



Stakeholder Comments on Advance Notice of Proposed
Rulemaking

230-RICR-20-30-4

Powers and Duties of the Office of the Health Insurance
Commissioner

Received as of 6/24/19

June 7, 2019

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

RE: Affordability Standards

Dear Mr. King:

Blue Cross & Blue Shield of Rhode Island (BCBSRI) appreciates the opportunity to provide comments on the Office of the Health Insurance Commissioner's (OHIC) Affordability Standards (the Standards) through the Advanced Notice of Proposed Rulemaking (Notice).

BCBSRI recognizes parts of the current Standards beneficially impact the total cost of care in Rhode Island and foster all-payer/all-provider system improvements. To continue those positive results, BCBSRI urges consideration be given to increasing flexibility for regulated entities so that we can be more responsive to emerging information and/or receptivity to efforts in the provider community. In addition, BCBSRI urges that decisions about the Standards be based on data and be reasonably designed to achieve measurable results based on nationally accepted benchmarks.

The Notice describes 15 goals encompassing over 30 detailed strategic activities. While BCBSRI shares OHIC's overarching goal of improving affordability, quality and access to care for all Rhode Islanders, we are concerned that the cumulative effect of these efforts may have unintended consequences contrary to these goals. Specifically, because the total cost of care cannot increase beyond the cost growth target, required investments in specified areas may crowd out necessary investments in other areas.

BCBSRI, along with many other healthcare entities in Rhode Island, has committed to the cost growth target. Dictating both the target and the means by which issuers should achieve the target ties our hands and, respectfully, goes far beyond the efforts undertaken in other states in setting a target. Some of the efforts in the Notice may increase costs, others may prove to be ineffective, and still others may not be met with receptivity in the provider community. The regulatory process is an inflexible mechanism to reach the goal of affordability in that the process to change or eliminate requirements is time consuming and does not allow regulated entities to respond quickly to data and developments. While the regulation currently provides a waiver process, that process has the potential to be inconsistently applied and, again, fails to give flexibility to regulated entities who need to react to developments and data quickly.

We suggest a narrowing of the Standards, based on a number of factors. The Standards should include those elements that provide a high return in terms of improvements to cost and quality. OHIC should consider the extent to which plans have the ability to successfully achieve the element or conversely are limited in their ability to unilaterally implement an element. The Standards should not set metrics so high or so voluminous that plans are driven to seek multiple waivers. In revising the list, OHIC might consider items that are inter-related (e.g. how payment

reforms might support behavioral health integration) or those which conflict (i.e. how new activities might add to provider burnout and innovation fatigue).

The consideration of which elements to include should also take into account preserving the balance between directing activities best conducted on a community-wide level and allowing plans and providers appropriate management discretion and room for flexibility, innovation, and competition.

Careful attention should also be given to avoid exposing the participants to the risk of antitrust allegations. OHIC should ensure it has sufficient statutory authority before imposing any requirements that could raise antitrust concerns.

With those general comments as background, BCBSRI offers the following specific comments, provided in the order each element is presented. While we provide comments on each individual item, we wish to make clear that we do not support adoption of these Standards in total.

A. Primary Care Investment

1. Continue requiring insurers to meet a primary care spending target.

BCBSRI conditionally supports the proposal to continue the investment in primary care. Before determining its position, BCBSRI asks OHIC to make available reports comparing RI to other states in terms of spending and results, reflecting current trends, preferably reflecting 2017 activity at least. BCBSRI also asks for clarification of the spending target as the document says the current level is 10.7% and the goal is 11% less the effect of removing indirect primary care spending. BCBSRI is unclear whether OHIC intends for this proposal to result in an increase in the current required level.

We also note that employer groups increasingly demand information to validate the value of this investment. If this item is retained as a Standard, then to maintain employer support for the spending, OHIC might consider establishing standardized primary care organization reports about the benefits to their patient populations and the cost efficiencies or other financial returns on the investment.

Furthermore, we encourage OHIC to consider how this spending could encompass or support the interest in improving the integration of medical care with behavioral health care.

2. Re-examine and more tightly define what constitutes primary care spending, and consider definitions being adopted in other states to promote comparisons across states.

BCBSRI does not support this element. The definitions of primary care services in the other identified states are too limiting. Oregon, for example, appears to be narrowly tailored and based on only specified CPT codes. BCBSRI believes the model here in Rhode Island more appropriately accounts for all of the services performed by the primary care provider and provides for flexibility and innovations among payers and providers.

3. Eliminate the requirement to limit indirect primary care spending to <1% and require insurer support for CTC-RI administrative infrastructure and Current Care elsewhere in OHIC regulation.

BCBSRI would like to better understand the intent of this element, particularly as to CTC. BCBSRI believes CTC's primary purpose is close to being achieved as most practices have "graduated" by completing the CTC-led transformation.

B. Care Transformation

1. Remove the current PCMH target, but require continued insurer financial support of OHIC-recognized PCMHs.

BCBSRI supports the removal of the primary care/PCMH transformation target, sharing OHIC's belief that there are a limited number of viable remaining practice candidates for transformation.

BCBSRI notes the opportunity to align strategy detail (b), relating to financial support, with element 2 relating to integrated behavioral health, and both with the OHIC's and BCBSRI's shared goal of implementing alternative payment methods including capitation.

Finally, BCBSRI urges OHIC consider ways in which the affordability standards throughout this "care transformation" section, and especially the parts on financial support, also align with OHIC's declared policy objective of improved health care quality.

2. Facilitate improved integration of primary care and behavioral health services.

BCBSRI supports the general theme of this goal to improve the integration of primary (medical) care with behavioral health. As such, BCBSRI believes the work described in part by "additional" strategy option (d), "defining the foundational elements of an integrated behavioral health practice" truly is a foundational element. Any Standards designed to facilitate improved integration of care should focus first and foremost on this goal.

As BCBSRI has voiced within OHIC's Integrated Behavioral Health (IBH) work group, proposals such as that described in strategy option (a): mandating health plans eliminate "same-day" copays would require plans to pay more (by covering the amount the member would have paid in cost sharing) when a member sees any primary care and behavioral health practitioner on the same day, without distinction for the actual level of integration between the two providers. While we applaud this effort, absent specific statutory authority, BCBSRI does not believe OHIC has the authority to mandate plan design in support of the Affordability Standards.

BCBSRI again notes that any strategy item requiring specific payments should be well supported in terms of the potential return in improved cost and quality, and provide for flexibility to support alternative payment methods including capitation.

3. Support improved and cost-effective specialist services.

BCBSRI shares the concern raised in this element but does not agree with the strategy of requiring insurers to utilize reference pricing. This action could have the unintended effect of driving members to providers outside of Rhode Island where costs may be lower. BCBSRI also notes employer reluctance to adopt reference-based pricing. Rather, BCBSRI would be supportive of activities that build on and strengthen ongoing efforts: cost and quality transparency, Center of Excellence distinctions, and fostering Systems of Care (aka ACOs/AEs) taking on more risk under which they might sub-capitate some specialist services.

4. Create a new requirement for insurers to act to reduce primary care practice administrative burden and reduce burnout.

BCBSRI shares the concern raised in this element but does not agree with the strategy of requiring insurers to reduce the burden and other stressors. BCBSRI undertakes many activities to address affordability and quality – many at the direction of OHIC. Some of these may add administrative work, require investments, and impose additional medical efforts.

While BCBSRI supports the aim of reducing burden and unnecessary administrative costs, this is not a goal that insurers alone can address. BCBSRI recommends that OHIC engage with CTC to lead efforts to identify community-wide activities to address the goal, especially as some of the organization's other efforts are nearing completion.

C. Payment Reform

1. Adopt new APM targets and Risk-Based Contract requirements

BCBSRI supports the adoption of alternative payment methods including for risk-based contracting with downside risk standards.

That said, OHIC establishment of targets for adoption of APMs is no longer as useful as it was in the past, given the markets' acceptance of the need to move away from fee-for-service payments. By setting a model and targets, OHIC is creating a degree of rigidity preventing innovations and flexibility. Most importantly, and contrary to OHIC's policy goal, the target effectively creates a ceiling; providers are unwilling to take on more risk than OHIC's defined minimums.

2. Regarding the aggregate APM target and the Non-FFS APM target, count both shared savings and shared losses equally so that carriers with downside risk arrangements are not penalized for them.

BCBSRI supports this element and the options for better calculating the magnitude of these contracts and compliance towards the targets.

Of the two alternative strategy options, BCBSRI prefers (a), which treats losses, and gains, equally in the calculation. BCBSRI's concern with option (b) is that by referring only to

“prospectively paid” dollars, the calculation would not include payments that are made retrospectively, after validating performance, such as for quality.

3. Add a Primary Care APM requirement

BCBSRI shares the aim raised in this element but does not agree with the strategy of requiring insurers to implement primary care APMs or requiring adoption of an OHIC developed primary care APM. This payment method is complex to administer and requires close collaboration to implement effectively. BCBSRI is working towards PCP capitation, but is concerned the strategy elements suggest too prescriptive an approach. For those reasons, the third strategy detail, to set APM targets for primary care, may be the most workable.

Additionally, a primary care APM target should be calculated in a manner that takes into account any other APM agreed to with a parent provider organization (ACO/SoC) that includes primary care providers. This is especially true as the ACO/SoC takes on the burden of risk and provides administrative resources in the implementation of the APM.

4. Maintain the cap on hospital rate growth.

BCBSRI supports this element and agrees with the first strategy detail: Maintain the rate growth cap. However, BCBSRI does not support the second detail which would modify the cap and diminish the savings potential. More details are provided in element 10 below.

5. Align the ACO Budget Growth Cap with the new cost growth target.

BCBSRI shares the aim of the new cost growth target work but does not agree with adopting alignment efforts and the strategy details at this time.

The current OHIC ACO Budget Growth Cap and Affordability Standards methods appear to be having the intended result and are on a sustainable path in terms of BCBSRI’s contracting initiatives with ACOs. BCBSRI has been collaboratively working with provider organizations to develop ACOs, or Systems of Care (SoCs). The risk contracts are based on the entity’s historical total medical expenditures. The SoCs need to continually improve to capture year-over-year savings and realize the fiscal rewards. BCBSRI’s concern with this element and the strategy to lower the cap or make other adjustments is that moving too far or too fast will result in breaking the current system with negative results – for example the SoC might carve out some spending such as specialty drugs.

Furthermore, BCBSRI’s application of the OHIC ACO Budget Growth Cap to SoC contracts allows funding for investments in infrastructure to achieve improvements in care and ultimately financial savings. Linking the OHIC Cap to the cost growth target is not realistic especially at this early stage.

A second reason for not linking the OHIC Budget Growth Cap with the new Cost Growth Cap is because the Cost Growth Cap *is new*. BCBSRI suggests that at least during this initial period there be some reporting on the likely results of the Budget Growth Cap, applied to expected

utilization, to measure and analyze achievement towards the cost growth target.

6. Assess community behavioral health spending

BCBSRI shares the underlying aim of improving the quality of behavioral health services and including a behavioral health element in the Affordability Standards, but is concerned with the proposed rationale and strategy details.

BCBSRI suggests additional consideration be given to defining the goals and the strategy work of this element. Items for consideration:

- Distinguish strategy efforts aimed at outpatient office settings, intermediate levels of care (partial, intensive outpatient, community based, etc), and inpatient.
- Strategy efforts could incorporate a review of community based spending in relation to hospital based spending. For example, if there is high spend on inpatient care relative to community based spending, then the data and decisions might drive efforts to rebalance this. (Recall the state's studies by Truven reported high spending in RI on inpatient and pharmacy services).
- Strategy efforts should include measurement to assess the impact of greater investments, in terms of objective quality measures, timeliness of access, patient experience and patient informed feedback. This would be critical to ensuring investments are benefiting the health of members.
- Last, these efforts should be inclusive of those to integrate BH and primary care.

These efforts should also be aligned with Medicaid as it is a significant payor for these services and reportedly under-pays for services.

The OHIC-led stakeholder work on primary care may provide a roadmap (as referenced in the strategy detail) but the environment for behavioral healthcare differs. The above items will help to better establish the appropriate efforts to improve the quality and costs of care.

7. Clarify the requirements for hospitals to use units-of-service payments

The Notice does not provide enough detail to allow us to comment. We would welcome the opportunity to better understand the intent and provide feedback.

8. Move the administrative requirements from the Affordability Standards

The Notice does not provide enough detail to allow us to comment. We would welcome the opportunity to better understand the intent and provide feedback.

9. Address disparity in commercial hospital rates (*the hospital rate cap*).

BCBSRI does not support this element. BCBSRI strongly believes this is an inappropriate

approach for the following reasons:

- The hospital rate caps are the most important factor in slowing total commercial health care spending growth, as reported by Health Affairs (link provided in the proposed Standards). The variable application of the caps as proposed in this element would weaken the effect of the Standards and lead to increases in premiums.
- Increasing prices above the established cap would directly conflict with plans' ability to manage spending and achieve the target.
- The variations in hospital reimbursement rates exist for rational reasons. For instance, teaching hospitals may appropriately earn a differential. Furthermore, some entities received cash infusion payments rather than rate increases prior to the adoption of the existing cap. Additionally, some hospitals may have been eligible for quality payments but did not earn the entirety of the payments they were eligible to receive. The proposed Standards should not look at the rate differential without consideration of the entirety of the current and historical situation.
- Strategy details (b) and (c) suggest OHIC would define the quality measures, targets, and add-on amounts to achieve a higher rate cap. This is of significant concern. Plans need to be able to direct specific activity to address NCQA requirements. The variation in payments reflect real quality concerns (i.e., the hospital is not able to retain the payments if the agreed-to quality or other performance metrics are not met). Describing the goal as addressing disparity and the strategy detail as authorizing OHIC to define the quality measures and targets (and presumably payment levels as well) becomes very troubling as it suggests encroachment on a core managerial function. Members' money should be spent on improvements, not just on increased spending to address variations, incomplete evidence, and individual interests.
- The higher payments contemplated by this element would directly and negatively impact members through premiums and cost-sharing and deductibles.

