Analytical Framework for State Cost Containment Models: Rhode Island

Domain #1: Administrative and Clinical Data Collection, Analysis and Reporting	
What types of administrative data does the state collect?	The Rhode Island Office of the Health Insurance Commissioner (OHIC) prepares an annual market report that profiles participants in the health insurance market, and enrollment for each insurance carrier. OHIC also researches a variety of policy topics, preparing reports such as a Total Cost of Care Study in 2015, and a Primary Care Spending report in 2012 and 2014. • The Total Cost of Care Study examined claims data to identify drivers of cost of care in the state from 2011 to 2013. • The Primary Care Spending Report examines actual and projected primary care spending across Rhode Island's three largest commercial insurers (Blue Cross Blue Shield of Rhode Island, United Healthcare and Tufts Health Plan). *Source:* *For more information about OHIC's research and reports, click here.*
What types of clinical data does the state collect?	The Rhode Island Health Quality Performance Measurement and Reporting Program, managed by the Department of Health, was first established in 1998 and provides for annual reporting on clinical performance for licensed health care facilities, including hospitals, nursing homes, home health agencies and physicians. The most recent report available online shows that 11 measures of hospital care process are reported for acute care hospitals, and a variety of structural measures (e.g. number of physicians with EMRs, physicians who are e-prescribing) are reported for physicians. The state also collects clinical measures under its Care Transformation Collaborative, CTC-RI. CTC-RI is a multi-payer PCMH initiative with over 80 primary care practices. All CTC-RI primary care sites must collect and report on seven contractual clinical quality measures related to obesity, diabetes, hypertension and tobacco use. *Sources:* *Please click here to access the most recently available annual report of the Rhode Island Healthcare Quality Reporting Program. For more information on CTC-RI, click here.*
Does the state have a HIT strategy to promote use of clinical and administrative	The Rhode Island Quality Institute (RIQI), a non-profit multi-stakeholder organization established by state leaders, has assisted with implementation of EHRs among practices in the state. RIQI helped to enroll 95 percent of the state's PCPs in the EHR Adoption program and helped 1,173 practices in meeting Meaningful Use requirements. Historically, RIQI served as the state's regional health information organization (RHIO) and as the entity for HIE grant funding from the American Recovery and Reinvestment Act of 2009 (ARRA).

Domain #1: Administrative and Clinical Data Collection, Analysis and Reporting	
data to promote cost containment initiatives?	*Sources:* *For more information about RIQI's work in encouraging PCP adoption of EHRs, click here.* *To read more about the history of RIQI and its role in leading the state's HIT strategy, click here.*
Does the state have a centralized agency responsible for collecting, analyzing and reporting health care data?	No.
Does the state have a functioning APCD that it uses to collect data?	Yes, the state has an All-Payer Claims Database (APCD) but as of December 2016 it is not yet fully functional. HealthFacts RI is Rhode Island's APCD, jointly implemented by the Executive Office of Health and Human Service, the Department of Health, and the Office of the Health Insurance Commissioner, and HealthSource RI. *Source:* *For more information about Rhode Island's APCD, click here.*
Does the state report cost and quality to the public?	Yes, the Rhode Island Department of Health reports some administrative indicators of quality measures via its Healthcare Quality Reporting Program, as described earlier in this domain. *Source:* *More information about the Rhode Island Department of Health's Healthcare Quality Reporting Program may be found here.*
Does the state identify and track key cost drivers and high cost providers?	Yes. In 2013, the Rhode Island General Assembly amended current legislation to require the Health Care Planning and Accountability Advisory Council, in consultation with OHIC, to review health system total cost drivers. A 2015 report examined annual health spending over a three year period and against regional benchmarks, provided a breakdown of medical spending by payer type and category of service, and analyzed trend drivers with a focus on distinguishing utilization vs. cost components of trend within service categories. *Source:* *To access 2015 report on cost drivers, click here.*

