The Rhode Island Office of the Health Insurance Commissioner's

Report Pursuant to *House Resolution No. 6524*

March 1, 2024

This report contains the final recommendations of the Office of the Health Insurance Commissioner pursuant to House Resolution No. 6524

STATE OF RHODE ISLAND
Office of The Health Insurance Commissioner
Department of Business Regulation

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EXECUTIVE SUMMARY

House Resolution No. 6524 passed the Rhode Island House of Representatives on June 14th, 2023. The resolution requests that the State of Rhode Island Office of the Health Insurance Commissioner (OHIC) report data and provide recommendations on how to address access to behavioral health services in Rhode Island's commercial health insurance networks.

This report is in response to House Resolution No. 6524. The report summarizes OHIC's applicable statutory authority and relevant background information on the office's work to increase mental health parity in Rhode Island, estimated prevalence of behavioral health disorders in Rhode Island as compared to other New England states, and publicly available data related to behavioral health care access. Additionally, in response to House Resolution No. 6524, OHIC conducted a preliminary assessment of commercial health insurance carrier reimbursement rates. The results of this assessment are shared in this report, along with action steps OHIC will take to further assess behavioral health parity in the Rhode Island commercial health insurance market.

Increasing behavioral health care access and ensuring parity between behavioral and physical health care services are core tenets of OHIC's work. Rhode Island General Laws (RIGL) § 42-14.5-3 provides OHIC with the powers and duties to work to ensure the health insurance coverage of behavioral health care under the same terms and conditions as other health care, to collaborate with other state agencies to seek delivery system changes that improve access to a continuum of behavioral health treatment, and to direct the state's insurers towards innovative policies and practices that address the behavioral health needs of the public. OHIC carries out this charge in a variety of ways including but not limited to health insurance form review, network plan certification, market conduct examinations, and public reporting on behavioral health care expenditures and investment in services for children and adolescents.

Rhode Island's Health Insurance Landscape

The following table displays the percentage of Rhode Islanders by type of health insurance coverage as of 2022.

FIGURE 1. Rhode Island Population: Health Insurance by Coverage Type, 2022[1]

Type of Health Insurance Coverage	Percentage of Rhode Islanders
Employer	51.3%
Non-Group (plans purchased through HealthSource RI or directly from an insurance company)	6.5%
Medicaid	22.0%
Medicare	15.4%
Military	0.7%
Uninsured	4.1%

Certain types of health insurance in Rhode Island falls under OHIC's regulatory jurisdiction, while other types of health insurance do not. OHIC has regulatory authority over: individual market health insurance plans, large group market health insurance plans, small employer health insurance plans, Medicare supplemental insurance policies, and other fully insured policies such as dental, student health plans, stop loss policies, and other limited benefit plans. OHIC does not have regulatory authority over: self-funded plans (or self-insured plan) received through an employer, self-funded non-federal government plans (e.g., state of Rhode Island employee health insurance plans or health insurance offered through a municipal employer), Medicare plans, Medicaid plans, out-of-state health insurance plans, and all other types of insurance (e.g., life insurance, auto insurance, or long-term disability insurance).

[1] Kaiser Family Foundation. *Health Insurance Coverage of the Total Population.* (2022).

While the focus of House Resolution No. 6524 is on the commercial health insurance networks that are within OHIC's jurisdiction, access to in-network behavioral health services cannot be fully understood without accounting for the role of other payers, such as Medicaid and Medicare. One illustration of the connection between commercial payers and Medicaid payers is a Rhode Island Medicaid rule called "mainstreaming". This rule requires that Medicaid managed care organizations (MCOs) with commercial lines of business must ensure that their Medicaid network is the same as their commercial network. This means that if a Rhode Island health insurance carrier has both Medicaid and commercial lines of business, the carrier must ensure that any providers in their commercial health insurance network also accepts the carrier's Medicaid plans. Given the significance of Medicaid to the provision of health insurance for Rhode Islanders and health care financing for Rhode Island health care providers, any study that focuses solely on commercial health insurance networks is necessarily limited.

OHIC's Preliminary Assessment of Commercial Health Insurance Reimbursement Rates

On November 27, 2023, in response to House Resolution 6524, OHIC issued a Request For Information (RFI) to the six major health insurance carriers in Rhode Island[2] requesting aggregate data for mental health/substance use disorder (MH/SUD) and medical/surgical (M/S) provider reimbursement. Carriers provided the average commercial reimbursement rates for each provider specialty and current procedural terminology (CPT) code found in the U.S. Department of Labor (DOL) Self-Compliance Tool. This tool is a resource used to identify potential disparities that may indicate insurer non-compliance with federal Mental Health Parity and Addiction Equity Act (MHPAEA) standards. The tool does not address broader issues related to mental health care access, such as provider network adequacy; however, the tool can help identify potential disparities in reimbursement rates or payment practices that may indicate parity violations. While outcomes are not determinative of a MHPAEA violation, they can often serve as red flags or warning signs indicating that further review may be needed.

Following the DOL Self-Compliance Tool, OHIC utilized Medicare reimbursement rates as its benchmark for comparison. Aggregate reimbursement rates for the carriers in the fully-insured commercial market were compared to the 2023 Rhode Island Medicare Fee Schedule (RIMFS). Generally, if a plan's comparison of reimbursement rates indicates that the reimbursement rate is lower for MH/SUD providers, either as compared to M/S providers or as compared to an external benchmark, such as Medicare, the plan should consider further review. Plans need to ensure that the processes, strategies, evidentiary standards, and other factors used with respect to provider reimbursement for MH/SUD benefits are comparable to, and applied no more stringently than, those used with respect to provider reimbursement for M/S benefits.

The RFI did not show major disparities in provider reimbursement in the fully-insured commercial market compared to the 2023 RIMFS. However, comparing commercial reimbursement rates against an external benchmark, such as Medicare reimbursement, is meant only to serve as a warning sign to determine whether additional review for compliance with MHPAEA is warranted. It is not clearly determinative of MHPAEA compliance or non-compliance. OHIC has determined that further review is warranted to corroborate information presented through its preliminary analyses.

Action Steps and Recommendations

As the demand for behavioral health care services remains high it is critical that Rhode Island support access regardless of an individual's type of insurance. While this report does not address Medicaid, the Medicaid Program and the private managed care organizations (MCOs) that administer full benefits for approximately 90% of Medicaid enrollees have a key role to play. Two positive developments in the Medicaid space include the creation of Certified Community Behavioral Health Clinics (CCBHCs) and the implementation of reimbursement rate increases for behavioral health services following OHIC's social and human service programs review in 2023.

As stated in OHIC's FY 2025 Strategic Plan that was submitted with the agency's budget, OHIC will initiate a targeted market conduct examination to assess commercial health insurer compliance with federal and state behavioral health parity requirements. This examination will focus on ensuring that written and

[2] Aetna Life Insurance Company, Blue Cross Blue Shield of Rhode Island, Cigna Health and Life Insurance Company, Neighborhood Health Plan of Rhode Island, Tufts Associated Health Maintenance Organization, Inc., Tufts Insurance Company, Inc., United Healthcare Insurance Company, and United Healthcare of New England.

operational processes, strategies, factors, and/or standards used for provider admission to participate in their network, including reimbursement rates, are comparable between Mental Health/Substance Use Disorder (MH/SUD) and Medical/Surgical (M/S) providers, in accordance with state and federal laws and regulations.

To reduce barriers in access to care and alleviate administrative burden facing providers, OHIC strongly recommends that other commercial health insurers align with BCBSRI's policy to discontinue utilization review for behavioral health care services.

INTRODUCTION

House Resolution No. 6524 passed the Rhode Island House of Representatives on June 14th, 2023. The resolution requests that the State of Rhode Island Office of the Health Insurance Commissioner (OHIC) report data and provide recommendations on how to address access to behavioral health services in Rhode Island's commercial health insurance networks.

This report is in response to House Resolution No. 6524. The report reviews OHIC's applicable statutory authority and relevant background information on the office's work to increase access to behavioral health care and mental health and substance use coverage parity in Rhode Island. The report also includes the estimated prevalence of behavioral health disorders in Rhode Island as compared to other New England states, and publicly available data related to behavioral health care access as compared to other New England states. In response to House Resolution No. 6524, OHIC conducted a preliminary assessment of commercial health insurance carrier reimbursement rates. The results of this assessment are shared in this report, along with action steps OHIC will take to further assess behavioral health parity in the Rhode Island commercial health insurance market.

BACKGROUND

Created in 2004, OHIC is Rhode Island's commercial health insurance policy reform and regulatory enforcement agency. OHIC seeks to improve health care access, affordability, and quality. The office does so as it: (1) protects the interests of consumers of commercial health insurance, (2) encourages fair treatment of health care providers by commercial health insurers, (3) improves the health care system as a whole, and (4) guards the solvency of commercial health insurers.

Certain types of health insurance fall under OHIC's regulatory jurisdiction, while other types of health insurance do not. Here is a breakdown of different types of insurance broken out by whether OHIC has regulatory authority or not:

OHIC has regulatory authority over:

- **Individual market health insurance plans** for people who are not connected to employer-based coverage. These plans are purchased by individuals or families through Rhode Island's state-based exchange, HealthSource RI, or directly from an insurance company in Rhode Island.[3]
- **Large group market health insurance plans** for people who obtain health insurance for themselves and their dependents through a group plan maintained by a large employer in Rhode Island, which is generally defined as an employer with at least 51 employees.[4]
- **Small employer health insurance plans** for people who obtain health insurance for themselves and their dependents through a plan maintained by a small employer in Rhode Island, which is generally defined as an employer with no more than 50 eligible employees.[5]
- **Medicare supplemental insurance policies** for people who are eligible for Medicare to use as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses.[6]

[3] See Rhode Island General Laws § 27-18.5-2 for the full definition.
[4] See Rhode Island General Laws § 27-18.6-2 for the full definition.
[5] See Rhode Island General Laws § 27-50-3 for the full definition.
[6] See Rhode Island General Laws § 27-18.2-1 for the full definition.

