from 2009 spending."7 The authors concluded: "State regulators in Rhode Island achieved among the largest total health care spending changes observed from payment reforms to date."8*
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> *Under this new requirement, OHIC would apply a cap on the average annual price growth of professional services, similar to the regulations applied to hospital inpatient and outpatient services. The cap would be linked to an economic index, such as the Consumer Price Index, or an alternative. It would be operationalized as a weighted average across the set of billable services offered by the provider where aggregate spending within each category of service (such as a specific evaluation and management codes) provides the weight.*
>
> *OHIC is actively considering two refinements to this price growth cap construct for professional services that are different than the current price growth cap construct for hospitals. The first is that OHIC is considering excluding some provider specialties from the growth cap, such as behavioral health providers. In addition, or as an alternative, OHIC is actively considering excluding providers who are engaged in advanced value-based payment (VBP) from the price growth cap. Advanced VBP encompasses payment models, such as sub-capitation, that substitute prospective payment for fee-for-service payment. OHIC also specifically invites public comment regarding alternative regulatory approaches to the design elements of this proposal that will achieve the double aim of restraining price growth and incentivizing the efficient delivery of care through the transition to advanced VBP.*

Comments:

OHIC very wisely is considering behavioral health providers as one of the specialties to exclude from the growth cap. The Covid pandemic has greatly impacted the behavioral health of many Rhode Islanders. Simultaneously, the workforce shortage has reached crisis proportions for many providers. Even before

the pandemic, many providers were experiencing financial strain. This confluence of factors must be seriously considered so that services are not cut. In fact, with the continued presence of Covid, services should be expanded to eliminate health disparities. Finally, individuals with behavioral health conditions benefit from regular interventions with clinicians and care coordinators. Limiting access to these services may result in decompensation or relapse which is not beneficial to the individual or the health plan.

Patrick Tigue

Commissioner

Office of the Health Insurance Commissioner

Via email

December 22, 2021

Dear Commissioner Tigue,

Thank you for allowing comments on the Next Generation Affordability Standards. These comments are submitted as from an individual and not a representative of an organization. The comments are submitted in the order of the request and not based upon priority or expertise of the commenter.

The OHIC is looking at how it can through regulation change a community and not just the lives of the fully insured commercial member. This is a challenge and Medicaid must follow similar actions. Actions that potentially burden the employer or insured employee will potentially lack support even if they create a stronger community. Health insurance is not a general tax source for community investments, even those investments that almost all in the healthcare community would support.

BEHAVIORAL HEALTH SPENDING REQUIREMENT

A well-functioning behavioral health care system is essential. Behavioral health, like most health, has strong association with social determinants, but experiences of deprivation and socio-economic hopelessness have a very strong impact on behavioral health including substance use disorders. It is my understanding that many past evaluations of RI suggest a high use of BH services, if perhaps only in the insured populations. This is both outpatient and inpatient services and probably cuts across gender, age, and insurance types. The Commonwealth references should be treated for what they are and no more. The first is about perceptions of unmet need. It is not rare that greater access and use also creates a sense of greater need. Differences between “high performing” states and “low performing states” were small in absolute numbers. It was noteworthy that Mississippi was an excellent performer in the alcohol death rate, whereas it has never been held to be a state with healthcare quality and access excellence. Drug poisoning likely reflects patterns of fentanyl adulteration. Therefore, the current evaluations are especially important in assessing how the increased investments should occur. Particularly important are those investments that reduce high-cost inpatient care or the costs of the criminal justice system. Consideration of the adverse effect on the educational system or learning of the student is also important. A global community satisfaction score is insufficient. As in primary care, investments should not be focused on fee increases. Key investments are likely:

Integrating BH into primary care.

Integrating primary care into the behavioral health entities that serve the most severely afflicted, where the medical home is the BH home not the typical PCMH (largely a Medicaid or Dual issue). The primary care service is ideally connected to a larger primary care entity.

Case management and care coordination. Require provider entities to cease erroneously hiding behind privacy laws that are not as restrictive as stated. In many cases community health team workers are needed as well as transportation and supports in subsidized/specialized housing or group homes.

Support of pediatrician access to consultation services and consideration of school-based services.

COMMUNITY INVESTMENT REQUIREMENT

The primary investment should be keeping health insurance affordable, i.e., rate stabilization. Many community investment activities by not for profit and for-profit entities have been commendable, but fundamentally this is not a role of health insurance. In some cases (and not necessarily specific to RI) the investment while important to those affected seems more oriented to an annual report glossy than the community at large. Determining a cap on net revenue after medical expenses is reasonable, if not current law for some products. Directing how reserves can be invested is even more problematic but incentivizing investments or creating guidance to suggest better funds may be reasonable. This also likely affects different insurers differently. A useful investment that more closely aligns with healthcare delivery and finance is supporting integration of social services agencies and technology that creates links from practices to agencies (e.g., Unite US). Additionally, requiring reporting of quality and service utilization by race and ethnicity should be standard. Finally, the OHIC along with academic and service institutions can help all of us better understand investments that meet cost effectiveness standards and would be of interest to those directly and indirectly paying for healthcare. Comments were requested on this matter, but investments made by regulated entities that reduce healthcare costs for other than their population may be a social good but should be made by society at large and not by purchasers of fully insured products. These employers often are already at a disadvantage competitively compared to the self-insured employer and do not need additional burden.

PROFESSIONAL SERVICES GROWTH CAP

This is particularly challenging and technically complex. An initial comment would be that the RAND study 3.0 is puzzling. While it represents a subset of services, in no way is it credible that professional fees average 225% of the RIMPFS (Medicare fees). As a small state there are challenges in any cap that could simply lead professionals to locate cross border and get uncapped fees whereas those that stay in the communities they serve suffer. The Medicare sustainable growth rate though conceptually reasonable is an example of a failed attempt at prices regulated by economic growth.

Some key considerations include the following:

The Medicare Physician Fee Schedule changes annually and has budget neutrality provisions. If an inappropriately low valued service (e.g., office visits prior to 2021) is increased, all other service will be decreased. The conversion factor as a capped item could work, but this would be across all services in a weighted mix.

Medicare has rules that may not be desirable. For example, in the past they allowed excessive interest rates and significant underuse when calculating the per service cost (direct practice expense) of high-cost equipment. Currently, Medicare is updating labor costs, but this was overdue. Medicare practice expense calculations are complex and rely upon pools and do not truly reflect actual expense. While the MPFS is as legitimate as any fee schedule it is flawed and reliance upon it must take this into consideration. Most significantly, the *value* in RBRVS does not have anything to do with social or health value. It is the value that is resource based and “relative”.

The MPFS is made up of three components (work, practice expense and PLI) and is resource based. Anything beyond 100% can create distortions that could be good or bad. Take 4 examples:

A service such as an office visit may be roughly equally work and PE. So, a percentage factor does not create a distortion.

A service such as an emergency department physician evaluation and management service is 5:1 work to PE, so at a 150% RIMPFS payment supports clinicians who provide free care disproportionately.

A lumbar MRI done in a radiologist's facility is 1:3 work to PE, so a higher percentage supports profit on equipment or equipment upgrades (and payment is not variable based on the quality of the equipment).

An endovenous laser surgery is 1:5 work to PE and a higher percentage supports a substantial mark up on the cost of a disposable catheter which accounts for most the fee. The catheter may be obtained for less than the Medicare input and the physician payment bears little relationship to work and incentivizes overuse. Work largely correlates with time, so a given professional's output is capped when services are paid on work. Services paid on PE are not so restricted. This is how a capped price has a greater adverse impact on a "work physician" than a "PE physician".

A significant action would be to divide the components of the fee schedule before setting any caps. Then one might consider a certain cap threshold that is exempt.

The OHIC has a clear goal of moving towards value-based payments. Caps may be reasonably used to incentivize this. For that reason, participants in VBP may be exempted or treated more favorably. VBP should be total cost of care, unless there are statewide specialty budget pools, which seems untenable (although it may be an option in a highly consolidated market). Episode based payment stimulates episodes and does not pay based upon the whole patient. It would be difficult to consider growth and total cost. The most expensive component of the MPFS is the office visit, so capping it would be problematic. The high growth services are sometimes over-valued but automatically go back to the RUC for review and may be reduced. They may also represent new useful services. It seems that caps have unpredictable consequences overall by themselves. However, if the primary goal is to drive providers into VBP and not save money on price alone, they may be useful.

Deciding which services are of greatest and least social and health value would be good. Stimulating the ideal workforce would be good. Both are doubtfully feasible. Ultimately, there will be winners and losers. It is almost certain some undesirable consequence will occur, but that also occurs today. Close monitoring and correction must be planned if any form if caps are introduced.

Sincerely,

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CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

December 23, 2021

Cory King
Department of Business Regulation
1511 Pontiac Avenue Bldg. 69-1
Cranston, RI 02920
Cory.king@ohic.ri.gov

Dear Cory,

Thank you for inviting public comment on the *Next Generation Affordability Standards: Concepts, Rationale and Additional Information* document. The Care Transformation Collaborative of Rhode Island/PCMH Kids (CTC-RI/PCMH Kids) welcomes this opportunity as we have witnessed the major impact that OHIC policy has had on improving health care outcomes for Rhode Islanders by investing in primary care including the integration of behavioral health. The comments and recommendations we offer below are based on our primary care transformation experiences.

A. Behavioral Health Investment:

1. Multi-payer/Common Contract approach: Primary care in Rhode Island has been able to achieve significant success by taking a multi-payer stakeholder approach including developing a patient centered medical home common contract, metrics, payments and accountability framework. We would recommend that OHIC consider taking a similar approach for integrating behavioral health (IBH) in primary care. OHIC has started its integrated behavioral health efforts through the 2020 affordability standards. The IBH implementation strategy did not include a multi-payer approach. Instead, health plans have individually submitted to OHIC their policies aimed at meeting IBH requirements. This approach has increased complexity and administrative burden for primary care practices as practices need to locate, and apply four different health IBH policies. Additionally, this approach has been confusing for patients who do not have a clear understanding on their new IBH benefits.
   Presently, CTC-RI/PCMH Kids is successfully working with primary care practices that are working towards integrating behavioral health using NCQA Behavioral Health Distinction requirements which provide practices with a common set of IBH standards. Primary care practices would be more successful in their ability to integrate behavioral health services within primary care if practices also had a reliable PMPM payment support and a multi-payer approach.

2. Clear Focus on IBH Primary Care Prevention Strategies to Children, Adults and Families: The Executive Office of Health and Human Services recently requested public comment on the *Draft Plan: Rhode Island Behavioral Health System of Care for Children and Families* which identified important priorities based on the fact that Rhode Island ranks 33rd in overall child behavioral health outcomes. Our concern with the proposed strategies outlined in the Draft Plan report is

that it takes a reactive investment approach to our current crisis with very little preventive action planning and investment in what could be done within primary care, which is a common ground for obtaining care for children, families and adults. It is important for OHIC to develop intentional strategies that incorporate both an investment in prevention as well as an investment in more intensive services and to distinguish and intentionally support integrated behavioral health from specialty mental health, which serves different populations at different points of access. Both would benefit from a PMPM but it may look different in different settings.

The proposed BH spend could support sustainable funding and build on current investments in IBH strategies such as PediPRN, MomsPRN. It may be helpful to test primary care team access to regularly occurring primary care practice team "office hours" as recommended in the evidence based Collaborative Care Model (CCM) with a PMPM payment model, as the current billing requirements for CCM are cumbersome and require significant electronic health record modifications. Other considerations could include a proposed annual mental wellness visit added to the routine pediatric well child schedule, having a transition of care visit for pediatric and adult providers to help support youth at the critical point of transition as they move from pediatric to adult care.

3. Linking Behavioral Health Investment with Community Investment Strategy

We notice that in your description in the Next Generation Community Investment Fund Community Benefit Activities description "community benefit activities could include addressing birth-related health disparities" which would be clearly important for successfully addressing the large disparities with infant mortality as noted in results highlighted in the 2021 Scorecard on Racial and Ethnic State Health System Equity Commonwealth Report[1].

We recommend that you consider broadening your description of community investment fund which indicates that "funds would be used to support a focus upstream to address underlying inequities and influences of health disparities such as affordable housing and food security" and include community investment strategies that are additionally integrated with clinical care. In partnership with EOHHS/Medicaid and RI Department of Health, CTC-RI is implementing The Rhode to Equity Learning Collaborative which integrates both upstream and downstream strategies that work together to effectively address clinical needs and the underlying inequities and influences of health disparities. Some IBH examples that could be enhanced with community investment funds that support addressing health related social determinants of health are outlined below:

a. Prenatal Time Period: CTC-RI is currently working with Rhode Island Department of Health to assist with implementing a five year HRSA funded project that supports screening for depression, anxiety and substance use disorders within practices that provide prenatal care. Practices have access to psychiatric consultation through the MomsPRN Maternal Psychiatric Resource Network. This project could be strengthened if there was sustainable

multipayer funding for behavioral health screening within the prenatal practice sites and access to social work/community health worker interventions that could address some of the health related social needs that can lead to depression, anxiety and substance use in the prenatal population

b. Early Childhood Time Period: CTC-RI will be implementing an evidence based pilot program Developmental Understanding and Legal Collaboration for Everyone (DULCE) to transform the way that families experience health care in pediatric primary care practices. This innovative approach proactively addresses social determinants of health that are identified in the clinical setting, promotes the healthy development of infants and provides support to parents during the critical first six months of life. The DULCE team includes a medical provider, a behavioral health provider, a community health worker and a legal partner who work together to reduce family stress, and give families more time and energy to bond with and care for their child and family. In a randomized controlled trial, assignment to the Project DULCE intervention led to improvements in preventive health care delivery and utilization and accelerated access to concrete supports among low-income families.[2]

4. Behavioral Health Workforce Clinical Training Strategies

Especially during the pandemic, primary care practices that want to integrate behavioral health within primary care have experienced significant difficulties with recruiting behavioral health clinicians. We strongly recommend that OHIC allow and support IBH investment strategies that include but are not limited to financial payment that covers the cost of on-line training programs and the time involved with taking this training, coaching support for integrating on-line learning content within the primary care setting, financial support for supervision for behavioral health clinicians who require clinical supervision prior to taking the licensing exam, and financial support for primary care practices that provide supervision for social work and psychologist students seeking to primary care placement sites

B. Community Investment Requirement

1. Providing a systematic approach to ensure that all Rhode Islanders with complex needs have access to community health team support.

