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November 6, 2024

Charles Estabrook
Office of the Health Insurance Commissioner
1511 Pontiac Ave. Bldg. 69-1
Cranston, RI 02920

RE: Power and Duties of the Office of the Health Insurance Commissioner ("OHIC"), 230-RICR-20-30-4 Proposed Amendment

Dear Mr. Estabrook:

We write to provide comments on OHIC's proposed amendment to 230-RICR-20-30-4 (the "Amendment"). Brown University Health commends OHIC for its ongoing support for primary care initiatives. This Amendment seeks to increase the mandatory minimum spend to PCPs. As it was reported in OHIC's Primary Care in Rhode Island report (the "Report"), the State's primary care workforce faces very significant shortages soon whether from an aging workforce, increasing administrative burdens, lower reimbursements, or a combination of each. Effective primary care requires a team-based approach to serve the broad and complex needs of patients, a principle the Report details in its recommendations and is reflected in this Amendment. Moreover, as data indicates, a robust system of PCP care provides better care with less cost to the system than treating basic patient problems in the emergency room. OHIC's own data hub unfortunately reveals that emergency department visits since 2019 remain relatively consistent in terms of volume while the total spend, especially on high intensity episodes, continues to increase. We agree that steps are necessary to increase PCP-patient encounters. Recognition is also afforded to OHIC for the speed within which it has acted from the Report's issuance in December 2023 to the proposal of the Amendment that we see as a reflection of OHIC's understanding of a very serious problem coupled with its desire to immediately address it.

In addition, we support OHIC's efforts to make significant reductions in the administrative burdens placed on primary care practices and providers. Brown University Health is a participant in OHIC's Administrative Simplification Task Force and as a member continues to raise the cost to the system and impact on patient care because of these burdens like prior authorization. The continuation of the Administrative Simplification Task Force allows for all parties to further discussions on the means to address these issues, and this Amendment demonstrates OHIC's willingness to listen and to act.

We appreciate the opportunity to provide comments on the Office's Proposed Amendment.

Sincerely,

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BROWN MEDICINE
BROWN PHYSICIANS, INC.

November 13, 2024

Charles Estabrook
Department of Business Regulation (includes the Office of the Health Insurance Commissioner)
1511 Pontiac Avenue, Bldg. 69-1
Cranston, RI 02920
Via email charles.estabrook@ohic.ri.gov
RE: Proposed revisions to 230-RICR-20-30-4

Dear Mr. Estabrook:

Thank you for the opportunity to comment on the proposed revisions. These comments are submitted on behalf of Brown Medicine but have been shared with the Care Transformation Collaborative of RI (CTC-RI) and the RI Medical Society (RIMS). I have represented these entities at the Office of the Health Insurance Commissioner (OHIC) in matters related to these regulations.

These revisions are a continuation of positive steps taken by the OHIC to promote team-based advanced primary care and a stable primary care workforce, which in turn promotes access, population health, appropriate use of resources and affordability. This in turn promotes our state economy and the personal economies of our citizens. The proposal also continues the promotion of adequate behavioral health care and the integration of behavioral health into primary care (IBH).

We appreciate that the OHIC and RI has been a national leader in promoting measurement and expansion of primary spending as a proportion of total health care expenditures. We also understand the value of using methodologies to standardize comparisons between states. However, we do hope that RI will also preserve a "best methods" approach in data collection and methodology as we seek to improve the national standards.

The proposals regarding prior authorization are fully supported as an initial step in reducing these processes that take time away from patient care, are a major cause of dissatisfaction with primary care practice and are costly to primary care practices, all of which degrade the access and availability of primary care.

Comments on specific sections follow (the proposed numbering is used):

4.3.A.18 It is important that the definition of primary care expenditures retain concordance in all 3 attributes: paid **to** a primary care practice or larger entity, **for** a primary care service, **at** a

primary care site. In other words, **BOTH** the service and practitioner taxonomies must be met. It is appropriate to exclude first contact service sites that are not comprehensive longitudinal care in nature, i.e., urgent care and retail pharmacy clinics. Since urgent care centers do not require licensure as such, the OHIC will rely upon requiring insurers to adequately identify them. In

4.3.A.18.a there are services that are not necessarily primary care when provided by an individual who is not a primary care practitioner. Therefore, the taxonomy code must be considered in conjunction. It is also important to carefully classify the services. For example, "Hospice/Home Health" does not include "Home Visits." A service by a Family Medicine, Hospice Palliative practitioner is only include for the limited services classified as Hospice/Home Health. Comments on specific taxonomy and services codes are presented with 4.13 and 4.14.

4.3.A.18.b.2 Incentive payments create potential volatility and uncertainty in predicting the primary care spend and revenue. There is also complexity in allocation. Overall targets could be met but some practices may not receive incentives even while providing excellent primary care. The OHIC should not just determine allocation methodology but review incentive methodologies for fairness. In many cases, achieving the incentives requires substantial investments by practices.

4.3.A.19-20 See also comments on 4.13 and 4.14. We do not believe that behavioral health providers are primary care providers, though they may be in an IBH primary care practice. There should be a distinction between payments to a practice as compared to the practitioner classification. Likewise, specialists are not primary care practitioners. In many cases there is no specific "primary care fee schedule" and it is not clear that primary care responsibilities are accepted as most contracts are written for multiple provider types. If the OHIC required reporting methodology is sufficiently strong, this is a non-issue, but rather than over counting in a presumably small way, it may be better to risk slight under counting.

4.3.A.26 The "allowed" is used here, whereas it is not clearly "allowed" rather than "paid" in other areas (e.g., 4.3.A.18).

4.10.B.1.b,c A distinction is made between claims/service (APM) payments and those payments that are not claims/service. Presumably, the latter is incentive payments, but it is less clear where payments to support population health are classified (4.3.A.18.b.3), especially if included in a capitation for primary care or paid in lieu of care management services. It may also need to be considered when a payment rate is adjusted based upon quality whether that is a quality payment or a claims/service payment. A case can be made for either choice and consistency with a national standard may govern the decision. Absent a standard, it would be reasonable to consider both as "claims/service," especially as 4.10.B.1.c.(3) indicates that population payments can be used to meet the requirements. Claims payments for BH services in an IBH should not be included but support for team-based care and recovery of claims shortfalls related to non-billable time and services inherent in IBH is reasonable. While shared savings and quality payments may be part of the total primary care expenditure, they should not be used to make up any gap in claims/service payments and the 3 methods of meeting the requirements should be limited as stated.

4.10.B.2 The BH expenditures definitions are not proposed to be revised. They should be. The revision should be in the manner that primary care services are defined. A practitioner and service taxonomy should be created. A claims with an BH principal diagnosis is a flawed methodology. If the intent is to capture primary care clinicians treating BH conditions, the

requirement of a primary diagnosis is ill-advised as it may not be the primary diagnosis even if the most significant problem addressed. Further, primary care clinicians treating BH conditions is primary care, not BH. If practitioner type and service type are used, diagnosis become irrelevant.

4.10.C.1.b.(1), (2) It is proposed that infrastructure and care management payments may be at risk for quality performance. Presumably, this is contractual and would use the OHIC defined measures. But this should also require an OHIC defined performance rate. It is acceptable to have incentives for "reach" performance. It should not be acceptable to claw back or reduce future infrastructure payments when performance is acceptable. "At-risk" should be viewed as meaning only when a penalty is warranted. Different plans could also create very different standards, which could create premium distortions.

4.10.D.2.a.,d. Downside risk means there is a fair budget. The OHIC may wish to have a mechanism to review such budgets. While no revision is proposed on the "Physician-based Integrated System" a minimum of 7% of revenue and 2% of total cost of care are very divergent. If primary care is presently 6% of the total expenditure, then 2% is one third of the total primary care revenue *as a minimum*. Given overhead, that is nearly all of the practitioner's potential net income. Additionally, the term "Physician-based Integrated System," while understood to be a PCP ACO without a hospital, is not defined.

4.10.D.2.f.(1). The goal of not charging the Integrated System of Care for the increased payments the primary care clinicians receive seems laudable overall. Greater specificity may be required. For example, if over 3 years the payments went up 3% of total expenditure, would 3% be permanently exempted, a dollar amount permanently exempted, or would the exemption be for the next year's budget only?

4.10.D.2.h. High-cost drugs are creating budget issues for employers, plans, and integrated systems. It may be reasonable to allow them to be carved out, provide an example of a mitigation strategy or provide sub-regulatory guidance on acceptable risk-mitigation strategies.

4.10.D.4. The utility of specialty APMs should be reconsidered. If required, there should be credit for specialists participating in total cost of care contracts e.g., by being a member of the Integrated system. Plans need to review attribution and budget methods when specialists are in such arrangements as the risk adjustment can be inadequate. Incentives for judicious use of specialty drugs should qualify and may be already addressed as "limited scope of service models" though that is intent not certain as the services are not paid to the specialty.

4.11.F This process needs to be ongoing. Reviews are specified as such. There should also be a statement that a reduction target will be set annually rather than having to go through rule-making each year. The OHIC should seek comment at a sub-regulatory level for the forms and attestations proposed. We ask the OHIC to consider additional regulation and processes to implement RIGL 42-14.5-3.(h).(3).(ix) regarding electronic resources. Technology is rapidly evolving as are federal regulations. We encourage the OHIC to assemble a technical advisory group as part of the Administrative Simplification Task Force or other entity.

4.13 Provider Taxonomy Codes are insufficient for APRNs and PAs. Plans should be required to differentiate between primary care, specialty care, behavioral health, and other non-physician practitioners. APRN misclassification will significantly distort the calculations. Hospice and palliative care clinicians are generally not PCPs. Though the codes in the calculations are limited, their inclusion should be reconsidered. Additionally, most of the

services listed as Hospice/Home Health cannot be reported by such practitioners. I have met with the representative of the NUCC about the lack of granularity and reflection of actual practice in the APRN codes. There is an opportunity to improve the taxonomy. However, if the NPPES/PECOS system does not allow a taxonomy unless it exactly conforms to the license label, it will not be successful in RI as the licenses are the partial source of the practice type/taxonomy mismatch.

4.14 The listed codes are not entirely accurate. They may be acceptable for retroactive analyses, but for 2025 there are no telephone codes (99441-99443) and there are new telemedicine codes (98000-98016). CMS has also created advanced primary care management codes (G0556-G0557). Several of the codes are likely to be Medicare only or are uniformly not paid, though could be included in case a plan uniquely paid them. The list should be able to be revised without rulemaking. There should be a standard process of annual review, like the quality measures process. This would be done in early December and plans should be required to indicate their coverage and payment status at that time. Today, plans may not announce the status until after the effective date of the code. This is an administrative burden and can lead to incorrect payment. It would also be advisable to list short descriptors for CPT and be consistent in descriptor style. It is not clear who created the list and this may be part of the national/regional standard. Some codes are not primary care, e.g., 98966-98968 are for clinicians who may not report E/M. They are not for APRN/PA clinicians. Interprofessional consults and principal care management are mostly for specialists, but can be included if the provider is correctly classified as a PCP. These two families would be wrong most of the time without a better APRN taxonomy. The codes should be included or excluded by year to avoid failing to use deleted codes in retrospective analyses or having deleted codes listed as current.

Thank you for the opportunity to comment on these proposed regulations.

Sincerely,

Peter Hollmann, MD

CharterCARE Provider Group
of Rhode Island

November 14, 2024

To: Charles Estabrook, Director of Policy
Office of the Health Insurance Commissioner

From: Garry Bliss, Senior Director Government Programs & Communication

Re: Proposed Amendments to 230-RICR-20-30-4: Powers and Duties of the Office of the Health Insurance Commissioner

We are pleased to have this opportunity to offer our comments on the Proposed Amendments to 230-RICR-20-30-4: Powers and Duties of the Office of the Health Insurance Commissioner (OHIC) issued on 10/11/2024.

These comments are based on a review of the public notice, the draft changes, and the regulatory & cost-benefit analysis released in conjunction with the proposed amendments. Our comments are also informed by the two reports referenced in the public notice: *Primary Care in Rhode Island: Current Status and Policy Recommendations* (December 2023) and *Prior Authorization: Final Report of Recommendations* (June 2024) issued by OHIC's Administrative Simplification Taskforce.

The proposed amendments do a commendable job of responding to the findings and recommendations of these reports.

We support the goals OHIC seeks to achieve through these proposed amendments and believe that together these changes will:

- Promote primary care in Rhode Island
- Address provider burnout by reducing unnecessary administrative burdens
- Increase transparency of payer policies
- Further the collaborative transformation efforts of providers, payers, and stakeholders, and
- Improve outcomes, increase efficiency, lower costs, and improve provider experience.

Primary Care Definition & Spending Requirements

The proposed updates and refinements to the definition of primary care should help provide a more accurate and complete picture of primary care spending in Rhode Island and, coupled with the revised expenditure requirement, help to drive increased investment in primary care.

As noted in the cost-benefit analysis:

> *This analysis predicts that primary care expenditures, PMPM, would double from about $35 to about $70 through the end of the decade. Another way to look at the proposed primary care expenditure target of 10% is through a comparison of primary care expenditures in 2022 (the baseline year) to the counterfactual where 2022 expenditures represent 10% of TME. In 2022, primary care expenditures accounted for 6.4% of TME, or $35.11 PMPM. If primary care*

expenditures had accounted for 10% of TME in 2022, using the updated methodology, then PMPM expenditures would have been $55 PMPM, or 57% higher. (Page 17)

Increased primary care spending in line with these projects will strengthen Rhode Island challenged base of primary care providers, while directing investment to those who have the greatest opportunity to have a holistic impact on patient outcomes, utilization, and experience.

Administrative Simplification

We support the initiative OHIC is taking to address the widely held provider concern over the burden of overly restrictive prior authorization policies.

The suite of proposed changes should result in a near-term reduction in prior authorizations – welcome in and of itself – while also providing greater transparency, oversight, and accountability of prior authorization policy and practice over the long-term.

The transparency requirements OHIC is proposing regarding reporting will allow for more informed discussions on this important topic. The proposal to convene an advisory committee will help ensure Rhode Island's healthcare community continues to collaborate on reducing administrative burdens while ensuring efficiency and cost-effectiveness.

