State of Rhode Island Office of the Health Insurance Commissioner
Health Insurance Advisory Council
Meeting Minutes
November 21, 2023, 4:30 P.M. – 5:30 P.M.
1511 Pontiac Avenue
Building 73-1
Cranston, RI, 02920-4407

Attendance:
Members:
Co-Chair Acting Commissioner Cory King, Al Charbonneau, Daniel Moynihan, Eugenio Fernandez, Lawrence Wilson, Mark Jacobs, Sandra Victorino, Stacey Paterno (on behalf of Catherine Cummings)

State of Rhode Island Office of the Health Insurance Commissioner Staff
Taylor Travers

Not in Attendance
Catherine Cummings, David Feeney, Jocelyn Foye, Laurie-Marie Pisciotta, Shamus Durac, Co-Chair Stephen Boyle, Teresa Paiva Weed

Minutes

1. **Introductions and Review of September Meeting Minutes**
   Co-Chair and Acting Commissioner Cory King called the meeting to order as a public meeting as necessary attendance requirements were not met. All present members introduced themselves. Following the introductions, Acting Commissioner King addressed that the vote of approval for October's meeting minutes will take place at December's meeting.

2. **RIREACH Consumer Update**
   Acting Commissioner Cory King provided an update on behalf of Shamus Durac of RIPIN. In 2023, RIPIN has saved consumers $1.2 million in health care costs. This month they are continuing to see significant case volume related to the Medicaid Redeterminations. The office is preparing for the upcoming resumption of redeterminations of households including children, who will begin receiving paperwork next month with renewals in January. The office is also devoting energy to Open Enrollment which started earlier this month. Other states have reported an increase in activity from low-value, non-traditional forms of insurance that have lower monthly premiums but provide very limited benefits once the individual needs care. They have not yet seen specific evidence of this in Rhode Island.

3. **November Data Story**
   Acting Commissioner King introduced the topic of data stories, which will begin next week. Each month the office will release a data story drawn from analysis of medical expenditure data collected through the annual Health Spending Accountability and Transparency Program. The November data story will focus on the impact of rising health care cost on employer sponsored insurance and the impact on wages and wage growth. As insurance is a form of non-wage compensation; Employers must balance the cash compensation and benefits. There is empirical data that rising health care costs does erode wage growth. These stories will be short, no more than two pages in length. Upcoming topics include prescription drug prices, as Cory does anticipate this being a focus of the upcoming General Assembly session.

4. **All-Payer Health Equity Approaches and Development (AHEAD) Model**
   Slide decks were provided for all members of the HIAC and the public. Acting Commissioner King outlined the slides for the new state partnership model developed by the Centers for Medicare and Medicaid Innovation. The innovation center has existed for about a decade now and started as an outgrowth of the Affordable Care Act. The center led the development and implementation of many value-based purchasing and care delivery innovations, such as the Medicare Shared Savings Program. The objective is to establish a standard model for states that build upon existing and individualized state models. Acting Commissioner King advised that internal deliberations are occurring to determine if Rhode Island should apply for this new model, and which cohort they would apply to. Healthcare Purchasing is fragmented in this country, which can create challenges for providers existing in this multi-payer environment. In 2022, 51.4% of Rhode Islanders were covered through an employer, 6.5% through the individual market, Medicaid covered 22% and Medicare covered 15.4%. This data is from Kaiser state health facts. The Medicare market is around a 50/50 split between traditional Medicare and Medicare Advantage. In 2021 in Rhode Island the per capita spending for Medicare was $12,982, for commercial it was $6,171, and for Medicaid it was $7,123. The purpose of the AHEAD model is to develop a state total cost of care model to reduce health care costs and cost growth to drive health care transformation and multi-payer alignment. Under the total cost of care model, the participating state would use its authority to align with what Medicare has in place. Some of the elements would be all-payer in nature, and some would be specific to Medicare. This would be an opportunity to develop aligned targets for total cost of care for primary care investment. A crucial part of the approach would be to drive change for population health and health equity. Starting with statewide accountability targets, the state would develop a total cost of care growth target for Medicare and all-payers. Cory advised that a cost growth target does exist for all-payers now in Rhode Island. It would also develop a primary care investment target for Medicare and all-payers. Finally, there would be plans in place to develop interventions to address health equity and population health. The first component of the model is cooperative agreement funding for states to build capacity infrastructure, up to 12 million dollars. The second component is hospital global budget for hospital facility services, including inpatient and outpatient services. Hospital participation in the model is not

mandatory, and the state would have to recruit the hospitals which does include certain thresholds. The state does not have to have hospitals on board at the time of applying but there does need to be a plan to recruit said hospitals. By the completion of the pre-implementation period, hospitals would need to have been recruited to proceed in the process. The third component is Primary Care AHEAD, a mechanism to increase Medicare's investment in primary care through the development of a Medicare target. Cory clarified that if a primary care practice is already involved in an existing model called Primary Care First, they cannot simultaneously participate in Primary Care Ahead. Strategies as outlined include integrating equity across all model elements, supporting behavioral health integration, creating an all-payer approach, aligning Medicaid payment policy and Medicaid contracting, and accelerating existing state innovations. Mark Jacobs asked if OHIC has compared the monthly capitation payments between the two programs, they have not yet.