Public-private partnerships have proven to be an important structure to provide services to Rhode Islanders, improve healthcare, and improve population health. Evidence from other states, and from work in RI, demonstrate the value of a primary care-connected network of regional community health teams as a valuable infrastructure and "public utility". Community health teams are a vehicle for promoting a more equitable service delivery system by having community health workers as part of the core staffing model. In addition to value-based payments for community health worker, peer recovery support, community behavioral health, and other services, a basic infrastructure support can promote continued innovation, increased outreach and coordination, and ongoing medical-legal consultation. We would encourage community investment funds be allowed to support the infrastructure needed to support such projects and not be limited to direct services. Performance expectations, reporting

requirements, best practice sharing and learning with multi-stakeholder oversight can ensure accountability and increased effectiveness. Continuing to fund an ongoing learning collaborative is an important component as well. Other projects that promote community clinical linkages and foster collaboration across health plans, hospitals, and Health Equity Zones should be considered. Additionally, consideration should be given to improving the use of health IT to promote health system/community integration and reduce administrative burden.

We would encourage community members and people with lived experiences of inequities and people working in primary care settings have a strong voice in determining how community investment dollars are used.

2. <u>Use of Community Investment Funds to intentionally support efforts to address health care access priority areas</u>
   The RI 2021 Scorecard on Racial and Ethnic State Health System Equity published in the Commonwealth Report notes important policy actions needed to achieve health equity including:
   a) Ensuring universal, affordable and equitable health coverage;
   b) Strengthening primary care and improving delivery of services;
   c) Improving the collection and analysis of racial and ethnic data to identify gaps and develop equity-focused measures to inform and evaluate policy;
   d) Reducing inequitable administrative burdens affecting patients and providers;
   e) Investing in social services.

   To what extent can the community fund efforts be broadened to include a multi-payer data aggregation strategy for things like high risk registries that stratify/identify high risk individuals (adult and children) as well as identify high risk families? Could we add health/equity vulnerability index scores to the RIQI dashboard?

   Could we consider creating a state-wide approach to ensuring access to translation services? Of note, health plans serving commercially insured patients are not required to offer translation services. What more can be done to ensure affordable and equitable health care coverage since the Commonwealth Report found that there is a large gap between white and non-white uninsured rates and a large gap between white and non-white populations for preventive care visits for children?

C. <u>Professional Services Average Annual Price Growth Cap</u>

<u>Recommend a coordinated multi-payer statewide approach including econsults</u>

CTC-RI has been working to improve access to care and improve care coordination between primary care and specialists using an enhanced referral process and econsultation. We are testing this approach and model in an effort to reduce costly and unnecessary utilization, and help deal with horizontal and vertical market influences. Developing innovative payment models for specialists that align with primary care and system of care value-based payment

efforts require multi-payer approaches. Under the present Affordability Standards, health plans may not apply spending to test the specialist use of e-consult as part of their primary care spend. We support the strategy of using a professional services average annual price growth cap and we recommend that expenses related to improving care coordination between primary care providers and specialists be allowed as part of the primary care spend health plan requirement. Promoting statewide agreement and performance expectations on standards and expectations for PCP-specialist communications can be valuable. Appropriate use e-consults can also be considered as an important tool.

D. Other primary care transformation considerations:

Could OHIC influence the State Employees health plans by having the State plan get involved with primary care transformation?

Could OHIC reduce primary care administrative burden and improve primary care engagement by convening a group to look at a consistent system for supporting remote patient monitoring within primary care? Right now, health plans do not provide coverage for pediatric practices that are interested in providing remote patient monitoring technology or using aps. Adult/family medicine practices have limited ability to provide patients with remote patient monitoring. Some Medicare Advantage plans provide coverage but health plans are using vendors outside of existing primary care structures to provide services and there is no coverage for remote patient monitoring under Medicaid.

In closing, please know that the Care Transformation Collaborative of Rhode Island/PCMH Kids applaud your leadership and your efforts to broaden insurer accountability and health care system performance through behavioral health investment/spending requirement, a community investment requirement and a professional services average price growth cap. We welcome the opportunity to work with you in primary care transformation efforts.

Sincerely,

Debra Hurwitz, MBA, BSN, RN
Executive Director, CTC-RI

[1] "Achieving Racial and Ethnic Equity in U.S. Health Care: A Scorecard of State Performance". The Commonwealth Fund, accessed November 18, 2021. www.commonwealthfund.org .

[2] "Medical-Legal Strategies to Improve Infant Health Care: A Randomized Trail. Pediatrics. Volume 136, Number 1, July 2015.

EOHHS Response to OHIC's Next Generation Affordability Standards Proposal

The Executive Office of Health and Human Services (EOHHS) is pleased that the Office of the Health Insurance Commissioner (OHIC) has proposed Next Generation Affordability Standards and is writing to support the Spending Requirement for Behavioral Health Services and the Insurer Community Investment Requirements. These new Standards align with the system transformation work that EOHHS has been focused on, especially regarding access to quality behavioral healthcare and addressing social determinants of health.

In this document, you will find the EOHHS response, and then in Appendix 2, a response from Christopher Ausura from the Rhode Island Department of Health (RIDOH).

Behavioral Health Spending Requirement.
EOHHS has been focused on improving our behavioral health (BH) system of care across the lifespan, and we agree that a BH Spending Requirement would contribute to that work. We note how the Primary Care Spending Requirement instituted within the first iteration of the Affordability Standards has been shown to have significantly improved our primary care system, and we support its use within the BH system.

We have attached slides with our current vision of the BH Continuum of Care and our conception of a Comprehensive BH Treatment Service Array. As OHIC moves forward in overseeing the implementation of the Affordability Standards and Investment Strategies, we hope that it is helpful to see our overarching vision of a strong BH system – and this vision informs our perspective on your proposal.

Specific Comments on the Spending Requirement:

1) EOHHS particularly likes your description of insurers as Anchor Institutions. We agree that they are - or should be – rooted in their local communities by mission, invested capital, and /or relationships to customers, employees, and vendors. This meets our desire to ensure place-based investments, and knowing what local systems need those investments.
2) **Principles for Transformation -** We call your attention to the EOHHS BH Principles, which may also be helpful in your creation of these new Affordability Standards and to help you guide "the additional investment and support for transformation that will lead to improved health outcomes" that you refer to on Page 3. We encourage you to adopt any or all of these as overarching state principles for transformation:
    i. A focus across the lifespan, from prenatal care, to infant mental health, all the way to geri/psych.
    ii. Rebalancing toward community services, and away from more restrictive services – the right services from the right entities at the right time, when they need it, including the integration of physical and behavioral health
    iii. Investing in our workforce, which is in a particular crisis due to COVID but was struggling before COVID

iv. Services that are culturally, linguistically, and developmentally appropriate – answering the question: what is the service that will help this particular person at this particular time.
v. A reliance on data-based decision-making
vi. Investments in prevention
vii. A focus on peer services

3) **Addressing Gaps in the System –** EOHHS encourages you to review the Behavioral Health System Review carried out by the Faulkner Consulting Group, in partnership with Health Management Associates and finalized in July 2021 (and through which the principles were created).
    a. Here is a summary of the key findings:
    b. **Key Findings:** Through quantitative and qualitative data analyses, the following findings have emerged:
        1. Rhode Island has several behavioral health system capacity challenges to address including both gaps in key service lines and a shortage of linguistically and culturally competent providers, that together disproportionately negatively impact communities of color.
        2. Underlying drivers that perpetuate the challenges described above include:
            i. Fragmentation in accountability both across state agencies and across providers, insufficient linkages between services to support care coordination and transitions of care, and a lack of integration between behavioral health and medical care.
            ii. Payments for behavioral health services largely rely on a fee-for-service chassis that does not account for quality or outcomes.
            iii. Lack of sufficiently modern infrastructure hinders providers of behavioral health services in Rhode Island, as well as creates barriers for Rhode Island to monitor the behavioral health system effectively and efficiently on an ongoing basis.
    c. **Suggestions for the Spending Requirement Funding:** EOHHS's focus as a result of the BH System Review has to create implementation plans for public/private investments in two top priorities – Certified Community Behavioral Health Clinics (CCBHCs) and Mobile Crisis. We are also working with an interagency and public/private team on specific population needs, such as prevention services for youth at high risk of suicide attempts – and on workforce needs. As a result, we have the following suggestions for OHIC, as you think about funding opportunities for the spending requirement:
            i. Support for system transformation, such as the interagency CCBHC proposal, the Children's System of Care Components, services for people who are unhoused, and other value-based payment transformations
                a. Examples: A key component of system transformation is setting a community-based target for care, as opposed payment systems that make hospital interventions the easiest referrals, so that payers are focused on keeping people in the least restrictive care possible. Other examples include strengthening the array of children's BH services, and universal reimbursement of peer services and community health workers, to expand their availability.
            ii. Programs that ensure integrated healthcare – both integrating BH into physical health and physical health into BH (which CCBHCs support).

        a. Example: This type of integration would require supporting BH providers to employ nurse care managers, and those investments should include initial technical assistance to those BH providers determine how to bill for those.
    iii. Improving BH providers ability to rely on data for population health decision-making and treatment
        a. Examples: Ongoing investments in system improvements, including electronic health records (which have not been funded by the federal government as primary care EHRs were), the state's Quality Reporting System, and the BH quality measurement tool called Mirah. We are happy to provide additional information on these systems at your request.
    iv. Prevention, which is too often de-prioritized.
        a. Examples include the proposals for AdultPRN, which provides support for primary care providers providing BH services; Infant Mental Health training and support; prevention of substance use disorders (SUD) that ensures ties between SUD providers and overall family health to prevent child maltreatment.
    v. A strong focus on workforce support.
        a. Examples including ensuring adequate reimbursements for care; addressing employee burn-out; creating transparency of fee schedules across insurers, for parity, and ensuring recruitment and training for the workforce in home and community-based services

    Note: All of the proposals above must include services for people who are uninsured or undocumented. Everyone should be responsible for these Rhode Islanders who need services.

4) **Interagency Partnerships:** EOHHS strongly supports your office's obligation to work with other state agencies – and we look forward to strengthening our partnership and continuing to work together on BH benchmarking and other Affordability Standard components.

Next, please find EOHHS feedback pertaining to the proposed mechanisms for addressing the social determinants of health and investing in communities using a place-based lens:

Community Investment Spending Requirement.
EOHHS also strongly supports OHIC's proposed Community Investment Requirement and we have suggestions for making it even stronger. As you know, EOHHS has also been strategically focused on improving place-based community investments across funding portfolios and mechanisms to address community-identified priorities and address the local systems that drive disparate health outcomes in Rhode Island. We agree that a Community Investment Spending Requirement would contribute to that work. We note how this type of investment would complement Medicaid's Health System Transformation Project (HSTP) Social Determinants of Health Investment Strategy (attached) and the EOHHS-led Health Equity Zone Expansion, Scaling, and Sustainability Plan being developed for Blue Meridien Partners. At the end of this document, we include a full description of the HEZ Blue Meridien Partners project, for your background information.

Specific Comments on the Community Investment Requirements:
We have attached documents related to our current strategies, planning approaches, and place-based investments for Rhode Island. As OHIC moves forward in overseeing the implementation of the Affordability Standards and Investment Strategies, we hope that it is helpful to see our overarching vision of s**hifting systems and investments to prevention, value, choice, and equity** – and this vision informs your final proposal.

To do so, EOHHS see advantages to a blended model, perhaps 80% option #2 and 20% option #1 to community investment spending requirements. We see #1 as being driven by insurer priorities that would likely focus on population-specific improvement, while #2 is likely to be broader, more systemic, and focused on true improvements to community functioning. Both #1 or #2 should include services for people who are uninsured or undocumented. All insurers should be responsible for these Rhode Islanders who need services.

1) **Community Benefit Activities**
    a. Overall, this approach makes sense, and the concept is sound. That being said, there needs to be an increased focus on place—meaning where members reside (e.g., live, play, learn, and grow).
    b. A portion of investments should be directed to improve the underlying community systems in which the most marginalization, oppression, unhealthy environments, and high-risk utilization occurs.
    c. Specifically, a strong focus on investing in Housing First—permanent, supportive housing free of sobriety, criminal justice, and employment requirements should remain and be aligned with reducing hospital capacity and overcrowding as well as other investments such as Pay for Success and Rhode Island's Down Payment Strategy.
    d. Another consideration for these types of activities may be investing in developing diverse, culturally competent health system workforce from within Rhode Island's communities of color and investing in implicit bias recognition and behavior change for providers in the assessment of patients, delivery of care, and referral to child welfare.
    e. Requiring the insurers to implement a participatory budgeting process with the community it serves, representative of those members reflective of the insurer community with the greatest health disparities would be an enhancement to this approach. Medicaid's Health System Transformation Project has funded such a participatory budgeting process, and would be a good resource for OHIC as you consider this approach. You will find more information in this HSTP SDOH Investment Strategy document, on Page 9.
    f. Addressing many of the underlying systemic factors that affect key health outcomes, such as overdose, premature birth, etc., are vital but needs to be both place-based and systems-focused in investment.
    g. Learning from experiences with hospital community benefits programs, this investment should consider the exclusion of charity care as an appropriate expenditure.

2) **Community Investment Fund**
    a. Overall, this approach makes the most sense, and the concept is sound. And again, there needs to be an increased focus on place—meaning where members reside (e.g., live, play, learn, and grow).
    b. Much of these investments should be targeted to building the community capacity to address structural racism, catalyze policy, system, and environmental change, and maintain

critical partnerships that deliver social services and address fundamental socio-economic determinants of health with cultural competence.

c. Maintaining a participatory budgeting process with the community, representative of those collective members reflective of the those experiencing the greatest health disparities would be an enhancement to this approach.
d. Consideration of core investments that continue to expand and build place-based community collaboratives focused on health equity is strongly encouraged. This includes investing in the Blue Meridian Opportunity focused on expansion, scaling, and sustainability of Health Equity Zones.
e. Examples of success in these types of community infrastructure investments within Health Equity Zones include:
    a. Each HEZ Community Overdose Engagement (CODE) backbone agency/collaborative successfully engages the community on a regular basis, sharing data and progress with stakeholders and garnering partner input on strategies. *As such, each community has successfully engaged individuals with lived experience in their CODE collaboratives. These individuals are involved with decision making and strategy implementation. The two Providence CODE collaboratives successfully engaged community stakeholders in a needs assessment and prioritization process, despite the challenges of the COVID-19 pandemic.*

    b. CODE collaboratives use RIDOH data (and technical assistance) to tailor their outreach strategies to locations where high rates of overdose occur. *For example, the Kennedy Plaza area consistently appears as an overdose hot spot. As a result, Downtown Providence recently worked with Project Weber/RENEW to hire two Certified Peer Recovery Specialists (CPRS) to provide a consistent daily presence in Kennedy Plaza to distribute harm reduction supplies and basic needs.*

    c. CODE Collaboratives have a focus on the social determinants of health. In addition to providing basic needs, housing is another top priority in both Providence and Woonsocket. *Amos House has set aside five shelter beds for those in immediate need of shelter in order to support their treatment/recovery. When the outreach teams encounter an individual in need of this resource, they can refer them directly to Amos House. In Woonsocket, Sojourner House is focused on improving access to housing for the LGBTQ+ population who use drugs, as well as those who use drugs who are also victims of abuse. They have hired a housing advocate who is also a CPRS to provide outreach in Woonsocket and connect individuals to resources and services. The agency also maintains a 24/7 hotline for emergencies.*

    d. CODE Collaboratives invest in projects that are data-driven and remain adaptable to emerging priorities. *Each CODE collaborative conducted a comprehensive needs assessment around the impact of overdose and substance use in their community to identify key strengths/barriers/gaps and priorities, prior to designing strategies. In addition, the collaboratives work in close partnership with RIDOH to translate data (both state level surveillance as well as local measures) into action. RIDOH shares detailed data packets with each CODE on a quarterly basis; partners then bring this data to their collaborative to shape strategy implementation and brainstorm new ways to reach the most impacted.*
f. Learning from experiences with hospital community benefits programs, this investment should consider the exclusion of charity care as an appropriate expenditure.

