



OFFICE OF THE
HEALTH INSURANCE COMMISSIONER

STATE OF RHODE ISLAND

**System Affordability Priorities and Standards for
Health Insurers in Rhode Island**

Summary of development and recommendations
in support of the insurer rate review process

April 17, 2009

A report of the Health Insurance Advisory Council
for the Office of the Health Insurance Commissioner

Table of Contents

Executive Summary	3
Background and Context.....	5
The Rate Review Process and the Need for Affordability Standards	5
Project Plan	6
Idea Generation	7
Literature Review	7
Local Health Plan Perspectives	8
Summary of Ideas.....	9
Prioritization.....	11
Preliminary Recommendations	12
Final Recommendations	14
Setting Standards.....	14
Priority 1: Primary Care	14
Priority 2: Chronic Care Medical Home	18
Priority 3: Electronic Medical Records	19
Priority 4: Fundamental Payment Reform	21
Enforcement: What if standards are not met?	22
Implementation.....	24
Public Comment.....	25
Appendix A: Detailed Standards.....	26
Appendix B: Primary Care Spend Metric	29
Appendix C: Public Comment	30

Executive Summary

The establishment of the Office of the Health Insurance Commissioner (OHIC) in 2004 created two broad new criteria for which health insurers were to be held accountable:

- fair treatment of providers, and
- policies that promote improved accessibility, quality and affordability for the RI health system.

The need for clearer priorities and standards for these criteria, for both health plans and the OHIC, is particularly acute as health plan rating factors – which drive what they charge subscribers and pay providers – are reviewed by OHIC. What constitutes meeting these criteria? At the request of OHIC, the Health Insurance Advisory Council (HIAC) undertook a project *to develop clearer priorities and standards for OHIC and health insurers regarding health plan policies that will improve the affordability of the medical care system in Rhode Island.*

This report documents the Council's deliberations and recommendations.

Process

To meet this goal, OHIC staff and consultants and HIAC members carried out the following steps:

Phase 1: Idea Generation (Oct/Nov, 2008)

Ideas for priorities and standards were gathered. Ideas were generated through literature reviews, expert interviews, brainstorming sessions with local health plan Medical Directors and separately with the HIAC.

Phase 2: Prioritization (Dec 2008/Jan, 2009)

Prioritize ideas based on criteria developed by OHIC staff, “tested” with national experts and local health plan Medical Directors, and ultimately deliberated by the HIAC.

Phase 3: Set Standards and solicit public input (Feb-April, 2009)

Once affordability priorities have been established, standards were developed by the HIAC for each priority with input from all key stakeholders identified above.

All HIAC meetings were open to the public. Extensive efforts were made to make decisions based on documented health services research.

Final Recommendations

After deliberation, the Council selected a set of priorities and standards that reflect a balance between what health services research indicates truly improves system affordability and what health plans could be held singularly accountable for without depending upon other stakeholders. In addition, the recommendations focused on actions health plans would not otherwise address because the benefits accrue to the delivery system as a whole rather than to individual health plans.

Recommended System Affordability Priorities

Health plans will improve the affordability of health care in Rhode Island by focusing their efforts upon provider payment reform, beginning with primary care. Achievement of this goal will not add to overall medical spend in the short-term, and is expected to produce savings thereafter. Specific areas of focus in support of this goal are as follows:

1. Expand and improve the primary care infrastructure in the state -- with limitations on ability to pass costs to premiums
2. Spread Adoption of the “Chronic Care Model” Medical Home
3. Standardize electronic medical record (EMR) incentives
4. Work toward comprehensive payment reform across the delivery system

Standards

With these priorities selected, the Council then recommended standards for each priority to which health plans would be held accountable as a condition of rate factor review. These standards are listed in the document and summarized in Appendix A.

- Health plans will increase the proportion of their medical expenses spent on primary care by five percentage points over the next five years. This money is to be an investment in improved capacity and care coordination, rather than a simple shift in fee schedules.
- As part of the increased primary care spend, health plans will promote the expansion of the CSI-Rhode Island project or an alternative all payer medical home model with a chronic care focus by at least 15 physicians in the coming year and promote EMR incentive programs that meet or exceed a minimum value.
- Health plans commit to participation in a broader payment reform initiative as convened by public officials in the future.

Implementation

These priorities and standards will be unique in the country if implemented. They represent a clear departure from the current uncoordinated method of delivery system development that promotes inefficiency and are an attempt to address the inadequacies of current provider payment systems. They also help the Commissioner fulfill his/her statutory obligation to “view the health system as a comprehensive entity and encourage and direct towards policies that advance the welfare of the public through overall efficiency, improved health care quality and appropriate access”.¹

¹ RI GL 42-14.5-3.

Background and Context

The Rate Review Process and the Need for System Affordability Standards

The Office of the Health Insurance Commissioner (OHIC) is authorized by statute to perform an annual review of the rate factors proposed for use by health insurers in calculating proposed premiums for small and large employers in Rhode Island. An external actuary provides the necessary analysis in support of the OHIC rate review process. Informed by the results of this analysis, OHIC can approve, reject or modify the proposed rate factors.

There are three primary categories of rate factors proposed by the health plans:

- Projected Administrative Costs
- Contribution to Reserves, or Surplus/Profit Margin
- Projected Medical Inflation Factors

Prior to 2005 (in accordance with its statutory authority), the Department of Business Regulation – OHIC predecessor agency in these matters - evaluated whether these proposed rate factors were “consistent with the public interest and the proper conduct of business”² based on two key standards:

1. Solvency and soundness

Were the proposed rates sufficient to ensure the continued solvency of the health plan?

2. Consumer protection

Would consumers receive adequate contractual benefit in return for the proposed rates?

In 2005, with the enabling legislation for the Office of the Health Insurance Commissioner, the rate review process was substantially revised. In addition to actuarial soundness and solvency and consumer protection, two additional criteria for the public interest were added:

3. Fair treatment of providers

4. Health Plan policies to improve affordability, quality and accessibility of medical care

The fourth criterion is particularly significant, and believed to be unique to Rhode Island; it acknowledges the importance of the role played by health plan policies in promoting system affordability, quality and accessibility. The legislation provided little guidance for standards for interpretation or assessment of either of these new criteria.

The goal of this project was to develop clearer priorities and standards for OHIC and health insurers regarding health plan policies that will improve the affordability of the medical care system in Rhode Island.

² Language from Statute

The ability to use regulatory levers to establish these priorities and standards across health plans is based on four primary assumptions:

1. Health plan activities can affect medical cost trends.
2. Reasonable alignment among payers is possible and beneficial to achieving systemic goals. Without this sort of direction, health plan affordability efforts will be bounded by what each is able and willing to influence on their own.
3. Communities can identify system priorities.
4. Public discussion of tradeoffs and priorities is better than private discussion.