These recommendations are a comprehensive and meaningful response to the work and recommendations of the Administrative Simplification Taskforce.

November 15, 2024

Charles Estabrook
Office of the Health Insurance Commissioner
1511 Pontiac Ave., Bldg. 69-1
Cranston, RI 02920

By email to charles.estabrook@ohic.ri.gov

Dear Mr. Estabrook:

Thank you for the opportunity to provide these comments in support of the Office of the Health Insurance Commissioner's proposed amendments to 230-RICR-20-30-4, particularly with regard to § 4.10, the "Affordability Standards," and the new § 4.11(F), "Prior Authorization."

As Rhode Island's health insurance consumer assistance program, we routinely encounter Rhode Islanders who face challenges in accessing routine primary care, or are simply unable to find a provider with availability without unreasonably long wait lists. To that end, RIPIN is strongly in support of actions to increase investment in primary care within the state, and agrees with the methodology OHIC has laid out for driving that increased investment.

We concur with OHIC's determination to achieve this through a rebalancing of health care investment in a Total Medical Expense context, and we are strongly supportive of the inclusion of out-of-state payments in the denominator of that TME calculation so as to more adequately capture the true proportion of TME dedicated to primary care. RIPIN encourages OHIC, in response to the new data which will be captured under the proposed rules, to dig deeper on the impact various insurer activities have on consumer access to primary care, particularly whether the investments driven through "increas[ed] reimbursement for primary care services" as contemplated by § 4.10(B)(1)(c)(1) are sufficient to achieve the level of primary care access Rhode Islanders require.

RIPIN similarly encounters many Rhode Islanders whose medically necessary care is delayed or denied because of obstacles in the prior authorization process. As such, RIPIN is strongly supportive of OHIC's decision to take meaningful action through the regulatory process (rather, as detailed as an alternative in OHIC's regulatory and cost-benefit analysis, than relying solely on voluntary action by insurance carriers to reduce prior authorization burden). RIPIN believes that the 20% reduction from the 2023 baseline proposed by OHIC represents a meaningful initial reference point, and we encourage OHIC to directly connect future targeted refinements and required reductions to both the impact on consumer access to care and administrative impacts to providers.

RIPIN encourages OHIC to consider further action, including through the establishment of more particularized standards regarding the considerations enumerated at § 4.11(F)(4)(a)(1)–(5), such as prohibiting prior authorization for service lines with an average cost below a certain threshold and approval rates above a certain threshold; service lines identified as being particularly onerous for providers vis-à-vis their approval rate; and service lines where patient experience of and continuity of care are particularly implicated, such as within priority areas such as primary care or behavioral health. As has been discussed in many public fora, the rationale for prior authorization has been to ensure the health care delivered to consumers is safe, effective, and avoids negative externalities of unnecessary cost to individuals and to the system as a whole. This rationale is less convincing in areas where there is underinvestment and where additional care is less likely to create waste or jeopardize health.

RIPIN appreciates the opportunity to provide these comments, and looks forward to reviewing the data OHIC plans to make available as part of this process and to continuing to participate in stakeholder engagement to refine these proposals and make quality, affordable health care more accessible for Rhode Islanders across the lifespan and needs spectrum.

Thank you,

/s/

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/s/

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RHODE ISLAND MEDICAL SOCIETY

November 15, 2024

Charles Estabrook
Department of Business Regulation (includes the Office of the Health Insurance Commissioner)
1511 Pontiac Avenue, Bldg. 69-1
Cranston, RI 02920

Via email: charles.estabrook@ohic.ri.gov

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

Dear Mr. Estabrook,

The Rhode Island Medical Society (RIMS) appreciates the opportunity to comment on the proposed revisions to 230-RICR-20-30-4. On behalf of the physicians of Rhode Island, we would like to express our strong support for the comments submitted by RIMS board member Dr. Peter Hollmann. His insights highlight the critical impact of these regulations on the stability and accessibility of primary care in Rhode Island.

Administrative burdens, particularly those tied to prior authorization, remain a significant challenge for physicians. These processes detract from patient care, contribute to clinician dissatisfaction and burnout, and impose unnecessary costs on practices, further straining the healthcare system.

We commend OHIC for taking steps to address these concerns and for its leadership in promoting advanced primary care models and integrated behavioral health. Streamlining administrative processes is essential to improving patient outcomes, ensuring a sustainable primary care workforce, and maintaining affordability within Rhode Island's healthcare system.

RIMS strongly encourages OHIC to continue its efforts to alleviate administrative burdens by:

- Simplifying Prior Authorization: Standardizing and automating prior authorization processes to reduce variability and administrative overhead.
- Ensuring Equitable Incentive Structures: Incentives should reward quality care without penalizing practices for systemic challenges beyond their control.
- Enhancing Transparency: Providing clear, consistent reporting standards to ensure predictability for primary care practices.

We are grateful for OHIC's commitment to improving the healthcare landscape in Rhode Island and look forward to working collaboratively to address these ongoing challenges.

Sincerely,

Kara Stavros, MD
President

171 Service Avenue
Warwick, RI 02886
401-430-2000
integracare.org

Public Comment on Proposed Amendments to 230-RICR-20-30-4

Submitted via email on November 13, 2024

Integra Community Care Network (Integra) appreciates the opportunity to provide comments on the proposed amendments to 230-RICR-20-30-4: Powers and Duties of the Office of the Health Insurance Commissioner. Integra is an Accountable Care Organization (ACO), or Integrated System of Care, that is part of the Care New England Health System. Integra includes approximately 120 primary care providers (PCPs) and 1,200 specialists, as well as Butler Hospital, Kent Hospital, Women and Infants Hospital, The Providence Center, and the VNA of Care New England. We offer the following feedback for OHIC's consideration, to ensure the sustainability of both primary care and value-based care in the state of Rhode Island.

4.10 Affordable Health Insurance – Affordability Standards

Integra is highly supportive of OHIC's overarching aim to increase primary care funding. Primary care teams are the backbone of ACOs, and the key mechanism for controlling health care quality, outcomes, and spend. Yet, due to funding and recruitment challenges, Rhode Island's primary care workforce is in an incredibly fragile state.[1,2,3] Increased primary care funding will allow Integra and its PCPs to help maintain our primary care workforce and sustain wrap around services such as pharmacy, behavioral health, and care management.

4.10.B.1.A While we appreciate OHIC's directive to increase annual primary care expenditures beginning in 2025, we do not believe that the target set for 2025 goes far enough. **We ask that OHIC increase the proposed percentage increase in annual primary care expenditures in 2025 from 0.5% to 2%** for the following reasons:

- PCPs and the patients they serve need OHIC's rapid support to sustain operations and keep their doors open, and a 0.5% increase from commercial payers is insufficient.
- Integra's current commercial spend on primary care visits is approximately 5% of total medical expense. If OHIC aims to get insurers to 10% by 2028, we ask that OHIC sets more ambitious targets for 2025.

4.10.B.1.B Integra supports OHIC's goal to increase primary care spend by 2028 so that at least 10% of total annual medical expenditures are primary care expenditures, and at least 8% of total annual medical expenditures are claims-based payments for primary care services and/or service-based primary care payments under a primary care alternative payment model. Current primary care funding amounts are unsustainable and this increased funding offers a lifeline to primary care practices, ACOs, and ultimately the patients they support. That said, **we ask OHIC for clarification as to why OHIC is *reducing* primary care spend targets from at least 10.7% to at least 10% of total annual medical expenditures.**

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[1] "The collapse of primary care in Rhode Island and how we can fix it", Dr. Michael Wagner, *Providence Business News*, November 7, 2024, available online at: https://pbn.com/opinion-the-collapse-of-primary-care-in-rhode-island-and-how-we-can-fix-it/

[2] "Rhode Island Faces Worsening Crisis in the Shortage of Primary Care Physicians", G. Wayne Miller, *Rhode Island PBS*, October 3, 2024, available online at: https://www.ripbs.org/news-culture/health/rhode-island-faces-worsening-crisis-in-the-shortage-of-primary-care-physicians

[3] "On brink of bankruptcy, Thundermist seeks $8 million bailout", Eli Sherman, *wpri.com*, October 7, 2024, available online at: https://www.wpri.com/target-12/on-brink-of-bankruptcy-thundermist-seeks-8-million-taxpayer-bailout/

4.10.B.1.C AND 4.10.C.1.B Integra applauds OHIC for promoting prospective payment models, including primary care capitation. We also support OHIC's proposed change clarifying that PCMH infrastructure and care management payments are not at risk for total cost of care performance. Prospective payment models coupled with increased and guaranteed primary care funding promote predictability amidst a funding environment plagued by lagged payments.

The current and proposed regulations around primary care financial support, however, leave a considerable amount of discretion to the health plans. The variation in the way the plans currently interpret their obligations leads to unnecessary confusion and negotiation. **A single shared model for primary care support might be worth exploring, including a specific OHIC-defined PMPM (that isn't at risk).**

4.10.D.2.F We support OHIC's proposed change in which health insurers must hold Integrated Systems of Care harmless for the mandated increase in primary care expenditures, and **we ask OHIC to clarify what it means to be held harmless.** For example, would primary care payments be excluded from total cost of care calculations?

4.10.D.2.H We appreciate that OHIC recognizes the detrimental impact that high-cost specialty drugs are having on ACO performance under value-based agreements. **We ask OHIC to clarify whether high-cost specialty drugs can be carved out of the budget under population-based contracts. If they cannot be carved out, we ask OHIC to provide examples of the types of contractual mechanisms that are permissible to mitigate risk from high-cost specialty drugs.**

Finally, we ask that OHIC partner with EOHHS to work to extend these primary care sustainability goals of Part 4.10 to Medicaid. In many of our primary care practices, the majority of patients are covered by Medicaid or Medicare. Integra and our primary care practices aim to offer the same services to all populations, regardless of insurer, but the sustainability of that approach is challenged when the payment models do not support this approach.

RHODE ISLAND
PHYSICIANS CORPORATION
PRIMARY CARE

Dear Commissioner,

Please accept the following comments in response to proposed amendments to 230-RICR-20-30-4 on behalf of Rhode Island Primary Care Physicians Corporation.

In totality, RIPCPC supports the proposed changes to 230-RICR-20-30-4 and commends the office on its commitment to primary care in Rhode Island. The following comments reflect suggested clarifications and/or additions to the proposed amendment.

4.3.A.19 – Taxonomy Codes – Some duals, functioning primarily as specialists, may be included in some of these taxonomy codes. It is likely a good idea to also have insurers report on their internal specialty designations established through the credentialing process. This is of specific concern in the advanced practitioner categories.

4.10.B.1 – Insurers shall provide reporting to each system of care, which identifies the % of TME (denominator) and % of PCP expenditures (numerator) with a breakdown by direct to PCP payments and infrastructure/population-based payments specific to the system of care.

4.10.C.4 – OHIC should impose a minimum PMPM instead of the existing language 'shall be independently determined by the health insurer and the primary care practices.'

4.10.D.2.h – Given the continued, and at time unpredictable increase in specialty drugs, leniency should be provided for inclusion of Rx costs in contracts. At a minimum, trend-based contracts should account for new drugs to market and/or new therapeutic uses for existing drugs, which might turn a trend-based model upside down.

4.10.D.4 – Despite this language being a carry over from previous versions, specialists remain unaccountable and absent from true transformation and/or cost cutting requirements set forth by OHIC. Instead, PCPs and hospitals are the primary levers employed. If payors are expected to increase spend to PCPs, they must have regulatory support by OHIC to impose contractual requirements to specialists.

4.10.D.5.c – Payors should be required to publish finalized measure targets for programs. Quality Compass License Requirements are as follows:

- For each year of access to the Product under the Agreement, Licensee may share/publish data externally outside of Licensee for up to a total of 15 individual HEDIS Measure Indicators contained in the Product. The restrictions in this Section 2(A) apply to all Data and reports generated by the Product by Licensee and its Licensed Users and represent the only data that may be shared externally by Licensee.
- Subject to the foregoing restriction, Licensee may share/publish externally no more than 2 benchmarks for each selected HEDIS Measure Indicator.

As such, payors must publish the tiered targets used for incentive or contractual programs. The 15 individual measure requirement exceeds the number of core measures.

RHODE ISLAND
PHYSICIANS CORPORATION
PRIMARY CARE

4.14.A – The list of acceptable CPT/HCPCS codes should include language that allows for adjustment of the list of codes outside the annual rulemaking process, since some changes will likely occur throughout the year.

Sincerely,

Andrea Galgay

Chief Operating Officer

Rhode Island Primary Care Physicians Corporation

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

November 15, 2024

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

Dear Commissioner King,

Thank you for the opportunity to review the proposed rules for Amendment 20-30-4 2024. Below are the italicized comments submitted on behalf of CTC-RI.

4.3 Definitions

18. "Primary care expenditures" means all claims-based and non-claims- based payments by the health insurer directly to a Primary Care Practice or Integrated System of Care for primary care services delivered to Rhode Island residents at a primary care site of care, which shall include a primary care outpatient setting, federally qualified health center, school- based health center, or via telehealth, but shall not include a third-party telehealth vendor that does not contract with such sites of care to deliver services. A primary site of care also does not include urgent care centers or retail pharmacy clinics. Primary care expenditures shall be limited to:

b. Non-claims-based payments, for:

(*3) Payments to support population health management, team-based care and primary care infrastructure at the primary care site of care including, but not limited to, nurse care managers, pharmacists, behavioral health clinicians, community health workers and peer recovery coaches. Consideration may be given to support transformation initiatives associated with strengthening prenatal care that aim to improve pediatric and family health outcomes.*

c. *Payments for administrative expenses of the medical home initiative endorsed by R.I. General Laws Chapter 42-14-.6 in an amount approved by the Commissioner*

…and include health plan payments in support of state-wide centralized resources including ***Care Transformation Collaborative of Rhode Island with required payments based on market share*** *and in support of single-payer or multi-payer initiatives that improve population health, PediPRN, RI MomsPRN,* ***Medical Legal Partnership*** *support and other initiatives that strengthen the primary care delivery system (such as, but not limited to, improving primary care investment and the supply of the primary care workforce.*

19. "Primary care practice" … except that specialty medical providers, including behavioral health providers, may be designated as a primary care provider if the specialist is paid for primary care services on a primary care provider fee schedule, and contractually agrees to accept the responsibilities of a primary care provider.

