2023

Public Comments

230-RICR-20-30-4

RHODE ISLAND OFFICE OF THE HEALTH INSURANCE COMMISSIONER

March 7, 2023

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

Re: Notice of Proposed Rulemaking, 230-RICR-20-30-4, "Powers and Duties of the Office of the Health Insurance Commissioner" (Affordability Standards)

Dear Mr. King:

RIPIN thanks OHIC for the opportunity to provide these comments in **support** of the proposed revisions to 230-RICR-20-30-4, "Powers and Duties of the Office of the Health Insurance Commissioner," familiarly known as the "Affordability Standards."

As noted in our comments in response to the ANPR issued in 2021, the Affordability Standards represent the deep commitment by OHIC to support access to affordable health insurance that provides meaningful health care coverage by driving investment in primary care, integrating behavioral health services into primary care, and building quality-driven alternative payment models that reward improved health outcomes. The proposed additional standards in the Notice of Proposed Rulemaking around 1) investment in children's behavioral health, 2) health equity requirements, and 3) professional provider contract terms expand upon the success of the current Affordability Standards. **RIPIN particularly supports the proposed investment in children's behavioral health**, a critically underfunded area of the Rhode Island health care delivery system where insufficient investment has driven lack of access and poor health outcomes for years. RIPIN offers the following technical comments in response to the Notice of Proposed Rulemaking:

Investment in Children's Behavioral Health

As detailed by OHIC in its whitepaper accompanying the Notice of Proposed Rulemaking, Rhode Island KIDS COUNT's report entitled "Children's Mental Health in Rhode Island" and the "Declaration of a Rhode Island State of Emergency in Child and Adolescent Mental Health" identify the crisis faced by children in lack of access to needed behavioral health services in Rhode Island. While this crisis of access was exacerbated by the Covid-19 pandemic, these challenges stem from years of underinvestment in behavioral health services. This underinvestment has driven significant gaps in the continuum of care, as identified in the July 2021 Rhode Island Behavioral Health System Review Technical Assistance report prepared by Faulkner Consulting Group and Health Management Associates.

While these gaps exist across the behavioral health care system, the 2021 Behavioral Health System Report identified more, and more significant, gaps in the continuum of care for children as compared to adults and older adults. That report noted that there was no evidence of several crucial behavioral health services for children being available anywhere in Rhode Island, including community step-down services, transition-age youth services, and residential treatment facilities for children with eating disorders. The report also found that there were

significant shortages in behavioral health prevention services, hospital diversion, state-sponsored institutional services, nursing homes, and residential programs.

RIPIN **strongly supports** the implementation of a behavioral health spending requirement whereby insurers will be required to significantly increase their baseline spending on community-based children's behavioral health. RIPIN acknowledges that the current proposal (in the Notice of Proposed Rulemaking) may be more administrable and is more targeted than the broader proposal from the ANPR to establish a system-wide spending standard in line with the percentage-of-medical-spend-based primary care spending standard. Nonetheless, RIPIN does note that a carrier-specific requirement to double community-based children's behavioral health spending from that carrier's own baseline, while addressing the significant lack of funding invested in the children's behavioral health care continuum, does not address disparities between carriers in their current level of investment. RIPIN encourages OHIC to investigate where disparities currently exist and consider further regulatory action to create a benchmark that sets a level playing field, bringing carriers who currently lag in investment up to a standard of universal application.

RIPIN offers one minor technical comment. In both the proposed rule and the accompanying whitepaper, carriers are required (at the proposed 230-RICR-20-30-4.10(B)(2)(c)) to increase their baseline expenditures *by* 200% of the current baseline. This would represent a tripling of current expenditures. However, in the accompanying cost-benefit analysis the increased expenditures appear to be based on an increase *to* 200% of the current baseline, or a doubling of that baseline. RIPIN recommends that OHIC clarify the precise increase it is proposing.

Health Equity Requirements

As addressed in our comments in response to the ANPR, RIPIN remains supportive of OHIC's efforts to address social determinants of health and advance health equity while dismantling systemic racism in the existing healthcare system. RIPIN supports the requirement that carriers obtain NCQA Health Equity Accreditation on as accelerated a timeline as would be practicable.

RIPIN agrees with OHIC's contention that improved demographic data would help drive more meaningful investments in ameliorating health disparities, as (based on information provided in recent sessions of the OHIC Measure Alignment Working Group) several carrier's current demographic data acquisition rates are inadequate to support sound, data-driven conclusions. RIPIN supports the requirement that, once sufficient data are available, significant financial incentives be tied to ameliorating health disparities. RIPIN specifically encourages that OHIC's understanding of "remediating health disparities" to particularly mean **improving health outcomes** faced by marginalized groups, particularly in infant and maternal mortality, the impacts of environmental hazards, and children's health.

RIPIN also encourages that OHIC explore avenues by which the financial incentives proposed in 230-RICR-20-30-4.10(E)(5)(b) can be coordinated across carriers to help ensure that certain communities are not left out due to over-concentration of investments in other communities. RIPIN appreciates OHIC's commitment to public engagement and the convening of working groups to explore both the demographic data collection standards and the requirements for health insurer financial incentives to remediate health disparities.

Professional Provider Contract Terms

RIPIN is in agreement with OHIC's discussion, in the whitepaper accompanying the proposed 230-RICR-20-30-4.10(D)(8), of the significant impact of increased prices driving affordability challenges. RIPIN supports transparency in those price structures so determinations can be made as to where actions to restrict price growth can be focused.

RIPIN repeats its suggestion from our comments in response to the ANPR that participation in advanced value-based payment models not be seen as a reason to exclude participating providers from analysis of their prices and/or price growth. RIPIN further encourages that, insofar as decisions are made utilizing data received through the proposed transparency requirements, those decisions be made with consideration to the "triple aim" of access, affordability, and quality (particular health outcome quality), not solely with regard to the impacts of price on affordability.

Conclusion

Thank you for the opportunity to provide these comments. We look forward to continuing to work with OHIC as these proposals are finalized and implemented. Thank you for your continued leadership in innovative approaches to drive needed investment in health care, particularly in areas where underinvestment has led to unacceptable health care outcomes.

Please do not hesitate to contact us if additional information would be helpful.

Sincerely,

/s/

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/s/

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March 17, 2023

Cory King, Acting Commissioner
Office of the Health Insurance Commissioner
Via email: cory.king@ohic.ri.gov

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

Dear Acting Commissioner King:

Blue Cross & Blue Shield of Rhode Island (BCBSRI) appreciates the opportunity to provide comments on the proposed amendments to 230-RICR-20-30-4, Powers and Duties of the Office of the Health Insurance Commissioner (the Affordability Standards, or "the Standards").

BCBSRI shares the goals of the Office of the Health Insurance Commissioner (OHIC) to improve access to pediatric behavioral health care and health equity. In fact, addressing health equity is one of four pillars of BCBSRI's recently approved long term strategy and improving pediatric behavioral health is a key focus area of the health equity work. We have already made significant investments in this work. BCBSRI is also committed to achieving the Cost Growth Target, as affordability and access to care for all Rhode Islanders is dependent on containing the high cost of health care. As we have stated before, balancing these goals requires allocating investments carefully to realize the greatest returns and reacting quickly to data and developments if initial investments do not have the expected outcomes. Flexibility to invest in the right places at the right time will be critical to our collective success.

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

Section 4.10(B)(2)(b)—Behavioral Healthcare Expenditures

BCBSRI appreciates OHIC's recognition in the proposed Standards that "behavioral health expenditures" should include more than just fee for service payments to behavioral health providers. Additionally, BCBSRI recommends that OHIC make several clarifications and/or revisions to the identified non-claims-based expenditures to capture the amounts more accurately being spent on behavioral health care.

First, with respect to "per member per month payments to support behavioral health care integration into primary care," insurers often make payments to Systems of Care ("SOC") to be allocated between medical and behavioral health providers at the SOC's discretion. In determining behavioral health expenditures, insurers should be permitted to make a reasonable estimate of what portion of those payments should be allocated to behavioral health, with guidance from the SOCs.

Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.

Second, health care expenditures should include not only quality payments "made" as provided in the proposed Standards, but also quality payments that were available but not achieved. Understanding the full scope of potential payments, as well as where providers fell short of achieving those payments, will be increasingly important as these payment arrangements become more common.

Finally, OHIC should not limit the grants included in the expenditures to only amounts spent on the needs of "insured members." Grants are typically designed to support a broad population, and may benefit Rhode Island residents generally, not just BCBSRI fully insured members. For example, BCBSRI provides grants to support PediPRN (a resource line to assist pediatricians with their patient's behavioral health needs) and for Bradley hospital to conduct training, both of which benefit more than just BCBSRI members. Apportioning grant amounts to insured members would not be practical or necessary.

Section 4.10(B)(2)(c)—Increase in Behavioral Healthcare Expenditures

BCBSRI is in alignment with OHIC's goal to address the pediatric behavioral health crisis and agrees that investments to improve access and quality of care are critical. However, BCBSRI opposes the mechanism proposed for supporting pediatric behavioral health in the Standards, namely increasing per member per month expenditures on community-based behavioral healthcare by 200% by January 1, 2024.

Spending requirements that are not tied to quality risk increasing the overall cost of care without any benefit to members. Any spending target must allow insurers to tie payment increases to achieving quality metrics. The spending requirement proposed in the Standards, however, combined with the short time in which insurers would have to implement the required increase, provides no flexibility to structure those increased payments in a way to incent improved quality or access.

In addition, the requirement to increase spend by a fixed percentage over payments made in 2022 will effectively penalize insurers who have been more proactive in investing in behavioral health programs already. For example, a payer with a $10 PMPM in 2022 would be required to implement a fee increase resulting in a $20 PMPM (200% of $10), while a payer with a $5 PMPM in 2022 would only be required to increase its payments to $10 PMPM. Some investments in pediatric behavioral health in 2022 may have been planned as one-time investments and would not be sustainable over time. Requiring insurers who made these investments to then double them would put those insurers who tried to do the right thing before it was a regulatory requirement at a competitive disadvantage.

Moreover, the spending requirement is targeted at just one type of care—community-based behavioral health care. While this may be the setting where increased spending will be most impactful, there are other areas of investment that may increase access as well, such as increased access to telemedicine services or integrated behavioral health care. There should be some measurement of the effectiveness of the additional spending requirements before insurers are required to maintain the additional spending over time. If other investments prove more effective, insurers should have the flexibility to redirect the spend to those more effective programs. BCBSRI is also concerned that without addressing disparities in Medicaid payments, increases in spending by commercial insurers may not be enough to fund additional capacity and

access in community based behavioral health care. It could also have the unintentional consequence of incentivizing providers to prefer commercial members over Medicaid members, resulting in less access for those children covered by Medicaid.

BCBSRI reiterates its suggestion from the advance notice of proposed rulemaking that prior to imposing a regulatory obligation on spending, OHIC should first employ its collaborative, all-payer, all-provider care transformation-type work, informed by the data provided by the new reporting required by the proposed Standards and knowledge gained from OHIC's work on Medicaid rates. This effort would best define the areas of investment most likely to improve pediatric behavioral health.

If OHIC chooses to impose the spending target proposed in the revised Standards, it should at least incorporate greater flexibility to condition additional payments on quality and time to measure the effectiveness of the increased spending. BCBSRI would also suggest using the spending obligation to promote contracting with those providers that have been designated as Certified Community Behavioral Health Centers by the Executive Office of Health and Human Services. If not, OHIC should define which providers will be considered community-based behavioral health care and should be included in the calculations. OHIC also may want to clarify the appropriate calculation for the increased spend. The supporting document shows the intent is for the new spend to be 200% <u>of</u> the 2022 baseline (i.e., doubling the spend), rather than an increase <u>by</u> 200% (i.e., tripling the spend). An alternative phrasing may be to require a 100% increase.

Section 4.10(E)—Health Equity

BCBSRI shares OHIC's goals related to health equity and has made health equity and eliminating health disparities a strategic priority. BCBSRI supports the requirement to obtain NCQA Health Equity Accreditation, but the timeline established in the proposed Standards is too short. We understand that NCQA is receiving a large number of applications for Health Equity Accreditation, and the process is taking a considerable amount of time. As an example, BCBSRI has already submitted its application for Health Equity Accreditation and received a survey date from NCQA of May 2024. Moreover, insurers may need to do significant foundational work before they would be successful in achieving accreditation from NCQA, so may need time before they can even submit an application. BCBSRI recommends revising the requirement to require plans to file an application for NCQA Health Equity Accreditation by July 1, 2024 and obtain such certification by July 1, 2026.

BCBSRI also supports the collection of self-reported demographic data and has recently completed configuration of our systems to capture this data. Earlier this month we launched a communications campaign to encourage member self-reporting but we recognize it will take a lot of time and effort just to obtain this type of data for a small portion of our membership. While OHIC's requirement to collect data for at least 80% of members by January 1, 2025, is an admirable goal, we think it is likely unattainable. BCBSRI has heard anecdotally from insurers who have been involved in this work for several years already that this collection is a slower process than we would all like. BCBSRI suggests that a goal of 10% by January 1, 2025, is more realistic.

In closing, BCBSRI reiterates support for OHIC's Affordability Standard efforts and appreciates the Office's approach to having collected information and comments prior to the release of these draft regulations. We welcome the opportunity to share further feedback or explanation of the comments as appropriate.

Thank you for your consideration.

Sincerely,

Kristen Shea McLean

Kristen Shea McLean
Vice President, General Counsel

cc: Michele Lederberg, Esq.

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

March 6, 2023

Cory King, Acting Commissioner
Office of Health Insurance Commissioner
1511 Pontiac Avenue Building 69-1
Cranston, RI 02920
Cory.king@ohic.ri.gov

Re: Office of Health Insurance Regulation and Affordability Standards-230 RICR-20-30-4

Dear Acting Commissioner King,

On behalf of the Care Transformation Collaborative of Rhode Island (CTC-RI), we appreciate the opportunity to provide public comment regarding the OHIC Regulation including the Affordability Standards 30-RICR-20-30.4. We commend the Office of Health Insurance Commissioner (OHIC) for its efforts to increase critical investment in primary care, integrated behavioral health, and health equity. We generally agree with and support the suggested changes to the Regulation.

Attached please find a document with comments and recommendations for your consideration. Our comments consider the potential impact of the changes around accountability, evaluation and oversight, and the urgent need to increase investment in primary care, behavioral health, and health equity.

We are proud that Rhode Island ranked 6th nationally in the Commonwealth Fund 2022 Scorecard on State Health System Performance Report. In addition, Rhode Island ranks 1st in the nation in COVID-19 vaccination rates in children which points to our state's ability to mobilize and leverage cross-agency collaboration and our primary care resources to achieve public health goals. We attribute the ability of OHIC to effectively develop, implement and oversee regulations to improve the health care of all Rhode Islanders as a key driver in that success.

CTC-RI welcomes the opportunity to support OHIC's efforts to improve primary care, behavioral health integration, and health equity. Specifically, there are 3 areas which CTC-RI will be working on over the next year, that directly support the OHIC regulations:

1) Continued work on integrated behavioral health in primary care for children and adolescents. At OHICs request, we will work to develop standards and a process for behavioral health recognition as an alternative to NCQA;
2) Working with EOHHS and RIDOH, CTC-RI will launch a demographic data collection project to train practices on capturing demographic data that will inform our efforts around reducing/eliminating health disparities; and
3) The CTC-RI Board approved OHIC's request for CTC-RI to convene key stakeholders, to build on the work that the OHIC has done in the area of streaming the prior authorization process.

Thank you for your continued leadership.

Sincerely,

Debra Hurwitz, MBA, BSN, RN
Executive Director

Peter Hollmann, MD
President

230-RICR-20-30-4

TITLE 230 – DEPARTMENT OF BUSINESS REGULATION

CHAPTER 20 – INSURANCE

SUBCHAPTER 30 – HEALTH

INSURANCE

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

4.1 Authority

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

4.2 Purpose and Scope

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

1. Ensure effective regulatory oversight by the OHIC;

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

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

4.3 Definitions

A. As used in this regulation:

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

2. "Aligned measure set" means any set of quality measures adopted by the Commissioner pursuant to § 4.1O(D)(5) of this Part. An Aligned Measure Set shall consist of measures designated as 'Core Measures' and/or 'Menu Measures.' Aligned Measure Sets are developed for specific

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

3. "Commissioner" means the Health Insurance Commissioner.

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

5. "Demographic data" means self-reported data on race, ethnicity, preferred language, sex assigned at birth, gender identity, sexual orientation, and disability.

~~5~~6. "Direct primary care expenses" means payments by the Health Insurer directly to a primary care practice for:

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

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

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

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

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

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

(CC) Funding the purchase by the practice of analytic software that enables primary care practices to

Commented [HPM1]: Insert definition for use in 4.10.B.2 and renumber:
"Community Based Behavioral Health Care"
We do not have specific language but note--
Probably not intended to include inpatient. Intended to include outpatient/office based practices and CMHC.
What about residential treatment, IOP, support services like Cedar? May be sub-regulatory and may wish to define as those entities defined by the OHIC.

Commented [HPM2]: We commend the OHIC for addressing equity. Does the OHIC wish to be less prescriptive on the elements and add a qualifier given the later references to national standards and definitions? Create sub-regulatory authority to revise?

Commented [DH3]: Note: CTC will be working with EOHHS (Liv King) and RIDOH on demographic data project. The initial SOW has been approved and definition of the elements for data collection is a deliverable. We will work with key stakeholders and the States HIT committee to gain consensus on the list.

analyze patient quality and/or costs, such as software that tracks patient costs in near-to-real time;

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

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

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

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

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

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

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

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

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

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

Commented [HPM4]: Insert punctuation between "Homes" and "Acceptable"

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

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

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

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

~~6~~7. "Examination" means the same as set out in R.I. Gen. Laws § 27-13.1-1 *et seq*.

~~7~~8. "Health insurance" means "health insurance coverage," as defined in R.I. Gen. Laws §§ 27-18.5-2 and 27-18.6-2, "health benefit plan," as defined in R.I. Gen. Laws § 27-50-3 and a "medical supplement policy," as defined in R.I. Gen. Laws § 27-18.2-1 or coverage similar to a Medicare supplement policy that is issued to an employer to cover retirees.

~~8~~9. "Global capitation contract" means a Population-Based Contract with an Integrated System of Care that:

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

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

~~9~~10. "Health insurer" means any entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the Commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for,

Commented [HPM5]: May wish to consider insertion of definition and renumbering related to 4.10.E
"Equity" means attaining access, quality and outcomes regardless of social determinants of heath and demographic characteristics.

Commented [HPM6]: "Total" and "Near total" are actually described later (4.10.D.2) and you may elect to reference those sections as there are caps and minimums and some may not be "near total".

or reimburse any of the costs of health care services, including, without limitation, an insurance company offering accident and sickness insurance, a health maintenance organization, a non-profit hospital service corporation, a non-profit medical service corporation, a non-profit dental service corporation, a non-profit optometric service corporation, a domestic insurance company subject R.I. Gen. Laws Chapter 27-1 that offers or provides health insurance coverage in the state and a foreign insurance company subject to R.I. Gen. Laws Chapter 27-2 that offers or provides health insurance coverage in the state.

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

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

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

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

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

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

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

176. "Patient-centered medical home" means:

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

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

c. A Primary Care Practice designated by contract between a Health Insurer and a primary care practice, or between a Health Insurer and an Integrated System of Care in which the Primary Care Practice is participating. A contractually designated Primary Care Practice must meet pre-determined quality and efficiency criteria and practice performance standards, which are approved by the Commissioner, for improved care management and coordination that are at least as rigorous as those of the collaborative initiative endorsed by R.I. Gen. Laws Chapter 42-14.6. For the purposes of this definition a primary care practice that participates in a primary care alternative payment model and participates in an integrated system of care will be deemed to have met the requirements of a patient-centered medical home, and

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

187. "Population-based contract" means a provider reimbursement contract with an Integrated System of Care that uses a reimbursement methodology that is inclusive of the total, or near total medical costs of an identified, covered-lives population. A Population-Based Contract may be a Shared Savings Contract, or a Risk Sharing Contract, or a Global Capitation Contract. A primary care or specialty service capitation reimbursement contract shall not be considered a Population-Based Contract for purposes of this Part. A Population-Based Contract may not

Commented [HPM7]: We support increasing flexibility towards meeting the OHIC definition of a PCMH. Resources spent on accreditation may be better used for transformation and services delivery. We appreciate that the OHIC has not retained a parallel set of standards that create administrative burden.

