Notice of Proposed Rulemaking 230-RICR-20-30-4

UnitedHealthcare Comments

UnitedHealthcare Insurance Company and UnitedHealthcare of New England, Inc. (collectively "UnitedHealthcare") are grateful for the opportunity to provide comments on the Office of Health Insurance Commissioner's (OHIC) proposed amendments to 230-RICR-20-30-4 *Powers and Duties of the Office of the Health Insurance Commissioner* (230-RICR-02-30-4).

UnitedHealthcare would also like to take this opportunity to thank OHIC for the work done on this legislation and its role in developing a culture of collaboration that has improved the health status of Rhode Islanders and promoted Rhode Island health care cost containment.

§ 4.10(B) Primary Care Spend Obligation

UnitedHealthcare supports the investment in primary care and appreciates its impact on health care utilization. UnitedHealthcare also appreciates OHIC's acknowledgement that the marginal effect of primary care spending on practice performance, and ultimately on outcomes, has not been clearly demonstrated. UnitedHealthcare would recommend that further research be conducted to evaluate the effect of the primary care spending obligation in general, and specific research to determine what aspects of primary care spend result in the greatest return on investment.

§ 4.10(C) Primary Care Practice Transformation

Primary care transformation requires the ability and willingness of providers to participate in any such efforts. UnitedHealthcare is supportive of continued funding for primary care practices, but feels that a plan must be developed that allows the program to be self-sustaining and not a separate revenue stream.

§ 4.10(C)(1) Primary Care Practice Transformation & Patient Centered Medical Home (PCMH) Financial Support Model

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

§ 4.10(C)(2) Behavioral Health Integration

To eliminate ambiguity, UnitedHealthcare would recommend that "by doing the following" be added to section **§ 4.10(C)(2)(a).**

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

§ 4.10(C)(2)(a)(1) Behavioral Health Integration - Financial Barriers

UnitedHealthcare strongly supports current efforts to promote access to care through the integration of behavioral health into primary care. It has been the experience of UnitedHealthcare that a significant barrier continues to be patient awareness. Patients do not always understand that they can receive behavioral health screening, and, in some situations, obtain behavioral health services, in their primary care setting. Primary care services which are preventative are not subject to prior authorization and are subject to few financial barriers. Co-pays are not applied to preventative services.

As expressed in UnitedHealthcare's comments on the Advance Notice to this Proposed Rulemaking, the elimination of co-pays for on-going care will require a benefit change that employer groups will need to support. Without 100% cooperation, this will likely add confusion and disparity. UnitedHealthcare has appreciated the existing flexibility with regard to product creation and is concerned that this may limit that ability. UnitedHealthcare would be supportive of looking for other solutions such as a global payment for both services when provided as integrated. Practices identified by OHIC as a "Qualifying Integrated Behavioral Health Primary Care Practice" will require education around coding to ensure that copayments are not collected or charged at the time of such same day services.

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

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

§ 4.10(C)(2)(c) Health insurers shall submit a report [. . .] no later than June 30, 2020

UnitedHealthcare would ask OHIC to provide additional background on barriers to behavioral health integration in primary care created by and/ or that could be remedied by the health insurers, to support the creation of specific strategies.

§ 4.10(D) Payment Reform

UnitedHealthcare is supportive of the continued move toward alternative payment models, bundled payments, and/ or population-based payments. UnitedHealthcare also shares OHIC's belief that payment models must evolve until they incorporate greater downside risk in order to fully leverage payment reform.

The feedback we have received from providers is that they are not prepared at this time, or in the foreseeable future, to incorporate downside risk into their contracts with payors. This is due to concerns around provider performance, infrastructure requirements, scale and other administrative barriers they face. Health insurers cannot force providers to enter into these reimbursement models. Thus, the requirement to enter into an APM, when it is imposed on the health insurers, will have limited impact. UnitedHealthcare has and will continue to promote provider incentive programs that include APMs. However, UnitedHealthcare asks that regulatory measures directed at providers, to further prompt provider participation, be considered.

UnitedHealthcare is grateful to OHIC for flexibility around the structure of primary care APMs and, as previously stated, agrees with OHIC on the overall benefit of these arrangements. UnitedHealthcare will continue to promote these models with its provider partners but, as we state above, we cannot force the providers to adopt these models.

§ 4.10(D)(6)(f) Hospitals which have been paid by a health insurer at less than the median [. . .] shall receive an equal percentage increase in payment for each inpatient service [. . .] equal to the median.

UnitedHealthcare appreciates the progress OHIC has made to date to promote quality and health care cost containment through the employment of innovative models. UnitedHealthcare is concerned that this regulation may be counter to the progress that has been made which encourages innovation and strives to reduce the total cost of care. This amendment will put pressure on the newly created State spending target and advance affordability burdens. UnitedHealthcare would recommend that alternative models be pursued that would bolster the great work of OHIC as a national pioneer of affordability.

UnitedHealthcare appreciates the quality performance requirement. UnitedHealthcare asks that OHIC consider looking at the most recent performance data, prior to payment, rather than wait three years to determine eligibility and require those not able to meet the requirements return the funds. UnitedHealthcare would also ask that eligibility include all core hospital measures, sanctioned by OHIC, be at or better than the national benchmark.

UnitedHealthcare has further concerns on the timing of this proposed amendment, its impact on contracts and rate filing which have already been established for calendar year 2020 and will not reopen until next fall for calendar year 2021.

UnitedHealthcare would again like to thank OHIC for the work it has done to better the lives of our members and for demonstrating what can be accomplished through collaboration. We are truly grateful for the opportunity to comment on this important regulation.

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RE: Proposed Amendment to the Powers and Duties of the Office of the Health Insurance Commissioner
230-RICR-20-30-4 Affordable Health Insurance-Affordability Standards

Date of Public Comment 1.16.2020

Dear Commissioner Ganim,

Thank you for the opportunity to respond to the Proposed Amendment regarding revisions to the Affordability Standards.

We incorporate by reference Lifespan's Comments to the Office of the Health Insurance Commissioner pertaining to 230-RICR-20-30-4 Affordability Standards dated May 21, 2019.

Please note below OHIC's proposed Amendments in italics, Lifespan's edits in red and our Rationale.

4.10 D Payment Reform

1. **410 D. 2. d. (1)**

For contracts with Integrated Systems of Care including Hospital Systems between 10,000 and 20,000 attributed commercial lives, health insurers shall employ a risk-sharing rate of at least 40%, and if applicable, a risk-exposure cap of ~~at least~~ no more than *5% of the total cost of care and a minimum loss rate of no more than 3% of the total cost of care. For such contracts entered, renewed, or amended on or after January 1, 2021, health insurers shall employ a risk-sharing rate of at least 50%, and if applicable, a risk-exposure cap of at least 6% and a minimum loss rate of no more than 3% of the total cost of care.*

Rationale: The language as written in the Amendment would permit the risk-exposure cap to be a greater number than 5% and not meet the intent of the Amendment to condition a limit or a ceiling on risk-exposure.

2. **410 D. 2. d. (2)**

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

Rationale: (same as above) The language as written in the Amendment would permit the risk-exposure cap to be a greater number than 5% and not meet the intent of the Amendment to condition a limit or a ceiling on risk-exposure.

3. **4. 10. D. 2. e.**

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

Rationale: Due diligence is conducted by both the health insurer and provider organization prior to entering a risk sharing contract or a global capitation contract. During contract negotiations, proprietary information is shared to permit both parties to address any applicable legal or financial matters as well as to better identify risk using predictive data analytics and should remain confidential without the need of a provider's reasonable request.
These comprehensive risk contracts are changing the healthcare environment and the quality and efficiency of health care delivery due in part to the guidance of the Office of the Health Insurance Commissioner. This guidance is valuable for health transformation, but approval by the Commissioner prior to two parties executing a contract should not be compulsory.

4. **4.10. D. 2. h.**

Population-based Contracts shall not carve out behavioral health ~~or prescription drug claims~~ experience from the provider budget.

Rationale: Without effective State or federal intervention tackling drug pricing controls or value based agreements with drug manufacturers, there is too much uncertainty associated with the price of drugs. For example, while pharmaceutical efforts to inform patients of lower drug cost alternatives is on-going

and important, there is little a provider organization can do to impact pharmacy cost control when a new life saving therapeutic or expensive chemotherapeutic regimen is the best treatment.

5. **4.10 D. 3. d.**

Health insurers shall take such actions as necessary when there is agreement between the parties to achieve the following primary care alternative payment model contracting targets.
(1) By January 1, 2021, a goal of at least 20% of insured Rhode Island resident covered lives shall be attributed to a prospectively paid primary care alternative payment model.
~~*(2) By January 1, 2022, at least 40% of insured Rhode Island resident covered lives shall be attributed to a prospectively paid primary care alternative payment model.*~~
~~*(3) By January 1, 2023, at least 60% of insured Rhode Island resident covered lives shall be attributed to a prospectively paid primary care alternative payment model.*~~

Rationale: Lifespan is engaged in alternative payment models and believes they are a significant factor in decreasing healthcare costs and improving patient outcomes.
Acknowledging this, not all practices feel this is the best path, especially those with a higher percentage of complex patients or smaller attribution. Various aspects must be considered before placing ambitious percent targets for alternative payment contracts, including capitation agreements.
Speed to increase the number of residents attributed to an APM does not ensure success. Indeed, both insurers and providers find savings and conversely, losses, can be realized based on random variations. Use of analytics to study the impact of these random variations (such as a hospital savings achieved at the expense of their own revenues or realizing we are relying on the wrong types of outcome metrics) must be methodically examined while continuing to review innovations and best practices from other regions.
Success here is found when a specific APM design results in savings and significant improvement in patient outcomes. It is then that greater expansion in a targeted percent participating in APM contracts should be considered.

6. **4.10 D. 6. f**

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

~~*(1) After three years after the first increase in payments, the hospital shall attain performance no different or better than the national benchmark for Clostridium difficile (C. diff) intestinal infections,*~~

~~*Central line-associated bloodstream infections (CLABSI), and the rate of readmission after discharge from hospital (hospital-wide) as published on the Medicare.gov Hospital Compare website; and*~~

~~*(2) The contract contains a provision for recovery of monies paid to the hospital by the health insurer pursuant to this § 4.10(D)(6)(f) of this Part should the hospital fail to achieve the quality targets defined in § 4.10(D)(6)(f)(1) of this Part. Such provision shall be subject to audit by the Commissioner.*~~:

Rationale: As indicated in Lifespan's comments in the Advanced Notice of Proposed Rulemaking, we are concerned about regulations that allow for increased payments to providers that purport to correct for "disparities" under the current system. As we stated in our prior comments, we oppose the concept of addressing hospital rate variation and further believe that hospital rate variation is acceptable among hospitals with varying underlying cost structures such as level 1 trauma and teaching hospitals. OHIC's current proposal has further conditioned these disparity costs on benchmarks that pertain to metrics already part of state, federal or contractual requirements and of which defeat the overall purpose for implementing such a disparity correction system as it now becomes quality payments. Finally, as previously stated, while in-state hospitals face hospital rate variations, we also face price variations within our region of competition as well. Lifespan once again requests OHIC to recognize this fact and provide a consistent process that analyzes regional rate variation particularly due to the fact that outmigration continues that under this rate variation substantially benefits out-of-state hospitals while concurrently adversely impacting all in-state hospitals.

We appreciate being provided the opportunity to submit our revisions to the Proposed Amendments to the Affordability Standards and thank you for your consideration.

Best regards,

Daniel Moynihan
Vice President, Lifespan Contracting and Payor Relations

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January 24, 2020

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

RE: Comments on proposed rule 230-RICR-20-30-4, Powers and Duties of the Office of the Health Insurance Commissioner

Dear Mr. King:

Blue Cross & Blue Shield of Rhode Island (BCBSRI) appreciates the opportunity to provide comments on the amendments to this regulation containing the Office of the Health Insurance Commissioner's (OHIC) Affordability Standards (the Standards). As noted in our comments to the Advanced Notice, BCBSRI recognizes many parts of the current Standards beneficially impact the cost and quality of care in Rhode Island and foster all-payer/all-provider system improvements. We read with care OHIC's response to comments from BCBSRI and others in the paper titled *Revisions to the Affordability Standards* (the *Revisions*), as well as the *Regulatory & Cost-Benefit Analysis (Cost - Benefit Analysis).*

BCBSRI shares OHIC's overarching goal of improving affordability, quality, and access to care for all Rhode Islanders. We are concerned, however, that some of the proposed amendments to the Standards are contrary to these goals. Some of the amendments to the Standards will increase costs and some are untested and may prove to be ineffective. BCBSRI, along with many other healthcare entities in Rhode Island, has committed to the Cost Growth Target. Achieving the target will require allocating investments carefully to achieve the greatest returns, and reacting quickly to data and developments if initial investments do not have the expected outcomes. Dictating both the Cost Growth Target and the means by which payers should achieve the target, by requiring certain actions and removing levers carriers may otherwise have used to achieve the target, goes far beyond the efforts undertaken in other states in setting a target. We respectfully urge OHIC to include only those amendments that provide a high return in terms of improvements to cost, quality, and access, and allow payers and providers flexibility to change course and innovate to achieve our shared goals.

With those general comments as background, BCBSRI offers the following specific comments in the order in which the amendment appears in the Standards.

Section 4.3(A)(18)—Definition of Qualified Integrated Behavioral Health Primary Care Practice

BCBSRI supports the concept of developing a classification of primary care that supports the delivery of behavioral health services: the Qualified Integrated Behavioral Health Primary Care Practice (QIBHPCP). BCBSRI recommends OHIC amend the definition of QIBHPCP in the Standards to include the three-year time limit for being in transition suggested in the *Revisions*

(page 50). Including the time limit would encourage providers to move more quickly towards an integrated model of care.