Establishing these priorities and standards is a groundbreaking task – while national experts have considered how best to address affordability, rarely have these policy ideas been considered through the specific lens of health plan regulations and the opportunity to establish common priorities and standards.

Project Plan

The goal of this project was to develop clearer standards for OHIC and health insurers regarding health plan policies to improve the affordability of the medical care system in Rhode Island.

In the context of the rate review process, OHIC must evaluate whether the medical cost trends proposed by the health plans are built upon sufficient efforts to improve the affordability, quality and accessibility of medical care. *Because the rate factor review process is most clearly tied to affordability component of this criterion, the project focused on developing standards for the affordability efforts of health plans.*³

OHIC performed this project through a combination of staff research and analysis, local health plan interviews/expertise, expert policy review, and discussions with other stakeholders. Decisions were made through a deliberative process with the Health Insurance Advisory Council (HIAC). Efforts were made throughout to be consultative, deliberative and transparent.⁴

The project consisted of three primary phases:

Phase 1: Idea Generation (October - November 2008)

Ideas for priorities and standards were gathered. Ideas were generated through literature reviews, expert interviews, brainstorming sessions with local health plan Medical Directors and separately with the HIAC.

Phase 2: Prioritization (December 2008 - January 2009)

Prioritized ideas based on criteria developed by OHIC staff, “tested” with national experts and local health plan Medical Directors, and ultimately deliberated by the HIAC.

³ In prioritizing affordability, it was understood that efforts to improve system affordability would affect the redundancy and significant variation in medical practice that currently exists, and thus would positively affect system quality as well.

⁴ The Council gratefully acknowledges the significant and superior work of the following people in this process: Deb Faulkner, consultant to OHIC, Angela Sherwin, Brown University Master of Public Health student, and Michael Bailit of Bailit Health Purchasing, LLC. Financial support was provided by The Commonwealth Fund.

Phase 3: Set Standards and solicit public input (February - April 2009)

Once affordability priorities were established, HIAC developed standards for each priority with input from all key stakeholders identified above.

A public process was used to define the areas of focus and standards. Once established, health plans themselves will use these standards as guidance in choosing actions to meet them.⁵ There were three key challenges inherent in this process:

1. Choosing an area of focus that was both substantial enough to be worth the effort of coordination and focus, but still within the scope of health plan and OHIC authority. One could not hold health plans accountable for factors beyond their control.
2. Creating measurable, well-defined standards that provide meaningful guidance to and accountability for the health plans without dictating how the standard is implemented.
3. Determining the degree of involvement of OHIC in the implementation of these standards. Can OHIC set standards and leave health plans to implement? Does it require a more facilitative OHIC role in order to be effective?

Idea Generation

OHIC consulted current published literature on medical cost expenditures, interviewed national experts, and held brainstorming sessions with local health plan Medical Directors to generate and explore a set of possible areas of focus to improve system affordability.

Literature Review

In 2001, the Institute of Medicine (IOM) published “Crossing the Quality Chasm”⁶ which defined a set of principles for system reform and subsequent recommendations for change.

While the IOM provides guiding principles for overall health delivery system reform, the Commonwealth Fund released two reports in 2007 providing specific recommendations for national strategies to increase savings and efficiency of medical care financing.

In “Slowing the Growth of US Health Care Expenditures”⁷, the Commonwealth Fund addresses factors that contribute to one-time savings in areas such as inefficiency and waste, as well as possibilities for long-term savings which address the root of rising health care expenditures. In the second Commonwealth Fund report, “Bending the Curve”⁸, the Commonwealth Fund examined federal health policy options for curbing health care expenditures and provided a detailed cost analysis for each option.

From these three reports, OHIC drafted a working list of possible areas of focus:

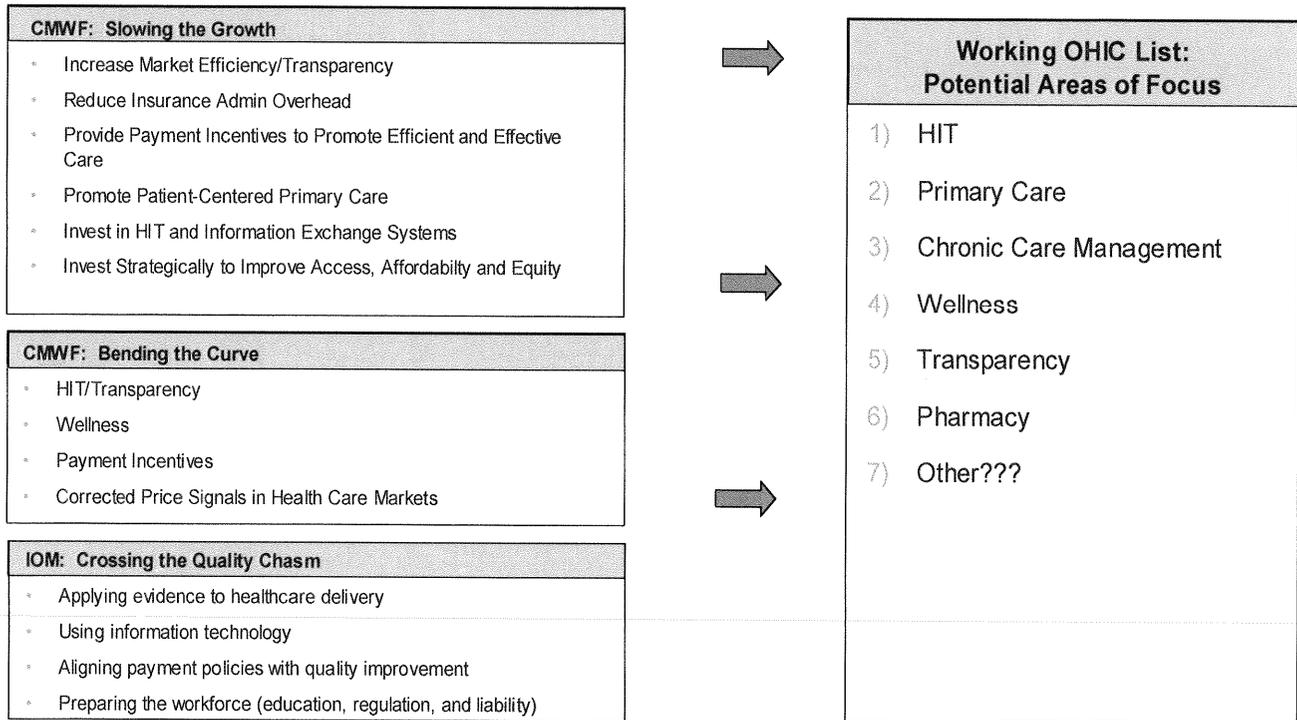
⁵ This project assumes that health plans will continue their own affordability efforts within their organization, based on opportunities and needs they identify. Overtime, more of those efforts may align more with the system priorities developed through this work.