Commented [DH8]: Note: We raise up PCMH for children and adolescents and note that traditional alternative payment models focus on adults with complex medical needs and have less emphasis on prevention and costs associated with keeping children and families healthy. By eliminating NCQA, which takes a population based approach (inclusive of children) in care delivery and reporting, we may lose visibility into the investment and performance of pediatric practices.
Consideration should be given to including assurances from systems of care that pediatric populations and practices are receiving resources needed to maintain standards of PMCH as defined by OHIC.

Commented [HPM9]: See comment above regarding "Global capitation contract"

transfer insurance risk or any health insurance regulatory obligations. A Health Insurer may request clarification from the Commissioner as to whether its proposed contract constitutes the transfer of insurance risk.

19. "Primary care alternative payment model" means a payment model that relies on prospective payment to a primary care practice or a primary care provider for evaluation and management services in addition to any amounts paid to support care management and infrastructure of the primary care practice.

2018. "Primary care practice" means the practice of a physician, medical practice, or other medical provider considered by the insured subscriber or dependent to be his or her usual source of care. Designation of a primary care provider shall be limited to providers within the following practice type: Family Practice, Geriatrics, Internal Medicine and Pediatrics; and providers with the following professional credentials: Doctors of Medicine and Osteopathy, Nurse Practitioners, and Physicians' Assistants; except that specialty medical providers, including behavioral health providers, may be designated as a primary care provider if the specialist is paid for primary care services on a primary care provider fee schedule, and contractually agrees to accept the responsibilities of a primary care provider.

2119. "Qualifying Integrated Behavioral Health Primary Care Practice" means:

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

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

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

Commented [HPM10]: Consider: "Primary care alternative payment model" means a payment model that relies on prospective payment to a primary care practice or a primary care provider for a defined set of primary care services (including office evaluation and management services) in addition to any amounts paid to support care management and infrastructure of the primary care practice. It may also include a model that includes additional services in the alternative payment methodology, such as integrated behavioral health.
Suggested as this promotes IBH integration

Commented [DH11]: Note: We also believe that there should be more specific definitions for "primary care alternative payment models" that recognize pre-payment for a bulk of primary care through either "hybrid", or preferably, "full" prepayment for expected primary care services. These payments should recognize investments above and beyond historical "fee-for-service plus infrastructure" payments, most of which should not be at risk beyond quality and patient experience measures. Alternative payment methodologies related to risk sharing do not currently take into account the primary care costs associated with caring for patients and families with greater socioeconomic risk or medical complexity. An unintended consequence could be that Accountable Care Organizations (ACOs) could decide to reduce the financial risk associated with caring for patients who need more resources. We recommend that OHIC identify how it will safeguard and evaluate the impact of this regulatory change and address the associated risks.

Commented [HPM12]: Integrated Behavioral Health - Qualifying Practice would make this more logically placed alphabetically. Would then need to revise term when used subsequently.
We support the changes to b and c.
Would the OHIC be required to approve CTC standards and if so, presumably on a sub-regulatory basis?

Commented [DH13]: Note: CTC is prepared to support the OHIC in developing IBH standards and a process for recognition as an alternative to NCQA.

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

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

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

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

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

253. "Shared savings contract" means a Population-Based Contract that:

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

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

4.4 Discharging Duties and Powers

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

1. Guard the solvency of health insurers;

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

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

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

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

Commented [HPM14]: We commend the OHIC on significant changes to 4.10 Affordability Standards that address Equity.
Throughout these regulations the term "quality and efficiency" is used. "Quality" can include efficiency and equity, but for good cause efficiency" was called out. We believe "equity" should receive similar treatment and the phrase should be "quality, equity and efficiency" in all or nearly all places this phrase appears. This is appropriate, even if it is not in the legislation that established the OHIC as it is an integral part of quality.

4.5 Guarding the Solvency and Financial Condition of Health Insurers

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18. Whether the management of a health insurer has

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

    b. Furnished false and misleading information concerning an inquiry by the Commissioner, the Department of Business Regulation, the Department of Health, the Department of the Attorney General, any other state or federal agency regarding the financial condition of the health insurer; or

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

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

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

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

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

4.6 Protecting the Interests of Consumers

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

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

C. Whenever the Commissioner determines that one of the circumstances in §§ 4.6(C)(1) through (3) of this Part exist, the Commissioner shall, in addition to exercising any duty or power authorized or required by R.I. Gen. Laws Titles 27 or 42 related specifically to the protection of the interests of the consumers of health insurance, act to protect the interests of consumers of health insurance when exercising any other power or duty of the Office, including, but not limited to, approving or denying any request or application; approving, denying or modifying any requested rate; approving or rejecting any forms, trend factors, or other filings; issuing any order, decision or ruling; initiating any proceeding, hearing, examination, or inquiry; or taking any other action authorized or required by statute or regulation.

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

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

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

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

   1. The privacy and security of consumer health information;

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

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

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

3. The effectiveness of a health insurer's consumer appeal and complaint procedures.;

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

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

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

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

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

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

4.7 Encouraging Fair Treatment of Health Care Providers

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

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

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

filings; issuing any order, decision or ruling; initiating any proceeding, hearing, examination, or inquiry; or taking any other action authorized or required by statute or regulation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Whenever the Commissioner determines that any of the circumstances listed in §§ 4.8(C)(1) or (2) of this Part exist, the Commissioner shall, in addition to exercising any duty or power authorized or required by R.I. Gen. Laws Titles 27 or 42 related specifically to improving the efficiency and quality of health care delivery and increasing access to healthcare services, act to further the interests set out in § 4.8(C)(1)(a) of this Part when exercising any other power or duty of the Office, including, but not limited to, approving or denying any request or application; approving, denying or modifying any requested rate; approving or rejecting any forms, trend factors, or other filings; issuing any order, decision or ruling; initiating any proceeding, hearing, examination, or inquiry; or taking any other action authorized or required by statute or regulation.

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

   a. Can be made in a manner that will

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

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

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

   b. Should include conditions when feasible that will

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

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

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

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

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

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

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

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

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

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

e. Prioritize the use of limited resources

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

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

b. Encouraging public understanding, participation and dialog with respect to the rising costs of health care services, technologies, and pharmaceuticals; the role played by health insurance as both a financing mechanism for health care and as a hedge against financial risk for the consumers of health care; and potential

solutions to the problems inherent in the health insurance market (e.g., market concentration, increasing costs, the growing population of uninsureds, market-driven changes to insurance products (such as the growth of high deductible plans) and segmentation of the insurance market due to state and federal laws); and

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

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

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

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

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

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

a. Collaborating with state and local health planning officials;

b. Participating in the legislative and regulatory processes; and

c. Engaging the public in policy debates and discussions.

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

4.9 Affordable Health Insurance - General

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

Commented [HPM15]: This is slightly dated. Consider deletion of "the growing" or "the growth"

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

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

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

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

5. Reduced provision of low-value care.

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

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

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

1. Trends, including:

   a. Historical rates of trend for existing products;

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

   c. Regional medical and health insurance trends; and

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

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

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

Commented [HPM16]: While this section is more about Cost than Transformation, the latter is integral to cost control. Reducing disparity is also essential to cost control and certainly for quality and positive transformation. Consider adding at 3 and then renumbering:
3. "Reduction in health and healthcare disparities due to social determinants of health or demographics."

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

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

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

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

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

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

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

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

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

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

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

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

b. Whether the insurer addresses consumer need for cost information through increasing the availability of provider cost information and

promoting public conversation on trade-offs and cost effects of medical choices; and

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

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

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

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

3. Health insurer solvency requirements.

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

4.10 Affordable Health Insurance – Affordability Standards

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

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

1. Primary care expenditures.

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

~~2~~b. Direct Primary Care Expenses shall be accounted for as medical expenses on the health insurer's annual financial statements.

Indirect Primary Care Expenses shall be accounted for as administrative costs on the health insurer's annual financial statements. Indirect Primary Care Expenses may be deducted from the statement's administrative cost category as cost containment expenses, in accordance with federal Medical Loss Ratio calculation rules.

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

2. Behavioral health care expenditures.

a. Each health insurer shall report its annual, actual expenditures on behavioral health care in a form and manner determined by the Commissioner.

b. Behavioral health care expenditures shall be inclusive of claims-based expenditures where the claim includes a behavioral health condition as a principal diagnosis, inclusive of mental health and substance use disorder. Additionally, behavioral health care expenditures shall include non-claims-based expenditures, such as per member per month payments to support behavioral health care integration into primary care, pay for performance payments made to behavioral health care providers, and grants designed to address the behavioral health care needs of insured members

c. By January 1, 2024, each health insurer shall increase baseline per member per month expenditures on community-based behavioral health care for children and adolescents, age 0 – 18, by 200% and maintain the increase over time. Baseline expenditures shall be defined as payments incurred and paid in calendar year 2022.

C. Primary care practice transformation. The purpose of ~~this~~ $ 4.10(C) of this Part is to transform how primary care is delivered in Rhode Island and to ensure sustainable funding for advanced primary care, in order that the goals of these Affordability Standards can be achieved. While primary care practice transformation should not be considered an ultimate goal in itself, the Commissioner finds that it produces higher quality and potentially lower cost care and is a necessary foundation for the effective participation of practices in Integrated Systems of Care. One element of primary care transformation is the integration of behavioral health care into primary care practice. Integration is in the best interest of the public as it improves health status for those with behavioral health needs and may also result in more efficient use of health care resources. Further, behavioral health integration is a necessary and proper

Commented [DH17]:
The following may not need to be explicitly stated in the regulation but could be part of a guidance document that provides examples of direct and indirect expenses that can be included in the primary care spend.

We recommend taking into account costs associated with improving care coordination and access to care with specialists by including use of eConsult and enhanced referrals. (See note in Specialist section below).

Due to severe workforce shortages, we recommend that the definition of primary care expenditures include payments for student loan repayment for all health care workers.

The primary care team needs to screen for and address health related social needs. We recommend that primary care expenditures include the costs associated with connecting with community based organizations and using resource platforms such as Unite.

Commented [HPM18]: We support the intent of this section. We note "b." is not restricted to "community-based behavioral health" (CBBH) and other BH may not be relevant. We previously commented that CBBH is not defined.
We offer the following comment:
"Principal diagnosis" is often difficult as secondary diagnoses may be equally relevant. While the intent relates to CBBH, an example (perhaps not perfectly reflecting ICD10 rules)would be an emergency department claim with a principal diagnosis of wrist laceration and a secondary diagnosis of suicide attempt. In primary care it would often be the case that a BH diagnosis would not be primary, yet was addressed. Is the goal to include payments to primary care specialists? Is the goal to only include payments to BH specialists (eg psychiatry, psychology and clinical social work) and entities (eg CMHC)?
We do agree that designated IBH components of capitation to IBH-Qualified Practices should be counted.
Grants probably should be included if approved by the OHIC. This is not dissimilar to grants that the OHIC allows as primary care direct or indirect payment. Some flexibility is appropriate at this time.

Commented [DH19]: CTC-RI has been working with the Rhode Island Department of Health on its implementation of the grant funded HRSA program that includes the Psychiatric Resource Network (PRN) teleconsultation program. Should HRSA funding end, we recommend the PRN, PediPRN and MomsPRN programs qualify as behavioral health expenditures.

strategy to fulfill the Office's legislative mandate under R.I. Gen. Laws § 42-14.5-3, which directs insurers toward policies and practices that address the behavioral health needs of the public and greater integration of physical and behavioral health care delivery.

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

   a. Primary care practices which meet the requirements of a Patient-Centered Medical Home in § 4.3(A)(175) of this Part shall be deemed eligible for practice support payments.

   b. Health insurers shall fund primary care practices which have met the requirements of a Patient-Centered Medical Home in § 4.3(A)(175) of this Part in accordance with the following guidelines:

      (1) Primary care practices actively engaged in first-time transformation activity ~~and without NCQA recognition~~, or practices which have completed transformation activity~~with NCQA recognition~~, but which have not met the requirements outlined in § 4.3(A)(175)~~(d)~~ of this Part, shall receive both infrastructure and care management per member per month (PMPM) payments. The care management PMPM payment shall support development and maintenance of a care management function within the practice site.

      (2) Primary care practices that have completed transformation activity~~with NCQA recognition~~ and which have met the requirements in § 4.3(A)(175) of this Part shall receive a care management PMPM payment and have an opportunity to earn a performance bonus.

      (3) Health insurers shall not impose a minimum attribution threshold for making care management PMPM or infrastructure payments to a Patient Centered Medical Home.

      (4) The monetary levels of practice support payments shall be independently determined by the health insurer and the primary care practices. If the primary care practice is part of an Integrated System of Care, the health insurer may make the PMPM payment to the Integrated System of Care, provided the Integrated System of Care is contractually obligated to use the PMPM payment to finance care management services at the primary care practice earning the payment.

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

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

      (1) Financial barriers. By January 1, 2021 health insurers shall eliminate copayments for patients who have a behavioral health visit with an in-network behavioral health provider on the same day and in the same location as a primary care visit at a Qualifying Integrated Behavioral Health Primary Care Practice as defined in $ 4.3(A)(21~~19~~) of this Part.

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

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

   b. The Commissioner shall determine which practices are Qualifying Integrated Behavioral Health Primary Care Practices ~~.~~ by November 30, 2020, and annually thereafter. The Commissioner shall issue guidelines on any time limitations for practices to qualify under $$ 4.3(A)(21~~19~~)(a) and (b) of this Part.

   c. ~~Health insurers shall submit a report to the Commissioner no later than October 31, 2020, that delineates strategies, in addition to the requirements in $ 4.10(D)(3)(c) of this Part, to facilitate and support the integration of behavioral health care into the primary care~~

Commented [HPM20]: We have no comment on the regulation, but question whether a market conduct analysis has been to done regarding compliance.

~~setting. The Commissioner shall issue documentation no later than August 1, 2020 that includes specific questions for the health insurers to respond to and any additional requirements for the report. The Commissioner shall post the completed reports on the OHIC website.~~

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

1. Alternative payment models

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

   b. Health insurers shall take such actions as necessary to have 50% of insured medical payments made through an alternative payment model by January 1, 2021, and annually thereafter. The Commissioner shall issue a policy and guidelines manual by January 1 of each year that specifies the types of payments and payment models which may be credited toward the 50% target.

2. Population-based contracts

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

Commented [HPM21]: We do not believe it is possible to provide specific recommendation on the topics of equity and community health teams and other community based services other than to request the OHIC convene the appropriate parties to evaluate how community based programs that address behavioral health and health disparities should be incorporated into the affordability standards. A clause 3 indicating this objective may be added.

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

c. ~~By January 2021, h~~Health insurers shall take such actions as necessary to have 30% of Rhode Island resident commercial insured covered lives attributed to a risk-sharing contract or global capitation contract.

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

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

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

(3) For contracts with Physician-based Integrated Systems of Care between 10,000 and 20,000 attributed commercial lives, health insurers shall employ a risk-sharing rate of at

least 40%, and if applicable, a risk-exposure cap of at least 7% of provider revenue or at least 2% of the total cost of care and a minimum loss rate of no more than 3% of the total cost of care. For such contracts entered into, renewed, or amended on or after January 1, 2021, health insurers shall employ a risk-sharing rate of at least 50%, and if applicable, a risk-exposure cap of at least 8% of provider revenue or at least 3% of the total cost of care and a minimum loss rate of no more than 3% of the total cost of care.

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

(5) The Minimum Downside Risk requirements above, while not applicable to risk-sharing contracts with fewer than 10,000 attributed commercial lives, should not be construed to preclude or discourage health insurers and providers from entering into risk-sharing contracts with fewer than 10,000 attributed lives. OHIC recommends health insurer and provider caution when doing so, however, in order to account for the decreased statistical certainty with attributed populations less than 10,000.

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

e. A health insurer shall not enter into a Risk Sharing Contract or a Global Capitation contract unless the health insurer has determined, in accordance with standard operating procedures filed and approved by the Commissioner, that the provider organization entering into the contract has the operational and financial capacity and resources needed to assume clinical and financial responsibility for the provision of covered services to members

attributable to the provider organization. At the reasonable request of the provider organization, the health insurer shall maintain the confidentiality of information which the health insurer requests to make its determination. The health insurer shall periodically review the provider organization's continuing ability to assume such responsibilities. The health insurer shall maintain contingency plans in the event the provider organization is unable to sustain its ability to manage its responsibilities. The foregoing shall not be construed to permit the transfer of insurance risk or the transfer of delegation of the health insurer's regulatory obligations.

f. Population-Based Contracts shall include a provision that agrees on a budget for each contract year. Review and prior approval by the Office of the Health Insurance Commissioner shall be required if any annual increase in the total cost of care for services reimbursed under the contract, after risk adjustment, exceeds the US All Urban Consumer All Items Less Food and Energy CPI ("CPI-Urban") percentage increase (reported~~determined~~ by the Commissioner by October 1 of each year, in accordance with the method set forth in $ 4.10(D)(6)(i) of this Part~~based on the most recently published United States Department of Labor data)~~. Such percentage increase shall be plus 1.5%.

g. Should any Integrated System of Care have had three immediately prior years of average historical risk-adjusted total cost of care per capita spending for the provider's attributed patient population that was significantly below the health insurer's risk-adjusted commercially insured average (statistically significant at p <= .05 and excluding the provider from the calculated average), the health insurer may prospectively adjust that provider's budget upward by up to, but not more than, 2% of the provider's unadjusted expected per capita spending. The adjusted budget shall never exceed the health insurer's projected risk-adjusted commercially insured average spending. Only Integration Systems of Care with risk-sharing contracts shall qualify for the upward budget adjustment.

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

g. Population-Based Contracts shall include terms that relinquish the right of any party to contest the public release, by state officials or the parties to the contract, of the provisions of the contract demonstrating compliance with the requirements of $ 4.10(D)(2) of this Part; provided that the health insurer or other affected party

may request the Commissioner to maintain specific contract terms or portions thereof as confidential, if properly supported with legal and factual analysis justifying the claim of confidentiality.

3. Primary care alternative payment models

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

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

c. For primary care practices recognized as a Qualifying Integrated Behavioral Health Primary Care Practice under $ 4.3(A)(2118) of this Part, Health Insurers shall develop and implement a prospectively paid alternative payment model for primary care that compensates practices for the primary care and behavioral health services delivered by the site.

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

(1) ~~By January 1, 2021, a~~At least ~~12~~0% of insured Rhode Island resident covered lives shall be attributed to a ~~prospectively paid~~ primary care alternative payment model by the end of 2023.

(2) ~~By January 1, 2022, a~~At least ~~23~~5% of insured Rhode Island resident covered lives shall be attributed to a ~~prospectively paid~~ primary care alternative payment model by the end of 2024.

(3) ~~By January 1, 2023, a~~At least 4~~5~~0% of insured Rhode Island resident covered lives shall be attributed to a ~~prospectively paid~~ primary care alternative payment model by the end of 2025.

Commented [HPM22]: The only proposed changes relate to timelines, which we support. Even if the Consensus Model contains some recommendations we suggest a new lower case "c" and re-lettering thereafter:
C. Models should address the difference in primary care services expected as part of the standard of care for different age groups. There should also be methods to address payment adequacy related patients or populations of greater medical, behavioral or social risk and complexity.

Commented [DH23]: To provide comprehensive primary care, practices needed to support team members including medical assistants, pharmacists, integrated behavioral health clinicians, community health workers, scribes, and nurse care managers. We recommend that alternative payment models take into account the scope of services offered by the primary care practice and the expenses related to team based care.