3) **Investment Portfolio Allocation**
    a. EOHHS believes that this Community Investment Requirement proposal is the least advantageous for improving our community, as it would be dependent on investment returns fully outside of OHIC's or insurers' influence and could easily be incorporated into a blended option of #1 and #2 with a place-based lens.

Appendix 1: Rhode Island/Blue Meridien HEZ Partnership

In Rhode Island, Blue Meridian Partners, in partnership with the Governor's Office, EOHHS, the Rhode Island Foundation, and ONE Neighborhood Builders, is making a significant community investment to build upon decades of place-based, community-driven work in Central Providence that is more critical than ever, given the effects of COVID-19. With significant investment, support and technical assistance, this work is accelerating an inclusive recovery, in two of the hardest hit zip codes in Rhode Island and establishing a blueprint for a statewide investment to tackle some of the state's most intractable challenges. The work builds upon the State's broader vision for an equitable recovery in Rhode Island. Throughout the COVID-19 pandemic, the Rhode Island has remained committed to our long-term goals of building a prosperous economy with educated and healthy residents. The public health and economic crises have tested the state's existing approach to achieving those goals, highlighting where our state is strong and revealing areas where we must expand our investments or rethink our tactics. The State is committed to not only recovering to pre-COVID-19 benchmarks, but to building resilient communities where all residents can succeed.

The State is actively working to significantly increase investments in affordable housing, public education, and jobs creation. Moving forward, the State is deepening a commitment to a place-based approach to serving our most vulnerable residents by increasing investment in community infrastructure, namely via Rhode Island's HEZ. The state currently has ten "HEZ's" strategically located across Rhode Island, with its Central Providence HEZ being a notably effective example of this place-based infrastructure. The pandemic elevated the need for these investments statewide, but also, the disproportionate impact of COVID-19 in communities of color reinforced our resolve to making these investments using equity centered strategies to ensure we are developing and implementing these policies in ways that focus on the needs of the community.

Rhode Island's Executive Office of Health and Human Services (EOHHS) is working to ensure alignment of the Blue Meridian investment with other sizeable community investments. As such, EOHHS is assisting with the facilitation and implementation of identified strategic directions within a State Scaling and Sustainability Workgroup as part of the overall Blue Meridian award to Rhode Island. The Scaling Workgroup is charged with working closely with EOHHS and RIDOH to establish a strategic framework for scaling Rhode Island's existing HEZs that build from the collective success of the HEZ model, and the specific lessons learned through the pilot phase of the Central Providence Opportunities investment to embrace replication of the Blue Meridian model and assess and deliver technical assistance/capacity building supports, as applicable. A final product will result and be a Statewide Scaling and Sustainability Plan for Place-Based Investments—building upon Rhode Island's Health Equity Zones that will be submitted to Blue Meridian as part of the Central Providence Opportunities award to inform future funding investments. This plan will also be operationalized within Rhode Island to continue to expand, scale, and sustain place-based investments.

Appendix 2: RIDOH Comment on the Affordability Standards – Christopher Ausura at RIDOH has shared the following commentary with EOHHS, for us to share with OHIC.

Executive Summary and Overall Reflections:

- Most, if not all, of the recommendations contained are broad in nature and leave significant work to be done to flesh out the concepts so it is challenging to say that there is concrete support or opposition to any particular concept.
- For all components of the proposed plan RIDOH would like the opportunity to participate as a formal member of all committees, commissions and boards to ensure representation from the Department in the development of the three priorities presented as they are all essential to the health of the public.
- To accomplish the equity goals proposed in the outline, OHIC should leverage the Health Equity Zones and other community based foundational work to ensure community leaders are part of the formation and execution of any equity strategies; specifically, going beyond the typical type of community engagement and focusing on community empowerment and ownership.
- Many of the proposed changes can potentially negatively affect equitable access to care for potentially vulnerable populations and care should be taken in establishing and implementing these changes to ensure market reactions will not inadvertently exacerbate existing inequities or create new inequities.

Behavioral Health Spending Requirement:

- The approach to establishing a minimum spend for behavioral health that mirrors the PCP spend requirement would provide much needed resources to that component of the care delivery system and could potentially significantly improve provider access and bolster supportive services for BH; which as the briefing document clearly articulates is desperately needed.
- The ambiguity of the threshold for that requirement as well as the lack of clarity in what would be deemed acceptable claims and non-claims spending presents a challenge to the ability to comment on the proposed approach. On its face the concept seems to provide the necessary foundation but additional information is needed to better understand what services would qualify as compliant costs under this model.
- The lack of acknowledgement and focus on the social, environmental and economic determinants of behavioral health seems to be a glaring omission and something that I would recommend including as this concept advances, specifically as it pertains to non-claims spending on both non-clinical interventions and non-reimbursable community based supportive services, such as those delivered by community health workers who provide support for non-clinical BH needs.
- The approach, as described, does not address many of the systemic and structural issues with the BH system, such as police response to SUD and mental health calls, the lack of emergency/acute BH care capacity, lack of step down capacity, and barriers to accessing patient records between BH and PCPs. While I appreciate that many of these details can and likely will be worked out in subsequent conversations regarding the specifics on qualifying expenditures and quality measurement, their omission seems concerning as they are well documented and long standing barriers.

Community Investment Requirement:

- It seems important to acknowledge the massive shift in approach that this proposal represents for OHIC and to reinforce the level of support we all have for their taking action and making this recommendation.
- Of the three proposals provided under the Community Investment Requirement, the Community Investment Trust is the ideal approach. The two alternative approaches leave the distribution of resources at the discretion of the plans which would likely present the same challenges as the hospital community benefits, specifically it would open the possibility that in-kind contributions be considered satisfaction of the requirement.
- Recommend including a requirement that these investments be directed at the establishment and sustainability of community infrastructure, such as Health Equity Zones, to reflect the need to make system and long term investments in strategic approaches that reflect the systemic nature of health disparities and the duration of effort that is required to improve outcomes and address inequities.
- The structure of the decision making body/board of directors of this trust seems to be the crux of it's success or failure. Recommend adding RIDOH as one of the leads for this group as a long standing champion of HE/SDOH work in the state, and ensuring that there is a community advisory board that directs where these resources are ultimately invested. The greatest challenge to accomplishing the equity goals stated are ensuring that the residents/community have a clear leadership and ownership role in shaping the structure of the trust, the priorities of the trust, and the commitments of funding; as we're all aware, it's impossible to do equity work without starting from a foundation of equity that places the community in a leadership role but it's worth overtly stating in the feedback to this proposal to ensure it's incorporated in the plan moving forward. HEZ can represent a strong starting point for a steering body for that type of structure and should be engaged early in the process to help shape the approach.

Professional Services Average Annual Price Growth Cap:

- This approach appears in line with other capitation strategies that were recently released and it seems worthwhile to recommend an analysis of how this would affect existing and proposed VBP strategies, such as the hospital capitation strategy and the AE program. It seems clear that there is a broader market share that this approach seeks to cover but it is worth exploring whether a patchwork quilt approach will create confusion for providers and consumers, therefore it's worth recommending that an assessment be conducted to determine whether a global capitation approach that creates common standards for the existing VBP approaches AND this new recommendation rather than establishing potentially conflicting standards for consumers and providers to navigate.
- In line with the comments above, the proposed approach presents the possibility that the differing VBPs in different markets establishes new inequities in coverage and access to care due to providers gravitating to higher VBPs or FFS rates outside the patchwork VBP approaches. With PCP shortages and BH provider shortages this approach could exasperate the existing issues with access to care for covered services due to market reactions to the proposed/enacted policies. However, since the approach that is described does not provide adequate specifics of which services could/will be affected by this approach it would be hard to measure the affect that these policies would have on the issues described above and therefore an analysis of the impact on these factors, and more, would be beneficial as a next step.
- The approach as described appears to offer the possibility to incentivize certain services over others. Although the approach as described is intended to act as a cost containment strategy

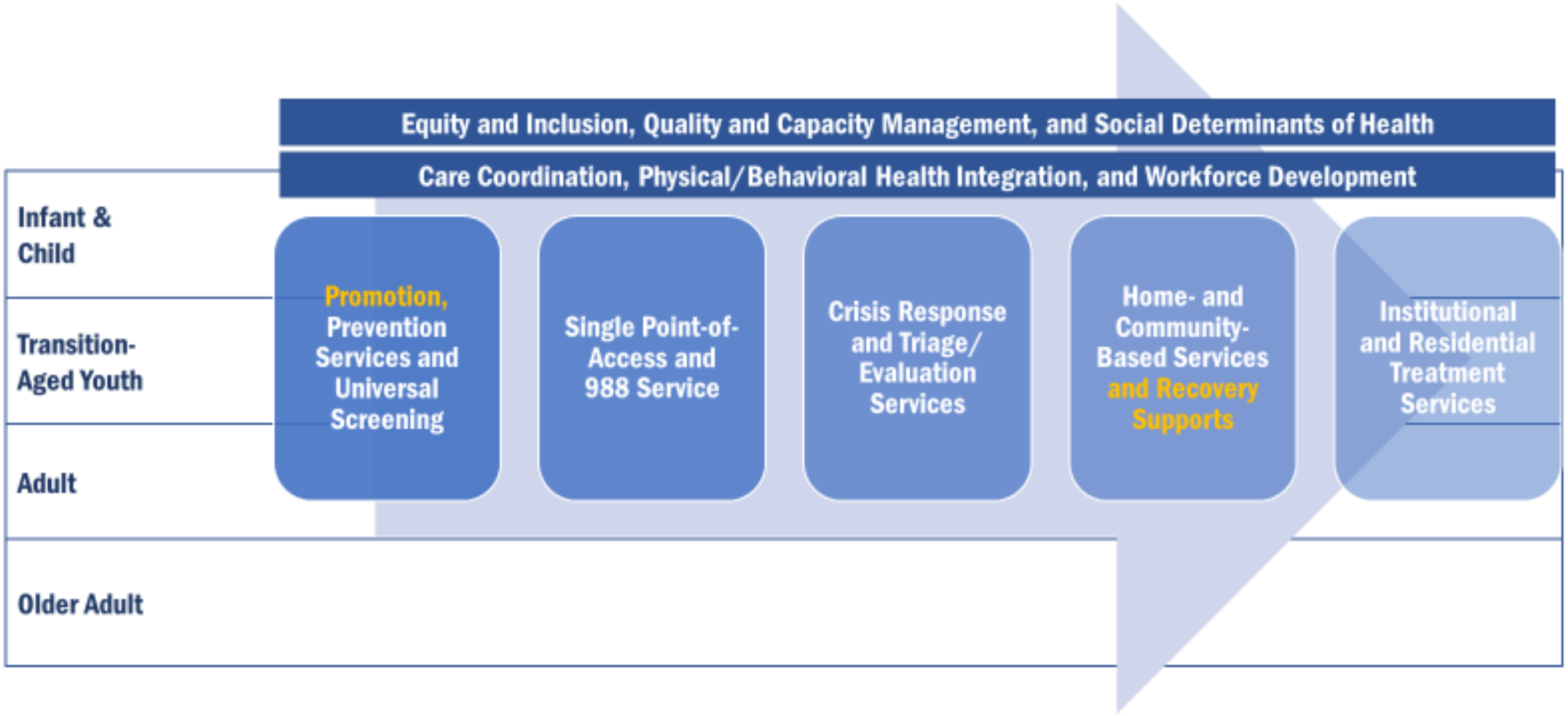
the approach could also benefit public health, behavioral health, and state health outcomes by incentivizing growth in particular markets by offering higher rates of compensation for services and procedures that are in high demand, that provide high levels of population health benefit, and are currently in low supply. Some concrete examples of those types of services are CHWs, SDOH support, BH services, primary care, etc. It would be worth recommending OHIC conduct an analysis of which covered services/high impact services could be incentivized in addition to which high cost, low value services could be disincentivized.