- **Other fully insured policies** such as dental, student health plans, stop loss policies, and other limited benefit plans.

OHIC does not have regulatory authority over:

- **Self-funded plans, or self-insured plan, received through an employer** (e.g., health insurance plans offered by CVS to its employees). These plans are usually offered by large companies where the employer collects premiums from enrollees and takes on the responsibility of paying employees' and dependents' medical claims. Employers can contract for insurance services with a third-party administrator, or insurance services can be self-administered.[7]
    - These plans fall under the jurisdiction of the federal government.
- **Self-funded, non-federal government plans** (e.g., state of Rhode Island employee health insurance plans or health insurance offered through a municipal employer).
    - These plans fall under the jurisdiction of the federal government.
- **Medicare plans**, including Medicare Advantage plans (e.g., United Senior of Blue Chip for Medicare). Medicare is a federal health insurance program for individuals who are 65 and older and certain younger individuals with disabilities.[8]
    - These plans fall under the jurisdiction of the federal government.
- **Medicaid plans**, including managed Medicaid products provided by Neighborhood Health Plan of RI, UnitedHelathcare, or Tufts Health Plan. Medicaid is a government-assistance plan for individuals and families who have low incomes or a qualifying disability.[9]
    - These plans fall under the jurisdiction of the Rhode Island Executive Office of Health and Human Services.
- **Out-of-state health insurance plans.**
    - These plans are regulated by the state of origin or the federal government, depending on the plan type.
- **All other types of insurance** (e.g., life insurance, auto insurance, or long-term disability insurance).
    - These plans are regulated by the Rhode Island Department of Business Regulation.

In 2022, about half of Rhode Islanders received their health insurance through an employer either as an employee, spouse of an employee, or dependent of an employee[10]. Nearly a quarter of Rhode Islanders, received health insurance through the Medicaid program, with approximately 15% receiving health insurance through Medicare. The following table displays the percentage of Rhode Islanders by type of health insurance coverage as of 2022.

FIGURE 2. Rhode Island Population: Health Insurance by Coverage Type, 2022[11]

Type of Health Insurance Coverage	Percentage of Rhode Islanders
Employer	51.3%
Non-Group (plans purchased through HealthSource RI or directly from an insurance company)	6.5%
Medicaid	22.0%
Medicare	15.4%
Military	0.7%
Uninsured	4.1%

[7] https://www.healthcare.gov/glossary/self-insured-plan/
[8] https://www.healthcare.gov/glossary/medicare/
[9] Kaiser Family Foundation. *Health Insurance Coverage of the Total Population.* (2022).
[10] Ibid.
[11] Ibid.

The preponderance of Rhode Islanders with employer-sponsored insurance are covered through self-funded employers. In 2022, approximately 60% of Rhode Island residents with employer-sponsored insurance were covered through an employer with self-insured health benefits based on reporting from Rhode Island's four largest commercial health insurers. This figure has grown over time.

While the focus of House Resolution No. 6524 is on the commercial health insurance networks that are within OHIC's jurisdiction, access to in-network behavioral health services cannot be fully understood without accounting for the role of other payers, such as Medicaid and Medicare. One illustration of the connection between commercial payers and Medicaid payers is a Rhode Island Medicaid rule called "mainstreaming". Under 210-RICR-30-05-2, current "mainstreaming" rules require that Medicaid managed care organizations (MCOs) with commercial lines of business must ensure that their Medicaid network is the same as their commercial network. This means that if a Rhode Island health insurance carrier has both Medicaid and commercial lines of business, the carrier must ensure that any providers in their commercial health insurance network also accepts the carrier's Medicaid plans. Given the significance of Medicaid to the provision of health insurance for Rhode Islanders and health care financing for Rhode Island providers, any study that focuses solely on commercial health insurance networks is necessarily limited.

Mental Health Parity

Parity laws are intended to ensure equal treatment, by health insurance plans, of mental disorders with other physical illnesses.[12] The primary laws used for the regulatory oversight of parity implementation in Rhode Island include the Federal Mental Health Parity and Addiction Equity Act (MHPAEA) and the State Mental Health Parity law, RIGL §27-38.2-1, which require that a health insurance plan provide coverage for the treatment of mental health and substance-use disorders under the same terms and conditions as that coverage is provided for other illnesses and diseases.

The Federal Mental Health Parity and Addiction Equity Act (MHPAEA) was first enacted in 2008, and subsequent regulations in 2010 and 2014. The federal regulations provide requirements for health insurers relating to:

- Quantitative treatment limitations (QTLs) which are clear and more understandable for regulators to identify (e.g., co-pays, co-insurance).
- Non-quantitative treatment limitations (NQTLs): The federal government's interim regulations issued February 2, 2010, provided little clarity in the area that generates the most consumer inquiries and confusion: non-quantitative treatment limits (described in the bullets below). According to these federal policies, parity between mental health benefits and all other types of health benefits must be exhibited among the following categories:
    - Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether a treatment is experimental or investigative,
    - Formulary design for prescriptions drugs,
    - Standards for provider admission to participate in-network, including reimbursement rates for contracted providers,
    - Plan methods used to determine usual, customary, and reasonable fee charges (for out-of-network benefits),
    - Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols), and
    - Exclusions based on failure to complete a course of treatment.

The health insurance practices and programs listed above are not prohibited outright, but rather are prohibited when they are not established in a comparable manner for both behavioral health and medical surgical benefits or are applied more stringently to behavioral health benefits than to medical surgical benefits.

[12] Rhode Island Office of the Health Insurance Commissioner. *RI Behavioral Health Parity Implementation Report*, (2017).

In July 2023, the federal government proposed new updates to the regulations under MHPAEA, which are intended to clarify and improve compliance with the federal mental health parity law.[13,14] If finalized as proposed, these changes would establish a new three-part framework for plans and insurers to show that certain treatment limits on behavioral health coverage comply with the parity law.[15]

The State Mental Health Parity law RIGL §27-38.2-1: Coverage for the treatment of mental health and substance use disorders, requires the following:

> (a) A group health plan and an individual or group health insurance plan shall provide coverage for the treatment of mental health and substance use disorders under the same terms and conditions as that coverage is provided for other illnesses and diseases.
>
> (b) Coverage for the treatment of mental health and substance use disorders shall not impose any annual or lifetime dollar limitation.
>
> (c) Financial requirements and quantitative treatment limitations on coverage for the treatment of mental health and substance use disorders shall be no more restrictive than the predominant financial requirements applied to substantially all coverage for medical conditions in each treatment classification.
>
> (d) Coverage shall not impose non-quantitative treatment limitations for the treatment of mental health and substance use disorders unless the processes, strategies, evidentiary standards, or other factors used in applying the non-quantitative treatment limitation, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.
>
> (e) The following classifications shall be used to apply the coverage requirements of this chapter: (1) Inpatient, in-network; (2) Inpatient, out-of-network; (3) Outpatient, in-network; (4) Outpatient, out-of-network; (5) Emergency care; and (6) Prescription drugs.
>
> (f) Medication-assisted treatment or medication-assisted maintenance services of substance use disorders, opioid overdoses, and chronic addiction, including methadone, buprenorphine, naltrexone, or other clinically appropriate medications, is included within the appropriate classification based on the site of the service.
>
> (g) Payors shall rely upon the criteria of the American Society of Addiction Medicine when developing coverage for levels of care for substance use disorder treatment.
>
> (h) Patients with substance use disorders shall have access to evidence-based, non-opioid treatment for pain, therefore coverage shall apply to medically necessary chiropractic care and osteopathic manipulative treatment performed by an individual licensed under § 5-37-2.
>
> (i) Parity of cost-sharing requirements. Regardless of the professional license of the provider of care, if that care is consistent with the provider's scope of practice and the health plan's credentialing and contracting provisions, cost sharing for behavioral health counseling visits and medication maintenance visits shall be consistent with the cost sharing applied to primary care office visits.

Under RIGL § 42-14.5-3(j), OHIC is vested with the power and duty to monitor the adequacy of insurer's compliance with the provisions of the federal Mental Health Parity Act, including a review of related claims processing and reimbursement procedures. This OHIC responsibility pertains to commercial health insurance in Rhode Island and does not include Medicaid or Medicare plans. OHIC utilizes numerous regulatory tools to undertake this work including health insurance form review, network plan certifications, and market conduct examinations.

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[13] Manatt. *First Look at Proposed New Federal Mental Health Parity Rules*, (2023).
[14] U.S. Department of Health and Human Services. *Departments of Labor, Health and Human Services, Treasury announce proposed rules to strengthen Mental Health Parity and Addiction Equity Act,* (2023).
[15] Kaiser Family Foundation. *Proposed Mental Health Parity Rule Signals New Focus on Outcome Data as Tool to Assess Compliance,* (2023).