(4) ~~By January 1, 2024, a~~At least 60% of insured Rhode Island resident covered lives shall be attributed to a ~~prospectively paid~~ primary care alternative payment model by the end of 2026.

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

4. Specialist alternative payment models

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

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

(1) Orthopedics;

(2) Gastroenterology;

(3) Cardiology;

(4) Behavioral health; and

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

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

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

e. Health insurers shall meet this requirement according to the following schedule: by December 31, 2021: two specialties; by

Commented [HPM24]: This section does not appear to have been met or to be active. This may be best addressed by removing dates and considering more generic language about specialties. Having "Behavioral Health" seems especially odd given the emphasis on IBH and CBBH spending.

Commented [DH25]: CTC is working with Lifespan and CNE on the implementation of enhanced PCP-specialist referrals and eConsults. BCBS stated that based on this pilot they will begin paying for eConsults 10/1/23.
We would like to see all commercial plans reimburse for eConsults.
We recommend the costs associated with improving care coordination and access to care with specialists by using eConsult and enhanced referrals be included in primary care expenditures.

December 31, 2022: three specialties; by December 31, 2023: four specialties; by December 31, 2024: five specialties.

5. Measure alignment

   a. The purpose of this $ 4.10(D)(5) of this Part is to ensure consistency in the use of quality measures in contracts between health insurers and health care providers in Rhode Island, to reduce the administrative burden placed on providers by the unaligned use of quality measures across health insurers, to improve the quality of care by channeling clinical focus on core areas of health care delivery, to formally adopt Aligned Measure Sets to be used in contracts between health insurers and health care providers in Rhode Island, and to articulate a process for annually refining and updating the Aligned Measure Sets.

   b. $ 4.10(D)(5) of this Part applies to contracts between health care providers, including primary care providers, specialists, hospitals, and Integrated Systems of Care and a health insurer which incorporate quality measures into the payment terms of the contract and are entered into, renewed, or amended on or after July 1, 2020, or the effective date of this regulation, if earlier.

   c. Health insurers shall adopt the Aligned Measure Sets for primary care, hospitals, Accountable Care Organizations (ACOs, otherwise known as Integrated Systems of Care as defined in $ 4.3(A)(12) of this Part), maternity care, outpatient behavioral health and any other Aligned Measure Set developed pursuant to this $ 4.10(D)(5) of this Part.

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

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

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

      (4) Health insurers shall not incorporate a Core Measure into the terms of payment with a de minimis weight attached to

the measure, such that performance on the Core Measure lacks meaningful financial implication for the provider.

(5) A health insurer may petition the Commissioner to modify or waive one or more of the requirements of $ 4.1O(D)(5) of this Part. Any request to modify or waive one or more of the requirements must articulate a clear rationale supporting the waiver request and must demonstrate how the health insurer's request will advance the quality, accessibility, and/or affordability of health care services in Rhode Island.

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

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

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

(3) Propose measures as Core Measures and Menu Measures.

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

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

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

(2) Health insurers;

(3) Hospital systems;

(4) Health care providers;

(5) Consumers;

(6) Quality measure experts; and

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

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

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

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

6. Hospital contracts

a. Each health insurer shall include in its hospital contracts the terms required by § 4.1O(D)(6) of this Part.

b. This § 4.1O(D)(6) of this Part shall apply to contracts between a health insurer and a hospital licensed in Rhode Island which are entered into, renewed, or amended on or after July 1, 2O23O, or the effective date of this regulation, if earlier. To ensure compliance with § 4.1O(D)(6) ~~this subsection~~ of this Part in the event of any hospital conversions pursuant to R.I. Gen. Laws Chapter 23-17.14, the health insurer shall, in terms of contracting, treat the contract of the successor hospital or entity as a continuation of the contract of the predecessor hospital or entity with whom the health insurer had contracted.

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

d. Hospital contracts shall include a quality incentive program.

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

measures to those listed as Menu Measures in the Aligned Measures Set for hospitals.

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

(3) Quality incentive payments will not be due and payable until the quality incentive measure targets have been met or otherwise achieved by the hospital. A health insurer may make interim payments in the event that interim quality performance targets have been met; provided that the interim payments are commensurate with the achievement of the interim targets; and provided further that if the annual quality performance targets have not been achieved, the hospital shall be required to remit unearned interim payments back to the health insurer. A health insurer may also make prospective payments without consideration of performance, provided that if the annual quality performance targets have not been achieved, the hospital shall be required to remit unearned prospective payments back to the health insurer. Earned quality incentive payments shall become part of base payment rates.

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

(1) The average rate increase, including estimated quality incentive payments, is greater than the US All Urban Consumer All Items Less Food and Energy CPI ("CPI-Urban") percentage increase (reporteddetermined by the Commissioner by October 1 each year, in accordance with the method set forth in § 4.1O(D)(6)(i) of this Partbased on the most recently published United States Department of Labor data). Such percentage increase shall be plus 1%, or

(2) Less than twenty-five percent (25%O%) of the average rate increase is for expected quality incentive payments.

f. Hospitals which have been paid by a health insurer at less than the median commercial payments made to all Rhode Island acute care hospitals for inpatient services, including inpatient behavioral health services, in the health insurer's provider network, as determined by the health insurer summing all of its inpatient payments (numerator) and dividing that by a sum of all DRG case weights (denominator) to provide a case-mix-adjusted discharge payment rate for each

Commented [HPM26]: This seems potentially unclear given other sections. Is the goal to take earned payments and add to the base so that increased percentages in payments will be on the incentives previously earned and then additional incentives may be added, even if the same measure? As a formula is the intent:
A= medical services
B= incentive year X
C= Incentive Year X+1
A 5% increase over year X plus the incentive would be 1.05(A+B)+C

Commented [HPM27]: Has this historically been "estimated" (ie highly probable amount) or "potential" (the maximum amount irrespective of probability)?

hospital for inpatient services, shall receive an equal percentage increase in payment for each inpatient service until the hospital's average payment per case-mix-adjusted DRG for inpatient services is equal to the median. At the time of the calculation, the health insurer shall utilize the most recent 12-months of claims data for which the health insurer's Rhode Island hospital claim runout is at least 95% complete. The increase in payment rates shall not be construed as an ongoing price floor. The increase in payment rates shall be contractually contingent on the following:

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

(2) At the mutual agreement of the health insurer and hospital, alternative quality measures and performance targets may be employed as a substitute for the quality measures and performance targets specified in $ 4.1O(D)(6)(f)(1). If the parties cannot agree to an alternative set of quality measures, then the quality measures and performance targets in $ 4.1O(D)(6)(f)(1) shall be used.

(3) The contract contains a provision for recovery of monies paid to the hospital by the health insurer pursuant to this $ 4.1O(D)(6)(f) of this Part should the hospital fail to achieve the quality targets defined in $ 4.1O(D)(6)(f)(1) of this Part. Such provision shall be subject to audit by the Commissioner.

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

h. Hospital contracts shall include terms that relinquish the right of either party to contest the public release, by state officials or the parties to the contract of the provisions of the contract demonstrating compliance with the requirements of this $ 4.1O(D)(6) of this Part; provided that the health insurer or other

Commented [HPM28]: Peter Hollmann (not RIMS or CTC):
Item 1 creates inflexibility in the quality measure, which is not ideal, but may be acceptable over the limited timeframe. The aligned measure workgroup may be better positioned to create the measure..
This section appears to fail to recognize payment differences that reflect adjustments by insurers for: Medicaid share of population served, uninsured population served, critical services that operate at a loss (eg trauma center) and graduate medical education all of which facilitate a better healthcare community.
These should be allowed considerations, but may require a comment period if added to the regulation.

Commented [HPM29]: Insert "and prior authorization". While this is not intended to be an all inclusive list, PA processes are at the level of eligibility/claims and major burden and cost.

affected party may request the Commissioner to maintain specific contract terms or portions thereof as confidential, if properly supported with legal and factual analysis justifying the claim of confidentiality.

i. The US All Urban Consumer All Items Less Food and Energy CPI ("CPI-Urban") percentage increase to be reported according to the Standard Method by the Commissioner shall be equal to the 12-month percent change in the CPI-Urban published by the United States Bureau of Labor Statistics in September of each year. The September report will reference the 12-month percent change from August of the prior year to August of the report year. Due to significant epidemiological or macroeconomic events the Commissioner may elect to utilize a different method of determining the value of the CPI-Urban Should the Commissioner elect to utilize a different method than the Standard Method, the Commissioner shall announce his or her intention of doing so by August 1 and allow for thirty days of public comment on the proposed method prior to issuing a final decision. If the Commissioner ultimately elects to utilize a different method than the Standard Method, any entity that submitted a public comment and is aggrieved by the Commissioner's determination may challenge the determination through all available methods of appeal.

Commented [HPM30]: Does "entity" include an individual? Does "aggrieved' require actual harm or highly likely harm? Consider common language terminology if using definitions in law.

7. Nothing in $ 4.1O(D)(2) or (6) of this Part is intended to require that the health insurer must contract with all hospitals and providers licensed in Rhode Island. Consistent with statutes administered by OHIC, health insurers must demonstrate the adequacy of their hospital and provider network.

8. Professional provider contracts

a. The purpose of $ 4.1O(D)(8) of this Part is to ensure that health insurer contracts with professional providers include terms that allow for the release of contracts, in whole or in part, to OHIC for purposes of monitoring professional provider fee schedule increases, substantiating unit cost trend data filed as part of the health insurer's rate filing, or assessing compliance with state laws and regulations adopted pursuant to Titles 27 or 42 in which the Commissioner holds jurisdiction.

b. Professional provider contracts shall include terms that relinquish the right of either party to contest the release of the contract, or parts thereof, to OHIC; provided that the health insurer or other affected party may request that OHIC maintain specific contract terms or portions thereof as confidential, if properly supported with legal and factual analysis justifying the claim of confidentiality.

E. Health equity

1. By July 1, 2024, health insurers are required to obtain NCQA Health Equity Accreditation or NCQA Health Equity Accreditation Plus in support of making progress toward eliminating health disparities, improving health outcomes, and reducing overall health care cost growth.

2. Demographic data collection principles

   a. Health insurers are required to systematically collect, maintain, protect, and report on demographic data. When collecting, maintaining, and reporting demographic data, health insurers shall aim to align their practices with established national standards where possible.

   b. Health insurers are required to utilize industry-wide best practice for demographic data in terms of data collection strategies and survey language that has been consumer-tested and is widely recognized for increased accuracy and responsiveness.

   c. The disclosure of demographic data by prospective members and members to health insurers must always be voluntary and based on self-identification or disclosure and be accompanied by a detailed reasoning for why demographic data is being requested and that it will support efforts to provide equitable care.

   d. To the extent that health insurers use staff to collect and/or analyze demographic data, health insurers shall develop and implement trainings on how to ask questions about the demographic data, including training on how to maintain privacy of this sensitive information.

3. Demographic data use principles

   a. Health insurers shall strictly adhere to any and all existing federal and/or state prohibitions or restrictions on the collection and/or reporting of demographic data.

   b. Health insurers shall apply Health Insurance Portability and Accountability Act of 1996 protections to demographic data and treat demographic data as protected health information.

   c. Health insurers shall strictly adhere to any and all existing federal and/or state requirements governing analysis and information sharing of demographic data.

   d. Legally and ethically acceptable use cases relative to the use of demographic data may include:

Commented [HPM31]: We hope that plans comment on the feasibility of this deadline. It is the impression of CTC participants in data collection projects that this may be unattainable and another year may be more reasonable. Otherwise we support these changes

Commented [DH32]: As mentioned earlier --- Note: CTC will be working with EOHHS (Liv King) and RIDOH on demographic data project. The initial SOW has been approved and definition of the elements for data collection is a deliverable. We will work with key stakeholders and the States HIT committee to gain consensus on the list. We support these changes.

(1) Evaluating algorithms to identify and mitigate disparate impact or bias;

(2) Analyzing claims, enrollment, and complaint data to better understand health care disparities or to evaluate the efficacy of programs intended to reduce health care disparities;

(3) Provider network development and coordination of care;

(4) Service quality improvement; or

(5) Assessing or planning to meet the need for health-related social services and supports, including trauma-informed care, and outreach to populations that have been marginalized, among other uses.

4. Development of demographic data collection standards and demographic data use standards and provider financial incentive requirements

a. No later than October 2023, the Commissioner shall convene a working group charged with developing recommendations, for consideration by the Commissioner, on specific demographic data collection standards and demographic data use standards consistent with the data collection principles outlined in $ 4.10(E)(3) of this Part and the data use principles outlined in $ 4.10(E)(4) of this Part. The Commissioner shall consider the recommendations and will promulgate guidance as is necessary to effectuate any recommendations adopted by the Commissioner.

b. No later than October 2024, the Commissioner shall convene a working group charged with developing recommendations, for consideration by the Commissioner, on specific requirements for health insurers to tie provider financial incentives to meaningful progress in remediating health disparities identified by the collection and use of demographic data. The Commissioner shall consider the recommendations and will promulgate guidance as is necessary to effectuate any recommendations adopted by the Commissioner.

5. Demographic data completeness and provider financial incentive requirements

a. By January 1, 2025, health insurers must obtain demographic data for at least 80% of their members, as specified by the Commissioner.

b. By January 1, 2026, health insurers must tie provider financial incentives to meaningful progress in remediating health disparities

identified by the collection and use of demographic data, as specified by the Commissioner.

FE. Stakeholder input, waiver and modification

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

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

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

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

      (2) Health insurers;

      (3) Integrated Systems of Care;

      (4) Hospital systems;

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

      (6) Consumers; and

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

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

      (1) To create or maintain an effective incentive for provider organizations to participate in care transformation,

population-based contracts and alternative payment models; or

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

2. The Commissioner, upon petition by a health insurer for good cause shown, or in his or her discretion as necessary to carry out the purposes of the laws and regulations administered by the Office, may modify or waive one or more of the requirements of ~~this Section~~$ 4.10 of this Part. Any such modifications shall be considered and made during the formal process of the Commissioner's review and approval of health insurance rates filed by the health insurer.

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

~~F~~G. Data collection and evaluation

1. ~~On or before 15 days following the end of each quarter, e~~Each health insurer shall submit to the Commissioner, in a format approved by the Commissioner, a Primary Care Spend Report, a Behavioral Health Care Spend Report~~Care Transformation Report~~, and a Payment Reform Report, including such data as is necessary to monitor and evaluate the provisions of ~~this Section~~$ 4.10 of this Part. ~~The Care Transformation Report shall include data measuring the integration of behavioral health care into Patient-Centered Medical Homes and other provider practices, and measuring the impact of such integration on health care quality and cost.~~

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

3. Health insurers shall provide to the Office, in a timely manner and in the format requested by the Commissioner, such data as the Commissioner

determines is necessary to evaluate the Affordability Standards and to monitor compliance with the Affordability Standards established in this $ 4.1O of this Part. Such data may include any hospital or provider reimbursement contract, and any data relating to a hospital or provider's attainment of quality and other performance-based measures as specified in quality incentive programs referenced in $$ 4.1O(D)(6)(d) and (e) of this Part.

4. To the extent possible, the Office shall use the All Payer Claims Database authorized by R.I. Gen. Laws Chapter 23-17.17 to collect data required by ~~this subsection~~$ 4.1O(G) of this Part.

4.11 Administrative Simplification

A. Administrative Simplification Task Force

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

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

Commented [DH33]: Note: CTC Board of Directors has approved the OHIC request that CTC convene key stakeholders to build on the OHIC work related to Prior Authorization. We think this is an important opportunity to improve efficiency and reduce provider burnout. No further regulator language needed.

purposes of ~~this section~~$ 4.11 of this Part, and the purposes of R.I. Gen. Laws $ 42-14.5-3(h).

B. Retroactive terminations

1. The purpose of $ 4.11(B) of this Part ~~this Subsection~~ is to reduce administrative burdens as well as the associated costs in connection with the practice of retroactive terminations, create an incentive for efficiencies among stakeholders for timeliness of notices of termination, and establish an equitable balance of financial liability among health insurers, employers and enrollees in light of the unavailability of real time, accurate eligibility information.

2. Health Insurers shall cease the administrative process of seeking recoupment of payment from providers in the case of retroactive terminations of an enrollee, except when verified by the Health Insurer that the enrollee is covered by another Health Insurer for the service provided during the retroactivity period. For purposes of $ 4.11(B) of this Part~~this Subsection~~, the term Health Insurer includes state and federal government programs, a self-insured benefit plan, and an entity providing COBRA coverage.

3. Health insurers may include the reasonable cost of retroactive terminations into their filed rates. Health insurers shall establish reasonable policies and procedures for providers to conduct eligibility checks at the time services are provided. If the health issuer requires by administrative policy or provider contract that the eligibility check is a prerequisite to the application of the provisions of $ 4.11(B) of this Part~~this Subsection~~, the Health Insurer must also provide an administratively simple mechanism, approved by the Commissioner, for the provider to document that eligibility was checked by the provider at the time of service. In addition, Health Insurers may include reasonable adjustments attributable to the Insurer's financial burden with respect to retroactive terminations with its employer groups, so long as the process does not include recoupment of payments from providers not permitted under this $ 4.11(B) of this Part in the event of retroactive termination.

C. Coordination of benefits

1. The purpose of $ 4.11(C) of this Part ~~this Subsection~~ is to improve on the accuracy and timeliness of information when an enrollee is covered by more than one Health Insurer, and to communicate to affected parties which health insurer's coverage is primary.

2. Health Insurers shall:

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

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Commented [HPM34]: Title change: "Retroactive terminations of enrollees"

Commented [HPM35]: Does this clearly define that the new coverage must be consistent with the ACA, essential health benefits and RI Law regarding minimum standards?

Commented [HPM36]: The intent is "at a reasonably proximate time prior to the service" The OHIC may wish to specify a time, eg within 5 business days.
Taken literally it is not a reasonable expectation for checking eligibility.

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

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

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

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

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

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

D. Appeals of "timely filing" denials

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

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

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

a. A copy of the timely filing denial;

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

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

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

(1) Benefit determination documents from another carrier,

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

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

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

4. Health Insurers shall notify providers that upon submission of the information required by $ 4.11(D)(3) of this Part the Health Insurer shall not deny the appeal of a claim due to the failure to file the claim in a timely manner. Nothing in $ 4.11(D) of this Part ~~this Subsection~~ precludes the denial of a claim for other reasons unrelated to the timeliness of filing the claim.

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

b. Health Insurers may implement the requirements of $ 4.11(D) of this Part ~~this Subsection~~ either by amendments to their claims processing system, or by amendments to their provider appeal policies and procedures.

E. Medical records management

Commented [HPM37]: The OHIC should convene a working group to evaluate the transfer of medical records information. This is written in an era of fax or postal mail. Current methods include direct access into EMRs. Information transfer can enhance care coordination and NCQA is moving HEDIS to ECDS formats. On the other hand , practices are concerned about being required to grant payers (or their delegates) access to their EMR. Significant privacy/security and other concerns should be addressed.

1. The purpose of $ 4.11(E) of this Part ~~this Subsection~~ is to maintain the confidentiality of patient information during the process of transmittal of medical records between providers and health insurers, and to reduce the administrative burden of both the providers and carriers with regard to medical record submissions.

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

3. Health insurer requests for medical records shall specify:

   a. What medical record information is being requested;

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

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

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

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

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

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

   b. What specific records are to be sent, and

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

4.12 Price Disclosure

A. The purpose of this ~~regulation~~ $ 4.12 of this Part is to empower consumers who are enrollees in a health insurance plan to make cost effective decisions concerning their health care, and to enable providers to make cost-effective treatment decisions on behalf of their patients who are enrollees of a health insurance plan, including referral and care coordination decisions.

