State of Rhode Island Office of the Health Insurance Commissioner
Health Insurance Advisory Council
Meeting Minutes
October 15, 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, Hub Brennan, Al Charbonneau, Howard Dulude, Shamus Durac, Eugenio Fernandez, Bob Hughes, Mark Jacobs, Sandra Victorino, Laurie-Marie Pisciotta

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

Not in Attendance
Catherine Cummings, David Feeney, Jocelyn Foye, Dan Moynihan, Lawrence Wilson

1. Introduction and Review of Meeting Minutes

Commissioner and Chair Cory King called the meeting to order at 4:30 PM. Present members voted to approve the September meeting minutes.

2. RIPIN RIREACH Update

Shamus Durac provided an update on the RIREACH program. A significant portion of recent work has been dedicated to the resumption of verification of Medicaid enrollees. The RIREACH has been assisting many individuals who have transitioned to new insurance or those who have lost insurance. He invited attendees to reach out with any concerns or trends they might see.

3. Affordability Update

Commissioner King provided an overview of OHIC's recently proposed amendments to regulation 4, OHICs Powers and Duties regulations. The notice of proposed rulemaking was provided to all attendees. He provided a brief overview of the history and purpose of OHIC. When the office was created, a regulation was issued to set forth various standards for commercial health insurance companies that would help the office as an agency to advance the statutory mission. The statutory mission is multi-faceted as it directs the office to protect the interests of consumers of commercial health insurance, encourage fair treatment of health care providers by commercial health insurers, guard the solvency of commercial health insurers, and to direct health insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access.

The initial outgrowth of conception was OHICs affordability standards, developed around 2008. The starting point was to focus on improving the resourcing for primary care to advance primary care practices into Patient Centered Medical Homes (PCMHs) that met and exceeded various quality measures. To do that, the agency established a primary care expenditure target for regulated commercial health insurers, consisting of a ratio of primary care expenditure to total medical expenditures for a population. The ratio would be

required to increase 1% annually over a five-year period. That was the initial financial driving force between the chronic care sustainability initiative through CSI Rhode Island which later became CTC-RI (Care Transformation Collaborative- Rhode Island). That collaborative was very effective in which it went from zero to 180 practices that are presently recognized by OHIC as PCMHs. It was done largely through multi-payer involvement including commercial, Medicare Advantage, and Medicaid. In 2015, the OHICs progression from the baseline rate for primary care spending was completed. At that time the market value was 10%, which was the binding regulatory requirement for primary care. 9.7% had to be direct for primary care support and an additional 1% could fund the administrative costs of CTC-RI and the Health Information Exchange.

In 2020 OHIC began to look at how primary care spending was being measured in Rhode Island as part of that regulatory requirement. Rhode Island was the first state to establish a primary care expenditure target, as well as require one through regulation. OHIC created the specifications for insurers, and several decisions were made which did not include payments to out-of-state providers. It provided general guidance in terms of the types of professional credentials that could be considered primary care but did not provide specific taxonomy codes related to primary care. A directive also provided that the support of primary care needed to occur largely through non-fee-for-service mechanisms, such as pay-for-performance or care management payments made on a per member per month basis. A review of how non-claims-based payments were being measured was needed to ensure payments were actually going to primary care. For this, OHIC piloted a new program with the first year of measurement being 2021, the second year being 2022.

The recently proposed regulations do two things, provide improved insights into how much money is going into primary care and amend the regulatory requirement expenditure target for commercial insurers. The amendments also aim to reduce administrative burden on primary care practices. The accompanying regulatory analysis provides specific taxonomy and procedure codes that are aligned with the definitions and measurements OHIC has been following for the last several years relating to primary care. These measurements also align with that of other states. Various definitions were changed related to non-claims-based expenditures. Under the old methodology, OHIC was measuring payments to Rhode Island providers in a numerator and denominator only. When measuring payments to all providers for Rhode Island residents it equates to 6.4% of total medical expenditure, dedicated to primary care. Effectively, OHIC is changing the ratio and requiring a higher expenditure obligation for primary care services by commercial payers in Rhode Island. The baseline would be 6.4%, with a goal of 10% achieved over a period of years. OHIC also set forth some direction on how to get there such as increased reimbursement rates for primary care, provide enhanced primary care capitation payments consistent with the new definition, and invest additional dollars in patient equity. Commissioner King does anticipate several questions and comments about the specific taxonomy and procedure codes attributed to primary care services. Regarding administrative burden, the Administrative Simplification Task Force was convened in 2023 through legislation to focus on activities relating to prior authorization. This task force convened stakeholders to gain consensus on effective ways to reduce administrative burden stemming from prior authorization processes. The recent proposed regulations add a new standard to the regulation focusing on the reduction of prior authorization requests by 20%, stemming from the work of the task force. Regulation also states that in meeting the prior authorization reduction target, health insurers shall prioritize items, services, treatments, and procedures ordered by primary care providers. There is a law in Vermont that eliminates prior authorization for items ordered by a primary care provider.