Section 4.9(A)(5)—Low value care

BCBSRI believes that reducing payments for low value care is critical to improved patient experience, quality and affordability, and we encourage OHIC to initiate efforts that will support the carriers' efforts in this area. The goal of reducing the provision of low value care, however, cannot be accomplished by payers alone. Instead of including this provision in the Standards, BCBSRI recommends that OHIC convene a work group of both payers and providers to focus in this area, with a potential initial focus on reduction of unnecessary pre-operative testing and more broad adoption of other Choosing Wisely campaigns.

Section 4.9(C)(1)(e)—Comparison to Rhode Island's Cost Growth Target

BCBSRI supports the state's Cost Growth Target work effort, and indeed is a signatory to the compact. We do not support, however, adding the payer's performance towards the Cost Growth Target to the list of trends to be considered as part of a rate review when determining whether a payer's products are affordable. As an initial matter, the Cost Growth Target and the cost and utilization trends examined in connection with a rate review are not the same thing. The Cost Growth Target encompasses a payer's entire book of business, including commercial products, self-funded plans and Medicare Advantage products, where the cost and utilization trends used in calculating premium rates are for commercial products only, and in some cases may vary even within different commercial markets. In addition, the Cost Growth Target analysis looks at spending in prior years, while the rate filings project future spending. Including a comparison of the historical Cost Growth Target for a payer's entire book of business with its trend projections for certain sub-sets of its business will be misleading and create unnecessary confusion.

Moreover, payers entered into the compact with the understanding that compliance would be voluntary, and achievement of the target will require collaboration across the health care market, including payers, providers and public programs, some of which are not subject to the Standards. Holding one party to the Cost Growth Target agreed to in the compact while other parties are not subject to any obligation is not appropriate.

BCBSRI supports review of the state's progress towards the Cost Growth Target, but such review should be conducted outside of the rate review process and should include all parties to the compact.

Section 4.9(D)(2)(a)—Affordability strategies

BCBSRI opposes the addition of a payer's efforts to implement incentives for integrated behavioral health care as a consideration for affordability during rate review. As described in our comments on Section 4.10(C)(2), BCBSRI is committed to working towards integrated behavioral health. Accomplishing this goal requires partnership with providers, however, who may not yet be ready for such integration. While we intend to continue to work towards this goal, it should not be included as a consideration in the review of BCBSRI's rates.

Section 4.10(D)(6)(f)—Rate increases for in-patient services

BCBSRI strongly opposes required payment increases to address "disparity" in hospital reimbursements. First and foremost, this proposed amendment to the Standards will increase costs. As estimated by OHIC, the proposal would add approximately $7.5 million per year in additional medical costs (*Cost - Benefit Analysis*, page 8). This increase in costs will result in increases in premiums for all subscribers, additional costs for self-funded employer groups like the state of Rhode Island and every municipality in the state, and higher out-of-pocket costs for members with high deductible health plans for the same services. As OHIC stated in its rationale for maintaining the current cap on hospital rate increases, monies that accrue to hospitals from higher reimbursements "translate into increased health care costs for Rhode Island's employers, workers and families" and "Rhode Island's families are not positioned to bear these costs..." (*Revisions*, pages 18 and 20). Increased hospital reimbursement is also inconsistent with the Cost Growth Target, and will make it more difficult to achieve the target. If OHIC proceeds with this amendment, BCBSRI urges OHIC to make the increase cost neutral.

The proposal to adjust in-patient commercial rates should not be adopted a host of other reasons as well:

- Hospital reimbursement should be viewed in totality, across all services and in historical context. Current hospital reimbursement rates may reflect trade-offs, such as higher outpatient reimbursements in exchange for lower in-patient reimbursements. Some entities may have received cash infusion payments instead of reimbursement increases prior to the adoption of the existing cap, and others may not have earned the full quality payments for which they were eligible because they failed to meet the required quality standards. Higher reimbursements also may be appropriate for teaching hospitals or hospitals that provide specialized services, or due to additional services such as care management. Looking only at the differences between current in-patient reimbursement rates without considering these factors is misleading.

- Increasing in-patient reimbursement is inconsistent with the efforts OHIC and stakeholders across the healthcare industry have invested in the goal of reducing spending on inpatient services. To the extent any of those efforts succeed in reducing inpatient <u>utilization</u>, this proposal defeats the savings by increasing <u>prices</u>. The negative financial impact to rates will be even higher to the extent a facility is incented to increase in-patient services as a result of the higher prices. Increased fee-for-service reimbursement also disincents hospitals to move towards alternative payment methodologies (APMs), and makes payers' compliance with the other policy goals around this transition to APMs more difficult.

- Any insufficiency in payments from governmental programs should not be subsidized by higher payments in the commercial market. Furthermore, the proposal would unfairly add costs for a payer with a range of payment rates for in-patient services for different hospitals, while leaving unaddressed the situation South County Hospital called attention to in its

earlier comments, where a payer linked commercial rates with Medicaid-Medicare dual eligible products and thus pays a uniformly low rate across its hospital network (*Revisions* p. 16).

- Increasing reimbursement rates discourages hospitals from addressing their cost structure and making necessary changes to control costs.

The Standards would require hospitals to meet certain quality metrics in order to retain the increase in reimbursement rates, but the quality metrics set out in the Standards are not meaningful. All but one hospital in Rhode Island already meets or exceeds the quality metrics included in the Standards, and the one hospital that does not meet them all, meets all but one. As a result, the proposal would do little to drive quality improvement at the hospitals eligible for rate increases.

While BCBSRI strongly believes OHIC should not move ahead with this payment increase mandate, if it were to do so, then the following changes to the disparity calculation method, quality measurers, and recoupment process, should be considered.

The calculation methodology based on the median rate is skewed by the comparatively higher payments made for hospitals paid on a daily case rate (per diem) basis and by payments for specialty hospitals and service lines (such as maternity). The methodology should allow for exclusions of these outlier rates.

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

In addition, BCBSRI recommends modifying the recoupment provision, which would require hospitals to repay three years of increased payments if they failed to achieve the quality metrics. This may result in financial difficulty for a hospital, especially if it is subject to recoupment from multiple payers, and enforcement would likely trigger intense public and political pressure on both payers and OHIC. Instead, BCBSRI recommends that the Standards be amended to allow payers to withhold some percentage of the payment increases, with full payment occurring upon attainment of the quality measures after the measurement period. An alternative would be to allow recoupment each year, rather than after an accumulation of three years of payments.

Finally, while the quality obligations in the Standards only last three years, the payment increases continue in perpetuity. As the hospital continues to receive the benefit of the increased payment, payers and patients should similarly receive a benefit. The regulation should include a provision requiring the hospital to demonstrate sustained quality. After three years, the regulation should require payer contracts to continue to include a provision for a percentage payback, or withholding, if the hospital failed to meet the quality metrics.

Section 4.10(C)(2)—Behavioral Health Care Integration

Blue Cross shares the goal of improving access to high quality, affordable behavioral health care, and agrees that this care should be integrated in a meaningful way with medical care, particularly

in the primary care setting. Blue Cross has been supporting these efforts, working with providers to develop robust networks and innovative programs, and removed all in-network utilization management for behavioral health services. Furthermore, we offered grants to support behavioral health provider's adoption of electronic health records, which we believe is a foundational component of integrating care.

Nonetheless, we raise the following concerns with the amendments to the Standards.

4.10(C)(2)(a)(1) Financial barriers – waiving same-day copayments

BCBSRI opposes mandating the waiver of copayments for "same day" services. As an initial matter, BCBSRI does not believe OHIC has the authority to impose this requirement. We understand from the *Revisions* that OHIC believes the recent changes to its enabling act provide the necessary statutory authority to implement these requirements. OHIC's analysis fails to take into account, however, that in the very legislative act that expanded OHIC's powers, the General Assembly directly addressed cost sharing, mandating that cost sharing for behavioral health counseling visits and medication maintenance visits must be consistent with the cost-sharing applied to primary care office visits. Public Law of 2018, Chapter 169 and duplicate Ch. 253. This demonstrates that the General Assembly has reserved for itself the authority to dictate benefit design and cost sharing, and suggests OHIC needs explicit legislative authority to impose these kinds of requirements.

Additionally, implementing this requirement will pose significant operational challenges and result in considerable administrative expenses, as BCBSRI would need to make changes to its claims processing system in order to waive co-payments when members see certain behavioral health providers on the same day as certain primary care providers. It is unlikely that the benefit to members would justify these expenses, as it is likely to be only a limited number of members who might receive services on the same day from the subset of providers meeting the QIBHPCP requirements and would be eligible for a co-pay waiver. In addition, members with HSA-qualified high deductible health plans would have to be excluded from any waiver of cost sharing in order to satisfy federal requirements for those plans. Given this limited impact, it would make more sense to spend this time and money on initiatives that promise greater impact.

There also may be simpler ways to address the specific problem of same day copayments for warm handoffs to a behavioral health clinician in a QIBHPCP. BCBSRI currently provides coverage for the General Behavioral Health Integration Care Management code (99484) with no cost sharing (other than for HSA-qualified high deductible health plans). QIBHPCPs should meet the requirements to use this code. This code would offer the additional benefit of being utilized for ongoing care management-illness education, screening and coordination of care with no member cost share.

If OHIC does proceed with implementing this provision, BCBSRI recommends that the proposed timeline in section 2(b) be extended. As it is currently drafted, with certification of QIBHPCPs to occur initially in the fall of 2020, for administration in January of 2021, it provides insufficient time for implementation. Payers would need more time to build and test the coding changes necessary to process these claims and properly communicate with members and providers as to

which services would be eligible for the co-pay waiver.

Two other administrative issues would need resolution. In addition to identifying which primary care practices have satisfied the requirements to be QIBHPCPs, OHIC will also need to identify the behavioral health providers that are co-located and integrated with the QIBHPCP. Payers will need this information to determine which behavioral health visits qualify for a co-pay waiver. Second, the proposed regulation does not define the services for which copayments are to be waived or a process for determining those services. The *Revisions* document suggests these would be identified by CTC-RI and approved by the Commissioner, at page 50. Problematically, the codes suggested by CTC in prior OHIC documents do not appear to reflect the purported goals articulated by stakeholders of warm hand-offs and brief interventions (*Integrated Behavioral Health Work Group Final Report).* For example, the codes listed there include one for 60 minutes of therapy (CPT code 90837). BCBSRI believes traditional 60 minute visits are not consistent with an integrated behavioral health model as they erode the capacity of the integrated behavioral health clinician to receive warm handoffs for other patients. BCBSRI urges OHIC to include carriers in the process of defining the relevant services.

4.10(C)(2)(a)(2) Billing and Coding Policies – policies for HABI codes

BCBSRI recommends that this section be amended to reflect that the use of the HABI codes be consistent with CPT guidelines and applicable to services rendered by behavioral health care providers. The reference to CMS coding guidelines should be removed to the extent those are only applicable to psychologists.

4.10(C)(2)(a)(3) Out-of-pocket costs for Behavioral Health Screening

While BCBSRI acknowledges the importance of behavioral health screening, we oppose the addition of this provision. For the reasons set forth above, BCBSRI believes that OHIC lacks authority to impose this requirement. Moreover, BCBSRI opposes any expansion of already existing coverage with no cost sharing for specified behavioral health screenings pursuant to the preventative care definition of the ACA. The ACA requires payers to cover a broad range of preventive services without cost sharing, including those outlined here. If OHIC were to create a different list of codes to be covered without cost sharing, those requirements would only apply to a subset of Rhode Island residents. It would not apply to residents with self-funded plans, covered by out-of-state carriers, or with high deductible health plans. Allowing the federal framework to define the services that will be covered without cost sharing will allow consistency among nearly all plan types. Additionally, the federal framework includes a method for revising the inventory of preventive services over time based on the recommendations of expert panels. If OHIC believes a carrier is non-compliant with the federal law on coverage for these preventive services, it has other means to ensure Rhode Islanders have access to these important screenings.

4.10(C)(2)(c) Payer reporting of integration strategies

BCBSRI sees value in this exchange of ideas and regularly engages in work groups to share ideas and collaborate with other stakeholders on integration strategies. While BCBSRI intends to continue to engage on these issues, we oppose these additional reporting obligations. First, the

timeline specified in the regulation is overly aggressive, with OHIC issuing questions in April and payers reporting in June, likely within a few short weeks of the regulation becoming effective. Second, OHIC's plan to post the completed reports on the OHIC website and/or use the reports to suggest proposed strategies and issue guidance on criteria for improving integration beginning January 1, 2021, as described in the *Revisions* (page 51), is problematic. Posting the reports publicly might stifle innovation and collaboration between carriers and providers, and would appear to move away from the collaborative work that OHIC has traditionally employed successfully on these kinds of issues. Moreover, any additional requirements OHIC might impose for 2021 as a result of such reporting would not be issued until after carriers submitted rate filings for 2021, and therefore, the cost of such requirements could not be appropriately accounted for in rates. BCBSRI encourages OHIC to remove this reporting obligation, and continue to engage stakeholders through work groups to continue this discussion.

Section 4.10(D)—Alternative payment models

4.10(D)(2)(g) allowing for a payment increase to provider organizations up to 2%

BCBSRI fully supports the transition away from fee for service payments towards risk bearing and other alternative payment models. BCBSRI opposes, however, the addition of payment increases once targets are met. The intent of these payment arrangements is to share the savings generated, but this "give back" provision would reduce the amounts shared with payers and consumers. Instead, the proposal creates a mechanism under which payers give extra payments to providers for reducing costs – negating the savings achievements. BCBSRI estimates the cost as being approximately $1 million annually, with no commensurate return for the spending. Like other new provisions in the Standards, this increase in payments is inconsistent with the Cost Growth Target, and threatens payers' ability to meet the target. While the provision is purportedly at the payer's discretion, providers will expect these increases, and it will create an additional challenge for payers in negotiating contracts with providers that align with the goals of the Cost Growth Target. It is also counter to OHIC's goal of migrating providers to more sophisticated payment models.