⁶ Institute of Medicine..Crossing the Quality Chasm: The IOM Health Care Quality Initiative. 2001. Available at <http://www.iom.edu/focuson.asp?id=8089>

⁷ K. Davis, C. Schoen, S. Guterman, T. Shih, S. C. Schoenbaum, and I. Weinbaum, Slowing the Growth of U.S. Health Care Expenditures: What Are the Options?, The Commonwealth Fund, January 2007

⁸ C. Schoen, S. Guterman, A. Shih, J. Lau, S. Kasimow, A. Gauthier, and K. Davis, Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending, The Commonwealth Fund, December 2007

Figure 1. Potential Areas of Focus Based on Learnings from National Experts



Local Health Plan Perspectives

After compiling a draft list of potential areas of focus from the literature review (as shown in Figure 1), OHIC presented these possibilities to medical directors from Blue Cross Blue Shield Rhode Island (BCBSRI), United Healthcare (UHC), and Neighborhood Health Plan (NHP) for feedback and brainstorming additional areas of focus.

A clear distinction was made between medical cost initiatives that are systemic and those that are managerial in nature and thus more likely to be undertaken by the health plans. Recent examples of the latter include efforts to increase generic prescribing rates, reduce inappropriate utilization of radiology services, detect fraud and abuse, and contract selectively for certain services.

Health plan staff pointed out that this process should continue to foster these efforts but focus on more systemic challenges which health plans are reluctant to address because returns accrue in later years and to the system rather than the health plans directly, or because of competitive disadvantage and free rider concerns. Potential areas of focus for medical cost improvement identified and discussed with local health plans are listed below (and described in detail below in “Summary of Ideas”):

- Transparency
- Physician Reporting/Outlier Analysis
- Hospital contracting
- Primary Care
- Health Information Technology
- ER reduction
- Wellness

At the conclusion of this brainstorming session, the representatives from the local health plans and OHIC agreed to prioritize the following:

- (1) Primary Care (include medical homes definition, health plan spending, ER reduction)
- (2) Public reporting/ Outlier Utilization
- (3) HIT
- (4) Hospital Contracting

The group also agreed that some of the topics discussed would be better addressed through a different pathway (outside of this affordability initiative). These include:

- (1) Transparency
- (2) Wellness

Summary of Ideas

The following list of possible medical cost areas of health plan focus – as a condition of medical cost rate factor review and approval -- was compiled⁹ based on observations from industry experts and local health plan Medical Directors. Ideas were then reviewed and refined by the HIAC.

Definition of an idea:

A proposed course of activity by a health plan which:

- is within the control of the health plan;
- no health plan would do it by itself for fear of incurring a “free rider problem”; and
- if successfully implemented by all commercial health plans in RI would reduce some of the systematic cost drivers in the state’s medical care system.

Primary Care

1. Medical Home: All health plans to make available in standard primary care contracts a supplemental payment program based on achieving national standards for primary care excellence (e.g., NCQA PPC-PCMH standards). The chronic care model medical home is defined as follows: “The chronic care model (CCM) is a primary care–based approach that conceptualizes care as being provided by multidisciplinary practice-based teams in productive interactions with informed, motivated patients. The CCM calls for health care organizations to implement delivery system redesign, patient self-management support, systematic decision support, clinical information systems, and links to available community resources.”¹
2. Primary Care Spend: Set standard that payments to primary care constitute at least xx% of total medical care expenses by plan.
3. Standardized PC Payment Model: All plans to implement a standardized primary care payment model based on required elements. Possible elements include:
 - Standardization of base pay level as a starting point: Focus on fairness & parity (MA & CT).

⁹ This list is by design expansive -- no endorsements were implied. Refinement would come later.

- Supplements: Care management fees, medical home incentives, pay for performance bonuses
 - Alternative of Primary Care Capitation
4. Health Plan Primary Care Performance Standards: Require all plans to meet OHIC established standards of performance on selected HEDIS measures of primary care effectiveness
 5. Post-Hospital Care: Health plans fund a collaborative to focus on discharges from hospital to reduce re-hospitalization rates and frequency of hospitalization (examples: NC, Colorado)

Health Information Technology (HIT)

6. Mandated EMR incentive: Health plans must have EMR incentive for primary care physicians with specifications for amount.
7. Mandated E-Prescribing Incentive: Health plans must have E-Prescribing incentive with specifications for amount.
8. Mandated HIE Investment: Health plans must have investments in health information exchange with specifications for amount.

Emergency Care

9. Appropriate Use of Emergency Care: Health plans must participate in initiatives such as product-design consumer incentives or incentives for providers to encourage appropriate use of emergency care.

Hospital Payment

10. Allowable Hospital Margin: OHIC specifies the allowable “margin” in health plan/hospital commercial contracts associated with uncompensated care, charity care, Medicaid/Medicare losses.
11. Hospital Payment Model: All plans to implement standard method of hospital payment (e.g. DRGs) with Medicare standardization as key principle.
12. Cap hospital rate increases: OHIC sets caps on total rates of increase.
13. Standardize Hospital Payment for Procedures: OHIC would impose a cap on payments to hospitals for “top ten” highest cost trending procedures

Transparency

14. Provider Rates: Require health plan publication of provider rates by provider, service and line of business. Accessible on the Web.
15. Categorize (and communicate) Health Plan Product Choices: Require health plan investment into an independent, web enabled consumer information tool, which would inform employer and consumer decisions about which health plan to choose as well as what is “really” included in each plan’s benefit designs. Differentiate “levels” of benefits for consumers (gold/silver/bronze).

16. Physician Reporting: Require health plan investment in a system of public reporting of claims data.

Wellness

17. Wellness Performance Standards: Require all plans to meet OHIC-established standards of performance for wellness related HEDIS measures.
18. Wellness Spending: A portion of health plan expenses must be devoted to wellness.
19. Wellness-Related Product Requirements: Require health plans to offer products that encourage wellness, disease management, and use of high value services consistent with the concepts of Value-Based Benefit Design. Include both consumer and provider incentives.

Broad/Comprehensive Reform

20. Administrative Simplification: Require insurers to fund and participate in health plan/provider collaborative to incent adoption of national standards for administrative data transactions, based on CAQH/CORE standards.
21. Evidence-Based Coverage: Require insurers to make greater use of research on clinical and cost effectiveness in setting coverage policy in order to address problems of misuse and overuse (estimated 25-50% of current spending is for services of no benefit). Offer a facilitated process to develop a common set of coverage policies to be consistently implemented across insurers.
22. Fundamental Payment Reform: Facilitate a process to look at fundamental changes in how health care services are paid in Rhode Island, considering nationally discussed concepts including bundled payments and shared savings models.
23. Organized Systems of Care: Facilitate a multi-stakeholder process and/or make requirements upon insurers to support the organization of physician practices and hospitals into systems, along the lines advocated by Eliot Fisher and others. Organized systems have demonstrated the ability to deliver care more efficiently and with higher quality.
24. HSA Eligible Participation: Health plans incent participation in HSA eligible health plans.