Rhode Island Behavioral Health System Transformation Across the Lifespan

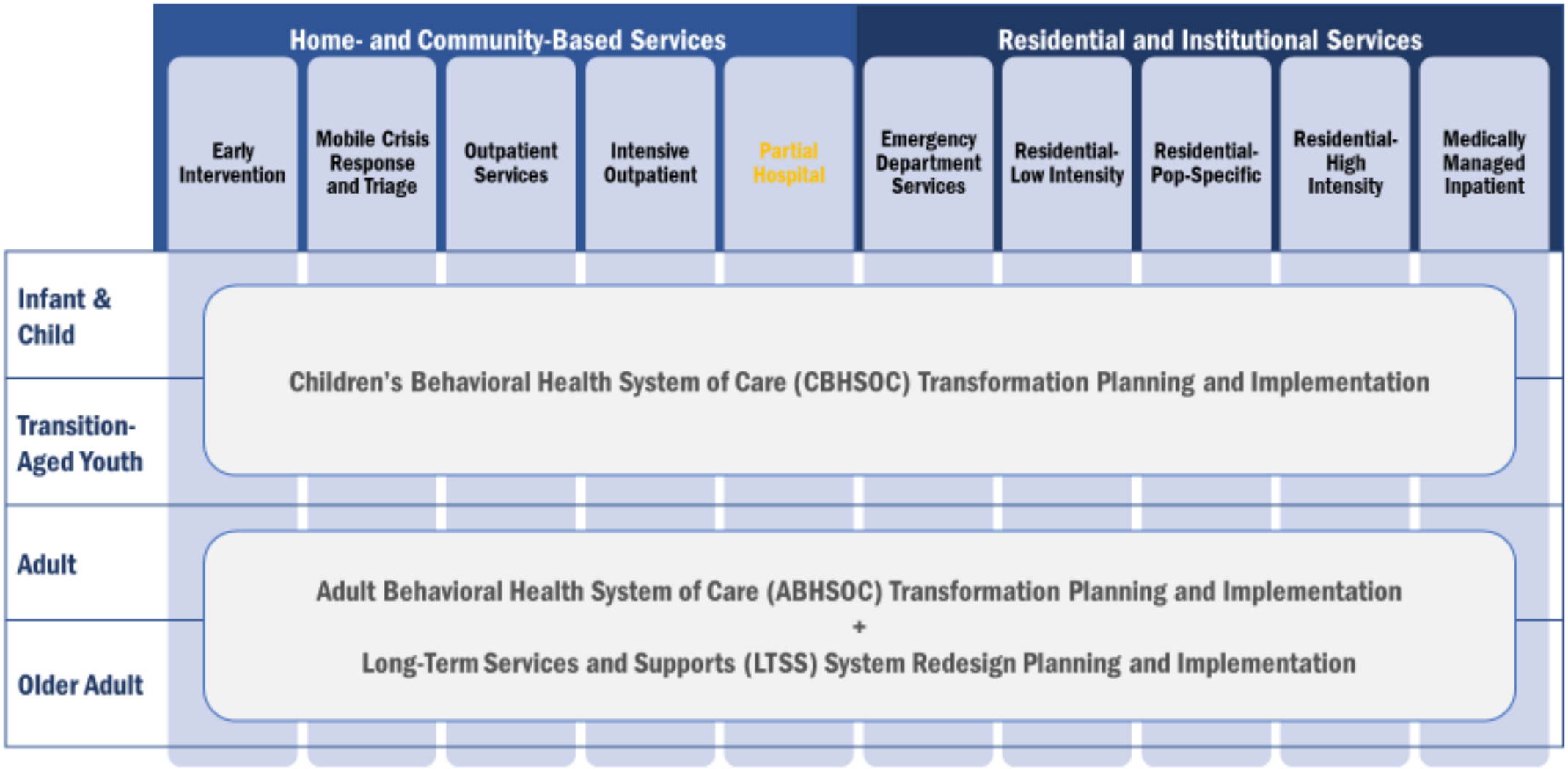
January 14, 2022

RHODE ISLAND

Rhode Island Vision of a Behavioral Health Continuum of Care

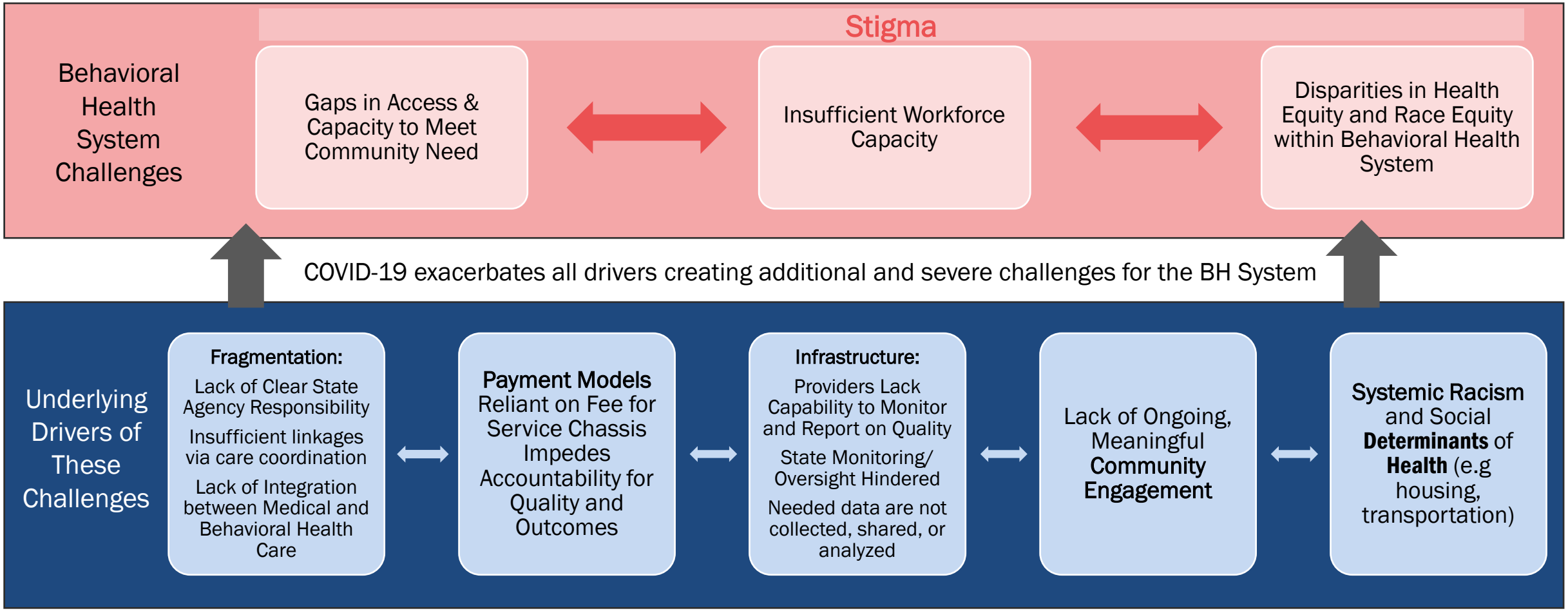


Comprehensive Behavioral Health Treatment Service Array



Problem Diagnosis: Underlying Drivers, from the RI Behavioral Health System Review

Key themes have emerged from quantitative and qualitative research include challenges in the current behavioral health system, and underlying drivers of those challenges. Any policy solutions must address the underlying drivers, otherwise the challenges will persist.



System of Care Transformation Strategies

The following strategic framework that was informed by the Rhode Island BH System Review Report:

I. **Improve capacity, alleviate social barriers, and close continuum of care gaps to treat mild to moderate to complex adult behavioral health conditions across the adult lifespan in RI.**

II. **Transform practices and behavioral health centers to provide high-quality, integrated, value-based, evidence-driven, and community-focused behavioral health services in the least restrictive settings.**

III. **Invest in prevention, equitable access, comprehensive addiction treatment, and necessary supportive services for vulnerable and marginalized populations.**

IV. **Forecast and address emerging needs and priorities that will challenge the existing and future systems.**

Blue Cross Blue Shield of Rhode Island
500 Exchange Street, Providence, Rhode Island 02903-2699
(401) 459-1000 bcbsri.com

January 21, 2022

Cory King, Principal Policy Associate
Office of the Health Insurance Commissioner
Via email: cory.king@ohic.gov

RE: Comments on Advanced Notice of Proposed Rulemaking – Affordability Standards

Dear Mr. King:

Blue Cross & Blue Shield of Rhode Island (BCBSRI) appreciates the opportunity to provide comments on the Advanced Notice of Proposed Rulemaking (ANPR) on the future of affordability standards (the Standards).

BCBSRI shares OHIC's overarching goal of improving affordability, quality, and access to care for all Rhode Islanders. We recognize that addressing social determinants of health and improving health equity are critical to these goals, and we have made significant investments in these areas. While we support these goals, the details of how the Standards are developed and implemented will be very important. Specifically, changes must not increase costs, must afford flexibility in implementation, and must incent providers to move toward value-based care (VBC).

As you know, BCBSRI has been and continues to be committed to the Cost Growth Target. While the COVID pandemic has shaken the core of the healthcare system in Rhode Island, we continue to believe the target is meaningful and that it must come with increased oversight and incentives for all parties. Achieving the target will require allocating investments carefully to realize the greatest returns and reacting quickly to data and developments if initial investments do not have the expected outcomes.

Lastly, as has been the case since the inception of the Standards, BCBSRI is mindful that OHIC's direct authority is limited to oversight of insurers. As the Commissioner has said, the cost of health insurance is high because the cost of health care is high. Despite much progress, there is a significant gap in authority to directly drive healthcare providers toward adoption of alternative payment models to moderate costs while driving improvements in quality, population health, and ensuring access to care for all Rhode Islanders. BCBSRI encourages OHIC to collaborate with other state agencies, payers, employers, community-based organizations, and providers to develop an oversight structure to hold payers and providers equally and directly accountable for addressing affordability, quality, access, and health equity. This is necessary now, more than ever, as the proposed merger of Lifespan and Care New England is under review by the Attorney General and Department of Health. BCBSRI would be an eager and active participant in this discussion.

With those general comments as background, BCBSRI offers the following specific comments on the ANPR.

Behavioral Health Spending Requirement:
BCBSRI recognizes the need for comprehensive, coordinated behavioral health and substance use disorder treatment in Rhode Island. We support mechanisms that would stop fragmentation, drive quality, and encourage multi-payer activities such as the children's system of care and the development of certified community behavioral health centers (CCBHCs). Indeed, BCBSRI increased its fee schedule for behavioral health services significantly in both 2021 and 2022 and also invested more than $600,000 in behavioral health quality programs in 2021.

While we appreciate OHIC's goal of creating a well-functioning system capable of serving the comprehensive healthcare needs of Rhode Islanders, this requires much more than an increase in spending. It requires a unified understanding among both payers and providers about what a well-functioning behavioral health system looks like and aligned incentives to achieve it. The primary care spend requirement establishes spending that is based on two categories (1) direct primary care payments (i.e., direct reimbursement) and (ii) indirect primary care spending (e.g., RIQI investments, etc.). The primary care spend requirement has been successful in increasing primary care reimbursement but has not necessarily improved affordability. In the commercial market, BCBSRI has not observed any material differentiation in cost, trend, or quality in systems of care (including PCMH) as compared to non-systems of care, and true population health management is still lacking, despite significant investment.

Rhode Island faces many challenges in advancing behavioral healthcare and the integration of behavioral healthcare into primary care. These include lack of electronic medical records, lack of timely notification of discharge from emergency departments or inpatient settings, and general coordination of care issues. Systems that primary care providers use for information, like Current Care, have limited behavioral health information. For example, Current Care provides discharge alerts, but the two primary behavioral health hospitals do not participate.

Rather than focus on a spending target, OHIC should consider mechanisms that would address these challenges. Doing so will improve the continuum of care, increase access, and improve integration and quality. Toward that end, we encourage building on the foundational, collaborative, all-payer, all-provider care transformation-type work, in conjunction with the Executive Office of Health & Human Services to define what should be invested in and create a road map, prior to imposing a regulatory obligation on spending.

If OHIC adopts spending requirements related to behavioral health, we strongly recommend that insurers be given flexibility. In addition, we recommend that spending not be directed toward increases in reimbursement without tying such increases to adoption of quality programs. For example, OHIC might consider adopting a requirement that a substantial percentage of any increase in reimbursement be tied to electronic medical record adoption and participation in Current Care, participation in integrated behavioral health and primary care practices, appointment availability for urgent needs and new patients, and participation in state programs such as the children's system of care.

Community Investment Requirement:

BCBSRI supports the goals of advancing health equity, addressing social determinants of health (SDOH), and improving population health. We have made significant investments toward these goals, at our own initiative, and will continue to do so. Most notably, BCSBRI funded and produced the Rhode Island Life Index in collaboration with the Brown University School of Public Health. The Rhode Island Life Index is a statewide perception survey about the barriers, e.g., social determinants, to Rhode Islander's health and just completed its third year. From the results of this survey, we have directed our philanthropy to the areas which were found to be the biggest barriers to health, most notably access to safe affordable housing. Since 2020, we have focused our competitive BlueAngel Community Health Grants program on investments in programs where housing and health intersect. We have awarded over $1.5 Million under this program to 18 agencies since 2020. In addition, we have awarded over $600,000 to funding an aging in place program with Greater Providence Habitat for Humanity.

Notwithstanding our commitment to advancing health equity and addressing SDOH, we believe any requirement on insurers to make such investments is beyond OHIC's authority. Instead, we urge OHIC to consider adopting requirements that would advance the standardized collection and utilization of self-reported race, ethnicity, language (REL), and sexual orientation and gender identity (SOGI) data to measure health system performance and progress. For example, OHIC might require insurers to:

- Implement REL and SOGI data collection mechanisms and tie provider incentives to provider collection of and reporting of certain quality metrics by REL.
- Use advanced analytic models to segment "at risk" and "cost bloomers" to close disparities and gaps in care.
- Build REL metrics into VBC models to identify issues related to SDOH such as maternity bundles aimed at reducing infant mortality.

We recommend that OHIC, based on input from insurers and providers, adopt a standard definition for REL data collection such as the HHS Implementation Guidance on Data Collection Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status.[1]

Specifically with regard to any requirements related to excess surplus, it is important to note that the purpose of reserves is to ensure that an insurer can pay providers timely and meet its obligations to members even in the face of unanticipated events. Insurers face many different risks, most notably underwriting risk, especially in times of uncertainty. COVID has presented a serious time of uncertainty. While in many ways, there has been a reduction in utilization due to delayed elective services, this is expected to bounce back. In addition, new requirements such as coverage for over-the-counter testing and unknowns about future costs for COVID treatment and vaccination create significant risk and uncertainty. Claim levels were over three times as volatile during the pandemic relative to historic levels and remain at pre-pandemic highs. In addition to

[1] HHS Implementation Guidance on Data Collection Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status | ASPE

claims volatility, economic volatility such as unemployment levels impact revenue. Putting reserves in context, if an insurer pays $1 billion in claims annually, reserves of $400 million are only sufficient to pay claims at a typical rate for four months. Sufficient levels of reserve (or surplus) are critical to ensuring obligations can be met.

Professional services Average Annual Price Growth Cap:

The limitation on hospital increases has served as a valuable tool during contract negotiations to keep costs at a reasonable level and transition toward quality based payments. For all the reasons noted in the concept paper, BCBSRI supports adoption of an average annual price growth cap for professional services.

We urge the Commissioner to consider the recommendations contained in the white paper "A Proposal to Cap Provider Prices and Price Growth in the Commercial Health-Care Market."[2] In this paper, the authors recommend "…a three-pronged approach that includes the following: 1. Local market- and service-specific price caps that bind at the very top of the commercial price distribution. 2. Service-, insurer-, and provider-specific price growth caps that constrain price inflation. 3. Flexible oversight by state and/or federal authorities to address potential circumvention."[3] The article provides persuasive and practical recommendations for adopting price caps and price growth caps, all of which could be considered. Capping provider prices and price growth could result in a 5.7% reduction in commercial health care spending.[4]

OHIC requested input on the following questions to which BCBSRI will respond in turn.