4.10(D)(2)(h) prohibiting carving out behavioral health or prescription drug claims experience

BCBSRI is supportive of this concept generally, but recommends the regulation be amended to allow payers flexibility to adjust for claims and services not covered by the payer. Provider contracts typically cover both fully-insured and self-funded groups, and self-funded groups sometimes carve out certain aspects of coverage, such as pharmacy and/or behavioral health.[1] Payers need flexibility to adjust a population-based contract where pharmacy or behavioral health claims are paid for by other administrators. BCBSRI recommends revising the provision to allow a population-based contract to include a methodology to reflect the member-months for which the payer covers pharmacy and/or behavioral health claims.

4.10(D)(3)(b) and (c) primary care alternative payment models

[1] While BCBSRI does not have any self-funded groups who currently carve out behavioral health, and we would discourage our customers from doing so, self-funded groups have the ability to carve out those services if they so choose. BCBSRI needs flexibility to address this situation if it arises.

BCBSRI supports expanding primary care APMs generally, but believes it is premature to impose the requirements in this provision due to a lack of actual experience in this area. Payers and primary care providers might reasonably want to gauge their actual experience before implementing a prospectively paid model for primary care and behavioral health services. PCP capitation is difficult – it requires practices to manage towards a budget and to care for their patient population in new ways. When combined with the new concept of QIBHPCPs, the practices and payers will have had little experience in the services and costs necessary to build capitation. This requirement may serve to discourage providers from seeking the QIBHPCP designation. Instead, providers and payers should have flexibility to include behavioral health services in an alternate payment model, such as a per-member per-month payment or incentive payments with quality metrics, rather than one designed on a "prospective payment" basis.

4.10(D)(3)(d) mandating targets for prospectively paid primary care APMs

BCBSRI opposes adopting the target rates for prospectively paid primary care APMs included in this provision. Based on BCBSRI's experience, the capitation thresholds proposed are unrealistic. BCBSRI has initiated prospective payment arrangements with willing providers in 2020, but the regulation's capitation target of 20% in 2021 and ramping up to 60% in the third year is too aggressive, and puts providers who do not yet have the capabilities to manage a payment budget at risk.

Moreover, this requirement is duplicative of other requirements for members in primary care practices that are part of Systems of Care (SoCs) with risk sharing or capitation arrangements, which BCBSRI believes is preferable as these arrangements include both primary care and other services. This goal of SoC expansion would be inhibited if payers and providers are also obligated to expand carved-out primary care capitation agreements.

Rather than add additional targets directed to primary care specifically in this section, BCBSRI suggests that OHIC instead rely on the target in 4.10(D)(2)(c), which measures members attributable to a risk sharing or capitation contract more broadly, and may include primary care practices.

4.10(D)(4) Specialists APMs

BCBSRI agrees alternative payment methodologies for specialists may be an appropriate vehicle for cost and quality improvements, but opposes including this section. As an initial matter, as this section only applies to payers with 30,000 or more covered lives, BCBSRI may be the only carrier subject to this provision. Compliance with these targets may result in higher specialist payments, as specialists will have little incentive to move from a fee-for-service model except for increased payments in an APM model. These increased costs will increase BCBSRI's premiums and may make its products less competitive.

Even if BCBSRI were not the only payer subject to this requirement, the existence of a specialist APM arrangement, by itself, does not accomplish goals of quality and affordability. BCBSRI independently and with other stakeholder groups, notably CTC, have been working on this issue, and OHIC should allow the stakeholders to continue to innovate outside of the regulatory process.

This will allow the parties to identify alternative payment models that will be both well received by the specialist communities and that are also designed specifically to address evidence-based medicine, by specialty, with the goal of increasing quality and improving affordability, while reducing low value care.

Rather than focusing on alternate payment methodologies between specialists and payers, encouraging specialists to become part of SoCs might be a better strategy for achieving the desired result of cost and quality improvements. SoCs are better positioned to engage specialists in alternative payment arrangements than payers, as SoCs hold the ability to direct their patients to particular specialists for services and therefore may have more leverage in their contract negotiations with the specialists than payers. Specialists' agreements with SoCs would then be included in the regulatory obligations relating to the larger SoC organizations, namely (D)(2)(d) requiring downside risk, (D)(2)(f) imposing cost-control provisions, and (D)(5) relating to measure alignment, which has well-defined measures applicable to SoCs. These controls are likely to yield better results in cost and quality than specialist/payer agreements.

If OHIC does require payers to have a certain number of APM agreements with specialists, the Standards should be amended to provide greater flexibility for payers in determining the appropriate specialists with which to enter into those arrangements. Rather than require payers to have two contractual arrangements for each specialty (section (c)) and then set an annual schedule for expansion into additional specialties (section (d)), the Standards should count any specialist APM agreement in any specialty towards meeting the total numerical requirements. This change would reserve payers' ability to determine whether to expand into new specialty categories or to increase penetration within a specialty category based on its assessment of business needs and provider readiness rather than compliance obligations. It would also give payers much needed negotiating flexibility. The Standards should also be amended to clarify when performance will be measured for each year and to make clear that the target numbers include the prior years' arrangements.

In closing, BCBSRI reiterates support for OHIC's Affordability Standards efforts. We appreciate OHIC's approach to having collected information and its thoughtful review and thorough response to those comments. Thank you for your consideration of this second round of remarks. We are available at OHIC's convenience to discuss further these comments or alternative approaches.

Sincerely,

Monica A. Auciello
Vice President, Legal Affairs and Policy
General Counsel

January 16, 2020

SENT VIA ELECTRONIC MAIL

Mr. Cory King
Department of Business Regulation
Office of the Health Insurance Commissioner
1511 Pontiac Ave, Bldg 69-1
Cranston, RI 02920

RE: Comments on Proposed Changes to the Affordability Standards Promulgated by OHIC on 12/6/19

Dear Mr. King:

We appreciate the opportunity to provide our comments on the proposed rulemaking for 230-RICR-20-30-4 (the "Regulation"). We are in substantial support of the changes that OHIC has made to the Regulation and we applaud OHIC for making the changes based upon stakeholder input the results of which were included in the thoughtful analysis in the document "Revisions to the Affordability Standards".

We have been a very interested and active participant in this process and do have some clarifications that we seek in the final Regulation promulgated by OHIC. We are supportive of the Minimum Downside Risk Requirements established 230-RICR-20-30-4.10(D)(2)(d) to move health insurers farther and faster in establishing provider downside risk contracts. We have discussed our concern with OHIC previously that establishing a minimum risk floor as these requirements do sometimes has the unintended consequence of becoming a ceiling. It is clear from OHIC's analysis that these risk requirements "do not preclude contracts with greater degrees of risk assumption, such as global capitation." Therefore, we ask that a new section be added at 4.10(D)(2)(d)(6) that makes this statement specifically as follows:

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

We do modify our position and specific language recommended regarding the Hospital Contract Rate Disparity by this letter. We now are in general support of the changes OHIC has made in 230-RICR-20-30-4.10(D)(6)(f) requiring health insurers to adjust their future payments for any

hospital that has been paid less than the median commercial payment made to all Rhode Island acute care hospitals for inpatient services in the health insurers provider network and the methodology outlined to accomplish the payment increase to those hospitals. However, our support is qualified subject to the following clarifications and recommended changes:

1. We want to clarify that the resulting inpatient percentage increases should also apply to inpatient behavioral health admissions for hospitals that are paid less than the median commercial payment and ask that the language be clear to that effect;
2. We want to clarify that these increases should apply to all payments made by a health insurer to eligible hospitals including those made on behalf of self-funded employers and ask that the language be clarified to that effect;
3. We strongly urge OHIC to include outpatient charges in the adjustment for the rate disparity. Outpatient rates suffer the same rate disparity issues as inpatient rates and the problem has been exacerbated as more services transition from inpatient to outpatient. From a cost and public policy perspective, OHIC should want that shift from inpatient to outpatient to continue. Therefore, advantaging inpatient rates over outpatient rates will create an unfortunate and unintended incentive to resist the transition to outpatient services and make the healthcare system less efficient. We propose adding the following language to § 4.10(D)(6) as new section (g.):

   > Hospitals which have been paid by a health insurer at less than the median commercial payments made to all Rhode Island acute care hospitals for outpatient services in the health insurer's provider network, as determined by the health insurer summing all of its payments for outpatient services that are payable under Medicare's Ambulatory Payment Classifications (APC) (numerator) and dividing that by a sum of all APC weights for such outpatient services (denominator) to provide a mix-adjusted outpatient payment rate for each hospital, shall receive an equal percentage increase in payment for each outpatient service until the hospital's average payment per mix-adjusted average payment for outpatient services is equal to the median. If the health insurer is unable to calculate the outpatient services increase in this matter, it may use the percentage increase calculated in f. above and apply it to the hospital outpatient rates. At the time of the calculation, the health insurer shall utilize the same 12-months of claims data as utilized in f. above. The increase in payment rates shall not be construed as an ongoing price floor. The increase in payment rates shall be contractually contingent upon f. (1) and (2) above.

We are concerned with the new section added to the Regulation at 230-RICR-20-30-4.10(E)(3) which provides for a health insurer to request a waiver to the requirements of 4.10. We ask that the requirement 4.10(D)(6)(f) be specifically excluded from such a waiver or if it is not specifically excluded, add the words to the phrase as follows: "...compliance with any of these requirements was not possible ***due to the substantial risk of insolvency of the health insurer,...***". This would make it clear that a health insurer would not be relieved of meeting the one-time requirement of increasing payments set forth in 4.10(D)(6)(f) except due to extreme financial circumstances.

We have previously submitted comments in a letter from Jeffrey Chase-Lubitz, Esq. dated September 18, 2018. We resubmitted those comments in a letter from Jeffrey H. Liebman dated January 28, 2019 and again on May 30, 2019. By this letter, we reiterate the positions we espoused in those letters regarding Alternative Payment Methodologies and Health Care Provider Participation in the OHIC Regulatory Process and the specific wording changes we recommended to the Regulation. We believe that these provisions do not expand OHIC's statutory mandate but are entirely supportive of and consistent with the OHIC statutory mandate to: "Encourage fair treatment of providers."

As you are aware, CharterCARE has been at the forefront advocating for greater use of alternative payment methodologies, advancement of provider-based risk contracting and care integration, provider accountability for quality and cost and fair, sustainable hospital reimbursement. CharterCARE has come to be known as the most innovative provider in Rhode Island in this regard. Further, we have worked closely with the State to alleviate access issues to Eleanor Slater Hospital for long term behavioral health patients by opening a 20-bed unit to care for these patients at a very favorable rate and we want to maintain our commitment to these kinds of innovative behavioral and substance abuse solutions for the Rhode Island community.

The implementation of the regulatory changes proposed by OHIC for inpatient hospital rates and the extension of the change to outpatient rates will allow CharterCARE to continue its leadership in advocating for these issues in Rhode Island and remain the lowest cost competitor in the Rhode Island hospital market. We applaud OHIC's willingness to listen and act on this critical issue.

If we can provide any additional information either in writing or in person, we would welcome the opportunity.

Sincerely,

Jeffrey H. Liebman
Chief Executive Officer

cc: Steve O'Dell, Prospect/CharterCARE

Public Comment from Coastal Medical on Proposed Amendments to 230-RICR-20-30-4
January 24, 2020

We appreciate the opportunity to offer public comment on the proposed amendments and wish to recognize the thoughtful and comprehensive nature of the supporting documents prepared by OHIC in concert with the proposed amendments.

Coastal strongly supports the continuation of health insurer payments to support advanced primary care and we also support amendment of the definition of PCMH to include the implementation of cost management strategies and clinical quality performance attainment and/or improvement as components of the PCMH.

Coastal is very pleased to see the proposed amendment to require that health insurers eliminate copayments for patients who have a behavioral health visit with an in-network behavioral health provider on the same day and at the same location as a primary care visit at a Qualified Integrated Behavioral Health Primary Care Practice. The "second" co-pay for a co-located BH visit has long been identified by primary care practices in RI as a significant hurdle that limits the ability of patients to take advantage of integrated behavioral health services when they are available in primary care practices.

We agree that reducing the provision of low value care will contribute to improving the affordability of care and help to improve the overall performance of the RI health care system.

Coastal supports the inclusion of the RI Cost Growth Target amongst benchmark trends that the Commissioner can reference when making determinations related to affordability.

Coastal agrees that population-based contracts should not carve out behavioral health or prescription drug claims experience from the provider budget. We agree that providers should coordinate care across the full continuum of healthcare goods and services. Parenthetically, we would add that stop-loss thresholds for prescription drug costs at the individual member level appear to be a useful construct in population-based contracts.

Coastal believes that OHIC's ongoing efforts to advance alternate payment models are an important piece of the work to improve the affordability of healthcare for the citizens of our state.

Coastal appreciates the provision in the proposed amendment that grants health insurers discretion to execute an upward adjustment to the population budget for providers with low risk-adjusted spending. We agree that such adjustment will help to preserve the participation of efficient providers in accountable care by recognizing their achievement in efficiency and the comparatively diminished potential they have for further cost reduction as compared to higher cost providers. We respectfully suggest that the language in section 4.10 (D)(2)(g) relative to statistical significance of cost performance that is favorable relative to the network be considered for revision, possibly in consultation with an actuary. We are uncertain as to whether the proposed p value of <.05 is meant to refer to performance in each of the three prior years or to the aggregate performance over three years. The former would appear to impose an unreasonably exacting standard.