Brief History of OHIC's Behavioral Health Work

Increasing behavioral health care access and ensuring parity between behavioral and physical health care services are core tenets of OHIC's work. Rhode Island General Laws (RIGL) § 42-14.5-3 provides OHIC with the powers and duties to work to ensure the health insurance coverage of behavioral health care under the same terms and conditions as other health care, to collaborate with other state agencies to seek delivery system changes that improve access to a continuum of behavioral health treatment, and to direct the state's insurers towards innovative policies and practices that address the behavioral health needs of the public. OHIC carries out this charge in a variety of ways, as discussed below.

Health Insurance Form Review

An essential process in improving parity and access to behavioral health care services in the state is OHIC's annual in-depth review of health insurance benefit coverage documents. This annual review helps ensure that all insurers provide coverage for treatment of behavioral health services under the same terms and conditions as other illnesses and diseases. Forms may be approved, modified, or rejected.

Network Plan Certification

OHIC performs Network plan certification every two years. OHIC certifies all network plans in the state to ensure consumer protections are in place such as ensuring compliance with network adequacy set forth in regulation under 230-RICR-20-30-9. These regulations include a provision requiring that insurers evidence to OHIC compliance with state and federal behavioral health parity statutes and any applicable regulations. Network plan certification also ensures that provider credentialing and contracting requirements are met.

Market Conduct Examinations (MCE)

Authorized under Chapter 13.1 of the Rhode Island General Laws, OHIC conducts periodic examinations of insurance companies and other regulated entities in Rhode Island to determine compliance with Rhode Island insurance laws. Examinations may be conducted based on consumer complaint trends or in a routine manner to determine or follow up on a company's compliance with state and federal laws and regulations.

In 2020, OHIC completed a Market Conduct Examination for Mental Health and Substance Abuse Parity. The MCE evaluated the four major commercial health insurers operating in Rhode Island to monitor whether behavioral health care was being covered at parity with physical health care—consistent with federal and state law. This examination measured compliance with laws and regulations relating to coverage of behavioral health services and played a critical role in the effort to eliminate disparities between physical and behavioral health care in Rhode Island.

In 2017, the parity MCE led OHIC to reach out to the four insurers to consider ways to improve access to certain prescription drugs used to treat patients with opioid dependence disorder.[16] This resulted in OHIC executing agreements with each of the health insurers to end the practice of requiring prior authorization for these prescription drugs, often referred to as "Medication Assisted Treatment" or "MAT". These agreements allow patients more timely access to these lifesaving medications.

Effective August 1, 2018, Blue Cross Blue Shield of Rhode Island (BCBSRI) eliminated utilization review for all in-network behavioral health services rendered by network providers and only required the network provider to provide a notification of admission or services.[17] Recently, as of Plan Year 2023, BCBSRI removed preauthorization requirements for behavioral health services rendered by non-network providers, only requiring a notification of admission or service.

The parity MCE also led to the four insurers fixing non-compliant procedures and to insurer contributions of more than $5 million, in lieu of penalties, to create two behavioral health funds at the Rhode Island

[16] Rhode Island Office of the Health Insurance Commissioner. *Health Insurance Commissioner Announces Partnership with Health Insurers to End Prior Authorization for Opioid Dependency Medications*, (2017).
[17] Blue Cross Blue Shield of Rhode Island. *Provider Update*, (2018).

Foundation. The funding was distributed through a competitive grant process to provide critical resources for nonprofit organizations across the state working to meet the behavioral health needs of Rhode Islanders.

OHIC is now exploring pursing additional market conduct exams to further support behavioral health care access and parity.

Expansion of Telehealth Services

Throughout the COVID-19 state of emergency, OHIC took actions to make telemedicine more widely accessible and facilitate its use as well as to enforce the suspension of certain state telemedicine restrictions that were in place prior to the state of emergency. OHIC also successfully supported the enactment of amendments to the Telemedicine Coverage Act that went into effect on July 6, 2021. These amendments included requirements that telemedicine for behavioral health services should be paid at the same rate as in-person visits regardless of modality, increasing consumer access to such services.

Public Reporting on Behavioral Health Care Expenditures and Investment in Services for Children and Adolescents

In 2023, OHIC promulgated amendments to 230-RICR-20-30-4 (powers and duties) to require commercial health insurers to annually report total expenditures on behavioral health care services, including claims and non-claims-based expenditures for purposes of public reporting. As of February 2024, OHIC is finalizing the data specifications and reporting template for distribution and reporting later in the year. OHIC will publicly report data on total expenditures in the commercial market as a whole and by insurer. Reporting will include breakdowns by site of service and age of patient. In addition to the collection of expenditure data, the amendments direct commercial health insurers to double their investment in community-based behavioral health services for children and adolescents in 2025. It is well documented that the COVID-19 pandemic has had significant impacts on children and adolescents. A 2022 report by Rhode Island KIDS COUNT, Children's Mental Health in Rhode Island, highlighted the burden of mental health issues facing children and adolescents in the state. Rhode Island children and adolescents also face substance use issues. In April 2022 the Rhode Island Chapter of the American Academy of Pediatrics, Rhode Island Council for Child and Adolescent Psychiatry, Hasbro Children's Hospital, and Bradley Hospital jointly issued a Declaration of a Rhode Island State of Emergency in Child and Adolescent Mental Health.

As part of OHIC's Health Spending Accountability and Transparency Program, OHIC has created public-facing data dashboards that draw from Rhode Island's All-Payer Claims Database. The Mental Health dashboard was published in April 2023 on the OHIC Data Hub. Users can access the dashboard to measure changes in mental health claims per member per month (PMPM), payment per unit, and utilization with filters by age, gender, diagnosis, and insurer market. The dashboard shows a steep increase in children's mental health spending PMPM in recent years. This increase has been driven by utilization, not payment per unit. The dashboard is available to policymakers, industry representatives, advocates, researchers, and the general public.

Social and Human Service Programs Review

OHIC was tasked with conducting a comprehensive review of all social and human service programs having a contract with or licensed by the state, inclusive of the Rhode Island Executive Office of Health and Human Services (EOHHS) and the state agencies under its purview. This comprehensive and unprecedented review was required by amendments to OHIC's enabling statute, RIGL § 42-14.5-3(t), that went into effect on July 1, 2022. Social and human service programs include publicly funded services in the following subject areas and disciplines: social, mental health, developmental disability, child welfare, juvenile justice, prevention services, habilitative, rehabilitative, substance use disorder treatment, residential care, adult/adolescent day services, vocational, employment and training, and aging.[18] To simplify the organization of the diverse disciplines and service areas that were within the scope of the review, OHIC created a typology of four major service categories around which reporting and recommendation were organized. Behavioral health services is one such category of services, which is comprised of mental health and substance use services, including outpatient, residential, and mobile services.

[18] Rhode Island General Laws § 42-14.5-2.1.

The social and human service programs review has a specific focus on the Medicaid fee-for-service (FFS) reimbursement rates paid to providers of social and human service programs as defined under RIGL § 42-14.5-2.1. OHIC recognizes that the charge of House Resolution No. 6524 is to examine behavioral health care access within commercial health insurance networks; however, as discussed above, the market dynamics between commercial health insurance reimbursement rates and government payer rates is relevant to this report.

OHIC's review of reimbursement rates for behavioral health services found that a significant percentage of state fiscal year (SFY) 2022 Medicaid FFS expenditures were associated with reimbursement rates that had not been changed for several years.[19] Most Medicaid FFS reimbursement rates for behavioral health services have not been updated since SFY 2016 or prior.[20] Many reimbursement rates have not been updated since the early 2000s; in some instances, reimbursement rates have not been updated since the 1990s.[21] More so than any other in-scope major service category, the Medicaid FFS reimbursement rates for behavioral health services have been in use for the longest period of time without change.

In September 2023, OHIC recommended significant adjustments to social and human service program reimbursement rates, including approximately 150 behavioral health Medicaid FFS code/modifier combinations, with recommended behavioral health rate increases as high as 71%. In accordance with statute, OHIC submitted its recommendations to the Rhode Island Executive Office of Health and Human Services (EOHHS) for consideration.[22]

BEHAVIORAL HEALTH DISORDER PREVALENCE – STATE COMPARISONS

This section of the report includes 2022 National Survey on Drug Use and Health (NSDUH) estimated percentages of Rhode Islanders who experienced the following in the past year: Any Mental Illness (AMI), Serious Mental Illness (SMI), Major Depressive Episodes (MDE), and Substance Use Disorders (SUD).[23, 24, 25] Rhode Island estimated prevalence percentages are compared to the average estimated prevalence percentages in the United States and to other New England states. States with the lowest and highest estimated behavioral health disorder prevalence percentages are also noted. This section includes where Rhode Island and other New England states rank out of the 50 states and District of Columbia in estimated prevalence – lower rankings out of 51 indicate lower behavioral health disorder estimated prevalence, while higher rankings out of 51 indicate higher behavioral health disorder estimated prevalence.