Domain #1: Administrative and Clinical Data Collection, Analysis and Reporting	
Does the state monitor health care cost growth?	Not as of December 2016. A proposal to monitor state health care cost growth is under consideration. Specifically, in December 2015, a Governor-appointed group, the Working Group for Healthcare Innovation, recommended that a newly established Office of Health Policy "should establish a process to regularly calculate and publish up-to-date figures on total medical expenses for the state." *Source:* *The December 2015 report of the Working Group for Healthcare Innovation may be accessed here.*
Does the state define cost growth targets?	Yes, OHIC has developed a series of Affordability Standards designed to address high health care costs in Rhode Island. Standard #4c related to hospital contracts stipulates the following: • Caps hospital rate increases to CPI-Urban plus 0.75 percent during 2016, plus 0.50 percent during 2017, plus 0.25 during 2018, and limits it to the CPI-Urban after 2018; and • Caps ACO budget increases to the CPI-Urban plus 3 percent in 2016, plus 2.5 percent during 2017, plus 2.0 percent during 2018, and reducing it to CPI-Urban plus 1.5 percent after 2018. In 2015, Governor Gina Raimondo tasked a group of health care experts and stakeholders to further develop a plan for curbing health care spending; the group is considering a variety of recommendations which have not yet been released to the public. *Sources:* *The December 2015 report of the Working Group for Healthcare Innovation may be accessed here.* *To read more about the four recommendations for curbing health care spending in Rhode Island, click here.*

Domain #2: Medicaid Purchasing and Coverage Strategies to Contain Costs	
Does the state coordinate Medicaid and state employee health plan performance requirements and cost control strategies?	No, there is no evidence that the Medicaid program and state employee health plan purchasing activities are linked either in terms of performance requirements or cost strategies. However, Medicaid has already adopted OHIC's definition of PCMH and contracting targets for PCMHs and ACOs.
Is the state pursuing an all-payer or	Rhode Island is participating in CPC+, a national advanced primary care medical home model that aims to strengthen primary care through a regionally-based multi-payer payment reform and care delivery

Domain #2: Medicaid Purchasing and Coverage Strategies to Contain Costs	
Medicare waiver with CMS in order to align cost control strategies?	transformation. *Sources:* *For more information on CPC+ click here.*
What other waivers, grants or federal demonstrations is Medicaid pursuing to promote cost containment?	Rhode Island has an 1115 waiver demonstration, the Global Consumer Choice Compact Waiver. The state's risk-based managed care program, RIte Care, operates under this waiver. Rhode Island does not have any Home and Community Based Waiver Programs. Prior to 2009, there were nine HCBS waivers. In 2009, these programs were consolidated under the 1115 waiver. Many of Rhode Island's medical home projects are receiving support through various federal funding streams. CMS has approved three Health Home State Plan Amendments in Rhode Island. Rhode Island was one of eight states selected to participate in the Medicare Advanced Primary Care Practice (MAPCP) demonstration program, and is now participating in CPC+. Rhode Island was awarded a $15.9 million Beacon Community grant in July 2010. Beacon funding ended in 2013, but the Rhode Island Quality Institute continues to support practices participating in the Care Transformation Collaborative of Rhode Island in achieving meaningful use and linking to the state's HIE. *Source:* *To learn more about Federal support for Rhode Island, click here.*
What APMs are being pursued by Medicaid?	RI Medicaid Managed Care Organizations are required to have 20 percent or more of their total payments to providers in APM arrangements by the last quarter of SFY 2016. Targets for APM arrangements increase over time, and the state has provided definitions on what qualifies as an alternative payment model. The state is also operating an ACO pilot with five "Accountable Entities" (AEs) where the state's two managed care plans contract under a total cost of care methodology. *Sources:* *To access the May 2015 report of the Rhode Island Working Group to Reinvent Medicaid, click here.* *To access the Rhode Island Executive Office of Health and Human Services June 2016 report, "Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Organizations," click here.*

