State of Rhode Island Office of the Health Insurance Commissioner
Health Insurance Advisory Council
Meeting Minutes
May 21, 2024, 4:30 P.M. – 5:30 P.M.
1511 Pontiac Avenue
Building 73-1
Cranston, RI, 02920-4407

Members in Attendance:
Commissioner Cory King, Catherine Cummings, Shamus Durac, David Feeney, Eugenio Fernandez, Bob Hughes, Mark Jacobs, Dan Moynihan, Teresa Paiva Weed, Laurie Marie Pisciotta, Lawrence Wilson

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

Not in Attendance
Hub Brennan, Al Charbonneau, Jocelyn Foye, Sandra Victorino

1. Introduction and Review of Meeting Minutes

Health Insurance Commissioner and Chair, Cory King called the meeting to order at 4:30PM. Members voted to approve the April meeting minutes. Laurie Marie voted to abstain as she was not present at the April HIAC meeting.

2. Rhode Island Parent Information Network (RIPIN) RIREACH Update

Shamus Durac provided the RIREACH update, it is now the first month into the second year of Medicaid renewals. He thinks there has been a slight decrease, although it is still early to make that determination on case volumes. A couple of broader issues include the general delay in legislative changes and the impacts it has on consumers accessing services. There has been a noticeable uptick in cases relating to the relatively new doula mandate. There has also been a slight increase in cases involving self-insured plans requiring RIPIN's partnering with the Department of Labor. He noted that as they see more plans self-funding that it complicates some jurisdictional factors and how they are able to do their work. They are an all-payer consumer assistance program, but they are seeing an increase in cases that require collaboration with other agencies.

Teresa asked about the volume of undocumented individuals being directed to the correct plan, whether it be Cover All Kids, or KIDS COUNT. She mentioned that the General Assembly appropriated funds, but she does want to ensure that all available federal dollars are being utilized.

Shamus advised that he would follow-up with the correct figures.

Dan noted that they are seeing an increase in what is referred to as emergency Medicaid, but he does not have specific figures.

Catherine asked Cory that with the increasing self-insured plans, is it a requirement that the plans register in Rhode Island?

Cory advised that at a high level OHIC tracks the 4 major carriers total enrollment divided into self-funded and fully insured which are the markets they regulate. Over time, they have noticed a trend towards more Rhode Islander's obtaining their insurance through a self-funded employer, and fewer through a fully insured employer.

Catherine asked if they know which employers are choosing self-funded, or if they are required to report.

Cory noted that the carriers report enrollment, but it is an employer benefit, and he is unsure if they are required to register with the Department of Labor. In effect it is the larger companies, universities, cities, and towns. Although there are traditional small groups under fifty that are moving to self-insured products. The insurance company will typically pair a stop loss plan with that, they are seeing this particularly with United Healthcare.

Larry asked if there is a sense of how fast that group is growing?

Cory does not have specific numbers, he asked if other members had that figure.

Shamus mentioned that estimates vary. Before the most recent increase, estimates varied significantly.

Teresa noted that before this recent change there was about 4,000 children that had been enrolled in All Kids. Which was a higher number than anticipated. She asked if there was a way to ensure they were enrolled in the correct plans, as they were coming through RIPIN.

Shamus mentioned that some number of them are coming through RIPIN. He noted that some children are eligible for Medicaid though they are not enrolled. Ensuring that the numbers are accurate, and they are doing what they can for maximum coverage is at the forefront.

3. Affordability Update

Cory outlined the affordability standards, in a report released in December, OHIC outlined that they would be modifying the primary care expenditure requirement. As well as taking action to alleviate administrative burden faced by providers. They are currently working on drafting changes to the affordability standards regulations and running various financial scenarios. Under the Administrative Procedures Act, they are required to conduct a cost-benefit analysis. They make efforts to project all associated costs of a particular proposal. He further explained that the financial modeling is figuring out how the target values can be set in a way that compels insurance companies to commit more funding to primary care and through what mechanism. This, as they move from a very old and imperfect way of measuring primary care to a better way, driven by more consensuses driven definitions that have emerged across states in recent years.

The administrative burden piece is leveraging the recommendations from the CTC-RI workgroup that preceded the Administrative Simplification Task Force that wrapped up its work earlier this year. Coupling that to produce a reduction in the volume of prior

authorization faced by all providers, and a targeted reduction in volume and burden for primary care providers specifically.

Additionally, under evaluation is the potential change to the hospital rate cap to address outpatient rates. OHIC is currently working on a methodology to implement that, though that will not hold up the primary care work. When they promulgate a new primary care expenditure target, it will be promulgated in such a way that insurance companies have to either increase their reimbursement for primary care services or pay enriched capitation payments for primary care services.

Teresa noted that OHIC did great work at the cost trends forum. She understands that there is much discussion about commercial rates in the General Assembly. She anticipates that when OHIC looks at the affordability standards, the Hospital Association will also be asking them to look at their current standard, particularly as it pertains to current rates of inflation.