The percentages of estimated prevalence of behavioral health disorders in this section present point estimates from the NSDUH survey data. Data on whether differences between states are statistically significant are not included in this report.[26]

Any Mental Illness and Serious Mental Illness Estimated Prevalence

The estimated amount of Rhode Islanders with Any Mental Illness (AMI) and the estimated amount with Serious Mental Illness (SMI) exceeds the average estimated prevalence in the United States. An estimated 24.67% of Rhode Islanders who are aged 18 or older experienced AMI in the past year and an estimated 6.31% experienced SMI in the past year. Estimates of SMI are a subset of estimates of AMI – SMI is limited

[19] Rhode Island Office of the Health Insurance Commissioner. *Social and Human Service Programs Review: Final Report*, (2023).
[20] Readers can examine Appendix 1 of the report *Social and human service programs review: Reimbursement Rates*, specifically the field labeled Effective Date (excl. ARPA), to review the dates that specific behavioral health reimbursement rates were last changed. OHIC was unable to identify whether the changes were due to rate increases, rate decreases, or coding changes.
[21] Caveats to this data are outlined in OHIC's *Social and Human Service Programs Review: Final Report* on p. 21.
[22] Readers can examine Article 9 of the Governor's Budget and FY2025 Budget Overview, slide 18, for more information on the Governor's proposed implementation of OHIC and EOHHS recommendations on social and human service rates.
[23] SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021 and 2022.
[24] According to SAMHSA, "the 2022 National Survey on Drug Use and Health (NSDUH) used multimode data collection, in which respondents completed the survey in person or via the web. Estimates based on multimode data collection in 2022 are not comparable with estimates from the 2020 NSDUH or prior years. Although most estimates can be compared between 2021 and 2022."
[25] Readers are encouraged to refer to the primary data source to review the definition of each behavioral health disorder included in this section.
[26] Readers are encouraged to refer to the primary data source to review information regarding statistical significance.

to individuals with AMI that resulted in serious functional impairment. Neither AMI, nor SMI, include developmental or substance use disorders.

Regarding AMI, of the 50 states and the District of Columbia, RI ranks 31st, which means that there are 30 states/districts that have a lower proportion of adults who were classified as having any mental illness. The state with the lowest AMI estimated prevalence was New Jersey with a prevalence of 19.38%, and the highest was Utah with an estimated prevalence of 29.19%.

Regarding SMI, of the 51 states/districts, Rhode Island ranks 29th, which means that there were 28 states that have a lower proportion of adults with serious mental illness. The state with the lowest SMI estimate was New York with a prevalence of 5.05%, and the highest was Utah with 8.02%.

In comparison to the other New England states, Rhode Island has second highest proportion of adults who are estimated to have experienced AMI and SMI. The New England state with a higher estimated prevalence in both categories is Vermont. Figure 3 compares the estimated percentage of AMI and the estimated percentage of SMI in adults by New England state. It is important to note that estimates of SMI are a subset of estimates of AMI – SMI is limited to individuals with AMI that resulted in serious functional impairment.

FIGURE 3. Any Mental Illness (AMI) and Serious Mental Illness (SMI) in the Past Year: Among People Aged 18 or Older; by New England State, Average Annual Percentages, 2021 and 2022[27]

New England State	AMI: Estimated % Age 18+	State Rank out of 51	SMI: Estimated % Age 18+	State Rank out of 51
Total United States	23.08%	N/A	5.86%	N/A
Connecticut	21.05%	4	5.41%	8
Maine	24.07%	24	5.48%	10
Massachusetts	23.18%	18	5.92%	23
New Hampshire	23.06%	17	5.87%	21
Rhode Island	**24.67%**	**31**	**6.31%**	**29**
Vermont	26.80%	45	6.68%	41

NOTE: "State Rank out of 51" is ranked lowest prevalence to highest prevalence.

Major Depressive Episode Estimated Prevalence

The estimated amount of Rhode Islanders experiencing a Major Depressive Episode (MDE) in the past year exceeds the average estimated prevalence in the United States for ages 12-17 (adolescents) and for ages 18 and older (adults).[28] An estimated 22.15% of Rhode Island adolescents experienced a MDE in the past year, and an estimated 9.78% of Rhode Island adults experienced an MDE in the past year.

Regarding adolescents experiencing an MDE, of the 50 states and the District of Columbia, RI ranks 44th, which means that there are 43 states/districts that are estimated to have a lower proportion of adolescents who experienced an MDE in the past year. The state/district with the lowest estimated rate of adolescent MDE is the District of Columbia with an estimated prevalence of 16.02%, and the highest state was Oregon with an estimated prevalence of 24.96%.

Regarding adults experiencing an MDE, of the 50 states and the District of Columbia, RI ranks 36th, which means that there are 35 states/districts that are estimated to have a lower proportion of adults who experienced an MDE in the past year. The state/district with the lowest estimated prevalence of adult MDE

[27] SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021 and 2022.
[28] According to SAMHSA, "there are minor wording differences in the questions in the adult and adolescent MDE modules. Therefore, data from youths aged 12 to 17 were not combined with data from adults aged 18 or older to produce an estimate for those aged 12 or older."

is Mississippi with an estimated prevalence of 6.93%, and the highest state was Oregon with an estimated prevalence of 11.11%.

In comparison to the other New England states, Rhode Island has the highest proportion of adolescents estimated to have experienced an MDE in the past year, and the second highest proportion of adults who are estimated to have experienced an MDE. Out of all of the New England states, Vermont is estimated to have the highest proportion of adults who experienced an MDE in the past year. Figure 4 compares the estimated percentage of adults and the estimated percentage of adolescents who experienced an MDE by New England state.

FIGURE 4. Major Depressive Episode (MDE) in the Past Year: Among People Aged 12 or Older; by Age Group and New England State, Annual Average Percentages, 2021 and 2022[29]

New England State	MDE: Estimated % Age 12-17	State Rank out of 51	MDE: Estimated % Age 18+	State Rank out of 51
Total United States	20.17%	N/A	8.63%	N/A
Connecticut	19.83%	20	8.56%	19
Maine	19.93%	23	8.79%	22
Massachusetts	19.18%	11	8.54%	18
New Hampshire	21.63%	39	8.76%	21
Rhode Island	**22.15%**	**44**	**9.78%**	**36**
Vermont	19.25%	13	10.29%	42

NOTE: "State Rank out of 51" is ranked lowest prevalence to highest prevalence.

Substance Use Disorder Estimated Prevalence

The estimated amount of Rhode Islanders experiencing a Substance Use Disorder (SUD) in the past year exceeds the estimated prevalence in the United States for ages 12-17 (adolescents) and for ages 18 and older (adults). An estimated 11.03% of Rhode Island adolescents experienced a SUD in the past year, and an estimated 22.61% of Rhode Island adults experienced a SUD in the past year.

Regarding adolescents experiencing a SUD, of the 50 states and the District of Columbia, RI ranks 43rd, which means that there are 42 states/districts that are estimated to have fewer adolescents who experienced a SUD in the past year. The state/district with the lowest estimated rate of adolescents experiencing a SUD is Utah with an estimated prevalence of 13.08%, and the highest state/district was the District of Columbia with an estimated prevalence of 23.40%.

Regarding adults experiencing a SUD, of the 50 states and the District of Columbia, RI ranks 45th, which means that there are 44 states/districts that are estimated to have a lower proportion of adults who experienced a SUD in the past year. The state/district with the lowest estimated prevalence of adult SUD is Utah with an estimated prevalence of 14.15%, and the highest state was Alaska with an estimated prevalence of 24.30%.

In comparison to the other New England states, Rhode Island has the highest proportion of adolescents estimated to have experienced a SUD in the past year, and the second highest proportion of adults who are estimated to have experienced an SUD. Out of all of the New England states, Vermont is estimated to have the highest proportion of adults who experienced an SUD in the past year. Figure 5 compares the estimated percentage of adults and adolescents who experienced SUD by New England state.

[29] SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021 and 2022.

FIGURE 5. Substance Use Disorder in the Past Year: Among People Aged 12 or Older; by Age Group and New England State, Annual Average Percentages, 2021 and 2022[30]

New England State	SUD: Estimated % Ages 12-17	State Rank out of 51	SUD: Estimated % Ages 18+	State Rank out of 51
Total U.S.	8.95%	N/A	17.82%	N/A
Connecticut	7.66%	6	18.39%	26
Maine	8.66%	19	18.80%	30
Massachusetts	8.14%	12	19.16%	34
New Hampshire	7.13%	2	17.37%	13
Rhode Island	**11.03%**	**43**	**22.61%**	**45**
Vermont	10.10%	35	22.79%	47

NOTE: "State Rank out of 51" is ranked lowest prevalence to highest prevalence.

Rhode Island Behavioral Health Disorder Prevalence Discussion

Across all four behavioral health disorder measurements reviewed above, Rhode Island ranked as the highest, or the second highest, in estimated prevalence as compared to other New England states. These data show interesting trends, but as noted earlier, were not evaluated for statistical significance. These numbers do not explain why Rhode Island tends to have higher estimated behavioral health disorder prevalence than its neighbors. For example, it could be argued that the higher behavioral health disorder prevalence in Rhode Island might be connected to less access to treatment than other New England states. However, it could also be argued that the higher behavioral health disorder prevalence in Rhode Island might be connected to better screening for such disorders. Either way, access to behavioral health treatment is critically important to the wellbeing of Rhode Islanders. The next section explores various data points regarding behavioral health care access in Rhode Island, and how Rhode Island compares to the other New England states.

DATA RELATED TO BEHAVIORAL HEALTH CARE ACCESS

This section includes three subsections that assess different measures related to behavioral health care access. Select composite measures from the comprehensive State of Mental Health in America 2022 report are summarized. Multiple measures of behavioral health care workforce are reviewed. And relevant data from the Rhode Island Health Information Survey is included. Comparisons of Rhode Island to other New England states are made where possible.

The State of Mental Health in America 2022 – State Comparisons

The tables that follow are select rankings from The State of Mental Health in America 2022 report, which uses fifteen measures to assess the prevalence of behavioral health concerns and access to insurance and treatment across states.[31,32] Data from this report was primarily collected between 2018-2019.