If OHIC continues to believe the disparity is an element to be addressed, then strategy (d) on transparency could be explored. As reporting on price variation by itself may be inflationary, a preferable approach may focus on well-tailored transparency of agreed-upon cost and quality metrics. This should be done in a manner that incents competition and informed consumers, rewarding those hospitals which demonstrate higher quality and offer lower prices.

10. Require insurer acceptance of multi-payer provider-generated quality measurement information in value-based provider contracts when requested by providers.

BCBSRI does not support this element. BCBSRI has historically supported OHIC's efforts to harmonize quality measures, which has benefited providers by simplifying their administrative work, but believes this element is neither required for that effort nor is an appropriate Standard.

This effort to adopt system-wide reporting has been raised in other venues. BCBSRI has been

Cory King
June 7, 2019
Page 8 of 8

and continues to be opposed for a range of reasons. In order to satisfy NCQA, CMS, and HEDIS requirements, BCBSRI must report quality measurement information specific to our members. The statistical validity of the measures BCBSRI uses is sufficient and intentionally set at the SoC level, intending for all the providers within the group to function cohesively and to drive change within the SoC. Furthermore, BCBSRI does not desire to make incentive payments based on statewide information.

Last, BCBSRI believes technology improvements will continue which will make plan-specific reporting simpler for providers as information comes directly from electronic medical records.

As OHIC considers adopting new Standards, we ask that OHIC also undertake a holistic review of all reports submitted by insurers in support of the Standards with a goal of streamlining and reducing reports whenever possible.

In closing, BCBSRI reiterates support for OHIC's Affordability Standard efforts and appreciates the Office's approach to this collecting information and comments prior to the release of draft regulations. We would welcome the opportunity to meet with you to discuss these comments and share further feedback in response to other comments as appropriate.

Thank you for your consideration of these comments.

Sincerely,



Monica A. Neronha
Vice President, Legal Affairs & Policy



May 30, 2018

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

Dear Mr. King:

We appreciate the opportunity to provide our comments on the proposed rulemaking for 230-RICR-20-30-4 (the "Regulation"). 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. Leibman dated January 28, 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 do modify our position and specific language recommended regarding the Hospital Contract Rate Disparity by this letter. We now recommend the following language:

Each acute care hospital, who provides at least 30% of their total available inpatient occupancy in mental health services and has been paid by a Health Insurer at less than 90% of the average commercial payments made to all Rhode Island acute care hospitals in the Health Insurer's provider network, shall receive an increase in payment from such Health Insurer to an amount equal to or exceeding the 90% threshold for the 12-month period beginning October 1, 2019. In order to maintain continued eligibility for the rate floor in the years following the establishment of the floor, such hospitals must meet minimum quality standards established by OHIC in the Regulation.

We have modified our proposal because we have had numerous discussions with state and local officials and other policy and community leaders in which there were concerns expressed

Mr. Cory King
May 30, 2019

Page 2

regarding maintaining the adequacy of inpatient mental health services provided in the acute hospital setting in Rhode Island. Therefore, we heard that concern and now recommend that the 90% rate floor only be applied to those hospitals who maintain the provision of at least 30% of their total available inpatient occupancy in mental health services. In addition, we understand that employers and other payors in the state do not want to pay for even a small increase in the cost of hospital services without being assured that the providers of those services meet reasonable quality standards. Therefore, we have also added to our proposal a provision that to remain eligible for the rate floor, hospitals must meet quality standards established by OHIC.

We have reviewed OHIC's "Potential 2019 Modifications and Supporting Rationale" (Potential Modifications) to the Affordability Standards. We applaud OHIC's commitment to "address disparity in commercial hospital rates" because "the variation in hospital rates will continue to get wider". We are pleased that OHIC has now publicly recognized the hospital rate disparity crisis caused by the implementation of Regulation 2 and that the disparity has gotten worse since 2010 causing those few community hospitals most severely impacted by the current rate cap to discontinue community critical but unprofitable hospital services or be forced to close entirely, as Care New England did recently with Memorial Hospital.

Despite the recognition that the current hospital rate disparity locked in by the Regulation is an immediate and critical problem and that it has gotten worse by the imposition of the rate cap, we are dismayed by the ineffectiveness of the solutions proposed in item #9 of the Potential Modifications document. There are several reasons for our serious concern over the solutions proposed in the Potential Modifications as follow:

1. This is an immediate problem caused by the Regulation enacted nearly a decade ago. The solution needs to be immediate and enacted by the Regulation to correct the problem. The OHIC solution to allow a higher cap for "lower-priced hospitals" is at best a solution that will take years to correct the immediate problem;
2. The higher cap for lower paid hospitals is not a mandatory floor as it must be. It is, at best, a suggestion to the health insurers. The original rate disparity problem was the result of large system hospital negotiations with health insurers based upon their market power in the years leading up to 2010. It is unlikely that the health insurers, based upon their own behavior, will voluntarily agree to the higher cap for the lower paid hospitals. Therefore, unless mandatory, the problem will not likely be corrected at all;
3. The OHIC proposed solution requires the lower paid hospitals to demonstrate higher quality to "earn any available add-on above the standard rate cap". It is not clear what the quality standards will be since they are yet to be developed by OHIC. However, this

Mr. Cory King
May 30, 2019

Page 3

4. again delays a solution that needs to be immediate. While we understand that employers and citizens in Rhode Island should not pay higher prices for health care services that are not of a minimum quality, such a standard should be implemented after the problem is corrected with a rate floor such as we have proposed and with the requirement that eligible hospitals meet minimum quality standards as developed by OHIC to be eligible for the rate floor in subsequent years;
5. We agree that there should be annual reports on hospital price variation so that employers and citizens of Rhode Island can understand which hospitals they can use to reduce their healthcare costs. However, if OHIC does not take immediate action, there will be fewer lower cost alternatives for healthcare consumers to choose in the market. In fact, the solution we proposed at 90% of the average will raise healthcare costs an infinitesimal amount immediately and guarantee that the Rhode Island market has lower cost alternatives from which to choose. Further, the entire increase in cost in our proposal could easily be offset by rate transparency, health insurer and employer benefit design and consumer choice of the lower cost hospital alternatives. In fact, the summary of a recent report by the RAND Corporation concludes by saying: "Employers can also use network and benefit design to move patient volume away from high-priced, low value hospitals and health systems. Employers can encourage expanded price transparency by participating in state-based All-Payer Claims Databases...But transparency by itself is likely insufficient, and employers may need state or federal policy interventions to rebalance negotiating leverage between hospitals and employer health plans." ¹

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.

While the imposition of the rate limit in 2010 has protected the health insurers from the stronger bargaining positions of the larger hospital systems, it has also prohibited some community

¹ White, Capin and Christopher Whaley, *Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely: Findings from an Employer-Led Transparency Initiative*, Santa Monica, Calif: RAND Corporation, Research Report, May 2019.

Mr. Cory King
May 30, 2019

Page 4

hospitals from realizing anything close to sustainable commercial rates. Rather, CharterCARE and other community hospitals have seen increasingly challenging payor mixes with most of their patients being covered by Medicare or Medicaid – at rates that historically fail to cover the total cost of providing services. The long-term impact of the annual rate increase limit is manifest in the receiverships of two community hospitals and the closure of another will likely lead to similar outcomes if not corrected.

With this set of circumstances, CharterCARE is already contributing to limiting health care cost growth for any commercial patients that come to our hospitals by being the lowest paid hospitals in Rhode Island. However, CharterCARE will not be able to continue to provide the leadership in innovation and lower cost solutions we have already demonstrated without immediate relief from the significant and widening rate disparity with other hospitals caused by the rate cap. Therefore, we strongly urge OHIC to implement the solution we have proposed to institute a very reasonable rate floor to solve the immediate rate disparity problem, while maintaining the current hospital rate cap to restrain hospital cost increases in the future.

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

Sincerely,



Jeff H. Liebman

Chief Executive Officer

cc: Steve O'Dell, Prospect/CharterCARE

Principles

- Simplicity
- Evidence supported
- Plans can comply
- Enforceable
- Align with Medicare nationally
- Either align with or can be adopted by RI Medicaid

A. Primary Care Investment

1. Continue requiring insurers to meet a primary care spending target.

Rationale:

- According to the most recent evaluation of the Affordability Standards, stakeholders believe that the required investments towards primary care have been extremely important and have created a platform for primary care practice transformation.
- In 2017, RI insurers spent between 9.0% and 12.8% (for an average of 11.5%) of total spend on primary care¹, above the required level of 10.7%
- The Milbank-funded primary care spend study (2017) did not reveal a consistent level of primary care spend as a percentage of total spend among high-quality health plans.

Strategy Detail:

Modify the primary care spend standard to 11.0%, less the effect of removing indirect primary care spending (see Option #3 below

Comments

- Support in general. Not sure of effect of option three.

2. Re-examine and more tightly define what constitutes primary care spending, and consider definitions being adopted in other states to promote comparisons across states.

Rationale:

- _Oregon now has a primary care spend standard², and Delaware may be in the process of developing one.

Strategy Detail:

- a. Define primary care spending within regulations or a new integrated policy manual, and not through guidance letters issued by OHIC.
- b. Utilize a more technical definition that specifically includes and excludes certain categories of spending.

- c. Investigate aligning definitions with Oregon (except for the PCP definition³) to allow for cross-state comparison.
-

Comments – do not support. Should not be in regulation. Not a standard to be imposed on health plan. If OHIC wants to take on this activity, it may. (not sure it is needed)

3. Eliminate the requirement to limit indirect primary care spending to <1% and require insurer support for CTC-RI administrative infrastructure and CurrentCare elsewhere in OHIC regulation.

Rationale:

- This does not constitute true spending on primary care. Elimination of this requirement would streamline reporting.

Strategy Detail: N/A

Comment – disagree. There are common-good elements like HIE that improve affordability and benefit primary care.. They should be included in affordability standards. Keeping them in in Primary Care definition has administrative advantages because it reduces chances of OHIC being an arbiter of the precise funding number and putting that regulation – instead Plans (and physician representatives) negotiate directly with the common good provider,

B. Care Management

1. Remove the current PCMH target, but require continued insurer financial support of OHIC-recognized PCMHs.

Rationale:

Rhode Island has made great strides in primary care transformation. Those practices should continue to receive support, but there are a limited number of viable remaining practice candidates for transformation.

Strategy

Detail:

- a. Eliminate the care transformation requirement as currently written, which focuses on primary care practices functioning as PCMHs.
- b. Require that practices that meet OHIC's PCMH definition continue to receive financial support, e.g., as specified in the Commissioner's 2019 Care Transformation Plan.

Comment – no position. If no in law already, I would also suggest insurers be required to ask all enrollees – regardless of benefit plan - at the time of enrollment who their pcp is, using standard language as provided by OHIC and to record it in their health plan database. This can used as a basis for attribution (and member education) until claims

indicate otherwise.

2. Facilitate improved integration of primary care and behavioral health services.

Rationale:

- Stakeholders placed priority emphasis on this topic during the fall 2018 Care Transformation Advisory Group meetings.
- Medicaid requested an OHIC requirement for insurer payment support for integrated care and SDOH work on 2-8-19.
- Brown's CTC RI BHI pilot evaluation yielded promising results.⁴ Other research estimates that a reduction of between 5-10% of total health care costs over a period of 2-4 years for patients receiving collaborative care, though there is wide variability in study findings and quality of studies.⁵

Strategy Options:

Options to be developed by OHIC's Integrated Behavioral Health Work Group by June 2019, but could include:

- a. elimination two co-pays for same-day primary care and behavioral health services provided in the same location;
- b. requiring the reimbursement of Collaborative Care codes, or other codes that are paid for by Medicare and/or Medicaid (to be fully defined by the IBH Work Group, but might also include health and behavior assessments, screening, warm hand-offs, etc.), and
- c. credentialing requirements that support providers practicing in an integrated environment (to be fully developed by the IBH Work Group).

An additional option includes:

- d. defining the foundational elements of an integrated behavioral health practice and requiring insurers to financially support practices that achieve the foundational elements for non-reimbursed costs supportive of integrated care, e.g., warm hand-offs, health behavior groups. OHIC could look to the PCMH PRIME Certification program developed by NCQA for Massachusetts as a starting point for practice expectations.⁶

Comment – agree affordability standards should facilitate IBH. RI has severe deficiencies in BH status. What's model for doing so? If this amounts to an expanded definition of comprehensive primary care – that was originally promoted with practice (PCMH) standards, health plan money for TA and support and multipayer table, can OHIC expand that definition to include IBH? This could tie with an explicit focus of CTC-RI?

3. Support improved and cost-effective specialist services.

Rationale: Many specialists are independent and have been unaffected by OHIC's Affordability Standards.