Domain #2: Medicaid Purchasing and Coverage Strategies to Contain Costs	
	To access Bailit Health's March 2016 report "The Role of State Medicaid Programs in Improving the Value of the Health Care System," prepared for the National Association of Medicaid Directors, click here.
What delivery system redesign strategies are being pursued by Medicaid?	In addition to contracting with five Accountable Entities that have a financial incentive to managed the costs and quality of care for Medicaid beneficiaries and the comprehensive patient centered medical home program (CTC-RI), the state has also: • Established a special Accountable Entity program designed to serve Rhode Islanders with serious mental illness; • A program to address the needs of Rhode Islanders with substance use disorders so that they are served better outside the emergency room; • A program to serve people who are at risk of homelessness; and • A program which offers parents of children with special needs more choices and flexibility. *Source:* *For more information about these programs, click here.*
What benefit designs are being pursued by Medicaid to incentivize effective use of health care services?	No evidence found of changes in benefit design being pursued by state Medicaid program.
Does Medicaid use MMCOs to manage care?	Yes. 88 percent of Medicaid beneficiaries are enrolled in health plans that have contracted with the RIte Care Program (the state's risk-based managed care program). Rhode Island first began offering comprehensive, risk-based managed care twenty years ago with the introduction of its RIte Care program, which originally covered low-income children and families and has expanded over time to include low-income working families and children with special health care needs. RIte Care covers acute, primary and specialty care, pharmacy, and behavioral health services on mandatory across the state (except for foster care children, who may enroll on a voluntary basis). *Sources:* *For more information about Rhode Island's Medicaid managed care program, click here and here.*
What reimbursement policies has Medicaid implemented to	None.

Domain #2: Medicaid Purchasing and Coverage Strategies to Contain Costs	
promote cost containment?	
What initiatives has Medicaid pursued to manage cost of special populations of beneficiaries?	The state's Connect Care Choice provides primary care services and case management to most adults with disabilities. Rhody Health Partners, a comprehensive, risk-based program introduced in 2008, provides acute and primary care services to older adults and individuals with disabilities who are not enrolled in Connect Care Choice. In addition, most children can receive dental services through RIte Smiles, a statewide prepaid dental plan introduced in 2006. The state also operates a PACE program to provide all Medicaid and Medicare services to individuals age 55 and over. The state received federal permission to develop a network of community mental health organizations, serving as health homes, to coordinate behavioral health and primary care for Connect Care Choice beneficiaries with chronic mental illnesses. In 2013, the state also began integrating long term services and supports (LTSS) into its Rhody Health Partners program; LTSS for adults with developmental disabilities and behavioral health services for individuals with serious and persistent mental illnesses are not yet covered. This demonstration program, the Integrated Care Initiative, aims to combine Medicaid and Medicare funding for dual eligible into a single funding stream. *Source:* *For more information about Rhode Island's Medicaid managed care program, click here.*

Domain #3: State Employee Health Plan Coverage and Payment Strategies to Contain Costs	
What APMs is the state employee health plan using to control health care costs?	None currently known at this time.
What benefit design is the state employee health plan using to control health care costs?	Rhode Island's state employee Rewards for Wellness program allows eligible employees to earn up to $500 in credit toward their health insurance premium cost share for completing wellness activities and screenings. *Source:* *For more information about the Rhode Island State Employee Wellness Initiative, and the Rewards for Wellness Incentive*

	program, click here.

Domain #4: State Actions to Enhance Competition in the Marketplace	
Does the state certify or otherwise regulate Accountable Care Organizations?	In 2014, the state developed recommendations related to promoting and regulating ACOs, which were published in this report. In October 2015, EOHHS issued a program description and application for its Accountable Entity Coordinated Care Pilot Program, including qualifications necessary for a qualifying Coordinated Care Pilot Entity across five domains: • Domain 1: Responsible entity and governance • Domain 2: Organizational Capability: Leadership and management structure • Domain 3: Organizational Capability: readiness to develop and/or provide an integrated multidisciplinary system of care • Domain 4: Minimum population served • Domain 5: Data and analytics capacity *Sources:* *To access the 2014 report "Recommendations Regarding State Action to Promote and Regulate Accountable Care Organizations (ACOs)," click here.* *To access EOHHS's Accountable Entity Coordinated Care Pilot Program, Program Description and Application, click here.*
Does the state collect data regarding the structure of the state's health care market, such as ACO information on number of participating physicians?	No.
Does the state use the collected data to produce reports to encourage marketplace competition, such as hospital quality and cost report cards, and cost impact reports?	Yes, to the extent that the state shares the reports described in Domain #1 with providers – and the public.
Does the state promote or set limits on consolidation	No.