The 15 measures in the report include:

1. Adults with Any Mental Illness (AMI)
2. Adults with Substance Use Disorder in the Past Year

[30] SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021 and 2022.
[31] Reinert, M, Fritze, D. & Nguyen, T. (October 2021). "The State of Mental Health in America 2022" Mental Health America, Alexandria VA.
[32] OHIC chose not to use the more recent report, "The State of Mental Health in America 2023" when referencing certain measures if those measures rely on State Data Tables and Reports From the 2019-2020 NSDUH because according to SAMHSA, "state estimates for these years are no longer available due to methodological concerns with combining 2019 and 2020 data."

3. Adults with Serious Thoughts of Suicide
4. Youth with At Least One Major Depressive Episode (MDE) in the Past Year
5. Youth with Substance Use Disorder in the Past Year
6. Youth with Severe MDE
7. Adults with AMI Who Did Not Receive Treatment
8. Adults with AMI Reporting Unmet Need
9. Adults with AMI Who Are Uninsured
10. Adults with Cognitive Disability Who Could Not See a Doctor Due to Costs
11. Youth with MDE Who Did Not Receive Mental Health Services
12. Youth with Severe MDE Who Received Some Consistent Treatment
13. Children with Private Insurance That Did Not Cover Mental or Emotional Problems
14. Students Identified with Emotional Disturbance for an Individualized Education Program
15. Mental Health Workforce Availability[33]

Behavioral Health Care "Overall Ranking"

The State of Mental Health in America 2022 report's "Overall Ranking" is a composite ranking comprised of scores from all fifteen measures listed above. The report explains that a lower overall ranking indicates lower prevalence of mental illness and higher rates of access to care. A higher overall ranking indicates higher prevalence of mental illness and lower rates of access to care.[34] Rhode Island ranked 11th overall out of 50 states and the District of Columbia. As can be seen below, Rhode Island had the second lowest overall score in New England. New Hampshire had the lowest overall ranking out of the New England states at 13, and Massachusetts had the highest overall ranking of any state in the nation.

FIGURE 6. The State of Mental Health in America 2022: Overall Rankings, New England States[35]

New England State	State Rank out of 51
Connecticut	4
Maine	8
Massachusetts	1
New Hampshire	13
Rhode Island	**11**
Vermont	5

[33] The "mental workforce availability" measure from the more recent report, The State of Mental Health in America 2023, is included later in the report.
[34] Reinert, M, Fritze, D. & Nguyen, T. (October 2021). "The State of Mental Health in America 2022" Mental Health America, Alexandria VA.
[35] Ibid.

Behavioral Health Care "Adult Ranking"

The State of Mental Health in America 2022 report's composite "Adult Ranking" measure is comprised of the seven measures specific to adults. The report explains that a lower ranking indicates lower prevalence of mental illness and higher rates of access to care for adults. A higher ranking indicates higher prevalence of mental illness and lower rates of access to care. Like the "overall ranking", Rhode Island ranked 11th out 50 states and the District of Columbia. As can be seen in figure 7, Rhode Island had the third highest ranking in New England. Massachusetts had the highest ranking at 3, and Maine had the lowest ranking at 37.

Additionally, Rhode Island was one of three states highlighted in the report as having one of the largest improvements in "Adult Rankings" year-over-year, moving from a ranking of 26 in The State of Mental Health in America 2021 report to a ranking of 11 in the 2022 report. The report attributes this to the percentage of "Adults with Cognitive Disability Who Could Not See a Doctor Due to Cost" decreasing from 25.71% to 18.48%, and the percentage of "Adults with AMI Reporting Unmet Need" decreasing from 27.9% to 25.4%.

FIGURE 7. The State of Mental Health in America 2022: Adult Rankings, New England States[36]

New England State	State Rank out of 51
Connecticut	4
Maine	37
Massachusetts	3
New Hampshire	30
Rhode Island	**11**
Vermont	19

Behavioral Health Care "Youth Ranking"

The State of Mental Health in America 2022 report's composite "Youth Ranking" measure is comprised of the seven measures specific to youth. A lower ranking indicates lower prevalence of mental illness and higher rates of access to care for youth. A higher ranking indicates higher prevalence of mental illness and lower rates of access to care for youth. Rhode Island ranked 15th out of 50 states and the District of Columbia. As can be seen in figure 8, Rhode Island has the lowest composite youth ranking of the New England states. Maine is ranked 2nd in the nation, which is the highest ranking of New England states on this composite measure.

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

FIGURE 8. State of Mental Health in America 2022: Youth Ranking, New England States[37]

New England State	State Rank out of 51
Connecticut	8
Maine	2
Massachusetts	5
New Hampshire	6
Rhode Island	**15**
Vermont	4

Behavioral Health Care "Access to Care Ranking"

The State of Mental Health in America 2022 report's composite "Access to Care Ranking" measure indicates how much access to behavioral health care states have relative to one another. This composite measure is comprised of nine of the fifteen measures in the report related to access to insurance, access to treatment, quality and cost of insurance, access to special education, and mental health workforce availability. Lower rankings indicate that a state provides relatively more access to insurance and behavioral health treatment. As can be seen in figure 9, every New England stated ranked in the top 10 in the nation for the highest rate of relative access to behavioral health care. Rhode Island ranked 7th, which is the second lowest composite access ranking of New England States. Vermont ranked 1st in the nation, and Connecticut ranked 9th, which is the lowest of the New England states.

FIGURE 9. State of Mental Health in America 2022: Access to Care Ranking, New England States[38]

New England State	State Rank out of 51
Connecticut	9
Maine	3
Massachusetts	2
New Hampshire	6
Rhode Island	**7**
Vermont	1

Discussion of The State of Mental Health in America 2022 – State Comparisons

To summarize Rhode Island's ranking in the above select rankings from the State of Mental Health in American 2022 report:

- **Composite "overall ranking" measure:** Rhode Island ranked 11th relative to all other states, and 6th relative to New England states.
- **Composite "adult ranking" measure:** Rhode Island ranked 11th relative to all other states, and 2nd relative to New England states.
- **Composite "youth ranking" measure:** Rhode Island ranked 15th relative to all other states, and 6th relative to New England states.

[37] Reinert, M, Fritze, D. & Nguyen, T. (October 2021). "The State of Mental Health in America 2022" Mental Health America, Alexandria VA
[38] Ibid.

- **Composite "access to care" measure:** Rhode Island ranked 7th relative to all other states, and 5th relative to New England states.

Rhode Island performed relatively well as compared to all other states, and has room to improve, especially relative to New England states. While these rankings illustrate interesting trends, it is important to contextualize them. As noted earlier, Rhode Island was highlighted in the report due to its dramatic change in the composite "adult ranking" measure – improving from a ranking of 26 in the 2021 report to a ranking of 11 in the 2022 report. This demonstrates that states' rankings have the potential to change dramatically year-over-year. Because the rankings in the State of Mental Health in American 2022 report is informed by data from 2018-2019, it is unclear how Rhode Island, or any other state, would rank currently.

Something else to consider is that the "over all ranking", "adult ranking", and "youth ranking" composite measures include behavioral health disorder prevalence data (e.g., adults with any AMI, youth with substance use disorder in the past year, etc.). As discussed in the Behavioral Health Disorder Prevalence section of this report, prevalence data alone does not indicate why certain states are estimated to have a higher proportion of residents with behavioral health disorders than other states.

For Rhode Islanders to be able to access essential behavioral health care, a requisite workforce is necessary. The next section further explores data related to behavioral health care access by summarizing available behavioral health care workforce data and looks at how Rhode Island's behavioral health care workforce compares to the other New England states based on this data.

Behavioral Health Care Workforce Data – State Comparisons

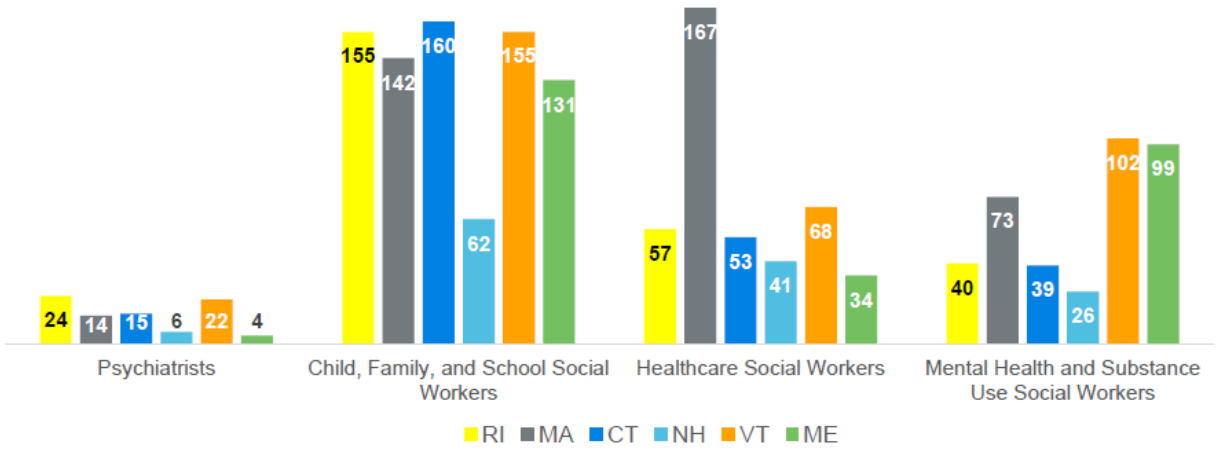
Nationwide there has been an ongoing behavioral health workforce shortage coupled with increasing need of behavioral health services.[39] A 2023 issue brief developed by Kaiser Family Foundation noted that "the pandemic has exacerbated mental health and substance use issues, and 90% of Americans believe the nation is in the midst of a mental health crisis. Despite increases in need, data show that treatment rates across all payers are low. Documented workforce challenges contribute to barriers in access to care."[40] Additionally, low rates of insurance acceptance by behavioral health providers may also contribute to access barriers.[41]

Due to the fact that access to behavioral health services is very likely impacted by the national behavioral health workforce shortage,[42] this report looks at a number of measures of behavioral health workforce capacity in Rhode Island and in other states in New England to identify relevant trends in capacity. Much of this section of the report draws from behavioral health workforce data included in OHIC's 2023 report, Social and Human Service Programs Review: Access to programs[43]. Because that report was a part of the Social and Human Service Programs Review, the primary focus was access to services through the lens of the Rhode Island Medicaid program. Though the 2023 access report primarily focused on Medicaid, some of the workforce data included in the 2023 report is applicable to the behavioral health system at large and, therefore, is relevant to access to behavioral health services in Rhode Island's commercial health insurance networks. The 2023 access report offered consistent findings that access to behavioral health services was "highly limited." Stakeholder interviews conducted for the report revealed that the drivers of present access challenges include provider capacity/network barriers and reimbursement barriers.