Prioritization

The twenty-four ideas generated were then prioritized, which involved three key elements:

- 1. Research and document the rationale for each of the twenty-four ideas**

What problem is it trying to address? Are there specific, tested health plan driven interventions related to this idea? What is the potential impact of the intervention on medical cost, and – secondarily – quality?

- 2. Assess each idea, based on available documented evidence of efficacy in reducing system costs and ability to hold health plans directly accountable for the effort.**

Evidence was gleaned from peer-reviewed literature and categorized as:

- ++ Solid evidence
- + Some evidence, but could be disputed
- ~ Relatively unproven

3. **Group ideas with reasonable supporting evidence into three sets of recommended options to consider.** These options were brought to the Council for discussion and feedback.

Preliminary Recommendations Presented to HIAC

Based on the prioritization process described above, the list of twenty-four “ideas” described in the Idea Generation section of this document were narrowed down to nine recommendations, which were brought to the Health Insurance Advisory Council in December 2008¹⁰. This “short list” of ideas was organized into three basic categories, as shown below:

- **Option 1: Delivery System Focus**
Focus on payment levers of the health plans to realign incentives for care delivery in Rhode Island. Begin with primary care.
- **Option 2: User Focus**
Focus on health plans' ability to change consumer behavior and reduce unnecessary services through information and benefit design.
- **Option 3: Infrastructure Focus**
Use health plan funds and national standards to upgrade and simplify the administrative and clinical information processing and analysis functions in the medical care system.

Table 1: Overview of Preliminary Recommendations brought to HIAC

	Option 1: Delivery System Focus	Option 2: User Focus	Option 3: Infrastructure Focus
Description:	Focus on payment levers of the health plans to realign incentives for care delivery in Rhode Island. Begin with primary care.	Focus on health plans' ability to change consumer behavior and reduce unnecessary services through information and benefit design.	Use health plan funds, national standards to upgrade and simplify the admin and clinical information processing and analysis functions in the medical care system
Short-Term Ideas:	1. Primary Care Spend <i>(Limit ability to pass on in premiums)</i> 2. Chronic care model style medical home	4. Select Wellness Performance Standards: Increased smoking cessation counseling 5. Reduce Ambulatory Sensitive ER visits	7. Standardized EMR Incentive 8. Standardized E-Prescribing Incentive

¹⁰ The 24 ideas were narrowed down to nine recommendations based on research and analysis performed by Deb Faulkner (consultant to OHIC) and Angela Sherwin (OHIC intern), with expert advisory assistance provided by Michael Bailit (Bailit Health).

	Option 1: Delivery System Focus	Option 2: User Focus	Option 3: Infrastructure Focus
LT Ideas:	3. Fundamental Payment Reform	6. Evidence-Based Coverage	9. RHIO/Health Information Exchange
Rationale	<p>Primary Care Spend</p> <ul style="list-style-type: none"> ++ General decline in choosing primary care residencies ++ A higher ratio of primary care doctors results in better health outcomes ++ Increasing share of primary care physicians would result in overall healthcare cost savings ≈ Increasing primary care payments will stem declines in primary care MDs, shift to PC-centric model <p>Chronic Care Model-Style Medical Home</p> <ul style="list-style-type: none"> ++ Implementing a CCM-style Medical Home delivers higher quality care, reduced cost <p>Fundamental Payment Reform</p> <ul style="list-style-type: none"> ++ The current FFS system is inflationary ≈ Unproven, but generally believed, that alternative payment model should produce cost savings 	<p>Wellness Performance Standards, esp. Smoking</p> <ul style="list-style-type: none"> ++ Tobacco use, obesity results in higher health care costs ++ Increased smoking cessation counseling will reduce costs ≈ Less evidence of the value of other wellness- related interventions <p>Reduce Ambulatory Sensitive ER visits</p> <ul style="list-style-type: none"> ++ Solid evidence of overuse of ERs + A reduction in ACSC/ER use and ACSC hospitalizations can be achieved through a combination of health plan driven strategies <p>Evidence Based Coverage</p> <ul style="list-style-type: none"> ++ Solid evidence of misuse/overuse of services ≈ The value of establishing consistent, collaborative evidence based health plan coverage is relatively unproven; however, limited applications have proven value 	<p>Standardized EMR Incentive</p> <ul style="list-style-type: none"> ++ Solid evidence of the cost-effectiveness of EMR investments <p>Standardized e-Prescribing Incentive</p> <ul style="list-style-type: none"> ++ Adoption of e-prescribing both saves money and reduced medical errors <p>RHIO/Health Information Exchange</p> <ul style="list-style-type: none"> ≈ Some evidence that a coordinated RHIO/HIE increases quality of care

Detailed supporting evidence for these recommendations was documented in the Affordability Strategy Materials provided to the HIAC on December 16th.¹¹ In most cases, these ideas had solid evidence that the problem was deemed significant/worth considering, that the interventions were proven, and that there was opportunity for significant medical cost savings from implementation of these recommendations. In some instances, however, there was general consensus that an intervention was worth considering, although evidence was not yet available.

The preliminary recommendations summarized above were discussed at the December 2008 and January 2009 HIAC meetings – after which the group agreed on the following system affordability priorities for commercial health insurers in RI.

¹¹ An additional fifteen ideas were considered by the committee but not included in this set of recommendations – mostly due to the lack of sufficient evidence to justify the intervention. These additional alternatives were listed, with supporting evidence, in the December 2008 HIAC meeting.

Final Recommended System Affordability Priorities

Health plans will improve the affordability of health care in Rhode Island by focusing their efforts upon provider payment reform, beginning with primary care. Achievement of this goal will not add to overall medical spend in the short-term, and is expected to produce savings thereafter. Specific areas of focus in support of this goal are:

1. Expand and improve the primary care infrastructure in the state - with limitations on ability to pass cost on in premiums
2. Spread Adoption of the Chronic Care Model Medical Home
3. Standardized EMR incentive
4. Work toward comprehensive payment reform across the delivery system

HIAC acknowledged that consumers must also be engaged in this work as well. While insurers can engage consumers through education and benefit design, HIAC recommendations specifically did not include ideas from the user focus option. While HIAC acknowledges that consumer engagement is needed, HIAC determined there was greater potential for impact through delivery system and infrastructure reform.