There is a significant role for stakeholder engagement, as states must take the lead in creating that multi-payer collaboration. Rhode Island must ensure that the Medicaid program is in alignment with that, and that there is at least one commercial payer involved. The states would establish a governance model for the program, which is a nine-performance year program, up to eleven years when you include the pre-implementation period. There are requirements to set the all-payer cost growth target, which Rhode Island does already have. As well as increasing primary care investment which Cory is committed to doing in his role as Acting Health Insurance Commissioner. Additionally, the implementation of statewide health equity plans which Rhode Island does currently have in place which can act as a framework. Hospitals can participate in global budget; but it is not mandatory. Cory continued to outline Primary Care Ahead on slide eight. CMS aims to strengthen primary care, improve care coordination, increase screening and referrals, increasing resources such as housing and transportation, and address social risk factors. CMMI anticipates that eligible practices would receive enhanced primary care payments, ranging from $15 to $21 dollars, with an average of $17 dollars per member per month. The state would then have to have concurrent targets in place for Medicaid commercial that align in methodology, which would be negotiated with CMMI. OHIC does have an existing process in place, through regulation, in which they require commercial payers to support patient-centered medical homes (PCMH) with ongoing care management support and other infrastructure that meet requirements set by OHIC. Practices can use the enhanced payments to invest in infrastructure and staffing. He noted that practices owned by a hospital that do not participate in a global budget cannot participate in Primary Care Ahead. Cory encouraged everyone, including the hospitals to review the NOFO to review the value proposition. Beyond hospital participation, the state must recruit one commercial payer as indicated previously. Developing a health equity strategy is a key element which would be done using cooperative agreement funding. He acknowledged that EOHHS and the Department of Health has done great work thus far around centering health equity as part of its state policy discussions. The AHEAD governance model, there are some represented parties that need to be a part of that, it does need to be multi-sector and include a lot of key

players including patient advocates, advocacy organizations, providers, and state agencies. Cory outlined that CMS has released the Notice of Funding Opportunity (NOFO) and expects to award eight states. He envisions Rhode Island submitting a joint application with EOHHS and OHIC, with EOHHS being the recipient of the grant. Slide 14 provides an overview of the anticipated timeline which consists of three cohorts. The first NOFO which we are currently in is comprised of cohort one and cohort two. Cohort one is an accelerated pre-implementation period of 18 months and the NOFO outlines the expectations upon the end of the period. There are nine performance years, ending in 2034. Cohort two consists of a pre-implementation period of 30 months recognizing that some states will have to develop cost growth targets, and primary care investment targets. Cohort three is another option, which consists of a 24-month pre-implementation period and fewer performance years. The last slide outlines the high-level planning considerations for Rhode Island. He states that Rhode Island is well positioned to apply as the state currently has a commitment to health equity, health equity zones in place, an existing statewide cost growth target, and more importantly the methodology for data collection and reporting. On the commercial side, Rhode Island does also have a primary care investment target. Additionally, the state has a long history of multi-stakeholder collaboration. There is no definite timeline for decision as of yet, but Cory will keep the HIAC apprised. Al Charbonneau asked what the access points are for consumers to ask questions and voice opinions in relation to this initiative. Cory outlined that the secretary of EOHHS and himself would be the main points of contact, but more specifically the secretary of EOHHS. Mark Jacobs added that there is a major element of meeting total cost of care goals, and asked if there were any punitive or mandates associated with not meeting that goal. Cory outlined that for the AHEAD model, the hospital global budgets would be adjusted for performance on total cost of care within the Medicare population as there are adjustments for effectiveness. For the statewide cost growth target, there is no downside. Mark Jacobs added that there is a need for meaningful engagement from specialists. Dan Moynihan added that from a hospital perspective, they are looking closely at the model. Cory concluded that the application is due in March 2024.

5. **RI Business Group on Health – Arnold Ventures Grant Presentation**

Al Charbonneau presented the Rhode Island Business Group on Health Arnold Ventures Grant. The Rhode Island Business Group on Health was awarded the grant in support of its health care transparency and payment reform initiative. This utilizes NAIC (National Association of Insurance Commissioners) data that was made available under the Affordable Care Act, called the Supplemental Health Care Exhibit. In addition to the Medical Expenditure Panel Survey and the Medicare Cost Report. These sources provide an overview of what is being sold in the community for the fully insured population. Although it does not provide a total picture it gives a fairly robust portrayal. This data in conjunction with the SERFF (System for Electronic Rates and Forms Filing) data was used to look at delivery system expenses and medical expenses. Al outlined that overhead cost continues to increase dramatically, in conjunction with an increase in mergers and acquisitions. In the collaboration with Arnold Ventures, the group has committed to developing data to create a non-actuarial, non-health policy message. The objective is to

create something that is understandable for all consumers. In addition to using that data to educate the business community and legislative leadership within Rhode Island. Al has also committed to the National Alliance of Healthcare Purchaser Coalitions to share this database nationally upon its completion. This grant also allows Al to work closely with the Business Analytics and Artificial Intelligence Department of the College of Business at the University of Rhode Island. The idea is to build the database, which Al has started, and potentially use that database to have a course taught at URI focusing on data visualization. The takeaways from the hospitals are that overhead costs have gone up 5-7% nationally over 25 years. He is not only interested in costs, but in strengthening hospitals as well. He has been working with a writer, and the final report is expected within the next couple of weeks. Al expects there to be 5-7 pieces total with each roughly containing about 700-1000 words.

6. **Public Comment**
   There were no public comments.

7. **Adjournment**
   The meeting was adjourned at 5:30 P.M.