Figure 10 shows that a state-by-state comparison suggests a different mix of behavioral health workforce professionals in Rhode Island compared to neighboring states. Specifically, Rhode Island has more psychiatrists on a per capita basis – 24 psychiatrists per 100,000 residents, versus 14 in Massachusetts (MA), and 15 in Connecticut (CT). Additionally, Massachusetts has nearly three times the number of social workers per 100,000 population as compared to Rhode Island – 167 healthcare social workers per 100,000 people in MA versus 57 in RI.

[39] Kaiser Family Foundation. *A Look at Strategies to Address Behavioral Health Workforce Shortages: Findings from a Survey of State Medicaid Programs.* (2023).
[40] Ibid,
[41] Kaiser Family Foundation. *How Does Use of Mental Health Care Vary by Demographics and Health Insurance Coverage?* (2022).
[42] The Commonwealth Fund. *Understanding the U.S. Behavioral Health Workforce Shortage*, (2023).
[43] Rhode Island Office of the Health Insurance Commissioner. *Social and Human Service Programs Review Final Report*, (2023).

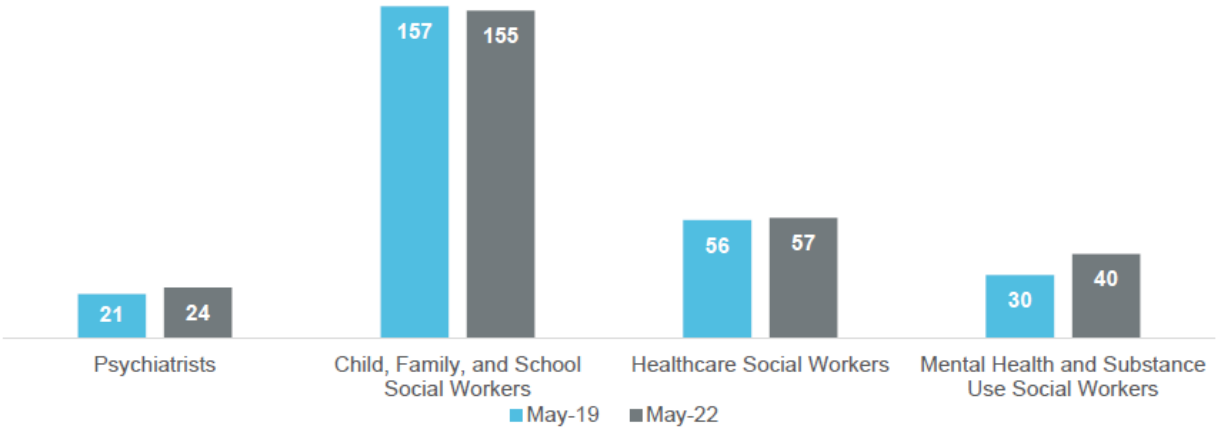
FIGURE 10. General Behavioral Health Services Provider Per 100,000 Population: RI, MA, CT, NH, VT & ME, 2022*



***Note:** Behavioral Health Care Professionals was defined using BLS codes 29-1223, 21-1021, 21-1022. 21-1023.

The overall number of BH professionals has increased in Rhode Island by about 5%, from 264 per 100,000 residents in May 2019 to 276 per 100,000 residents in May 2022. As shown in figure 11, psychiatrists and mental health and substance abuse social workers are driving this increase; the number of child and family social workers and healthcare social workers remained flat (less than 2% change in both categories).

FIGURE 11. General Behavioral Health Service Providers Per 100,000 in RI: May 2019 vs. May 2022[44]



A Kaiser Family Foundation (KFF) analysis of mental health care shortages supported the finding that Rhode Island has more psychiatrists per capita than other states in New England. In that study, the percent of met need was identified for each state with an identified health care professional shortage area (HPSA). "Percent of need met is defined as the ratio of psychiatrists to the number needed to eliminate the HPSA

[44] Bureau of Labor Statistics. *Occupational Employment and Wage Statistics*, 2022.

designation."[45] Mental health shortage areas are primarily based upon the number of psychiatrists compared to the population. Figure 12 compares the percentage of need met in Rhode Island with other states. Based on that research, Rhode Island is outperforming all states in New England with capacity that can meet nearly 62% of the need for care. The estimated number of new practitioners needed to meet the remaining care needs is 15 additional psychiatrists. However, this study did not take into consideration the practice profile of psychiatrists to determine if they accept health insurance.

FIGURE 12. Mental Health Care Health Professional Shortage Areas (HPSA), November 2023[46]

New England State	Percent of Need Met	Practitioners Needed to Remove HPSA Designation
Connecticut	19.0%	91
Maine	19.7%	31
Massachusetts	41.1%	16
New Hampshire	57.8%	25
Rhode Island	**61.9%**	**15**
Vermont	N/A	N/A

Note: N/A means data not available.

2021 survey data from County Health Rankings, indicates that there is one mental health provider for every 350 individuals in the United States.[47] Rhode Island has a significantly higher ratio of one mental health provider per 220 residents. In this case, the definition of "mental health provider" is much broader than the federal HPSA definition and includes psychiatrists, psychologists, counselors, licensed clinical social workers, marriage and family therapists, and advanced practice nurses specializing in mental health care. Nationwide, the state with the most mental health providers per resident is Massachusetts with a ratio of 140 residents to 1 mental health provider, and the state with the least mental health providers per resident is Alabama with 850 residents to 1 mental health provider. Figure 13 compares state provider ratios of the New England states. Rhode Island has the 7th highest ratio in the nation and the 4th highest ratio out of the six New England states. The state with the lowest provider to resident ratio is New Hampshire with a ratio of 290:1.

[45] Kaiser Family Foundation. *Mental Health Care Health Professional Shortage Areas (HPSAs)*, (2023).
[46] Ibid.
[47] Reinert, M, Fritze, D. & Nguyen, T. (October 2022). "The State of Mental Health in America 2023" Mental Health America, Alexandria VA.

FIGURE 13. Mental Health Workforce Availability; New England States, 2021[48]

New England State	State Rank out of 51	Ratio of People to Provider
Connecticut	8	230:1
Maine	5	190:1
Massachusetts	1	140:1
New Hampshire	16	290:1
Rhode Island	**7**	**220:1**
Vermont	6	200:1

This measure simply indicates the presence of mental health providers in each state.[49] According to County Health Rankings, these numbers may include providers who are not currently practicing or accepting new patients and therefore may be an overestimate of provider availability. Additionally, these numbers do not account for whether a provider accepts health insurance.

Discussion of Behavioral Health Care Workforce Data

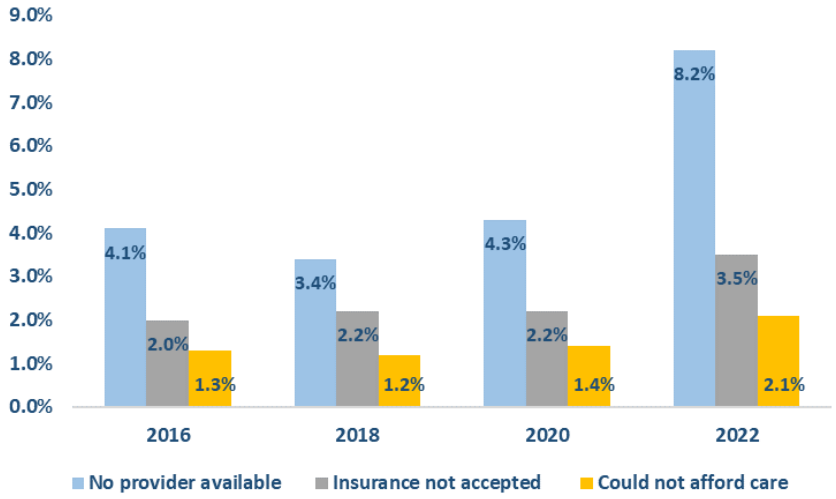
Available data related to the behavioral health care workforce suggests that Rhode Island may be doing better than many states, and there is also room for improvement. As noted above, workforce data is not very nuanced – whether providers are accepting new patients, what kind of insurance they accept, and if they accept insurance at all is not factored into mental health workforce numbers. The national behavioral health care workforce shortage is well documented and has affected every state, including Rhode Island. This coupled with an increasing demand for behavioral health services has exacerbated access issues. Some speculate that a major driver of this shortage is mental health provider reimbursement rates. Further study of reimbursement rates would be needed, as well as an assessment of other factors, such as competition with other professions, such as other medical specialties.