Setting Standards

The Council then turned to setting standards for these priorities, for which commercial health plans doing business in Rhode Island would be held accountable. These standards would apply to fully insured, commercial business only. This section outlines the development of the standards. See Appendix A for the explicit wording of the standards.

To demonstrate adherence to their statutory obligations, health insurers would have to document that they meet these standards in conjunction with their annual filing of rate factors for small and large group commercial insurance products. This is discussed further in the Enforcement section below.

Priority 1: Expand and improve the primary care infrastructure in the state - with limitations on ability to pass on cost in premiums

Supporting Evidence

++ General decline in choosing primary care residencies

- From 1997-2005, the number of U.S. medical school graduates entering family medicine residencies dropped by 50%ⁱⁱ
- In 2007, family medicine had lowest average salary at \$186,000ⁱⁱⁱ
- According to a recent study, only 2% of internal medicine medical students intend to enter general internal medicine^{iv}

++ Increasing share of primary care physicians would result in overall health care cost savings

- A national study estimates that increasing proportion of PCPs from 35% to 40% in an area with a population of ~775,000 would reduce ED utilization by 15,000 visits/yr, reduce surgery by ~2,500 cases/year, and reduce hospital admissions by 2,500 a year, saving ~\$23 M annually.^v
- An increase in one primary care physician per 10,000 people is associated with a reduction in overall spending of \$684 per Medicare beneficiary.^{vi}

++ A higher ratio of primary care doctors results in better health outcomes

- High ratio of primary care MDs reduces:
 - Mortality due to CVD, pulmonary disease^{vii}, and colon^{viii} and cervical^{ix} cancers
 - Use of emergency care^x
 - Tests ordered^{xi}
 - Overall healthcare costs^{xii}
 - Health disparities in treatment outcomes^{xiii,xiv}
- High ratio of primary care MDs improves: (1) detection of breast cancer^{xv}; (2) preventive care^{xvi}; and (3) patient satisfaction^{xvii}.
- An increase in one primary care physician per 10,000 people is associated with an average mortality reduction of 5.3%^{xviii} and a rise in the quality ranking of a state by more than 10 places.^{xix}

Unproven: whether increasing primary care payments will stem declines in primary care MDs in RI and shift towards a primary care centric model

- Council members were comfortable with the logic that increasing primary care payments was at least necessary for achieving this primary-centric model, if not perhaps sufficient.

Baseline: Where We Are

	Primary Care Spend as a percentage of total medical spending (7/1/07 – 6/30/08)
Blue Cross	5.6%
United	7.3%
RI Commercial Average	5.9%¹²

¹² Plan specific spend rates are greatly influenced by membership mix.

How We Stack Up: Benchmark Data

Primary Care Spend as a percentage of total medical spending	
High Performing Health Insurers in US	<ul style="list-style-type: none"> ▪ Geisinger Health Plan: 8.25% ▪ Intermountain (health plan): 7.6%
Other International Systems	<ul style="list-style-type: none"> ▪ National Health Service, England: 26-28%¹³
Other Benchmarks	<ul style="list-style-type: none"> ▪ Massachusetts HMOs¹⁴: 7.1% ▪ Group Health Cooperative, Seattle WA¹⁵: 14%¹⁶ ▪ BCBS Tennessee reported 7% in 2002¹⁷ ▪ Tufts Health Plan (Massachusetts HMO only): 8.3% ▪ Neighborhood Health Plan RI: 10.8%

Proposed Target

Increase to 10.9% the average commercial medical spend in RI for primary care: Add 5 points to the percentage of total medical spending that goes to primary care statewide by 2014 (i.e. in 5 years). Increase this percentage by one percentage point each year for five years from baseline of 2008.

- Submit a plan, demonstrating that the increases will be accomplished in a manner that does not contribute to an increase in premiums.

Proposed Standard

The proportion of the insurer's medical expense to be allocated to primary care for the 12 months starting January 1, 2010 shall be one percentage point higher (e.g., from 6% to 7% of medical expense) than reflected in actual spending for the twelve months starting January 1, 2008.

The proportion shall continue to increase by one percentage point per year for five years

- BC: 1 point increase by 2010 from 5.6% to 6.6%
- United: 1 point increase by 2010 from 7.3% to 8.3%
- Tufts: 6.9% primary care spend by 2010 (no baseline for 2008, set at RI statewide average)

Each insurer must submit a plan to OHIC that demonstrates how the increase will be achieved, and that it will be accomplished in a manner that does not contribute to the increase of premiums, with an emphasis on innovative contracting and payment and primary care system investment, not merely fee schedule manipulation.¹⁸

¹³ Overstated, as it includes Rx spending (which has been excluded from other benchmarks + RI baseline).

¹⁴ Oliver Wyman Study, Sept 2008, based on commercial, fully insured HMO members only. Primary care includes OB-Gyn, excludes p4p

¹⁵ Edward H Wagner, director of MacColl Institute for Healthcare Innovation at the Center for Health Studies (CHS) Group Health Cooperative

¹⁶ Group Health Cooperative is a group model HMO, with owned facilities, like Kaiser Permanente

¹⁷ See http://findarticles.com/p/articles/mi_m0EIN/is_2002_March_5/ai_83481900.

¹⁸ It is the general opinion of the council that increases in primary care fee schedules should be a necessary component, but not sufficient to meet the standard. That is, the standard can and should result in an increase in primary care fee

- As an initial assessment, in the spring of 2010, OHIC will measure and report on the proportion of the insurer's medical expense allocated to primary care for the 12 months starting January 1, 2009. It is expected this number will be at least .5 percentage points higher than the same calculation for the twelve months starting January 2008 (or in the case of Tufts, the commercial average). There will be no enforcement activity in 2010, however, should this expectation not be met.

Assessment: Immediate Market Impact

- Baseline Measures: Primary care is currently 5.9% of total medical spend -- \$47 Million
- Estimated Value of New Standard: \$8-10 Million increase in primary care spend in 2010, cumulative over \$120 Million over 5 years
- Estimated Increase Captured by Other Standards (see details pages 19 and 21):
 Medical Home: Est. Cost of Medical Home Pilot Expansion: \$500,000
 EMR: Est. Cost of Mandated EMR Incentive: \$1.9 Million

Potential Unintended Consequences

Health Plans raised the following concerns about potential unintended consequences of the investment:

- Would it be only possible to meet this standard by primarily reducing fees paid to other physicians and what sort of resistance might that engender?
- Would specialists practice to an income target and stimulate utilization to compensate for any lack of fee increase?

The Advisory Council notes the potential for such outcomes or other unforeseen ones. The priority however is increased care coordination capacity across all providers – including hospitals and specialists. This will require different practice and contracting arrangements across specialists, which this investment standard should make possible. The Council recommended that OHIC monitors early and often for these consequences, and adjusting the process accordingly

Evaluation Metrics

This effort must be evaluated to assess its effectiveness. The Council believes strongly that the following metrics need to be monitored at least annually and summarized for public consideration.