...except that ~~***specialty***~~ *medical providers including behavioral health providers****, and pharmacists*** *may be designated as the primary care provider if the specialist is paid for primary care services on the primary care provider fee schedule and contractually agrees to accept the responsibilities of the primary care provider.*

B. Primary care and behavioral health care expenditure obligation
1. Primary care expenditures.

(2) *Making enhanced service-based capitation payments consistent with the definition of a primary care alternative payment model for primary care providers and in support of preventive care and developmental support (medical and behavioral health) which is needed, but does not have an associated diagnostic code.*

4.7 Encouraging Fair Treatment of Health Care Providers

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

Insurers should offer options for providers and SOC for participation in value-based contracts. Some ACOs may not be able to take on the downside risk at the highest level. Insurance risk versus clinical risk should be considered separately. CTC-RI does not believe the primary care practices should take on insurance risk (the SOC can do this); however, practices can and should be accountable for downside on quality.

4.9 Affordable Health Insurance - General

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

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

State should ensure that there are funds for data collection and analysis using APCD database to determine the number of FTE primary care providers (MD, DO, NP, PA).

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

Can OHIC and the State Employees health insurance commission work together to promote primary care? Tiered plans? Alignment of self-insured with other state goals?

4.10 Affordable Health Insurance – Affordability Standards

B. Primary care and behavioral health care expenditure obligation. The purpose of § 4.10(B) of this Part is to ensure financial support for primary care providers and providers of behavioral health

services in Rhode Island that will assist in achieving the goals of these Affordability Standards.

1. Primary care expenditures.

c. Health insurers shall meet these annual primary care expenditure requirements by:

2. Making enhanced service-based capitation payments, consistent with the definition of a primary care alternative payment model, to primary care providers;

OHIC should require payers and SOC to identify "reasonable" team-based care costs, at the SOC and practice level. OHIC may want to recommend which services can be centralized versus practice-based. The PMPM should be sufficient to sustainably pay for staffing and/or services provided through team-based care. There is also the opportunity to require a multi-payer approach "as determined by the Commissioner" to provide practices/SOC with sufficient volume of patients under alternative payments including advanced primary care capitation.

4.10 C. 1 b (1) and (2) It is recommended that there be a common methodology to exclude infrastructure/care management/IBH infrastructure from downside risk (aside from quality) of total medical expense as determined by the Commissioner. This should also be considered for full primary care capitation payments.

4.10 Affordable Health Insurance – Affordability Standards

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

2. Population-based contracts

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

Do the SOC and practices have the data they need to manage downside risk? If not, OHIC should support efforts to develop data and reporting needed for practices to be managed under these arrangements.

4.10 Affordable Health Insurance – Affordability Standards

D. Payment reform. The purpose of § 4.10(D) of this Part is to improve the affordability and quality of health care through the implementation of alternative payment models. Alternative payment models are provider contracting practices that are designed to align provider financial incentives with

the efficient use of health care resources and encourage the proactive management of the health needs of their patient populations. Furthermore, the Commissioner finds that provider contracting practices that incentivize the efficient use of health care resources and which invest in the capacity of health care providers to manage population health are essential to support the care transformation agenda articulated in § 4.10(C) of this Part and to meet OHIC's legislative mandate to direct health insurers toward policies and practices that address the behavioral health needs of the public and greater integration of physical and behavioral health care delivery.

3. Primary care alternative payment models

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

This seems dated. We need PMPM recommendations for team-based care members that may be part of a practice team, to include nurse care managers, IBH licensed social workers, community health workers, pharmacists etc. CTC-RI, with assistance from Freedman Health, has developed a PMPM calculator that practices can use to determine PMPM for the care team.

4.10 Affordable Health Insurance – Affordability Standards

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

4. Specialist alternative payment models

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

We strongly agree that specialist rates be brought in alignment with APM and value-based care. Recommend that OHIC work with health plans to establish specialist payment caps on FFS arrangements and incentives to engage specialists in population health agreements.

4.10 Affordable Health Insurance – Affordability Standards

D. Payment reform. The purpose of § 4.10(D) of this Part is to improve the affordability and quality of health care through the implementation of alternative payment models. Alternative payment models are provider contracting practices that are designed to align provider financial incentives with the efficient use of health care resources and encourage the proactive management of the health needs of their patient populations. Furthermore, the Commissioner finds that provider contracting

practices that incentivize the efficient use of health care resources and which invest in the capacity of health care providers to manage population health are essential to support the care transformation agenda articulated in § 4.10(C) of this Part and to meet OHIC's legislative mandate to direct health insurers toward policies and practices that address the behavioral health needs of the public and greater integration of physical and behavioral health care delivery.

4. Specialist alternative payment models

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

Build on CTC-RI's work on enhanced referrals from PCP to Specialists and e-consults. CNE and Lifespan participated and are making great progress in standardizing referral templates between PCP and Specialist. Templates are now part of EPIC EMR. We are in discussion with RIQI on an HIE-enabled referral system for providers outside of the SOC EPIC system.

4.10 Affordable Health Insurance – Affordability Standards

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

6. Hospital contracts

Can OHIC recommend that hospitals report spending to train primary care providers (MD, NP and PA) in community settings?

4.10 Affordable Health Insurance – Affordability Standards

E. Health equity

4. Demographic data completeness goals

Just a note and question to OHIC: CTC-RI, with funding from RIDOH, is working with primary care practices and SOC on demographic data collection. Would funding to expand this project be considered an allowable non-claims primary care spend?

4.11 Administrative Simplification

A. Administrative Simplification Task Force

1. An Administrative Simplification Task Force is established to make recommendations to the Commissioner for streamlining health care administration so as to be more cost-effective, and less

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

CTC-RI established a workgroup to make recommendations to OHIC on PA. Do you want to include CTC-RI as an organization to include on task force or is it better to have CTC-RI as unaffiliated?

4.11 Administrative Simplification

F. Prior Authorization

7. The Commissioner shall convene a statewide advisory committee on prior authorization that shall be a subcommittee of the Administrative Simplification Task Force. The advisory committee shall be comprised of representatives of health care providers and health insurers with relevant experience and expertise in prior authorization and other utilization management practices and processes. The advisory committee shall meet at least two times per year and will be charged with reviewing prior authorization data submitted to OHIC, health insurer attestations, and making recommendations to improve prior authorization processes for medical services and prescription drugs over time.

Consider an annual survey of primary providers on admin burden -- including PA as well as other issues related to health plans or state requirements.

Some other recommendations that could be added in 230-RICR-20-30-4 Proposed Rule October 2024 document:

4-13 Primary Care Specialty Provider Taxonomy Codes:

Do you want to consider including taxonomy codes that are supported in other states not listed here? Maine--for OB/GYN taxonomy codes, they only included payments for primary care services listed in narrow definition; IHA & NESCO--restrict to only the delivery, antepartum, postpartum, newborn care, gynecological service, and contraception care service list.

4.14 Primary Care Payment Codes

Add payment codes that are used for Collaborative Care:

99492:	*Used to bill for the first 70 minutes in the first initial month of collaborative care*
99493	*Used to bill for the first 60 minutes in any subsequent months of collaborative care*
99494	*Used to bill each additional 30 minutes in any month. It can be used with 99492 or 99493*
G2214	*Used to bill for the first 30 minutes in the first month of care or any subsequent month*

Add codes associated with provision of community health worker services

98966	*5-10 minutes of medical discussion*
98967	*11-20 minutes of medical discussion*
98968	*21-30 minutes of medical discussion*
G0019	*Community health worker integration services performed by certified or trained auxiliary personnel including community health worker for 60 minutes a month*
G0022	*CHW integration services for an additional 30 minutes*

Add codes associated with Health Risk Assessment and Care Management

99495	*Used for moderate medical complexity with a face-to-face visit within 14 days after discharge*
99496	*Used for high medical complexity with a face-to-face visit within 7 days of discharge.*

Other Considerations
Consider including pilot to test Massachusetts subcap model that bases the cap rate on three tiers which represent the number of "primary care transformers that the practice has implemented https://www.mass.gov/info-details/masshealth-primary-care-sub-capitation-program-overview

Sincerely,

Debra Hurwitz, MBA, BSN, RN
Executive Director, CTC-RI

HARI
Hospital Association of Rhode Island

Howard Dulude
Interim President

November 15, 2024

Charles Estabrook
Office of the Health Insurance Commissioner
1511 Pontiac Ave, Bldg. 69-1
Cranston, RI 02920
charles.estabrook@ohic.ri.gov

Subject: Comments on Proposed Amendments to 230-RICR-20-30-4

Dear Mr. Estabrook,

The Hospital Association of Rhode Island (HARI) appreciates the opportunity to submit comments on the proposed amendments to 230-RICR-20-30-4 regarding the Powers and Duties of the Office of the Health Insurance Commissioner (OHIC). We commend OHIC's commitment to promoting affordable, high-quality healthcare for Rhode Islanders and applaud your efforts to strengthen primary care funding, address prior authorization burdens, and ensure long-term sustainability within the healthcare system.

Primary Care Funding

We support OHIC's initiative to increase primary care funding. Primary care providers are critical to managing overall healthcare quality and cost, yet Rhode Island's primary care workforce faces significant financial and recruitment challenges. Increased funding can expand access to primary care services by enabling practices to enhance resources, improve service delivery, and better meet patient needs. Additionally, it can help attract and retain a strong and stable primary care workforce, ensuring that providers have the financial stability and support necessary to sustain their practices and continue delivering high-quality care.

Additionally, we request OHIC to clarify the reasoning behind adjusting the primary care expenditure target from at least 10.7% to 10% of total medical expenditures. This change warrants further explanation to understand how it aligns with OHIC's overarching goals for long-term sustainability for primary care.

Prior Authorization Reform

We support OHIC's amendments addressing prior authorization processes. Reducing administrative burdens associated with prior authorizations is essential to enhancing patient access and ensuring timely care. By mandating a 20% reduction in prior authorization volume and implementing evidence-based, provider-selective protocols, OHIC will alleviate some of the operational burdens on providers, particularly in primary care and behavioral health settings.

Additional Clarifications on High-Cost Specialty Drugs

As noted by HARI members, high-cost specialty drugs present a growing challenge in population-based contracts under value-based models. We encourage OHIC to clarify whether these drugs can be excluded from total cost of care budgets or recommend allowable contractual mechanisms to mitigate the associated financial risks.

Extension of Primary Care Goals to Medicaid

Nearly thirty percent of Rhode Island's population is enrolled in Medicaid. To ensure equitable care for all Rhode Islanders, we encourage OHIC to partner with EOHHS to extend the primary care sustainability goals to Medicaid. Aligning funding structures across payers would enhance continuity of care for all patient populations.

In closing, we appreciate the direction OHIC is taking with these proposed amendments. We believe these changes are a positive step toward securing sustainable primary care funding, reducing administrative barriers, and supporting high-quality healthcare across the state.

Thank you for considering our comments.

Sincerely,
Lisa P. Tomasso
Senior Vice President

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November 15, 2024

Commissioner Cory King
Office of the Health Insurance Commissioner
Department of Business Regulation
1511 Pontiac Avenue
Cranston, RI 02920

RE: AHIP Comments on Proposed Amendments to 230-RICR-20-30-4, Prior Authorization

Dear Commissioner King,

America's Health Insurance Plans appreciates this opportunity to provide the Office of the Health Insurance Commissioner (OHIC) and the Department of Business Regulation with information on how health insurance providers use Prior Authorization (PA) as an important tool to ensure safe, effective, and evidence-based care for patients and to help prevent over-utilization perpetuated by fraud. We hope that AHIP can be a resource for you as OHIC considers rulemaking that impacts the ability for health carriers to employ utilization management tools while providing access to care producing high quality outcomes.

We are aligned with OHIC's commitment to increase access to high-quality, affordable health care for everyone in Rhode Island. We believe these aims are best achieved when the regulations and policies are not overly restrictive, since we would want to ensure policies do not inadvertently harm patient safety and increase health care costs for all patients.

AHIP urges OHIC to consider more reasonable approaches to reduce the administrative burdens of PA that do not rely on arbitrary standards. This could include collaborating with insurers and providers to require the use of electronic prior authorizations, and monitoring adoption and compliance with the Centers for Medicare and Medicaid Services' interoperability rules. Furthermore, we urge OHIC to collect data from both insurers and providers on existing PA requests and determinations, including any associated trends, prior to implementing broad restrictions. This would help give a holistic view of what the actual issues are so that policies may be tailored to best fit Rhode Island's needs.

Prior Authorization

We are concerned with § 4.11(F)(2)'s mandate that health insurers reduce PA volumes by 20% compared to the 2023 baseline volume on a normalized per member per month basis, with an emphasis on services, treatments, or procedures ordered by primary care providers. Over the past few years, health insurers have taken several steps to streamline PA processes and volumes using measures that engage all stakeholders that not only protect the safety of patients, but which helps to rein in health care costs. Requiring a 20% reduction appears arbitrary and may potentially be overly restrictive given the stages at which various health insurers are with their PA overhauls.

PA is used to prevent potential negative impacts to the patient, ensure medical necessity and clinical appropriateness. It is also utilized to prevent waste and unnecessary care. When needed, PA is a proven tool to ensure patients get the most up to date evidence-based care.

Health insurance providers continue to collaborate with health care providers and other stakeholders to implement innovative solutions to improve the prior authorization process. An AHIP clinical appropriateness project with Johns Hopkins found that almost 90% of health care providers practice consistent with evidence-based standards of care.[1] Still, 30% of all heath care spending in the U.S. may be unnecessary, and in many cases harmful to patients. Every year low-value care costs the U.S. health care system $340 billion. Prior authorization is an important tool health insurers utilize to ensure high value care is delivered to patients, while reducing waste in health care spending. Providers have shown to also share in the goal of ensuring patients are getting proven, high value care. Eighty-seven percent of doctors have reported negative impacts from low-value care.