Strategy Detail:
a. Require insurers to utilize reference pricing for selected high volume and high cost specialist services, (e.g., joint replacement surgery, diagnostic services).⁷

Comment – seems like more study is needed. This is not a very detailed proposal and may not be ripe for OHIC regulation

4. Create a new requirement for insurers to act to reduce primary care practice administrative burden and reduce burnout.

Rationale: Primary care burnout is stressing the availability of primary care providers, decreasing quality of patient care and may increase medical errors. While unintended, rapid transformation, like which occurs in practices undergoing transition to PCMH, may contribute to primary care burnout.⁸

Strategy Detail:
a. Require insurers to act independently and collectively to reduce primary care practice administrative burden and other stressors on the quality of work. Require reports to OHIC and presentation in a public forum annually on insurer efforts.

Comment – this does not directly effect affordability. If OHIC wants to do it – do it but not in regulation.

C. Payment Reform

1. Adopt new APM targets and Risk-Based Contract requirements

Rationale:
• OHIC should ensure a minimum percent of payments are dedicated to APMs. The current percentage target is 50%.
The target values need updating, as they don't run past 2019
• Risk-based contracting is an important tool driving provider performance on cost and quality.

Strategy Detail:
• Set an APM adoption floor requirement that insurers must meet.
• Articulate risk-based contracting targets and

minimum downside risk standards that increase over time.

2. Regarding the aggregate APM target and the Non-FFS APM target, count both shared savings and shared losses equally so that carriers with downside risk arrangements are not penalized for them.

Rationale: Insurers are concerned that shared losses incurred by providers in risk-based models are not considered medical payments, therefore penalizing health plans that would have met the target if those providers had earned shared savings payments. (OHIC does remove these losses from the denominator in the APM spending calculation, however.)

Strategy Options:

- a. When codifying this language in the Affordability Standards, clarify a method for health plans to include shared losses within their expected non-fee-for-service target.
- b. Alternatively, clarify that medical payments refers only to those dollars which are prospectively paid, as this non-FFS APM target is meant to encourage the amount of prospectively paid payments. While this would be a harder requirement for health plans to meet, it is truer to the initial intent. Also, making performance of an ACO against a shared savings or risk arrangement impact compliance creates a perverse incentive for insurers to set shared savings or risk targets that are too high or too low.

Comments on one and two. The national evidence is clear that primary care/physician governed ACO's do better, How can OHIC facilitate that?

- *Define physician-governed ACO and advantage them in regulation (or define the apm target using this definition)*
- *Mimic CMMI and hasten move to two sided risk*
- *Require the health plan to document non ffs payments in ACO's so as to ensure ACO funds benefit primary care,*

3. Add a Primary Care APM requirement.

Rationale:

- A primary care APM can support clinical activities and functions that are indicative of well-functioning primary care practices, including care coordination, interdisciplinary-team based care, support for patient self-management and ongoing communication. It can also reduce the stress and burden created by a fee-for-service office visit volume incentive.
- Movement toward primary care APM in RI has been slow and some payers have been resistant to multi-payer and

provider collaboration.

Strategy Detail:

- a. Require insurer implementation of primary care APMs for their contracted network providers.
- b. Require adoption of an OHIC developed primary care APM.
- c. Set APM and Non-FFS APM targets specifically for primary care.

Comment: I think OHIC should facilitate alignment of commercial payers with CMMI and Medicare strategy for primary care. Have a track like CPC+ track one and a track like primary care first. Allow those practices to participate in ACO's and have their performance payments come before ACO payments. Allow FFS payment levels to shrink or not increase greatly.

4. Maintain the cap on hospital rate growth.

Rationale: Based on the 2018 Affordability Standards evaluation and the *Health Affairs* study by Baum et al.⁹, the hospital rate limits were mostly responsible for observed cost trend decreases and therefore the requirement should be maintained, if not made more aggressive, for hospital contracts.

Strategy Detail:

- a. Maintain the rate growth cap.
- b. Option #10 below proposes a modification to address rate disparities between hospitals in a way that encourages improved quality of care and value for consumers.

Comments – support option A. It is working.

5. Align the ACO Budget Growth Cap with the new Cost Growth Target.

Rationale: The OHIC ACO budget growth cap and the new Cost Growth Target are both focused on annual change in total cost of care growth, the difference being the ACO cap, based on the Consumer Price Index, is on commercial contractual cost targets and the new Cost Growth Target is focused on actual cost growth at state, insurance market, insurer and large provider levels.

Strategy Detail:

- a. Change the ACO budget growth cap to equal prospective Gross State Product (PGSP) with an add-on, with a multi-year transition to lower the current cap from its current level.
- b. Address possible adjustment for ACOs with comparatively low risk-adjusted PMPM spending.

Comment – support alignment with cost growth target

6. Assess community behavioral health spending

Rationale: OHIC has received stakeholder feedback that there are gaps in the community with respect to behavioral health services.

Strategy Detail:

- a. Assess baseline spending for community behavioral health services, much as OHIC previously did for primary care.
- b. Direct insurers to make investments if upon further quantitative and qualitative analysis the Commissioner finds it to be necessary.

Comment – A study is not a standard. Should not be included in Regs.

7. Clarify the requirement for hospitals to use units-of-service payments.

Rationale: Units-of-service payments are not used in all inpatient and outpatient cases (e.g., inpatient psychiatry, emergency department).

Strategy Detail: N/A

8. Move the administrative requirements from the Affordability Standards.

Rationale: The hospital contract administrative requirements may be important but are not a key focus of the Affordability Standards.

Strategy Detail:

- a. Move administrative simplification requirements outside of the Affordability Standards and to the administrative simplification requirements section of Part 4.

Comments – neutral

9. Address disparity in commercial hospital rates.

Rationale: As the hospital rate caps continue, the variation in hospital rates will continue to get wider in that the highest

reimbursed hospitals will continue see higher rate increases than the lowest reimbursed hospitals in absolute dollar terms. This has been a concern of some community hospitals in Rhode Island.

Strategy Detail:

- a. Variable application of rate growth caps, e.g., standard caps for “higher-priced hospitals”, and earnable higher caps for “lower-priced hospitals” _vis a vis the state median.
- b. Tie the rate cap differential to quality performance, such that “lower-priced” _hospitals must earn any available add-on above the standard rate cap.
- c. OHIC shall define the quality measures and targets necessary to realize the higher rate cap.
- d. Publish annual reports on hospital price variation to increase attention to the topic.

Comment – This seems complex to administer, with no clear standards for judgment. I suggest instead that OHIC and Department Health continue to document the performance of hospitals on selected quality measures and their commercial payment rates relative to Medicare to better understand the connection (or lack thereof) among them.

10. Require insurer acceptance of multi-payer provider-generated quality measurement information in value-based provider contracts when requested by providers.

Rationale: Providers incur additional costs when they are required to generate separate payer-specific quality measurement data for commonly used measures. These costs do not add value, decrease the statistical strength of the measurements due to reduced denominator size, and don't recognize that clinicians do not deliver care differently based on a patient's insurer.

Strategy Detail:

- a. For those ACOs and providers that wish to use an aggregated calculation of performance across all commercial (insurer and self-insured) patients for performance measures used in ACO and provider contracts and which rely upon clinical data for their calculation, the insurer is obligated to accept those measurements.
- b. Insurers may elect to impose reasonable audit requirements upon the ACO or provider to ensure validity of reported data.

Comment – support strongly in principle the role of government in aligning quality measures across payers and providers. Alignment brings focus and improvement.



ADVANCING INTEGRATED HEALTHCARE

Date May 31, 2019

Cory King
Office of the Health Insurance Commissioner
1511 Pontiac Ave.
Building 691
Cranston, RI 02920
cory.king@ohic.ri.gov

Dear Cory,

Thank you for the opportunity 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 welcome the opportunity to work with you on the proposed draft OHIC regulations. Outlined below are recommendations from the Care Transformation Collaborative of Rhode Island (CTC-RI) for your consideration:

1. Primary Care Investment: Continue requiring insurers to meet a primary care spending target.
Recommendation: Primary Care Spend Definition: We would need to see the details and guidance in the proposed definition of primary care spend. Proposed change identified in # 2 states as the proposed plan "to re-examine and more tightly define what constitutes primary care spending and consider definition being adopted in other states to promote comparison with other states" The document does not delineate the specifics of the new primary care spend definition.
Indirect Primary Care Spend: Eliminate the requirement to limit indirect primary care spending to <1% and require insurer support for CTC-RI administrative infrastructure and CurrentCare elsewhere in OHIC regulation.
Recommendation: We would need to see the details of the language for covering CTC-RI administrative infrastructure and where that language is located in the regulations. Additionally, Health Plans currently provide funding to CTC-RI and PCMH Kids for special projects when they anticipate being under spend in primary care spend (i.e. training program for nurse care managers). Would special project transformation funding be considered as direct or indirect spend? Will health plans still be able to make project specific contributions to CTC and have it count toward their primary care spend?
2. Care Transformation:
Improved integration of primary care and behavioral health services:
Recommendations: Expand multi-payer strategy options to more clearly commit to rapid, early adoption of integrated behavioral health in a capitation model; In the absence of a capitated model, other strategies to consider include:

ADVANCING INTEGRATED HEALTHCARE

- 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 teleBH pilots for high –need patient populations with the aim of 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.
 - Licensed Clinical Social Workers:
Standardize the option of using licensed clinical social workers (LCSW) across all payers. Presently Managed Medicaid allows LCSW to provide services that are billed under LICSW’s. 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 would be very helpful, particularly given the challenges associated with hiring behavioral health clinicians, especially in primary care practices that require clinical staff that speak languages other than English.
 - LICSW supervision requirements: Standardize and make available: CTC requested health plan documents that clearly define the supervision requirements related to LCSW and have not yet received them.
 - Coding and billing for behavioral health services: Simplify and standardize coding and billing for behavioral health services across all payers (Commercial and Managed Medicaid) and age groups (pediatric and adult) including BH care coordination, health and behavioral assessment, screening for substance use.
 - 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 Move 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.
- Multi-payer Support for Pharmacy Services: Rhode Island in many ways has been a leader in expanding the public health scope of the pharmacy in providing immunizations. Blue Cross and Blue Shield of Rhode Island provides selected systems of care with financial support for medication therapy management for the BCBSRI patients and demonstrated significant cost savings. These strategies have great potential for improving quality and reducing costs,

ADVANCING INTEGRATED HEALTHCARE

particularly if they were expanded as a multi-payer efforts that additionally included recognition of the pharmacist as an independent provider especially in meeting important public health needs.

3. Support improved and cost-effective specialist strategies

Recommendations: Expand strategies to consider how to improve quality outcomes by setting standards with accountability for high value care coordination and communication. Primary care providers presently spend considerable time tracking down specialist test results in areas such as eye exams for patients that have diabetes, in obtaining colonoscopy results. Other areas of consideration could be to hold both primary care and specialist providers accountable for closing the referral loop. Analysis of low value care findings could provide additional direction for strategy opportunities.

Women's Health Initiative: Vermont, as an 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. Reduce Administrative burden:

Recommendation: Consider strategies that would benefit primary care and patients such as investment in IT functionality for Surescripts that would provide formulary and price information at the point of prescribing.

5. Assess community behavioral health spend:

Recommendations: Expand strategy to include financial support for community health teams that 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.

6. Other considerations:

Measuring, monitoring and improving Customer Experience: Primary care practices that participate in the Care Transformation Collaborative 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.

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.



ADVANCING INTEGRATED HEALTHCARE

All Payer Claims Data Base Investments: On point 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.

The Care Transformation Collaborative of Rhode Island 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 RN Executive Director

Pano Yeracaris MD MPH

Susanne Campbell Senior Project Director



M. Teresa Paiva Weed
President

June 6, 2019

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

Re: Advanced Notice of Proposed Rulemaking

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 which OHIC has received however, in the absence of complete proposals from stakeholders, reserves the opportunity to participate in the regulatory process as well.

The Advanced Notice proposes maintaining the current rate cap on hospitals. On December 19, 2018, a “Compact to Reduce the Growth in Health Care Costs and State Spending in Rhode Island” was signed by the members of the Rhode Island Health Care Costs Steering Committee. The compact established a cost growth target of 3.2% based on Rhode Island’s potential Growth State Product. Yet, it is an “aspirational target.” This is substantially different from the firm cap on hospitals.

During that process it became clear that pharmaceutical expenses are a major driver of increasing medical expense. According to NORC at the University of Chicago, average total drug spending per hospital admission in the U.S. increased 18.5% between FY15 and FY17. The Advanced Notice does not address or consider those increased costs or give consideration to the impact of these increased costs on hospitals. Hospitals are the only providers which serve every Rhode Islander regardless of whether or not they have insurance. They are competing with neighboring states which have higher rates of reimbursement as well as outpatient specialty providers who do not provide care for our most vulnerable populations.

The overall operating margin for hospitals in our state is negative.

Since the regulations were promulgated, we have seen the closure of Memorial Hospital. CMS eliminated the Imputed Rural Floor in the Medicare 2019 IPPS Final Rule which reduced Rhode Island Wage Index 9.8%. The Medicare 2020 IPPS Proposed Rule results in an increase in Rhode Island of 2.3% versus a 3.1% National Average. HARI has attached hereto a map that demonstrates the regional Wage Index for 2019.

Hospitals are being asked to invest in community partnerships to address the social determinants of health, yet the current structure provides no recognition of those community investments.



M. Teresa Paiva Weed
President

As OHIC considers future investments, HARI would urge consideration for both community investments and workforce development.