- Primary Care Satisfaction (OHIC annual survey)
 Baseline: 6.9% response rate, 30.8% of all providers satisfied with reimbursement¹⁹

schedules to better attract and retain primary care physicians in Rhode Island; however, the standard will not successfully improve affordability unless this investment includes more innovative payment models that move beyond the traditional fee for service system. The Council makes no specific recommendations about the alternatives but refers to models in the literature and in practice in other communities, including pay for performance incentives, case management fees, and carefully-conceived risk sharing mechanisms.

¹⁹ Survey of all physicians in RI, instrument needs to be amended to capture type of provider

- Primary Care Supply: Total Primary Care Providers
Baseline: 1,035 total primary care providers in Rhode Island²⁰
Baseline: 33.5% of Rhode Island physicians identified as PCPs²¹
- Primary Care Supply: Primary Care Physicians as a Percentage of RI Physicians
Baseline: To be reported by the carriers
- Incidence of Hospitalizations for Ambulatory Care Sensitive Conditions (AHRQ)
Current RI incidence²²: 16.6% of all RI hospitalizations of insured patients
National benchmarks²³: 11% of all hospitalizations of commercially insured patients
- Incidence of ER Visits for Ambulatory Care Sensitive Conditions
Baseline: To be reported by the carriers in annual metrics report
- Overall RI Medical Trend, for Fully Insured, Commercial Business
Metric will be based historical data filed as part of commercial filings

Priority 2: Spread Adoption of the Chronic Care Model Medical Home

Supporting Evidence

++ Solid evidence that a CCM Medical Home delivers higher quality care, reduced cost

- A meta-analysis of 112 studies assessed chronic care intervention for asthma, CHF, depression, and/or diabetes) and found that interventions containing at least one element of CCM improved outcomes, processes, and quality of care^{xx}
- In an analysis of the association between CCM interventions and cost reduction, 18 of 27 studies (focused on congestive heart failure, asthma, and/or diabetes) demonstrated reduced health care costs or lowered use of health care services^{xxi}
- After adopting the six elements of the Chronic Care Model, the VA hospital system steadily improved perceptions to the point where it regularly outscores private sector providers while also reducing per patient health care costs by 25%.^{xxii}
- Community Care of North Carolina is a CCM model that saved approximately \$77-85 million in SFY05 and approximately \$154-\$170 million in SFY06^{xxiii}
- In a Patient-Centered Medical Home pilot in NJ, compliance among patients with diabetes for HbA1c blood tests increased from 43% to 91% over one year.^{xxiv}

Baseline Measures: Where we are

CSI-RI is an all payer medical home collaborative in Rhode Island. Current pilot participants: 27.5 PCP FTEs, 5 sites, 25,000 members

²⁰ BCBSRI, measured as of June, 2008, includes PAs, NPs, PCPs and duals that receive PCP fees (consistent with PC spend definition). UHC provided comparable estimate

²¹ Based on Kaiser physician counts, December 2007

²² Using 2000 AHRQ data from <http://www.health.ri.gov/chic/statistics/hbn-march2005.pdf>. Note benchmark is for commercial insured population only, but RI statistic is across all populations. Carriers will self report commercial data for ongoing assessment.

²³ Using 2000 AHRQ data from <http://www.ahrq.gov/data/hcup/factbk3/fbk3fig6.htm>

Program description

- Sites commit to establish a Medical Home. Must be NCQA certified as a Medical Home. Require self audited progress to level 1 (9 months in), and level 2 (18 months). Sites agree to go through training in Chronic Care Model (participate in the Chronic Care Collaborative Training Program). Sites agree to hire and use Nurse Care Manager. Participating groups must self report on specified quality measures associated with depression, coronary artery disease, and diabetes mellitus
- Carriers pay a supplemental \$3 pmpm to qualifying pilot participants. Carriers also pay a share of the cost of an on-site Nurse Care Manager. Carriers standardized enrollment and utilization reporting requirements for participating physicians/groups. (Includes ER, Rx, and inpatient admissions)

Program cost:

- Additional \$3 pmpm for each participating PCP FTE
- Allocated payment for nurse case manager

Proposed Standard

“The insurer shall commit in writing to supporting an expansion of either the Rhode Island Chronic Care Sustainability Initiative (CSI-RI) or an alternative all payer medical home model with a chronic care focus during the period July 2009 through June 2010...an increase of at least 15 primary care physician FTEs...”

- 15²⁴ new participating PCP FTEs by June 2010

Assessment: Immediate Market Impact

We estimate that insurers will invest at least \$500,000 (Cost per PCP X 15) in the Medical Home initiative, by June 2010²⁵.

Metrics: Targeted, Longer-term Goals

The CSI-RI project has programmatic goals for improved quality measures in the three chronic conditions of focus, and reduced ER visits, inpatient readmissions and system costs. In addition, a third party evaluation is being conducted as part of the project.

Priority 3: Standardized EMR incentive

Supporting Evidence

++ Solid evidence of the cost effectiveness of investments in EMRs

- One model of EMR implementation in an outpatient primary care setting with 2,500 patients found a net benefit of \$86,400 per provider over 5 years^{xxv}

²⁴ To be confirmed. The addition of 15 physician FTEs will increase the patients affected by the program, as a percentage of the total state population, from 2.38% to 3.69%, the latter being the national multi-payer medical home benchmark level that PA will achieve in 2009.

²⁵ The standard does not require this specific spending – this is only an estimate of carrier spending assuming the targeted medical home expansion is implemented as proposed.

- Benefits^{xxvi, xxvii, xxviii} include
 - Reduced hospital lengths of stay,
 - reduction of nurses' administrative time
 - Reduction of drug and radiology usage in the outpatient setting
 - Reduction of dropped charge
 - Provides better documentation for E/M coding
 - Reduction of "time leaks"
 - Improved quality of care
 - Improved patient safety
 - Reduction in medical errors
 - Increased public health monitoring and disease management
 - Improved emergency care (via quick access to records)
 - Potential for increased transparency
 - Potential to dramatically accelerate clinical research
 - Potential for system-wide cost savings

Baseline Measures: Where we are

- Specific goals and standards for adoption and effective use of electronic medical records have been established by the RI Quality Institute and the RIQI adoption committee
- Current EMR Adoption (including CCHIT certification)
14.8% of physicians surveyed, 7.2%-14.8% of all physicians²⁶
Low estimate of 325 total physicians²⁷
- Current EMR Incentive program
Blue Cross: provides an initial payment of \$5,000 per physician, plus a 5% rate increase
United: provides an initial payment of \$2,000 per physician