Prior authorization is critical to ensuring safe, effective, and cost-efficient health care for patients.

Health insurance providers are focused on ensuring that patients get the right care, at the right time, in the right setting, and covered at a cost that patients can afford. Insurers are uniquely positioned to have a holistic view of a patient's health care status and thus can use PA as an effective tool to lower a patient's out-of-pocket costs, protects patients from overuse, misuse or unnecessary (or potentially harmful) care, and ensure care is consistent with evidence-based practices before care is delivered.

When providers and plans work together, the patient benefits with better outcomes and less financial burden. Health insurance providers continue to innovate and collaborate with providers and other stakeholders to implement solutions to promote evidence-based care and improve the prior authorization process. Examples include:

- Streamlining prior authorization for complete courses of treatment for musculoskeletal and other conditions.
- Promoting electronic prior authorization requests and decisions.
- Providing feedback to health care providers on their performance relative to their peers and professional society guidelines.
- Waiving prior authorization for providers with a demonstrated track record in practicing evidence-based care.

PA also promotes the appropriate use of medications and services by helping to confirm that they do not interfere with other types of medications or potentially worsen existing conditions. This includes verifying that medications are not co-prescribed that could have dangerous, even potentially fatal, interactions. Additionally, PA helps to ensure that medications and treatments are safe, effective, and appropriate.

It also provides guardrails to help ensure that drugs and devices are not used for clinical indications other than those approved by the Food and Drug Administration or those that are supported by medical evidence. And finally, it helps to ensure that patients with a newly prescribed medication or course of treatment will receive accompanying services such as counseling, peer support, or community-based support, as appropriate.

The use of PA is based on evidence-based medical criteria developed by nationally recognized entities. One study shows that the amount of medical knowledge ***doubles every 73 days***.[2] And according to another study from the Journal of Internal Medicine, primary care providers would have to practice medicine for nearly 27 hours per day to keep up with the latest guidelines.[3] Thus, PA helps providers ensure they are adhering to the most up-to-date evidence-based standards.

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[1] *Clinical Appropriateness Measures Collaborative Project.* America's Health Insurance Plans. December 2021. https://www.ahip.org/documents/AHIP_AppropriatenessMeasures_2022.pdf.

[2] Densen, Peter. *Challenges and Opportunities Facing Medical Education.* Transactions of the American Clinical and Climatological Association 2011. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3116346/.

[3] Porter J, Boyd C, Skandari MR, Laiteerapong N. *Revisiting the Time Needed to Provide Adult Primary Care.* Journal of General Internal Medicine. January 2023. https://pubmed.ncbi.nlm.gov/35776372.

Even with these fast-paced innovations, health insurance providers use PA sparingly, with the percentage of covered services, procedures, and treatments requiring PA at less than 15%.[4] Additionally, 73% of insurance providers reported that initial prior authorization requests are denied because the requested procedure or medication is not clinically appropriate for the patient based on medical literature or clinical guidelines.[5] On appeal, 91% of insurers report that a denial is for failure to follow medical literature or clinical guidelines.[6]

Health insurance providers are committed to working with providers to streamline the prior authorization process.

It is important to note that PA programs are collaborative – health insurance providers use provider input to help ensure treatment plans are protecting patient safety, improving outcomes, and controlling costs. In this spirit, in January 2018, AHIP, together with providers and hospitals, issued a joint consensus statement on steps forward on improving the PA process in all aspects of the healthcare system. [7]

Recent surveys show that health insurance providers are waiving or reducing PA requirements, - between 2019 to 2022, the percentage of plans waiving or reducing PA based on participation in risk-based contracts increased from 25% to 46% for medical services, from 25% to 46% and from 5% to 8% for prescription medications.[8]

AHIP and our members promote the use of electronic authorization (ePA). However, this will only work when providers are also included in this transaction to ensure that the program is as effective and efficient as possible. For instance, even though almost all health insurance providers offer ePA, 60% of PA requests for medical services are still being submitted manually by providers, and over a third of PA requests for medications are submitted manually.[9]

In January 2020, AHIP along with two technology partners and several member insurance providers, launched the Fast Prior Authorization Technology Highway (Fast PATH) initiative to better understand the impact of electronic prior authorization on improving the prior authorization process.[10] AHIP's Fast Path study shows:

- 60% of experienced users (providers) said electronic prior authorization made it easier to understand if prior authorization was required.
- The median time between submitting a prior authorization request and receiving a decision from the health plan was more than three times faster, falling from 18.7 hours to 5.7 hours in processing time – a 69% reduction.

As plans continue to take additional steps with encouraging ePA, the 2019 CAQH (Council for Affordable Quality Healthcare) Index conducted a study to measure progress in reducing the costs and burden associated with administrative transactions exchanged across the medical and dental industries.[11] During this study, CAQH found of the $350 billion dollars spent on healthcare administrative costs in 2019, $40.6 billion was spent on administrative transactions and the health care market could have saved $13.3 billion

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[4] *Prior Authorization: Selectively Used & Evidence-Based: Results of an Industry Survey.* America's Health Insurance Plans. https://www.ahip.org/wp-content/uploads/Prior_Authorization_Survey_Infographic.pdf.
[5] *Key Results of Industry Survey on Prior Authorization.* AHIP. June 8, 2020. https://www.ahip.org/resources/key-results-of-industry-survey-on-prior-authorization.
[6] *Id.*
[7] *Consensus on Improving the Prior Authorization Process.* American Hospital Association, America's Health Insurance Plans, American Medical Association, American Pharmacists Association, Blue Cross Blue Shield Association, and Medical Group Management Association. Available at https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf.
[8] *Improving Prior Authorization Processes: How Health Insurance Providers Are Delivering on their Commitments.* America's Health Insurance Plans. https://www.ahip.org/documents/202207-AHIP_1P_Consensus_Statement_Actions-v02.pdf.
[9] *Id.*
[10] *Prior Authorization: Helping Patients Receive Safe, Effective, and Appropriate Care.* America's Health Insurance Plans. https://www.ahip.org/prior-authorization-helping-patients-receive-safe-effective-and-appropriate-care. ,
[11] *2019 CAQH Index.* CAQH. https://www.caqh.org/news/caqh-2019-index-133-billion-33-percent-healthcare-administrative-spend-can-be-saved-annually.

by automating utilization management tools. Therefore, AHIP recommends stakeholders consider exploring available pathways to increase provider adoption of electronic prior authorization technology.

Also, the Centers for Medicare & Medicaid (CMS) released the Advancing Interoperability and Improving Prior Authorization Processes final rule early this year which requires plans in federal programs to build and maintain four new application programming interfaces (APIs): 1) to enable electronic prior authorization, 2) to share large-scale population health data files with providers for value-based care, 3) allow patients to more easily access their claims and clinical data, and 4) to support coordination of care when a patient moves from one payer to another. Industry and health care stakeholders are analyzing this nearly 900-page rule. We look forward to having additional discussions through our state partners on this important development.

Gold Carding

AHIP cautions against policies that restrict prior authorization through gold carding programs. Section 4.11(F)(3) requires health insurers to develop and implement programs involving selective PA requirements, based on stratification of health care providers' performance, among other things. The proposed rule also requires health insurers to, at least annually, conduct a review of medical services, including behavioral health services and prescription drugs, subject to PA, to determine whether to remove PA requirements.

Broadly waiving PA and mandating gold carding programs could lead to clinically inappropriate care, exposing patients to potential harm by using a service or drug where there is little to no evidence of clinical benefit, and could raise costs for all consumers and purchasers.

Patients should expect to receive safe and appropriate care 100% of the time, period. Allowing for any percentage of care that is medically inappropriate will significantly limit a carrier's ability to ensure health care dollars are used most efficiently to produce high quality health outcomes, effectively ending provider accountability for fraud, waste, and abuse.

Eliminating PA by mandating broad gold carding programs will significantly and negatively impact the Rhode Island's health care system. With Texas' experience implementing its gold carding law, HB 3459 which passed in 2021, we now have a better picture of these impacts. Aside from the overly complex implementation process, ***the law is estimated to increase premiums for small businesses and individuals by more than $1 billion annually in the fully insured market alone.***[12] ***Just one health plan estimated that the gold carding mandate may cost consumers $500 million a year to end prior authorizations – a figure that is estimated for just its members.***[13]

Another Texas plan used back surgeries as an example of a procedure that is a high-cost intervention for medical issues that could potentially benefit from less extreme, and more affordable, care delivery approaches to highlight the cost impacts of the gold carding mandate.[14] Under the law, employers would have to pay 100% back surgeries, even though they are inappropriate at least 10% of the time. ***The claims for this one procedure alone could cost the plan $150 million a year.***

Outside of Texas, a Milliman study found that eliminating PA could increase premiums by $20.1 - $29.52 PMPM – a total increase of $43 - $63 billion annually in the commercial market nationwide.[15] A second Milliman study of the PA landscape in nearby Massachusetts predicts the elimination of PA to increase premiums from $51.19 - $130.28 PMPM in the state. One key factor for these huge increases is due to

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[12] *Veto Letter Request to Governor Abbot on HB 3459.* Texas Association of Health Plans. June 3, 2021.
[13] *Id.*
[14] *Id.*
[15] Busch, Fritz S. and Stacey V. Muller. *Potential Impacts on Commercial Costs and Premiums Related to the Elimination of Prior Authorization Requirements*. Milliman Report. March 30, 2023. https://www.milliman.com/-/media/milliman/pdfs/2023-articles/8-18-23_bcbsa-prior-authorization-impact.ashx.

the elimination of the Sentinel Effect on providers[16]. When providers know they are being monitored, their performance tends to improve. Removing PA cuts out the one party that has the fullest view of patient care and that understands contraindications. As a result, health insurance providers have reported increased utilization when gold carding programs are put into place.

We are also concerned about the administrative difficulties of operationalizing gold carding programs which causes further confusion and frustration for providers and patients. Again, using Texas as an example, while the law had an effective date of January 1, 2022, implementation was delayed due to a particularly cumbersome rulemaking process.

Gold carding programs are most effective when provider performance is closely monitored because they are not appropriate for all providers and all services. Gold carding programs should:

- Be targeted to specific services and where provider performance can be regularly reviewed.
- Separate out prescription benefits from the medical benefits to allow for more tailored review processes and allow health plans and their PBM partners to fully utilize the safety and efficacy tools already in place to protect patients and consumers from harmful and costly drugs.
- Allow health insurance providers to monitor providers participating in these programs to ensure that the provider's standard of practice is consistent with the standard of safe, timely, evidence-based, affordable, and efficient care.
- Allow insurers to revoke a provider's participation in a gold carding program if a provider is not following those standards.[17]

These guardrails are necessary to ensure that providers who receive gold card privileges continue to deliver consistent patterns of high performance to the patients they serve. Health insurance providers thus need flexibility in operationalizing these programs to keep up to date with medical and safety innovations.

Finally, for the impacts of prior authorization to be fully studied, we ask providers to have a shared responsibility with insurers in submitting data as required under § 4.11(F)(5). Without such requirements, the data electively submitted by the provider population does not give a complete view of the provider experience and risks outliers having an outsized impact on any future policymaking if only a select few, with potentially extreme experiences, submit impact reports.

Thank you for your consideration of our comments. AHIP and its members stand ready to work with Rhode Island on this important issue. If you have any questions or concerns regarding our comments and would like to discuss these matters further, please contact Sarah Lynn Geiger at slgeiger@ahip.org or by phone (609) 605-0748.

Sincerely,

Sarah Lynn Geiger, MPA
Regional Director, State Affairs

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[16] Busch, Fritz S. and Peter Fielek. *Potential Impacts on Costs and Premiums Related to the Elimination of Prior Authorization Requirements in Massachusetts*. Milliman Report. November 29, 2023. https://www.milliman.com/-/media/milliman/pdfs/2023-articles/11-29-23_mahp-prior-authorization-impact.ashx

[17] *New Survey: Effective Gold Carding Programs are Based on Evidence and Value for Patients.* America's Health Insurance Plans. July 19, 2022. https://www.ahip.org/resources/new-survey-effective-gold-carding-programs-are-based-on-evidence-and-value-for-patients.

AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone. Visit www.ahip.org to learn how working together, we are Guiding Greater Health.

November 15, 2024

Charles Estabrook
Director of Policy
Office of the Health Insurance Commissioner
Via email: charles.estabrook@ohic.ri.gov

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

Dear Mr. Estabrook:

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

BCBSRI shares the goals of the Office of the Health Insurance Commissioner (OHIC) to improve access to primary care and reduce practitioners' administrative burdens. In fact, BCBSRI has been a leader in voluntarily making significant investments towards these goals. BCBSRI is also committed to achieving the Cost Growth Target, as affordability and access to care for all Rhode Islanders is dependent on containing the high cost of health care. Investments in the right places at the right time will be critical to our collective success. While we support OHIC's underlying goals in the proposed revisions to the Standards, we are concerned that the cumulative effect of increasing primary care expenditures and reducing prior authorization will have a negative impact on affordability. We urge OHIC to consider modifying and phasing in these changes over time to allow insurers to implement the changes thoughtfully with consideration to affordability.

With those general comments as background, BCBSRI offers the following specific comments.

Implementation Timeline

As discussed more fully below, BCBSRI has serious concerns with the timeline for implementation in the proposed Standards, which would require insurers to implement both primary care expenditure increases and prior authorization reductions in 2025. While OHIC states in the Regulatory and Cost Benefit Analysis (Cost Benefit Analysis) that it does not expect either requirement to increase overall medical costs, BCBSRI's experience suggests otherwise. Mitigating the impact to affordability will be even more challenging if insurers are required to rush through implementing these changes without sufficient time for thoughtful analysis. Moreover, insurers' financial solvency will be strained if required to potentially significantly increase medical expenses without an opportunity to incorporate those expenses in rates, particularly in the current environment of escalating medical costs. While BCBSRI recommends a number of revisions to the proposed Standards below, if nothing else, BCBSRI urges OHIC to revise the proposed Standards to begin implementation in 2026 rather than 2025.