Cory mentioned that he is happy to discuss the standards longer term. At minimum he is interested at reviewing the outpatient rate distribution, as OHIC did for inpatient some time ago. Broader structural changes in the rate cap, particularly whether they encourage or incentivize other types of activities and types contracting will be reviewed. When OHIC promulgated the hospital rate cap a decade ago, it was structured in a way that if the hospital and the payer wanted to come forward with an innovative strategy that manages total cost of care, assumes financial risk, etc., that the rate cap could potentially be taken off the table. No facility or payer came to OHIC with an alternative strategy.

Teresa asked that, wouldn't it have to be the insurer that approached them for relief.

Cory outlined historically it has only been done around the rate cap itself. However, if the hospital and insurer came to him with something innovative and negotiated a global budget, they could potentially look at rebasing and the relevance of the rate cap there. It is those types of other types of value-based payments that should be in play.

Teresa noted that the RI Foundation showed that there is a significant differential and inequity, some of the poorer hospitals are at the bottom. The question is can what was done on the inpatient side be done on the outpatient side.

Dan asked how primary care is defined today, as Cory mentioned previously that the definitions have changed.

Cory outlined that today it is a very high-level, consisting of internal medicine, family practice, and pediatrics. It is those high-level specialties and they do not go into specific procedure code level detail. For non-claims there is a lot of opportunity for health plans to classify things as primary care related, but that they are not necessarily directly beneficial to the primary care physician. When this was developed fifteen years ago, there was nothing to work with at that time. Since then, they have worked with other states in New England to come up with definitions of primary care from a specific provider taxonomy perspective. In addition to identifying the specific taxonomy codes and procedure codes that fit into primary care. That new definition has been adopted as part of the Cost Growth reporting. There is now two years of data under the new definition of primary care spending to be compared the

old definition to then make the switch. The way that the numbers are going to work out, is the target numerical value they have today is going to be pretty similar to what it will be in the future. By changing the definition, they are actually increasing the total medical spending denominator and having a tighter definition of primary care. He explained that it will be a little confusing at first, but the important aspect is that there is a baseline, and if you have to increase from the baseline over the course of three to five years, you have to find the money. It is not a matter of reclassifying spending but a matter of actually increasing the valuation of the services that are falling within that numerator.

Larry echoed Teresa's comment regarding the wonderful job at the cost trends forum. He was particularly pleased about the transparency of demographic rate data that they have and don't have, and the efforts to improve it. He remembers a time when the data wasn't available, so it wasn't talked about.

Cory noted that there are still gaps in data, particularly when classifying by race and ethnicity. One of the new dashboards OHIC launched recently is a 'chronic conditions' dashboard which allows one to review at a zip code level and see how many patients who live in a particular zip code have a particular type of condition.

4. Rate Review Update

Cory outlined that the rate filings came in and are very high. They range from 5% on the low end to 22% on the high end; most of them are well above 10%. OHIC will be releasing that information publicly within the next few weeks once they review for completion. OHIC will then conduct another review, consisting of an actuarial review, as well as a review of the appropriateness of their requested profit or contribution to reserve margins. He added that what is driving these results is 2023 data, they knew going into 2023 that there would be an uptick in healthcare claims expenses, which is being seen. It is incumbent upon OHIC to determine if the insurance companies are appropriately projecting their future utilization and incurred claims. Which is the purpose of rate review, rate review on an ever-shrinking market as many are going self-insured.

5. Cost Trends Update

Cory outlined OHIC's recent public forum, held Monday May 13th. There was good news for 2022, in that Rhode Island achieved their cost growth target, and is running below the target on a three-year average. He noted that it might not be a similar story for 2023 but that is ok because there is a lot of analytic infrastructure now to understand how much money is being spent in healthcare and where the money goes. OHIC is able to drill down and see shifts in services, from inpatient to outpatient and variations in emergency department visit intensity across hospitals. The new dashboards do not identify the specific hospitals, but it does show hospital emergency room visit information. He noted that some hospitals have much higher intensity than others. He also emphasized that there is a lot of opportunity in the future to explore why healthcare spending is not only increasing but why it varies across populations and providers.

Mark Jacobs noted that during his time at this committee there has been a lot of talk about affordability and cost, but one of the major metrics is quality and quality is not talked about