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

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

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

4.13 Severability

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

4.14 Construction

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

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

HARI
Hospital Association of Rhode Island

M. Teresa Paiva Weed
President

March 7, 2023

Mr. Cory King
Health Insurance Commissioner
Office of the Health Insurance Commissioner
1511 Pontiac Avenue
Building #69 First Floor
Cranston, RI 02920

Re: Powers and Duties of the Office of the Health Insurance Commissioner

Dear Commissioner:

The Hospital Association of Rhode Island (HARI) appreciates the opportunity to provide comments on the Office of Health Insurance Commissioner's (OHIC) proposed amendments to 230-RICR-20-30-4 Powers and Duties of the Office of the Health Insurance Commissioner (230-RICR-02-30-4). HARI also strongly supports the focus on health equity and the investments in behavioral health proposed in the regulation.

1. **§ 4.10(B)1 Primary Care Spend Obligation**

HARI supports the continued investment in primary care. Primary care providers manage day-to day health needs and research shows that access to primary care is associated with positive health outcomes. HARI applauds the work of insurers to exceed the primary care expenditure benchmark. Unfortunately, its effect has not demonstrated all the intended health outcomes. HARI requests the following amendment:

§ 4.10(B)(1)(d) By January 1, 2026, 100% of insured Rhode Island residents covered lives shall be attributed to a primary care provider.

2. **§ 4.10(B)(2) Behavioral Healthcare Expenditures**

HARI supports the investment in children's behavioral healthcare in Rhode Island. COVID-19 exacerbated the need for behavioral health services while children with existing disorders faced additional barriers to care. Since the pandemic the wait for children's community based behavioral healthcare treatment has risen from days to months forcing families to seek hospital level care where the number of children boarding has dramatically increased.

3. **§ 4.10(D)(6)(f) Median Adjustment**

The rationale for § 4.10(D)(6)(f) in 2020 was "*to mitigate the wide variation in commercial payments for inpatient services across Rhode Island's acute care hospitals.*" It has been recognized by OHIC that since that time "*hospitals have faced significant operational challenges due to staffing shortages and other factors beyond the control of administrators and caregivers"*, and that "*Due to the potential influence of these factors on performance measures and the resulting financial implications for hospitals, commercial health insurers subject to the requirements of 230-RICR-20-30-4.10 are released from their regulatory obligation to have a quality incentive program for performance years beginning on or after July 1, 2021 and concluding no later than June 30, 2023.*" HARI believes the rationale supporting OHIC Bulletin 2022-7 also applies to §4.10(D)(6) (f) and requests the following amendment:

~~*The increase in payment rates shall be contractually contingent on the following: (1) At the conclusion of three (3) years after the first increase in payments, or at the mutual agreement of the health insurer and hospital to establish a shorter time period, the hospital shall attain performance no different or better than the national benchmark for Clostridium difficile (C. diff) intestinal infections, Central line-associated bloodstream infections (CLABSI), and the rate of readmission after discharge from hospital (hospital-wide) as published on the Medicare.gov Hospital Compare website; (2) At the mutual agreement of the health insurer and hospital, alternative quality measures and performance targets may be employed as a substitute for the quality measures and performance targets specified in § 4.10(D)(6)(f)(1). If the parties cannot agree to an alternative set of quality measures, then the quality measures and performance targets in § 4.10(D)(6)(f)(1) shall be used. (3) The contract contains a provision for recovery of monies paid to the hospital by the health insurer pursuant to this § 4.10(D)(6)(f) of this Part should the hospital fail to achieve the quality targets defined in § 4.10(D)(6)(f)(1) of this Part. Such provision shall be subject to audit by the Commissioner.*~~

4. § 4.10(E)(5)(b) Financial Incentive in Remediating Health Disparities

HARI strongly supports the collection and sharing of demographic data to close the gap on preventable differences in the burden of disease and to ensure every Rhode Islander has a fair opportunity to achieve optimal health. HARI also supports the utilization and analysis of data to develop improved strategies to remediate these health inequities. Health disparities are a result of multiple societal factors. Through the triennial Community Health Needs Assessment, participation in Health Equity Zones and other tools, hospitals in Rhode Island are working to identify disparities and making investments in strategies to address the societal factors that contribute to health disparities. HARI believes that the demographic data should be used to inform on-going efforts and support collaborative community-based solutions, not provider incentives.

5. § 4.10(F)(1)(a) Payment and Care Delivery Advisory Committee

HARI opposes the amendment of "shall" to 'may" in this section. Stakeholder input is vital to the performance improvement and affordability of healthcare in Rhode Island. While OHIC has convened stakeholders to consider and develop hospital performance and affordability through the Cost Trends Steering Committee Value Based Payment Subcommittee, this work is solely focused on hospitals. HARI recommends that OHIC maintain its requirement to convene the Payment and Care Delivery Advisory Committee to ensure stakeholders in the healthcare community can consider and develop recommendations for action by the commissioner to advance the performance and affordability of all parts of the Rhode Island healthcare system.

Sincerely,

M. Teresa Paiva Weed

M. Teresa Paiva Weed
President

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Integra Community Care Network, LLC, an accountable care organization ("Integra"), is pleased to have the opportunity to provide comments on the proposed amendments to 230-RICR-20-30-4: Powers and Duties of the Office of the Health Insurance Commissioner. We are strongly supportive of the proposed emphasis and focus on health equity and the collection and use of demographic data, and the attention paid to funding for behavioral health services.

Our specific comments follow:

4.3 Definitions

4.3.A.17: Integra recommends adding the following new definition of a patient-centered medical home, as an alternative to (b), which includes primary care practices recognized by a national accreditation body (e.g., NCQA):

> [Or] A Primary Care Practice that adheres to standards mutually agreed upon by providers, payors, and the Commissioner, which incorporate quality, cost, and integration of behavioral health requirements

Our rationale is that the current NCQA process has run its course. Many practices have renewed their recognition annually since 2017 (prior to 2017, the requirement was every three years). This process consumes a significant amount of staff time and financial resources. These resources are better served investing in transitioning practices to alternative payment models. This option should have an end date, setting the expectation that all practices must achieve the requirement through participation in an alternative payment model within three years.

We believe that the "and" at the end of paragraph (c) should be an "or."

4.10 Affordable Health Insurance – Affordability Standards

4.10.B

Integra is strongly supportive of the requirement that insurers increase behavioral health spending for children and adolescents to three times the CY2022 baseline. Our members under age 18 with behavioral health and/or substance use diagnoses represent the largest share of hospital admissions and readmissions for the pediatric population, with the exclusion of newborns. Access to BH services has grown scarcer over the course of the COVID-19 pandemic, and our members are often unable to obtain the right care at the right time. However, the crisis in behavioral health access exists for adult populations as well. Just as OHIC's requirements around primary care spending apply to all covered populations, we encourage OHIC to extend the requirement regarding behavioral health spending to include all covered populations.

The primary care expenditure requirement includes a provision that "a health insurer's insured covered lives shall not bear a financial burden greater than their fair share of expenses that benefit both insured covered lives, and non-insured covered lives whose health plans are administered by the health insurer." We recommend that this protection apply to both the primary care and the behavioral health spend.

While we understand the rationale behind including quality/performance payments, infrastructure payments, and indirect primary care expenses in the calculation of "primary care expenses," the breadth of this definition may have the effect of diluting the effect of OHIC's requirement. Although insurers may be directing significant funding towards primary care through these auxiliary payments, the actual reimbursement for health care services received by primary care providers has not increased sufficiently to address the capacity and access issues in primary care and has not addressed the shortage of primary care providers. We encourage OHIC to evaluate the effect and impact of these requirements, and whether they have been adequate and successful in meeting the goal of the regulation. (The same concern potentially applies to the broad definition of "behavioral health care expenditures.")

We also strongly recommend that OHIC work with EOHHS to apply this increased expenditure requirement to Medicaid managed care organizations in addition to commercial payers, to avoid exacerbation of disparities in access to services.

4.10.C

We believe the strikethrough and addition in the first sentence of 4.10 .C.2 is grammatically incorrect, and probably intends to say "the goal of this Part."

Integra encourages OHIC to issue guidance on strategies to align screening codes across health insurer (and suggest rejecting the change from "shall" to "may" in section 4.10.C.2.a.3.

4.10.D

What consequences accrue to health insurers who do not meet the 50% target in 4.10.D.1.b?

Integra agrees that, in general, "[d]ownside risk strengthens provider economic incentives to act as responsible stewards of scarce health care resources and to proactively manage the health needs of their patient populations." However, we encourage OHIC to consider where the downside risk falls, and whether the right set of providers are being held accountable for costs. For example, most population-based contracts focus both incentives and risk on primary care providers, even though many of the factors that drive health costs are not within the direct control of primary care providers (including, for example, adequacy of behavioral health access, the costs of specialty drugs, etc.). We encourage OHIC to evaluate the effectiveness of this section on health care cost trends and explore other approaches to controlling costs.

4.10.D.2.c: While Integra appreciates the need to postpone the target date for health insurers to have 30 percent of RI commercially insured covered lives attributed to a risk-sharing or global capitation contract, we do not agree with eliminating the target date entirely. We recommend that OHIC identify a target date for the 30 percent threshold to be met.

4.10.D.2.f: By requiring single-year budgets, the state is incentivizing providers and payers to design solutions that have a one-year return on investment, and potentially inadvertently discouraging implementation of preventive and public health initiatives that may reduce costs and improve health in future years. We recommend that OHIC and insurers consider alternative constructs that could include three-to-five-year budgets to allow for investment in the long-term health of Rhode Islanders.

4.10.D.2.h: While we agree that population-based contracts should include behavioral health claims, we note that the majority of the growth in prescription drug spending is driven by high-cost specialty drugs that are generally not prescribed by, or controlled by, primary care providers. To the extent that population-based contracts are oriented around primary care attribution and management, requiring the inclusion of prescription drug claims has the effect of holding primary care providers accountable for costs they do not have the ability to control.

4.10.E HEALTH EQUITY

We strongly support the effort to increase the collection of race, ethnicity, and language data to support health equity. We encourage OHIC to consider other (potentially competing) requirements regarding data collection so as not to create additional administrative burden. For example, data collected should be consistent (or at least adaptable) to reporting requirements for the NIH.

In addition, we encourage OHIC to require insurers to share the demographic data they collect with providers, to support our own health equity efforts.

We support the intention to require insurers to develop approaches and incentives for providers to address health disparities. We caution that it will be impossible to effectively alleviate disparities without deeply engaging with the communities that are impacted by these disparities. Health insurers and healthcare providers absolutely need to be part of this work; however, a true commitment to equity requires that these efforts be led by communities, not the healthcare industry. In addition, in many cases disparities are caused or exacerbated by provider shortages and other workforce issues: these need to be addressed collaboratively by providers and insurers, and not solely through provider incentives.

4.10.F STAKEHOLDER INPUT

We recommend that "may" in paragraph 1.a be changed back to "shall."

March 7, 2023

Cory King
Office of the Health Insurance Commissioner
1511 Pontiac Ave., Building 69-1
Cranston, RI 02920
Cory.king@ohic.ri.gov

Re: Proposed Amendments to 230-RICR-20-30-4

To Whom It May Concern:

The National Committee for Quality Assurance (NCQA) appreciates the opportunity to provide feedback on Rhode Island's Proposed Amendments to the Powers and Duties of the Office of the Health Insurance Commissioner. We strongly support Rhode Island's efforts to promote quality oversight and improvement in an integrated model of care. We have included our comments and recommendations below.

NCQA Health Equity Accreditation. We commend the Office of the Health Insurance Commissioner (OHIC) in their requirement of all health insurers to achieve NCQA Health Equity (HEA) or Health Equity Plus Accreditations. NCQA's HEA program helps state agencies ensure organizations in which they oversee proactively identify equity gaps and implement high-quality health care to all segments of their populations. NCQA HEA focuses on helping organizations identify disparities, address social risk factors and work toward dismantling the systemic and structural barriers that generate bias or discrimination in health care.

Taking this one step further, NCQA's Health Equity Accreditation Plus builds on the activities of Health Equity Accreditation by guiding organizations in their work to establish the processes and cross-sector partnerships necessary to continuously identify and address the social risk factors of the community where they operate and the social needs of the individuals they serve. Organizations seeking this Accreditation will put structures in place that support leadership and staff in making an ongoing commitment to addressing social risks and needs, in collaboration with other organizations that share their goals.

Organizations must earn Health Equity Accreditation as a prerequisite but may pursue both programs simultaneously. Health Equity Accreditation Plus (HEA+) is not intended to be performed separately from the foundational work in Health Equity Accreditation. Rather, this program layers new activities that enrich the organization's understanding of individuals' intersectional characteristics, identities and needs. Organizations will identify subpopulations that share intersectional characteristics and identities, as well as specific social risks or social needs, and will have the context to target interventions that account for and respect individuals' multifaceted lived experiences. By understanding the unique needs of individuals in the context of their community, organizations are better positioned to understand their role in working to improve health equity. OHIC might consider a special recognition for plans that do the extra work of HEA+ and we recommend highlighting this important work.

Currently 12 states are harnessing a standardized framework to reduce health inequities on health outcomes, consumer experience and the cost of care by requiring and/or recommending NCQA's HEA for compliance within their state delivery system. We support the alignment of insurance health plans with other health equity policy efforts in your state. Alignment on quality and equity policies can ease provider burden and increase the overall impact of health equity efforts. framework

We commend OHIC on adopting a standard definition for race, ethnicity and language (REL) data collection. The inclusion of race, ethnicity, sexual orientation and gender identity align with the data elements collected as part of both NCQA Health Equity Accreditation and NCQA health equity requirements in PCMH Recognition. NCQA is actively working to drive quality care that is equitable care and earlier this year published "Health Equity and Social Determinants of Health in HEDIS: Data for Measurement," an issue brief that explores NCQA's approach to highlight disparities in care, including stratification of HEDIS measures. Gathering meaningful data on disparities in the state's beneficiary community holds plans accountable for implementing interventions to reduce those disparities. NCQA developed a measure to assess screening and referral for unmet social needs, such as food insecurity, housing instability and transportation needs that was introduced into HEDIS MY 2023. We are also exploring additional measures, such as those addressing social isolation. As the state and plans work toward improving equity, we hope to be a resource to the state.

Sustain the NCQA PCMH Recognition Requirement for Providers Participating in An Integrated System of Care and Part of a Primary Care Alternative Payment Model. The Patient-Centered Medical Home (PCMH) model operates under a continuous quality improvement cycle. Therefore, NCQA constantly evaluates and updates the PCMH Recognition program to make certain the requirements address the evolving landscape, ensuring practices do not stagnate in old policies, workflows and measure reporting. The value for practices in sustaining this evaluation is to ensure the maintenance of the gains practices have achieved withstands any disruption that might be caused by workforce shortages, staffing changes, leadership transitions and other structural stabilities that influence sustaining the infrastructure required to remain Recognized. As the state continues to move the needle on value-based purchasing, the need for a single and standardized approach is critical to support providers and reduce the measurement burden that can result from MCOS using varying approaches.

Having Transformed and Sustained medical homes participating in alternative payment models is the very foundation of a strong ACO. Evidence from a report conducted by the Patient-Centered Primary Care Collaborative reviewed the role of PCMHs in the success of an ACO. The report showed that MSSP ACOs with a greater share of PCPs who practiced in NCQA PCMHs had higher quality, showed improvements on quality measures and were more likely to generate savings.[1]

As mentioned, NCQA continuously updates the PCMH recognition program, so once practices are Transformed, the continuous quality improvement doesn't end there. Recently, NCQA updated the PCMH requirements to include mandatory reporting on standardized measures by practices for Measurement Year 2023. This update allows the State to measure performance based on a standard measure set across practices achieving the PCMH Recognition. The measures reported by practices as a part of the PCMH program are electronic clinical quality measures (eCQMs). In addition, NCQA can support the evaluation of state-specific PCMH requirements by building on the framework of PCMH standards to tailor reporting to meet the unique needs of the State's population. We support the use of Rhode Island's Aligned Measure Set and its use of measures that practices in an NCQA PCMH will also report as part of the standardized measures requirement. In Figure 1, you'll find a crosswalk from the standardized measures that PCMH-Recognized practices are required to report, which align with RI Aligned Measure Set. The close alignment will prevent any undue burden on the practices.

Additional updates to NCQA PCMH Recognition include aligning requirements for providers to collect sexual orientation and gender identity, in addition to race and ethnicity. This aligns with the requirement in Rhode Island for plans to collect this data and ensures practices and providers are implementing best practices to support data collection.

Promoting a Behavioral Health Continuum. NCQA supports and commends the qualification of an NCQA-Recognized PCMH Practice with Behavioral Health Distinction to be a "Qualifying Integrated Behavioral Health Primary Care Practice." NCQA's Distinction in Behavioral Health Integration recognizes primary care practices that put the right resources, evidence-based protocols, standardized tools and quality measures in place to support the broad needs of patients with behavioral health related conditions within the primary care setting. This enhances the level of care provided in a primary care practice and improves access, clinical outcomes and patient experience for patients with behavioral health conditions. Distinction in Behavioral Health Integration (BHI) is a way for practices to highlight where they excel beyond the PCMH standards. Nationally, 358 recognized practices have achieved BHI. Of Rhode Island's 185 NCQA recognized Patient-Centered Medical Homes, 35 have already achieved the Distinction for Behavioral Health Integrations. OHIC has been a trailblazer in the methods used for integrating behavioral health, and we often point to Rhode Island as a model for this work.

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[1] https://www.pcpcc.org/sites/default/files/resources/PCPCC%202018%20Evidence%20Report.pdf

PCMH practices with Behavioral Health Distinction play a pivotal role in the Behavioral Health Framework and provide valuable insight into the needs of this population.

We continue to enhance NCQA's work on behavioral health standards and measures and would welcome your input and collaboration on some of our developing concepts.

NCQA is extremely supportive of the state's efforts to build a highly integrated and equitable delivery system. Our goal is to be a valuable resource as you think through critical quality oversight policies and functions.

We would welcome the opportunity to discuss these programs with you in greater detail. To coordinate, please contact Amy Maciejowski at maciejowski@ncqa.org or 202-735-3688.

Regards,

Amy Maciejowski
Senior Program Manager, State Affairs
National Committee for Quality Assurance (NCQA)

FIGURE 1. Confidential-Please do not share.

Rhode Island OHIC Measures to NCQA PCMH Measures Crosswalk

The table below compares measures between Rhode Island's 2023 OHIC measures and NCQA's Patient-Centered Medical Home (PCMH) 2023 measures.