HARI and its members are eager to continue to work with OHIC to transform health care, but need to ensure we are aligning initiatives, investing in our delivery system, and addressing all areas impacting medical expense trend. If we want to achieve true delivery system reform, job growth and maintain the economic impact of hospitals, then we must invest in hospitals. Hospitals need the infrastructure to transform the delivery and payment system built around collaboration and innovation.

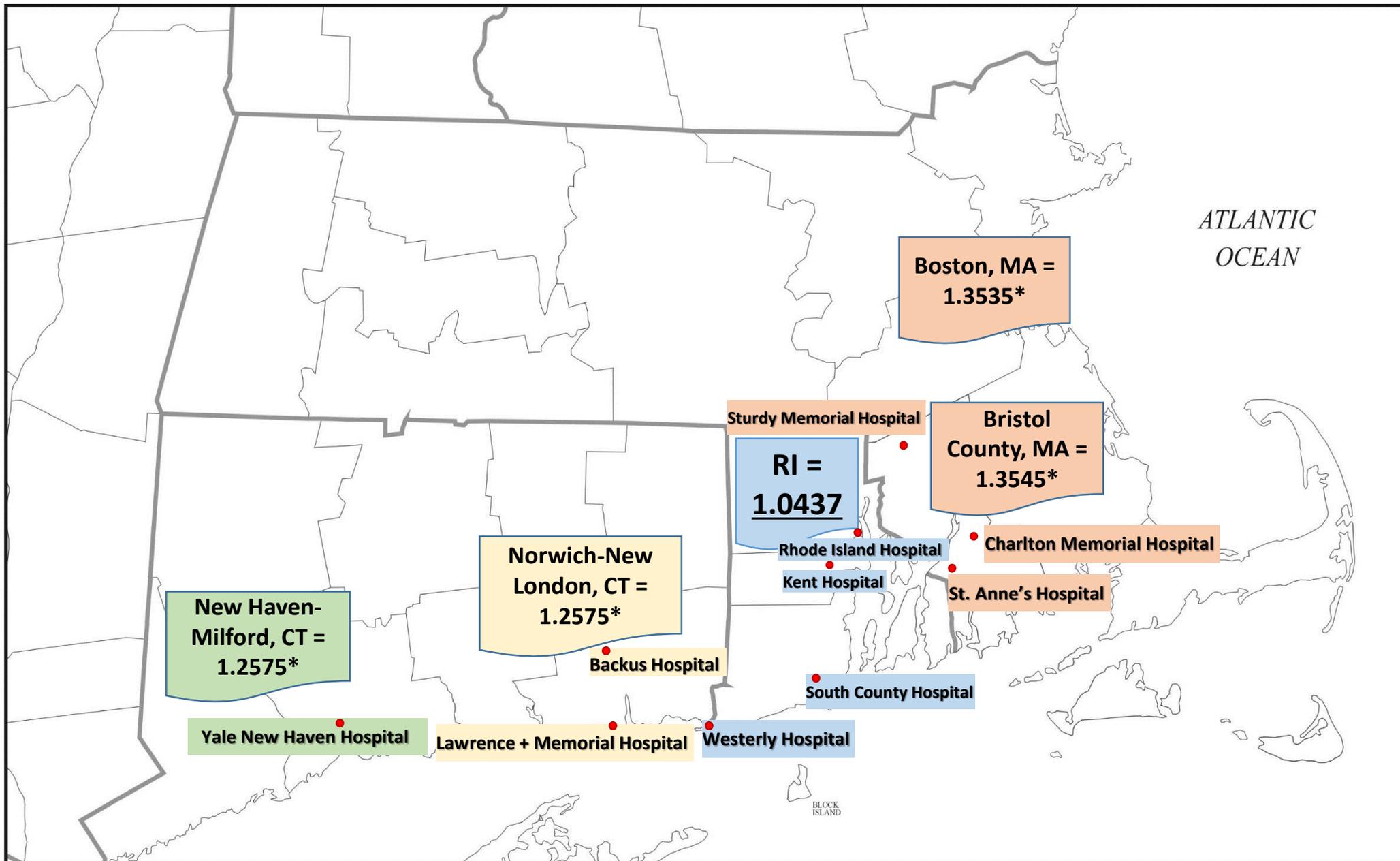
Sincerely,

A handwritten signature in black ink that reads "M. Teresa Paiva Weed".

M. Teresa Paiva Weed
President

WAGE INDEX DISPARITIES BETWEEN RHODE ISLAND AND SURROUNDING AREAS

Selected hospitals shown. Asterisks indicate wage index values that have been adjusted upward based on the state's "rural floor."



OHIC Affordability Standards: Potential 2019 Modifications and Supporting Rationale

Imbedded comments from Michael Lichtenstein, President/CEO of Integrated Healthcare Partners - May 31, 2019

Thank you for the opportunity to weigh in on the priorities for the consideration by OHIC. I have identified brief comments below the sections on which I wanted to comment. I have included a lengthier comment related to licensing and credentialing of providers at the end of this document.

In 2019 OHIC intends to revise the Affordability Standards, Part 4.10 of 230-RICR-20-30, to continue to improve the affordability of health care in Rhode Island through enhanced, modified and clarified standards. The purpose of this document is to inform stakeholders regarding options under consideration by OHIC, and to invite stakeholder reaction. The potential modifications identified herein were gathered during OHIC stakeholder meetings in late 2018 and early 2019 and were also identified through Affordability Standards evaluation activity.

OHIC considered many additional stakeholder recommendations made over the past several months. This document contains only those that remain under serious consideration by OHIC. Interested parties are invited to propose alternative ideas for consideration by OHIC.

Each potential modification is presented below with a brief supporting rationale and some additional detail. This document organizes modification options in the following order:

- A. Primary Investment
- B. Care Transformation
- C. Payment Reform

A. Primary Care Investment

1. Continue requiring insurers to meet a primary care spending target.

Rationale:

- According to the most recent evaluation of the Affordability Standards, stakeholders believe that the required investments towards primary care have been extremely important and have created a platform for primary care practice transformation.
- In 2017, RI insurers spent between 9.0% and 12.8% (for an average of 11.5%) of total spend on primary care¹, above the required level of 10.7%
- The Milbank-funded primary care spend study (2017) did not reveal a consistent level of primary care spend as a percentage of total spend among high-quality health plans.

Strategy Detail:

Modify the primary care spend standard to 11.0%, less the effect of removing indirect primary care spending (see Option #3 below).

¹ Marie Ganim. Presentation to the Delaware Health Care Commission. October 10, 2018.

2. Re-examine and more tightly define what constitutes primary care spending, and consider definitions being adopted in other states to promote comparisons across states.

Rationale:	<ul style="list-style-type: none"> Oregon now has a primary care spend standard², and Delaware may be in the process of developing one.
Strategy Detail:	<ol style="list-style-type: none"> Define primary care spending within regulations or a new integrated policy manual, and not through guidance letters issued by OHIC. Utilize a more technical definition that specifically includes and excludes certain categories of spending. Investigate aligning definitions with Oregon (except for the PCP definition³) to allow for cross-state comparison.

Comments: The definition is critical. We need to be sure we don't wrap BH (both MH and SUD in this definition) It is critical to determine a reasonable methodology to establish a required level of spending on BH services by insurers.

3. Eliminate the requirement to limit indirect primary care spending to <1% and require insurer support for CTC-RI administrative infrastructure and CurrentCare elsewhere in OHIC regulation.

Rationale:	<ul style="list-style-type: none"> This does not constitute true spending on primary care. Elimination of this requirement would streamline reporting.
Strategy Detail:	N/A

² SB 934 requires health insurance carriers and Medicaid Coordinated Care Organizations to allocate at least 12 percent of their health care expenditures to primary care, by 2023.

³ Oregon includes categorizes psychiatrists and OB/GYNs as primary care providers. It has produced analyses with those providers excluded,

however. For detailed information on Oregon’s methodology and performance data, see www.oregon.gov/oha/HPA/ANALYTICS/Documents/SB-231-Report-2019.pdf.

B. Care Transformation

1. Remove the current PCMH target, but require continued insurer financial support of OHIC-recognized PCMHs.

Rationale:	Rhode Island has made great strides in primary care transformation. Those practices should continue to receive support, but there are a limited number of viable remaining practice candidates for transformation.
Strategy Detail:	<ul style="list-style-type: none"> a. Eliminate the care transformation requirement as currently written, which focuses on primary care practices functioning as PCMHs. b. Require that practices that meet OHIC’s PCMH definition continue to receive financial support, e.g., as specified in the Commissioner’s 2019 Care Transformation Plan.

2. Facilitate improved integration of primary care and behavioral health services.

Rationale:	<ul style="list-style-type: none"> • Stakeholders placed priority emphasis on this topic during the fall 2018 Care Transformation Advisory Group meetings. • Medicaid requested an OHIC requirement for insurer payment support for integrated care and SDOH work on 2-8-19. • Brown’s CTC-RI BHI pilot evaluation yielded promising results.⁴ Other research estimates that a reduction of between 5-10% of total health care costs over a period of 2-4 years for patients receiving collaborative care, though there is wide variability in study findings and quality of studies.⁵
Strategy Options:	Options to be developed by OHIC’s Integrated Behavioral Health Work Group by June 2019, but could include: <ul style="list-style-type: none"> a. elimination two co-pays for same-day primary care and behavioral health services provided in the same location;

⁴ Brown M. and Coleman RE. CTC-RI Integrated Behavioral Health Pilot Program Full Evaluation Final Report. August 29, 2018.

⁵ Melek S et al. “Potential economic impact of integrated medical-behavioral healthcare.” Milliman Research Report. January 2018. See www.milliman.com/uploadedFiles/insight/2018/Potential-Economic-Impact-Integrated-Healthcare.pdf

- b. requiring the reimbursement of Collaborative Care codes, or other codes that are paid for by Medicare and/or Medicaid (to be fully defined by the IBH Work Group, but might also include health and behavior assessments, screening, warm hand-offs, etc.), and
- c. credentialing requirements that support providers practicing in an integrated environment (to be fully developed by the IBH Work Group).

An additional option includes:

- d. defining the foundational elements of an integrated behavioral health practice and requiring insurers to financially support practices that achieve the foundational elements for non-reimbursed costs supportive of integrated care, e.g., warm hand-offs, health behavior groups. OHIC could look to the PCMH PRIME Certification program developed by NCQA for Massachusetts as a starting point for practice expectations.⁶

Comment: Excellent set of recommendations. In addition to the elimination of two co-pays, we need to better address parity and the higher co-pays for BH related services.

⁶ See www.mass.gov/service-details/the-hpc-patient-centered-medical-home-pcmh-certification-program.

3. Support improved and cost-effective specialist services.

Rationale:	Many specialists are independent and have been unaffected by OHIC's Affordability Standards.
Strategy Detail:	a. Require insurers to utilize reference pricing for selected high volume and high cost specialist services, (e.g., joint replacement surgery, diagnostic services). ⁷

4. Create a new requirement for insurers to act to reduce primary care practice administrative burden and reduce burnout.

Rationale:	Primary care burnout is stressing the availability of primary care providers, decreasing quality of patient care and may increase medical errors. While unintended, rapid transformation, like which occurs in practices undergoing transition to PCMH, may contribute to primary care burnout. ⁸
Strategy Detail:	a. Require insurers to act independently and collectively to reduce primary care practice administrative burden and other stressors on the quality of work. Require reports to OHIC and presentation in a public forum annually on insurer efforts.

⁷ Reference pricing high cost, high volume, non-emergency services has shown to be cost effective. Robinson, J et al. University of California, Berkeley. <https://bcht.berkeley.edu/sites/default/files/Reference-Pricing-Cost-Control.pdf>

⁸ See www.aafp.org/news/focus-on-physician-well-being/20180131burnoutstudy.html.

C. Payment Reform

1. Adopt new APM targets and Risk-Based Contract requirements

Rationale:	<ul style="list-style-type: none">• OHIC should ensure a minimum percent of payments are dedicated to APMs. The current percentage target is 50%.• The target values need updating, as they don't run past 2019.• Risk-based contracting is an important tool driving provider performance on cost and quality.
Strategy Detail:	<ol style="list-style-type: none">a. Set an APM adoption floor requirement that insurers must meet.b. Articulate risk-based contracting targets and minimum downside risk standards that increase over time.

2. Regarding the aggregate APM target and the Non-FFS APM target, count both shared savings and shared losses equally so that carriers with downside risk arrangements are not penalized for them.

Rationale:	Insurers are concerned that shared losses incurred by providers in risk-based models are not considered medical payments, therefore penalizing health plans that would have met the target if those providers had earned shared savings payments. (OHIC does remove these losses from the denominator in the APM spending calculation, however.)
Strategy Options:	<ol style="list-style-type: none">a. When codifying this language in the Affordability Standards, clarify a method for health plans to include shared losses within their expected non-fee-for-service target.b. Alternatively, clarify that medical payments refers only to those dollars which are prospectively paid, as this non-FFS APM target is meant to encourage the amount of prospectively paid payments. While this would be a harder requirement for health plans to meet, it is truer to the initial intent. Also, making performance of an ACO against a shared savings or risk arrangement impact compliance creates a perverse incentive for insurers to set shared savings or risk targets that are too high or too low.

3. Add a Primary Care APM requirement.

Rationale:	<ul style="list-style-type: none">• A primary care APM can support clinical activities and functions that are indicative of well-functioning primary care practices, including care coordination, interdisciplinary-team based care, support for patient self- management and ongoing communication. It can also reduce the stress and burden created by a fee-for-service office visit volume incentive.• Movement toward primary care APM in RI has been slow and some payers have been resistant to multi-payer and provider collaboration.
Strategy Detail:	<ol style="list-style-type: none">a. Require insurer implementation of primary care APMs for their contracted network providers.b. Require adoption of an OHIC developed primary care APM.c. Set APM and Non-FFS APM targets specifically for primary care.