as much. He noted there was an important presentation at the cost trends forum pertaining to chronic medical disease that were able to be put into three to four slides including, Hemoglobin A1C (HbA1c), diabetic eye exams and hypertension control. Those three factors are probably the most important risk factors for cardiovascular disease, for diabetics in particular those risk factors contribute to incredible morbidity and mortality. He added that though our numbers are better than the national average, they are not great. Especially when drilled down by insurance carrier, particularly in the Medicaid population. He thinks that is incredibly disappointing, as one third of diabetics do not have an annual eye exam, one quarter of diabetics have HbA1c levels over eight, and one quarter of hypertensives are not controlled. If looking for a way to decrease costs in the system, they need to address chronic medical disease in a more efficient and effective way. While it is talked about supporting hospital systems and increase funds, the best way to save money in that area is to keep people out of the hospitals. He thinks its a symptomatic weakness of the primary care system, which he thinks has to do with access and affordability. He thinks this is an area that they haven't placed enough emphasis on. He noted that when ACO's first came to be, some highly motivated physician groups put teams together (consisting of Certified Diabetic Educators, Registered Dietitian's, Pharm D's, Nurse Practitioners, Case Managers, etc.) and addressed these chronic conditions, the numbers were a lot better than what is being seen in the present day. He is not sure where the effort is on that now, but 65% doesn't cut it for him. He thinks that perhaps the Cost Trends Steering Committee or the HIAC should look at it, as it is incredibly important for the healthcare system.

Catherine agrees to the number of individuals she sees with those chronic conditions.

Cory agrees that it is very worthwhile discussing with the Cost Trends Steering Committee, and if the committee wants to specify some targets for improving performance, that would be a reasonable step.

Teresa also thinks that with these investments in primary care, doctors having more flexible office hours might be a worthwhile campaign for Rhode Island Medical Society and others to take on.

Catherine noted that with the present workforce it is just not physically possible for them to do more.

Teresa thinks that is part of the problem. She mentioned the Lifespan walk-in on Aquidneck Island as an example, it is the only place for care. If that wasn't there then everyone would have to go to the Emergency room. The problem is that they are booked solid on at any given time, and they are open until 8pm. She knows how hard they are working and what they are trying to do, but it is still continues to be a problem.

Cory outlined an OHIC analysis currently being worked on which they should be in a condition to publish within the next 4-5 months. They are looking at trends in primary care, urgent care and emergency room visits by payer type over time. They will then layer on top of that, avoidable emergency room visits. He mentioned an old algorithm created in New York in the 1990's which they will not be using as other states have created some more recent ones. He hopes that will bring some additional clarity. When he looks at the dashboard on the

emergency room visit intensity in the APCD commercial population it is still under its pre-pandemic emergency room visit count. He added that Medicaid is still up there, and Medicare has recovered. He is wondering if there are more differences in payer mix. He outlined that they do not have all commercial data within the APCD because the self-insured groups do not contribute.

Catherine noted that many urgent care centers do not take Medicaid, which then leaves individuals only one option.

Teresa agreed to Catherine's statement. She has also seen a significant rise in boutique medicines, she added that as much as she wants to invest in primary care there are trade offs that they have to be careful of. For example, with telehealth and behavioral health, it made it easier for providers to set up private offices and leave the hospitals and mental health centers.

Cory thinks they need to identify a few key performance indicators for this, and the emergency room visit utilization might be one of them. If investing millions of dollars more in primary care, he wants to see an increase in availability and access to new patients.

Bob asked if there was adequate data on access.

Cory does not think the available data is not well assembled. He noted that practices at the ACO level will use a third best available appointment metric, which he thinks comes from NCQA. He does think practices may be providing untimely information to insurers for the provider directory.

Teresa mentioned that the Governor is proposing increasing Medicaid for primary care which the Hospital Association has supported very strongly. There are also talks about increasing on the commercial side as well. There are also scholarships pending for primary care doctors.

Cory mentioned that he has been talking to CTC-RI around developing a primary care dashboard. This would be similar to Massachusetts and New York and could be another way of monitoring access. He also mentioned a recent publishing by RI Current focusing on Massachusetts currently facing the same issues related to primary care. He added that Rhode Island needs to be in a position to compete with them on primary care.

Teresa noted that there are good stories, particularly the new Graduate Medical Education program and primary care clinic at Landmark that supplements Thundermist. She added that out of the first class of seven, four stayed.

Larry mentioned that he is stuck on that fact that walk-ins do not take Medicaid.

Catherine does not want to say that they all don't but many of them do not. She added that there are a lot of practices that aren't necessarily looking for self-insured or any type of difficult insurance. She mentioned that an interesting survey would be to ask the urgent cares which insurances they do take.

Dan mentioned that Lifespan does accept Medicaid.

Laurie-Marie shared that through conversations she had with BCBSRI, they confirmed that when they eliminated prior authorization for all levels of behavioral health, the long-term

costs reduced over time as fewer patients needed to go to the emergency room. They did not observe fewer patients going to the hospital over and over again. She added that it could be that they are not giving patients enough time in the hospital to get stable. It could also be that there is not enough lower level of cares, such as partial hospitalization or intensive outpatient services. If there are no catch services in place when leaving the hospital, individuals can relapse quickly.

6. Asthenis Public Health Model Presentation by Dr. Eugenio Fernandez Jr.

Dr. Eugenio Fernandez Jr., member of the HIAC provided a PowerPoint presentation showcasing an overview of the Asthenis Pharmacy Public Health model. The presentation highlighted reimbursement, activities of Pharmacy Benefit Managers and activities conducted by Asthenis.