The Rhode Island Health Information Survey: Behavioral Health Care Access

The Rhode Island Health Information Survey (RI HIS) is conducted on behalf of Rhode Island Executive Office of Health and Human Services (EOHHS) and HealthSource RI (HSRI).[50] Rhode Islanders' insurance status, experience getting care, use of medical services, and relevant demographic variables have been collected over the phone every two years between 2016 and 2022.[51,52] This survey shows that barriers and delays to accessing mental health services were attributed to lack of provider availability, insurance not being accepted, or not being able to afford such services[53]. Figure 14 shows from 2016 to 2022, the percentage of individuals with private health insurance who delayed or did not receive mental health care by reason.[54]

[48] Reinert, M, Fritze, D. & Nguyen, T. (October 2022). "The State of Mental Health in America 2023" Mental Health America, Alexandria VA.
[49] Ibid.
[50] HealthSource Rhode Island. *2022 Health Insurance Survey, "Survey Overview".*
[51] Ibid.
[52] See the *2022 Rhode Island Health Information Survey Technical Documentation* for more information on the survey methodology, data analysis and weighting, and the survey questions.
[53] HealthSource Rhode Island. *Rhode Island Health Insurance Survey (HIS): 2022 Executive Summary*, (2022).
[54] HealthSource Rhode Island. *2022 Health Insurance Survey, "Mental Health Utilization"*, filtered for "private insurance."

FIGURE 14. RI HIS: People with Private insurance who delayed of did not receive mental health care, 2016-2022

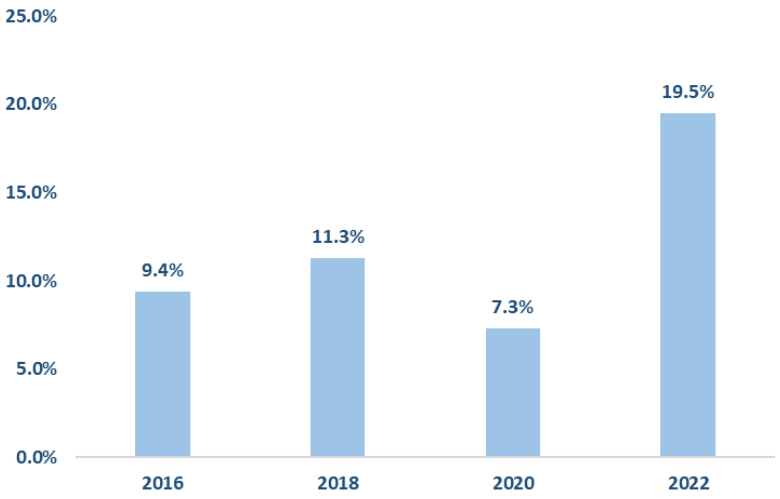


Data Source: The Rhode Island Health Information Survey.

Figure 14 provides insight into which barriers to mental health care access need to be addressed by policymakers so that more Rhode Islanders can access care. Most notably, delayed or not received care due to lack of provider availability increased by 3.9 percentage points, from 4.3% in 2020 to 8.2% in 2022. Interestingly, as seen in figure 15, people with private health insurance who received mental health care increased by 12.2 percentage points, from 7.3% in 2020 to 19.5% in 2022.[55] The increase in barriers to accessing mental health care illustrated in figure 14, coupled with the increase in individuals who received mental health care illustrated in figure 15 tells an interesting story. This likely indicates that both the increase in individuals experiencing barriers and the increase in individuals receiving care can be attributed to an increase in demand for mental health care due to the COVID-19 pandemic. The observed increase in demand for mental health care from the survey data is corroborated by other sources, including OHIC analysis of the APCD.

[55] HealthSource Rhode Island. *2022 Health Insurance Survey, "Mental Health Utilization"*, filtered for "private insurance."

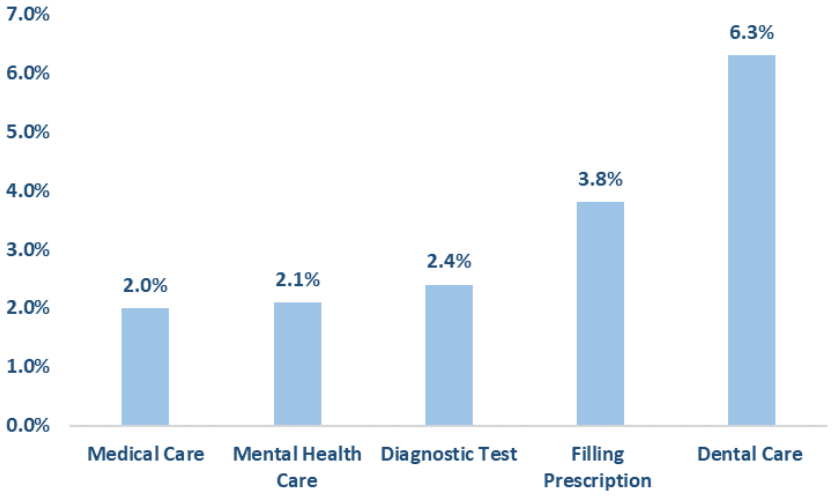
FIGURE 15. RI HIS: People with private health insurance who received mental health care in the past 12 months, 2016-2022



Data Source: The Rhode Island Health Information Survey.

HealthSource RI's 2022 Health Information Survey "Interactive Tool" illustrates the percentage of Rhode Islanders, of all insurance types, who chose to delay needed care due to cost by service type.[56] Figure 16 shows that mental health care was delayed at a slightly higher rate than medical care, at 2.1% and 2.0% respectively, and dental care had the highest percentage of people delaying needed care at 6.3%.

FIGURE 16. RI HIS: People of all insurance types who chose to delay needed care due to cost, 2022



Data Source: The Rhode Island Health Information Survey.

Note: "All insurance types" includes Medicaid, Medicare, military insurance, private insurance, and no insurance.

[56] HealthSource Rhode Island. *2022 Health Information Survey, Interactive Tool*.

Discussion of The Rhode Island Health Information Survey

The data from the Rhode Island Health Information Survey (RI HIS) is not comparable to other states, however, it shows valuable directional trends in Rhode Islanders' insurance status, experience getting care, and use of medical services. Notably, barriers and delays that Rhode Islanders with private health insurance face, when trying to access behavioral health services, are attributed to lack of provider availability, insurance not being accepted, or not being able to afford such services. The majority of Rhode Islanders with private health insurance who delayed or did not receive mental health care was due to a lack of provider availability. As discussed earlier in the report, this is likely caused by the combination of the workforce shortage and an increase in demand for behavioral health care. It has been hypothesized that one of the contributing factors behind this workforce shortage is behavioral health provider reimbursement rates. To confirm this hypothesis, more research on reimbursement rates would be needed, as well as an assessment of other factors, such as competition with other professions, such as other medical specialties. The following section shares results from a preliminary assessment, recently conducted by OHIC, of commercial health insurance carriers in Rhode Island.

PRELIMINARY ASSESSMENT OF COMMERCIAL HEALTH INSURANCE CARRIERS IN RHODE ISLAND

On November 27, 2023, in response to House Resolution 6524, OHIC issued a Request For Information (RFI) to the six major health insurance carriers in Rhode Island[57] requesting aggregate data for mental health/substance use disorder (MH/SUD) and medical/surgical (M/S) provider reimbursement. Carriers provided the average commercial reimbursement rates for each provider specialty and current procedural terminology (CPT) code found in the U.S. Department of Labor (DOL) Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act. The purpose of the U.S. DOL Self-Compliance tool and the results of the RFI are discussed in this section.

Summary of Provider Reimbursement Parity Requirements

To comply with the Mental Health Parity and Addiction Equity Act (MHPAEA), a plan or issuer must be able to demonstrate that it follows a comparable process in determining reimbursement rates for in-network and out-of-network providers for both M/S and MH/SUD benefits. For example, if reimbursement rates for M/S benefits are determined by reference to the Medicare Physician Fee Schedule, reimbursement rates for MH/SUD benefits must also be determined comparably and applied no more stringently by reference to the Medicare Physician Fee Schedule.

Any variance in rates applied by the plan or issuer to account for factors such as the nature of the service, provider type, market dynamics, or demand must be comparable and applied no more stringently to MH/SUD benefits than M/S benefits. In other words, issuers may attempt to address shortages in M/S specialist providers and ensure reasonable patient wait times for appointments by adjusting provider admission standards, through increasing reimbursement rates, and by developing a process for accelerating enrollment in their networks to improve network adequacy. But, to comply with MHPAEA, issuers must take measures that are comparable to and no more stringent than those applied to M/S providers to help ensure an adequate network of MH/SUD providers, even if ultimately there are disparate numbers of MH/SUD and M/S providers in the plan's network. Substantially disparate results—for example, a network that includes far fewer MH/SUD providers than M/S providers—are a red flag that a plan or issuer may be imposing an impermissible non-quantitative treatment limitation (NQTL) – see discussion of NQTLs in the background section of this report.