Domain #4: State Actions to Enhance Competition in the Marketplace	
of health care providers of similar services?	
Does the state promote or set limits on vertical integration of health care providers of different services?	No.
Does the state promote or limit other types of affiliations among health care providers that impact referral and utilization practices?	No.
What strategies, if any, has the state's insurance department taken to ease insurer entry into the marketplace to enhance insurer competition?	None.
Does the state have consumer protection regulations that promote cost containment?	OHIC has a variety of enforcement powers, including: 1. Guidance letters to insurers laying out expectations for meeting Affordability Standards rate review requirements. 2. Monitoring through regular data and implementation plan submissions by payers. 3. Regulations that define Affordability Standard requirements. 4. Annual rate review process with power to reject a rate filing, thereby denying the insurer the ability to sell insurance in Rhode Island. In 2015 regulation, OHIC described its role in protecting the interest of consumers, enumerating those protections to include oversight of the effectiveness of a health insurer's appeals process, access to claims information, effectiveness of insurer communications to its insureds, and steps taken by insurers to enhance the affordability of its products. *Sources:* *For an overview of OHIC's role in developing regulations, click here.* *For access to the 2015 OHIC Regulation 2, click here.*

Domain #5: State Regulatory Actions to Contain Health Care Costs	
Does the state directly (vs indirectly through setting or approving insurer rates) limit price increases by providers?	As described in the 2015 OHIC Regulation 2, OHIC has broad authority to determine the affordability of a carrier's health insurance products and may consider such factors as: historical rates of trend for existing product, national and regional medical and health insurance trends, price comparison to other market rates, ability of lower income individuals to pay, efforts of insurers to control administrative costs, and insurer strategies to enhance affordability of their products. Yes, OHIC Affordability Standard #4c related to hospital contracts stipulates the following requirements: • Cap hospital rate increases to CPI-Urban plus 0.75 percent during 2016 and to CPI-Urban after 2018. • Cap on ACO budget increases to CPI-Urban plus 3 percent in 2016 and to CPI-Urban plus 1.5 percent after 2018. • Prohibit contract terms that allow pre-payment of quality incentive. *Sources:* *For access to the 2015 OHIC Regulation 2, click here.* *To read more about Rhode Island's Affordability Standards, click here.*
Has the state mandated payment and delivery system reform?	Yes, in February 2015, OHIC issued regulations that require commercial payers to "significantly reduce the use of FFS payment as a payment methodology, in order to mitigate FFS volume incentive which unreasonably and unnecessarily increase the overall cost of care, and to replace FFS payment with alternative payment methodologies that provide incentives for better quality and more efficient delivery of health services." OHIC convened an Alternative Payment Methodology Advisory Committee, which defined APMs, and developed annual regulatory targets for commercial insurer implementation of APMs through 2018. The work of the Alternative Payment Methodology Advisory Committee resulted in OHIC issuing an Alternative Payment Methodology Plan, which set payment reform targets for commercial health insurers for the aggregate use of APMs as a percentage of an insurer's annual commercial insured spend of at least 40 percent of insured medical payments to be made through APMs in 2017, and 50 percent during 2018. Approved APMs include: total cost of care budget models, limited scope of service budget models, bundled payments, pay-for performance payments for 2016-17, and other non FFS payments. The Plan also sets non-FFS target (bundles, capitation, quality payments, shared savings