1. Should the professional services price growth cap be effective only for provider prices that are above a defined Medicare relativity benchmark? For instance, if a provider's prices are above 150% of the Medicare rate, then the professional services rate cap would apply. If this design feature is desirable, how should the appropriate Medicare relativity benchmark be established?

The price growth cap should apply to all professional services regardless of Medicare relativity. We recommend that there be an inflationary cap on high-cost professional services (as measured by PMPM targeting the top 20 service categories), consistent with the cost trend work. Consideration should also be given to any service categories beyond the top 20 for which there is limited competition within Rhode Island. For those professional service providers at or above the total median average of an insurer's book of business, at least 50% of the increase be tied to VBC contracts.

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[2] Michael E. Chernew, et al, A Proposal to Cap Provider Prices and Price Growth in the Commercial Health-Care Market. *CDP_PP_WEB_FINAL.pdf (hamiltonproject.org)

[3] Ibid at 10.

[4] Capping Provider Prices and Price Growth in the US Commercial Health Sector - 1% Steps for Health Care Reform - Policy Briefs (onepercentsteps.com)

2. Should certain providers be excluded from the professional services price cap? For example, providers types that do not constitute high-cost or high-cost growth service classifications.

As discussed above, we recommend adopting the price growth cap for high-cost service categories and expanding to other services over time.

3. Should providers that are engaged in advanced VBP for a significant portion of their revenue be excluded from the professional services price growth cap?

No. Instead, as further described below, participation in advanced VBP models should be a prerequisite for reimbursement at the high end of the price growth cap.

4. Are there other design features that OHIC should consider?

In adopting such a proposal, we recommend that OHIC consider an approach that incents the adoption of VBC by limiting the maximum increase in payment to those providers who are taking on a specified level (e.g., 15% or more) of downside risk.

5. Are there any unintended consequences that should be considered?

One risk associated with adopting such a cap is that it could encourage providers to remain in a fee for service payment model and to negotiate to the high end of the cap. To mitigate this concern, we recommend that OHIC establish thresholds which must be met before a provider could achieve an increase at the upper limit of the rate cap. For example, if a provider does not have an electronic health record and is not open to integration with a health plan, does not meet meaningful quality targets, or does not participate in alternative payment arrangements, the maximum increase for that provider must be limited to a fraction of the cap.

***

In addition to the response directly to the concepts within the ANPR, BCBSRI recommends that OHIC consider other modifications to the Standards. These include:

- Creating additional flexibility for insurers to implement what works and change course as needed. Overly prescriptive requirements could limit an insurer's ability to move the needle at a pace that suits their organization and reflects collaboration with providers. OHIC should set high level goals but allow variation to achieve those goals.
- Driving toward total cost of care (TCOC) reductions. Investments in PCMHs have been foundational, but primarily focused on process rather than outcomes. As discussed above, these investments have not resulted in TCOC reductions in commercial segments.
- Evolving current models. PCMH activities may have reached the intended goal. Consider moving away from continued infrastructure payments to incent primary care capitation. Continue to align quality programs to payment, expanding the hospital rate increase tied to quality to other areas (i.e., primary care, key specialties). Bundled/episode-based models for defined services and/or populations are critical next steps, particularly in engaging

specialists who have widely sat outside these risk models and have not held accountability for costs.

- Enabling providers to transition toward VBC through electronic medical record integration, data, and other support (such as pharmacists, behavioral health integration, etc.) to drive toward better team-based care. Encourage the move away from infrastructure payments toward management service organization like services.
- Facilitating transition away from open access plans. Regulatory requirements (outside of the affordability standards) take a strict view on network adequacy which inadvertently limits options for narrow and/or tiered network plans. Create new flexibility to support transition to VBC. Employer and consumer education around plan design and transition away from open access PPO plans may accelerate transition to VBC.

In closing, BCBSRI remains committed to working with OHIC to advance the Standards. Thank you for your consideration of these comments. We are available at OHIC's convenience to discuss further these comments or alternative approaches.

Sincerely,

Monica Auciello

Monica Auciello
SVP, Legal Affairs & Policy

cc: Michele B. Lederberg
Kristen McLean

OHIC and the Capitation Follies *(Continued v3.0)*

It appears that the several proponents of capitation try to re-invent the model name, which creates confusion, so please be forthright. It is still **capitation** and **needs to be called what it is:**

- Prospective Payments = Capitation
- Alternative Payment Models = Capitation
- Payment Reform = Capitation
- Alternative Quality Contracts = Capitation
- Modified Bundled Payments = Capitation
- Primary Care Reimagined = Capitation
- Advanced Value Based Payments = Capitation
- Non-fee-for-service = Capitation

Pediatrics is already the **lowest paid** of all medical specialties,

- RI ranks in the lowest 10 of all 50 states for physicians to practice. (Actually **#51** in 4/2021 *Medical Economics* review) Ref: The 10 worst states for doctors in 2021 (medicaleconomics.com) It is very **difficult to recruit** new peds to this scenario. Access to care will be even more **limited**.
- RI, Alaska, and New Mexico are the only states where 40-49% of pediatricians polled said that they 'would retire now if affordable." Ref: https://www.aap.org/en-us/Documents/members_aap_state_pediatrician_workforce_survey.pdf This would severely **limit access** to quality primary care.
- "The increasing numbers of generalist and subspecialty **pediatricians working part-time** may also exacerbate workforce shortages." | "Many of the pediatric subspecialties have also raised concerns about workforce shortages." | "Any hope that pediatric advanced practice providers will augment the pediatric and family medicine workforce is challenged by an **impending critical shortage of the pediatric nurse practitioners**." Ref: https://pediatrics.aappublications.org/content/pediatrics/early/2021/03/08/peds.2020-013292.full.pdf
- By some estimates as many as much as **40% of children live below the poverty threshold.** This puts an **inordinate burden on pediatrics** to attend to these additional Social Determinants of Health which are not adequately reimbursed through capitation.
- Age bands of capitation must be very narrowed in the first 3 years. This is not only for the more frequent well child checks and vaccines; parents of new babies require much more education and support.
- **Pediatrics does not fit into the MediCare** model for administration or for capitation. The vast **majority of PCMH capitation savings are in adult care**, not pediatrics. What we need is **MediCare parity.**
- While most of us are members of the AAP, and have childrens' health foremost in our mind, **we still demand, we still need to receive adequate reimbursement to survive.**
- As one Prominent Pediatric leader asked, **"Are we all lemmings?"** No, we are not--**we are all medical professionals** and need to be treated as such. We need to maintain our **critical thinking skills so as to not be duped**. **We CAN take action,** but we need the bureaucrats and insurance companies to know our positions, and our plights. Elsewise, governmental and health insurance **entities will mistakenly interpret our silence as assent.**

If one takes the time to **actually review** the accompanying material provided by Freedman Healthcare via the RI-AAP Zoom conference of March 31st, 2021 it becomes obvious that **capitation is NOT in our favor:**

1. A 2016 paper published in *Pediatrics* estimated that 80% of real world pediatric practices would actually require **$35 PMPM to break even.** Ref: Farmer, SA et al.: 'Fully Capitated Payment Breakeven Rate for a Mid-Size Pediatric Practice' https://pediatrics.aappublications.org/content/pediatrics/138/2/e20154367.full.pdf. (Do you actually believe insurance companies will pay that?). **Pediatric EHR vendor PPC recommends a $30 PMPM minimum.** Ref: https://chipsblog.pcc.com/passing-the-sniff-test-capitation-prequel (2020).
2. Milliman Healthcare Reform Briefing Paper: Risk adjustment for pediatric populations. ''In Alternative Payment Models that use risk adjustment to distribute payments for providers, this could also result in **inequitable reimbursement to providers specializing in pediatric populations**. Ref: https://milliman-cdn.azureedge.net/-/media/milliman/importedfiles/uploadedfiles/insight/2013/risk-adjustment-for-pediatric-populations-healthcare-reform-bulletin.ashx
3. How to Prepare Your Practice for Implementing Alternative Payment Modes presented by Suzanne Berman, MD, FAAP via AAPTV (8/2015) "**If payors suddenly insist that everybody assumes risk, I think we're going to see a lot more people drop out of plans**, and honestly, Medicaid payors in particular cannot sustain their network…" Ref: https://www.youtube.com/watch?v=t6_Mtr8V7QQ [@55:40]

Contrast this with OHIC policy slides, "APMs [Alternative Payment Methodologies] **should incorporate meaningful downside risk and prospective payment** over time" Ref: March 22, 2021 Zoom meeting of the RI Health Care Cost Trends Project-Steering Committee- https://zoom.us/rec/play/7JCD09SM-2Q6x6tr9uyMRHwZSIlK_edBDnn1ymkUQ3JZnqSpi5nOioyn_aNofmvLi30pm1XHLietQeTm.xHYIlN-cx2ofTMnn?startTime=1616419897000&_x_zm_rtaid=gqwy-_TmSRunkyMN5PBjSg.1617386529308.0a24c0295ef836423bd2aa6e4ec27b24&_x_zm_rhtaid=61 [Slide 14 @43:30].

- Actually, OHIC policymakers expressed desire for risk-based contracts **across all payors** with capitation **attribution across commercial**, Medicaid and MediCare Advantage plans. Ref: *ibid* [Slide 25 @55:30]
- **OHIC touts the Oregon Health Plan as a model** for capitation, but which "…has not been any more or less successful than the U.S. as a whole in controlling costs. Initial hopes for broad participation by providers have been dashed by the **pullout of larger managed care providers** and a **shrinking pool of providers** willing to accept Oregon Health Plan enrollees as new patients." Ref (2020): https://www.researchgate.net/publication/228323174_The_Oregon_Health_Plan_a_Bold_Experiment_that_Failed
- Capitation advocates claim idyllic scenarios of health quality improvements, better access, improved population health, flexibility, and patient experience. **But actually our ACOs (Integra and PCMH-Kids,** and others**) perform well on these measures, no capitation required.**
- **And our ACOs also perform well and achieve improved Social Determinants of Health within Fee For Service payment models, no capitation required.**
- From the above it may be concluded that OHIC staff are rolling all the gains attributable to PCMH concepts into their arguments for capitation. But they are **separate; don't confuse them**. You must separate quality measures from payment methodology.
- Proponents of capitation often say derisively that **Fee for Service rewards volume, but know FFS also rewards both quality and patient satisfaction,** elsewise the provider would lose their patients**.**
- But any lookback of income from FFS to calculate capitation rates would require 2 years of data that **cannot include the economic downturn from the COVID pandemic.**
    - Plus **carveouts** for vaccines/procedures/ and licensed screening tools like CHADIS.
    - Reimbursements for Videocalls and telephone encounters must continue.
    - **Must have $10-15 copayments** or will be overrun in open access capitation.

Capitated rates are too inviting a **target for bureaucratic budget cuts** so as to achieve 'health care cost targets.' Remember, this is Rhode Island, and about three years ago Gov. Raimondo gave a **5% 'haircut'** to all Medicaid payments as administered through the insurance companies.

Added stuff:

The OHIC Health Care Cost Trends Meeting of April 29th, 2021 there were some interesting revelations regarding 2019 RI health care costs. By far, **the biggest drivers for increased health care expenditures were 1) hospital outpatient services and 2) retail pharmacy expenditures. Non physician/non PCP health professional expenses (PT/OT/Speech/Behavioral Health, etc) were a third leading cause** [Slide 43@0:53]. It may be surmised that the whole concept of capitation to PCPs is something developed to throw at the bigger problem; PCP costs were not a big factor. Pediatricians are the particularly low-hanging fruit, so to speak. To paraphrase one committee member**, "You're going to spend more money administering a VBP (capitation) program than you'd save."** [Slide 46] @1:08.

OHIC 'Consensus Model for Primary Care Alternative Payment Model' 2017 (revised 2021) is merely a bureaucratic policy statement, and in my mind has **no legal weight.**

Tales of doom—the end of primary care private practice is near! In 2015-2016 an associate director of EOHHS told me that their office would **no longer be negotiating with private practices**-all medical care would be 'transformed' into large groups of employed providers.

While the stated 'goal' of OHIC capitation is not to reduce spending or increase practice risk, a '**goal' is by no means a guarantee**.

The concept of **risk sharing** should not apply to private practice at all. One Vermont plan requires **withhold** as well.

Meeting coordinators will often express excitement with impressive attendance at any videoconference, citing that it must reflect interest in their presentations. But please **do NOT mistake attendance as agreeing to terms of capitation.** The speakers talk in kumbaya terms of 'opportunity' and 'promise'… We must fear as well the opportunity to fail and the promise to fail.

"Questions to Ask" before signing onto a capitated plan are moot in a scenario of **health insurance companies banding together at the behest of OHIC to force capitation**. A 'take it or leave it' approach of **"we don't have to sign a contract"** is an implied threat to us all if we do not actually participate.

Taxpayer funded-paid consultants (from out of state) serve on RI advisory committees on health care spending.

Speakers claim that administrative burdens would be lessened under capitation: But these **burdens are replaced by PMPM patient lists updating** requirements. Health insurance companies are historically awful at this.

Capitation still requires submission of **P4P data.** Speakers indicate we still need to 'account' for the ancillary services we provide (whether reimbursed or not), but **what we need is to be paid fairly and adequately.**

Comments to: jeconcannon@gmail.com

You may also want to talk to members of the OHIC-sponsored RI Health Care Cost Trends Project-Steering Committee (present at the March 22, 2021 and *April 29, 2021* meetings) – Next meeting May 17, 2021 930 pm

- Michele Lederberg/BCBS of RI
- Betty Rambur/URI College of Nursing
- Michael DiBiase/RI Public Expenditure Council
- Tim Babineau/Lifespan
- Beth Roberts/Tufts-HarvardPilgrim
- Ben Shaffer/EOHHS-Medicaid
- Peter Hollman/RI Medical Society
- Diana Franchitto/HopeHealth
- *Michael Bailit, Bailit Health, Needham MA*
- *Daniel Moniyhan*
- *Sam Salganik -, RI Parent Info. Network*
- Patrick Tigue/OHIC
- Larry Warner/United Way-RI
- Teresa Paiva Weed/RI Hospital Assn
- Al Charbonneau/RI Business Group on Health
- James Fanale/Care New England
- Jim Loring/Amica
- Al Kurose/Coastal Medical
- Larry Wilson/Wilson Organization

Lifespan

Delivering health with care.