4. Maintain the cap on hospital rate growth.

Rationale:	Based on the 2018 Affordability Standards evaluation and the <i>Health Affairs</i> study by Baum et al. ⁹ , the hospital rate limits were mostly responsible for observed cost trend decreases and therefore the requirement should be maintained, if not made more aggressive, for hospital contracts.
Strategy Detail:	<ol style="list-style-type: none">a. Maintain the rate growth cap.b. Option #10 below proposes a modification to address rate disparities between hospitals in a way that encourages improved quality of care and value for consumers.

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>

5. Align the ACO Budget Growth Cap with the new Cost Growth Target.

Rationale:	The OHIC ACO budget growth cap and the new Cost Growth Target are both focused on annual change in total cost of care growth, the difference being the ACO cap, based on the Consumer Price Index, is on commercial contractual cost targets and the new Cost Growth Target is focused on actual cost growth at state, insurance market, insurer and large provider levels.
Strategy Detail:	<ol style="list-style-type: none">a. Change the ACO budget growth cap to equal prospective Gross State Product (PGSP) with an add-on, with a multi-year transition to lower the current cap from its current level.b. Address possible adjustment for ACOs with comparatively low risk-adjusted PMPM spending.

6. Assess community behavioral health spending

Rationale:	OHIC has received stakeholder feedback that there are gaps in the community with respect to behavioral health services.
Strategy Detail:	<ul style="list-style-type: none">a. Assess baseline spending for community behavioral health services, much as OHIC previously did for primary care.b. Direct insurers to make investments if upon further quantitative and qualitative analysis the Commissioner finds it to be necessary.

7. Clarify the requirement for hospitals to use units-of-service payments.

Rationale:	Units-of-service payments are not used in all inpatient and outpatient cases (e.g., inpatient psychiatry, emergency department).
Strategy Detail:	N/A

8. Move the administrative requirements from the Affordability Standards.

Rationale:	The hospital contract administrative requirements may be important but are not a key focus of the Affordability Standards.
Strategy Detail:	<ul style="list-style-type: none">a. Move administrative simplification requirements outside of the Affordability Standards and to the administrative simplification requirements section of Part 4.

9. Address disparity in commercial hospital rates.

Rationale:	As the hospital rate caps continue, the variation in hospital rates will continue to get wider in that the highest reimbursed hospitals will continue see higher rate increases than the lowest reimbursed hospitals in absolute dollar terms. This has been a concern of some community hospitals in Rhode Island.
Strategy Detail:	<ol style="list-style-type: none">a. Variable application of rate growth caps, e.g., standard caps for “higher-priced hospitals”, and earnable higher caps for “lower-priced hospitals” vis a vis the state median.b. Tie the rate cap differential to quality performance, such that “lower-priced” hospitals must earn any available add-on above the standard rate cap.c. OHIC shall define the quality measures and targets necessary to realize the higher rate cap.d. Publish annual reports on hospital price variation to increase attention to the topic.

10. Require insurer acceptance of multi-payer provider-generated quality measurement information in value-based provider contracts when requested by providers.

Rationale:	Providers incur additional costs when they are required to generate separate payer-specific quality measurement data for commonly used measures. These costs do not add value, decrease the statistical strength of the measurements due to reduced denominator size, and don't recognize that clinicians do not deliver care differently based on a patient's insurer
Strategy Detail:	<ul style="list-style-type: none">a. For those ACOs and providers that wish to use an aggregated calculation of performance across all commercial (insurer and self-insured) patients for performance measures used in ACO and provider contracts and which rely upon clinical data for their calculation, the insurer is obligated to accept those measurements.b. Insurers may elect to impose reasonable audit requirements upon the ACO or provider to ensure validity of reported data.

Comment: The goal to reduce administrative burdens is laudable. One area for consideration is in provider licensing and credentialing. This includes and goes beyond MD and DO level licensing and credentialing. All disciplines that result in payment by an insurer require significant paperwork, staff time, and processing of data. Each time a provider moves to another practice, they are required to go through an extensive credentialing process, after what might have been a long licensing process. Depending on the state of prior practice, education and prior licensure, there may or may not be state to state reciprocity. Some insurers will say they have an expedited process for a provider previously credentialed with them that adds a practice or moves to another practice. The RIDOH has been working to expedite the licensure process with some success.

In many fields, there are shortages in qualified providers, and this is especially true in behavioral health. Some clinicians work in more than one clinical setting. If Clinician A works for Practice X and s/he may go through a 3-month credentialing process before the clinician can treat a patient and before the practice can bill for the service. Even if Clinician A is duly licensed and credentialed, if they work part time for Practice X and want to treat patients in Practice Y, they have to go through another lengthy process (sometimes taking months) to complete the credentialing process with their new practice, even with the same panel of insurers. The administrative cost is significant. If we look at all practices and all disciplines and all insurers in RI, the administrative and cost burden is quite significant.

Now imagine the delay in access to care for patients who are seeking services if they must wait for the licensing and credentialing process to conclude satisfactorily. For those who can not gain access to care at an outpatient practice due to a lack of licensed and credentialed

providers, they may wait and be OK. Many can not wait, and they will seek care and treatment at an urgent care or a hospital setting – resulting in higher costs for less effective treatment.

This is an abbreviated description and it is offered for illustrative purposes. There are many nuances and other factors that need to be explored to fully understand the scope of the problem, to understand the root causes, and to propose potential solutions that will reduce the administrative burden and cost of the current licensing and credentialing system. Even more significant, is the reduction in access to appropriate lower cost care, because of licensing and credentialing challenges.

OHIC is likely aware of this set of concerns, and I hope this can be an area of priority for the Health Insurance Commissioner in the near future.



Lifespan

Delivering health with care.

Contracting

167 Point Street
Suite 2B
Providence, RI 02903

Tel 401 444-2529
Fax 401 444-5433
Email dmoynihan1@lifespan.org

Daniel S. Moynihan
Vice President
Contracting & Payer Relations

June 10, 2019

Marie Ganim, PhD
Health Insurance Commissioner
Office of the Health Insurance Commissioner
1511 Pontiac Ave. Bldg 69-1
Cranston, RI 02920

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

Dear Commissioner Ganim:

We write to provide comments on the Office of the Health Insurance Commissioner's ("OHIC" or the "Office") Advance Notice of Proposed Rulemaking (230-RICR-20-30-4). Lifespan's comments are based on and follow the "Supporting Rationale" document posted by the Office.

A. Primary Care Investment

1. Continue requiring insurers to meet a primary care spending target

Comment: Lifespan supports the continued requirement of insurers to meet a primary care spending target. Rhode Island must continue to support the advancement of the primary care infrastructure in the State.

2. Re-examine and more tightly define what constitutes primary care spending, and consider definitions being adopted in other states to promote comparisons across states.

Comment: Lifespan has no comment.

3. Eliminate the requirement to limit direct primary care spending to <1% and require insurer support for CTC-RI administrative infrastructure and CurrentCare elsewhere in OHIC regulation.

Comment: Lifespan has no comment.

B. Care Transformation

1. Remove the current PCMH target, but require continued insurer financial support of OHIC-recognized PCMHs.

Comment: Lifespan strongly supports the continued requirement of insurers to support OHIC-recognized Patient Centered Medical Homes (PCMHs) at no less than the current amounts or in a greater capacity. Lifespan is concerned for the potential erosion of these funds in the future – either by way of removing the guarantee to PCMHs and placing the funding at risk or by simply underfunding or removing the funding entirely. The PCMH transformation initiative has arguably been a success in improving the quality and outcome of care delivered in the primary care setting. Unfortunately, regardless of its success, PCMH remains a costly endeavor. As fee-for-service reimbursement levels remain flat or decrease, the guaranteed funding afforded PCMH is the only means by which PCMH can be maintained.

2. Facilitate improved integration of primary care and behavioral health services.

Comment: Lifespan supports this proposal.

3. Support improved and cost-effective specialist services.

Comment: Lifespan has no comment.

4. Create a new requirement for insurers to act to reduce primary care practice administrative burden and reduce burnout.

Comment: Lifespan supports efforts to address and curtail physician burnout. Lifespan shares the concerns of OHIC and notes that this issue is larger than primary care.

C. Payment Reform

1. Adopt new APM targets and Risk-Based Contract requirements

Comment: Lifespan supports this proposal.

2. Regarding the aggregate APM target and the Non-FFS APM target, count both shared savings and shared losses equally so that carriers with downside risk are not penalized for them.

Comment: Although Lifespan supports the continuation of APM targets and risk based contract requirements past the 2019 expiration, we strongly disagree with the proposal to include shared losses paid to the insurer by the ACO as medical spend. These losses should in fact be treated as a debit against the APM spending calculation. By classifying these amounts as credit, insurers no longer have any concern about losses that may be borne by the risk-bearing entity.

With regard to adding a Primary Care APM requirement, it is apparent that some primary care practices have the desire and capabilities to accept this form of reimbursement while others do not. Accordingly, any APM adoption should be optional and mutually agreed to by the payor and the primary care practice and not required as proposed.

3. Add a Primary Care APM requirement

Comment: Lifespan opposes a new APM mandate but agrees on the concept of capitation being utilized in negotiated contracts.

4. Maintain the cap on hospital rate growth.

Comment: Lifespan believes that after the execution of the Mutual Compact with a PGSP target of 3.2% and the Governor's subsequent executive order the continuation of such a cap is an artificial barrier to providers being able to meet this newly-developed target.

5. Align the ACO budget growth cap with the new cost growth target.

Comment: Lifespan opposes this proposal. The Governor's convening of the Cost Trends Steering Committee and the Mutual Compact that was the product of those meetings was done so under OHIC's auspices with the continued assurances that the discussion was intended to reach a soft cost growth target that contained no penalty provisions. The imposition now of the PGSP as the new ACO budget growth cap is a form of penalty that will adversely impact ACOs by removing their flexibility.

6. Assess community behavioral health spending

Comment: Lifespan has no comment.

7. Clarify the requirement for hospitals to use units-of-service payments.

Comment: Lifespan is unclear what this proposal means and ask for clarification and further specificity.

8. Move the administrative requirements from the Affordability Standards.

Comment: Lifespan is unclear what this proposal practically means and asks for clarification.

9. Address disparity in commercial hospitals rates.

Comment: Lifespan opposes the concept of addressing hospital rate variation and believes that hospital rate variation is acceptable among hospitals with varying underlying cost structures. For example, within Lifespan reimbursement rates vary among our 4 hospitals. This variation is acceptable and reflects the resource demands of – as an example - an academic medical center and level 1 trauma such as Rhode Island Hospital as compared to a community-based hospital like Newport Hospital. If, however, the Office pursues this regulation, Lifespan urges the Office to recognize that price variation exists not only within Rhode Island but within the region as well. Accordingly, rate variation analysis should also include Massachusetts and Connecticut providers who impact the medical cost trends. Lifespan believes this impact is a crucial issue to understand, as out of state hospitals are beyond the regulatory reach of the current OHIC Affordability Standards regulations leaving in-state hospitals to bear the full impact of cost containment efforts. Lifespan

further believes that such a process should be standardized or, at the very least, made as consistent as possible and go beyond efforts to increase rates to hospitals deemed "lower-priced hospitals".

10. Require insurer acceptance of multi-payer provider-generated quality measurement information in value-based provider contracts when requested by providers.

Comment: Lifespan supports this proposal.

We appreciate the opportunity to provide comment on the Office's Advance Notice of Proposed Rulemaking.

Sincerely,

A handwritten signature in black ink, appearing to read "D. Moynihan", with a long horizontal flourish extending to the right.

Dan Moynihan
Vice President of Contracting and Payer Relations
Lifespan

Neighborhood Response to OHIC Affordability Regulation

A. Primary Care Investment

1. Continue requiring insurers to meet a primary care spending target.

Rationale:	<ul style="list-style-type: none"> • According to the most recent evaluation of the Affordability Standards, stakeholders believe that the required investments towards primary care have been extremely important and have created a platform for primary care practice transformation. • In 2017, RI insurers spent between 9.0% and 12.8% (for an average of 11.5%) of total spend on primary care¹, above the required level of 10.7% • The Milbank-funded primary care spend study (2017) did not reveal a consistent level of primary care spend as a percentage of total spend among high-quality health plans.
Strategy Detail:	Modify the primary care spend standard to 11.0%, less the effect of removing indirect primary care spending (see Option #3 below).

NHPRI Comments:

Neighborhood values high-quality investments in primary care and look forward to working with OHIC to determine an inclusive definition that allows our primary care infrastructure to advance efficiently. Neighborhood’s primary concern with item A1 is the methodology used to calculate primary care spending. The percent driven calculation off of total health expenditures does not take into account unconstrained cost growth in other areas such as pharmacy and specialist services. We look forward to dialog on cost containment strategies in these service areas but are concerned that absence of a strategy it may result in constraining potential dollars that could be used to fund other innovative initiatives.

2. Re-examine and more tightly define what constitutes primary care spending, and consider definitions being adopted in other states to promote comparisons across states.