Domain #5: State Regulatory Actions to Contain Health Care Costs	
	distribution, supplemental payments) at 6 percent during 2017 and 10 percent during 2018. Regulation 2, adopted in February 2015, further establishes that by the end of CY 2015, 30 percent of insured covered lives will be under population-based contracts; and by the CY 2016, at least 45 percent of insurer lives will fall under a population-based contract with at least 10 percent covered by a risk sharing or global capitation contract; for CY 2017 and beyond, the Commissioner has authority to establish targets. In addition, OHIC's Care Transformation Plan requires insurers to increase the percentage of their primary care network functioning as a PCMH by 5 percentage points for 2016 and sets a target of 80 percent of Rhode Island primary care clinicians functioning as a PCMH by 2019. This target is codified in Regulation 2, which charges OHIC with convening Care Transformation Advisory Committee, tasked with developing an annual care transformation plan that will achieve this 80 percent target. The regulation also requires health insurers to fund the state's care transformation plan according to a formula established by the Commissioner, based on the insurer's market share and other considerations. *Sources:* *OHIC's Alternative Payment Methodology Plan may be accessed here, and its Care Transformation Plan may be accessed here.* *For access to the 2015 OHIC Regulation 2, click here.*
Does the state have a Determination or Certificate of Need program or other programs to limit introduction of high cost services?	Yes. The Department of Health's Center for Health Systems Policy and regulation administers the state's Certificate of Need (CoN) program to prevent unnecessary duplication of medical services, facilities, and equipment. In addition to certifying the need for expensive medical equipment and services, the Center for Health Systems Policy issues approval/denial of initial licenses for health care facilities, and approval/denial of changes in ownership of health care facilities. *Source:* *To read more about Rhode Island's CoN process, click here.*
Are there any requirements of commercial payers to provide comparative cost and quality data regarding contracted providers?	Insurers are required to provide de-identified claims information to the state's APCD. In addition, OHIC's Affordability Standard #4c related to hospital contracts specifies data submission requirements for payers.
Is the state insurance	Yes. OHIC established a comprehensive set of Affordability Standards that establish general

Domain #5: State Regulatory Actions to Contain Health Care Costs	
department implementing any strategies to limit provider cost increases?	affordability priorities and insurer expectations, which are outlined as follows: 2015 Affordability Standards: • Standard #1 Primary Care Spend must be at least 10.7 percent of total medical spend. • Standard #2 PCMH Promotion sets target of 80 percent of PCP practices function as a PCMH by 12/31/19. • Standard #3 Support CurrentCare via continued insurer support. • Standard #4a Payment Reform – Population-based Contracting creates new ACO standards and population-based contracting targets for shared savings, risk sharing or global capitation. • Standard #4b Payment Reform sets APM requirements to strengthen APM adoption. • Standard #4c Hospital Contracts prohibit contract terms that allow pre-payment of quality incentives, and other requirements. *Source:* *To read more about Rhode Island's Affordability Standards, click here.*

Domain #6: Payment Reform and Delivery System Reform	
What entities are driving payment and delivery system reform in the state?	The Office of the Health Insurance Commissioner (OHIC) has served as the lead agency promoting cost containment initiatives since 2008. In addition to approving insurance rates, OHIC has implemented a number of regulations aimed at addressing rising health insurance costs. In 2009, OHIC first implemented a primary care spend requirement, and subsequently developed and issued affordability standards, which shifted more providers into PCMHs. In 2015, regulation promulgated by OHIC charged the agency with convening the Care Transformation Advisory Committee for purposes of achieving the state's target of having 80 percent of primary care practices functioning as a PCMH by end of 2019. Governor Raimondo would like to build on OHIC's success and better coordinate health care reform activities across agencies. The Health Care Planning and Accountability Advisory Council, is co-chaired by the Secretary of the Executive Office of Health and Human Services and the Health Insurance Commissioner; the Council's role is to oversee health care planning in Rhode Island. Under the oversight of the Department of Health, the Council reviews appropriate supply and allocation of resources, making recommendations to the Governor and General Assembly.