OHIC's Core Primary Care Measure Set

Measure ID	OHIC Measure	PCMH Measure	Steward	Notes
NQF 0018	**Controlling High Blood Pressure**	Yes	NCQA	HEDIS & eCQM
NQF 0055	**Eye Exam for Patients with DM**	Yes	NCQA	HEDIS & eCQM
NQF 0575	**HgbA1c Control <8.0%**		NCQA	
NQF 2372	**Breast Cancer Screening**	Yes	NCQA	HEDIS & eCQM
NA	**Child and Adolescent Well-Care Visits (Total)**		NCQA	
NQF 0033	**Chlamydia Screening**	Yes	NCQA	HEDIS & eCQM
NQF 0034	**Colorectal Cancer Screening**	Yes	NCQA	HEDIS & eCQM
NQF 1448	**Developmental Screening in the First Three Years of Life**		OHSU	
NA	**Lead Screening in Children**		NCQA	

OHIC's Menu Primary Care Measures Set

Measure ID	OHIC Measure	PCMH Measure	Steward	Notes
NA	Kidney Health Evaluation for Patients with Diabetes		NCQA	
NQF 0032	Cervical Cancer Screening	Yes	NCQA	HEDIS & eCQM
NQF 1407	Immunizations for Adolescents (Combo 2)		NCQA	
NA	The following measures, stratified by race, ethnicity, and language: *Controlling High Blood Pressure *Developmental Screening in the First Three Years of Life *Eye Exams for Patients with Diabetes *HgbA1c Control for Patients with DM (<8.0%)		NCQA and OHIC	
NA	Depression Remission or Response for Adolescents and Adults		NCQA	
NA	Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults		NCQA	

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Measure ID	OHIC Measure	PCMH Measure	Steward	Notes
NA	Statin Therapy for Patients with Cardiovascular Disease	Yes	NCQA	HEDIS & eCQM
NA	CAHPS Surveys, specifically CG CAHPS and/or PCMH CAHPS		AHRQ	
NA	Depression Screening and Follow-Up for Adolescents and Adults	Yes	NCQA	eCQM
NA	Fluoride Varnish (Core in 2024)		RIDOH	
NA	Social Determinants of Health Screening		RI EOHHS	

OHIC's Menu Outpatient BH-MH Measure Set

Measure ID	OHIC Measure	PCMH Measure	Steward	Notes
NQF 0576	Follow-Up After Hospitalization for Mental Illness		NCQA	HEDIS & eCQM
NQF 0104	Adult Major Depressive Disorder: Suicide Risk Assessment	Yes	AMA-PCPI	eCQM
NQF 1365	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	Yes	AMA-PCPI	
NQF 0105	Antidepressant Medication Management		NCQA	HEDIS & eCQM
NA	Depression Remission or Response for Adolescents and Adults		NCQA	
NA	Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults		NCQA	
NA	Depression Screening and Follow-up for Adolescents and Adults	Yes	NCQA	eCQM
NA	Unhealthy Alcohol Use Screening and Follow-Up		NCQA	
NA	Social Determinants of Health Screening		RI	

OHIC's Core BH Hospital Measure Set

Measure ID	OHIC Measure	PCMH Measure	Steward	Notes
NQF 0576	Follow-Up After Hospitalization for Mental Illness		NCQA	HEDIS & eCQM
NQF 2860	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization		CMS	

OHIC's Menu BH Hospital Measure Set

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Measure ID	OHIC Measure	PCMH Measure	Steward	Notes
NQF 1664	Alcohol & Other Drug Use Disorder Treatment at Discharge		TJC	
NQF 0640	Hours of Physical Restraint Use		TJC	
NQF 0641	Hours of Seclusion Use		TJC	
NQF 3205	Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification		CMS	
NQF 3205	Medication Continuation Following Inpatient Psychiatric Discharge		CMS	
NQF 0649	Transition Record with Specified Elements Received by Discharged Patients		AMA-PCPI	

OHIC's Core ACO Measure Set

Measure ID	OHIC Measure	PCMH Measure	Steward	Notes
NQF 0018	Controlling High Blood Pressure	Yes	NCQA	HEDIS & eCQM
NQF 0055	Eye Exam for Patients with Diabetes	Yes	NCQA	HEDIS & eCQM
NQF 0575	Hgb A1c Control <8.0%		NCQA	
NQF 0576	Follow-Up After Hospitalization for Mental Illness		NCQA	HEDIS & eCQM
NQF 2372	Breast Cancer Screening	Yes	NCQA	HEDIS & eCQM
NA	Child and Adolescent Well-Care Visits		NCQA	
NQF 0033	Chlamydia Screening	Yes	NCQA	HEDIS & eCQM
NQF 0034	Colorectal Cancer Screening	Yes	NCQA	HEDIS & eCQM
NQF 1448	Developmental Screening in the First Three Years of Life		OHSU	

OHIC's Menu ACO Measure Set

Measure ID	OHIC Measure	PCMH Measure	Steward	Notes
NQF 0004	Initiation and Engagement of Substance Use Treatment		NCQA	
NA	Kidney Health Evaluation for Patients with Diabetes		NCQA	
NQF 3489	Follow-Up After Emergency Dept Visit for Mental Illness		NCQA	HEDIS
NQF 3488	Follow-Up After Emergency Visit for Substance Use		NCQA	
NQF 1789	Hospital-wide Readmit		CMS	
NQF 1768	Plan (ACO) All-Cause Readmission		NCQA	
NQF 0032	Cervical Cancer Screenings	Yes	NCQA	HEDIS & eCQM
NQF 1407	Immunizations for Adolescents (Combo 2)		NCQA	
NA	Lead Screening in Children		NCQA	

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Measure ID	OHIC Measure	PCMH Measure	Steward	Notes
NA	Social Determinants of Health Screening		RI	
NA	The following measures, stratified by race, ethnicity, and language: *Controlling High Blood Pressure *Developmental Screening in the First Three Years of Life *Eye Exams for Patients with Diabetes *HgbA1c Control <8%		NCQA	
NA	Depression Remission or Response for Adolescents and Adults		NCQA	
NA	Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults		NCQA	
NA	Statin Therapy for patients with CVD	Yes	NCQA	HEDIS & eCQM
NA	CAHPS		AHRQ CMS NCQA	
NQF 1517	Prenatal & Postpartum Care – Timeliness of Prenatal Care		NCQA	
NQF 1517	Prenatal & Postpartum Care – Postpartum Care Rate		NCQA	
NA	Depression Screening and Follow-Up for Adolescents and Adults	Yes	NCQA	eCQM
NA	Unhealthy Alcohol Use Screening and Follow-Up		NCQA	

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Neighborhood Health Plan OF RHODE ISLAND™

910 Douglas Pike, Smithfield, RI 02917

March 17, 2023

Cory King
Acting Health Insurance Commissioner
1511 Pontiac Ave, Building #69
Cranston, R.I. 02920

Dear Commissioner King:

Neighborhood Health Plan of Rhode Island (Neighborhood) appreciates the opportunity offered by the Office of the Health Insurance Commissioner (OHIC) to provide public comment on the proposed changes to the Affordability Standards within 230-RICR-20-30-4. The Affordability Standards regulation has offered important checks and balances for consumer affordability as well as for provider and payer sustainability. Neighborhood feels strongly that regulations should build regulatory guardrails with which providers and payers shall operate while being cautious not to prescribe details that may have unintended consequences on the public and healthcare community. Neighborhood's comments herein speak to balancing the appropriate line between regulations and operations.

Health Equity - (§ 4.10(E))

Neighborhood has been a leader in Rhode Island for over 28 years, serving Rhode Islanders with the greatest health needs and addressing social determinants of health. Neighborhood continues to innovate in this space, using data to improve health outcomes and set the standard for quality care for the most vulnerable populations in Rhode Island.

Early on in the COVID-19 pandemic, Neighborhood was a leader in the state working directly with the Rhode Island Department of Health (RIDOH) in developing COVID-19 vaccination strategies. Neighborhood recognized that the collection of race and ethnicity (r/e) data was critical for targeted outreach campaigns. Neighborhood implemented a quality improvement project to enhance demographic data through collaborations with RIDOH and community partners. Neighborhood updated internal systems to allow for the consumption of r/e data from external sources. This project improved the coverage of r/e data among Neighborhood members from 40% to nearly 90%. Neighborhood is currently using this information to identify healthcare disparities within our membership and prioritize opportunities for improvement.

Neighborhood strongly cautions in OHIC developing state specific demographic data collection standards in the absence of consideration of nationally recognized standards. The charge of the proposed Work Group should be focused on identifying and aligning with national standards such as those set forth by the Office of Management and Budget's (OMB) standards of r/e data. To our knowledge, there are no such standards for several of the demographic data elements covered by the proposed requirements, including notably gender identity, sexual orientation, and disability. Neighborhood also notes that the OMB has issued a proposal to revise the current standards for r/e data. It would be counterproductive to establish data collection requirements under the current standards then have to revise them if and when the OMB standards are changed.

Currently, Neighborhood relies primarily on self-reported demographic data collected through Health Source Rhode Island's (HSRI) application. As this is Neighborhood's source of truth, HSRI's enrollment application would require modifications to ensure that it meets regulatory required standards (state and/or federal). Changes to the collection

of data directly corresponds to system updates and may require resource-intensive changes in data collection procedures, information systems and file transfers for not only payers but also state agencies that oversee the collection of demographic information, including HSRI.

Neighborhood is in full support of NCQA Health Equity Accreditation and is already in the planning stages of submission. Obtaining Heath Equity Accreditation or Health Equity Accreditation Plus by July 1, 2024 is not feasible for an insurer which has not yet submitted the application. The NCQA requirements are based on health plans' having supporting documentation in place for 12 months preceding the accreditation survey, including having information systems and operational procedures in place to collect, store, protect and use the demographic data in support of identifying and addressing health care disparities. Neighborhood recommends OHIC move out the date to January 1, 2026.

Neighborhood cautions OHIC with instituting regulation on demographic completeness and provider incentive requirements prior to convening the Work Group. The recommendations from the Work Group should influence further rule-making, not the inverse. Neighborhood recommends the Work Group be comprised of inter-disciplinary and diverse members, and at minimum the Work Group should include members from the provider community, State agencies, health insurance plans, and consumer-based organizations, and advocacy group for the black, indigenous and people of color.

Professional Provider Contracts - (§ 4.10(D)(8))

Neighborhood is concerned with the provision that exposes provider contracts to substantiate unit cost trend, inform potential future regulations (e.g. capitated annual rate increases), and/or to evaluate equity of provider rates across specialties. Neighborhood believes that plan and provider's right to confidentiality under Rhode Island General Law §6-41 and §38-2-2 (4)(B) are protected and this proposed regulation is unnecessary and of limited value. Information of this detail is unnecessary in the rate setting process as aggregated trends based on historic data can substantiate rate increases. Rhode Island currently requires more detail in the rate setting process than for example, the Centers for Medicare and Medicaid, that reviews and approves rates for a large number of Federally Facilitated Marketplace states that serve Exchange members. It is unclear how additional data would improve the process or the rationale for such an extensive broadening of authority of requiring all information in every professional contract in order to assess general compliance. OHIC currently has the tools to review compliance through the existing Market Conduct Exam process.

Neighborhood is concerned that the exposure of provider rates would adversely impact OHIC's charge of ensuring affordability and access to care. As proven in § 4.10(D)(6)(f)), OHIC had the authority to rebalance average hospital rates through regulation, leading to an overall increase in costs to the health care system. Transparency is often seen as a tool to produce positive competition; however, in this instance it was used to rebase the payment level for lower-than-average outliers while ignoring those well above the average. The burden of that regulatory driven hospital rate inflation was borne by consumers in higher premium rates. Attributing a similar process to professional rates could unintentionally impact consumers by establishing a new floor and requiring median increases.

Should OHIC move forward with this provision, Neighborhood requests that OHIC consider the 1) significant administrative burden of adjusting thousands of individual provider contracts to meet this charge and 2) the risk of exposing provider's ability to terminate if they disagree with the amendment, regardless of who is requiring it.

Neighborhood recommends and would support providing OHIC provider data that is aggregated and de-identified. To ensure the reporting is consistent and precise across carriers, OHIC should provide detailed definitions for reporting criteria.

Behavioral Health Spend - (§ 4.10(B)(2))

Neighborhood acknowledges the need for a robust behavioral health continuum of care for children and adolescents. Neighborhood commends OHIC for taking on this challenging initiative within the Affordability Standards. However this approach has proven to be limited in scope to only Rhode Islanders accessing care through Commercial insurance. Neighborhood recommends OHIC working directly with other state partners to identify and prioritize strategic areas that would benefit from succinct government and private payer investments.

For example, the recommendations issued in the Declaration of a Rhode Island State of Emergency in Child and Adolescent Mental Health and further discussed in Rhode Island KIDS COUNT, Children's Mental Health in Rhode Island report, outline a multi-prong approach to improving the behavioral health continuum of care that includes workforce development, expansion of school-based mental health support, investment in social-determinants of health and investment in community-based systems of care. An arbitrary infusion of pay increases ignores the overarching systemic challenges without posing a strategic solution. Neighborhood feels strongly that a unified multi-year strategy would make the most measurable impact.

There are significant state activities currently ongoing, including the Social and Human Service Review Program and the development of the Certified Community Behavioral Health Clinic's that offer a broader view of the behavioral health landscape. Neighborhood suggests monitoring results of those activities ahead of any further changes. Neighborhood welcomes any further dialog with OHIC on working to establish a program to holistically address the behavioral health needs of children and adolescents.

Hospital Contracts - (§ 4.10(D)(6)(i))

Neighborhood cautions OHIC on the timeline and process when electing to utilize any method of determining the annual hospital rate increase without consideration for the timing of the rate review process for insurers. The timeline should take into consideration the impact to insurers, specifically the potential impact hospital rate increases have on rate setting.

Neighborhood cautions OHIC in stating broad reasons (significant epidemiological or macroeconomic events) for a change in methodology for Hospital rate increases without clearly defining what would trigger a consideration. For example, macroeconomic events could be positive or negative; would both be an option for consideration? Neighborhood also recommends OHIC provide greater detail around the appeal process including timeline, parameters for appealing and potential outcomes for appellants. Further, Neighborhood recommends resolving a methodology other than the Standard well in advance of the publication date, and that appeals prior to that date be limited to organizations in which OHIC has direct oversight.

Hospital Contracts - (§ 4.10(D)(6)(d-e))

Since July 2021, OHIC provided flexibility around the hospital quality program due to hospitals facing significant operational challenges and staffing shortages during the COVID-19 public health emergency. This has weakened insurers' ability to incentivize hospitals to continue to improve quality. Instituting permanent regulation to incorporate earned quality into hospital base payments and reduce the quality incentive payment to 25% further deteriorates insurer's ability to safeguard quality care for Rhode Islanders. The hospital maximum increase limit is the primary tool

to suppressing and controlling health care costs in Rhode Island. It remains unclear how this proposed change aligns with OHIC's Value Based Payment principles, including the current sub-committee working towards Hospital Global budgets.

Primary Care APM (§ 4.10(D)(3))

Rhode Island insurers have been challenged with engaging providers, including primary care providers, in alternative payment arrangements (APM's). Since the COVID-19 pandemic and even prior to that a growing concern has evolved around provider retention and attracting talent at the practice level. Provider burnout, competition, as well as shifts in care models through technology such as telemedicine continues to drive providers away from applying for in-office positions. Neighborhood's focus will be on maintaining an adequate network and supporting an environment to meet potential future access challenges. New payment models, while helpful, may be too far of a reach with the current workforce challenges.

Neighborhood encourages OHIC to continue to act as a convener amongst primary care providers, commercial insurers, State and Federal payers in a collaborative effort to encourage and support transition from the fee-for service to alternative payment methodologies. In support of this effort, Neighborhood has established a Manager of Value Based Contracting and Oversight with the specific purpose of working toward APM opportunities across providers including primary care.

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

Sincerely,

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

TO: Acting Commissioner Cory King, Office of Health Insurance Commissioner
FROM: Karen Malcolm, Coordinator, Protect Our Healthcare Coalition
DATE: March 6, 2023
RE: Public Comment, Rulemaking, "Powers and Duties of the Office of the Health Insurance Commissioner" (Affordability Standards)

On behalf of the members of the Protect Our Healthcare Coalition, I submit the following comments in support of OHIC's proposed revisions to 230-RICR-20-30-4, "Powers and Duties of the Office of the Health Insurance Commissioner," specifically the "Affordability Standards."

More details of our support for the three proposed areas of revision within the Affordability Standards -- investment in children's behavioral health services; health equity requirements; and professional provider contract terms -- are outlined in more detail below.

I. Investment in children's behavioral health services to ensure a well-functioning continuum of care for Rhode Island children and youth with behavioral health needs.

The Coalition strongly supports the implementation of a behavioral health spending requirement whereby insurers will be required to significantly increase their baseline spending on community-based children's behavioral health. In the OHIC paper accompanying the proposed rulemaking, the argument for this update to Rhode Island's affordability standards is clear. This targeted approach addresses the significant gaps in the continuum of care for children and begins to address the decades of under-investment the system has suffered from. As noted by RI Kids Count, "an estimated 33% of children ages 3 to 17 who needed mental health treatment or counseling had a problem obtaining needed care." (RI Kids Count)

The Coalition also endorses the RIPIN recommendations that encourage OHIC to investigate existing disparities between carriers in their current level of investment in children's behavioral health, and to consider subsequent regulatory action to create a benchmark that sets a level playing field, bringing carriers who are currently lagging in investment up to the standards set by carriers who have a higher current baseline.

II. Health Equity Requirements

The Coalition supports OHIC's proposed requirements to create a new Health Equity subsection within §4.10 to "establish foundational processes for measuring health disparities in order to close those disparities within their covered populations." That said, the Coalition sees the proposed requirements – that health insurers obtain NCQA Health Equity Accreditation for the collection and analysis of demographic data; that insurers obtain demographic data for at least 80% of members by January 1, 2025; and that carriers tie provider financial incentives to meaningful progress in remediating health disparities identified – as purely foundational, a first

step. We endorse RIPIN's recommendation that OHIC refine "its understanding of remediating health disparities to more particularly mean **improving health outcomes** faced by marginalized groups, particularly in infant and maternal mortality, the impacts of environmental hazards, and children's health."

We feel it is important to restate our comment made in response to OHIC's 'Advance Notice of Proposed Rulemaking' in November 2021. While we recognize insurers must maintain adequate reserves, and while we acknowledge OHIC's statutory responsibility in regard to protecting insurer solvency, we believe that exceedingly high reserves are not an efficient or appropriate use of revenue, especially in light of the urgent need to address social factors that directly impact health and well-being. Added to this is that excess reserves are supported – at least in part -- by the significant public investment through Medicaid and Medicare funds. The public provenance of funds intended to support disadvantaged communities, which instead support higher carrier reserves is an important consideration when considering health equity.

We encourage, as a critical component of this more limited proposal (as compared to that which was proposed in the advance notice of proposed rulemaking), that the proposed OHIC working group to develop recommendations based on data collection include community-based leaders from those communities most impacted by existing disparities.

III. Professional Provider Contract Terms

Rhode Island has been a leader nationally in demonstrating the effectiveness of price growth caps in healthcare through our existing affordability standards. As stated previously, the Coalition believes that in Rhode Island's significantly consolidated healthcare market, caps are an important tool for managing cost growth. Data transparency is important to OHIC's capacity to measure and regulate cost growth. Therefore, we support OHIC's amendment to gain access to professional provider contract information in order to better understand and more adequately address the issue. We also believe that this transparency may provide OHIC with improved insight into disparities in negotiated reimbursement rates that we believe may exist between behavioral health specialists and comparable physical health specialists. Finally, we endorse RIPIN's recommendation that "insofar as decisions are made utilizing the data received through the proposed transparency requirements, they be made with consideration to the 'triple aim' of access, affordability, and quality (particularly health outcome quality), not solely with regard to the impacts of price on affordability."

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

To: Cory King
Acting Health Insurance Commissioner
Office of the Health Insurance Commissioner
State of Rhode Island
1511 Pontiac Ave, Building 69, Cranston, RI 02920
cory.king@ohic.ri.gov

From: Margaret Howard, PhD

Date: 02/23/23

Re: Comment regarding proposed rules relating the powers and duties of the Office of the Health Insurance Commissioner (OHIC), including revised affordability standards

The Center for Women's Behavioral Health at Women & Infants Hospital is pleased to provide the following comments on proposed revisions to the power and duties of the OHIC, including those specific to behavioral health expenditures.

Support the Inclusion of Behavioral Health Care in Revised Affordability Standards
We strongly support a focus on behavioral health care expenditures in the proposed revised affordability standards. We welcome the tracking and reporting of expenditures on behavioral health care by health insurers for claims in which a behavioral health condition, is a principal diagnosis. Similarly, we believe it is prudent to require the reporting of behavioral health care funding that are non-claim-based expenditures, such as per member per monthly payments to support behavioral health care integration into primary care, pay for performance payments made to behavioral health care providers, and grants designed to address the behavioral health care needs of insured members.