Coastal has previously expressed skepticism as to whether stand-alone primary care capitation (i.e. implementation of prospectively paid APM's for primary care without any incentive to reduce total cost of care) is likely to achieve the intended improvements in Triple Aim performance. In light of the proposed amendment, we would like to suggest that OHIC attempt to collect data over time to allow a comparison of the performance of stand-alone primary capitation versus performance of primary care capitation nested within a total cost of care based risk model versus performance of total cost of care based risk models that do not include primary care capitation.

We also have concerns about potential unintended consequences of stand-alone primary care capitation and recommend that OHIC attempt to collect before and after data to understand if there is any reduction in the availability of same day sick visits and after hours and weekend visits with PCP's under a capitated model that offers a financial incentive to expand patient panels while removing any financial incentive to maintain or increase the availability of such visits. It will also be necessary to rationalize any primary care physician capitation model with the payment model for advanced practitioners who may provide primary care services to the same population of patients.

Coastal agrees that greater implementation of APM's for specialists in RI has significant potential to improve Triple Aim performance.

Respectfully submitted by G. Alan Kurose MD, President and CEO of Coastal Medical, on 1/24/20.

COMMENTS 230-RICR-20-30-4

Support all changes with the following comments on changes and existing language:

4.3.A.11: The last sentence regarding an assessment by 5/1/2016 may be deleted

4.3.A.X: The term "low value care" is subsequently used. This may warrant definition or reference to organizations that define low value care.

4.3.17: Geriatrics should be listed as a primary care specialty.

4.6.D.3: It is presumably statutory that UR regulation remains in the Department of Health. It is odd that it does.

4.9.A.5 No definition of low-value care

4.10.C.2: "Behavioral health care is an … and refers to services for mental health and substance use diagnosis and treatment." It may be style that "treatment" always includes diagnosis. In integrated behavioral health the services may most commonly be diagnosis oriented. Consider addition of UL words.

4.10.C.2.a.1: It is unclear what co-payment is being eliminated. Presumably only one copayment would be allowed. There may be an allowed BH copayment when the "medical" service was an annual preventative exam. This will be difficult to implement without a modifier that designates a behavioral medicine services as being provided same encounter by a separate provider. I would work with OHIC to create either a HCPCSII modifier of CPT modifier.

4.10.C.2.a.2: There are no CMS "Coding Guidelines". CPT defines coding. CMS may define eligible providers, benefits for Medicare etc. This is ambiguous. Perhaps the reference could be provider (Medicare Manual citation).

4.10.C.2.a.3: USPSTF A/B recommendations must be covered without beneficiary cost sharing. That does not mean a payer must pay for specific or general codes that may relate to these services. The intent is unclear.

Existing 4.10.C.2 Assure that removal of this language does not reduce the ability to have a state action exemption to anti-trust. This same issue relates to other advisory committees (below).

4.10.D.1: There is an annual review of work to meet the 50% target. Is it intentional that there is no year when the target is to be met?

4.10.D.2.d: This section appears to be written incorrectly. Risk corridors are being created where risk shall not be less than X nor more than Y. The actual language suggests the cap is a minimum, so that 100% risk would be acceptable. The language suggests that the floor is a ceiling of sorts. For example, subsection 1 calls for a risk corridor between 3% minimum risk and 5% maximum risk. This is not how it would be read by most readers. Subsection 2 uses a risk sharing rate of at least 50%. This may be correct, or it may be a cap, but it is uncertain given the other statements. It is also important to be clear on the order in which the calculation is made. For example, the loss is shared 50/50. Then the apportioned loss shall not exceed 5%. Alternatively, it could be the loss cannot be more than 5% which is then shared 50/50. It would be expected that smaller populations would have more narrow risk

corridors as the floor is usually to avoid random effects, whereas the cap is to avoid excess provider financial jeopardy.

4.10.D.2.e: Provider suitability for risk. The “standard operating procedures” are unclear; but may be reasonable. Any risk arrangement involves a “transfer of insurance risk”. The regulation makes sure the transfer is limited and appropriate by establishing the corridor and minimum populations. Additionally, the OHIC could require “risk adjustment” methods to reduce the transfer. However, there is no clear standard methodology to risk adjust.

4.10.D.2.f: The goal is understood, but this incentivizes avoidance of population contracts as other providers may receive greater increases.

4.10.D.2.g: The “risk-adjusted…insured average” is unclear. Is this the average among population contract holders, the “normalized” typical patient, i.e. the total cost of care for patients with a risk adjustment factor of 1.0? Benchmark procedures and regional comparisons are important processes that can strongly affect the outcomes of a contract.

4.10.D.4: Specialists should be involved. They should be involved in total cost of care. This proposes fragmentation which detracts from the efforts of entities that assume total cost of care responsibility. If the process requires specialists to share in the global risk based on their patients being attributed to an entity (most have a primary care provider or the specialist has a primary affiliation), that may promote coordinated care. This proposal promotes siloed care. Additionally, if the rates are based on historical over or under payments, this is perpetuated.

4.10.D.5.e.(6): “and/or” appears incorrect. It should be “and”.

4.10.D.6.f: There may be justification for differential payment rates. Medicare pays direct and indirect medical education expenses. Private payers do not label differentials that may relate to medical education. Certain institutions incur higher costs to provide unique essential services. Certain institutions disproportionately treat patients with lower payment profiles. There is no clear justification to equalize payments. It would also be unwise to set rules for specific services when hospitals care about total revenues. Setting quality measures in regulation as compared to setting a process to define quality measures also bears reconsideration. A hospital rate setting commission would be more fair than arbitrary “equalization”.

4.11.E: With HIE and other changes in EMR connectivity, it is appropriate to expect payers to use existing resources and methods to obtain information, rather than have providers fax or mail information. It is a moment when these processes should be examined with goals to reducing requests for information.

4.12.C.: Allowing a referring provider to call one provider at a time related to one service does create the appearance of price disclosure. This would be so burdensome as to make the process infeasible.

Submitted 1/15/2020

Peter Hollmann MD

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

January 14, 2020

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

Dear Cory,

Thank you for the opportunity for the Care Transformation Collaborative of Rhode Island (CTC-RI) and PCMH Kids to provide feedback to your recent document "Advance Notice of Proposed Rulemaking with respect to 230-RICR-20-30-4: Powers and Duties of the Office of the Health Insurance Commissioner". We are very appreciative of the time and effort which you have put into obtaining input and your careful deliberation around changes that will make positive differences in quality and cost. We applaud your efforts to strengthen the ability of patients to obtain behavioral health services in primary care. We fully support your planned efforts to develop APM plans for specialists. We welcome the opportunity to work with you on the proposed OHIC regulations and offer the below recommendations from CTC-RI and PCMH Kids for your consideration:

1. 4.3 Definitions: (15 d) Patient-Centered Medical Home: A primary care practice which has demonstrated development and implementation of meaningful cost management strategies and clinical quality performance attainment and/or improvement. The requirements for meaningful cost management strategies and for clinical quality performance attainment and/or improvement and the measures for assessing performance, shall be determined annually by the Commissioner.

   Recommendation: Consider review of Primary Care First performance-based payment tied to clinical quality, patient experience, health improvement, cost and/or utilization measures. Outside of CTC-RI contract, presently there are limited quality measures tied to patient experience or utilization in the aligned core quality measures.

2. 4.3 Definition: (18) Qualifying Integrated Behavioral Health Primary Care Practice: a) A primary care practice that is recognized by a national accreditation body (such as NCQA) as an integrated behavioral health practice, or b) A primary care practice that participated in a successfully completed an integrated behavioral health program under the oversight of the collaborative initiative endorsed by R.I. Gen. Laws Chapter 42-14.6 or c) a primary care practice

that completes a qualifying behavioral health integration self-assessment tool approved by the Commissioner and develops an action plan for improving its level of integration.

Recommendation: Consider under b) participated in or "currently participating in integrated behavioral health initiative". Consider providing greater clarity around option c): How will progress be monitored and tracked? For practices with 5000 adult patient attributed lives or 3500 pediatric attributed lives, CTC-RI recommends a staffing plan that supports patient access to behavioral health clinician within 72 hours of identified need and implementation of universal screening for depression, anxiety and substance use disorders. Consider an IBH track option for practices with less than 5000 attributed patient lives such as being supported in use of community health teams which provide behavioral health support for high-risk patients and families.

3. 4.3 Definitions: (19) "Risk exposure cap" means a cap on the losses which may be incurred by the provider under the contract, expressed as a percentage of the total cost of care or the annual provider revenue from the insurer under the population-based contract; (21) "Risk sharing rate: means the percentage of total losses shared by the provider with the insurer under the contract after the application of any minimum loss rate.

   Recommendation: Align with Primary Care First (see Appendix A for Primary Care First Alignment Grid).

4. 4.9: Affordable Health Insurance-General: A.2 "Improved integration of behavioral health services into the primary care delivery system to meet the physical and behavioral health needs of the public; 5. Reduced provision of low-value care".

   Recommendation: Align with Primary Care First core model principles to include: rewarding value-based outcomes over process; supporting efforts to improve primary care — specialist collaboration, supporting actionable data aggregation including a "community analytics" approach to reduce costs across the system, using data to drive practice accountability and performance improvement and leveraging multi-payer alignment; consider strategies to address pharmacy costs, and identify and address health-related social needs.

5. 4.10 Affordable Health Insurance-Affordability Standards C. Primary Care Transformation "One element of primary care transformation is the integration of behavioral health care into primary care practice. 1. Primary Care Practice Transformation and Patient-Centered Medical Home Financial Support model. a. Primary care practices which meet the requirements of a Patient-Centered Medical Home in 4.3 (A) (15) of this Part shall be deemed eligible for practice support payments".

   Recommendation: Primary care practices which integrate behavioral health would benefit from having infrastructure payment support and training support while the practices credential behavioral health clinicians and learn how to successfully integrate behavioral health services and bill for services. CTC-RI understands that OHIC will be working on developing an alternative

payment mechanism (APM) that includes IBH. While this APM development work is in process, added infrastructure care management and incentive payments are needed at least in IBH Year 1 as billing alone, even with added codes, will not adequately support the costs of the IBH clinician and infrastructure support needed for billing and reporting of quality information.

Recommendations: Align infrastructure and incentive payment with Primary Care First and increase payment amount presently provided to PCMH Kids practices to more adequately cover expenses associated with providing care management and advanced primary care.

- Agree with 1(3) Health insurers shall not impose a minimum attribution threshold for making care management PMPM or infrastructure payments to a PCMH;
- Recommend adding an attribution option that is available in Primary Care First called "voluntary alignment" whereby a beneficiary can attest to his or her choice of primary care practitioner;
- Recommend that there be language added that practices which continue to meet the definition of PCMH, practices/SOC shall not experience a gap in infrastructure and care management payment(s);
- Recommend that the health insurers provide a system, a contact person and on-going prospective payment schedule to practices/ SOC.

6. 4.10 (2) Behavioral Health Integration (a): "Health insurers shall take such actions as necessary to decrease administrative barriers to patient access to integrated services in primary care practices."

   (1) Financial Barriers: Health insurers shall eliminate copayments for patients who have behavioral health visit with an in-network behavioral health provider on the same day and in the same location as a primary care visit at a qualifying integrated behavioral health primary care practice as defined in 4.3 9A) (18) of this part.

   Recommendations:

   - Add language around credentialing process whereby practice is notified by health insurer within 1 month if behavioral health credentialing application is complete and in the case of missing information, which added information should be provided to health insurer by the practice;
   - Add language that behavioral health screenings be considered preventive services not subject to co-pay;
   - Add language that health insurers not restrict screening payment when more than 1 screening is done;
   - Add language that when behavioral and mental health screenings in pediatrics are provided according to Bright Futures, the national AAP standard for quality pediatric care, that these screens be recognized with payment for each and every screen that is provided during the visit. Each screening should be paid for by the insurer and paid "with first dollar", not dropping the deductible as this is the pediatric standard of care.

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

Recommendation: Add language around adopt, align with other insurers and publish policies for HABI codes because policies can be difficult to find and implement, particularly when there is lack of alignment across health insurers.

- Psychiatric Collaborative Care Codes: Add language around covering Psychiatric Collaborative Care Codes which financially would help support access to psychiatry integration within primary care.
- Pediatric: Integrated Family Care Codes: Two recent reports by the CT Health Foundation "Transforming Pediatrics to Support Population Health: Recommendations for Practice Changes and How to Pay for Them" and United Hospital Fund Report "Plan and Provider Opportunities to More Toward Integrated Family Health Care" by Suzanne Brundage discuss work that is being done by other states to promote and provide payment for dyadic (parent-child) mental health interventions. This approach could be particularly relevant in Rhode Island, given the recent eco-system maltreatment analysis and the opioid epidemic. A recent American Academy of Pediatrics report on the principles of financing the medical home for children recommends first dollar coverage without deductibles or co-pays or other cost sharing for necessary preventive care services; adoption of a uniform definition of medical necessity across payers that embraces services promoting optimal growth and development, and prevent, diagnose and treat the full range of pediatric physical, mental, behavioral and developmental conditions.
- Qualifications of eligibility for billing services:
  Licensed Clinical Social Workers:
  - Standardize the option of using licensed clinical social workers (LCSW) across all payers. A LCSW has successfully completed a 2-year masters-level social work program and passed the social work licensing exam. Presently Managed Medicaid allows LCSWs to provide services that are billed under LICSWs. Blue Cross and Blue Shield of Rhode Island does not allow practices to use and bill for behavioral health services that are provided by LCSW and supervised by LICSW. Rhode Island College now has a 2-year masters of social work program with an integrated behavioral health track including a field placement in a primary care practice setting. This option of using qualified LCSW staff in primary care would be very helpful, particularly given the challenges associated with hiring behavioral health clinicians, especially in primary care practices which require clinical staff that speak languages other than English. The differences between an LCSW and LICSW is that an LICSW has completed a master's program, received two years of clinical supervision and passed a licensing exam.
  - Recommend that there be alignment among health insurers standardize and make available supervision requirements when billing for LCSW services that are provided under the supervision of an LICSW CTC-RI requested health plan documents that clearly define the supervision requirements related to LCSW and have not yet received them.