	Sources: *An overview of the various entities with oversight of health care system reforms in Rhode Island, may be found here (see pages 6-8).* *For access to the 2015 OHIC Regulation 2, click here.* *The Health Care Planning and Accountability Advisory Council's 2013 report on improvements to the state's Certificate of Need Program may be found here.*
What support has the state received to promote payment and delivery system reform?	In 2014, Rhode Island received a $20 million State Innovation Model (SIM) Design Award Grant from the Center for Medicare and Medicaid Innovation (CMMI), following an initial $1.63 million Model Design SIM grant in 2013. *Source:* *To learn more about Rhode Island's SIM grant, click here.*

Domain #7: Environmental Context for the Cost Containment Strategies	
Does the state's culture promote cost reform?	Yes. The foundation for the state's current affordability standards date back to 2007 when OHIC revised the process for annually filing rate factors to ensure consistency across insurers and to increase public input. Subsequently, in 2008, OHIC required insurers to include descriptions of activities to increase affordability of coverage and made those public. When this produced limited results, the Commissioner pursued a targeted approach, leading to establishment of initial affordability standards in 2010. OHIC has nurtured a sense of trust among payers, providers and employers and advocates. OHIC sought payer and provider input at all stages of process to develop Affordability Standards and used input to make decisions. OHIC further used this public process to present evidence of need for change and possible directions of change. OHIC obtained input from employers, providers and consumers via its advisory council, and is willing to update standards, when needed, using a consensus approach. Governor Raimondo is building on OHIC's work to broaden cost containment initiatives across stage government.
What are/were the governmental facilitators?	The Governor has been a strong driver of health care reforms, signing an executive order in July 2015 to form the Working Group on Health Care Innovation, with a charge to propose a way to limit the growth in public and private health care spending, including consideration of a cap on health care spending.

Domain #7: Environmental Context for the Cost Containment Strategies	
	The legislature supports OHIC's broad use of its powers. OHIC has a strong and creative leader with a vision about the role of the office in pursuit of affordability, and utilizes its informal convening powers to build new trusting relationships among stakeholders. OHIC has used its convener role to engage major payers and met with them quarterly to impress upon them the seriousness of OHIC intent and oversight. *Source:* *To read more about Governor Raimondo's call for a cap on health care spending, click here.*
Are there any key insurers that are driving cost containment strategies?	Rhode Island has two major insurers: BCBSRI with 68 percent of the market, and UnitedHealth Care with 27 percent market share. BCBSRI adopted its own PMCH program in 2010, involving more than 75 practices. Today, approximately 54 percent of RI PCPs are in PCMHs. Insurers provided input to OHIC's Affordability Standards via the Council and public process described previously.
Do health plans promote use of high-quality, low cost providers in their plan designs?	Yes. Lifespan, Rhode Island's largest health system collaborates with Tufts Health Plan to implement a tiered network health plan that groups hospitals and affiliated physicians into different levels or "tiers," for which members pay varying amounts for cost sharing based on the provider's tier designation. *Source:* *To read more about Lifespans' collaboration with Tufts Health Plan to implement a tiered network health plan, click here.*
Have health plans implemented alternative payment models with providers?	Yes, the state's health insurers are implementing the APMs described previously and as envisioned by the Affordability Standards, which call for transition to APMs by setting population-based contracting and non-FFS targets.
How have health plans promoted delivery system transformation?	Rhode Island health plans must participate in the Care Transformation Collaborative of Rhode Island (CTC-RI), which is seeking to transform primary care in Rhode Island. As discussed earlier, CTC-RI is co-convened by OHIC and the EOHHS to promote adoption of the PCMH model. For example, Tufts Health Plan has funded three initiatives in Rhode Island, designed by the CTC that aim to improve integration of behavioral health, by testing strategies for improving patient access to behavioral health services within primary care settings. They are: • Provide education and training to primary care staff that help foster integration of behavioral health services;