We also applaud efforts to mandate increased per member per month expenditures on community-based behavioral health care for children and adolescents, age 0-18, by 200% relative to calendar year 2022 expenditures, starting in 2024. The pediatric mental health system in our state remains in crisis, given unprecedented need for services in an overtaxed and often under resourced provider community. As such, we recommend clarity be added to ensure that expenditures are explicitly defined as inclusive of both claims-based expenditures and administrative costs. Workforce development, recruitment, and capacity building in the behavioral health sector, especially at community-based settings, will take time to implement given the unprecedent burn-out, and overwhelming demand on these providers. As such, investments in programs such as provider-facing psychiatry resource network teleconsultation services are critical. These programs leverage a limited sub-specialty maternal and behavioral health workforce and help improve front-line provider self-efficacy and competency. Psychiatry resource network teleconsultation services continue to be available to any healthcare providers across the state regardless of a patients' insurance type or carrier and they most often support frontline clinicians, such as primary

care and obstetric providers, for which much of the burden for initial mental healthcare falls. Since lessons learned through real-time psychiatry teleconsultations can potentially be applied to future patients by front-line providers, it behooves the state and provider community alike to incentivize continued investments in psychiatry teleconsultation lines. As such, we recommend investments in non-claims expenditures to be considered a factor in any increased spend requirements to help incentivize health plan investments in provider supports that help increase access to care.

Recommend Health Plan Investments to both the RI MomsPRN and PediPRN Programs be Deemed as Qualifying Expenditures for Meeting Increased Pediatric Behavioral Health Spend

We strongly urge that both the RI MomsPRN and PediPRN programs be deemed and/or explicitly specified through final rules and regulations as qualifying non-claims-based expenditures that can help health plans meet the proposed 200% increase of expenditures to community-based behavioral health care for children and adolescents age 0-18 starting in 2024. These provider-facing psychiatry resource network teleconsultation lines help expand workforce capacity, maximize a limited subspeciality workforce, and more immediately connect patients to needed services. Since their launch, these psychiatric teleconsultation services have fielded 4,061 initial encounter calls from 877 providers at 329 practices state-wide. As a result, 3,032 perinatal and pediatric patients have been helped.

Given the well-documented adverse impacts on offspring of untreated maternal mental health conditions, we strongly urge OHIC to specify that funding support provided to the RI MomsPRN program be considered a qualifying expenditure of the proposed mandated pediatric behavioral health spend increase. We worry that if OHIC does not specify this explicitly in its finalized administrative rulemaking, health plans will not consider or opt to make investments in the RI MomsPRN program, which will put its sustainability at risk. Current RI MomsPRN grant funding is ending September 2023.

Similar to PediPRN, the RI MomsPRN program has made tremendous strides in helping the state's provider community identify and address behavioral health concerns and conditions among perinatal patients. Since RI MomsPRN launched in September 2019, 1,855 initial encounter calls from 598 providers at 211 practices have been made, which have helped 1,611 perinatal patients (10% of the estimated perinatal population in Rhode Island). In addition to providing same-day teleconsultation support for diagnosis, treatment planning, medication safety and resource/referral, the RI MomsPRN program has delivered intensive quality improvement and professional education to 15 obstetric practices to help optimize screening, treatment, and referral protocols for perinatal depression, anxiety, and substance use disorder. Unfortunately, momentum is now at risk given that current grant funding is ending this September at the same time demand for mental healthcare is growing and both the RI MomsPRN and PediPRN teleconsultation services are now established as a "go-to" place for immediate, and tailored support. As such, we strongly recommend that OHIC continue to incentivize potential investments in both the RI MomsPRN and PediPRN programs by health plans through written clarification with any finalized affordability standard rulemaking and/or by defining the pediatric age as from pregnancy/prenatal through age 18. This will help ensure RI MomsPRN and PediPRN teleconsultation services can be sustained given a growing recognition about maternal mental health and long-lasting impacts on infant and child development.

Recommend Inclusion and Focus on Perinatal Behavioral Health Expenditures

Maternal behavioral health conditions -- including depression, anxiety, obsessive compulsive disorder, posttraumatic stress disorder (PTSD), and substance use disorder are serious illnesses that can begin

during pregnancy or the year following childbirth. If left untreated, they can result in negative long-term impacts on parents, babies, and even entire families. For example, depression and anxiety disorders during pregnancy are associated with premature delivery, low birth weight, impaired mother-infant attachment, and cognitive and behavioral impairments during the child's development. Given the adverse impacts that can result if maternal behavioral health conditions are unrecognized and untreated, we strongly recommend analyzing behavioral health expenditures specific to the perinatal population and the behavioral health system of care who provide this specialized care.

While our state is fortunate to have nationally recognized behavioral health treatment for pregnant and postpartum patients, including innovative models of care offered at the Center for Women's Behavioral Health at Women & Infants Hospital that include the RI MomsPRN teleconsultation services, partial hospital treatment at our Day Hospital Program, Perinatal OCD intensive program, outpatient services, and a medically assisted treatment program for pregnant women requiring buprenorphine treatment/supervision that and includes The Providence Center programs that focus exclusively on substance abuse prevention and treatment for pregnant and postpartum women, more is still needed. There are not enough specialized behavioral health providers with perinatal expertise to meet demand for services, evident by ongoing waitlists being seen across the state. Having OHIC facilitate the routine collection and detailed reporting of behavioral health expenditures, inclusive of both claims and administrative, that are specific to perinatal populations, will ensure that access to care continues to meet demand more closely and that efforts are taken to address known service gaps.

Closing

We appreciate the opportunity to submit this testimony and welcome continued support from the Office of the Health Insurance Commissioner to help ensure Rhode Island continues to lead the nation in addressing perinatal and pediatric behavioral health.

Thank you very much,

Margaret Howard, Ph.D.
Professor of Psychiatry & Human Behavior, Clinician Educator and Medicine, Clinician Educator
Warren Alpert Medical School of Brown University
Division Director, Women's Behavioral Health
Executive Director, Women's Mental Health, Care New England
Women & Infants Hospital
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Rhode Island Psychiatry Resource Network (PRN)
TELECONSULTATION PROGRAMS FOR PROVIDERS:

RI MomsPRN Maternal Psychiatry Resource Network

WOMEN & INFANTS

PediPRN Pediatric Psychiatry Resource Network

Bradley Hospital

The need for pregnant, postpartum, and pediatric access to mental health support is urgent and growing. Rhode Island's RI MomsPRN and PediPRN programs empower providers, build competency, and increase patient access to care. Grant funding for these services will end in September 2023.

RHODE ISLAND'S TWO PRN PROGRAMS SUPPORT PROVIDERS

Rhode Island has two statewide Psychiatry Resource Network (PRN) teleconsultation programs:

RI MomsPRN and PediPRN. These programs support Rhode Island healthcare providers by offering same-day specialized clinical consultations and resource/referral services related to mental health. This service enables providers to comprehensively care for their patients more promptly with the goal of avoiding lengthy wait times for specialized care.

- **RI MomsPRN:** serves providers treating pregnant and postpartum patients. Services are implemented by the Center for Women's Behavioral Health at Women & Infants Hospital. Launched in September 2019.
- **PediPRN:** serves primary care providers (PCPs) treating children and adolescents. Services are implemented by Bradley Hospital. Launched in December 2016.

3,032 perinatal and pediatric patients have been helped as a result of their provider calling either PRN line, with

55.1% being covered by Medicaid, and

32.9% residing in the four core cities.

Source: Rhode Island's Psychiatry Resource Network Programs, Rhode Island Department of Health, 2023

Rhode Island's two PRN programs have helped providers support 3,032 unique perinatal and pediatric patients as of February 8, 2023.

Together, the RI MomsPRN and PediPRN lines have supported more than

4,061 encounter calls

from **877** providers

at **329** practices

Source: Rhode Island's Psychiatry Resource Network Programs, Rhode Island Department of Health, 2023

THE NEED

FOR PREGNANT AND POSTPARTUM PATIENTS,

mental health and substance use conditions often go underdiagnosed, and engaging with care may be challenging for many reasons. Psychiatric medication may be discontinued or delayed due to concerns about medication safety during pregnancy and while breastfeeding. In addition, there is growing evidence that maternal substance use is increasing. The effects of unmet mental health needs can often extend to babies and entire families, with the potential for long-lasting negative impacts.

RHODE ISLAND FACT:

Mood and anxiety disorders are the most common complication of pregnancy and childbirth, and maternal substance use is increasing.

Nearly one in three (29.4%) women report experiencing depression either immediately before, during, or after their pregnancy.

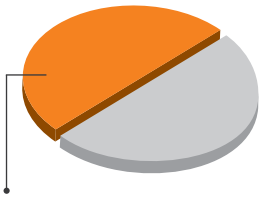
Nearly one in four (23.7%) women report substance use* at any time immediately before, during, or after their pregnancy.

Source: Rhode Island Pregnancy Risk Assessment Monitoring System (PRAMS), Rhode Island Department of Health, 2019

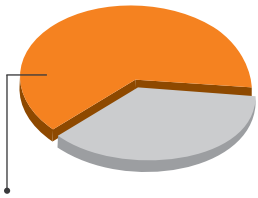
* Substance use includes the consumption of alcohol, tobacco, e-cigarettes, cannabis, opioids, or other drug use.

RHODE ISLAND FACT:

Among mothers experiencing depression during pregnancy



44.9% did not receive any counseling.



70.1% did not take medication.

Source: Rhode Island Pregnancy Risk Assessment Monitoring System (PRAMS), Rhode Island Department of Health, 2019

FOR PEDIATRIC PATIENTS (UP TO AGE 17),

mental health cuts across all backgrounds, regardless of age, race, gender identity, or zip code. For developing children and adolescents, untreated mental health needs can disrupt functioning at home, school, and in the community and are increasing at an alarming rate.

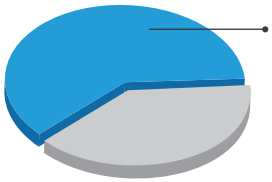
RHODE ISLAND FACT:

Nearly one in five children (19.0%) age six to 17, has a diagnosable mental health problem.

Nearly one in 10 children (9.8%) age six to 17, have significant functional impairment.

Source: 2021 Rhode Island Kids Count Factbook, Providence, RI: Rhode Island KIDS COUNT

RHODE ISLAND FACT:



64.9% of adolescents (age 12-17) did not receive mental health treatment for a major depressive episode in the past year.

Source: Reinert, M, Fritze, D. & Nguyen, T. (October 2021). "The State of Mental Health in America 2022" Mental Health America, Alexandria VA

For pregnant, postpartum, and pediatric patients, data indicate that the need for mental health services will continue to grow. The COVID-19 pandemic will continue to negatively impact these vulnerable populations and further drive the need for enhanced access, care, and support.

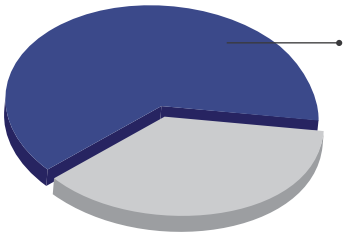
SERVING ALL RHODE ISLANDERS

RI MomsPRN and PediPRN services support providers and their patients across Rhode Island, regardless of a patient's insurance status, coverage type, or health plan carrier. Both programs address health equity through enhanced outreach to providers serving communities that are medically and/or geographically underserved.

For pregnant, postpartum, and pediatric patients, provisional diagnoses reported from PRN clinical consultations include depression, anxiety, post-traumatic stress disorder, autism spectrum disorder, attention-deficit/hyperactivity disorder, bipolar disorder, substance use disorder, and other psychiatric disorders. These are mental health conditions that may otherwise have had a delayed diagnosis and treatment, or ultimately been undiagnosed.

In addition, for pediatric patients, PediPRN empowers PCPs to take an active role in their patients' mental healthcare. Pediatric providers build trusted relationships with their patients and families, enabling open communication and ongoing monitoring over the course of their patients' development—factors that are critical in identifying and addressing mental health issues.

With access to PediPRN, PCPs can effectively treat their patients' mental health symptoms via medication management, brief targeted interventions, and other strategies. This timely intervention leads to better outcomes, including faster initiation of treatment with a familiar provider.



78% of PediPRN engagements result in the PCP continuing to be a part of the management of the child's mental health treatment.

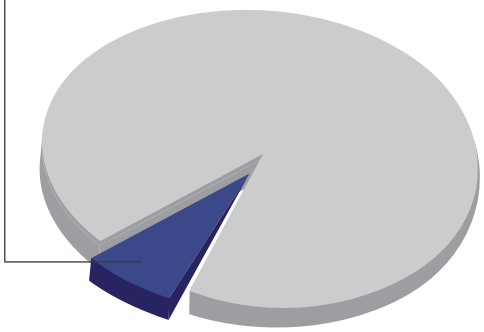
Source: Rhode Island's Pediatric Psychiatry Resource Network Program, Rhode Island Department of Health, 2022

Similarly, RI MomsPRN clinical consultations often result in the development of specific treatment plans that help providers connect patients to appropriate care.

INCREASING ACCESS TO MENTAL HEALTHCARE AMIDST SHORTAGES

While early diagnosis and access to care is critical in addressing mental health conditions, there is a significant shortage of specialized mental health providers and often long waitlists. As a result, much of the burden for initial mental healthcare falls on frontline clinicians, such as primary care and obstetric providers. They must navigate a complex and overtaxed system to connect their patients with the proper specialized mental health services.

It is estimated that only 11% of psychiatrists in Rhode Island provide specialized psychiatric care for perinatal and pediatric patients.



Source: Rhode Island's Psychiatry Resource Network Programs, Rhode Island Department of Health, 2022

To learn more about how the PRN programs help providers improve maternal, child, and adolescent mental health, visit **health.ri.gov/PRNprograms**.

All PRN Program data accurate as of February 8, 2023.
Policy Brief version 3, February 2023.

The RI MomsPRN and PediPRN programs increase access to mental health treatment by building frontline provider competency:

- **Growing provider knowledgebase and competency.** One consult call can impact many patients. Providers can leverage their experience from PRN consultations and educational trainings to treat any of their patients. As providers develop their own knowledgebase and comfort in treating mild-to-moderate mental health conditions, the state's limited subspecialty workforce is able to focus on patients with the most complex needs and conditions, including those at highest risk for hospitalization.
- **Continuing professional education.** Short- and long-term collaboration and provider training supports mental health awareness, identification, and treatment.

SOURCES

ACOG Committee Opinion No. 711: Opioid Use and Opioid Use Disorder in Pregnancy. (2017). *Obstetrics & Gynecology,* 130(2), e81–e94. https://doi.org/10.1097/AOG.0000000000002235.

ACOG Committee Opinion No. 757: Screening for Perinatal Depression. (2018). *Obstetrics & Gynecology,* 132(5), e208–e212. https://doi.org/10.1097/AOG.0000000000002927.

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RI MomsPRN Maternal Psychiatry Resource Network

WOMEN & INFANTS

RHODE ISLAND DEPARTMENT OF HEALTH

PediPRN Pediatric Psychiatry Resource Network

Bradley Hospital

RHODE ISLAND MEDICAL SOCIETY

March 7, 2023

Cory King, Acting Commissioner
Office of Health Insurance
Commissioner 1511 Pontiac
Avenue Building 69-1
Cranston, RI 02920
Cory.king@ohic.ri.gov

Re: Office of Health Insurance Regulation and Affordability Standards-230 RICR-20-

30-4

Dear Acting Commissioner King,

On behalf of the Rhode Island Medical Society (RIMS), we appreciate the opportunity to provide public comment regarding the OHIC Regulation including the Affordability Standards 30-RICR-20-30.4. We commend the Office of Health Insurance Commissioner (OHIC) for its efforts to increase critical investment in primary care, integrated behavioral health, and health equity. We generally agree with and support the suggested changes to the Regulation.

Additionally, RIMS supports all comments submitted by the Care Transformation Collaborative. We also respectfully added the additional comment noted below.

Thank you for your continued leadership to increase access to primary and behavioral health care services for Rhode Islanders. We look forward to continuing to work with you on this important work.

Sincerely,

Thomas Bledsoe, MD, FACP
President

230-RICR-20-30-4

TITLE 230 – DEPARTMENT OF BUSINESS REGULATION

CHAPTER 20 – INSURANCE

SUBCHAPTER 30 – HEALTH INSURANCE

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

4.1 Authority

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

4.2 Purpose and Scope

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

1. Ensure effective regulatory oversight by the OHIC;

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

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

4.3 Definitions

A. As used in this regulation:

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

2. "Aligned measure set" means any set of quality measures adopted by the Commissioner pursuant to § 4.1O(D)(5) of this Part. An Aligned Measure Set shall consist of measures designated as 'Core Measures' and/or 'Menu Measures.' Aligned Measure Sets are developed for specific

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

3. "Commissioner" means the Health Insurance Commissioner.

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

5. "Demographic data" means self-reported data on race, ethnicity, preferred language, sex assigned at birth, gender identity, sexual orientation, and disability.

~~5~~6. "Direct primary care expenses" means payments by the Health Insurer directly to a primary care practice for:

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

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

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

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

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

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

(CC) Funding the purchase by the practice of analytic software that enables primary care practices to

analyze patient quality and/or costs, such as software that tracks patient costs in near-to-real time;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~6~~7. "Examination" means the same as set out in R.I. Gen. Laws § 27-13.1-1 *et seq*.

~~7~~8. "Health insurance" means "health insurance coverage," as defined in R.I. Gen. Laws §§ 27-18.5-2 and 27-18.6-2, "health benefit plan," as defined in R.I. Gen. Laws § 27-50-3 and a "medical supplement policy," as defined in R.I. Gen. Laws § 27-18.2-1 or coverage similar to a Medicare supplement policy that is issued to an employer to cover retirees.

~~8~~9. "Global capitation contract" means a Population-Based Contract with an Integrated System of Care that:

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

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

~~9~~10. "Health insurer" means any entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the Commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for,

or reimburse any of the costs of health care services, including, without limitation, an insurance company offering accident and sickness insurance, a health maintenance organization, a non-profit hospital service corporation, a non-profit medical service corporation, a non-profit dental service corporation, a non-profit optometric service corporation, a domestic insurance company subject R.I. Gen. Laws Chapter 27-1 that offers or provides health insurance coverage in the state and a foreign insurance company subject to R.I. Gen. Laws Chapter 27-2 that offers or provides health insurance coverage in the state.

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

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

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

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

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

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

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

176. "Patient-centered medical home" means:

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

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

c. A Primary Care Practice designated by contract between a Health Insurer and a primary care practice, or between a Health Insurer and an Integrated System of Care in which the Primary Care Practice is participating. A contractually designated Primary Care Practice must meet pre-determined quality and efficiency criteria and practice performance standards, which are approved by the Commissioner, for improved care management and coordination that are at least as rigorous as those of the collaborative initiative endorsed by R.I. Gen. Laws Chapter 42-14.6. For the purposes of this definition a primary care practice that participates in a primary care alternative payment model and participates in an integrated system of care will be deemed to have met the requirements of a patient-centered medical home, and

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

187. "Population-based contract" means a provider reimbursement contract with an Integrated System of Care that uses a reimbursement methodology that is inclusive of the total, or near total medical costs of an identified, covered-lives population. A Population-Based Contract may be a Shared Savings Contract, or a Risk Sharing Contract, or a Global Capitation Contract. A primary care or specialty service capitation reimbursement contract shall not be considered a Population-Based Contract for purposes of this Part. A Population-Based Contract may not

transfer insurance risk or any health insurance regulatory obligations. A Health Insurer may request clarification from the Commissioner as to whether its proposed contract constitutes the transfer of insurance risk.

19. "Primary care alternative payment model" means a payment model that relies on prospective payment to a primary care practice or a primary care provider for evaluation and management services in addition to any amounts paid to support care management and infrastructure of the primary care practice.

2018. "Primary care practice" means the practice of a physician, medical practice, or other medical provider considered by the insured subscriber or dependent to be his or her usual source of care. Designation of a primary care provider shall be limited to providers within the following practice type: Family Practice, Geriatrics, Internal Medicine and Pediatrics; and providers with the following professional credentials: Doctors of Medicine and Osteopathy, Nurse Practitioners, and Physicians' Assistants; except that specialty medical providers, including behavioral health providers, may be designated as a primary care provider if the specialist is paid for primary care services on a primary care provider fee schedule, and contractually agrees to accept the responsibilities of a primary care provider.