(3) Out-of-Pocket Costs for Behavioral Health Screening: Health insurers shall adopt policies for the most common preventive behavioral health screenings in primary care that are no more restrictive than current applicable federal law and regulations for preventive services. For

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

Recommendation: See billing and coding recommendations. Include efforts to improve support for screening services when provided by OB/GYN providers. Vermont, for example, has implemented infrastructure and payment transformation strategies to impact screening for depression, anxiety, substance use disorder, social determinants of health, and intent for getting pregnant in OB/GYN practices with impressive results. This strategy is particularly important for RI to consider particularly in light of the opioid epidemic.

(4) Behavioral Health Integration (b) The Commissioner shall determine which practices are Qualifying Integrated Behavioral Health Practices beginning in the fall of 2020 for Health Insurer administration beginning January 1, 2021, and by November 30 each calendar year thereafter. The Commissioner shall issue guidelines on any time limitations for practices to quality under 4.3 (A) (18) (a) and (b) of this Part.

Recommendation: Expand multi-payer strategy options to more clearly commit to training and rapid, early adoption of integrated behavioral health in a capitation model. In the interim, allow for infrastructure and incentive payment for behavioral health clinician/practice/SOC while participating in an IBH primary care initiative in the same way that nurse care management is referenced. Alternatively, one could broaden the definition Primacy Care Transformation and Patient-Centered Medical Home Financial Support Model 4.10 C b (2) to provide care management PMPM for behavioral health clinicians who are participating in IBH transformation activity.

(5) 4.10D Payment Reform: "The purpose of this 4.10D of this Part is to improve the affordability and quality of health care through the implementation of alternative payment models. Alternative payment models are provider contracting practices that are designed to align provider financial incentives with the efficient use of health care resources and encourage the proactive management of the health needs of their patient populations. Furthermore, the Commissioner finds that provider contracting practices that incentivize the efficient use of health care resources and which invest in the capacity of health care providers to manage population health are essential to support the care transformation agenda articulated in 4.10© of this Part and to meet OHIC's legislative mandate to direct health insurers toward policies and practices that address the behavioral health needs of the public and greater integration of physical and behavioral health care delivery.

Recommendations:

- CTC-RI applauds the added focus on primary care pre-payment as an important next step in strengthening comprehensive primary care and improving affordability. Feedback for consideration includes ensuring that insurers develop their pre-payment contracts in an aligned manner to help the involved practices reach the 60% threshold that is believed to be a tipping point for their workflows and processes. Additionally, Medicaid should be encouraged to align with these efforts.

- Pre-payment for pediatric practices needs to be considered separately since there are sufficient differences that require special approaches. It is important to also support this process in a multi-payer way in order to help a burgeoning crisis in pediatric care.
- Continued support for community-based services, such as the statewide Community Health Team network (or equivalent) also should be seen as impacting affordability and quality of care for high-risk patients with increased behavioral health and/or social needs. Health plans should continue to explore ways to support and strengthen these efforts and should be encouraged to consider reducing health plan care coordination expenses that duplicate providing care coordination services through community health teams and primary care practices;
- Align with primary care first which also provides a risk adjustment to account for factors including but not limited to health status and patient demographics; this approach recognizes and pays for the added effort that is involved with caring for more vulnerable adult and pediatric populations.

(6) h. Population-based contracts shall not carve out behavioral health or prescription drug claims.

Recommendation: Agree.

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

Recommendation: Similar to other aspects of primary care transformation, CTC-RI recommends that there be alignment among the health insurers for IBH APM and that consideration be given to the differences between adult and pediatric population needs and support.

7. Telemedicine Behavioral Health Pilot:
Massachusetts Health Policy Commission (MPC) recently published a paper (May 2019) "Integrating Telemedicine for Behavioral Health: Practical Lessons from the Field". The MPC invested $2.5 million in 5 provider organizations to implement 12-18 month tele BH pilots for high –need patient populations with the aim or identifying and discussing practical lessons learned and implementation challenges to increase this underutilized service. Rhode Island could benefit from a telemedicine behavioral health pilot program.
4. a. Specialist alternative payment models: "It is in the interest of the public to expand innovative alternative payment models to specialist physician practices to encourage more efficient use of health care resources, reduce unwarranted variation in episode treatment costs and improve the quality of care through the reduction of potentially avoidable complications".

Recommendation: Expand language and strategies to consider how to improve quality outcomes by setting standards with accountability for high-value care coordination and communication between primary care and specialists. Poor communication leads to poorer

quality and more expensive care. Primary care providers presently spend considerable time tracking down specialist test results in areas such as eye exams for patients with diabetes and in obtaining colonoscopy results. Other areas of consideration could be to hold accountable both primary care and specialist providers for closing the referral loop. Having systems in place whereby there is confirmation that specialists have sent reports to primary care prior to being paid might assist with improving care coordination. Analysis of low-value care findings could provide additional direction for strategy opportunities.

Recommend Alignment with Primary Care First: Under the Primary Care First Model, the professional PBP will be adjusted to account for "leakage rate", or the percent of primary care service furnished outside of the practice to the Primary Care First to Primary Care First practice's attributed beneficiaries. This adjustment incentivizes a sustained practitioner — patient relationship.

8. 4.11 Administrative Simplification Task Force

Recommendation: Consider adding CTC-RI to the Task Force as the CTC-RI Clinical Strategy Committee has as a key objective to have providers, systems of care and health insurers to work together to identify and implement strategies to reduce administrative burden and increase provider experience.

9. *Other recommendations:*

(1) Assess Community Behavioral Health Spend: Expand strategy to include financial support for community health teams which meet patient needs for behavioral health services and additionally address patient needs for community health workers who can assist with responding to patient social determinants of health and connection to community resources.
(2) Measuring, Monitoring and Improving Customer Experience: Primary care practices participating in CTC-RI are eligible for incentive payments and monitored on their customer experience performance. Especially as systems of care move toward shared savings, it is essential that there be a method for measuring and monitoring how well primary care practices are meeting patient experience needs.
(3) Price Transparency and Health Care Spending Analysis: The Massachusetts Health Policy Commission 2018 Annual Health Care Cost Trends Report makes recommendations that might benefit Rhode Island including: efforts to reduce drug spending growth around high-cost drugs and ability of the state to negotiate directly with drug manufacturers; advancing specific data-driven interventions to address provider price variation, implementing site-neutral payments for select services, and flexible funding to address health-related social needs.
(4) All-Payer Claims Database Investments: Onpoint Health Data has the capability to include information on diagnosis as part of the utilization performance reports, but this added functionality is not yet available. This information would be very helpful in being able to identify and analyze utilization and cost trends.

(5) Early in Life Prevention: As noted in the AAP article on financing of pediatric PCMH, consider covering services that can be integrated into the medical home including home visiting during pregnancy and early childhood.
(6) Transition from Pediatrics to Adulthood: Recommend consideration of enhanced rate for services that are delivered when there is effective transition of care, especially from pediatric to adult providers, as well as from hospital to home care.

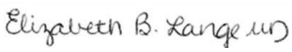
CTC-RI and PCMH Kids welcome the opportunity to work with OHIC on your policy efforts to improve the care for all Rhode Islanders.

Sincerely,

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

Pano Yeracaris, MD, MPH, CTC-RI Chief Clinical Strategist

Patricia Flanagan, MD, FAAP, PCMH Kids / Hasbro Children's Hospital



Elizabeth Lange, MD, FAAP, PCMH Kids / Coastal Medical / Waterman Pediatrics

Susanne Campbell, RN, MS, PCMH CCE, CTC-RI Senior Project Director

cc: Marie Ganim, PhD, Office of the Health Insurance Commissioner
Patrick Tigue, MPP, Executive Office of Health and Human Services
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Barry Fabius, MD; CMD, FACP, UnitedHealthcare
Christopher Ottiano, MD, Neighborhood Health Plan of RI
Claire Levesque, MD, Tufts Health Plan
David Bourassa, MD, Thundermist Health Center
Deborah Masland, RI Parent Information Network
Deborah O'Brien, BS, RN, MPA, The Providence Center
G. Alan Kurose, MD, Coastal Medical
Jeffrey Borkan, MD, PhD, Alpert Medical School, Brown University
Louis Giancola, Retired Healthcare Administrator
Margaret Wingate, Lifespan Corporation
Matthew J. Collins, MD, MBA, Blue Cross and Blue Shield of RI
Michael Lichtenstein, MS, Integrated Healthcare Partners
Sarah Fessler, MD, East Bay Community Action Program
Steven Lampert, MD, MBA, Lifespan Physician Group

Primary Care First Multi-Payer Alignment Principles

Primary Care First (PCF) is a multi-payer model, like Comprehensive Primary Care Plus (CPC+) Tracks 1 and 2. CMS will partner with selected payers, including Medicare Advantage plans, commercial health insurers (including plans offered via state or federally facilitated Health Insurance Marketplaces), states (through the Medicaid and CHIP programs, state employees program, or other insurance purchasing), Medicaid/CHIP managed care organizations, state or federal high risk pools, and self-insured businesses or administrators of a self-insured group (Third Party Administrator (TPA)/Administrative Service Only (ASO)). Payer partners must commit to offering participating practices a primary care payment model that is aligned with Primary Care First.

CMS believes that multi-payer engagement is critical for amplifying the impact of PCF and driving primary care transformation. Aligned multi-payer partnerships increase the potential impact of value-based primary care models by:

1) Promoting consistent value-based incentives across a practice's entire patient population, which strengthens the influence of those incentives;
2) Encouraging practices to work towards similar objectives for their entire patient panel. This enables them to develop one comprehensive care approach rather than having to apply different care delivery models depending on payer status, which is administratively burdensome and at odds with patient-centered care; and
3) Reducing the administrative burden that practices face working with all of their payers, resulting in a larger net reduction in burden and a greater increase in resources to devote to direct patient care.

Payer partners need not offer identical primary care models in order to make progress towards these goals. Aligned models may differ on specific details, including in the mechanics of their payment methodologies, as long as they are aligned with PCF's four core model principles and objectives. The four core principles of PCF are: (1) moving away from a fee-for-service payment mechanism; (2) rewarding value based outcomes over process; (3) using data to drive practice accountability and performance improvement; and (4) leveraging multi-payer alignment as a critical tool for driving adoption of value-based care models. The table below provides a rubric for how CMS will review payer partner proposals, including specific criteria tied to each of the four core PCF principles. For each of the criteria, the table defines what would be deemed "not sufficient alignment," "acceptable alignment," and "preferred alignment." CMS encourages prospective payer partners to design an aligned payment model that meets as many of the "preferred alignment" criteria as possible. However, CMS will still accept payers who meet "acceptable alignment" criteria in some areas, with the expectation that these payers will work towards meeting "preferred alignment" standards during the course of their participation in the model. CMS will also consider proposals from payers that fall under "not sufficient alignment" on one or two criteria, and will seek follow-up conversations with those payers about the reason for the lack of sufficient alignment before making a final decision about whether to select them as payer partners. CMS recognizes that state Medicaid agencies may face specific constraints that make it challenging to meet some of these alignment criteria, and intends to work closely with interested state agencies to facilitate their participation in the model.