Domain #7: Environmental Context for the Cost Containment Strategies	
	• Expand web-based referrals and care coordination to improve the behavioral health referral network available to primary care providers; and • Use technology tools to improve patient engagement in making lifestyle choices via interactive website applications. BCBSRI is working with 39 primary care practices across the state to help improve patient experience of care, supporting primary care infrastructure, and lowering costs via improved coordination of care with EHRs. BCBSRI reported that over the 2009-2014 time period, examining over 100,000 members within BCBSRI's PCMH, those patients with complex medical conditions (e.g. diabetes, cardiac health) were 16 percent less likely to be hospitalized or need an ED visit; in addition, readmissions to hospitals were 30 percent lower among this population. In late 2014, Rhode Island Primary Care Physicians Corporation (RICPC) and United Healthcare launched an ACO to improve care coordination for 15,000 residents enrolled in United Healthcare's plans in Rhode Island. RICPC providers are eligible to receive payment incentives based on measures such as hospital readmission rates, patient safety, patient satisfaction and total cost savings. *Source:* *To learn more about Tufts Health Plan CTC initiatives, click here.* *To learn more about BCBSRI's and UnitedHealth Care's initiatives in Rhode Island, click here.*
Are there any multi-stakeholder coalitions facilitating cost containment strategies?	OHIC used the Health Insurance Advisory Council to present and discuss strategy options in a public forum. The Council was legislatively required in 2005 with intent "to obtain information and present concerns of consumers, business and medical providers affected by health insurance decisions." The Council is required to include representation from community consumer organizations, small businesses, hospitals, and other health provider organizations. OHIC shaped the Affordability Standards based on this input. *Sources:* *For more information about the Health Insurance Advisory Council, click here.*
Is there a strong employer purchaser coalition in the market facilitating cost containment strategies?	Yes, the Rhode Island Business Group on Health (RIGBH) aims to promote "better care delivery, transparency and healthier outcomes at affordable, predictable costs." RIGBH represents employers of all sizes and various initiatives related to transparency, payment reform, and increased consumer engagement through value-based benefit design.

Domain #7: Environmental Context for the Cost Containment Strategies	
	Source: *To learn more about RIGBH, click here.*
Are there any individual employers that are driving cost control discussions and actions within the state?	No.
Does the state have a centralized agency or designated work group responsible for overseeing/driving health care cost strategies?	OHIC has been the key agency promoting cost containment initiatives since 2008. OHIC is a Cabinet-level office created by the legislature in 2004, and has three unique powers that were embraced as a legislative mandate to address affordability. • Provider-oriented responsibility: "encourage fair treatment of health care providers." • Health Provider oriented responsibility: "…improve the quality and efficiency of health care service delivery and outcome." • System-oriented responsibility: "…view the health care system as a comprehensive entity and encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access." In December 2015, a Governor appointed group, the Working Group for Healthcare Innovation recommended that a newly established Office of Health Policy "set statewide health policy goals and oversee effective implementation." This proposal would create an office within EOHHS to coordinate state health policy and would work with OHIC, state health employees' plan and EOHHS agencies (including Medicaid) to coordinate policy direction. This office would establish a total cost of care increase target. As of December 2016, no such office exists. *Source:* *The December 2015 report of the Working Group for Healthcare Innovation may be accessed here.*
Has the state or any of its executive branch agencies adopted a formal cost control strategy or roadmap?	Yes. OHIC's Affordability Standards, described above, provide such a roadmap. The goal of these standards is to identify affordability priorities and expectations for insurers. OHIC decided to target affordability efforts, in part on primary care payment reform, without adding to the overall costs of care. The affordability standards focus on: a) an area where insurers can be held accountable; b) insurers can reasonably be expected to change primary care payment models; and c) a strong primary care system can lead to increased affordability. *Source:* *To read more about Rhode Island's Affordability Standards, click here.*