2119. "Qualifying Integrated Behavioral Health Primary Care Practice" means:

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

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

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

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

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

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

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

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

253. "Shared savings contract" means a Population-Based Contract that:

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

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

4.4 Discharging Duties and Powers

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

1. Guard the solvency of health insurers;

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

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

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

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

4.5 Guarding the Solvency and Financial Condition of Health Insurers

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18. Whether the management of a health insurer has

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

    b. Furnished false and misleading information concerning an inquiry by the Commissioner, the Department of Business Regulation, the Department of Health, the Department of the Attorney General, any other state or federal agency regarding the financial condition of the health insurer; or

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

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

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

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

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

4.6 Protecting the Interests of Consumers

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

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

C. Whenever the Commissioner determines that one of the circumstances in §§ 4.6(C)(1) through (3) of this Part exist, the Commissioner shall, in addition to exercising any duty or power authorized or required by R.I. Gen. Laws Titles 27 or 42 related specifically to the protection of the interests of the consumers of health insurance, act to protect the interests of consumers of health insurance when exercising any other power or duty of the Office, including, but not limited to, approving or denying any request or application; approving, denying or modifying any requested rate; approving or rejecting any forms, trend factors, or other filings; issuing any order, decision or ruling; initiating any proceeding, hearing, examination, or inquiry; or taking any other action authorized or required by statute or regulation.

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

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

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

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

   1. The privacy and security of consumer health information;

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

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

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

3. The effectiveness of a health insurer's consumer appeal and complaint procedures.;

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

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

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

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

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

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

4.7 Encouraging Fair Treatment of Health Care Providers

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

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

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

filings; issuing any order, decision or ruling; initiating any proceeding, hearing, examination, or inquiry; or taking any other action authorized or required by statute or regulation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Whenever the Commissioner determines that any of the circumstances listed in §§ 4.8(C)(1) or (2) of this Part exist, the Commissioner shall, in addition to exercising any duty or power authorized or required by R.I. Gen. Laws Titles 27 or 42 related specifically to improving the efficiency and quality of health care delivery and increasing access to healthcare services, act to further the interests set out in § 4.8(C)(1)(a) of this Part when exercising any other power or duty of the Office, including, but not limited to, approving or denying any request or application; approving, denying or modifying any requested rate; approving or rejecting any forms, trend factors, or other filings; issuing any order, decision or ruling; initiating any proceeding, hearing, examination, or inquiry; or taking any other action authorized or required by statute or regulation.

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

   a. Can be made in a manner that will

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

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

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

   b. Should include conditions when feasible that will

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

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

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

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

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

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

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

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

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

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

e. Prioritize the use of limited resources

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

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

b. Encouraging public understanding, participation and dialog with respect to the rising costs of health care services, technologies, and pharmaceuticals; the role played by health insurance as both a financing mechanism for health care and as a hedge against financial risk for the consumers of health care; and potential

solutions to the problems inherent in the health insurance market (e.g., market concentration, increasing costs, the growing population of uninsureds, market-driven changes to insurance products (such as the growth of high deductible plans) and segmentation of the insurance market due to state and federal laws); and

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

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

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

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

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

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

a. Collaborating with state and local health planning officials;

b. Participating in the legislative and regulatory processes; and

c. Engaging the public in policy debates and discussions.

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

4.9 Affordable Health Insurance - General

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

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

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

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

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

5. Reduced provision of low-value care.

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

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

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

1. Trends, including:

   a. Historical rates of trend for existing products;

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

   c. Regional medical and health insurance trends; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

b. Whether the insurer addresses consumer need for cost information through increasing the availability of provider cost information and

promoting public conversation on trade-offs and cost effects of medical choices; and

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

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

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

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

3. Health insurer solvency requirements.

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

4.10 Affordable Health Insurance – Affordability Standards

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

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

1. Primary care expenditures.

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

~~2~~b. Direct Primary Care Expenses shall be accounted for as medical expenses on the health insurer's annual financial statements.

Indirect Primary Care Expenses shall be accounted for as administrative costs on the health insurer's annual financial statements. Indirect Primary Care Expenses may be deducted from the statement's administrative cost category as cost containment expenses, in accordance with federal Medical Loss Ratio calculation rules.

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

2. Behavioral health care expenditures.

a. Each health insurer shall report its annual, actual expenditures on behavioral health care in a form and manner determined by the Commissioner.

b. Behavioral health care expenditures shall be inclusive of claims-based expenditures where the claim includes a behavioral health condition as a principal diagnosis, inclusive of mental health and substance use disorder. Additionally, behavioral health care expenditures shall include non-claims-based expenditures, such as per member per month payments to support behavioral health care integration into primary care, pay for performance payments made to behavioral health care providers, and grants designed to address the behavioral health care needs of insured members

c. By January 1, 2024, each health insurer shall increase baseline per member per month expenditures on community-based behavioral health care for children and adolescents, age 0 – 18, by 200% and maintain the increase over time. Baseline expenditures shall be defined as payments incurred and paid in calendar year 2022.

C. Primary care practice transformation. The purpose of ~~this~~ § 4.10(C) of this Part is to transform how primary care is delivered in Rhode Island and to ensure sustainable funding for advanced primary care, in order that the goals of these Affordability Standards can be achieved. While primary care practice transformation should not be considered an ultimate goal in itself, the Commissioner finds that it produces higher quality and potentially lower cost care and is a necessary foundation for the effective participation of practices in Integrated Systems of Care. One element of primary care transformation is the integration of behavioral health care into primary care practice. Integration is in the best interest of the public as it improves health status for those with behavioral health needs and may also result in more efficient use of health care resources. Further, behavioral health integration is a necessary and proper

strategy to fulfill the Office's legislative mandate under R.I. Gen. Laws § 42-14.5-3, which directs insurers toward policies and practices that address the behavioral health needs of the public and greater integration of physical and behavioral health care delivery.

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

    a. Primary care practices which meet the requirements of a Patient-Centered Medical Home in § 4.3(A)(1~~7~~5) of this Part shall be deemed eligible for practice support payments.

    b. Health insurers shall fund primary care practices which have met the requirements of a Patient-Centered Medical Home in § 4.3(A)(1~~7~~5) of this Part in accordance with the following guidelines:

        (1) Primary care practices actively engaged in first-time transformation activity ~~and without NCQA recognition~~, or practices which have completed transformation activity~~with NCQA recognition~~, but which have not met the requirements outlined in § 4.3(A)(1~~7~~5)~~(d)~~ of this Part, shall receive both infrastructure and care management per member per month (PMPM) payments. The care management PMPM payment shall support development and maintenance of a care management function within the practice site.

        (2) Primary care practices that have completed transformation activity~~with NCQA recognition~~ and which have met the requirements in § 4.3(A)(1~~7~~5) of this Part shall receive a care management PMPM payment and have an opportunity to earn a performance bonus.

        (3) Health insurers shall not impose a minimum attribution threshold for making care management PMPM or infrastructure payments to a Patient Centered Medical Home.

        (4) The monetary levels of practice support payments shall be independently determined by the health insurer and the primary care practices. If the primary care practice is part of an Integrated System of Care, the health insurer may make the PMPM payment to the Integrated System of Care, provided the Integrated System of Care is contractually obligated to use the PMPM payment to finance care management services at the primary care practice earning the payment.

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

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

      (1) Financial barriers. By January 1, 2021 health insurers shall eliminate copayments for patients who have a behavioral health visit with an in-network behavioral health provider on the same day and in the same location as a primary care visit at a Qualifying Integrated Behavioral Health Primary Care Practice as defined in $ 4.3(A)(2~~119~~) of this Part.

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

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

   b. The Commissioner shall determine which practices are Qualifying Integrated Behavioral Health Primary Care Practices ~~by~~ by November 30, 2020, and annually thereafter. The Commissioner shall issue guidelines on any time limitations for practices to qualify under $$ 4.3(A)(2~~119~~)(a) and (b) of this Part.

   c. ~~Health insurers shall submit a report to the Commissioner no later than October 31, 2020, that delineates strategies, in addition to the requirements in $ 4.10(D)(3)(c) of this Part, to facilitate and support the integration of behavioral health care into the primary care~~

~~setting. The Commissioner shall issue documentation no later than August 1, 2020 that includes specific questions for the health insurers to respond to and any additional requirements for the report. The Commissioner shall post the completed reports on the OHIC website.~~

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

1. Alternative payment models

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

   b. Health insurers shall take such actions as necessary to have 50% of insured medical payments made through an alternative payment model by January 1, 2021, and annually thereafter. The Commissioner shall issue a policy and guidelines manual by January 1 of each year that specifies the types of payments and payment models which may be credited toward the 50% target.

2. Population-based contracts

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

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

c. ~~By January 2021, h~~Health insurers shall take such actions as necessary to have 30% of Rhode Island resident commercial insured covered lives attributed to a risk-sharing contract or global capitation contract.

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

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

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

(3) For contracts with Physician-based Integrated Systems of Care between 10,000 and 20,000 attributed commercial lives, health insurers shall employ a risk-sharing rate of at

least 40%, and if applicable, a risk-exposure cap of at least 7% of provider revenue or at least 2% of the total cost of care and a minimum loss rate of no more than 3% of the total cost of care. For such contracts entered into, renewed, or amended on or after January 1, 2021, health insurers shall employ a risk-sharing rate of at least 50%, and if applicable, a risk-exposure cap of at least 8% of provider revenue or at least 3% of the total cost of care and a minimum loss rate of no more than 3% of the total cost of care.

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

(5) The Minimum Downside Risk requirements above, while not applicable to risk-sharing contracts with fewer than 10,000 attributed commercial lives, should not be construed to preclude or discourage health insurers and providers from entering into risk-sharing contracts with fewer than 10,000 attributed lives. OHIC recommends health insurer and provider caution when doing so, however, in order to account for the decreased statistical certainty with attributed populations less than 10,000.

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

e. A health insurer shall not enter into a Risk Sharing Contract or a Global Capitation contract unless the health insurer has determined, in accordance with standard operating procedures filed and approved by the Commissioner, that the provider organization entering into the contract has the operational and financial capacity and resources needed to assume clinical and financial responsibility for the provision of covered services to members

attributable to the provider organization. At the reasonable request of the provider organization, the health insurer shall maintain the confidentiality of information which the health insurer requests to make its determination. The health insurer shall periodically review the provider organization's continuing ability to assume such responsibilities. The health insurer shall maintain contingency plans in the event the provider organization is unable to sustain its ability to manage its responsibilities. The foregoing shall not be construed to permit the transfer of insurance risk or the transfer of delegation of the health insurer's regulatory obligations.

f. Population-Based Contracts shall include a provision that agrees on a budget for each contract year. Review and prior approval by the Office of the Health Insurance Commissioner shall be required if any annual increase in the total cost of care for services reimbursed under the contract, after risk adjustment, exceeds the US All Urban Consumer All Items Less Food and Energy CPI ("CPI-Urban") percentage increase (reported~~determined~~ by the Commissioner by October 1 of each year, in accordance with the method set forth in § 4.10(D)(6)(i) of this Part~~based on the most recently published United States Department of Labor data~~). Such percentage increase shall be plus 1.5%.

g. Should any Integrated System of Care have had three immediately prior years of average historical risk-adjusted total cost of care per capita spending for the provider's attributed patient population that was significantly below the health insurer's risk-adjusted commercially insured average (statistically significant at $p <= .05$ and excluding the provider from the calculated average), the health insurer may prospectively adjust that provider's budget upward by up to, but not more than, 2% of the provider's unadjusted expected per capita spending. The adjusted budget shall never exceed the health insurer's projected risk-adjusted commercially insured average spending. Only Integration Systems of Care with risk-sharing contracts shall qualify for the upward budget adjustment.

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

g. Population-Based Contracts shall include terms that relinquish the right of any party to contest the public release, by state officials or the parties to the contract, of the provisions of the contract demonstrating compliance with the requirements of § 4.10(D)(2) of this Part; provided that the health insurer or other affected party

may request the Commissioner to maintain specific contract terms or portions thereof as confidential, if properly supported with legal and factual analysis justifying the claim of confidentiality.

3. Primary care alternative payment models

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

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

   c. For primary care practices recognized as a Qualifying Integrated Behavioral Health Primary Care Practice under $ 4.3(A)(2118) of this Part, Health Insurers shall develop and implement a prospectively paid alternative payment model for primary care that compensates practices for the primary care and behavioral health services delivered by the site.

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

      (1) ~~By January 1, 2021, a~~At least ~~1~~20% of insured Rhode Island resident covered lives shall be attributed to a ~~prospectively paid~~ primary care alternative payment model by the end of 2023.

      (2) ~~By January 1, 2022, a~~At least ~~23~~5% of insured Rhode Island resident covered lives shall be attributed to a ~~prospectively paid~~ primary care alternative payment model by the end of 2024.

      (3) ~~By January 1, 2023, a~~At least 450% of insured Rhode Island resident covered lives shall be attributed to a ~~prospectively paid~~ primary care alternative payment model by the end of 2025.

(4) ~~By January 1, 2024, a~~At least 60% of insured Rhode Island resident covered lives shall be attributed to a ~~prospectively paid~~ primary care alternative payment model by the end of 2026.

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

4. Specialist alternative payment models

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

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

(1) Orthopedics;

(2) Gastroenterology;

(3) Cardiology;

(4) Behavioral health; and

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

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

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

e. Health insurers shall meet this requirement according to the following schedule: by December 31, 2021: two specialties; by

December 31, 2022: three specialties; by December 31, 2023: four specialties; by December 31, 2024: five specialties.

5. Measure alignment

   a. The purpose of this $ 4.10(D)(5) of this Part is to ensure consistency in the use of quality measures in contracts between health insurers and health care providers in Rhode Island, to reduce the administrative burden placed on providers by the unaligned use of quality measures across health insurers, to improve the quality of care by channeling clinical focus on core areas of health care delivery, to formally adopt Aligned Measure Sets to be used in contracts between health insurers and health care providers in Rhode Island, and to articulate a process for annually refining and updating the Aligned Measure Sets.

   b. $ 4.10(D)(5) of this Part applies to contracts between health care providers, including primary care providers, specialists, hospitals, and Integrated Systems of Care and a health insurer which incorporate quality measures into the payment terms of the contract and are entered into, renewed, or amended on or after July 1, 2020, or the effective date of this regulation, if earlier.

   c. Health insurers shall adopt the Aligned Measure Sets for primary care, hospitals, Accountable Care Organizations (ACOs, otherwise known as Integrated Systems of Care as defined in $ 4.3(A)(12) of this Part), maternity care, outpatient behavioral health and any other Aligned Measure Set developed pursuant to this $ 4.10(D)(5) of this Part.

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

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

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

      (4) Health insurers shall not incorporate a Core Measure into the terms of payment with a de minimis weight attached to

the measure, such that performance on the Core Measure lacks meaningful financial implication for the provider.

(5) A health insurer may petition the Commissioner to modify or waive one or more of the requirements of $ 4.1O(D)(5) of this Part. Any request to modify or waive one or more of the requirements must articulate a clear rationale supporting the waiver request and must demonstrate how the health insurer's request will advance the quality, accessibility, and/or affordability of health care services in Rhode Island.

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

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

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

(3) Propose measures as Core Measures and Menu Measures.

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

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

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

(2) Health insurers;

(3) Hospital systems;

(4) Health care providers;

(5) Consumers;

(6) Quality measure experts; and

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

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

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

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

6. Hospital contracts

a. Each health insurer shall include in its hospital contracts the terms required by § 4.1O(D)(6) of this Part.

b. This § 4.1O(D)(6) of this Part shall apply to contracts between a health insurer and a hospital licensed in Rhode Island which are entered into, renewed, or amended on or after July 1, 2023, or the effective date of this regulation, if earlier. To ensure compliance with § 4.1O(D)(6) ~~this subsection~~ of this Part in the event of any hospital conversions pursuant to R.I. Gen. Laws Chapter 23-17.14, the health insurer shall, in terms of contracting, treat the contract of the successor hospital or entity as a continuation of the contract of the predecessor hospital or entity with whom the health insurer had contracted.

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

d. Hospital contracts shall include a quality incentive program.

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

measures to those listed as Menu Measures in the Aligned Measures Set for hospitals.

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

(3) Quality incentive payments will not be due and payable until the quality incentive measure targets have been met or otherwise achieved by the hospital. A health insurer may make interim payments in the event that interim quality performance targets have been met; provided that the interim payments are commensurate with the achievement of the interim targets; and provided further that if the annual quality performance targets have not been achieved, the hospital shall be required to remit unearned interim payments back to the health insurer. A health insurer may also make prospective payments without consideration of performance, provided that if the annual quality performance targets have not been achieved, the hospital shall be required to remit unearned prospective payments back to the health insurer. Earned quality incentive payments shall become part of base payment rates.

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

(1) The average rate increase, including estimated quality incentive payments, is greater than the US All Urban Consumer All Items Less Food and Energy CPI ("CPI-Urban") percentage increase (reporteddetermined by the Commissioner by October 1 each year, in accordance with the method set forth in § 4.1O(D)(6)(i) of this Partbased on the most recently published United States Department of Labor data). Such percentage increase shall be plus 1%, or

(2) Less than twenty-five percent (255O%) of the average rate increase is for expected quality incentive payments.

f. Hospitals which have been paid by a health insurer at less than the median commercial payments made to all Rhode Island acute care hospitals for inpatient services, including inpatient behavioral health services, in the health insurer's provider network, as determined by the health insurer summing all of its inpatient payments (numerator) and dividing that by a sum of all DRG case weights (denominator) to provide a case-mix-adjusted discharge payment rate for each

hospital for inpatient services, shall receive an equal percentage increase in payment for each inpatient service until the hospital's average payment per case-mix-adjusted DRG for inpatient services is equal to the median. At the time of the calculation, the health insurer shall utilize the most recent 12-months of claims data for which the health insurer's Rhode Island hospital claim runout is at least 95% complete. The increase in payment rates shall not be construed as an ongoing price floor. The increase in payment rates shall be contractually contingent on the following:

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

(2) At the mutual agreement of the health insurer and hospital, alternative quality measures and performance targets may be employed as a substitute for the quality measures and performance targets specified in $ 4.1O(D)(6)(f)(1). If the parties cannot agree to an alternative set of quality measures, then the quality measures and performance targets in $ 4.1O(D)(6)(f)(1) shall be used.

(3) The contract contains a provision for recovery of monies paid to the hospital by the health insurer pursuant to this $ 4.1O(D)(6)(f) of this Part should the hospital fail to achieve the quality targets defined in $ 4.1O(D)(6)(f)(1) of this Part. Such provision shall be subject to audit by the Commissioner.

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

h. Hospital contracts shall include terms that relinquish the right of either party to contest the public release, by state officials or the parties to the contract of the provisions of the contract demonstrating compliance with the requirements of this $ 4.1O(D)(6) of this Part; provided that the health insurer or other

affected party may request the Commissioner to maintain specific contract terms or portions thereof as confidential, if properly supported with legal and factual analysis justifying the claim of confidentiality.

i. The US All Urban Consumer All Items Less Food and Energy CPI ("CPI-Urban") percentage increase to be reported according to the Standard Method by the Commissioner shall be equal to the 12-month percent change in the CPI-Urban published by the United States Bureau of Labor Statistics in September of each year. The September report will reference the 12-month percent change from August of the prior year to August of the report year. Due to significant epidemiological or macroeconomic events the Commissioner may elect to utilize a different method of determining the value of the CPI-Urban Should the Commissioner elect to utilize a different method than the Standard Method, the Commissioner shall announce his or her intention of doing so by August 1 and allow for thirty days of public comment on the proposed method prior to issuing a final decision. If the Commissioner ultimately elects to utilize a different method than the Standard Method, any entity that submitted a public comment and is aggrieved by the Commissioner's determination may challenge the determination through all available methods of appeal.

7. Nothing in $ 4.1O(D)(2) or (6) of this Part is intended to require that the health insurer must contract with all hospitals and providers licensed in Rhode Island. Consistent with statutes administered by OHIC, health insurers must demonstrate the adequacy of their hospital and provider network.