Commissioner King provided an overview of the proposed changes contained in the documents provided to all members. Health plans should be thinking and developing selective prior authorization programs for high performing providers. OHIC is additionally proposing health plans conduct an annual review of medical services inclusive of behavioral health, and prescription drugs subject to prior authorization. It further

requires health plans to post any changes to the list of behavioral health services and prescription drugs on provider accessible websites. The regulation also requires that factors such as volume and cost of services, the administrative costs to the insurer and providers, and impacts to the patient be considered when determining the services to add, maintain or remove prior authorization requirements. OHIC is also proposing the collection of prior authorization data on a quarterly basis to validate the reduction target. The regulation would also form a new working group, an advisory committee convened by the Commissioner to meet twice a year to collect data, which came from the statute the General Assembly adapted in 2022.

A virtual public hearing will be held on November 4th at 8am, public comments will be accepted through end of day on November 15.

Mark inquired about a survey that was being conducted focusing on FTE primary care providers currently practicing in RI. He believes the survey produced a number of 610 practicing providers. Given the situation is more dire than originally thought he thinks OHIC will receive more pushback.

Commissioner King acknowledged that Brown's analysis did determine there was around 600 providers currently practicing in the state. He advised that these issues are multi-faceted; there is a need to compete in the short term with a limited supply of providers and in the long term improve the financing of primary care. He emphasized that OHICs top priority is ensuring the state has a robust primary care sector supported by commercial health insurance companies, which is the extent of OHICs purview. These proposed rules are the starting point OHIC needs to be able to track and observe an increase in spending allocated towards primary care. Whereas the current process severely limits OHICs ability to do. Reimbursement is only one element of total funding for primary care. He explained that Connecticut measures primary care spending a lot like how OHIC is proposing to measure it. OHIC found that the Rhode Island fully insured commercial per member per month funding for primary care was $35. In Connecticut it was $26, and in Massachusetts it was $44. When promulgating these amendments, OHIC will have a clearer picture. No one insurance company can step out and solve these issues, they may be able to marginally improve the situation. He advised that there must be fairness in implementation of the policy across the payers along with a common expectation to avoid a collective action failure. He is open to feedback and comments although he does not know how one can be against improved funding for primary care, and a reduction of administrative burden.

Mark asked beyond a public statement what would the enforcement of these regulations look like.

Commissioner King advised it is the same enforcement mechanisms that have been established since the affordability standards were created. OHIC could order corrective action. Health plans in the past have not met their primary care expenditure and they worked with OHIC to came to agreements and account for that money. He does not want to be in a position where insurers will miss the expenditure targets, but, if necessary, they can be fined.

Howard thinks prior authorization is only the tip of the iceberg, it may be more impactful in the primary care setting, but he is curious on the Commissioner's thinking on the whole process of utilization review including denials and appeals.

Commissioner King advised utilization review is a took in the toolkit to manage costs and provide evidence-based care, there is a place for it. In recent years, Blue Cross Blue Shield of Rhode Island was a leader in eliminating UR for behavioral health services. In their ability to do that, it shows that there are opportunities to reduce the burden. Pertaining to denials, that is an area where additional data would be useful, and perhaps a topic for the administrative simplification task force to focus on. He reminded all that OHIC is only unable to mandate certain aspects to regulated insurers. Insurers may choose to carry this over into their

other products. OHIC will be developing some tools for self-funded employers to provide additional guidance.

Ira Wilson asked if it is in OHICs power to specify that prior authorization processes are streamlined across all products.