	Preferred Alignment	Acceptable Alignment	Not Sufficient Alignment
Principle 1: Move away from fee-for-service payment mechanism			
Minimize volume-based incentive	• Partial primary care capitation with more than 50% of revenue reimbursed through capitated or other non-visit-based payment *OR* • Full primary care capitation	• Primary care episodes *AND/OR* • Shared savings/shared losses *AND/OR* • Partial primary care capitation with less than 50% of revenue reimbursed through capitated or other non-visit-based payment	• Fee-for-service plus care management fee *OR* • Fee-for-service plus at-risk care management fee *OR* • Reimburse additional codes for non-face-to-face services *OR* • Higher fee-for-service rates for primary care services
Risk adjustment	• Alternative to FFS payment is risk adjusted to account for factors including but not limited to health status and patient demographics	*Same as preferred alignment*	• Alternative to FFS payment is not risk adjusted
Principle 2: Reward outcomes, not process			

	Preferred Alignment	Acceptable Alignment	Not Sufficient Alignment
Practices' reimbursement influenced by outcomes, not process	• Performance-based payment tied to clinical quality, patient experience, health improvement, cost and/or utilization measures *AND* • Performance-based payment tied at least in part to utilization and/or total-cost-of-care measure(s) *AND* • Performance-based payment not tied to achievement of care delivery processes (though care delivery processes/ certifications may be used to determine practice eligibility at start of model)	• Performance-based payment tied to clinical quality, patient experience, cost and/or utilization measures *AND* • Performance-based payment tied at least in part to utilization and/or total-cost-of-care measure(s) *AND* • Performance-based payment tied in part to achievement of care delivery processes	• Practices' reimbursement not influenced by performance in any way *OR* • Performance-based payment tied in full to achievement of care delivery processes *OR* • Performance-based payment not tied to utilization and/or total-cost-of-care measure(s) in any way
Performance can have substantial impact on practices' payment	• Maximum possible performance-based payment adjustment can increase practices' primary care revenue by more than 15%	• Maximum possible performance-based payment adjustment can increase practices' primary care revenue by between 5% and 15%	• Maximum possible performance-based payment adjustment can increase practices' primary care revenue by less than 5%
Performance-based payment adjustment can be negative if practice has poor outcomes	• Performance can both increase and decrease payment, though potential upside is larger than potential downside	• Performance can both increase and decrease payment; potential upside is equal to potential downside	• Performance can only increase payment

	Preferred Alignment	Acceptable Alignment	Not Sufficient Alignment
Alignment with PCF measure set	• Payer uses the same quality and utilization measures as PCF to evaluate and reward or penalize practice performance *AND* • Payer uses few or no additional measures above and beyond the PCF measure set	• Payer uses at least three of the same quality and utilization measures as PCF to evaluate and reward or penalize practice performance[1] *AND/OR* • Payer uses no more than 10 total measures, including PCF-aligned measures and additional measures *AND* • Additional measures are drawn from CMS's "Meaningful Measures" initiative, which used broad stakeholder feedback to identify the highest priority areas for quality measurement and improvement, and includes measures that are applicable across multiple CMS programs and patient populations	• Payer uses none of the same quality and utilization measures as CMS[1] *OR* • Payer uses a large number of additional measures above and beyond the CMS measure set
Principle 3: Deliver meaningful, actionable data reports to drive practice accountability and performance improvement			
Attribution	• Practices receive list of prospectively attributed members at least monthly	• Practices receive list of prospectively attributed members at least quarterly	• Practices receive list of attributed members less than quarterly

[1] CMS may consider additional flexibility on this requirement if payer can demonstrate that the PCF measures are not appropriate or relevant for their attributed populations

	Preferred Alignment	Acceptable Alignment	Not Sufficient Alignment
Frequency[2]	• Payers provide service utilization and cost data at least quarterly	• Payers provide service utilization and cost data at least bi-annually	• Payers do not provide service utilization and cost data
Type of data[2]	• Payers provide practices with service utilization and cost of care data for attributed members	• Payers provide practices with some limited service utilization and cost of care data for attributed members	• Payers do not provide practices with service utilization or cost of care data for attributed members
Format of data[2]	• Data is delivered in user-friendly format that enables practices to readily identify improvement opportunities *AND* • Data is accompanied by tailored support and guidance to help practices use the data *AND* • Data can be exported into electronic formats (cvs, xls, etc.) for analysis in an EHR, Excel or other analytic software tools.	• Data is delivered in user-friendly format that enables practices to readily identify improvement opportunities *AND* • Data is accompanied by general (non-practice-specific) guidance about how to use the data *AND* • Data can be exported into electronic formats (cvs, xls, etc.) for analysis in an EHR, Excel or other analytic software tools.	• Data is not formatted in a way that allows practices to readily gain actionable insights; data cannot readily be exported into electronic formats (cvs, xls, etc.) for analysis in an EHR, Excel or other analytic software tools *OR* • No resources are provided to help practices navigate the data *OR* • Payer does not provide data reports to practices
Level of data[2]	• Payers provide practices with beneficiary-level service utilization and cost data	• Payers provide practices with practice-level or practitioner-level service utilization and cost data	• Payers do not provide practices with utilization and cost data

[2] Note: For payers who participate in data aggregation, i.e. combining data from multiple payers into a single platform, the frequency, type, format, and level of data will be dictated by their data aggregation platform. Payers who are not participating in data aggregation should work to align with CMS and other payers in their region on these dimensions to the greatest extent possible, per the "alignment with CMS and other local payers" criteria

	Preferred Alignment	Acceptable Alignment	Not Sufficient Alignment
Alignment with CMS and other local payers	• Payer either already participates in or is actively working towards participating in regional data aggregation with CMS and other regional payers, which provides multi-payer data in a single platform	• Payer participates in efforts to align data reporting with CMS and other local payers, including by aligning on the four preceding dimensions (i.e., frequency, type, format, and level of data)	• Payer makes no effort to align data reporting with CMS and other regional payers, including by aligning on the four preceding dimensions (i.e., frequency, type, format, and level of data)
Principle 4: Multi-payer alignment is critical for driving adoption of value-based care models			
Participation in regional multi-payer collaborative activities	• Payer actively participates in and contributes to regional multi-payer collaborative activities related to PCF	• Payer attends multi-payer collaborative events, but does not actively participate in or contribute to them	• Payer does not participate in multi-payer collaborative activities related to PCF that are available in their region
Goal-setting and continuous improvement	• Payers work with their regional peers to set annual goals for regional multi-payer collaboration and alignment, and develop plan for achieving goals/alignment targets AND • Payers demonstrate progress towards goals throughout the year	*Same as preferred*	• Regional payers do not set annual goals for regional multi-payer collaboration and alignment or develop plan for achieving goals/alignment targets

	Preferred Alignment	Acceptable Alignment	Not Sufficient Alignment
Transparency on non-payment related topics	• To the greatest extent possible, payer will share information about non-payment related topics, e.g. attribution and risk adjustment methodologies, quality measurement strategies, and practice coaching activities with CMS and other local payers to inform payer alignment and collaboration activities	*Same as preferred*	• Payer does not make an effort to share information about non-payment related topics with CMS and other local payers in order to inform payer alignment and collaboration activities
Enable sufficient practice participation to drive broad-based payment and delivery reforms	• Payer sets reasonable eligibility criteria, e.g. minimum attributed member thresholds, that enable most or all participating PCF practices in their region to participate in the payer's PCF-aligned model	• Payer sets moderately restrictive eligibility criteria, e.g. minimum attributed member thresholds, that would meaningfully limit the number of participating PCF practices in their region that could participate in the payer's PCF-aligned model AND • Payer provides data-driven to CMS rationale for how eligibility criteria is set, e.g., member threshold is set to allow for valid and reliable calculation of performance measures	• Payer sets highly restrictive eligibility criteria, e.g. high minimum attributed member thresholds, that prevent the majority of participating PCF practices in its region from participating in the payer's PCF aligned model

Neighborhood Health Plan OF RHODE ISLAND™
910 Douglas Pike, Smithfield, RI 02917 : 1-800-963-1001 : nhpri.org

January 24, 2019

Commissioner Marie L. Ganim, PhD
Office of the Health Insurance Commissioner
1511 Pontiac Ave, Building #69
Cranston, R.I. 02920

Dear Commissioner Ganim:

Neighborhood Health Plan of Rhode Island (Neighborhood) appreciates the opportunity to provide comments to the Office of the Health Insurance Commissioner (OHIC) concerning the proposed changes to regulation 230-RICR-20-30-4 on Affordability Standards. Neighborhood supports the overall goals of the OHIC in continuing to evolve regulation in the interest of better serving our Rhode Island (RI) consumers; however, we have significant concerns regarding the impact and feasibility of some of these changes. These concerns prioritized and provided by content area.

Oversight of Risk-Bearing Provider Contracts (§ 4.10(D)(2))
While supportive of payment reform, Neighborhood objects to the inclusion of the constraints placed on risk-based payment model contracts by OHIC beyond current statutory authority. These guarded measures add unnecessary restrictions on the flexibility of plans and providers to develop innovative solutions, either in financing or structure for risk-bearing provider contracts. This authority should continue to be pursued legislatively rather than through regulation, if this is the direction OHIC wishes to pursue.

Payment Reform (§ 4.10(D)(3) (§ 4.10(D)(4))
Neighborhood has demonstrated its commitment to the goals of alternative payment models in incentivizing quality over quantity, reducing unnecessary procedures, and targeting better outcomes. Successful strategies are ultimately dependent on alignment of several more general components including: 1) Critical mass of membership, 2) State aligned initiatives that support insurer and provider strategies, 3) Willingness by providers to accept risk, and 4) Ability of insurers to provide data necessary to track total cost of care. Such components should continue to be considered when assessing ability of carriers to achieve targets set out in regulations.

Inclusion of Cost Trends Target as Condition of Affordability (§ 4.9(C)(1)(e))
Neighborhood is strongly opposed to including language connecting the determination of health plan product affordability with the work of the RI Health Care Cost Trend workgroup. The workgroup established a voluntary target, not focused on rate setting, identifying drivers of overall state medical expense inflation; its validity as a proper assessment tool has yet to be established. In contrast, the actuarial principles of rate setting define a predictive exercise of trends and other components to define a prospective premium. Application of a simple inflationary cap principle creates an incentive to manage unit cost and not make investments in the drivers of overall population health/costs. Investments in social determinants of health or other wellness related services are becoming increasingly more necessary; however, these requirements would unduly restrict a plan's ability, or willingness, to make those investments. The purpose of the RI Health Care Cost Trend Project was

the voluntary collection of information on global expenditures in RI. The workgroup has no formal standing in state law, as it does in Massachusetts, and efforts to formalize should go through the legislative process.

One-Time Hospital Increase to Address Rate Variation (§ 4.10(D)(6)(f))
Neighborhood does not support the one-time hospital increase proposed by OHIC. While Neighborhood understands the importance of balancing the needs of affordability with the financial stability of vital medical resources in the state, any effort to support the financial health of hospitals in Rhode Island should be cost neutral so as not to harm consumer affordability. This would be inconsistent with the Administration's effort to establish a meaningful cost trend target noted above, as well as align with the proposed SFY2021 budget initiatives that freeze hospital rates for government programs. Any increase to the median for lower cost hospitals should at a minimum be coupled with one time decreases from higher cost hospitals to maintain the achievements of current regulations and negotiated contracts. The success articulated by an independent evaluation of the 2018 Affordability Standards[1] should not be undermined simply to correct market power dynamics that would likely be present even if no rate cap existed.

Primary Care Practice Transformation (§ 4.10(C))
Neighborhood has demonstrated its commitment to supporting high quality, lower cost care that can be offered by the primary care community. Current regulation has made strides in practice transformation, moving the majority of network practitioners inside an OHIC identified patient centered medical home (PCMH). Recently, however, the Executive Office of Health and Human Services (EOHHS) clearly indicated an unwillingness to provide further support in this area, likely recognizing saturation of available targeted primary care efforts. EOHHS will not provide support for sustainability payments for adult practices which have graduated from the Care Transformation Collaborative (CTC) program. Further directed support outlined in this regulation may position OHIC at odds with aligning goals across state agencies and likely cause provider disruption and confusion who serve both Medicaid and Commercial members.

Behavioral Health Integration (§ 4.10(C)(2))
Neighborhood supports efforts to create behavioral health care integration with primary care settings. In fact, Neighborhood and its health center partners have led a number of initiatives to further integrate behavioral health and primary care services. However, the model put forward lacks a cohesive and comprehensive strategy to achieve this goal. Neighborhood believes the legislative process should drive comprehensive strategies for integration, versus defining single components within regulation. The current proposed model deals only with addressing smaller pain points of providers and pushes the remainder of detail to a yet to be defined report. Neighborhood feels that policy in this area should be further clarified and driven by the legislature before any further regulatory action is taken. We welcome any further dialog with OHIC on working to establish a program that we can then bring to the legislature to ensure it is well supported.

Payment and Care Committee (§ 4.10(E)(1))
Neighborhood, as an active participant in other committees, supports open dialogue among stakeholders and policymakers to advance the systems of care in Rhode Island. Based on the proposed regulation, Neighborhood is seeking clarity on the gap in stakeholder input opportunities and how

[1] 9 Baum et al. "Health Care Spending Slowed After Rhode Island Applied Affordability Standards to Commercial Insurers" Health Affairs February 2019. https://doi.org/10.1377/hlthaff.2018.05164

this committee would be different than others that exist. Based on the broadness of the committee's charge, Neighborhood is seeking clarity on the need for the committee and the authority it may have regarding developing recommendations for necessary actions by the Commissioner.

Please contact me at (401) 459-6679 or EMcClaine@nhpri.org with any questions regarding these comments. Thank you for your consideration.

Sincerely,

Elizabeth McClaine
Vice President of Commercial Products
Neighborhood Health Plan of Rhode Island

M. Teresa Paiva Weed
President

HARI
Hospital Association of Rhode Island

January 15, 2020

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

Re: Amendment 230 – RICR-20-30-4 (formerly OHIC Regulation 2)

Dear Mr. King:

The Hospital Association of Rhode Island (HARI) and its members applaud the efforts of the Office of the Health Insurance Commissioner (OHIC) to improve the affordability of health insurance while increasing investments in primary care and practice transformation.

HARI appreciates the opportunity to provide comments and recommendations on the proposed Affordability Standards.

HARI is in substantial support of the proposed changes that OHIC has made to the regulation. The new rules will provide an opportunity for eligible hospitals to earn a rate adjustment to mitigate existing disparities in payment.

HARI appreciates and supports OHIC's conclusion that these regulatory changes not require cost neutrality. As stated in the HARI comment letter submitted in response to the Advance Notice of Proposed Rulemaking, the overall operating margin for hospitals in our state is negative.

HARI members are committed to improving and maintaining the highest quality of healthcare for all Rhode Islanders. The proposed amendments recognize this commitment and the cost benefits that quality care provides.

HARI and its members remain committed to continuing to work with OHIC to transform healthcare.