8. Professional provider contracts

a. The purpose of $ 4.1O(D)(8) of this Part is to ensure that health insurer contracts with professional providers include terms that allow for the release of contracts, in whole or in part, to OHIC for purposes of monitoring professional provider fee schedule increases, substantiating unit cost trend data filed as part of the health insurer's rate filing, or assessing compliance with state laws and regulations adopted pursuant to Titles 27 or 42 in which the Commissioner holds jurisdiction.

b. Professional provider contracts shall include terms that relinquish the right of either party to contest the release of the contract, or parts thereof, to OHIC; provided that the health insurer or other affected party may request that OHIC maintain specific contract terms or portions thereof as confidential, if properly supported with legal and factual analysis justifying the claim of confidentiality.

Commented [SP1]: RIMS suggests removing this proposed section because of concern related to the ability to keep contracts private as written: affected party may request that OHIC maintain specific terms or portions thereof as confidential, if properly supported with legal and factual analysis justifying the claim of confidentiality.

E. Health equity

1. By July 1, 2024, health insurers are required to obtain NCQA Health Equity Accreditation or NCQA Health Equity Accreditation Plus in support of making progress toward eliminating health disparities, improving health outcomes, and reducing overall health care cost growth.

2. Demographic data collection principles

   a. Health insurers are required to systematically collect, maintain, protect, and report on demographic data. When collecting, maintaining, and reporting demographic data, health insurers shall aim to align their practices with established national standards where possible.

   b. Health insurers are required to utilize industry-wide best practice for demographic data in terms of data collection strategies and survey language that has been consumer-tested and is widely recognized for increased accuracy and responsiveness.

   c. The disclosure of demographic data by prospective members and members to health insurers must always be voluntary and based on self-identification or disclosure and be accompanied by ~~a~~ detailed reasoning for why demographic data is being requested and that it will support efforts to provide equitable care.

   d. To the extent that health insurers use staff to collect and/or analyze demographic data, health insurers shall develop and implement trainings on how to ask questions about the demographic data, including training on how to maintain privacy of this sensitive information.

3. Demographic data use principles

   a. Health insurers shall strictly adhere to any and all existing federal and/or state prohibitions or restrictions on the collection and/or reporting of demographic data.

   b. Health insurers shall apply Health Insurance Portability and Accountability Act of 1996 protections to demographic data and treat demographic data as protected health information.

   c. Health insurers shall strictly adhere to any and all existing federal and/or state requirements governing analysis and information sharing of demographic data.

   d. Legally and ethically acceptable use cases relative to the use of demographic data may include:

(1) Evaluating algorithms to identify and mitigate disparate impact or bias;

(2) Analyzing claims, enrollment, and complaint data to better understand health care disparities or to evaluate the efficacy of programs intended to reduce health care disparities;

(3) Provider network development and coordination of care;

(4) Service quality improvement; or

(5) Assessing or planning to meet the need for health-related social services and supports, including trauma-informed care, and outreach to populations that have been marginalized, among other uses.

4. Development of demographic data collection standards and demographic data use standards and provider financial incentive requirements

a. No later than October 2023, the Commissioner shall convene a working group charged with developing recommendations, for consideration by the Commissioner, on specific demographic data collection standards and demographic data use standards consistent with the data collection principles outlined in $ 4.10(E)(3) of this Part and the data use principles outlined in $ 4.10(E)(4) of this Part. The Commissioner shall consider the recommendations and will promulgate guidance as is necessary to effectuate any recommendations adopted by the Commissioner.

b. No later than October 2024, the Commissioner shall convene a working group charged with developing recommendations, for consideration by the Commissioner, on specific requirements for health insurers to tie provider financial incentives to meaningful progress in remediating health disparities identified by the collection and use of demographic data. The Commissioner shall consider the recommendations and will promulgate guidance as is necessary to effectuate any recommendations adopted by the Commissioner.

5. Demographic data completeness and provider financial incentive requirements

a. By January 1, 2025, health insurers must obtain demographic data for at least 80% of their members, as specified by the Commissioner.

b. By January 1, 2026, health insurers must tie provider financial incentives to meaningful progress in remediating health disparities

identified by the collection and use of demographic data, as specified by the Commissioner.

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

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

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

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

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

      (2) Health insurers;

      (3) Integrated Systems of Care;

      (4) Hospital systems;

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

      (6) Consumers; and

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

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

      (1) To create or maintain an effective incentive for provider organizations to participate in care transformation,

population-based contracts and alternative payment models; or

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

2. The Commissioner, upon petition by a health insurer for good cause shown, or in his or her discretion as necessary to carry out the purposes of the laws and regulations administered by the Office, may modify or waive one or more of the requirements of ~~this Section~~$ 4.10 of this Part. Any such modifications shall be considered and made during the formal process of the Commissioner's review and approval of health insurance rates filed by the health insurer.

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

~~F~~G. Data collection and evaluation

1. ~~On or before 15 days following the end of each quarter, e~~Each health insurer shall submit to the Commissioner, in a format approved by the Commissioner, a Primary Care Spend Report, a Behavioral Health Care Spend Report~~Care Transformation Report~~, and a Payment Reform Report, including such data as is necessary to monitor and evaluate the provisions of ~~this Section~~$ 4.10 of this Part. ~~The Care Transformation Report shall include data measuring the integration of behavioral health care into Patient Centered Medical Homes and other provider practices, and measuring the impact of such integration on health care quality and cost.~~

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

3. Health insurers shall provide to the Office, in a timely manner and in the format requested by the Commissioner, such data as the Commissioner

determines is necessary to evaluate the Affordability Standards and to monitor compliance with the Affordability Standards established in this $ 4.1O of this Part. Such data may include any hospital or provider reimbursement contract, and any data relating to a hospital or provider's attainment of quality and other performance-based measures as specified in quality incentive programs referenced in $$ 4.1O(D)(6)(d) and (e) of this Part.

4. To the extent possible, the Office shall use the All Payer Claims Database authorized by R.I. Gen. Laws Chapter 23-17.17 to collect data required by ~~this subsection~~$ 4.1O(G) of this Part.

4.11 Administrative Simplification

A. Administrative Simplification Task Force

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

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

purposes of ~~this section~~§ 4.11 of this Part, and the purposes of R.I. Gen. Laws § 42-14.5-3(h).

B. Retroactive terminations

1. The purpose of § 4.11(B) of this Part ~~this Subsection~~ is to reduce administrative burdens as well as the associated costs in connection with the practice of retroactive terminations, create an incentive for efficiencies among stakeholders for timeliness of notices of termination, and establish an equitable balance of financial liability among health insurers, employers and enrollees in light of the unavailability of real time, accurate eligibility information.

2. Health Insurers shall cease the administrative process of seeking recoupment of payment from providers in the case of retroactive terminations of an enrollee, except when verified by the Health Insurer that the enrollee is covered by another Health Insurer for the service provided during the retroactivity period. For purposes of § 4.11(B) of this Part~~this Subsection~~, the term Health Insurer includes state and federal government programs, a self-insured benefit plan, and an entity providing COBRA coverage.

3. Health insurers may include the reasonable cost of retroactive terminations into their filed rates. Health insurers shall establish reasonable policies and procedures for providers to conduct eligibility checks at the time services are provided. If the health issuer requires by administrative policy or provider contract that the eligibility check is a prerequisite to the application of the provisions of § 4.11(B) of this Part~~this Subsection~~, the Health Insurer must also provide an administratively simple mechanism, approved by the Commissioner, for the provider to document that eligibility was checked by the provider at the time of service. In addition, Health Insurers may include reasonable adjustments attributable to the Insurer's financial burden with respect to retroactive terminations with its employer groups, so long as the process does not include recoupment of payments from providers not permitted under this § 4.11(B) of this Part in the event of retroactive termination.

C. Coordination of benefits

1. The purpose of § 4.11(C) of this Part ~~this Subsection~~ is to improve on the accuracy and timeliness of information when an enrollee is covered by more than one Health Insurer, and to communicate to affected parties which health insurer's coverage is primary.

2. Health Insurers shall:

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

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

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

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

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

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

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

D. Appeals of "timely filing" denials

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

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

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

a. A copy of the timely filing denial;

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

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

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

(1) Benefit determination documents from another carrier,

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

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

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

4. Health Insurers shall notify providers that upon submission of the information required by $ 4.11(D)(3) of this Part the Health Insurer shall not deny the appeal of a claim due to the failure to file the claim in a timely manner. Nothing in $ 4.11(D) of this Part ~~this Subsection~~ precludes the denial of a claim for other reasons unrelated to the timeliness of filing the claim.

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

b. Health Insurers may implement the requirements of $ 4.11(D) of this Part ~~this Subsection~~ either by amendments to their claims processing system, or by amendments to their provider appeal policies and procedures.

E. Medical records management

1. The purpose of $ 4.11(E) of this Part ~~this Subsection~~ is to maintain the confidentiality of patient information during the process of transmittal of medical records between providers and health insurers, and to reduce the administrative burden of both the providers and carriers with regard to medical record submissions.

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

3. Health insurer requests for medical records shall specify:

   a. What medical record information is being requested;

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

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

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

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

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

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

   b. What specific records are to be sent, and

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

4.12 Price Disclosure

A. The purpose of this ~~regulation~~ $ 4.12 of this Part is to empower consumers who are enrollees in a health insurance plan to make cost effective decisions concerning their health care, and to enable providers to make cost-effective treatment decisions on behalf of their patients who are enrollees of a health insurance plan, including referral and care coordination decisions.

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

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

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

4.13 Severability

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

4.14 Construction

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

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

From: Sen. Ujifusa, Linda L.
To: King, Cory (OHIC)
Subject: comments
Date: Monday, March 13, 2023 10:54:47 AM

This Message Is From an External Sender
This message came from outside your organization.

Report Suspicious

Hi Cory. I am submitting comments with respect to the proposed rules set forth here: https://rules.sos.ri.gov/Promulgations/part/230-20-30-4

Please also place the articles linked below into the comments as setting forth my concerns about the proposed rules' fundamental belief that:

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

My concerns are:

1) Fee-For-Service is Not the Problem. See, e.g., https://pnhp.org/news/fee-for-service-is-not-the-problem/ [pnhp.org]
2) Capitated reimbursement does not improve quality of care. See, e.g., https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-021-07313-3 [bmchealthservres.biomedcentral.com]
3) We should not accept the argument that even though "alternative payment models" don't work, they didn't make things worse, so policy makers should exploit them. See, e.g., Dr. Don McCanne's comments at https://pnhp.org/news/resistance-to-admitting-failure-of-alternative-payment-models/ [pnhp.org]
4) OHIC could perhaps shift to help do more research about the costs imposed by insurance companies "managing" healthcare, stop "protecting" them, and eventually help the state take over management. See, e.g., https://justcareusa.org/how-connecticut-eliminated-capitated-managed-care-in-medicaid/ [justcareusa.org]

Thank you so much for helping me better understand the issues. I appreciate all the work that you and your staff undertake.

Best,
Linda

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TUFTS Health Plan
a Point32Health company

March 7, 2023

Acting Commissioner Cory King
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 Acting Commissioner King,

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

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

I. Behavioral Health Spending Requirements

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

While we do not oppose a minimum spend requirement for BH, increased investment in BH must be balanced by decreased spending from other parts of the health care system, so that total health care spending is not increased. Furthermore, clarifying the goal of a minimum spend requirement would assist implementation. Is the goal to increase reimbursement to providers, increase utilization by member, or perhaps both? Creating meaningful progress toward these goals would best be supported by collaboration with the provider community and others, and sufficient time to achieve. Ideally, we would want to see spending increases tied to access and quality in partnership with providers and the health care system.

Required spending levels constrains our ability to manage overall costs and, ultimately, offer the most affordable premiums possible to our employer clients and consumers. A required spending level for behavioral health services, coupled with existing spending requirements for primary care, Care Transformation Collaborative programs, and a hospital rate cap – which is often viewed as a defined increase, rather than a maximum increase – severely constrains a health plan's ability to manage overall costs and demonstrate innovation within its provider health system arrangements. We would suggest starting with a more gradual spending requirement and introduced over a longer period of time if one is implemented. Additionally, we would propose including alternative investments behavioral health investments allowable as part of the required spending level.

II. Advanced Payment Methods

Tufts Health Plan and Harvard Pilgrim Health Care have both made creating APM arrangements a priority. We support the definition of APM's in the proposed rule. Like other areas of the proposed rule changes, we believe that partnerships with the health care system and providers are necessary to create meaningful and lasting change for the betterment of access and care for Rhode Islanders. The appetite for risk among Rhode Island providers varies and is generally lower in the RI market than we see elsewhere, and while we can propose such arrangements, whether a provider group accepts an APM or not is not in our hand. Elsewhere in our market where we've sought APM arrangements for a long time, we would not find ourselves achieving 65% participation, we believe this benchmark is too high. And given RI's heavy preference for PPO products, such arrangements would only be more challenging to forge.

III. Health Equity data

Point32Health's health equity vision is that all people have the opportunity to attain their full health potential, and no one is disadvantaged from achieving this potential because of social position or any other socially defined circumstance. The company works to invest in the resources, infrastructure, and programs to address inequities and disparities. To date, Point32Health has developed more than 70 initiatives to address health equity across the organization, positioning Point32Health to best address disparities in its member population and the communities it serves. Examples of this work includes provider contractual agreements targeting the reduction of health disparities, programs focused on maternal health, renal disease, and rural health access.

Harvard Pilgrim Health Care and Tufts Health Plan, both Point32Health companies, have earned Full Health Equity Accreditation from the National Committee for Quality Assurance (NCQA) on seven of our organizational licenses across our market area, including our THPP RI Medicaid license. Health equity is a top priority for Point32Health and we are incredibly honored by this recognition from the NCQA. We, however, have not yet sought NCQA Health Equity Accredited for our RI Harvard Pilgrim Health Care of New England or Harvard Pilgrim Health Care Ins, Co. Point32Health will continue to develop new and innovative programs and initiatives to drive health equity and help fulfill our purpose of ensuring our communities have access to equitable, high-quality and affordable health care.

Given our experience in the accreditation process, we have the following comments and recommendations to offer:

"Demographic data completeness and provider financial incentive requirements a. By January 1, 2025, health insurers must obtain demographic data for at least 80% of their members, as specified by the Commissioner."

Response: Clarity around the demographic data completeness requirement of obtaining demographic data for at least 80% of our members is requested. If that standard represents both direct and indirect demographic data then the 'at least 80% standard' is a standard we are supportive of. If the 'at least 80% requirement' includes only direct member data then we would have significant challenges achieving that standard and would need considerable more time to achieve. We recommend the standard be defined as utilizing both direct and indirect demographic data.

"**Demographic data collection principles a. Health insurers are required to systematically collect, maintain, protect, and report on demographic data.** When collecting, maintaining, and reporting demographic data, health insurers shall aim to align their practices with established national standards where possible. b. Health insurers are required to utilize industry-wide best practice for demographic data in terms of data collection strategies and survey language that has been consumer-tested and is widely recognized for increased accuracy and responsiveness. c. The disclosure of demographic data by prospective members and members to health insurers must always be voluntary and based on self-identification or disclosure and be accompanied by a detailed reasoning for why demographic data is being requested and that it will support efforts to provide equitable care. d. To the extent that health insurers use staff to collect and/or analyze demographic data, health insurers shall develop and implement trainings on how to ask questions about the demographic data, including training on how to maintain privacy of this sensitive information."

Response: These principles resonate with our approaches and industry best-practices. There is a tension between 2c (pressure-free and voluntary) and 5a (80% completion) as it would likely be appropriate to consider those who decline as having met the completion target. We would suggest a reduced target and one that requires joint accountability from providers to achieve.

"Demographic data use principles a. Health insurers shall strictly adhere to any and all existing federal and/or state prohibitions or restrictions on the collection and/or reporting of demographic data. b. Health insurers shall apply Health Insurance Portability and Accountability Act of 1996 protections to demographic data and treat demographic data as protected health information. c. Health insurers shall strictly adhere to any and all existing federal and/or state requirements governing analysis and information sharing of demographic data. d. Legally and ethically acceptable use cases relative to the use of demographic data may include: (1) Evaluating algorithms to identify and mitigate disparate impact or bias; (2) Analyzing claims, enrollment, and complaint data to better understand health care disparities or to evaluate the efficacy of programs intended to reduce health care disparities; (3) Provider network development and coordination of care; (4) Service quality improvement; or (5) Assessing or planning to meet the need for health-related social services and supports, including trauma-informed care, and outreach to populations that have been marginalized, among other uses."

Response: We believe importance of building ways for bilateral exchange of demographic data between us and the clinical delivery systems is critical given that much of the data is collected at the point of care.

We suggest that evaluation is more than algorithms and would suggest including any population health or performance related analytics used to assess member needs, evaluate performance, or assess KPIs We suggest wording should include clinical documentation systems (including EMRs) and that provider network performance should be included with "development"

"Development of demographic data collection standards and demographic data use standards and provider financial incentive requirements a. No later than October 2023, the Commissioner shall convene a working group charged with developing recommendations, for consideration by the Commissioner, on specific demographic data collection standards and demographic data use standards consistent with the data collection principles outlined in § 4.10(E)(3) of this Part and the data use principles outlined in § 4.10(E)(4) of this Part. The Commissioner shall consider the recommendations and will promulgate guidance as is necessary to effectuate any recommendations adopted by the Commissioner. b. No later than October 2024, the Commissioner shall convene a working group charged with developing recommendations, for consideration by the Commissioner, on specific requirements for health insurers to tie provider financial incentives to meaningful progress in remediating health disparities identified by the collection and use of demographic data. The Commissioner shall consider the recommendations and will promulgate guidance as is necessary to effectuate any recommendations adopted by the Commissioner."
Response: We recommend a priority use of CDC, OMB, or National Academy of Medicine federal standards as the baseline for any state standards, and alignment with national health IT interoperability standards (https://www.healthit.gov/isa/uscdi-data/ethnicity). Conflicting local, federal and accreditation based standards make compliance challenging. Massachusetts undertook a similar initiatives and the state-specific standards align in some areas with NCQA but do not fully align and creating administrative challenges.

"**Demographic data completeness and provider financial incentive requirements** a. By January 1, 2025, health insurers must obtain demographic data for at least 80% of their members, as specified by the Commissioner. b. By January 1, 2026, health insurers must tie provider financial incentives to meaningful progress in remediating health disparities identified by the collection and use of demographic data, as specified by the Commissioner."
Response: We have several concerns with this section. First, the threshold of 80% seems too high a target. Second, we need the state to help create conditions which promote sharing of this information between clinical partners (above) and plans to come close to reaching this level. Third, we believ that initial reporting of health inequities across demographic groups is an important missing step between 2025 and 2026. Consistent with industry best practices is the initial reporting of disparity information for several cycles to ensure actionable and reliable results before use in financial accountability. Lastly, we question the effectiveness of using financial incentives as the most appropriate mechanism for remediating health disparities as there is no conclusive evidence suggesting impact. We agree that shared collective action is necessary but it's not clear that requiring this approach is prudent. Broadening the definition for financial incentives to prove flexibility for other (potentially more effective) approaches, such as quality improvement collaboratives, to emerge may be appropriate given the current state of evidence. Revising this to "must tie provider financial or non-financial accountability to…" might be more effective.

IV. Hospital Cap Increase Waivers

We believe hospital cap increase waivers creates administrative complication, especially in the situation of an appeal, and how a mandated waiver and appeal would play into contract negotiations. We suggest that parameters are necessary to define the timeframe i.e. 60 days after August 1st announcements. Technical challenges exist around loading rates and retroactive claims. We are also concerned about the impact of annual changes on this. We believe significant capacity would be needed within OHIC to manage appeals.

In summary, we respectfully request review and consideration for the critical role of collaboration from other health system partners to meaningfully make progress on these goals. We request that targets are data-driven and more gradual and that timelines are extended to allow for the necessary collaborations and accountability throughout the health care system to build. Thank you for the opportunity to comment on these important proposed changes to the Affordability Standards. If you have any questions, please do not hesitate to contact us.

Sincerely,

Adam Martignetti

Vice President, State Government Affairs and Advocacy