Section 4.3(A)(18)(b)

The definition of "primary care expenditures" includes incentive payments, but leaves to the Commissioner's discretion an allocation methodology if the incentives are part of shared savings that are paid to an organization that includes non-primary care providers. Looking to the cost trend report as guidance for what the Commissioner might set as an allocation methodology given OHIC's indication at the public meeting that the primary care spending reporting is intended to align with the cost trend reporting, BCBSRI is concerned that the allocation methodology may not appropriately account for the portion of shared savings and other incentive payments that should be directed to primary care spend. The allocations in the cost trend report appear to vary widely among ACOs and provider groups, and have no correlation to any contract provisions or other agreements BCBSRI has with the organizations. BCBSRI is not privy to how the ACOs distribute the payments to the various kinds of providers in their practices. As such, OHIC should allocate the full amount of these payments to primary care expenditures so insurers can have predictability around what payments will count towards meeting the primary care spend requirements.

BCBSRI also recommends providing flexibility in the Standards to OHIC to update the primary care payment code list as needed to account for new codes and align with CMS or other industry standards as appropriate.

Section 4.3(A)(26)

BCBSRI recommends OHIC add an exclusion to the definition of "total annual medical expenditures" for high-cost claimants over a certain threshold, such as $750,000. As it is currently drafted, members with unpredictable non-recurring claims like neonatal intensive care unit stays or cell/gene therapies, which often exceed several million dollars, could materially impact the denominator of the primary care spend obligation. As these types of claims typically do not repeat year over year, including them in the denominator likely will skew the percentage of primary care spend, making it unpredictable for insurers to implement a plan to meet the required primary care spend percentages. For example, a one-time $3 million claimant would result in an additional $300,000 in required primary care spending in a given year, only to get reduced out the following year. Excluding high-cost claimants from the definition will provide stability and predictability to the primary care spend obligations.

Section 4.10(B)(1) — Primary Care Expenditures

While the percentage of primary care expenditures required by the Standards remains similar to the prior requirement, the changes in the methodology of that calculation will result in a significant increase in primary care spending, as OHIC acknowledges. As OHIC states in the Cost Benefit Analysis, it expects this requirement to result in a doubling of primary care spend through the end of the decade. While OHIC is optimistic that this increase in primary care spend will not result in a net increase in medical spend over time, it is not realistic to expect that these significant increases will be cost neutral, particularly in the early years of the measurement period.

Moreover, increasing the fee schedule or other spending on primary care could trigger increased spending in other areas, like behavioral health services, in order to comply with state and federal mental health parity requirements. The mental health parity regulations require insurers to

analyze payment rates for medical/surgical services and behavioral health services as part of their non-quantitative treatment limitation analyses. Increasing primary care reimbursement likely will require corresponding increases for comparable behavioral health services, which may significantly increase the expected financial impact of the revised Standards. These additional impacts were not considered in the Cost Benefit Analysis, but are likely to have a material impact on affordability. BCBSRI urges OHIC to perform additional analysis on the impact to affordability and the ability to achieve the Cost Growth Target before implementing these requirements.

If OHIC moves forward with these changes without additional analysis, BCBSRI recommends that OHIC revise the proposed Standards to implement the new primary care spend requirements in 2026 rather than 2025. In the first year specifically, BCBSRI would not expect to see any offset or redistribution of the increased primary care spend in other areas. Premium rates for 2025 have already been set without taking into account this additional primary care spend requirement, meaning implementing it in 2025 will result in inadequate rates for commercial insurers.

Moreover, requiring an increase of .5% in 2025 will be difficult to achieve in the limited time insurers will have to implement it. We expect OHIC will receive many comments on this proposed regulation, and responding to them before issuing the final rule will take time. Insurers will then have to make necessary adjustments to their fee schedules, provide 60 days' notice to providers of those changes, and potentially negotiate new contract provisions with ACOs before implementing the increases. By the time any fee schedule increases are effective, it will likely be mid-way through 2025, at the earliest. Rushing to implement the additional spend requirement will also not allow for thoughtful planning by insureds on how to mitigate the impact of additional spend on primary care on affordability. For these reasons, BCBSRI urges OHIC to consider shifting the initial year of the new requirements from 2025 to 2026, and the "final" year from 2028 to 2029. The initial base year of 2022 might similarly be shifted to 2023.

As primary care spending increases, it also will be important to ensure that the increased spend is directed in a way that provides the most impact to access and quality for Rhode Island residents. Even with the revisions, the Standards continue to require insures to pay per member per month (PMPM) infrastructure and care management payments to patient centered medical homes (PCMHs). While the certainty of fixed payments was important in the early stages of the PCMH practice transformation, it is important to ensure that those significant payments are being used wisely. BCBSRI asks OHIC to consider eliminating the PMPM payment requirement to allow insurers flexibility to find more appropriate mechanisms to support the important work done at PCMHs at a level that is fair for the work performed. As an example, BCBSRI now is allowing primary care providers to bill claims for care management services rather than just rely on PMPM payments as compensation. In addition to fairly compensating PCMHs for their care management activities, this change will serve as a mechanism to direct care management compensation directly to primary care providers rather than to broader organizations. Eliminating the PMPM requirement for care management beginning in 2026 would allow for a glidepath to a new system of compensating PCMHs and encourage innovation in funding PCMHs in the next phase of maturity.

4.11(F)(2) Prior Authorizations—20% reduction

BCBSRI supports OHIC's goal to reduce administrative burdens on providers where possible, particularly primary care providers, to ensure access and quality for Rhode Island residents. As OHIC is aware, BCBSRI has been a leader in this area, voluntary removing prior authorization for all behavioral health services and announcing a plan to reduce prior authorization requirements for primary care providers by nearly 65% in 2025. Notwithstanding, prior authorization has an important role in our healthcare system, ensuring patients receive safe, appropriate and cost-effective care. It is a critical lever in our collective efforts to improve affordability. As an example, an analysis released just this week concluded that hospitals performed more than 200,000 unnecessary back surgeries on Medicare members over a 3-year period resulting in approximately $2 billion in costs for "low value" procedures while patients were put at risk of poor outcomes.[1] Thoughtful removal of prior authorization can have benefits for providers, but if it is not done carefully with appropriate analysis, it will result in significant increases in medical expenses.

OHIC's proposal to require insurers to reduce prior authorization requirements by 20% by the end of 2025 is too much, too soon, and will not allow for the thoughtful analysis required to balance affordability with reduction of administrative burden. At a minimum, BCBSRI recommends OHIC revise the implementation date to the end of 2026, or provide a phased in approach over 2025 and 2026 to allow insurers time to identify the appropriate prior authorization requirements to remove to mitigate the corresponding increase in medical expenses.

The proposed standards also include a direction to insurers to prioritize reducing prior authorization requirements that most impact primary care providers. BCBSRI supports this prioritization, as reflected in its plan to reduce prior authorization requirements for primary care providers specifically in 2025. To this end, BCBSRI recommends that OHIC amend the proposed Standards to measure the reduction in prior authorization requirements with respect to primary care providers only to maximize the impact the reduction will have on this particularly overburdened segment of the provider population. As an illustration, BCBSRI's planned reduction of 65% of prior authorization requirements for primary care providers in 2025 will only result in an overall reduction of 13% across all providers. Focusing the reduction on primary care providers will avoid this dilution and result in a greater impact to that important provider segment. Services requiring prior authorization typically ordered by specialists are also often higher cost procedures, making it more difficult to balance a reduction in prior authorization requirements with affordability.

Additionally, using 2023 as a baseline will disproportionately impact BCBSRI and other insurers who have voluntarily taken actions to reduce prior authorization before 2023, as BCBSRI did by eliminating all prior authorization requirements for behavioral health services, for which it will not get credit in these new reduction requirements. BCBSRI suggests that OHIC allow for some credit for actions taken before 2023 to reduce prior authorization burdens.

[1] Medicare spent $2B on unneeded back surgeries (axios.com)

4.11(F)(3)—Prior Authorizations---Gold Carding

Finally, BCBSRI encourages OHIC to delay requiring implementation of the "gold carding" concept set forth in Section 4.11(F)(3). This concept was discussed in both OHIC's Administrative Simplification Task Force and in CTC's prior authorization workgroup without consensus on the issue, with both payers and providers raising questions and concerns. Moreover, implementing these programs with the current uncertainty of value-based care arrangements in the market would be counterproductive. If OHIC moves forward with this requirement in the Standards, then a significant timeframe for implementation should be granted, reflecting the extensive effort and expense necessary to design and develop the program.

In closing, BCBSRI reiterates its general support for OHIC's Affordability Standard efforts. We welcome the opportunity to share further feedback or explanation of the comments as appropriate.

Thank you for your consideration.

Sincerely,

Kristen Shea McLean

Kristen Shea McLean
Senior Vice President & General Counsel

cc: Michele Lederberg, Esq.

Christine Cooney
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November 27, 2024

Commissioner Cory King
Office of the Health Insurance Commissioner
1151 Pontiac Avenue
Cranton, RI 02920

Via email

Dear Commissioner King:

Thank you for the opportunity for Cigna Healthcare to provide comments on proposed amendments to 230-RICR-20-30-4: Powers and Duties of the Office of the Health Insurance Commissioner (OHIC). I would like to share come concerns regarding section 4.11 F. related to Prior Authorization.

As Cigna has shared previously, it is important to acknowledge that Prior Authorization (PA) promotes better health outcomes, lowers costs for patients and is an important tool that employers choose to combat premium inflation for employees (Rhode Island residents). Among other important benefits, precertification prior to services being provided allows Cigna the opportunity to confirm the patient's eligibility and available benefits based upon the current enrollment information; confirm the medical necessity of the proposed services; and evaluate the proposed setting and level of care to determine if it is clinically sound, safe and cost effective.

While eligibility, available benefits, and medical necessity can be determined after the service is provided, the failure to prior authorize denies Cigna the opportunity to effectively engage in other aspects of the precertification process which are designed to assist our customers to have access to high quality and cost effective care in the most appropriate setting.

Medical knowledge is growing at unprecedented rates and accelerating every year. This creates knowledge gaps for even the most talented physicians. Additionally, having deep knowledge and experience in one clinical area does not always translate to other areas. Prior Authorization can be used as a tool to address these gaps in knowledge, and this is an important benefit to patients that should not be overlooked. Prior authorization ensures that evidence-based clinical guidelines are applied to providers' requests to make sure they're in line with current medical science and best medical practices, which helps make sure patients receive the optimal treatment at the optimal site based on their individual diagnosis and prognosis. Additionally, utilization review creates a sentinel effect whereby performance improvement occurs because providers in a program know they are being evaluated. Without utilization review, this improvement dissipates.

Additionally, unnecessary tests, procedures, and therapies impact the quality of care patients receive, and increase costs for both consumers and the health care system. It is estimated that 21% of medical care provided in the U.S. lacks support in the available medical literature, equating to a cost of over $210 billion annually, and occurs across all specialties.[1]

Below, please find some specific concerns with the proposed regulations:

[1] https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0181970

Section 4.11 F.2.
"By the end of 2025, health insurers shall reduce the volume of prior authorization requests by 20% relative to baseline 2023 requests on a normalized per member per month basis for all insured lines of business. In meeting the reduction target, health insurers shall prioritize items, services, treatments, or procedures ordered by primary care providers."

A 20% reduction seems rather arbitrary and does not take into account varying starting points. For example, in August 2023, Cigna Healthcare announced the removal of nearly 25 percent of medical services from prior authorization (or precertification) requirements. https://newsroom.cigna.com/2023-08-24-Cigna-Healthcare-Removes-25-Percent-of-Medical-Services-From-Prior-Authorization,-Simplifying-the-Care-Experience-for-Customers-and-Clinicians With the removal of these more than 600 additional codes, the company has now removed prior authorization on more than 1,100 medical services since 2020, with the goal of simplifying the health care experience for both customers and clinicians. Less than 4% of medical services require a prior authorization for Cigna Healthcare plan members, but when they do, it is really about patient safety and experience, and to avoid unnecessary treatment.

Our goal is to eliminate most prior authorizations for physicians who are part of our fast-growing network of advanced, value-based care partnerships by 2026. We continuously review services, devices and their associated codes to determine if prior authorization is still necessary, and remove them if the clinical evidence has evolved, if they almost always get approved, if authorization denials often get overturned on appeal, or if the authorization is not aligned with our enterprise efforts to improve health equity. While we oppose this provision and request its removal altogether, at a minimum we request that OHIC consider adding an exception process to the reduction threshold.

Section 4.11. F.3.
"Health insurers shall develop and implement the use of programs that implement selective prior authorization requirements, based on stratification of health care providers' performance and adherence to evidence-based medicine with the input of contracted health care providers and/or provider organizations. Such criteria shall be transparent and easily accessible to contracted providers. Such selective prior authorization programs shall be available when health care providers participate directly with the insurer in risk-based payment contracts and may be available to providers who do not participate in risk-based contracts."

Focusing resources on implementing and maintaining goldcarding programs for a limited number of providers takes resources away from making PA as seamless and efficient as possible for all providers and patients. We are focused on addressing the root causes of provider and patient frustrations with prior authorizations, which is the misalignment of incentives in the current fee-for-service model, and moving toward deeper relationships with providers that will enable us to move beyond most authorizations.

Section 4.11. F.5.
"Health insurers shall submit a quarterly prior authorization report, in a form and manner determined by the Commissioner, that includes data on prior authorization requests, approval rates, and any other factors deemed relevant to the implementation and enforcement of this § 4.11(F) of this Part by the Commissioner."

While we understand that data reporting can be helpful to OHIC, we request that any new data elements be requested prospectively, as we would require sufficient lead time to have any reporting changes/enhancements tested and implemented. Additionally, it's unclear if quarterly reporting benefits would outweigh the additional efforts needed to collect the data. We would suggest requiring the prior authorization report at a frequency to be determined by the Commissioner, but not more than quarterly. We would also appreciate an opportunity to discuss any template prior to the implementation of the data collection to ensure that the data is available and provides OHIC with data that is meaningful and in line with intended uses.

We hope you can appreciate the value that prior authorization has in health care. For our part, we support that clinical review criteria be evidence-based and generally accepted as the standard of care and that there be transparency around what services require prior authorization. We also appreciate continuity of care provisions where appropriate.