Sincerely,

M. Teresa Paiva Weed

M. Teresa Paiva Weed
President

Hospital Association of Rhode Island
405 Promenade Street – Suite C, Providence, Rhode Island 02908 ■ p (401) 443-2803 ■ f (401) 533-9328 ■ www.HARI.org

MHARI
Mental Health Association of Rhode Island
An Affiliate of Mental Health America
SINCE 1916

January 24, 2020

Cory King, Director of Policy
Office of the Health Insurance Commissioner
1511 Pontiac Ave., Bldg. #69, First Floor
Cranston, RI 02920

By Email To: Cory.King@ohic.ri.gov

Re: Proposed Amendment to 230-RICE-20-30-4, "Revisions to the Affordability Standards"

Dear Mr. King:

Thank you for the opportunity to provide comments on the Office of the Health Insurance Commissioner (OHIC)'s proposed changes to 230-RICE-20-30-4, Powers and Duties of the Office of the Health Insurance Commissioner (the "Affordability Standards").

The mission of the Mental Health Association of Rhode Island (MHARI) is to promote and nourish mental health through advocacy, education, and policy development. One of our main areas of focus is increasing consumers' access to behavioral health treatment through our RI Parity Initiative. Nationally, Rhode Island ranks 41st in drug poisoning deaths, 39th in adult mental illness rates, 39th in alcohol use disorder, and is significantly higher than the national average in many other substance abuse metrics. For many, access to behavioral health treatment is a matter of life or death.

We appreciate OHIC's efforts to improve Rhode Island's healthcare system. MHARI respectfully submits the following comments on your proposed changes to the Affordability Standards.

1. Patient-centric, value-based care should be weighted equal to, if not more than, cost-saving measures.

2. Investments in primary care are sorely needed, as the shortage of primary care physicians (PCP) poses a significant hardship to patients who rely on PCPs for medication management or referrals to specialists.

3. Behavioral health integration and eliminating copays for same-day, co-located behavioral health visits are important steps toward increasing access to behavioral health treatment. Further, delivering behavioral health treatment at medical facilities reinforces the fact that mental disorders are health conditions. We believe this could help reduce stigma and shame as long as medical professionals are educated about the nature of mental illness. Surprisingly, our first round of Parity Initiative focus groups consisting of mental health consumers and providers revealed widespread stigma and discrimination *within* the network of medical professionals in hospitals and physical health facilities. Medical professionals who are in regular contact with mental health consumers would benefit from mandatory

sensitivity training. Lastly, behavioral health integration into the primary care setting would allow for regular mental health screenings. This will prove to be a wise cost-containment measure because the earlier an illness is diagnosed and fully treated, the less likely more costly levels of behavioral healthcare will be needed. Most importantly, early diagnosis improves patient outcomes.

4. We applaud your efforts to ensure "stakeholder involvement," and we request additional language to secure the inclusion of mental health consumers, providers, or advocates, who can speak to the issues of parity violation and discrimination.
5. Prevention of chronic physical disease and mental illness (including substance use disorders) is a cost-containment mechanism that is overlooked and undervalued in our healthcare system. People are living longer but sicker lives, and this accounts for some of the strain on our broken healthcare system. Educating hospitals, community health centers, private practices and patients about the protective benefits of a plant-based diet and incentivizing healthy diet and lifestyle choices will reduce costs on the medical/surgical side of the system. Preventing child abuse, neglect, and trauma will reduce costs on the behavioral health side because trauma changes the developing brain, increasing the likelihood of mental illness later in life. Value-based care and prevention go hand-in-hand; we should reward providers who ***prevent*** disease from happening in the first place. While it might take years to see the ripple effect of such efforts, emphasizing prevention will dramatically improve patients' lives AND reduce costs to insurers, employers, and the government. What other cost-saving measure could produce such a straightforward win-win situation?

Thank you for your consideration of our comments. Please feel free to reach out to me should you have any questions. The Mental Health Association is deeply grateful to Commissioner Ganim and everyone at OHIC for your steadfast commitment to upholding federal and state parity laws. You give people living with mental illness a chance for new and better lives.

Respectfully,

Laurie-Marie Pisciotta
Executive Director
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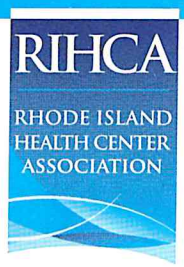


Providence, Rhode Island 02908
Facsimile: 401-274-1789

January 23, 2020

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

RE: 230-RICR-20-30-4: Powers and Duties of the Office of the Health Insurance Commissioner

Dear Mr. King,

The Rhode Island Health Center Association (RIHCA) appreciates the opportunity to provide comments regarding the Office of the Health Insurance Commissioner (OHIC) proposed revisions to the Affordability Standards. RIHCA represents Rhode Island's nine community health centers, including eight federally qualified health centers (FQHCs), one island-based health center, and associate community mental health center member. Last year, FQHCs provided care for over 178,000 Rhode Islanders, including those publicly insured (Medicaid), uninsured, underinsured, and privately insured.

RIHCA supports investments in primary care and efforts to improve the affordability of health insurance and have included comments on OHIC's proposed revisions below.

4.3 Definitions

15d. A Primary Care Practice that has demonstrated development and implementation of meaningful cost management strategies and clinical quality performance attainment and/or improvement. The requirements for meaningful cost management strategies and for clinical quality performance attainment and/or improvement, and the measures for assessing performance, shall be determined annually by the Commissioner.

FQHCs are held to a stringent set of federal requirements and yearly reporting measures. All Rhode Island's FQHCs are recognized patient-centered medical homes (PCMH) with NCQA recognition. RIHCA believes in the value of assessment but would ask that as this process progresses that input from primary care practice, including FQHCs, be part of the ongoing effort.

C. Primary Care Practice Transformation/Behavioral Health Care Integration

(2)(a1) Financial barriers. Health insurers shall eliminate copayments for patients who have a behavioral health visit with an in network behavioral health provider on the same day and in the same location as a primary care visit at a Qualifying Integrated Behavioral Health Primary Care Practice as defined in § 4.3(A)(18) of this Part.

RIHCA appreciated the opportunity to participate in OHIC's Integrative Behavioral Health Care meetings last year. As a strong advocate for integrative behavioral health, RIHCA supports efforts to remove barriers to behavioral health care and applaud efforts to eliminate two same day copays.

As OHIC progresses in the implementation of integration, RIHCA would encourage the Commissioner to seek input on an ongoing basis from primary care practices that have experience with integration of behavioral health, including the FQHCs.

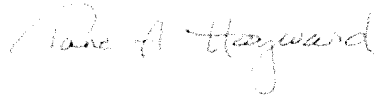
D. Payment reform/ Population based contracts

RIHCA recognizes the ongoing transition to value-based care in RI; health centers are a significant participant in the move towards improving the patient experience of care and toward population-based health while reducing the per capita cost of health care. FQHCs serve a crucial role in the state's health landscape, providing comprehensive, high-quality primary, behavioral, and oral health care to some of the most vulnerable populations. Last year, FQHC's cared for over 178,000 patients.

In a state with no county health department or public primary care infrastructure, FQHCs serve as the de facto public health primary care delivery system. Discussions on downside risk have included the Centers for Medicare and Medicaid Services (CMS) who has decided that FQHCs cannot take on downside risk in the Accountable Entity initiative. In that the CMS position should change, RIHCA wants to assure that EOHHS in its MOU with the OHIC begin a dialogue to assure care is taken not to undermine the financial stability of these organizations given the valuable and unique role they serve. In addition, FQHCs should not be disadvantaged in transformation opportunities because of the CMS prohibition to assume downside risk.

Again, RIHCA, thanks you for the opportunity to provide comments on the proposed revisions to the Affordability Standards.

Sincerely,



Jane Hayward
President & Chief Operating Officer

January 16, 2020

Mr. Cory King
By Email To: Cory.King@ohic.ri.gov

Re: Proposed Amendment to 230-RICR-20-30-4, "Revisions to the Affordability Standards"

Dear Mr. King:

Thank you for the opportunity to provide comments in response to the Office of the Health Insurance Commissioner (OHIC)'s proposed changes to 230-RICR-20-30-4, Powers and Duties of the Office of the Health Insurance Commissioner (the "Affordability Standards"). The Rhode Island Parent Information Network (RIPIN) helps thousands of Rhode Islanders to navigate the healthcare system every year. We operate an all-payer consumer assistance program (in partnership with OHIC) that helped clients save nearly $3 million over the past two years. We also operate numerous other programs that help Rhode Islanders, especially those with disabilities and special needs, to access the care they need. In this capacity, RIPIN sees the impact of OHIC's ongoing commitment to promoting the availability of high-quality, affordable healthcare in the commercial market, as well as OHIC's work to incentivize meaningful primary care reform and behavioral health integration.

The Affordability Standards are a critical catalyst for important improvements to Rhode Island's healthcare system. RIPIN applauds OHIC's commitment to modernizing the standards, and to continuing to use them as a tool to effectuate meaningful positive change in our healthcare system as a whole.

RIPIN submits the following top-level comments, discussed in detail below:

1) RIPIN encourages OHIC to ensure that payment models promoted in the Affordability Standards emphasize quality and outcome improvements at least as strongly as cost control;
2) RIPIN supports OHIC's efforts to encourage and reform primary care investment, including through infrastructure payments, PMPM care management funding, and performance bonuses, and encourages increased investment in quality improvement in health outcomes;
3) RIPIN strongly supports OHIC's efforts to encourage behavioral health integration by creating practice transformation incentives, and to resolve consumer confusion by eliminating copays for same-day, co-located behavioral health visits; and
4) RIPIN expresses concerns regarding OHIC's promotion of risk-based contracts including downside risk, and recommends that the movement to APMs and downside risk be subject to meaningful State oversight and be done at a more gradual pace.

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RIPIN Encourages OHIC To Emphasize Quality Equally to Cost Savings

RIPIN believes that the Affordability Standards represent an important area where OHIC can make meaningful progress in ensuring that Rhode Islanders have meaningful access to affordable, high-quality healthcare that improves healthcare outcomes in the state. The enabling legislation behind the Office of the Health Insurance Commissioner, R.I.G.L. § 42-14.5-2(4) requires OHIC to "[e]ncourage policies and developments that improve the *quality and efficiency* of health care service delivery *and outcomes*" (emphasis added). RIPIN fears that the new payment models promoted in the Affordability Standards, like new payment models in Medicare and elsewhere, emphasize cost control with far stronger incentives than quality and outcome improvements. RIPIN suggests reframing the Affordability Standards to give equal priority to quality improvement as is given to cost savings.

The United States undoubtedly face a crisis in healthcare spending. Healthcare spending has grown faster than GDP for decades, leaving Americans paying nearly double the per-capita OECD average. As OHIC has pointed out, premium growth has still outstripped state economic growth in each of the past four years in the small and large group markets, and in two of the past four years in the individual market. Nonetheless, thanks to the tireless work of OHIC and other state partners, Rhode Island has been hit less hard than other states, with lower-than-average premiums and cost increases.

However, Rhode Island faces a second healthcare crisis in health outcomes, a crisis potentially more deleterious and difficult to resolve, and one where Rhode Island is not necessarily outperforming its sister states. The United States ranks 44th in life expectancy at birth, 55th in maternal mortality, and 55th in infant mortality. Among disadvantaged racial and socioeconomic subgroups, the numbers are far worse. If African American infants were looked at as their own country, they would rank 98th in the world; African American mothers would rank 90th in maternal mortality, worse than El Salvador and Vietnam.

On these types of outcomes, Rhode Island has made far less progress. As of 2017, Rhode Island ranks fifteenth in the United States for life expectancy, having seen a decline in life expectancy between 2010 and 2017. Among African Americans, Rhode Island ranked last in the country, with a life expectancy approximately eight years shorter than that of Rhode Islanders as a whole. As OHIC has noted, Rhode Island has lagged even more severely in behavioral health outcomes; Rhode Island ranks 41st in drug poisoning deaths, 39th in adult mental illness rates, 39th in alcohol use disorder, and is significantly higher than the national average in many other substance abuse metrics.

Rhode Island's payment and delivery system reform efforts, including the Affordability Standards, have focused primarily on spending, with quality improvements clearly treated as a secondary priority. RIPIN would recommend that OHIC use the Affordability Standards as a springboard to focus more emphasis on outcome improvements. Two specific recommendations for change are 1) to provide for bonuses for ACOs for exceptional health outcomes, and 2) to ensure that quality measures used by payers and providers in APM contracts move toward tracking outcomes rather than process.

APM Contracts Should Reward Quality High-Performers

RIPIN would recommend including language in the "Alternative payment models" section to require that APM contracts provide bonuses to ACOs that perform exceptionally on quality outcomes, even if they do not achieve (significant) savings. These bonuses can be funded using portions of the sequestered shared savings payments that are withheld when ACOs miss quality targets. RIPIN would recommend adding a new §4.10(D)(1)(b) before the current sub-paragraph (b) (to be redesignated (c)), which would state:

> b. Health Insurers shall ensure that alternative payment models provide appropriate incentives for providers to pursue quality improvement as well as cost control, including by providing bonuses to providers who score above quality targets established by the Commissioner on designated outcome measures, regardless of their cost performance.

In the system as currently structured, an ACO with average performance on quality and outcomes that achieves significant savings will receive a shared savings bonus, but an ACO with average cost performance and extraordinary quality and outcomes performance receives nothing. That imbalance in the incentive model should be rectified.

APM Contracts Should Utilize Robust, Outcome-Based Quality Measures

RIPIN would recommend establishing in the section on Aligned Measures a policy of moving away from process and screening measures and toward robust, outcome-based quality measures. In its Aligned Measure Workgroup, OHIC has signaled support for movement away from "check the box" measures and toward ones that track meaningful health outcomes (such as reduced childhood obesity, the subject of a 2019 Kids Count data publication that could form the genesis of an outcome measure). RIPIN strongly supports this transition and encourages OHIC to facilitate accelerating movement in that direction through the inclusion of meaningful outcome measures in the core menu set that must be included in ACO contracts. To that end, RIPIN would support adding a sub-paragraph §4.10(D)(5)(d)(2) before the current sub-paragraph (2) and (3) (to be redesignated (3) and (4), respectively), which would state:

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

RIPIN Supports OHIC's Ongoing Commitment to Primary Care Investment

As OHIC has noted in its report accompanying the proposed regulatory revisions, access to meaningful primary care can facilitate cost savings through reduced emergency department, inpatient hospital, and low-value care utilization, as well as improved outcomes through early detection and meaningful care coordination. RIPIN strongly supports OHIC's ongoing commitment to improving access to substantive primary care through minimum spend requirements and payment incentives,

including infrastructure payment, PMPM care management and care coordination funding, and performance bonuses.