January 14, 2022

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

RE: Next Generation Affordability Standards; 230-RICR-20-30-4.10

Dear Commissioner Tigue:

We write to provide comments on the Office of the Health Insurance Commissioner's ("OHIC" or the "Office") Advance Notice of Proposed Rulemaking (230-RICR-20-30-4.10). Lifespan's comments are based on and follow the "Concepts, Rationale and Additional Information" document posted by the Office.

Behavioral Health Spending Requirement

Concept: Proposed spending requirement for behavioral health care that will promote the development of a high-quality, well-functioning delivery system capable of serving the comprehensive physical and behavioral health care needs of the public.

Comment: Lifespan strongly supports a requirement for behavioral health spending similar to that which is in place for primary care. As evidenced in Primary Care, analogous investment in Behavioral Health care through required spending has the potential to exert a tremendous positive effect on the health and wellbeing of our community and the patients we care for. We will look to the results of EOHHS behavioral health spending study referenced in the document to help inform where investment will best serve our shared goal of improving behavioral health for the populations we serve.

Community Investment Requirement

Concept: Require insurers to use a defined amount of their excess surplus that is consistent with both the public interest and proper business conduct on an annual basis to fund community benefit activities that advance health equity, address SDOH, and improve population health.

Comment: Lifespan fully supports investment in community benefit activities. As a not-for-profit organization, Lifespan's contribution to community benefit and charity care in fiscal year 2020 exceeded $276m. Creating a Community Investment Fund and requiring insurers to contribute a defined amount of their excess surplus annually will have a significant impact on advancing health equity, addressing social determinants of health (SDoH) and improving population health.

Lifespan also proposes including providers substantively engaged in population health management amongst the advisory group of stakeholders that will provide input to grantmaking by the community investment fund. Through strategic partnerships, the Lifespan Community Health Institute (LCHI) serves as a bridge between Lifespan departments and the community. LCHI initiatives such as Connect for Health and a recent successful pilot of medical respite housing in collaboration with multiple agencies have demonstrated the opportunity to successfully address complex challenges related to SDoH. Learnings from these and other innovative programs initiated by providers should help inform the stewardship of community investments contemplated under this new policy.

Professional Services Average Annual Price Growth Cap

Concept: The promulgation of a cap on average annual price growth for professional services (e.g., physician services or laboratory services) with consideration of excluding either or both of two specific categories of providers: 1. Specific specialties such as behavioral health; 2. Providers who are engaged in advanced value-based-payment (VBP).

Comment: Lifespan fully supports pursuit of the Triple Aim goals of better health and better care at a lower cost. Consideration of the potential role of annual price growth caps for different types of physician services as a policy tool in service of improving Triple Aim performance raises a myriad of complex technical issues as well as some concerns about unintended consequences. Lifespan is happy to participate in future community conversations regarding these various issues, and for the moment would offer the following comments:

- Lifespan fully supports the pursuit of advanced VBP and exclusion from the proposed annual price cap as an incentive for providers to participate in advanced VBP contracts.
- Lifespan also supports the exclusion from any annual price growth cap for behavioral health.
- Lifespan wants to call out the potential in a small state like RI for the unintended consequence of a flight of talent to neighboring states resulting in a scarcity or absence of certain subspecialty services if caps become a barrier to offering competitive reimbursement to such providers.
- Lifespan suggests that consideration be given to delaying a final decision on any new price growth caps until a clearer picture emerges regarding the potential long term (multiyear) impacts of recent disruptions in the healthcare labor market.

We appreciate the opportunity to provide public comment on the Office's concepts, rationale and additional information related to the Next Generation Affordability Standards.

Sincerely,

Daniel Moynihan
Vice President of Contracting and Payer Relations
ACO Executive Director

G. Alan Kurose, MD
President, Coastal Medical
SVP for Primary Care and Population Health

VIA EMAIL

November 24, 2021

Mark D. Jacobs MD

31 Snug Harbor Lane

Wakefield, RI 02879

Cory King, Chief of Staff

Office of the Health Insurance Commissioner

1511 Pontiac Avenue, Bldg. 69--1

Cranston, RI 02920

Dear Cory,

Re: ADVANCE NOTICE OF PROPOSED RULEMAKING, 230-RICR-20-30-4

I would like to comment on three areas of the communication: Next Generation Affordability Standards: Concepts, Rationale, and Additional Information

Behavioral Health Spending Requirement Concept:

OHIC is exploring proposing a spending requirement for behavioral health care that will promote the development of a high-quality, well-functioning delivery system capable of serving the comprehensive physical and behavioral health care needs of the public.

The qualifying behavioral health spending that would count toward the spending requirement would include both claims and non-claims payments

Comments: It is well understood that the care of patients with chronic medical disease by primary care providers is complicated, and undermined, by behavioral health co-morbid conditions such as depression, anxiety, and substance abuse. The co-location of behavioral health providers in the primary care office setting offers the opportunity to treat the whole patient in a coordinated and efficient manner. Identified barriers to this arrangement include: overhead costs, staff sharing, HIPAA privacy issues, co-mingling of electronic medical records, inadequate reimbursement for psychiatric consultation and care, multiple copay assessments for same day treatment.

If not already underway, I would propose that OHIC coordinate payers, as per the PCMH funding model, to devote funding to such a co-located entity AKA advanced primary care to: 1) Defray overhead costs for use of private exam rooms in the primary care office 2) cover cost of office employee utilization by

behavioral therapist 3) Clarify and simplify HIPAA rules for the appropriate sharing of medical/behavioral medical records by the patient's providers to allow team care 4) Offer behavioral health fee schedule sufficient to incentivize participation in co-location 5) forgive patient's second copay for same day care

Professional Services Average Annual Price Growth Cap Concept.

OHIC is exploring proposing the promulgation of a cap on average annual price growth for professional services (e.g., physician services or laboratory services).

OHIC is considering excluding some provider specialties from the growth cap, such as behavioral health providers……In addition, or as an alternative, OHIC is actively considering excluding providers who are engaged in advanced value-based payment (VBP) from the price growth cap.

Comments: A healthcare system that engages its primary care providers in capitation and value based payment is addressing only a portion of the cost problem. Incentivizing primary care physicians to be cost conscious while allowing specialists to work with an open checkbook is a recipe for failure. Accountable Care Organizations and their various iterations were designed to integrate all elements of a healthcare network in a shared responsibility to achieve the Triple Aim, and inherent in that design is the historically based global contract. That construct can incorporate specialists via subcaps, episode of care payments, and bundled payments to name a few. Hospitals should be likewise incentivized to participate in these two sided arrangements so that they can share in generated surplus for their efficiencies. Electronic medical record and insurance claim data can be utilized to help understand the practice patterns of every specialist so that determinations regarding efficiency, cost, value etc can be made. In my opinion, without this oversight and accountability, we will never bend the cost curve.

Several data points and trends in the Rhode Island market point to need to address professional provider prices beyond the existing regulations on hospital prices. First, the effects of hospital acquisition of physician practices, otherwise known as vertical integration, on prices is relevant to recent Rhode Island market developments.

Comments: Large hospital systems in the greater Boston area are implementing aggressive business plans to grow their primary care referral base to increase profitability and market share. Using their access to capital, these systems either purchase primary care practices (at multiples of their value) or enticed them (via lucrative bonuses and fee schedules) into tightly managed networks whose main purpose is to feed highly profitable ancillary services, employed specialists, and profit generating inpatient and outpatient service lines. "Leakage" of patients for services out of network to lower cost (but equal quality) providers or hospitals is strongly discouraged. This has profound implications as we view the proposed merger of our two largest hospital systems into an entity that could control 80% of the RI healthcare market.

Thank you for the opportunity to provide comment

Mark Jacobs MD

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Cory King, Chief of Staff
Office of the Health Insurance Commissioner
1511 Pontiac Avenue, Bldg. 69-1
Cranston, RI 02920

VIA ELECTRONIC MAIL - cory.king@ohic.ri.gov

December 22, 2021

Re: Advance Notice of Proposed Rulemaking –
Affordability Standards – 230-RICR-20-30-4

Dear Cory King:

Thank you for the opportunity to respond to this Advance Notice of Proposed Rulemaking with respect to *Next Generation Affordability Standards*.

MLPB believes that care should systematically account for people's legal rights, risks and remedies; and that care teams should be empowered as strengths-based, role-aligned partners in legal problem-solving. We equip communities of care with legal education and problem-solving insight that foster prevention, health equity and human-centered system change. Through training, consultation, and technical assistance, MLPB helps teams and organizations better connect people to the resources and legal protections they seek – in Rhode Island, Massachusetts, and nationally.

MLPB operates under the 501(c)(3) umbrella of TSNE MissionWorks, a national non-profit that builds the leadership and effectiveness of individuals, groups and nonprofits to support a more just and democratic society.

As an organization operating at the forefront of social care, we offer comments on two of the three proposals embedded in the concept paper developed by the Office of the Health Insurance Commissioner (OHIC). (We will not comment on the proposal relating to "capping average annual price growth for select professional services" as that is outside of our experience and expertise.)

- **"Necessary investment in behavioral health services to ensure a well-functioning continuum of care for Rhode Islanders with behavioral health needs"**

We applaud the prioritization of adequate behavioral health services for all. At the same time, there is a risk that investments in "clinical health services," "behavioral health services," and "initiatives to address social determinants of health" (including but not limited to meeting people's household-level health-related social needs) will become overly segmented and "siloed" in the new spending landscape.

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The relationship between material hardship (like housing instability), early and continuing life stress, and behavioral health conditions (like depression and anxiety) is increasingly well-documented. Patients will benefit if there is flexibility to meet their goals and needs in ways that recognize that behavioral health – like physiological health – often is tied to one's social, economic and environmental context. This recognition should inform any evolution of standards that call for – for instance – "access to a continuum of . . . treatment" and "greater integration of physical and behavioral health care delivery."

On this note, MLPB is committed to supporting policies and investments that are geared to optimizing life course health for all, meaning that we should strive for a new equilibrium of resources among primary prevention (public health), primary care (including OB/GYN) and complex care in ways that hopefully avoid zero-sum-framed resource struggles. And this means, among other things, **re-balancing how infants, children and youth figure into healthcare priority-setting in new and deeper ways**. Any new healthcare spending regime should prioritize investments that optimize life course health by focusing on perinatal health – **including parental and infant mental health**.

- **"Accountability for investment in initiatives to improve population health and address social determinants of health (SDOH)"**

This domain is focused on a new Community Investment Requirement, and a multi-component concept for implementation. We commend OHIC's commitment to health equity advancement that includes the dismantling of systemic racism and we offer the following input:

1. *Health care coverage for all* is foundational to any anti-racist health system and not clearly reflected in this concept.

2. *Community Benefit Activities and Community Investment Fund*

Both sub-concepts are described as intending to "advance health equity, address SDOH and improve population health" – sound and urgent goals. For 25+ years, MLPB has partnered with health care teams and organizations to address HRSN and SDOH through legal problem-solving strategies, and has pioneered a growing evidence based for the power of legal information and rights education to improve care quality and comprehensiveness.

MLPB's experience in equity- and prevention-focused partnerships with health organizations prompts the following recommendations:

- Increased investment to broaden health insurance eligibility to include Rhode Islanders currently excluded from accessing existing health insurance plans;
- Increased investment in community health workers and related workforce development infrastructure;
- Increased investment in workforce diversity and inclusion, including meaningful career-ladder pathways for health workers;
- Increased investment in multilingual staff and reimbursable interpreter services outside traditional healthcare settings to support community-based resources attending to people's health-related social needs;

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- Investment in the creation of reimbursable transportation costs to support increased access to community-based programs;
- Increased investment in strengths-based communication training for health workforce members, which includes by definition trauma-informed care and non-paternalism principles; and
- Increased investment in multidisciplinary teaming that can help to surface non-medical-model-based strategies to respond to people's needs and priorities.

On the latter point, we urge the state to adopt new standards that explicitly recognize *team-facing legal partnering* – an evidence-based practice involving close collaborations between community health workers and public interest advocates – as a type of activity aligned with the contemplated Community Benefit Activities and Community Investment Fund. This work has been tested in the context of RI's Community Health Teams and will help animate RIDOH's new CDC grant dedicated to *Community Health Workers for COVID Response and Resilient Communities.*

3. *Beyond the Written Word: Achieving Actual Accountability:*

This new/modified spending framework carries expectations for cross-sector actors whose operations impact the health and well-being of individual, families and communities across the Ocean State. A core tenet of anti-racism is that *intent and impact* are distinct phenomena, and impact matters most. The advisory body proposed by OHIC is a structure inherently vulnerable to conflicts of interest, implicating both well-meaning health care organizations (of all types) and community-based organizations who potentially would participate. **We recommend that the state consider appointing and financing an independent (fully disinterested) ombudsman to oversee the integrity of these initiatives.**

Please let us know if we can answer any questions about these observations and recommendations. We are happy to.

Sincerely,

Samantha J. Morton
CEO
MLPB, a fiscally sponsored program of TSNE MissionWorks

Neighborhood Health Plan OF RHODE ISLAND™

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January 12, 2022

Cory King, Chief of Staff
Office of the Health Insurance Commissioner
1511 Pontiac Avenue, Bldg. 69-1
Cranston, RI 02920
Submitted via email: cory.king@ohic.ri.gov

RE: **Advance Notice of Proposed Rulemaking – Affordability Standards Concept Paper**

Dear Mr. King,

Neighborhood Health Plan of Rhode Island appreciates the opportunity offered by the Office of the Health Insurance Commissioner (OHIC) to provide feedback on the Advance Notice of Proposed Rulemaking for the Affordability Standards within 230-RICR-20-30-4 and the associated concept paper. Neighborhood supports OHICs broad policy goals as articulated within the concept paper and offers the following respectful suggestions in constructing the regulation.

Neighborhood supports OHICs goal of ensuring appropriate resource investment from commercial insurers in the behavioral health system, so long as these resources are focused on several key areas. These areas include increasing primary care integration, targeted workforce investment, and developing services to fill in gaps in Rhode Island's behavioral health continuum. Neighborhood believes addressing these areas is best achieved through targeted means as opposed to broad resource distribution. Neighborhood looks forward to reviewing OHICs regulatory language and are hopeful it aligns to these goals.

Neighborhood supports OHICs goal to ensure community investment from commercial health insurers in order to address social determinants of health (SDOH), improve equity and reduce costs. As the State's largest Medicaid Managed Care organization, Neighborhood is well versed in the need to commit resources to community infrastructure in support of these public health goals. In consideration of advancing this goal in balance with OHICs other statutory obligations, Neighborhood offers the following considerations.