Domain #7: Environmental Context for the Cost Containment Strategies	
Does the state have any funding mechanism to support cost containment initiatives by unaffiliated providers such as independent primary care practices, small community hospitals or safety-net hospitals?	As part of the Affordability Standards, the state's health plans provide direct support to primary care practices via an agreement negotiated with OHIC and EOHHS, calling for supplemental PMPM payments designed to drive practice transformation and quality improvements. These payments are designated for structural improvements so that practices can apply for PCMH recognition, hire on-site care management coordination and enhance their data capabilities. The Care Transformation Collaborative (CTC-RI), described below, provides additional funding to participating primary care practices to support their transformation into PCMHs. In 2012, the Rhode Island Department of Health adopted a five year strategic plan with the goal of making Rhode Island the healthiest state in the country; to achieve this, the agency proposed building a primary care 'trust' to support a "neighborhood health station" model in each neighborhood of 10,000 or more people. While the status of proposed 'neighborhood health stations' is 'unbuilt,' the concept recently got a boost with award of $100,000 grant by Rhode Island Foundation toward creation of first such health station, the Central Falls Health Station. Half of the grant will go toward community health worker to server local middle schoolers, and the other half to hire a community health worker to conduct outreach to drug-overdose victims. *Sources:* *The Rhode Island Department of Health's 2012-2017 Strategic Plan may be accessed here.* *More information regarding recent developments in neighborhood health station model may be found here.*
Does the state have any resources and program initiatives to assist health care providers to increase quality and efficiency?	Care Transformation Collaborative, CTC-RI (formerly the RI Chronic Care Sustainability Initiative, or CSI-RI) is an all-payer program that promotes the patient-centered medical home (PCMH) model. CTC-RI offers an orientation program for new practices, and monthly best practice sharing meetings, as well as other educational opportunities. The state's health plans also provide direct support to primary care practices via an agreement negotiated with OHIC and EOHHS, calling for supplemental PMPM payments designed to drive practice transformation and quality improvements. These payments are designated for structural improvements so that practices can apply for PCMH recognition, hire on-sire care management coordination and enhance their data capabilities. *Source:* *For more information about the Care Transformation Collaborative, and support provided by the state's health plans to primary care practices, click here.*

What has been the effectiveness of state strategies on cost control according to formal evaluation activity, including independent party evaluations and self-reported studies?	
Key Findings	**Summary and Citation**
BCBSRI reported that that over the 2009-2014 time period, examining over 100,000 members within BCBSRI's PCMH: **1. Those patients with complex medical conditions (e.g. diabetes, cardiac health), were 16 percent less likely to be hospitalized or need an ED visit; in addition, readmissions to hospitals were 30 percent lower among this population.** **2. Patients at PCMH practices demonstrated improvements in a range of quality measures, including for diabetes care and colorectal screening.** **3. Return on investment in the PCMH program was more than 250 percent.**	A five-year study by Blue Cross & Blue Shield of Rhode Island (BCBSRI) found that PCMH practices were 5 percent less likely costly and saved $30 million when compared to non-PCMH practices. *Source:* *BCBSRI November 2015 press release, "New Study Shows Patient Centered Medical Homes Improve Health, Lower Costs."*
Highlights of a 2013 assessment of the OHIC Affordability Standards include the following: **1. The Affordability Standards are viewed as "good public policy," with stakeholders viewing the state's leadership role as having tipped "the balance to create momentum for change."** **2. State viewed as "particularly effective in moving medical home transformation forward and in slowing the rate of hospital cost increases."** **3. Generally, between 2010 and 2012, the report found that both BCBSRI and United Healthcare met the "Standard One requirement to increase primary care spending by 1 percent annually and to direct at least 30 percent of primary care spending in 2012 to non FFS activities."** **4. "The Primary Care Standard appears to have had a profound impact on primary care practices' ability to transform."**	In 2013, the Office of Health Insurance Commissioner commissioned a report that evaluated the Affordability Standards in terms of the efficacy of each standard tin achieving OHIC's aims. *Source:* *Bailit Health Purchasing's August 2013 "Assessment of the Rhode Island Office of the Health Insurance Commissioner's Affordability Standards," may be accessed here.*