How we stack up: Benchmark Measures

- Estimated cost of EMR adoption: \$25,000-35,000
- 9% of insurers, nationally, offer some form of EMR incentive.
Many incentives are integrated into a broader P4P program and algorithm.
- Connecting for Health estimated that a \$.50 to \$1.00 PMPM payment, or an office visit enhancement of between \$3.00 and \$6.00 PMPM, would be sufficient to spark EMR adoption by physician practices.
- Examples of Incentives provided:
 - Hawaii Medical Services Association (HI Blues): \$20,000 per physician
 - Medicare Demonstration Project: \$5,000 per practice and added payments tied to performance in subsequent years
 - Capital District Physicians' Health Plan (Albany): \$15,000 per practice initially; now 50% of acquisition cost

²⁶ DOH survey, March 2008

²⁷ Based on 4531 total physicians in Rhode Island, 14.8% take-up (from survey), adjusted for 48.5% response rate (Physician count from Kaiser FF, Dec 2007, accessed 1/27/09
<http://www.statehealthfacts.org/profileind.jsp?ind=429&cat=8&rgn=41>)

Proposed Standard²⁸

By January 1, 2010, the insurer shall demonstrate the implementation of a physician EMR adoption incentive that meets the following standards:

1. Initial payment per physician to subsidize the cost of EMR acquisition, adjusted for carrier market share as follows²⁹:
 - BC: \$5,000 or more, up to practice maximum of \$15,000
 - United: \$2,500 or more, up to practice maximum of \$7,500
 - TuftsHP: \$500 or more, up to a practice maximum of \$1500
2. Support for the cost of EMR implementation totaling in value at least 3% greater than the insurer's standard fee schedule.

Carriers may establish an annual cap on EMR incentive program enrollment at a level not less than 200 new providers per year. This cap will be revisited annually by OHIC.

Assessment: Immediate Market Impact

Total Incentive Program Cost: Estimated cost of \$1.9 Million per year.³⁰

BC: \$1.3 Million

United: \$0.4 Million

Tufts: \$0.1 Million

Metrics: Targeted, Longer-term Goals

- EMR Adoption vs. national benchmark
Currently 7.2%-14.8% of all physicians vs. 13% nationally^{31,32}

Priority 4: Work toward comprehensive payment reform across the delivery system

Supporting Evidence

++ SOLID evidence that the current FFS system is inflationary

- The current fee for service (FFS) payment system provides powerful incentives to do more, whether or not more is necessary or beneficial to the patient^{xxix}
- In a meta analysis of payment method changes, Cochrane found that the number of special visits increased, and the total number of visits to PCPs and specialists was greater in FFS structures than capitation^{xxx}

²⁸ The 2009 Federal Economic Stimulus HI-TECH project makes funds available for EMR adoption through Medicaid and Medicare. Plans are maintaining their EMR incentive programs at this time, and the importance of EMR adoption remains.

²⁹ Based on per physician EMR adoption cost of \$33,000, a target of 25% overall subsidy, and market shares of 60/30/10 respectively.

³⁰ Analysis assumes current primary care spend based on reported baseline for standard #1, with 8% annual trend. Assumes increased adoption of 100 new PCPs per year.

³¹ From NEJM, "Electronic Health Records in Ambulatory Care, A National Survey of Physicians," July, 2008

³² This is the same metric used by RIQI. Health plans will not be held accountable for increased adoption rates, but will have to show that they have an incentive program in place.

≈ UNPROVEN, but generally believed given the SOLID evidence supporting the inefficiencies of fee-for-service, that an alternative payment model should produce significant cost savings

- CMWF study identified \$23.1 billion in national health expenditure savings over 5 years if payment rates and methods were standardized for physicians and hospitals^{xxxii}

Baseline Measures

Currently, the prevailing provider payment methodologies for commercially insured in RI are fee for service for physicians, and per diem or DRG arrangements for hospitals.

Proposed Standard

The insurer shall commit in writing to participate in a state-facilitated process to explore, assess, recommend and adopt reforms to health care service payment in Rhode Island. Participation shall include:

- Active engagement as a member of the stakeholder body to be convened by OHIC in coordination with other state governmental entities, and
- Provision of non-competitive information to the body to assist it in its deliberations.

Comment

With this standard the Council notes that payment reform efforts must extend beyond primary care and other physicians. Provider payment reform that aligns participants' incentives around population health and costs is crucial to improving the performance of our medical system. While health plans are critical participants in this effort, they cannot be held exclusively accountable for this work. Additional work in the future by the Council and OHIC will define clearer expectations for health plans and a broader process to achieve these goals.

Enforcement: What if standards are not met?

Carriers are required to meet the standards, as defined in detail in Appendix A, in conjunction with the annual rate review process. These standards will be reviewed and enforced by OHIC on an annual basis.

The primary care spend standard will require a substantial investment by each of the carriers over the next five years – we estimate that carriers will invest a combined \$8-10 Million in primary care in 2010 alone in order to meet this standard.³³ There must be consequences for standards which are not met. As such, OHIC has established a “model” for enforcement, translating the primary care spend standard into specific penalties for non-compliance, thereby providing guidance to health plans as they prepare for the new requirements.

³³ Health Plan concerns with this standard should be noted. These can be characterized as two fold: unanticipated actions by other providers which drive up utilization and thus spend causing the health plan to fall short of the standard; and unforeseen swings in disease incidence which could drive up the denominator. The Council believes the second to be actuarially unlikely. The first risk is somewhat in the health plan's control and can also be mitigated by careful planning with OHIC.

The model consists of two steps, described below and by example. Please note that this example is illustrative – it is not intended to represent any specific carrier performance:

Step 1: Determining the primary care “spending gap”

OHIC will compare the reported primary care spend (in dollars) to what would have been spent on primary care had the targeted percentage been reached to quantify the ‘spending gap’.

1. Primary Care Spend	2010 Standard	2010 Actual
Total Medical	\$	800,000,000
Total Primary Care	\$	50,000,000
% Primary Care	6.6%	6.25%
Total Primary Care (if had met target)	\$	52,800,000
Primary care spending gap	\$	2,800,000

Step 2: Determining the penalty

OHIC will then apply a penalty to this spending gap, using the reported gap from step one and multiplying it by a number to be determined.³⁴ This new “rate penalty” will be subtracted from the carrier’s total medical spend at its proposed trend. A revised trend will then be allowed by OHIC, after adjusting for the penalty, as illustrated below:

Total Spending Gap, 2010	\$	2,800,000
Penalty (example)		2
Rate Penalty	\$	5,600,000
Proposed Medical Trend		8.0%
Resulting Proposed Total Medical Spend, 2011	\$	864,000,000
Allowed Total Medical Spend	\$	858,400,000
Allowed Rate Increase		7.3%
Resulting Trend Adjustment		-0.70%

Failure to meet standards two, three and four will not have a formulaic effect on the rate factors, but will be taken into considering by OHIC when reviewing the submissions by the plan.