Rationale:	<ul style="list-style-type: none"> • Oregon now has a primary care spend standard², and Delaware may be in the process of developing one.
Strategy Detail:	<ol style="list-style-type: none"> a. Define primary care spending within regulations or a new integrated policy manual, and not through guidance letters issued by OHIC. b. Utilize a more technical definition that specifically includes and excludes certain categories of spending. c. Investigate aligning definitions with Oregon (except for the PCP definition³) to allow for cross-state comparison.

NHPRI Comments:

Neighborhood believes that primary care spend in Rhode Island should focus on a flexible definition that meets the states needs and can be benchmarked where feasible. Neighborhood appreciates the desire to move towards greater specificity, but we feel a new integrated policy manual would be preferable to a regulatory approach. This definition should be adaptable to the needs of the changing market, and permit investment in innovative models of care. Neighborhood is interested in having this definition be adaptable enough to meet members at their primary point of attachment for routine care. The use of the manual over regulation would offer that greater flexibility without the need for an extensive

regulatory process. We are eager to engage in further dialog regarding what should be included in the category of primary care spend.

3. Eliminate the requirement to limit indirect primary care spending to <1% and require insurer support for CTC-RI administrative infrastructure and CurrentCare elsewhere in OHIC regulation.

Rationale:	<ul style="list-style-type: none"> This does not constitute true spending on primary care. Elimination of this requirement would streamline reporting.
Strategy Detail:	N/A

NHPRI Comments:

We request further clarification on the intent of this initiative? Where does OHIC intent to transfer the authority mandating support for these models?

B. Care Transformation

1. Remove the current PCMH target, but require continued insurer financial support of OHIC-recognized PCMHs.

Rationale:	Rhode Island has made great strides in primary care transformation. Those practices should continue to receive support, but there are a limited number of viable remaining practice candidates for transformation.
Strategy Detail:	<ol style="list-style-type: none"> Eliminate the care transformation requirement as currently written, which focuses on primary care practices functioning as PCMHs. Require that practices that meet OHIC's PCMH definition continue to receive financial support, e.g., as specified in the Commissioner's 2019 Care Transformation Plan.

NHPRI Comments:

Neighborhood agrees that our PCMH's will require some manner of continued financial support from their insurer partners. However, Neighborhood would respectfully advocate that there be a commitment to the development of flexible standards that allow for discretion between provider and payers about how this investment should continue.

2. Facilitate improved integration of primary care and behavioral health services.

Rationale:	<ul style="list-style-type: none"> Stakeholders placed priority emphasis on this topic during the fall 2018 Care Transformation Advisory Group meetings. Medicaid requested an OHIC requirement for insurer payment support for integrated care and SDOH work on 2-8-19. Brown's CTC-RI BHI pilot evaluation yielded promising results.⁴ Other research estimates that a reduction of between 5-10% of total health care costs over a period of 2-4 years for patients receiving collaborative care, though there is wide variability in study findings and quality of studies.⁵
Strategy Options:	Options to be developed by OHIC's Integrated Behavioral Health Work Group by June 2019, but could include: <ol style="list-style-type: none"> elimination two co-pays for same-day primary care and behavioral health services provided in the same location;

NHPRI Comments:

Neighborhood remains a strong advocate for the goal of primary care and behavioral health integration. We believe, as in other aspects of the potential language, the best approach is one that is adaptable and allows for further experimentation. Milliman Study indicates there is wide variability in findings indicating there is no one size fits all` approach to proper behavioral health integration. Any payer funding should flow to practices that are achieving certain benchmarks in developing this integrated structure.

3. Support improved and cost-effective specialist services.

Rationale:	Many specialists are independent and have been unaffected by OHIC's Affordability Standards.
Strategy Detail:	a. Require insurers to utilize reference pricing for selected high volume and high cost specialist services, (e.g., joint replacement surgery, diagnostic services). ⁷

NHPRI Comments:

Neighborhood supports effective cost containment strategies for specialists; however we have concerns regarding the impact of these types of initiatives on network adequacy. We recommend OHIC engage and facilitate discussion with key representatives of the specialist community.

4. Create a new requirement for insurers to act to reduce primary care practice administrative burden and reduce burnout.

Rationale:	Primary care burnout is stressing the availability of primary care providers, decreasing quality of patient care and may increase medical errors. While unintended, rapid transformation, like which occurs in practices undergoing transition to PCMH, may contribute to primary care burnout. ⁸
Strategy Detail:	a. Require insurers to act independently and collectively to reduce primary care practice administrative burden and other stressors on the quality of work. Require reports to OHIC and presentation in a public forum annually on insurer efforts.

NHPRI Comments:

Neighborhood has no opposition to engaging in conversations regarding reducing administrative burden for our provider partners. Neighborhood would like to note we continue to recognize the impact of

C. Payment Reform

1. Adopt new APM targets and Risk-Based Contract requirements

Rationale:	<ul style="list-style-type: none">• OHIC should ensure a minimum percent of payments are dedicated to APMs. The current percentage target is 50%.• The target values need updating, as they don't run past 2019.• Risk-based contracting is an important tool driving provider performance on cost and quality.
Strategy Detail:	<ul style="list-style-type: none">a. Set an APM adoption floor requirement that insurers must meet.b. Articulate risk-based contracting targets and minimum downside risk standards that increase over time.

these provider pain points and have an open referral process and engage with stakeholders through our provider advisory committees. We recommend potential topics for discussion including uniform credentialing standards, appeals and UR for select services. Additionally, we advocate steps should be taken to continue the efforts of SIM in streamlining the quality measures providers are asked to report on.

NHPRI Comments:

Neighborhood advocates these rules continue to be applied on a payer specific basis.

2. Regarding the aggregate APM target and the Non-FFS APM target, count both shared savings and shared losses equally so that carriers with downside risk arrangements are not penalized for them.

Rationale:	Insurers are concerned that shared losses incurred by providers in risk-based models are not considered medical payments, therefore penalizing health plans that would have met the target if those providers had earned shared savings payments. (OHIC does remove these losses from the denominator in the APM spending calculation, however.)
Strategy Options:	<ol style="list-style-type: none"> a. When codifying this language in the Affordability Standards, clarify a method for health plans to include shared losses within their expected non-fee-for-service target. b. Alternatively, clarify that medical payments refers only to those dollars which are prospectively paid, as this non-FFS APM target is meant to encourage the amount of prospectively paid payments. While this would be a harder requirement for health plans to meet, it is truer to the initial intent. Also, making performance of an ACO against a shared savings or risk arrangement impact compliance creates a perverse incentive for insurers to set shared savings or risk targets that are too high or too low.

NHPRI Comments:

Neighborhood advocates that if OHIC pursues this direction through regulation that this provision be implemented on a payer specific basis.

3. Add a Primary Care APM requirement.

Rationale:	<ul style="list-style-type: none"> • A primary care APM can support clinical activities and functions that are indicative of well-functioning primary care practices, including care coordination, interdisciplinary-team based care, support for patient self-management and ongoing communication. It can also reduce the stress and burden created by a fee-for-service office visit volume incentive. • Movement toward primary care APM in RI has been slow and some payers have been resistant to multi-payer and provider collaboration.
Strategy Detail:	<ol style="list-style-type: none"> a. Require insurer implementation of primary care APMs for their contracted network providers. b. Require adoption of an OHIC developed primary care APM. c. Set APM and Non-FFS APM targets specifically for primary care.

NHPRI Comments:

Neighborhood refers to our original comment letter provided to OHIC on this proposal. We oppose this measure as it would constrain how we engage and leverage our primary care relationships.

4. Maintain the cap on hospital rate growth.

Rationale:	Based on the 2018 Affordability Standards evaluation and the <i>Health Affairs</i> study by Baum et al. ⁹ , the hospital rate limits were mostly responsible for observed cost trend decreases and therefore the requirement should be maintained, if not made more aggressive, for hospital contracts.
Strategy Detail:	<ul style="list-style-type: none"> a. Maintain the rate growth cap. b. Option #10 below proposes a modification to address rate disparities between hospitals in a way that encourages improved quality of care and value for consumers.

NHPRI Comments:

Neighborhood strongly advises for the retention of the hospital rate cap in its current form. We believe it be an essential component of achieving cost growth targets consistent with the governor’s initiative in to control collective standing health expenditures. Further comments around 4b are discussed under item 9.

5. Align the ACO Budget Growth Cap with the new Cost Growth Target.

Rationale:	The OHIC ACO budget growth cap and the new Cost Growth Target are both focused on annual change in total cost of care growth, the difference being the ACO cap, based on the Consumer Price Index, is on commercial contractual cost targets and the new Cost Growth Target is focused on actual cost growth at state, insurance market, insurer and large provider levels.
Strategy Detail:	<ul style="list-style-type: none"> a. Change the ACO budget growth cap to equal prospective Gross State Product (PGSP) with an add-on, with a multi-year transition to lower the current cap from its current level. b. Address possible adjustment for ACOs with comparatively low risk-adjusted PMPM spending.

NHPRI Comments:

We recommend dialog taking place at the cost trend steering committee level on the appropriate timing and course of actions regarding achievement of the cost targets. This approach may ensure alignment of efforts in cost containment across agencies.

NHPRI Comments:

6. Assess community behavioral health spending

Rationale:	OHIC has received stakeholder feedback that there are gaps in the community with respect to behavioral health services.
Strategy Detail:	<ul style="list-style-type: none"> a. Assess baseline spending for community behavioral health services, much as OHIC previously did for primary care. b. Direct insurers to make investments if upon further quantitative and qualitative analysis the Commissioner finds it to be necessary.

Neighborhood understands the need to better understand potential gaps in the behavioral health system. We look forward to having further dialog concerning the methodology behind the assessment of items like community behavioral health services. Our belief is that investment should further align and expand in the direction of B2 and consider long-term investments in the workforce. These gaps in unmet need or specialist scarcity are unlikely to be impacted by general broad based investment in community providers.

7. Clarify the requirement for hospitals to use units-of-service payments.

Rationale:	Units-of-service payments are not used in all inpatient and outpatient cases (e.g., inpatient psychiatry, emergency department).
Strategy Detail:	N/A

NHPRI Comments:

Neighborhood supports use of an industry standard definition in regulation. Our understanding is that while units-of-service payments are widely used for medical services, its use for behavioral health hospital payments is not industry standard.

8. Move the administrative requirements from the Affordability Standards.

Rationale:	The hospital contract administrative requirements may be important but are not a key focus of the Affordability Standards.
Strategy Detail:	a. Move administrative simplification requirements outside of the Affordability Standards and to the administrative simplification requirements section of Part 4.

NHPRI Comments:

NHPRI has no comment on this proposed provision.

9. Address disparity in commercial hospital rates.

Rationale:	As the hospital rate caps continue, the variation in hospital rates will continue to get wider in that the highest reimbursed hospitals will continue see higher rate increases than the lowest reimbursed hospitals in absolute dollar terms. This has been a concern of some community hospitals in Rhode Island.
Strategy Detail:	<ul style="list-style-type: none"> a. Variable application of rate growth caps, e.g., standard caps for “higher-priced hospitals”, and earnable higher caps for “lower-priced hospitals” vis a vis the state median. b. Tie the rate cap differential to quality performance, such that “lower-priced” hospitals must earn any available add-on above the standard rate cap. c. OHIC shall define the quality measures and targets necessary to realize the higher rate cap. d. Publish annual reports on hospital price variation to increase attention to the topic.

NHPRI Comments:

This proposal could easily undermine the current success in cost containment largely driven by the hospital rate cap. While Neighborhood was not in the commercial market when the rate cap was put in place we strongly believe the decision to implement in this manner was a key element of the cap's success. Neighborhood respectfully recommends the cap be maintained as it currently exists in regulation.

NHPRI Comments:

10. Require insurer acceptance of multi-payer provider-generated quality measurement information in value-based provider contracts when requested by providers.

Rationale:	Providers incur additional costs when they are required to generate separate payer-specific quality measurement data for commonly used measures. These costs do not add value, decrease the statistical strength of the measurements due to reduced denominator size, and don't recognize that clinicians do not deliver care differently based on a patient's insurer
Strategy Detail:	<ul style="list-style-type: none"> a. For those ACOs and providers that wish to use an aggregated calculation of performance across all commercial (insurer and self-insured) patients for performance measures used in ACO and provider contracts and which rely upon clinical data for their calculation, the insurer is obligated to accept those measurements. b. Insurers may elect to impose reasonable audit requirements upon the ACO or provider to ensure validity of reported data.

Neighborhood requests information on what commonly used measures are being referred to in this proposal.

We are additionally concerned it would allow providers to pick or choose which payers they opt to leverage aggregate measures versus specific measures based upon performance.

Concluding Statement:

Thanks again Corey for the opportunity to comment and have some dialog on the draft regulations. I would summarize most of our commentary saying that we respectfully urge the revised regulations to maintain a certain level of flexibility in our rapidly changing marketplace, and also consider the cross agency nature that has increasingly become a part of achieving these goals.

The revised regulations should allow for achievement of broader goals while not constraining providers and payers from pursuing innovative arrangements. The opportunity to consider incorporation of items like telemedicine or unique payment arrangements could be welcomed and supported by a strong backbone of broad regulation coupled with OHIC guidance.

Increasingly we view this work, as I am sure you do, in the broader context of state dialog around quality and cost containment. Bringing many of these initiatives for some level of dialog at the Cost Trends Steering Committee may aid in bringing new ideas and investment to the table in support of achieving these goals.

Please let me know if you have any questions and how we can further engage in any discussion on these topics.