And last, but not least, it's important to support the continued advancement of prior authorization automation as a solution to address many of the perceived challenges related to the prior authorization process.

Thank you for the opportunity to submit comments for your consideration. If you have any questions, please do not hesitate to contact me at (804.904.3473) or Christine.Cooney@cignahealthcare.com. We appreciate the opportunity to provide you with comments and look forward to ongoing conversations as you look to finalize the rules.

Sincerely,

Christine M. Cooney

Christine Cooney
Cigna Healthcare, State Government Affairs Manager, New England

Neighborhood Health Plan OF RHODE ISLAND™

910 Douglas Pike, Smithfield, RI 02917

November 22, 2024

Charles Estabrook

Office of the Health Insurance Commissioner

1511 Pontiac Ave, Building #69

Cranston, R.I. 02920

Subject: Comments on Proposed Amendments to 230-RICR-20-30-4

Dear Mr. Estabrook:

Neighborhood Health Plan of Rhode Island (Neighborhood) appreciates the opportunity offered by the Office of the Health Insurance Commissioner (OHIC) to provide public comment on the proposed amendments to 230-RICR-20-30-4. As a health plan committed to improving access to high-quality, affordable health care for Rhode Islanders, Neighborhood supports efforts to strengthen the primary care investment and reduce administrative burdens. While we support OHIC's commitment to evolving regulation for the benefit of Rhode Island's healthcare system, we have several concerns regarding the feasibility and unintended consequences of some of the proposed changes. We believe these regulations must strike a balance to avoid increases Rhode Island's commercial members healthcare costs and promote insurers and providers equal contribution to achieving shared goals.

Prior Authorization (§ 4.11(F))

Neighborhood is invested in streamlining prior authorization and reducing administrative burden. Since OHIC's convening of the Administrative Simplification Taskforce on Prior Authorization Reduction in 2022, Neighborhood began activities in the review and reduction of prior authorization. In 2023, Neighborhood organized a prior authorization committee to analyze Neighborhood's prior authorization data, processes and forms. As of November 2024, Neighborhood has broadly addressed burden for access to Durable Medical Equipment, Behavioral Health outpatient services, home care services, vision care services, allergen testing, acupuncture and chiropractic services. As of 1/1/2025, prior authorization for all behavioral health services, including inpatient, will be removed. Since 2021, Neighborhood has transitioned many formulary medications from requiring prior authorization to step therapy. Step therapy reduces provider burden and streamlines members' access to affordable and appropriate treatment. Neighborhood requests OHIC considers the efforts insurers have taken independently to reduce prior authorization burden on the healthcare system.

OHIC's proposed changes to prior authorization requirements may unintentionally limit insurers' ability to ensure the delivery of clinically appropriate and cost-effective care. For example:

> **Patient Safety:** Prior authorization processes play a critical role in preventing overutilization of inappropriate services and mitigating patient harm. A 20% reduction in prior authorization volume based on a 2023

baseline risks undermining necessary care management controls, especially without considering the potential impact on patient safety and healthcare costs.

Health Equity: Relaxing prior authorization requirements without addressing systemic inequities in care delivery due to coverage differences between commercial, Medicaid and Medicare could exacerbate disparities and negatively impact access to healthcare for those that are most in need.

Increase Costs: Reducing prior authorization oversight could lead to higher overall medical expenditures and directly impact the State's cost growth trend target.

Operational Complexity: Requirements for stratification of prior authorization by provider performance (so-called "gold carding") and annual reviews of prior authorization lists may significantly increase administrative burden for insurers and providers.

Neighborhood advises OHIC leverage reporting from both insurers and providers to develop prior authorization metrics and convene a committee prior to instituting targets. If OHIC elects to keep the 20% target, Neighborhood requests OHIC include activities that reduce provider burden in the measurement such as extension of prescription duration requests. Neighborhood advises OHIC to exclude non-formulary drugs from the target. Neighborhood recommends moving the timeline to the end of 2026 as measurement timelines need to align with the annual Rate Review process to account for increases in spend. Neighborhood encourages OHIC to consider alignment with federal efforts, such as Interoperability, and capitalize on streamlining electronic efficiencies that improve communication of prior authorization requests. Lastly, Neighborhood recommends that implementation timelines for gold carding and other operational mandates account for the resources needed to establish effective systems.

Primary Care Expenditures (§ 4.10(B))

Neighborhood supports investing in Rhode Island's primary care infrastructure. Neighborhood believes that quality healthcare starts with the primary care provider. Neighborhood is concerned with the ability to increase primary care reimbursement in the fee-for-service space. In Section 4.10(B)(1)(b), the directive is to increase total annual primary care expenditures across "all insured lines of business."[1] In the absence of increased funding for its government products, Neighborhood is concerned in it's ability to meet the regulation as currently written. If the regulation does not apply to non-commercial products, the regulation should be clarified as such. Additionally, while Neighborhood supports the advancement of value-based payments such as capitation with quality, given its low volume of commercial membership there are concerns about provider willingness to accept risk-based payments without sufficient population to spread the risk. Neighborhood requests OHIC clarify in the regulation that targets are based on the insurers' individual expenditures and not on market average.

[1] RI Security of State, " Powers and Duties of the Health Insurance Commissioner, Proposed Rule,"https://rules.sos.ri.gov/Promulgations/part/230-20-30-4

OHIC's current regulation binds insurers to an annual primary care spend target of 10.7% in which Neighborhood has met or exceeded annually since 2015. As noted in the New England State Consortium Systems Organization **"The New England States' All-Payer Report on Primary Care Payment"**[2], the methodology and definition of primary care provider used in the current regulation has shown minimum impact on primary care. In the proposed regulation, OHIC has adopted some of the building blocks proposed by the Primary Care Investment Workgroup (The Workgroup) in the **"Primary Care Investments Are Top of Mind for Many New England States"**[3] article that included changes to the primary care expenditure obligation and definition of primary care. The lessons learned of The Workgroup also included the importance of developing "measures of success related to those investments." and of defining "the data required to support the "measures of success." Neighborhood recommends that OHIC leverage stakeholders to create "measures of success" to develop holistic measures of primary care investment, such as percent improvement target of the primary care provider full-time employee rate. Neighborhood also recommends extending the increase expenditure target date out to 2032.

Primary Care Provider Definition (§ 4.3(A)(20))

Neighborhood supports OHIC's proposed definition of primary care provider as it promotes flexibility for specialty providers and behavioral health practitioners to expand their breadth of service and support efforts to address primary care workforce shortages.

Conclusion

Neighborhood appreciates OHIC's ongoing efforts to improve health outcomes, affordability, and care delivery across Rhode Island. As a committed partner in this endeavor, we urge OHIC to carefully consider the impact of finalizing this rule will have on Rhode Island's commercial members healthcare costs and how costs directly impact premiums and affordability. We look forward to continued collaboration and stand ready to assist in refining these regulations for the benefit of all Rhode Islanders.

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

Sincerely,

Elizabeth McClaine

Vice President of Commercial Products

Neighborhood Health Plan of Rhode Island

[2] New England States Consortium Systems Organization (NESCSO). (2020, December 22). The New England States' all-payer report on primary care payments. NESCSO. **https://nescso.org/wp-content/uploads/2021/02/NESCSO-New-England-States-All-Payer-Report-on-Primary-Care-Payments-2020-12-22.pdf**

[3] Milbank Memorial Fund. (n.d.). Primary care investments are top of mind for many New England states. Retrieved November 22, 2024, from https://www.milbank.org/news/primary-care-investments-are-top-of-mind-for-many-new-england-states/

November 15th, 2024

Commissioner Cory King
Office of the Health Insurance Commissioner
Department of Business Regulation
1511 Pontiac Avenue
Cranston, RI 02920

RE: PCMA Comments on Proposed Amendments to 230-RICR-20-30-4, Prior Authorization

Dear Commissioner King,

On behalf of the Pharmaceutical Care Management Association (PCMA), I am writing you to provide our comments related to the Office of Health Insurance Commissioner and the Department of Business Regulation with information on how Prior Authorization (PA) is an important tool to help ensure patients get appropriate medications to treat their health conditions in the safest, most cost-effective way. PCMA is the national association representing pharmacy benefit managers (PBMs), which administer prescription drug plans for millions of Americans with health coverage provided through large and small employers, health plans, labor unions, state, and federal employee benefit plans, and government programs.

Prior Authorization promotes coverage of clinically appropriate, lower-cost drugs.

We are concerned with § 4.11(F)(2)'s mandate that health insurers reduce PA volumes by 20%. We believe this number is arbitrary and does not improve the patient experience in the long run. Concerns are related to drug-to-drug interactions and the rise in premiums with reduced PA. Instead, PCMA suggests providers use real-time benefits tools, and electronic prior authorization can shorten review times, ease provider administrative burden, and improve transparency.

Prior authorization is needed operationally to ensure the medication is clinically justified and appropriate to treat the patient's medical condition. The prior authorization process requires a prescriber to provide updated clinical information to the plan about the appropriateness of a drug. Drugs that require prior authorization typically have dangerous side effects and are harmful when combined with other drugs. Prior authorization is important as there are also equally effective, less costly drugs that would work.[1]

According to the National Academies of Sciences, Engineering, and Medicine (NASEM): "Every plan, whether Part D or an employer-sponsored pharmacy benefit, has an exception process that permits coverage of a drug not on formulary or reduces out-of-pocket cost if a physician provides information about side effects the patient has experienced from a lower tiered drug or offers another medical reason for switching."

[1] GoodRx. 2020. "What is Prior Authorization? A Look at the Process and Tips for Approval." https://www.goodrx.com/insurance/health-insurance/prior-authorizationwhat-you-need-to-know.

Pharmaceutical Care Management Association
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Plans and PBMs rely on independent Pharmacy and Therapeutics (P&T) Committees, comprised of physicians, pharmacists, and other medical professionals, to develop evidence-based guidelines for drug management programs, including prior authorization and other utilization management tools, to ensure that these management controls do not impair the quality of care.[2] After safety and quality are considered, cost is evaluated. Sometimes, there are many drugs—multiple brand name drugs and/or generic drug options—that treat the same condition. Typically, a generic is more affordable than its associated brand name drug, and when there are multiple brands in the class, there is typically one that has a lower net cost than the other(s). In this case, a utilization management program may require a prescriber to provide an explanation about why the more expensive drug is necessary.

Real time benefits tools and electronic prior authorization can shorten review times, ease provider administrative burden, and improve transparency.

Electronic prior authorization (ePA) is a useful tool that allows PBMs and prescribers to communicate electronically instead of using fax machines and voice calls, which are expensive and time-consuming.

Real time benefit tool (RTBT) technology allows prescribers to see the plan formulary, the patient's cost share, and other requirements at the time of prescribing. This helps the prescriber understand if documentation is required before coverage, and helps the patient understand their options and costs.

Although 75% of pharmacy prior authorizations are fully electronic and use the industry standard format (NCPDP SCRIPT) for PA[3], many prescribers are still using voice calls and fax machines. In today's world,100% of prescribers should be using electronic tools.

Thank you for considering our comments. PCMA and its members pledge to work with Rhode Island and the Department on this critical issue. If you have any questions or concerns regarding our comments, please contact Sam Hallemeier at shallemeier@pcmanet.org or by phone at (202) 579-7647.

Sam Hallemeier

Sr. Director, State Affairs
shallemeier@pcmanet.org
(202) 579-7647

[2] Visante. 2023. "Increased Costs Associated with Proposed State Legislation Impacting PBM Tools," p. 8. https://www.pcmanet.org/wp-content/uploads/2023/01/Increased-Costs-Associated-With-Proposed-State-Legislation-Impacting-PBM-Tools-January-2023.pdf.

[3] CAQH. 2020. "Issue Brief: The 2019 CAQH Pharmacy Services Index," pg. 2. https://www.caqh.org/sites/default/files/explorations/index/index-pharmacy-brief.pdf.

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

November 15, 2024

Re: *Comments on Proposed Amendments to 230-RICR-20-30-4, Affordability Standards and Prior Authorization*

Dear Commissioner King:

On behalf of Point32Health, the parent company of Harvard Pilgrim Health Care, I appreciate the opportunity to submit written comments to the Office of the Health Insurance Commissioner ("OHIC") relative to the proposed amendments to 230-RICR-20-30-4 *Powers and Duties of the Office of the Health Insurance Commissioner*. Point32Health provides high-quality, nationally recognized health care coverage to 1.9 million members across New England, including thousands of Rhode Island residents. Our commitment stems from our purpose, which is to guide and empower healthier lives for everyone, regardless of age, health, race, identity, income, and area.

As a stakeholder, we recognize that making health care more affordable is a shared responsibility and a duty we take seriously. We appreciate OHIC's leadership towards this goal, but believe that some of the proposed changes will have the opposite effect. We ask that you consider our comments below as you work to finalize the regulation.

§ 4.10 Affordability Standards

Threshold

One of our chief concerns with the proposed revisions of § 4.10 Affordable Health Insurance – Affordability Standards is lowering the threshold for compliance with the delivery system and payment reform strategies from 10,000 covered lives to 5,000.

As noted in OHIC's Regulatory & Cost-Benefit Analysis, without greater enrollment and membership, it is unlikely that we will be able to comply with several of the regulatory requirements imposed in §4.10.[1]

[1] "To account for the secular decline in the size of the fully insured market, the threshold for compliance with the delivery system and payment reform strategies set forth in § 4.10 is lowered from 10,000 covered lives to 5,000. Where satisfaction of regulatory requirements, such as risk-based contracting, is not technically feasible without greater enrollment, insurers may seek a waiver

Therefore, while we appreciate the opportunity to seek a waiver if compliance with certain requirements is currently unachievable, we respectfully request clarification as to how compliance would be achievable for carriers with membership levels below the current threshold of 10,000 covered lives and how compliance would improve the overall cost of health care. In addition, we believe there needs to be some transition period for carriers to implement all of the requirements in § 4.10. Requirements around primary care and behavioral health expenditures and contracting through alternative payment models and other valued-based arrangements will take time to discuss with providers given our low membership levels and, if an option, implementation is unlikely to be accomplished in only one year's time. Therefore, should OHIC move forward with lowering the threshold, we would request close partnership as we work towards compliance and meeting the requirements enumerated therein.