RIPIN further supports the incentives that OHIC has established for primary care practices to obtain NCQA PCMH certification, and to continue innovation and practice development once that certification has been obtained. RIPIN notes that NCQA requires that a PCMH develop and implement a quality improvement strategy that addresses one menu item from *either* the Care Coordination or the Cost-Effective Use of Services menu; in order to improve patient experiences, RIPIN would recommend incentivizing providers to develop quality improvement strategies that address both Care Coordination and Cost-Effective Use of Services.

Additionally (and as discussed above), RIPIN supports the use of robust, outcome-based quality measures to ensure practice transformation activities do not negatively affect (instead, preferably, improving) the quality of care received in the state. RIPIN would support a transition from process measures toward outcome measures in primary care alternative payment models to ensure that the implications of the increased responsibility allocated to primary care providers in managing patients' whole-body health are being adequately measured.

RIPIN Applauds OHIC's Support for Behavioral Health Integration

As the statistics discussed previously demonstrate, Rhode Island lags much of the nation in many behavioral health metrics. Despite efforts to reduce stigma and encourage meaningful access, primary care behavioral health services are both underutilized and underfunded, resulting in significantly greater downstream expenditures and significantly worse behavioral health outcomes. OHIC's commitment to ameliorating this issue is commendable and RIPIN fully supports OHIC's work to promote behavioral health integration.

RIPIN believes that the Affordability Standards represent an important venue for the promotion of meaningful reduction in administrative barriers to patient access, as established in § 4.10(C)(2) of the proposed Revisions to the Affordability Standards. RIPIN specifically supports the decision to require the elimination of separate copays for behavioral health services rendered the same day as primary care medical services in a co-located behavioral and primary care practice.

Federal and State law require parity in how behavioral health and medical/surgical services are treated by insurance payers. State law further requires that OHIC "direct insurers toward policies and practices that address the behavioral health needs of the public and greater integration of physical and behavioral health care delivery." Additionally, it is sound public policy to reduce stigma associated with seeking behavioral health care by incentivizing providers to incorporate behavioral health into the bevy of services addressed at the primary care level. As such, OHIC has both statutory foundation and policy rationale to support the elimination of separate copays for same-day, co-located behavioral and primary health services.

Rhode Island's Initial Movement to Downside Risk Should Be Tempered and Subject to Oversight

RIPIN would like to reiterate our concerns regarding the movement to downside risk-based contracting. Few providers in Rhode Island have sufficient attributed lives in any single risk-based contract to avoid high natural volatility risks. The minimum loss rates delineated in OHIC's standards for ACO risk-based contracts are constructed as ceilings, not as floors, allowing for contracts that set minimum loss rates lower than those established by OHIC. And the minimum loss rates set by OHIC are themselves low for provider groups as small as those permitted to engage in risk-based contracts; for example, the likelihood that a physician-based MCO with only 10,000 attributed lives sees a naturally-occurring instance of costs more than 3% higher than their true performance over the course of a year is not insignificant, but in the system as currently devised, that provider would be responsible for a significant risk-share even if their true cost performance was neutral. RIPIN is also concerned that the risk exposure caps as currently structured are higher than many provider groups could potentially endure. To avoid the risk of market disruption due to an ACO's failure, RIPIN would support additional actuarial review of these figures to determine whether the risk profiles they promote are reasonable.

RIPIN particularly objects to the inclusion at §4.10(D)(2)(d)(5) of language specifically "not [to] be construed to preclude or discourage" downside risk-based contracts with providers with less than 10,000 attributed lives. RIPIN strongly believes that OHIC should establish a floor of attributed lives beneath which risk-based contracts are affirmatively discouraged due to the inability for provider groups of that size to adequately absorb costs caused by natural volatility. RIPIN would advise revising §4.10(D)(2)(d)(5) to read:

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

Additionally, RIPIN suggests that OHIC utilize its authority to regulate the aggregate financial risk being assumed by provider organizations in risk-bearing contracts. If OHIC has the authority to determine the characteristics of APMs and risk-based contracts that qualify under the Affordability Standards (e.g. minimum risk levels), then it has the authority to include a required independent review of the risk-worthiness of the provider. As currently drafted, the Affordability Standards require insurer oversight of the risk profile of a provider group; however, the interests of the insurer in engaging in risk-bearing contracts and the interests of the public at large in supporting those contracts are not in synchrony. Additionally, an insurer may know little or nothing about a provider's risk-based contracts with other carriers. External oversight would help ensure that ACOs do not assume a level of risk that would result in serous disruptions to the healthcare system or increased incentives to restrict care. To that end, RIPIN would recommend revising §4.10(D)(2)(e) to read:

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

Thank you for the opportunity to provide these comments. Should you have any further questions, please feel free to contact us.

Sincerely,

/s/

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/s/

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Executive Director
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TUFTS Health Plan

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January 23, 2019

VIA E-MAIL

Cory King
Principal Policy Associate
Office of the 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. King,
On behalf of Tufts Health Plan (Tufts HP), 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 applaud OHIC for 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 supporting primary care, transitioning payment models to a value-based paradigm and improving access and coordination of behavioral health services. However, we do have concerns with some of the proposed modifications to the Standards, which we highlight below for your consideration:

<u>§ 4.9 (C)1(e) Comparison to the Cost Growth Target</u>
This section of the proposed regulation would add, as a rate review factor, a "comparison to the Rhode Island cost growth target". We oppose the adoption of this amendment for three reasons:

1. Performance against a Cost Growth Target and the development of rates are two substantially different calculations, which are not directly comparable. Performance against the cost growth target is a retrospective analysis of a health plan's total spend in a given year, while the development of premium rates is a prospective estimate of costs based on future price and utilization projections. This distinction is particularly important given the gap in time that would exist between measuring spending performance and filing premium rates. As an example, premium rates for 2021 will be filed for review in the Spring of 2020 while the current measurement of performance against the Cost Growth Target, during that time, would be from calendar year 2018. We contend that performance data three years removed for the rating period should not be considered a relevant condition for approval. Furthermore, these two calculations are based on different sets of data. While the Cost Growth Target will consider some self-funded data, premium rates are based on projections for the fully-insured insured

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market only. Also, premium rates are developed to be agnostic on factors such as membership shifts between plans and aging. The actual cost trend will be impacted by these factors and others that are not part of rate development. Again, this makes the two items not strictly comparable, and we oppose using historical performance, particularly such dated performance, to assess future premium rate filings.

2. During the development of the Cost Growth Target, we expressed concerns about including costs that were out of the control of a given stakeholder (e.g., pharmaceutical costs) as part of a stakeholder's performance against the trend. We observe some potential challenges with meeting the Cost Growth Target given several regulatory requirements included in this regulation. Requirements such as minimum spending on primary care and a potential new requirement to increase payments to certain hospitals will amount to built-in cost increases for commercial health plans. These requirements, taken together with utilization and cost increases, substantially limit the ability of health plans to manage overall spending and meet a cost growth target. Given this limited ability, we are concerned that historical performance could lead to premium rate disapproval.
3. Our comfort in signing the Compact and supporting this work during initial data submissions was based on the assertion, both in the compact itself and during meetings of the Steering Committee, that the goal of the cost growth target was to provide the market with greater transparency around healthcare costs and provide insights into spending that could help inform public policy. Since we have yet to complete a cycle of reporting, measurement and analysis, we believe it is premature to consider expanding the use of the Cost Growth Target from a program aimed at increasing transparency to one with potentially significant regulatory and business repercussions.

§4.10 (D) 2 (d) – Risk Sharing Contracts

This section sets minimum attributed lives thresholds for hospital and ACO contracts that include downside provider risk. While we agree that more significant patient panels assigned and/or attributed to a particular provider allows for more accurate projections of financial performance, we believe that downside risk agreements are still appropriate and beneficial even with patient volume beneath the 10,000 patient thresholds. As such, providers and health plans should collaborate on payment models that incorporate a framework that is cognizant of membership, a provider's capabilities and competencies and market expectations. We urge OHIC to include some language in this section allowing for flexibility and acknowledging that contracting for downside risk with fewer attributed lives than the thresholds can be appropriate.

§4.10 (D) 6 – Hospital Contracts

Section §4.10 (D) 6 (f) requires that health plans increase reimbursement rates to all hospitals that fall below the medium reimbursement rates in a given year. Although we recognize that price disparities exist among hospitals, the proposed approach will only lead to cost increases for health care purchasers and runs counter to OHIC's stated goal of increased affordability. Any payments made to hospitals

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below the median should be accounted for in a cost neutral fashion so that premiums are not negatively affected.

We are also concerned with how this provision interacts with other regulatory requirements, such as the minimum primary care spend and the Cost Growth Target. Requiring any minimum provider payments will make it difficult to achieve the state's new target trend. We urge OHIC to remove this provision from the finalized regulation.

Sincerely,

Kristin Lewis
Senior Vice President and Chief External Affairs Officer

America's Health Insurance Plans
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South Building, Suite Five Hundred
Washington, DC 20004

January 24, 2020

Cory King
Principal Policy Associate
Office of the Health Insurance Commissioner
1511 Pontiac Avenue, Building 691
Cranston, RI 02920

Re: AHIP's Comments on Affordability Standards Revisions: 230-RICR-20-30-4

Dear Mr. Cory King –

I write today on behalf of America's Health Insurance Plans (AHIP)[1] regarding the proposed revisions to the Office of the Health Insurance Commissioner's Affordability Standards: 230-RICR-20-30-4 (Standards).

We appreciate OHIC's commitment to advance policies that would improve: 1) the affordability of health care coverage; 2) access to behavioral and medical care; and 3) the quality of healthcare. Increasing support for primary care, behavioral health integration and coordination, and moving away from the fee-for-service payment model are important steps in achieving these goals.

However, AHIP is concerned that portions of the proposed Standards would limit plan flexibility that would help achieve these aims.

The use of the Cost Growth Target as a rate review factor relies on outdated and conflated data.

AHIP urges OHIC to remove provisions that would allow for the use of the Cost Growth Target as a rate review factor. Using these 2018 data to assess rates for the 2021 plan year is not appropriate and undermines actuarily sound rate filings. These are different sets of data in terms timing, purpose and scope.

The Cost Growth Target is a wholesale retrospective analysis of how healthcare dollars are spent in Rhode Island, which includes a health insurance provider's spending in a given year. It promotes transparency and sets a target benchmark for annual increases in healthcare costs.

[1] AHIP is the national association whose members provide coverage for health care and related services to millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities, and the nation.

However, it includes drastically increasing costs that are not determined by plans. For instance, pharmaceutical costs are wholly set by drug manufacturers. It also includes self-funded data.

Rate filings, on the other hand, are developed from a prospective analysis using actuarial science. These rates are based on data for the fully-insured market that estimate a plan's cost based on projected drug and service prices, as well as a plan's estimated utilization costs.

The Cost Growth Target should be used to solely craft public policy to stabilize healthcare costs. As it stands, this provision would allow OHIC to use outdated data based on several factors and conflate them to assess the validity of a single component of the overall healthcare cost economy. Also, when combined with increased spending requirements on primary care and hospital reimbursements, this rate review factor is likely to substantially limit plan designs and may leave Rhode Islanders with fewer options.

The standards for risk-bearing provider contracts are overly restrictive.

AHIP encourages OHIC to revise the proposed standards for risk-based contracts with hospitals and accountable care organizations to make them less prescriptive. These contracts are negotiated between sophisticated parties. It is paramount to retain as much flexibility as possible in order to allow for collaborative innovations with these arrangements.

This is especially true for insurers with membership at or near the thresholds outlined in the proposed standards, where minimum volume or 'critical mass' may be needed within certain products or at specific providers to make a risk-based contract practical for all parties. Attaining the goal of expanding use of risk-based contracts, and reducing the prevalence of fee-for-service payments, should not risk the larger goal of containing the growth of health care costs for Rhode Islanders.

Increasing reimbursements for below-median hospital charges without addressing above-median hospital charges will lead to overall increases in healthcare costs.

AHIP urges OHIC to revise provisions regarding hospital reimbursements so that they are cost neutral to Rhode Island. We also would like OHIC to clarify the word "hospital," to mean a hospital system and not each individual hospital within a system.

There should be provisions that would allow health insurance providers to reduce payments to hospitals that are paid above the median rate for services. If OHIC requires increasing reimbursements on the lower end without decreasing those on the upper end, Rhode Island would see an overall increase in healthcare spending as the median continually increases.

Without this balance, health premiums will increase as health insurance providers are required to increase spending and will make it particularly challenging to achieve higher target expenditures like for primary care, especially in light of the Cost Growth Target.

Thank you for considering these comments. AHIP and its members stand ready to work with you to improve access to care and appreciate the opportunity to provide comments on this bill and look forward to continued discussions with you on this important issue.

If you have any questions about the concerns raised in this letter, please contact me at terrance.martiesian@verizon.net or (401) 421-0480; or Brendan Peppard at bprepard@ahip.org or (202) 306-3722.

Sincerely,

America's Health Insurance Plans

By:_____
Terrance S. Martiesian