Neighborhood respectfully requests OHIC consider the use of maximum reserve threshold as an alternative measure to address this goal. The floor set for adequate reserve levels is important relative to protecting the financial health of insurers, but the community investment goal may be aided by considering an upper reserve threshold that would trigger the need for an appropriate level of mandated community investment. This would seek to ensure that insurers making windfall profits are contributing some amount of those funds back into the community as opposed to all insurers regardless of reserve status.

Independent of the approach taken to measure desired community contribution levels, Neighborhood generally believes that any allocation of these resources should take account existing appropriate community investment levels and should consider ongoing and new investments within a broad set of flexible guidelines that leave considerable autonomy in the hands of the health plan. There is little consensus on a single type of investment in SDOH that has proven more successful, and these needs are likely to vary by community. Of the options

presented in the concept paper, we feel that option number one "Community Benefit Activities" most closely aligns with these suggested goals. Neighborhood already invests in and fosters significant connections with community organizations as well as the development of enhanced analytics to look at the communities and areas in need of greatest investment. For example, this type of action led Neighborhood to identify Woonsocket as a community of significant need in food security and collaborate with a local health center to sponsor food pantries, farmers markets and a food box delivery pilot program. Neighborhood strongly advocates that proposed regulation retain the discretion of the health insurer and provide credit to enable programs like this to continue.

Neighborhood is in support of OHICs efforts to continue to evolve the regulatory framework to leverage the resources of the commercial market to support the health of Rhode Island's citizens regardless of what type of insurance coverage they retain. We look forward to further dialog when draft regulations are released.

Thank you for your consideration and should you have any questions or seek further information about the feedback provided, please do not hesitate to contact me by phone at 401-459-6679 or email at emcclaine@nhpri.org.

Sincerely,

Elizabeth McClaine
Vice President of Commercial Products

TO: Commissioner Patrick Tigue, Office of Health Insurance Commissioner
FROM: Karen Malcolm, Coordinator, Protect Our Healthcare Coalition
DATE: December 22, 2021
RE: Public Comment, Rulemaking, Next Generation Affordability Standards

On behalf of the members of the Protect Our Healthcare Coalition, I submit the following comments in support of OHIC's proposed revisions to the state's affordability standards. Affordability is among the most important components to ensuring access to quality, comprehensive health care for Rhode Island consumers regardless of how they get their coverage. We believe the proposed revisions are an important next step towards cost containment while redistributing health care dollars to meet urgent needs in behavioral health and towards addressing social factors that impact health outcomes.

Currently, Rhode Island, like much of the nation, faces a dilemma: On the one hand, a need for additional investment in behavioral health services and in mitigating social determinants of health; while on the other, fast rising health care costs that families and employers can't afford to pay. OHIC's proposed revisions represent a well-balanced approach to this dilemma – capping annual price growth for most professional services while instituting a spending requirement for behavioral health care and rules to promote insurer investment in community benefit programming.

More details of our support for each of the three proposed areas for revision are outlined in more detail below.

I. Investment in behavioral health services to ensure a well-functioning continuum of care for Rhode Islanders with behavioral health needs.

The most recent 'State of Mental Health in America' report issued by Mental Health America just a few weeks ago (December 3, 2021), documents that **25.4% of Rhode Island adults with a mental illness reported that they were not able to receive the treatment they needed**. Also alarming, MHA reports that **64.9% of Rhode Island youth with major depression do not receive any mental health treatment**. Contributing factors reported are complex, including:

- No insurance or limited coverage of services.
- Shortfall in psychiatrists, and an overall undersized mental health workforce.
- Lack of available treatment types (inpatient treatment, individual therapy, intensive community services).
- Disconnect between primary care systems and behavioral health systems.
- Insufficient finances to cover costs -- including copays, uncovered treatment types, or when providers do not take insurance.

This data is supported by the findings of the Mental Health Association of Rhode Island's newly released survey of licensed Rhode Island behavioral health professionals, which highlights the

urgent need to address systemically low reimbursement rates paid for behavioral health services as necessary to fix existing network inadequacies, including but not limited to child psychiatry, intermediate level behavioral health hospitalization, early intervention services, and substance use disorder services.

It is important to note that **it is critically important that OHIC maintain strict oversight of insurer adherence to state and federal mental health parity laws – independent of the proposed spending requirement in the affordability standards**. It is also important to maintain the existing incentives to help drive integration of primary and behavioral healthcare. All of these approaches are needed to rebuild a strong continuum of behavioral healthcare to meet Rhode Islanders' needs.

II. Community Investment Requirement

While we recognize insurers must maintain adequate reserves, and acknowledge OHIC's statutory responsibility in this regard, we believe that exceedingly high, excess reserves are not an efficient use of revenues, especially in light of the urgent need to address social factors that directly impact health and well-being. Added to this is the fact that excess reserves are shored up – at least in part -- by the significant public investment in Medicaid and Medicare.

The United States spends more on health care than any other nation in the world — and yet, our nation's health outcomes are comparatively worse. Research shows the social determinants of health have a much more significant impact on the health of a population than clinical interventions. If social determinants are adequately addressed, we have the potential to reduce down-stream healthcare spending while also improving the overall quality of life for Rhode Islanders. Community benefit program investments can be tied to already defined public health measures as outlined by the RI Department of Health, and could target disparities in access to safe housing and healthy food; reducing exposure to environmental toxins; creating culturally appropriate and accessible public health programming; and so much more.

Among the ideas proposed by OHIC, **Protect Our Healthcare most supports a requirement that would direct insurers to contribute a defined amount of their excess surplus into a community investment fund.** A community investment fund would provide a collective vehicle for directing dollars to expensive problems in a more substantive way than any single insurer (or entity) could accomplish on their own. Current community benefit programming in Rhode Island has been superficial at best, even considering some promising – though small scale -- pilot programs supported by individual insurers and health systems.

We encourage, as a critical component of this provision, that oversight should be shared with community-based leaders from those communities most impacted by existing disparities. More than an advisory group, we recommend this group be structured as a '**community oversight board' and provided at least partial decision-making authority** to identify investments, while held accountable to demonstrating investments result in improved health outcomes.

III. Professional Services Average Annual Price Growth Cap

Rhode Island has been a leader nationally in demonstrating the effectiveness of price growth caps in healthcare through our existing affordability standards. **We support, and believe** that in Rhode Island's significantly consolidated healthcare market, the more direct approach of extending the

state's **price growth cap to professional services is reasonable.** Based on above comments, we support excluding behavioral health services from the cap. The rationale for this exclusion is the fact that in Rhode Island, patients still find it difficult to access behavioral healthcare (mental health and substance use disorder treatment) for reasons directly linked to under-reimbursement of providers. A groundbreaking nationwide study by the actuarial firm Milliman – released in November 2019 -- shed light on this disturbing trend over a five-year period beginning in 2013. That report documented that, **in Rhode Island, mental health professionals received 23.4% less than other specialists for similar billing codes for the evaluation and management of conditions in 2017.**

Thank you for the opportunity to provide comment on this important work.

Protect Our Healthcare Coalition partners include: Economic Progress Institute, Mental Health Association RI, RI NOW, RI Parent Information Network, RI Health Center Association, NAACP Providence Branch, United Way of Rhode Island, Planned Parenthood of Southern New England, SEIU Rhode Island Council, Foster Forward, RI Coalition for the Homeless, Rhode Island Working Families Party, Mental Health Recovery Coalition, Oasis Wellness Center, RI Community Food Bank, Substance Use & Mental Health Leadership Council, Rhode Island Coalition for Children and Families, HousingWorks RI, RI Coalition for Reproductive Health, RI Lung Association, NASW RI, Rhode Island Organizing Project (RIOP), Thundermist Health Center

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RIHCA
RHODE ISLAND HEALTH CENTER ASSOCIATION

Providence, Rhode Island 02908
Facsimile: 401-274-1789

January 7, 2022

Mr. Cory King
Office of the Health Insurance Commissioner
1511 Pontiac Avenue
Building 691
Cranston, RI 02920

RE: Next Generation Affordability Standards: Concepts, Rationale, and Additional Information

Dear Mr. King:

Rhode Island Health Center Association (RIHCA) appreciates the opportunity to provide comments regarding the Office of the Health Insurance Commissioner (OHIC) Next Generation Affordability Standards. RIHCA represents Rhode Island's nine community health centers, including eight federally qualified health centers (FQHCs), one island-based health center, and an associate community mental health center member. FQHCs provided care for nearly 180,000 individuals in Rhode Islander last year, including those publicly insured (Medicaid), uninsured, underinsured, and privately insured.

RIHCA appreciates OHIC's efforts to improve health care affordability and primary and behavioral health care investments. We offer the following comments on the Next Generation Affordability Standards below.

Behavioral Health Spending Requirement Concept
Rhode Island continues to face disparities in mental, behavioral, and substance abuse health care services. RIHCA supports investments to advance integrative primary behavioral health care, substance abuse treatment, address workforce shortages and gaps in the continuum of care for individuals with behavioral and substance abuse issues. Investments should not compromise the primary care spend, and OHIC should remain focused on policies that ensure behavioral health parity.

Community Investment Requirement Concept
RIHCA supports the concept of investments to address the social determinants of health and equable health care system. Should OHIC pursue insurance surplus spending, decisions should include public input, allow flexibility in insurer investments, and align closely with existing initiatives. Additionally, surplus spending should not jeopardize the stability of reserves to ensure funds remain to protect consumers.

Professional Services Average Annual Price Growth Cap

RIHCA recognizes hospital annual price growth caps set by OHIC have contributed to health care savings. Should OHIC pursue the expansion of growth caps to include professional services, a thoughtful analysis should be undertaken to ensure limited disruption to the health care system. Any price growth cap should also be designed not to penalize providers who are efficient or otherwise engaged in alternative and value-based payment methodologies. Consumer affordability and access to care should be considered as well.

General Considerations

RIHCA commends OHIC for its dedication to health care affordability. We would encourage the Commissioner towards ongoing evaluation efforts to ensure actions undertaken by OHIC can demonstrate effectiveness, ensure goals are achieved and drive future initiatives. Additionally, we believe Affordability Standard proposals would benefit from a description of the impact said standards would have upon employers and employees to ensure health care cost savings translate to consumer savings.

Again, RIHCA thanks you for the opportunity to provide comments on the Next Generation Affordability Standards proposal.

Sincerely,

DocuSigned by:
Melissa Campbell
8E225C9624C144F...

Melissa Campbell, MPH
Policy Manager
Rhode Island Health Center Association

December 17, 2021

Mr. Cory King, Chief of Staff
Office of the Health Insurance Commissioner
1511 Pontiac Ave., Bldg. 69-1
Cranston, RI 02920
by email to cory.king@ohic.ri.gov

Re: Advance Notice of Proposed Rulemaking, 230-RICR-20-30-4, "Affordability Standards"

Dear Mr. King

The Rhode Island Parent Information Network (RIPIN) thanks OHIC for the opportunity to provide these comments in support of the proposed rulemaking regarding revisions to 230-RICR-20-30-4, the "Affordability Standards," and to the concept paper outlining the changes OHIC has proposed.

Since their inception, the Affordability Standards have represented a strong commitment by OHIC to ensuring consumers have access to affordable, meaningful health insurance by promoting meaningful primary care investment, integrated primary and behavioral health, and quality-driven alternative payment models. The proposed "Next Generation Affordability Standards" extend that commitment into areas where further investments and improvements are needed. RIPIN supports each of the three proposed substantive areas identified by OHIC (a behavioral health spending requirement; a community SDOH investment requirement; and a professional services average annual price growth cap), with especially strong support for the behavioral health spending initiative. RIPIN offers some technical suggestions regarding the implementation of these new standards.

Guiding Objectives

RIPIN is appreciative of the health policy objectives articulated to guide the development of input regarding the proposed modifications to the affordability standards. While these objectives appear to be included with the intention of guiding feedback, they nonetheless correspond to the overarching goals of the Affordability Standards, and the framing of those goals implicates how the evolution of the Affordability Standards will be guided. To that end, in bullet two (regarding health care quality), RIPIN encourages OHIC to specifically include "improved population health outcomes." Especially in the establishment of

requirements around behavioral health and social determinants of health, the measure of success should not be just that a particular episode of care is delivered properly and in an equitable way; instead, we would encourage the success of such a program to be measured (at least in part) on the overall impact such a program has on population health.

Behavioral Health Spending Requirement

RIPIN thanks OHIC for its proposal to implement a baseline behavioral health spending requirement in line with its existing primary care spending requirement. Years of underinvestment in behavioral health (both nationwide and specifically in Rhode Island) have exacerbated an existing behavioral health crisis; the recent Health Management Associates/Faulkner Consulting Group study on Rhode Island's behavioral health infrastructure found very few areas where Rhode island's performance was considered adequate, while identifying a laundry list of gaps in the continuum of care. While this study was largely focused on driving Medicaid reforms and investments, the shortages identified in the Medicaid market are parallel to those faced in the commercial market.

The gaps in services faced by Rhode Islanders with behavioral health needs largely, if not entirely, stem from underinvestment. This underinvestment contributes directly to the lack of sufficient provider workforce capacity, the unavailability of many intermediate and community-based alternatives to hospitalization, and the fact that more than half of Rhode Islanders receiving residential substance use disorder treatment receive that treatment outside of RI, MA, or CT. Downstream, the underinvestment in behavioral health results in outsized emergency room utilization by individuals with behavioral health needs, poor follow-up rates for emergency visits by individuals with behavioral health needs, and higher than average opioid overdose death rates. These deficiencies are exacerbated in communities of color and in communities where languages other than English are predominantly spoken. Each of these gaps results in significant downstream costs to the state's healthcare system, and to the economy generally. Appropriate behavioral health investment in areas where gaps have been identified can help save lives and improve population health while reducing downstream system costs.

Areas of particular concern in Rhode Island's behavioral health system infrastructure should be given particular attention within the regulatory structure OHIC anticipates constructing to implement such a behavioral health spending requirement. Investment should be directed to areas where gaps and significant shortages have been identified, including home-based therapeutic services (HBTS) and applied behavioral analysis (ABA) services for children; community step down services for children and adults; residential treatment facilities; transition age youth services; preventive services; intermediate inpatient and intensive outpatient services; and mobile crisis treatment services.

RIPIN also believes it is important to distinguish the behavioral health spending investment being proposed through the Affordability Standards from OHIC's existing commitments and authority regarding compliance with existing state and federal mental health parity law. Regardless of the approach taken through the Affordability Standards, federal parity laws still require that insurers construct a sufficient behavioral health provider network including through the provision of sufficient reimbursement rates vis-à-vis their medical/surgical provider network. OHIC retains the authority to enforce these existing parity laws independently from and in addition to any new requirement regarding total spend, and we recommend that any regulatory language emphasize that distinction.