Thanks,

Liz

Comments on “OHIC Affordability Standards: Potential 2019 Modifications”

Submitted by Al Kurose MD, CEO Coastal Medical on June 3, 2019

Comments on Section A. Primary Care Investment:

- I agree that the required investments toward primary care have been extremely important and have created a platform for primary care practice transformation.
- I agree with each of the proposed modifications in this section.

Comments on Section B. Care Transformation

- I agree with the emphasis on integration of primary care and behavioral health that is advocated in B.2. However, B.2 is rather quiet on other aspects of SDOH and I think that is perhaps a missed opportunity. Support for transportation to care and peer navigators are examples that come to mind. Housing, economic security, education etc. are also relevant but perhaps feel further out of reach.
- I agree with B.3, but I wonder if this section could be developed further in a direction that would prompt engagement of specialists rather than just passive treatment.
- The administrative burden placed on providers by care transformation and payment reform is an important topic but I have mixed feelings about whether regulatory efforts would be a useful next step on this issue at this moment in time.

Comments on Section C. Payment Reform

- Re: C1, RI is a small enough market with a sufficiently small number of systems of care to allow for assessment of the specific amount of *investment* risk (i.e. incremental spending on population health management) taken by each SOC. This investment risk is additive to any contractual downside risk in the business model for each organization that is actively pursuing care transformation and payment reform, and as such should be included in assessments of the amount of risk being taken by any given SOC. A related notion is the idea that a diversified portfolio of risk contracts reduces overall risk (in a manner analogous to diversification of risk in an investment portfolio).
- Re: Section C2, I too am uncomfortable with any regulation that specifically incents a payer to impose downside risk payments on a provider. The current levels of information asymmetry around risk scoring and other aspects of reconciliation of cost performance advantage payors over providers, and perverse incentives would only exacerbate this imbalance. Neither do I like the idea of switching to a standard based on prospective payments, as I'm skeptical that stand-alone primary care capitation will improve Triple Aim performance.
- Re: Section C3, I propose broadening the working definition of a primary care APM to include not only primary care capitation, but also primary care driven ACO's. Part of the challenge here is that the proposed regulation is trying to address PCP incentives which is really about PCP *compensation* models and not the payer-provider payment models which are regulated by OHIC but operate at the organizational level, not the individual provider level
- I agree with section C5a in order to align with the work of the Cost Trend Committee.
- I agree with C5b which is necessary for high performing (cost efficient) provider organizations to be able to continue working under total cost of care contracts and escape the “race to the

bottom” as they improve their cost performance. The need for an adjustment of this type becomes particularly acute if downside contractual risk is added to significant investment risk in a setting where risk adjusted PMPM spending is already low.

- Re: C9, I have less knowledge and experience. With that caveat, the proposed modification seems fair and reasonable.
- I am concerned that the proposed regulation in Section C10 may have unintended consequences because blending quality performance across different populations with different characteristics may invalidate comparisons of performance between different organizations that have differing payer mix. Limiting the “blending” of populations to commercial only does mitigate this concern but may not eliminate it, particularly if plan design or quality incentives vary significantly from one payor to the next.

I hope these comments are helpful. I appreciate the opportunity to submit them, and I want to thank OHIC for its work on affordability in pursuit of the common good.



**RHODE ISLAND
MEDICAL SOCIETY**

June 5, 2019

Cory King
Principal Policy Associate
Office of the Health Insurance Commissioner
Building 69-1
1511 Pontiac Avenue
Cranston, RI 02920

Comments on DBR NPRM 230-RICR-20-30-4
Notice of 5/09/2019

A. Primary Care Investment

We look forward to working to define the categories of spending. Certain subcategories have been developed to facilitate implementation of the requirement and we hope that flexibility with proper oversight can be maintained.

B. Care Transformation

1. PCMH Target

There may be utility in measuring by lives and not just practices. We agree that practices willing and/or capable of transformation may have reached a practical limit. Continued payment for advanced primary care is essential.

2. Integrated Behavioral Health

This is an important next step in advanced primary care. It is important that payers have clear and reasonable standards for allowing specific types of payment. Psychiatric Collaborative Care Management Services should be recognized. Elimination of two co-pays is desirable. We look forward to being able to review the recommendations of the Integrated Behavioral Care Work Group.

3. Specialist Services

Reference pricing is an option, but it does not involve specialist involvement in practice transformation and value-based payment. It also is relatively confusing for the beneficiary. In theory, higher payment for higher value should be desirable, not penalized.

4. Administrative Reductions to Reduce Burnout

This is an important step. There are opportunities to reduce burden and administrative cost. This must be balanced with the positive effects for cost and safety in some programs. The payers should report an estimated practice administrative cost related to certain processes. These costs should be validated by the OHIC. They should not count as primary care spend nor be part of the MLR.

C. Payment Reform

1. APM Targets

The targets should be continuously refined. Investment risk should be considered in the calculation of downside risk.

2. Calculating aggregate targets.

We agree that the requirements should be clear and consistent with the goals.

3. Add a Primary Care APM Requirement

Primary care can be more flexible and effective with population- based payments. It is essential that such payments do not lock in inadequate payment for primary care and serve to promote continued progress in creating advanced primary care, such as integrated behavioral health. There do need to be standards. Tying these programs to total cost of care participation does reduce the risk of stinting.

4. Maintain the hospital growth rate cap

This cap has been effective in holding the line hospital fees and overall costs. It is not clear that this is sustainable and could at some point be counter-productive to use fee for service (DRG payment is still volume driven) controls when population management is the goal. Hospital investments in new programs could be considered outside of the cap. For example, it may not be realistic to expect a hospital to invest in a Community Health Team or other new service in the hope of gaining shared savings. Additionally, it may be appropriate to allow hospitals to seek funds to subsidize primary care practices or to recruit clinicians to provide high quality care, education and research that is not otherwise available locally and which stimulates the local economy by bringing in revenue from outside our state. The funds do need to come from somewhere and a payer may even support the program though higher allowances to facilitate claims-based expensing in a population that is dominated by self-insured accounts. Likewise, community needs for education and training may be considered.

5. ACO Budget Growth Cap

This should be implemented cautiously. The state needs to engage in efforts to reduce drug costs if these are part of the cap.

6. Assess community BH spending

We believe standardized data collection may help to delineate further recommendations.

7. No comment

8. No comment

9. Disparity in hospital rates

The strategy detail offers some possible actions of interest. However, this approach is not a community needs assessment-based approach. Rather, a putative "fairness" approach seems to be the basis of the suggested approaches. That may not be the most appropriate mechanism to reduce community wide spending. Increased attention and discussion are appropriate, but fraught with political hazard and risk for a decision that is not based upon health economics.

10. Multi-payer generated quality reporting

The standardization of measures is a significant administrative simplification.

Standardizing reporting methods and formats has the potential to allow the state to have a multi-payer or all-payer data system. However, measurement success thresholds need to be adjusted for different populations. Today, much of the adjustment is not needed because within a given payer's population there is much less diversity that between plan types (e.g. Medicaid, Commercial and Medicare).



May 30, 2019

Cory King
Office of the Health Insurance Commissioner
By Email To: Cory.King@ohic.ri.gov

Re: **Proposed Affordability Standards**

To Whom It May Concern:

Thank you for the opportunity to provide comments in response to the proposed modifications of the Affordability Standards. The Rhode Island Parent Information Network (RIPIN) helps thousands of Rhode Islanders every year navigate the healthcare system. We operate an all-payer consumer assistance program (in partnership with OHIC) that helped clients save \$2.25 million last year. We also operate numerous other programs that help Rhode Islanders, especially those with disabilities and special needs, access the care they need.

The Affordability Standards have been a critical catalyst for important improvements to Rhode Island's healthcare system. We support this effort to continue modernizing the standards, and also strongly support the proposed continued commitment to primary care investments, CTC-RI, and CurrentCare.

The healthcare system in America and Rhode Island faces two crises. First, spending has grown far faster than GDP for decades, leaving the nation with the most expensive healthcare system in the world by far, nearly double the per-capita cost of the OECD average. Second, health outcomes lag. The United States, with its advanced economy and high healthcare spending, ranks 31st in life expectancy (with consecutive annual declines not seen since 1915-1918), 46th in maternal mortality, and 56th in infant mortality. Among certain racial and socioeconomic subgroups, the numbers are far worse.

Payment and delivery system reform efforts to date, including the Affordability Standards, have focused heavily on the first crisis (spending) and little on the second crisis (poor outcomes). While the attention on spending is important and necessary, we believe that OHIC has the opportunity in these Affordability Standards to increase the emphasis on outcomes, even if subtly. Recommendations to advance that and other goals provided below:

- ✓ The Affordability Standards should require that alternative payment methodologies (APMs) place equal financial emphasis on quality and outcome improvements as on cost reductions.
 - Bonuses should be available to ACOs that perform exceptionally on quality and outcomes, even if they do not achieve savings. These bonuses can be funded using portions of shared savings payments that are withheld after an ACO missed quality targets.

- Alternatively, withheld shared savings bonuses could be used to create public health funds, to be invested on initiatives likely to improve public health outcomes.
- To the extent there is movement to risk because of a belief that risk a great motivator (discussed below), that risk should also extend to quality and outcome goals.
- ✓ The Affordability Standards should encourage the development of new ways to tie payments to improvements in critical public health outcomes.
 - For example, Kids Count recently release data on childhood obesity that was based on healthcare claims and clinical data linkable back to a primary care provider. This type of data could be used to develop a new measure to reward providers with success addressing childhood obesity, a critical public health problem strongly associated with future healthcare spending.
- ✓ Access to in-network behavioral health services remains a challenge for many patients. We strongly support the proposal to assess community behavioral health spending and to direct further investments if needed. We urge that the assessment not focus on RI's position relative to other states, because most evidence indicates that this is a problem everywhere. Rather, the comparisons should be to access to medical/surgical services, as is required under parity laws.
- ✓ As stated in many other fora, we remain concerned about the movement towards risk-based contracting, for many reasons. First, very few providers in Rhode Island are large enough to have sufficient lives in any single risk-based contract to avoid high natural volatility risks. Research indicates high natural cost volatility even in very large ACOs (by RI standards), and that achieving 90% confidence that measured spending is within 1% of true performance requires an ACO to have 100,000 lives (achieving 99% confidence requires 250,000 lives).^{*} There is also currently no public body with the jurisdiction and resources to monitor whether entities have the capacity to bear risks. We recommend that risk-based contracting not be encouraged before the proper oversight is in place, and never be encouraged for contracts with fewer than about 50,000 lives.

Thank you again for the opportunity to submit these comments. Should you have any further questions, please feel free to contact me.

Sincerely,

/s/

Samuel Salganik, JD
Executive Director
401-270-0101, ext. 101
Salganik@ripin.org

^{*} Barr, Lynn, Anna Loengard, LeeAnne Hastings and Tim Gronniger "Payment Reform in Transition – Scaling ACOs For Success." Health Affairs, May 11, 2018.

June 6, 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 (Standards). We are supportive of OHIC's efforts towards improving quality and managing cost trends. We also applaud the open and inclusive approach taken in developing and implementing policies and programs associated with the Standards.

Pursuant to that approach, we would like to take this opportunity to highlight concerns with some of the proposed modifications to the Standards. Those concerns are highlighted below.

A. Primary Care Investment, 1. Continue requiring insurers to meet a primary care spending target.

Comment: While we are supportive of prioritizing primary care as a cornerstone of the health care delivery system, we are concerned about setting minimum spending requirements in general. With the newly enacted Cost Trend Benchmark, increasing the required percentage of spend on primary care further limits the flexibility of health plans to manage overall medical costs. While the Standards are designed to increase primary care spend, taken together with other spending requirements, they can also amount to a built-in costs for commercial health plans. These requirements, taken together with utilization, severity, and pharmacy cost increased as well as provider mix changes and service mix changes, could make it exceedingly difficult for commercial health plans to meet an overall trend target.

B. Care Transformation, 3. Support improved and cost-effective specialist services.

Comment: We are supportive of OHIC's efforts to engage specialists in affordability. We would caution OHIC specific to the implementation of reference pricing. It is plausible that reference pricing could result in providers seeking higher rates of reimbursement to account for increasing patient bad debt. Further, it is reasonable to believe that reference pricing could incentivize

providers to shift revenue to service lines untouched by reference pricing. Either of these conceivable outcomes would mitigate the value of reference pricing.

C. Payment Reform, 9. Address disparity in commercial hospital rates.

Comment: We appreciate OHIC's willingness to address price disparities among hospitals. However, one factor that should be kept in mind is that efforts to increase the standard rate cap for "lower-priced hospitals" would necessitate a reduced rate cap for "higher-priced hospitals." Without moderation on the rate cap for "higher-priced hospitals", increasing the rate cap for "lower-priced hospitals" will result in higher aggregate unit price increases and an increase in total spending. Any such policy action should be cost neutral.

Thank you again for the opportunity to provide comment on this important legislation. If I can answer any questions or provide further information, please feel free to contact me at (401) 480-0762 or patrick_ross@tufts-health.com.

Sincerely,



Patrick Ross
Manager, Government Affairs and Public Policy

UnitedHealthcare of New England, Inc. and UnitedHealthcare Insurance Company (“United”) provide the following comments on the affordability standards found in 230-RICR-20-30-4, which are designed to improve the affordability of healthcare.

Primary Care

- a. 230-RICR-20-30-4 will continue requiring insurers to meet a primary care spend target, but at increased level of 11% of total spend.