U.S. Department of Labor (DOL) Self-Compliance Tool[58]

The U.S. Department of Labor (DOL) Self-Compliance Tool is a resource used to identify potential disparities that may indicate insurer non-compliance with MHPAEA standards. The tool does not address

[57] Aetna Life Insurance Company, Blue Cross Blue Shield of Rhode Island, Cigna Health and Life Insurance Company, Neighborhood Health Plan of Rhode Island, Tufts Associated Health Maintenance Organization, Inc., Tufts Insurance Company, Inc., United Healthcare Insurance Company, and United Healthcare of New England.
[58] U.S. Department of Labor. *Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)*.

broader issues related to mental health care access, such as provider network adequacy, however, the tool can help identify potential disparities in reimbursement rates or payment practices that may indicate parity violations as further explained below.

Warning Signs: The following plan provisions related to provider reimbursements may be indicative of noncompliance and warrant further review:

1. **Inequitable reimbursement rates established via a comparison to Medicare:** A plan or issuer generally pays at or near Medicare reimbursement rates for MH/SUD benefits, while paying much more than Medicare reimbursement rates for M/S benefits. Again, while outcomes are not **determinative** of a MHPAEA violation, they can often serve as **red flags** or warning signs to alert the plan or issuer that a particular NQTL may warrant further review.
2. **Lesser reimbursement for MH/SUD physicians for the same evaluation and management (E&M) codes:** A plan or issuer reimburses psychiatrists, on average, less than M/S physicians for the same E&M codes.
3. **Consideration of different sets of factors to establish reimbursement rates:** A plan or issuer generally considers market dynamics, supply and demand, and geographic location to set reimbursement rates for M/S benefits, but considers only quality measures and treatment outcomes in setting reimbursement rates for MH/SUD benefits.

Payment Level Comparison

On November 27, 2023, in response to House Resolution 6524, OHIC issued a Request For Information (RFI) to the six major health insurance carriers in Rhode Island[59] requesting aggregate data for MH/SUD and M/S provider reimbursement. Carriers provided the average commercial reimbursement rates for each provider specialty and current procedural terminology (CPT) code found in the U.S. Department of Labor (DOL) Self-Compliance Tool and added additional CPT codes for high-volume services. CPT codes are a uniform language for coding medical services and procedures and are used for health insurance billing.

Following the DOL Self-Compliance Tool, OHIC utilized Medicare reimbursement rates as its benchmark for comparison. Aggregate reimbursement rates for the carriers in the fully-insured commercial market were compared to the 2023 Rhode Island Medicare Fee Schedule (RIMFS).

In accordance with DOL Self-Compliance Tool, generally, if a plan's comparison of reimbursement rates indicates that the reimbursement rate is lower for MH/SUD providers, either as compared to M/S providers or as compared to an external benchmark, such as Medicare, the plan should consider further review to ensure that the processes, strategies, evidentiary standards, and other factors used with respect to provider reimbursement for MH/SUD benefits are comparable to, and applied no more stringently than, those used with respect to provider reimbursement for M/S benefits.

The RFI did not show major disparities in provider reimbursement in the fully-insured commercial market compared to the 2023 RIMFS; however, comparing commercial reimbursement rates against an external benchmark such as Medicare reimbursement is meant only to serve as a warning sign to determine whether additional review for compliance with MHPAEA is warranted and is not clearly determinative of MHPAEA compliance or non-compliance.

A snapshot of the findings with respect to group and individual carriers can be found below in figures 17, 18, and 19:

[59] Aetna Life Insurance Company, Blue Cross Blue Shield of Rhode Island, Cigna Health and Life Insurance Company, Neighborhood Health Plan of Rhode Island, Tufts Associated Health Maintenance Organization, Inc., Tufts Insurance Company, Inc., United Healthcare Insurance Company, and United Healthcare of New England

FIGURE 17. Medical Doctor (MD) Level Provider Reimbursement Rate Comparison to Medicare, 2023

Specialty	CPT Code	2023 Rhode Island Medicare Rate (RIMFS)	Average of All Commercial Reimbursement Rates	All Commercial Reimbursement % of Medicare
Medical Doctor (MD)				
Orthopedic Surgery	99203	$115.93	$139.17	120%
	99213	$93.45	$98.16	105%
	99214	$132.11	$136.85	104%
Cardiologists	99203	$115.93	$143.58	124%
	99213	$93.45	$89.72	96%
	99214	$132.11	$141.49	107%
Internists MD, Doctor of Osteopathic (DO) Medicine (Specialist, not practicing as PCPs)	99203	$115.93	$128.45	111%
	99213	$93.45	$93.65	100%
	99214	$132.11	$138.03	104%
Internists MD, DO	99203	$115.93	$135.76	117%
	99213	$93.45	$101.05	108%
	99214	$132.11	$140.32	106%
Endocrinologists	99203	$115.93	$154.16	133%
	99213	$93.45	$100.74	108%
	99214	$132.11	$149.07	113%
Gastroenterologist	99203	$115.93	$137.22	118%
	99213	$93.45	$91.29	98%
	99214	$132.11	$129.25	98%
Neurologists	99203	$115.93	$149.59	129%
	99213	$93.45	$97.49	104%
	99214	$132.11	$137.20	104%
Pediatrician (Specialist, not practicing as primary care providers (PCPs))	99203	$115.93	$157.35	136%
	99213	$93.45	$102.23	109%
	99214	$132.11	$142.08	108%
Pediatrician MD, DO	99203	$115.93	$122.32	106%
	99213	$93.45	$97.40	104%
	99214	$132.11	$134.76	102%
Psychiatrists	99203	$115.93	$129.31	**112%**
	99213	$93.45	$91.51	**98%**
	99214	$132.11	$148.02	**112%**
	90792	$201.45	$221.25	**110%**
	90792TU, for children <18.	$201.45	$296.69	**147%**
Dermatologists	99203	$115.93	$128.54	111%
	99213	$93.45	$96.64	103%
	99214	$132.11	$150.25	114%
All M/S Provider Specialty and PCP Providers Average (no Psychiatry)	**99203**	**$115.93**	**$139.89**	**121%**
	99213	**$93.45**	**$96.64**	**103%**
	99214	**$132.11**	**$140.11**	**106%**

FIGURE 18. Doctoral Level Provider Reimbursement Rate Comparison to Medicare, 2023

Specialty	CPT Code	2023 Rhode Island Medicare Rate (RIMFS)	Average of ALL Commercial Reimbursement Rates	ALL Commercial Reimbursment % of Medicare
Doctoral				
Podiatrists	99203	$115.93	$116.48	100%
	99213	$93.45	$85.03	91%
	99214	$132.11	$138.60	105%
Psychologists	90832	$77.51	$84.01	**108%**
	90834	$102.51	$102.86	**100%**
	90837	$150.84	$156.10	**103%**
	90791	$179.38	$169.52	**95%**
	90791TU for children <18.	$179.38	$185.31	**103%**
Chiropractor	99203	$115.93	$72.83	63%
	99213	$93.45	$47.97	51%
	99214	$132.11	$60.87	46%

FIGURE 19. Master's Level Provider Reimbursement Rate Comparison to Medicare, 2023

Specialty	CPT Code	2023 Rhode Island Medicare Rate (RIMFS)	Average of All Commercial Reimbursement Rates	All Commercial Reimbursment % of Medicare
Master's				
Occupational Therapy	97165	$104.86	$81.33	78%
	97166	$104.86	$75.47	72%
	97167	$104.86	$94.51	90%
	97168	$72.37	$63.26	87%
Physical Therapy	97161	$104.86	$75.51	72%
	97162	$104.86	$72.11	69%
	97163	$104.86	$69.27	66%
	97164	$72.73	$47.80	66%
Licensed Clinical Socia Worker (LCSW)	90832	$58.13	$57.69	**99%**
	90834	$76.88	$84.63	**110%**
	90837	$113.13	$119.22	**105%**
	90791	$134.54	$135.95	**101%**
	90791TU for children <18.	$134.54	$157.14	**117%**

Discussion of the Preliminary Assessment of Commercial Health Insurance Carriers in Rhode Island

OHIC's review of NQTL analyses in the Plan Year 2024 Affordable Care Act (ACA) rate filings and the information submitted in the RFI did not appear to indicate major disparities in provider reimbursement. However, as discussed above, investigating whether carriers are complying with their legal obligations to establish comparable processes, strategies, factors, and standards when determining reimbursement rates for MH/SUD and M/S providers can be nuanced and challenging. Further review is warranted to corroborate information presented through the NQTL analyses.

ACTION STEPS AND RECOMMENDATIONS

As the demand for behavioral health care services remains high, it is critical that Rhode Island support access regardless of an individual's type of insurance. While this report does not address Medicaid, the Medicaid Program and the private managed care organizations (MCOs) that administer full benefits for approximately 90% of Medicaid enrollees have a key role to play. Two positive developments in the Medicaid space include the creation of Certified Community Behavioral Health Clinics (CCBHCs) and the implementation of reimbursement rate increases for behavioral health services following OHIC's social and human service programs review in 2023.

As stated in OHIC's FY 2025 Strategic Plan that was submitted with the agency's budget, OHIC will initiate a targeted market conduct examination to assess commercial health insurer compliance with federal and state behavioral health parity requirements. This examination will focus on ensuring that written and operational processes, strategies, factors, and/or standards used for provider admission to participate in their network, including reimbursement rates, are comparable between Mental Health/Substance Use Disorder (MH/SUD) and Medical/Surgical (M/S) providers, in accordance with state and federal laws and regulations.

To reduce barriers in access to care and alleviate administrative burden facing providers, OHIC strongly recommends that other commercial health insurers align with BCBSRI's policy to discontinue utilization review for behavioral health care services.