Community Spend Requirement

RIPIN is supportive of OHIC's proposed community spend requirement to address social determinants of health and advance health equity while dismantling systemic racism in the existing healthcare system. If, through OHIC's regulatory oversight, it is determined that carriers have inefficiently high levels of reserves, which as OHIC notes are frequently funded with taxpayer money through public programs, it follows that it would be in the public interest (and particularly in the interests of creating an effective health care delivery system) to direct that investments be made that would be a more efficient utilization of those excess reserves. While we do not take a position on the particular structure that such a program would take, we would encourage OHIC to consider directing that investments be made on a cross-payer basis to take advantage of scale and reduce duplication. A coordinated model can also help ensure that certain communities are not left out due to over-concentration of investments.

RIPIN also suggests that the anticipated scale of the cumulative required community spend be ascertained before a model is announced; the correct model for a $1M investment could be significantly different from a $10M investment.

Professional Services Average Annual Price Growth Cap

RIPIN also supports the proposed professional services price growth cap as articulated by OHIC. We are in agreement that such a price growth cap should be waived for specialties and subspecialties where capacity is limited, including behavioral health and pediatric specialists. We also concur with the proposal that the price growth cap be benchmarked, where it would apply variably to providers depending on how far above that benchmark their prices currently lie – such a model could assist with (or obviate the need for) identifying specialties where capacity issues exist due to low rates.

RIPIN does have questions regarding the proposed interplay between advanced VBP and an exclusion from the proposed price growth cap – if prices are already high in a

particular specialty where advanced VBP has not resulted in more affordable, higher quality care, then a provider's adoption of such a model in order to be excluded from the price growth cap would not necessarily advance the goals of improved affordability or health care quality.

Conclusion

Thank you for the opportunity to provide these comments. We look forward to continuing to work with OHIC as the specifics of these models are established and implemented. Thank you for considering these important investments to improve health care affordability and quality for Rhode Islanders, and please do not hesitate to contact us if we can be helpful in any way.

Sincerely,

/s/

Shamus Durac
Attorney / Health Policy Analyst
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/s/

Sam Salganik
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Hi Marea and Cory.

Thank you for the opportunity to review the Advance Notice of Proposed Rulemaking as it pertains to the Next Generation Affordability Standards. Below are two comments for your consideration as you move forward:

Pg. 2 – Behavioral Health Spending Requirement - Regarding behavioral health spending requirement, it is stated that the behavioral health spending would be defined in a similar manner to the existing primary care spending requirement, including eligible provider types, site of care, and procedure codes. Please consider adding the following date points – level of care, population served (i.e., adults, children, and/or families), and payment rates. These additional data points will provide a more comprehensive assessment of the system.

Pg. 3 – Community Investment Requirement – Within the rationale outlined on pg 5 it states " view the health care system…… and appropriate access." To that end, there needs to be some measure to assess and ensure network adequacy particularly as it pertains to behavioral health.

Again, thank you for this opportunity and hope you find my comments helpful.

Kind Regards,

Sue

Susan A. Storti, PhD, RN, NEA-BC, CARN-AP
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VIA E-MAIL

Patrick Tigue
Health Insurance Commissioner
1511 Pontiac Avenue, Building 691
Cranston, RI 02920

RE: Affordability Standards Revision: Advance Notice of Proposed Rulemaking 230-RICR-20-30-4

Dear Mr. Tigue,
On behalf of Tufts Health Plan (Tufts HP), a Point32Health company, we appreciate the opportunity to provide comment on proposed revisions to the Office of the Health Insurance Commissioner's (OHIC's) Affordability Standards ("the Standards"). We appreciate OHIC maintaining an open and inclusive approach to developing and implementing policies and programs associated with the Standards. We recognize that balancing affordability and access is challenging, and we offer our comments with those principles in mind.

We share OHIC's stated goals of improving affordability and overall health system performance. However, we do have concerns with some of the proposed modifications to the Standards, which we highlight below, for your consideration:

I. Behavioral Health Spending Requirements
As an organization, we recognize the importance of appropriate levels of investment, particularly in behavioral health (BH) services. We work closely with our BH provider-partners, as evidenced by our integrated BH model at Tufts HP, on ways to enhance the quality and access to behavioral health services in the state.

While we do not oppose a minimum spend requirement for BH, increased investment in BH must be balanced by decreased spending from other parts of the health care system, so that total health care spending is not increased.

Required spending levels constrains our ability to manage overall costs and, ultimately, offer the most affordable premiums possible to our employer clients and consumers. A required spending level for behavioral health services, coupled with existing spending requirements for primary care, Care Transformation Collaborative programs, and a hospital rate cap – which is often viewed as a defined increase, rather than a maximum increase – severely constrains a health plan's ability to manage overall costs and demonstrate innovation within its provider health system arrangements.

II. Community Investment Requirement

The appropriate means for carriers to make community investments is not through reserves, but rather through their charitable foundations. Reserves are meant to ensure carriers have adequate resources to cover future claims costs, particularly in the event of a pandemic like COVID-19.

Additionally, assessments on carrier reserves will cause undue premium increases for our employer clients and run counter to the affordability principles OHIC has put forward.

The Tufts Health Plan Foundation has supported community organizations across the state since 2009. More than $7 million has gone to nonprofits working to advance age-friendly communities and address the social determinants of health. While we share OHIC's goal of addressing social determinants and health inequities, we feel that it is more appropriate to fund community organizations working toward solution to these issues, rather than using the plan's reserves for funding.

As outlined above, Tufts HP is actively engaged in many elements that support addressing health disparities and feels that additional assessments from OHIC would be redundant. Furthermore, efforts being raised by the Care Transformative Collaborative around Community Health Provider pilot programs are perceived as duplicative in nature and, again, continue to hinder Tufts HP's ability to deploy financial arrangements that are driven by collaboration and innovation in plan/provider relationships. Finally, in any instance of community investment, Tufts HP believes that providers are likely to be the recipient of improved use of the healthcare system; therefore, community investments of any sort should not solely be the onus of the plan.

II. Professional Services Average Annual Price Growth Cap

While Tufts HP is supportive of provisions that aim to control the rapid increase of medical trend, Tufts HP is challenged, as a smaller heath plan, in its efforts to remain competitive as providers and health systems often view the growth caps as a minimum increase to reimbursement. Moreover, the volatility of growth caps being applied to the benchmark of Consumer Price Index (CPI) and the exacerbation of such trend being compounded by the additional OHIC increase (i.e., CPI + 1%), results in I) variation in forecasting and pricing for the plan and its fully-insured clients and II) elimination of predictability of medical expense for our self-insured clients. While we recognize that OHIC has limited regulatory capacity over self-insured commercial business, it is the perception of Tufts HP that OHIC's preference is that plans do not create a product imbalance due to funding source. As such, Tufts HP often aligns financial arrangements with providers, agnostic of product funding source.

If OHIC is to pursue any professional services growth cap, consideration should be given to revising the existing Hospital Growth Cap benchmark where any health system growth cap, regardless of service category (i.e., hospital or professional) adheres to the following principles:

1) Demonstrates higher degrees of stability and predictability in annual determination
2) Accounts for high-cost trends and variation in utilization between services categories (further detailed below)
3) Not be set higher than the states cost growth benchmark
4) View health systems as inclusive of hospital and professional services and apply rate caps at an aggregate health system level, and not independent of another
5) Be presented to stakeholders with emphasis that the trend not be viewed as a floor for rate adjustment
6) Establish any non-health system professional rate cap with consideration given to the applicable above-mentioned principles

With respect to principle number 2, above, when accounting for utilization and severity trends, it is worthwhile to note that the Office of the Massachusetts (MA) Attorney General previously indicated in a 2015 Examination of Health Care Cost Trends and Cost Drivers[1] that unit cost increases should be capped at 0.8% in order to achieve the MA Health Policy Commission's cost trend benchmark of 3.6%. An extrapolation of that report finding infers that a rate increase of less than 0.8% is needed to achieve the current cost trend target of 3.1%. More plainly put, Hospital business drives most of the volume in the state and not accounting for utilization and severity trends compromises any ability to adhere to such targets established by OHIC. Moreover, the fact that the OHIC Hospital rate cap for 2022 is 3.7%, outside of lending deference to the MA Attorney General's examination, is directly in conflict with trying to achieve a growth benchmark of 3.2%.

Thank you for the opportunity to comment on these important proposed changes to the Affordability Standards. If you have any questions, please do not hesitate to contact me.

Sincerely,

Kristin L. Lewis

Kristin L. Lewis
Chief Government and Community Affairs Officer

[1] https://www.mass.gov/files/documents/2016/09/va/cctcd5.pdf

475 Kilvert Street
Warwick, Rhode Island 02886

January 14, 2022

Cory King, Chief of Staff
Office of Health Insurance Commissioner
Via email: cory.king@ohic.gov

RE: Advance Notice of Proposed Rulemaking; 230-RICR-20-30-4

Dear Mr. King:

UnitedHealthcare Insurance Company and UnitedHealthcare of New England, Inc. (collectively UnitedHealthcare) are grateful for the opportunity to provide comment on the Office of the Health Commissioner's (OHIC) Advance Notice of Proposed Rulemaking (230-RICR-20-30-4).

UnitedHealthcare's comments outlined below are in response to OHIC's document, **Next Generation Affordability Standards: Concepts, Rationale, and Additional Information** (the Document). The Document describes proposed requirements related to insurer behavioral health investment/spending, community investment and a professional services average annual price growth cap.

UnitedHealthcare is supportive of OHIC's objective to create a more affordable value-driven health care system for Rhode Island residents. This shared focus is the basis for our suggestions and comments regarding the proposed revisions to the Affordability Standards outlined in 230-RICR-20-30-4.

Behavioral Health Spending

Concept: OHIC is exploring proposing a spending requirement for behavioral health care that will promote the development of a high-quality, well-functioning delivery system capable of serving the comprehensive physical and behavioral health care needs of the public.

Comment:
UnitedHealthcare recognizes the impact that social determinants of health (SDOH) and behavioral health disorders, including mental illness and substance abuse, have on the overall health of our members and the subsequent cost to the system. UnitedHealthcare is committed to meeting the behavioral health needs of its members both individually and as part of a system of care. UnitedHealthcare has taken proactive steps to focus our primary care spending efforts in

Rhode Island on behavioral health integration and SDOH screening to address these growing concerns.

UnitedHealthcare believes that support of primary care physicians, with a focus on the amount and how carriers invest in primary care, including improving behavioral health access and whole person care will achieve OHIC's desired outcomes. UnitedHealthcare has funded several pilot initiatives and on-going programs in Rhode Island to better coordinate member care through behavioral health integration, outreach, SDOH screening and team-based care. Further, UnitedHealthcare has been deeply engaged with the Executive Office of Health and Human Services (EOHHS) and our Accountable Entity (AE) partners on developing, executing, and implementing health system transformation programs specifically designed to address behavioral health integration and SDOH screening. Our AEs partner directly with community health organizations to support the mental health needs of our members attributed to the AE.

We believe that the continued focus on primary care has the best potential to achieve OHIC's desired result and that the adoption of a similar spending requirement for other specialties could be dilutive to the impact and learnings we hope to achieve from the primary care program.

Community Benefit Activities and Investment Fund Proposals

Concept: OHIC is exploring proposing community activity and investment requirements funded from yet to be defined excess surplus that is intended to mitigate growth in health care costs while advancing health equity, addressing SDOH, and improving population health.

Comment:
We applaud OHIC for recognizing the potential value that community activities and investments may bring in addressing disparities in health, underlying SDOH, and improving population health.

We believe the proposed funding approach focusing on "excess surplus" adopts a methodology and accounting principle associated with a particular type of health insurer and attempts to apply the concepts of surplus to insurers who must follow other accounting and tax requirements. In addition, the proposed "excess surplus" based approach does not appear to focus the comparative amount of the assessment on current Rhode Island commercial business but instead looks at accumulated surplus from prior periods and other lines of business. Aside from any legal concerns, this approach could result in the situation where an insurer with dominant market share in the Rhode Island commercial market actually having lower assessment than a competitor with significantly less market share. In such case, the proposal would negatively impact competition and be counter to the affordability goals of the proposal. We believe that a funding approach, agnostic to insurer structure and calibrated to the current competitive landscape, would be more effective, have a greater consumer benefit and less likely to negatively impact competition and consumer choice.

We also recommend that OHIC consider, with input from federal regulators, how such proposal(s) should be structured in order to have 100% of any assessment or investment treated as an

increase to the numerator or decrease in the denominator in state and federal medical loss ratio calculations. This structure will ensure maximum efficiency and greater availability of funds for the goals and purposes described by OHIC.

Lastly, we support OHIC's focus in this area and would be supportive of obtaining OHIC's input on future investment needs in Rhode Island. However, we believe that the intent of the proposal would be more effectively achieved via voluntary confidential disclosure report without adding unnecessary administrative costs associated with having these funds distributed through a third-party entity.

Community Investment – Portfolio Allocation

Concept: OHIC is exploring imposing a requirement on insurers to allocate a portion of their investment portfolio to investment vehicles identified and approved by OHIC.

Comment:

Putting aside any legal concerns, we are interested in discussing with you this proposal in more detail. From the initial information provided, we believe this proposal may be unnecessarily proscriptive and inefficient from a capital standpoint. For example, the annual process could result in portfolio churn generating additional capital gain taxes which will ultimately weaken the financial position of Rhode Island insurers and dilute funds that could be applied to these important causes. An alternative proposal that might accomplish the same goal more efficiently would be a voluntary confidential disclosure report that describes insurer investments and contributions to local community entities both public and private.

Professional Services Average Annual Price Growth Cap

Concept: OHIC is exploring proposing the promulgation of a cap on average annual price growth for professional services (e.g., physician services or laboratory services)… Under this new requirement, OHIC would apply a cap on the average annual price growth of professional services, similar to the regulations applied to hospital inpatient and outpatient services. The cap would be linked to an economic index, such as the Consumer Price Index, or an alternative.

Comment:
The proposed cap on professional services may result in unintended cost growth by creating an artificial base increase for all providers. The increase offers a one size fits all solution which hinders health plans' and providers' ability to negotiate contracted rates based on performance and need. Further, it will be challenging to find the right benchmark and method for determining the year over year increase methodology.

UnitedHealthcare thanks OHIC for the opportunity to comment on these proposed revisions and we are ready to discuss any and all of these recommendations as we pursue our shared goal of providing all Rhode Islanders with access to high quality care.

Sincerely,

Timothy C. Archer
Chief Executive Officer
New England Health Plan

cc: Kathleen Chrusciel-Desrosiers, Associate General Counsel