Comment: United supports continuing a primary care spend target but does not support increasing the target from 9.7% to 11%. There is no evidence to support an increase. Constituents report care transformation has been successful at current levels and there is no evidence that additional funding would translate to greater success.

- b. Better define “primary care spending,” and consider definitions being adopted in other states to promote state by state comparisons.

Comment: United supports better defining “primary care spending” and requests that the Office of the Health Insurance Commissioner (OHIC) provide supporting documentation that allows interested parties to provide comments. We also request that as “primary care spending” is defined, OHIC would allow for flexibility to encourage innovation.

- c. Eliminate the requirement to limit indirect primary care spending to <1% and require insurer support for CTC-RI administrative infrastructure and CurrentCare elsewhere in OHIC regulation.

Comment: Please define on how this change would be reflected in the new primary care spending target.

Care Transformation

- a. Eliminate the care transformation requirement which focuses on primary care practices functioning as Patient Centered Medical Homes (PCMHs), but provide that PCMHs continue to receive financial support (e.g., as specified in the Commissioner’s 2019 Care Transformation Plan).

Comment: Primary care transformation requires the ability and willingness of providers to participate in any such efforts. Insurers can encourage transformation through incentive programs but cannot transform practices on their own. United supports continued financial support but feels that a plan must be developed that allows the program to be self-sustaining and not a separate revenue stream.

- b. Improve integration of primary care and behavioral health services.

Comment: United supports improved integration of behavioral health services and primary care.

- i. Eliminate two co-pays for same-day primary care and behavioral health services at same location.

Comment: Elimination of co-pays would require a benefit change that employer groups would have to support. Without 100% cooperation, this would add confusion and disparity. United would be supportive of looking for other solutions such as a global payment for both services when provided as integrated.

- c. Support cost-effective specialists: require that insurers utilize reference pricing for select high volume/cost specialist services (i.e., joint replacement).

Comment: United would be supportive of this change however we request that OHIC take into consideration the necessary collaboration from specialists in order to be successful in developing reference pricing.

- d. Reduce PCP administrative burdens and reduce burnout (insurers find ways to work collectively)

Comment: United understands the need to address primary care practice administrative burdens, however we request a definition of “burn-out” and request additional information on how OHIC will be defining how an insurer is expected to address the administrative burden. We agree to work collaboratively to streamline our processes, to the extent we are able to do so.

Payment Reform.

- a. Set an Alternative Payment Measure (APM) requirement for insurers (currently 50%).
- b. Set risk based contracting targets and minimize downside risk standards that increase over time.
- c. Re the aggregate APM target and the non-FFS APM target, count shared savings and losses equally so that carriers with downside risk arrangements aren't penalized for them.
- d. Add a primary care APM requirement.

Comment: United is supportive of moving to APM, however if providers are reluctant to do so, we have limited opportunity to increase risk based agreements and new APMs that require provider support and collaboration. We agree risk sharing may be the next evolution in payment reform, but we continue to find resistance and concern on the part of providers. Insurers cannot force providers to enter into APMs. What actions are being taken to allay the concerns of providers?

The requirements to enter into APMs are imposed on the Insurers. What are the ramifications to providers for not entering into such agreements? Perhaps a negative incentive, such as a reduction on FFS payments, needs to be introduced.

United has and will continue to provide providers with incentive programs that include APMs.

- e. Maintain the cap on hospital rate growth.
- f. Align the ACO budget growth cap with the new cost growth target.
 - i. The ACO growth cap (based on the Consumer Price Index) is on commercial contractual cost targets, while the new Cost Growth Target is focused on actual cost growth. Change the ACO growth cap to equal the Gross State Product with an add on, with a focus on lowering the cap over multiple years.

Comment: Please define further what is intended by aligning the ACO cost growth cap with the cost growth target.

- g. Assess community behavioral health (BH) spending (to address gaps in services); direct insurers to make investments if the Commissioner finds it necessary.

Comment: Optum Behavioral Health will support OHIC's data collection efforts to assess community BH spend, to the extent we are able. Optum is committed to improving access to BH services in Rhode Island, and will be pleased to have our efforts informed by OHIC's analysis and recommendations.

- h. Clarify that hospitals must use units-of-service payments.
- i. Address the disparity in commercial hospital rates (for example, publish annual reports on hospital price variation, tie rate cap to performance).

Comment: United is supportive of the payment reform actions. In order to address the disparity in hospital rates, disparity across payors should also be addressed. The strategy OHIC outlined suggests that hospitals on the lower end of reimbursement should perform at a higher level. This would require additional dollars spent on quality programs. This strategy does not address the underlying issue of base rate disparity.

Additional areas of Payment Reform which are not addressed but which should be, are:

1. Surprise Billing – Requirements should be included that require hospital contracts to require hospitals to provide advanced notice to patients if their hospital based providers are not participating with a payor. Contracts should also include a penalty on the hospital if it contracts with a non-par provider.

2. Clinic Facility reimbursement should be inclusive of professional fees.

- j. Require that insurers accept provider generated quality measurement information in value based provider contracts (providers incur additional costs when required to generate separate payer specific quality measurement data).

Comment: United is supportive of a multi-payer generated measurement, for value based contracts.

Section 10.a, on page 12, states “For those ACOs and providers that wish to use an aggregated calculation of performance across all commercial (insurer and self-insured) patients for performance measures used in ACO and provider contracts and which rely upon clinical data for their calculation, the insurer is obligated to accept those measurements.” United suggests that Insurers be allowed to require reporting on plan-specific metrics, if no additional administrative burden is placed on the ACO to do that reporting.



SOUTH COUNTY HEALTH

South County Hospital ▪ South County Medical Group ▪ South County Home Health ▪ South County Surgical Supply

June 24, 2019

Ms. Marie Ganim, PhD
Health Insurance Commissioner
Office of the Health Insurance Commissioner
1511 Pontiac Ave, Building #69
Cranston, RI 02920

Dear Commissioner Ganim,

Thank you for taking the time to meet with me on June 7th. I appreciate the opportunity to have candid conversations regarding opportunities to develop mutually beneficial policies relative to affordability in health care. South County Health looks forward to opportunities to partner with OHIC and other governmental agencies in pursuing all aspects of the Triple Aim.

As discussed, South County Health fully supports the concept of the need for substantive, multi-faceted efforts across all sectors with respect to bending the cost curve in healthcare. We agree that the growth of health care expense, at nearly 18% of GDP nationally, is unsustainable and requires innovation in both the macro and microeconomic healthcare environment.

With the above said, the complexity and inherent inertia of the underlying business model in healthcare requires careful consideration with respect to policy that seeks to slow cost escalation without unfairly or disproportionately impacting major components of the delivery or payment systems.

Since 1960, there has been virtually no period of time in which the National Healthcare Expenditures (NHE) have not significantly exceeded GDP growth. From 1960 to 1990, NHE grew over 10 percent annually and exceeded GDP by at least 2%, then has slowed to outpace GDP by 1% on average since the 1990's. Only during the period surrounding the Great Recession and implementation of the ACA did NHE approximate GDP as the recession caused a sharp decline in employer-sponsored insurance coverage and increased uninsurance and Medicaid enrollment. Lower Medicaid provider payment rates and more limited use of services by the newly uninsured, combined with an anomalous slowing of prescription drug spending and increased generic utilization, brought NHE slightly below GDP from 2010 – 2013. Moreover, the payment provisions of the ACA and the Budget Control Act of 2011 reduced Medicare payment rates further through sequestration provisions. This dynamic quickly rebounded from 2013 – 2017 as ACA coverage expansion brought coverage access to as many as 20 million additional

people in 2015, ultimately pushing NHE to 1.1% greater than GDP at 4.9% (Centers for Medicare & Medicaid Services national health expenditure accounts).

The Bailit Health Assessment of the Affordability Standards claims “robust evidence” that the hospital price caps and DRG-based payments were “likely responsible” for the observed cost trend decreases in Rhode Island. Outside of the obvious inherent bias in OHIC-initiated studies that seeks to find efficacy of agency policy, the Bailit study attribution of OHIC policy as driver of cost reduction is far from conclusive. There are many parallel dynamics in the healthcare market that may be more significant drivers of the bending of cost in Rhode Island and this issue requires further, independent study over a much longer period of time to definitively claim conclusive evidence. Many factors could be attributed including the significant proliferation of effective ACOs (which SCH actively participates in through Integra), impact of Medicare Wage Index methodology in depressing Rhode Island’s revenue (e.g. ‘cost’) as compared to other New England states, significant shift from higher paying commercial payers to dramatically lower paying payers such as Neighborhood Health Plan, etc.

We believe OHIC policies can only (and unnecessarily) create harm for hospitals and health systems, while offering no potential benefit for those that share the goal of reducing cost and increasing value. Moreover, with no hospital in this state with a positive margin, we believe any policy that continues to reduce or limit hospital reimbursement is ultimately unsustainable and may contribute to destabilizing an already fragile Rhode Island healthcare delivery system.

The rate caps particularly advantage, indefinitely, those payers that happened to have a low rate structure when the rate limits were implemented. Further, limiting the commercial increase to the U.S. All Urban Consumer All Items Less Food and Energy CPI + 1% has no basis as a credible benchmark for healthcare cost and clearly does not fully compensate for normal health care inflation. The concept that hospitals and health systems could live with an annual increase in the 3% range (3.2% for 2019) certainly seems to have face validity, but hospitals and health systems will not actually experience a 3.2% increase in revenue due to other offsetting factors, and the costs of providing the care are increasing at a rate that is significantly higher than CPI-U and other offsetting factors discussed below.

As you are also aware, excluding Care New England, all hospitals in Rhode Island were impacted with a 9% reduction in Medicare wage index. This permanent reduction was the result of a federal regulatory change that eliminated the imputed rural floor and established a rate structure for Rhode Island hospitals that is 20 – 30% less than our competitors in Massachusetts and Connecticut. Commercial rate limits further disadvantage Rhode Island hospitals relative to our counterparts in neighboring states, as commercial rates, such as Medicare Advantage are set as a percentage of an already depressed base compared to the Southern New England market within which we compete. Additionally, Medicare is further challenging hospital revenues through other changes such as reductions in laboratory service reimbursement, reduction in disproportionate share (DSH) funding, and site of service payment changes. It is clear, these impacts will continue into the future. In fiscal year 2019 the Medicare reimbursement reductions will effectively offset any commercial rate increases.

Further exacerbating the revenue issue, commercial payers regularly change medical management criteria and are continually re-categorizing patients that were traditionally inpatient cases to an outpatient observation level of care, thereby reducing effective reimbursement for the same services. The net result of the transition to observation levels of care is a significant revenue reduction while expenses for the provision of those services remain at the same level. Hospital revenues are also further impacted by the continued proliferation of patients to physician-owned ambulatory surgery centers who are not required to service patients regardless of payment, thus allowing them to steer profitable patients to their centers and treat lower paying patients in the hospital environment. This movement, on the surface, appears to be a setting with a lower cost of care, but does not adequately account for the impact to the entirety of the healthcare economic environment.

Finally, the OHIC cap has frozen rate differentials into place. Neighborhood Health Plan of Rhode Island (NHPRI) currently reimburses hospitals only a fraction of any reasonable standard for commercial payers while (not surprisingly given this advantage) enjoying a 20% margin (\$20 million) on their "Hospital & Medical" book of business. This disparity results in lower hospital (and physician) reimbursement and further revenue compression every time a commercially insured patient switches to NHPRI (while costing the state millions of dollars in federal subsidies).

The cost of running hospitals and health systems continues to increase at a rate that is higher than CPI-U. Nursing salaries will continue to increase as the demand for nurses' increases with the aging population and the entry of new medical facilities (e.g. free-standing surgical centers). Technology costs continue to expand in the medical field. Aging hospital infrastructure must be replaced. Governmental assessments and compliance burdens increase each year. The General Assembly has been discussing a variety of bills that will add costs to hospitals (e.g. allowing municipalities to tax non-profit hospitals, job assessments on non-profits with 1,000 or more employees). The net result of the macro governmental policy impact will be weakened hospitals in Rhode Island and an outflow of jobs and Rhode Islanders to more modern hospitals in neighboring states for their care. However, to be clear, it will still be Rhode Island businesses and families paying the higher rates at those out-of-state facilities.

South County Health is committed to providing high value care, continuing our heritage of quality, service, and cost focus. We know that the commitment to quality lowers overall episodic cost of care through best practice, standardized protocols, effectively managing care across the continuum, and investing in community resources such as our Community Health Team and our support of Healthy Bodies, Healthy Minds. The effect is evident by CMS data for the average Medicare Spending per Beneficiary. South County has the among the lowest Medicare Spending Per Beneficiary in Rhode Island, while maintaining the highest quality and service standards achieved in Rhode Island. South County Health does this because it is the right thing to do. However, there is no business model that supports these investments, nor is there governmental incentive for those health systems that continue to invest in these efforts without any remuneration for the necessary infrastructure to achieve and maintain these

results. Achieving high value care requires health systems to have significant funding to invest into people, processes and technology that support such care.

For your consideration, we propose further study regarding the following adjustments to the OHIC Affordability Standards:

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

Thank you for allowing me the time to submit my thoughts. South County Health desires to be a part of the solution, and we look forward to working with you in the future to achieve our shared goals of high quality care at the lowest overall cost.

Sincerely,



Aaron S. Robinson
President & Chief Executive Officer
South County Health
100 Kenyon Avenue, Wakefield, RI 02879
Phone: (401)788-1601/Cell: (401) 410-3288
Fax: (401) 789-9765
Email: Arobinson@southcountyhealth.org