Commissioner King advised that they do not have the power to mandate consistent processes across all lines of business. He commented that the payers that have participated in their administrative simplification workgroups typically look to streamline processes across all products.

Ira asked what services were found to be most problematic pertaining to prior authorization.

Commissioner King advised that radiology and diagnostic imaging were among the top areas in terms of volume.

Al mentioned that a lot of issues are due to having a fee-for-service system. Payment reform could enable a lot of benefits for practitioners.

Ira indicated that it would not necessarily solve the problem. He commented that it is not only the insurer that is utilizing that tool.

Commissioner King advised that Taylor would send out all documents pertaining to the proposed regulations, in addition to the copies provided at the meeting.

4. OHIC Policy Updates/Accountable Care

Commissioner King advised that the Payment and Care Delivery Advisory Committee will be reconvening for the first time since 2020. He explained that over the last decade they have staked a lot in leveraging accountable care in the concept of total cost of care contracting as a lever to improve efficiency and affordability. After a decade, now is the time to reflect on what works well with accountable care and what factors lead to success. He has heard from providers that have been in risk-based contracts and have seen a significant increase in health care costs in 2023, effectively losing money. It has been a position of the office that insurance companies need to have these types of contracts in place and there needs to be an evolutionary progression towards meaningful downside risk. He does not want ineffective ACOs, and he also does not want providers to walk away these types of contracting due to elements of it that need changing. He hopes for a facilitated discussion over the course of three meetings. If that means that OHIC needs to go back to the drawing board for some of the regulations dictating the parameters of total cost of care contracting, then they will do that. If OHIC needs to publicize the factors of success, they will also do that.

5. Health Care System Planning Work

Commissioner King detailed the Health Care System Planning Work that is being led by EOHHS. The Governor issued an executive order earlier this year convening a health cabinet. It is a statutory body; he is co-chairing the subgroup on primary care with Dr. Larkin and Elena Nicolella from Rhode Island Health Center Association. The work is progressing, and the deliverable will be available in December in the form of a final report. It will contain a set of needs assessments, current capacities, and recommendations to improve the health care system across its sectors (hospitals, primary care, behavioral health, social services, long-term care). His priorities are primary care and creating some systematic data collection analysis and reporting on hospital and hospital based financial performance. Rhode Island does not currently have this

available in the public domain whereas other states do. He does not have the answer yet, but for physician group practice acquisitions, he thinks there needs to be a threshold. If it is big enough it, it needs to be reviewed a regulator. If transactions are not being reviewed there is no ability to condition or improve it. He noted that a lot of small things can amount to bigger things in the future. Such as big provider groups and big systems that managed to increase their market power due to incrementally piecing together smaller practices. He will be advocating for greater insight and regulatory overview.

Howard asked about the resources to fund this work.

Commissioner King advised that the applicants should be funding that. The way that the hospital conversion act is set up, the merging parties would pay for the expert services to review the transaction. The consultant fees would be charged to the applicants.

Howard asked if there would be time limit that a review could take.

Commissioner King agreed that there would have to be a clock on that.

Bob asked about the health care system planning work, and if there was an overarching group that is looking at integrating those items as well as system wide characteristics.

Commissioner King mentioned that there are cross cutting themes that have been identified for each. For instance, workforce, data analytics, and equity. EOHHS will be taking the work product of the five groups and bring it back to either the cabinet or the advisory committee to consolidate it. He is not sure if it will lead to a set of key performance indicators for Rhode Island health care, but it will provide a data driven assessment with some recommendations for improvement.

Sandra explained that she co-chairs the behavioral health committee. She advised that the work that has been done in health care, such as the health care dashboard leads the current work to create more sustainability across the board. The data part of it is very important. Parity will continue to be an issue for behavioral health pertaining to rates. RIDOH is involved with loan repayment to alleviate debt. She heard recently that some physicians are not taking the loan repayment because they cannot afford housing in Rhode Island.

Bob asked what the impetus for this was.

Commissioner King advised that the governor issued an executive order. The state has not done a health care plan under state offices since the 1980s. He mentioned the state innovation model document done in 2013. Under the coordinated health care planning act, a HICPAC should exist co-chaired by himself and several others. The previous convenings did not have a direction and produced piece meal reports. This iteration is more data driven and the work is progressing.

6. Public Comment

There were no public comments.

Commissioner King adjourned the meeting at 5:30 PM.