Primary Care and Behavioral Health Expenditures

Primary care is the backbone of our health care delivery system, and we believe provisions aimed at increasing primary care expenditures are an important first step towards reforming the way we pay and deliver health care services.

It is critical, however, that increased investments in primary care and behavioral health do not add to overall health care costs. Health care affordability remains a top concern for all Rhode Island residents, particularly at a time when the state is reporting record highs in medical trend Therefore, any requirement to increase funding for primary care must be coupled with offsets to other areas of spending to ensure that the overall cost of care does not increase unsustainably and place additional cost burdens on employers and consumers.

§ 4.10 (B)(1) revises the primary care expenditure obligation by requiring total annual primary care expenditures to be at least 10% of total annual medical expenditures by 2028. While we support the incremental approach proposed here by OHIC, Point32Health remains concerned the additional spending, without identified efforts to rein in spending elsewhere, will add to affordability pressures in the market.

As part of the combination of Tufts Health Plan and Harvard Pilgrim Health Care, we transitioned our membership from Tufts Health Plan to Harvard Pilgrim Health Care products throughout the 2024 calendar year on anniversary date to be completed for January 1, 2025, whereby all our Rhode Island group membership will be using Harvard Pilgrim Health Care products. Due to this transition, there was no Harvard Pilgrim membership on RI employer plans in 2022. Therefore, we would need to work closely with OHIC to evaluate what benchmark levels of spending are relevant for the requirements within § 4.10 to ensure consistency and, more specifically, that we are evaluating the correct population(s).

under § 4.10(F)(2)" Office of the Health Insurance Commissioner. Proposed Amendments to 230-RICR-20-30-4 Regulatory & Cost Benefit Analysis.https://ohic.ri.gov/regulations-and-enforcement/regulations

§ 4.11 Administrative Simplification: (F) Prior Authorization

Overview

Prior authorization is a carefully developed, scientifically derived, set of patient protections designed to ensure that the premium dollars employers and consumers pay to health plans are spent on clinically appropriate, evidenced-base care. When appropriately utilized, prior authorizations have a demonstrated benefit of avoiding unnecessary care and containing health care costs, as well as an effective tool to avoid fraud, waste and abuse. With continued growth in medical spending, it is imperative that we ensure the right care is delivered at the right time in the right setting – and covered at a cost both consumers and employers can afford. Prior authorization remains a valuable tool for doing that.

We also recognize that prior authorization can be burdensome for some providers and is a source of tension between providers and payers. We are committed to reviewing our prior authorization policies regularly and removing codes and services with high historical approval rates and where the standard of practice is appropriate. We also see great promise in the automation of prior authorization. The Centers for Medicare and Medicaid Services (CMS) Interoperability and Prior Authorization Final Rule requires plans in federal programs to streamline the prior authorization process by implementing and maintaining a Prior Authorization Application Programming Interface (API). With implementation of the CMS Rule underway, we anticipate significant provider burden to be alleviated when fully functional and operational in the near future.

We are concerned that efforts to limit prior authorization now will lead to higher medical spending and erode whatever value will come from the infrastructure investments needed to enable automation.

§ 4.11 Administrative Simplification: (F) (2)

This subsection requires insurers, by the end of 2025, to reduce the volume of prior authorization requests by 20% relative to baseline 2023 requests on a normalized per member per month basis. Our first concern with this proposed requirement is the lack of data that shows where plans are relative to one another relative to the use of prior authorization. Other than provider anecdotes, we do not know how much prior authorization exists in the market – neither the number of services that require authorization nor the dollar value associated with those services. We cannot compare authorization levels between plans. We would also note that there is ample evidence that as much as 60% of the time, providers request authorizations when they do not need one according to plan rules. For these reasons, a broadly-imposed 20% reduction of prior authorization across all carriers feels arbitrary without more data to support it. Such a standard also does not acknowledge work carriers have done recently to remove codes and services from authorization.

Prior to the enforcement or adoption of a targeted percentage reduction on prior authorization, OHIC should prioritize the data collection established in *§ 4.11 (F)(5),* which requires insurers to submit quarterly prior authorization reports on requests, approval rates and any factors deemed relevant.

As currently drafted, *§ 4.11 (F)(2)* imposes the burden on carriers to reduce the "volume of prior authorization requests", which is out of carriers' control (see above comments). We do not believe this measurement will result in the intended purpose of the regulation to reduce provider burden. Lastly, in § 4.11 (F)(2), we would request clarification on the "*20% reduction relative to baseline 2023 requests on a normalized per member per month*" to ensure our understanding of this calculation *and how OHIC may enforce it.*

Cost, + Access

In 2023, Milliman released a report on the impacts of health care costs, consumer out-of-pocket costs, and insurance premiums in Massachusetts if prior authorization was eliminated.[2] For the MA commercial market, Milliman found that removing health plans' ability to conduct prior authorization would result in annual premium increases between $2.2B and $5.6B.[3]

The study also considered the impact of eliminating prior authorization on the "sentinel effect." As it relates to prior authorization, the sentinel effect refers to the tendency of providers to refrain from ordering tests, procedures or treatments when approval for those services is subject to external review. Milliman estimated eliminating the sentinel effect by restricting prior authorization could increase premiums an additional 5.6% to 16.7%. [4] In other words, prior authorization prevents ordering of some unnecessary services and removal of prior authorization will lead to services being otherwise ordered despite being unnecessary or inappropriate.

Separately, Blue Cross Blue Shield Association engaged Milliman to model the potential cost impacts that can result from generally limiting or eliminating prior authorization on the commercial markets in the United States.[5] The report estimated premium increases could total between $43B and $63B annually if prior authorization is eliminated.[6]

§ 4.11 Administrative Simplification: (F) (3) – Gold Carding

Section 4.11(F)(3) requires insurers to develop and implement the use of programs that implement selective prior authorization requirements, based on the stratification of health care providers' performance and adherence to evidence-based medicine with the input of contracted health care providers and/or provider organizations.

We are adamant that any gold carding arrangements must include a risk-based contract or value-based arrangement with the provider. Risk arrangements ensure that providers have skin in the game and have financial incentives to adhere to appropriate clinical guidelines. While we are actively exploring how to implement and monitor gold carding arraignments with providers, our ability to do so in Rhode Island with low membership volumes through risk arrangements is

[2] Busch, Frederick and Fielek, Peter. Potential Impacts on Costs and Premiums Related to the Elimination of Prior Authorization Requirements in Massachusetts. (2023). https://www.milliman.com/en/insight/potential-impacts-costs-premiums-elimination-prior-authorization-massachusetts;
[3] Id.
[4] Id.
[5] Busch, Fritz S. and Stacey V. Muller. *Potential Impacts on Commercial Costs and Premiums Related to the Elimination of Prior Authorization Requirements* (2023) https://www.milliman.com/-/media/milliman/pdfs/2023-articles/8-18-23_bcbsa-prior-authorization-impact
[6] Id.

challenging. Additionally, we believe gold carding programs need to be more tailored to specific services and to provider groups with good historical adherence to clinical guidelines and a pattern of requests that result in a high-level, if not perfect level, of approvals as opposed to a pattern of denials. We are concerned that gold carding mandates can reward poor provider behavior and lead to the reduction of administrative tools designed to control spending and ensure the appropriate delivery of care.

Thank you for the opportunity to offer written comments. Please let us know if we can provide any additional information.

Sincerely,

Adam Martignetti
Point32Health
Vice President
State Government Affairs & Advocacy
Adam.Martignetti@Point32Health.org

STATE OF RHODE ISLAND
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Peter F. Neronha
Attorney General

November 15, 2024

VIA EMAIL ONLY

Office of the Health Insurance Commissioner
Attention: Charles Estabrook
1511 Pontiac Avenue
Building 69, First Floor
Cranston, Rhode Island 02920
Charles.Estabrook@ohic.ri.gov

Dear Mr. Estabrook,

The following Public Comment is submitted on behalf of the Office of Attorney General ("Attorney General") in response to the proposed amendment to 230-RICR-20-30-4: Powers and Duties of the Health Insurance Commissioner ("Proposal"). The Attorney General submits this comment in his role as the state's health care advocate, pursuant to which he is empowered to, "advocate for any changes necessary and appropriate . . . to support the goal of quality and affordable health care for all . . .." R.I. Gen. Laws § 42-9.1-2(a)(5).

The Rhode Island health care system is in crisis, with myriad signs that conditions are continuing to deteriorate. As of the 2022 Health Information Survey, only 2.9% of Rhode Islanders did not have health insurance, which is good news.[1] Yet, 11.6% of adult Rhode Islanders reported not having a regular place they can access health care.[2] Rhode Island has also struggled to maintain an adequate health care workforce. In the next 6 years, the state will need 99 more primary care doctors

[1] HealthSourceRI, "Rhode Island Achieves Lower ever Uninsured Rate," August 30,2022, https://healthsourceri.com/rhode-island-achieves-lowest-ever-uninsured-rate-survey-finds/
[2] The Commonwealth Fund, " Adults with a Usually Source of Care," https://www.commonwealthfund.org/datacenter/adults-usual-source-care

to meet demand. [3] The State's current provider shortages in primary care are only projected to get worse.[4] And again, while premium rates continue to rise, Rhode Island's reimbursement rates remain lower than our neighboring states, which is likely to contribute to these shortages.[5] The average inpatient and outpatient standardized price paid by employer sponsored health plans were lower in Rhode Island than in both Massachusetts and Connecticut,[6] meaning that revenues for providers are constrained even as consumers pay more.

Primary care providers serve a critical role in our health care system; seeing and treating patients; providing the care that keeps these patients out of emergency rooms; and allowing for continuation of care. These providers are the cornerstone of a healthy health care system. Yet, in Rhode Island, primary care providers are shackled with a combination of high administrative burdens and low payments. An American Medical Association survey of its members found that on average, physicians and their staff spend 12 hours each week completing prior authorizations.[7] Ninety-five percent of the physicians that responded to the survey reported that the current prior authorization demands are increasing provider burnout.[8]

Increasing payments to primary care providers and decreasing the burden of prior authorization, as this regulation proposes, are two important elements in mitigating the deficiencies in the Rhode Island health care system. As such, this proposed regulatory update is an important first step in addressing two of the many challenges that burden the Rhode Island health care system. At the same time, the Attorney General encourages OHIC to be more aggressive in its proposal. As set forth more fully in this comment, the Attorney General encourages OHIC to (1) provide a detailed explanation of its choice to require a 20% reduction in prior authorizations, rather than a larger

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[3] Robert Grahm Center, "Rhode Island: Projecting Primary Care Physician Work Force," https://www.graham-center.org/content/dam/rgc/documents/maps-data-tools/state-collections/workforce-projections/Rhode%20Island.pdf

[4] OHIC, Primary Care in Rhode Island: Current Status and Policy Recommendations 17-18 (December 2023), https://ohic.ri.gov/sites/g/files/xkgbur736/files/2023-12/Primary%20Care%20in%20Rhode%20Island%20-%20Current%20Status%20and%20Policy%20Recommendations%20December%202023.pdf.

[5] The Providence Journal, "Finding a primary care doctor in Rhode Island is getting more difficult. Here's why,' February 8, 2024, https://www.providencejournal.com/story/news/healthcare/2023/02/08/primary-care-doctor-shortage-in-ri/69843973007/.

[6] Rhode Island Foundation, "Examining the Financial Structure and Performance of Rhode Island Acute Hospitals and Health System," Page 8, March 2024, https://assets.rifoundation.org/documents/RIF-Hospital-and-Health-Systems-Study_March-FINAL.pdf

[7] American Medical Association, "2023 AMA Prior Authorizations physician survey," https://www.ama-assn.org/system/files/prior-authorization-survey.pdf

[8] *Id.*

reduction, (2) ensure any reduction in prior authorization levels is made from a baseline that complies with existing legal constraints, (3) clarify its intent to enforce existing law and regulation surrounding prior authorization, and (4) require that any increased investment in primary care results in increased payments and supports to primary care providers. The crisis plaguing the Rhode Island health care system demands more than piecemeal action; Rhode Islanders deserve aggressive enforcement of current law and robust solutions.

I. Prior Authorization

The Attorney General agrees that a reduction in prior authorization volume is a necessary step to relieve the excessive administrative burdens faced by primary care providers. However, the proposed regulations lack the necessary support, enforcement options, and public accountability to provide the benefit Rhode Island providers deserve.

The Proposal would require that health insurers reduce prior authorization volume by 20%. OHIC spent only two pages on its regulatory and cost benefit analysis describing this reduction.[9] In doing so, it did not explain why a 20% reduction would provide meaningful relief to providers and consumers. The only explanation provided was that insurance companies had already agreed to reduce prior authorization by 20%.[10] Even looking at the publicly available information on this agreement, it remains unclear what studies or analysis OHIC did or relied upon to decide that a 20% reduction would result in a meaningful reduction of the administrative burden for providers.[11]

Insurance companies benefit financially from utilization management. A reduction of prior authorizations, one utilization management tool, may lead to greater access to more costly care, thus resulting in a decrease in their bottom line. A number reached by those with a financial incentive to keep reduction in prior authorization low should be considered the floor and highly scrutinized by the Commissioner. The Attorney General encourages OHIC to release a fully fleshed out explanation as to why only a 20% reduction in prior authorization is a warranted starting point.

The burden needs to shift to the insurance companies to produce documents that show why any prior authorization should be required *at all*. The Attorney General understands that OHIC plans

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[9] Rhode Island Secretary of State, "Proposed Amendments 230-RICR 20-30-4 Regulatory and Costs Benefit Analysis," https://risos-apa-production-public.s3.amazonaws.com/DBR/13207/STD_13207_20241011095039962.pdf

[10] *Id.*

[11] The Office of the Health Insurance Commissioner "Administrative Task Force Meeting 2023-2024 Meeting Series Summary," https://ohic.ri.gov/sites/g/files/xkgbur736/files/2024-04/Administrative%20Simplification%20Task%20Force%202023-2024%20Meeting%20Series%20Summary.pdf

to continue to meet and talk with community partners, including payors and providers, to work together to further reduce prior authorizations. These meetings, and the data required by this proposed regulation should be available to the public for their review and input. And the starting point for those conversations should be a number chosen by OHIC through data collection and vigorous investigation, not a number most convenient to insurance companies. Moreover, by adopting the insurance companies' preferred number, without the underlying mechanics of how that number came to be, the public cannot be well informed in providing feedback on these proposals.

Further, the Attorney General cautions OHIC against crediting any insurer for either actions an insurer has already voluntarily taken to reduce prior authorization or is already required to take under the law. The 20% required in the Proposal should be *additional and new reductions.* No insurance company should be rewarded for taking steps they were either already required to take or previously took. If a company proposes a measure already required of them, or that they are already undertaking, to meet this 20% reduction, OHIC needs to reject that proposal. OHIC needs to aggressively protect consumers and providers by ensuring this already low target of 20% is, at the very least, in *addition to* any reductions or actions already required by law.

It appears the health insurance companies are able to call the shots when it comes to their own regulations. Rather than following the directive given to it by the General Assembly when it amended OHIC's enabling statute to focus on prior authorization, OHIC has seemingly blindly adopted the payors' recommended reductions. *See* R.I Gen Law § 42-14.5-3(h). Although OHIC has an obligation to ensure the solvency of insurance companies, it is tasked with equally important obligations to protect Rhode Island consumers and ensure the fair treatment of health care providers. R.I. Gen. Laws § 42-14.5-2. OHIC fails to live up to its legal obligations when it adopts a number created by those that have financial incentives to keep prior authorization intact. If 20% is a data-driven starting point, there needs to be well-reasoned detailed support provided to the public. Enacting an update to a regulation simply based on what payors agreed to voluntarily do is not sufficient to protect providers from the crushing burden of prior authorization.

OHIC should also consider issuing policy guidance regarding its intent to enforce existing law and regulation surrounding prior authorization. Rhode Island has statutes that already govern insurance companies during the benefit determination and utilization review process. R.I. Gen. Laws § 27-18.9 *et. seq.* For example, insurers are required to have a reviewer with the same licensure status as the ordering provider to review the claims for prior authorizations. R.I. Gen. Laws § 27-18.9-5 (b)(1). Insurers also have specific time standards with which they must comply. R. I. Gen. Laws §§

27-18.9-6(B)(1-3); 27-18.9-5(a)(1). And, although not directly aimed at prior authorization, health plans are required to provide coverage for mental health and substance use disorders under the same terms and conditions as that coverage is provided for other illnesses and diseases. R.I. Gen. Laws § 27-38.2-1(a). This requirement means that prior authorization cannot be more burdensome for mental health conditions when compared to prior authorization processes for somatic conditions. It is unclear from the proposal whether the 20% reduction proposed is from compliant prior authorization programs, or whether prior authorization has gone largely unmonitored and would already be at a lower level with increased enforcement.

The Office of the Health Insurance Commissioner has the necessary statutory tools available to investigate and enforce current law regarding prior authorization, including market conduct examinations. R.I. Gen. Laws § 27-13.1-1. OHIC publicly lists 15 market conduct examinations that it has undertaken during the agency's lifetime.[12] Each time the Commissioner has undertaken his duty to examine payor conduct, he has found repeated failures to comply with law or regulation. It is of concern to the Attorney General that no examination or investigation has been made publicly available regarding insurance compliance with benefit determination and utilization review laws and regulations so that any reduction in prior authorizations can be made from the level achieved by a *compliant* market. To the extent that OHIC lacks the necessary resources to undertake these examinations, then that needs to be made clear to the public and the General Assembly so that the public understands the need for increased enforcement resources. The Attorney General remains prepared and willing to cooperate with OHIC in achieving its enforcement priorities.

II. Primary Care Funding.

The Office of the Health Insurance Commissioner described the proposed primary care regulations as a tool to "hold insurers accountable for the appropriate financing of primary care that is necessary to ensure a high performing health care system and provision of affordable health insurance."[13] The Attorney General agrees that insurance companies need to be held accountable in the Rhode Island marketplace. It is the insurers' obligation to their enrollees to use the money collected from ever-growing premiums to invest in Rhode Island primary care providers, ensuring that their product delivers the health care it purports to provide. This proposed update, and the underlying

[12] Office of The Health Insurance Commissioner, "Regulations and Enforcement: Market Conduct Examinations," https://ohic.ri.gov/regulations-and-enforcement/market-conduct-examinations
[13] RI Security of State, " Powers and Duties of the Health Insurance Commissioner, Proposed Rule," https://rules.sos.ri.gov/Promulgations/part/230-20-30-4

original regulation, focuses on an investment in the primary care system, which includes a wide array of costs, including the overhead of running a practice, including electronic medical systems and basic physical infrastructure. [14] The proposed update changes how OHIC tracks primary care spending and investment and requires insurers to direct 10% of their payments to primary care over the coming years. However, there is no mechanism in the proposal to track whether these increased investments are likely to retain individual primary care providers.

Although the Attorney General agrees that primary care practice transformation may lower costs and provide higher quality care, no transformation will occur without the necessary provider population, a risk that is unfortunately a daily reality for many Rhode Islanders seeking continuing primary care provider coverage.

The Proposal lacks a mechanism to ensure that providers see a direct increase in their pay or improvements in their working conditions that would incentivize them to stay in Rhode Island. Overall, the Proposal will increase the funds that flow into practices, and while this money is important for increasing integrated systems of care, provider pay and support desperately needs to increase. OHIC should update this proposal to include a requirement that all payors subject to the update track and report what percentage of the increased investment in the practice is paid directly to the provider, and what percentage is directly tied to lowering administrative burdens on providers. This data needs to be public to hold all payors accountable for their share in increasing the salaries of primary care providers. Providers are the backbone of the health care system. An overinvestment in overhead of a practice, rather than increased provider payment, hurts Rhode Islanders. If OHIC continues to increase premium rates paid by Rhode Islander, then they deserve to see, transparently, how that money is spent in non-technical terms.[15]

III. Conclusion

The Office of the Health Insurance Commissioner's proposal is a step in the right direction to begin to address the Rhode Island health care crisis. However, given the magnitude of that crisis, the Attorney General encourages the Commissioner to be bold. The Proposal should be effectuated with the changes detailed above that would increase transparency, increase payments to providers, decrease prior authorization, and ensure payors are in full compliance with the law. Rhode Islanders

[14] 230-RICR-20-30-4.10(B); 230-RICR-20-30-4.10(C).

[15] The Office of the Health Insurance Commissioner, "2025 Commercial Health insurance Rates Have Been Approved with Modifications," September 3, 2024, https://ohic.ri.gov/sites/g/files/xkgbur736/files/2024-09/Rate%20Review%20Process%20Press%20Release%20-%20Approved%20Rates%20September%202024.pdf.

deserve aggressive enforcement of current law and robust solutions to the ongoing health care crisis. The Attorney General urges OHIC to adopt its recommendations to the Proposal.

Respectfully submitted,

Rhode Island Office of the Attorney General

By its attorneys,

PETER F. NERONHA
Attorney General

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November 15, 2024

Mr. Charles Estabrook
The Office of the Health Insurance Commissioner
Rhode Island Department of Business Regulation
1511 Pontiac Avenue, Bldg. 69-1
Cranston, RI 02920

Delivered by email to: charles.estabrook@ohic.ri.gov

Dear Mr. Estabrook:

MLPB is pleased to submit the comments on the proposed amendments to 230-RICR-20-30-4.

MLPB's mission is to create access to legal knowledge for health and social service sectors and empower those communities to use legal problem-solving to improve wellbeing. Through legal education, workforce support and social care program design, MLPB impacts systems, care professionals, and the individuals they serve. MLPB consults on more than 1,000 questions from care teams about health-related social needs of their patients and delivers more than 45 trainings each year.

MLPB is credited as the first medical-legal partnership in the country and today partners with health and social care systems in Massachusetts and Rhode Island. MLPB operates under the fiscal sponsorship of Third Sector New England, Inc. (TSNE), a 501(c)(3) non-profit organization that seeks to strengthen organizations working towards a just and equitable society.

In Rhode Island, MLPB partners with many communities of care that center primary and preventative care, including Accountable Entities (AEs), community health teams, family medicine practices, home visiting programs, and health equity zones.

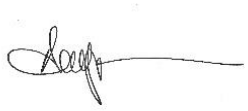
In general, MLPB appreciates the efforts of OHIC to integrate more fully the provision of primary care in Rhode Island through expanded definitions, incentives, and simplified administration for insurers. In particular, MLPB supports the proposed changes to the regulations that simplify and expand the definition of claims and non-claims primary care activities at 230 RICR 230-20-30 § 4.3.A.18. MLPB also supports the change in regulations at 230 RICR 230-20-30 § 4.10.B.1.c.(3) that holds insurers more accountable to provide increased funding for population-level resources, including "care management, integrated behavioral health, and staffing for team-based care." From our work and research, any effort to encourage primary care to include innovative and far-reaching population-level strategies is beneficial to the patients, care teams, and health systems.

In that vein, MLPB suggests that OHIC consider adding "Community Health Worker Services" to the definition of claims-based payments under 230 RICR 230-20-30 § 4.3.A.18.a. Rhode Island's investment in the CHW workforce is impressive, and they are essential contributors to many health care teams.

Creating reimbursement structures to encourage and integrate CHWs more fully beyond the Medicaid-insured patient population is a win-win both for the patients served and the rest of the provider team.

Thank you for your consideration of these comments.

Sincerely,



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November 15, 2024

Charles Estabrook
Office of the Health Insurance Commissioner
Department of Business Regulation
1511 Pontiac Ave, Bldg. 69-1
Cranston, RI 02920

RE: Proposed Revisions to 230-RICR-20-30-4

Dear Mr. Estabrook:

These comments are provided by the Rhode Island Health Center Association on behalf of the state's eight community health centers, referred to as federally qualified health centers (FQHCs) in this document. The FQHCs provide comprehensive, integrated primary medical, behavioral, and dental health to over 210,000 Rhode Islanders. While the majority of FQHC patients (66%) access insurance coverage through public payers, the number of patients who are privately insured grew by 19% between 2020 and 2023.

We appreciate the opportunity to comment and applaud the Office of Health Insurance Commissioner (OHIC) for these proposed amendments, which we believe recognize the continuing evolution of primary care investment measurement. We also appreciate OHIC's efforts to address the burden of prior authorization, especially on primary care offices.

Comments:

4.3 Definitions
A.18. Primary Care Expenditures

1. RIHCA supports the adoption of one definition of primary care expenditures that identifies allowable claims-based and non-claims-based expenditures.
2. The proposed rule excludes urgent care centers as primary care sites. In general, we agree with that approach but note that several of Rhode Island's FQHCs offer urgent care options. These sites enable patients to be seen outside of normal business hours and the majority of services provided are routine primary care services. We recommend that the Primary Care Payment Codes in Section 4.14 are recognized when provided at an urgent care site that is part of an FQHC. (Please see comments on 4.13 Primary Care Specialty Provider Taxonomy Codes.)

A.18.b. Non-claims based payments

3. We strongly request that this definition continue the previous definition's inclusion of expenditures that are "designed to increase the number of primary care physicians practicing in RI, and approved by the Commissioner, such as a medical school loan forgiveness program." Current contributions by insurers to the Rhode Island Health Professional Loan Repayment Program provide a significant portion of the funds awarded. If these contributions are no longer defined as "primary care expenditures," the insurers may decline to continue their contributions and the state's loan repayment program will be dramatically diminished. We believe these are justified expenditures and directly impact the ability of primary care providers that are located in health professional shortage areas to retain primary care clinicians.

A.18.b.(2) Incentive Payments

4. We recommend that OHIC strengthen its review of incentive payments to ensure the methodology is clearly aligned with the overall goals of the proposed rule.

A.19. Primary Care Practice

5. We recommend additional clarification on the treatment of integrated behavioral health (IBH) in determining primary care expenditures. Rhode Island's FQHCs have all implemented (IBH) practices and we support policies that advance and incentivize these programs but want to also ensure the approach does not inappropriately increase the level of primary care expenditures.

4.9 Affordable Health Insurance – General

D.3.

6. We support the proposed amendment to lower the Affordability Standards accountability threshold for commercial health insurers from 10,000 covered lives to 5,000 covered lives.

4.11 Administrative Simplification

F. Prior Authorization

7. We are in full support of this new section and appreciate that primary care is a priority focus.
8. We recommend that OHIC coordinate these prior authorization requirements with the CMS Advancing Interoperability and Improving Prior Authorization Processes Final Rule (CMS-0057-F). Coordination will reduce health insurer administrative burden and facilitate overall implementation and compliance.

4.13 Primary Care Specialty Provider Taxonomy Codes

9. We recommend adding 0516 to the "Notes or Restrictions" cell for Federally Qualified Health Center (FQHC). (Please see Comment 2 to A.18 Primary Care Expenditures.)

Thank you for the opportunity to comment.

Elena Nicolella

Elena Nicolella
President and CEO

MEMORANDUM

FROM: CORY KING, HEALTH INSURANCE COMMISSIONER
SUBJECT: HEARING ON PROPOSED AMENDMENTS TO 230-RICR-20-30-4
DATE: NOVEMBER 4, 2024
CC: EMILY MARANJIAN, LEGAL COUNSEL

On Monday November 4th, 2024, at 8:00 AM OHIC held a hearing on the proposed amendments to 230-RICR-20-30-4 *Powers and Duties of the Office of the Health Insurance Commissioner*. Health Insurance Commissioner Cory King served as the hearing officer. The hearing was attended by stakeholders, including representatives of health insurance companies and members of the public. One party offered oral public comments at the hearing. The hearing was recorded. The final deadline for written comments is November 15th, 2024.

Debra Hurwitz from Care Transformation Collaborative of Rhode Island offered comments on the proposed new section of 230-RICR-20-30-4 pertaining to the definition of primary care expenditures. Ms. Hurwitz also asked if OHIC would report on behavioral health care expenditures.

Heather Beauvais from Neighborhood Health Plan of Rhode Island ask if the proposed definition of primary care aligned with the definition used in the annual cost growth target reporting.

That concluded the oral comments. The recording of the meeting can be accessed upon request.