³⁴ HIAC is not recommending a specific number at this time. This process will not occur until the 2011 rate review. HIAC recommends a number greater than 1 to be determined in the coming year.

Implementation

The HIAC recognizes that system affordability priorities and standards for health insurers in Rhode Island are necessary but not sufficient. There was considerable discussion in the Council about the role of OHIC in implementation of these standards: Is OHIC a standards-setter and a judge when the rate factors are submitted?

Most Council members recommend an ongoing facilitative role for the Office, which must incorporate the following elements:

- **Communication**

Communications of the priorities and standards will be necessary to many stakeholders, including those who might misinterpret its intentions. OHIC should also be expected to coordinate State government efforts to reflect these priorities.

- **Facilitate and Monitor Carrier Efforts**

OHIC should monitor how plans intend to meet these standards. Creativity and innovation that encourage better and more affordable health care through more and better primary care should be encouraged. Rising fee schedules alone will not accomplish this. Plans may encounter resistance to any change they attempt to implement and will need to refer to the direction of the OHIC. The priority however is increased care coordination capacity across all providers – including hospitals and specialists. This will require different practice and contracting arrangements across specialists. OHIC should be demanding of change but not directive in all these efforts.

- **Coordination/Collaboration**

Council members recognize that if investments in care coordination are desired – not merely fee increases – some coordination and collaboration will be needed among plans, which will necessitate anti-trust mitigation. However, the council also cautioned that OHIC should be facilitative more than directive, allowing for health plan differentiation, innovation and competition.

- **Monitoring**

Ongoing monitoring of efforts, evaluation of results, and adjustments of the standards will be absolutely necessary, and will require expansion in information provided to OHIC by the plans. In turn, OHIC will oversee each of these processes, and provide timely feedback to plans on results.

Lastly, sufficient resources and prioritization must be allocated within the Office to increase the chances of these priorities and standards having the desired effect.

Public Comments

Members of the public were invited to attend the March meeting of the Health Insurance Advisory Council, and to offer written and/or verbal comment on the proposed standards. Comments were received from the following individuals:

- Ted Almon, CEO Claflin Group
- Jane Hayward, President and CEO of the Rhode Island Health Center Association
- Ken Sperber, MD, Hillside Family Medicine
- Roland Benjamin, Vice President, LFI, Inc.
- Charles Cronin III, D.O., Diplomat, American Board of Internal Medicine
- Michael Fine, Visiting Scholar, The Robert Graham Center
- David Gifford, MD, MPH, RI Director of Public Health
- Rick Harris, LICSW, Executive Director, National Association of Social Workers

These comments were largely supportive of the proposed standards, and are included for reference in Appendix C.

Appendix A: Detailed Standards

These proposed standards, developed with the guidance of the Health Insurance Advisory Council, would be for commercial insurers doing business in Rhode Island. To show adherence with their statutory obligation to engage in “policies that advance the welfare of the public through overall efficiency, improved health care quality and appropriate access”, in conjunction with their annual filing of rate factors for small and large group commercial insurance products, health insurers would have to demonstrate that they meet the following standards.

Standard #1: Primary Care Spend

1. March 2009: The insurer shall commit in writing that the rates that the insurer will propose to charge to small and large employers in Rhode Island for 2010 shall demonstrate that the proportion of the insurer’s medical expense to be allocated to primary care for the 12 months starting January 1, 2010 shall be one percentage point higher (e.g., from 5% to 6% of medical expense) than reflected in actual spending for the twelve months starting January 1, 2008.

This proportion shall continue to increase by one percentage point per year, for five years.

- a) Tufts Health Plan, as a new entrant, shall be required to achieve a 6.9% primary care spend (one percentage point higher than the current market average) by January 1, 2010.
 - b) Resulting primary care expense allocation shall be reported annually, starting in September, 2009, in accordance with the definition provided by OHIC (see Appendix B).
 - c) As an incremental step toward the 2010 goal, each insurer shall increase the proportion of medical expense allocated to primary care by 0.5% for the 12 months starting January 1, 2009³⁵.
2. September 2009: The insurer must submit a plan to OHIC that demonstrates how the primary care spend increase is to be achieved, and that it will be accomplished in a manner that does not contribute to an increase in premiums. That is, the insurer may fund the increase by:
 - a. increasing primary care payments, while either decreasing payments, not increasing payments, or funding smaller increases than what the insurer has historically awarded to other service providers, and/or
 - b. increasing volume of primary care delivery and decreasing volume of non-primary care services.
 - c. Funding expansion and innovations in care coordination
 3. March 2010: Rate factors that the insurer proposes to use for rates to charge to small and large employers in Rhode Island for the 12 months beginning July 1, 2010 shall reflect the new allocation of payments to primary care beginning January 1, 2010 and an additional one point higher allocation of payments to primary care beginning January 1, 2011 as compared to actual spending for the twelve months starting January 1, 2008.

³⁵ This increase is intended as an incremental step, to facilitate the larger increase in 2010. There will be no penalties for non-compliance on this 2009 requirement. The 2010 required increase will be measured against the 2008 baseline.

4. March 2011:
 - a. The insurer must demonstrate whether the required increase in primary care expenses projected for the 12-month period starting Jan 1, 2010 was achieved, and if so, exactly how it was accomplished in a manner that did not contribute to a larger increase in medical expense than would have otherwise occurred.
 - b. Rates factors that the insurer proposes to use for rates to charge to small and large employers in RI for the twelve months starting July 1, 2011 shall demonstrate that the proportion of medical expense to be allocated to primary care shall be an additional one percentage point higher for the twelve months starting January 1, 2012 than reflected in actual spending for the twelve months starting January 1, 2011.
5. OHIC may, at its discretion, require a review of the insurer's calculations by an independent auditor.

Standard #2: Chronic Care Model Medical Home

1. March 2009: The insurer shall commit in writing to supporting an expansion of either the Rhode Island Chronic Care Sustainability Initiative (CSI-RI) or an alternative all payer medical home model during the period July 2009 through June 2010.
 - a. The expansion shall entail an increase of at least 15 PCP FTEs³⁶ from the current 28 FTE level, including the addition of new practices beyond the initial 5 CSI-RI practice participants.
2. March 2010:
 - a. The insurer must demonstrate that the successful expansion of CSI-RI or an alternative all payer model medical home to at least 15 new physician FTEs from new practices occurred during the 12 month period starting July 2009
 - b. The insurer shall commit in writing to supporting an additional expansion of the Rhode Island Chronic Care Sustainability Initiative (CSI-RI), or an alternative all payer medical home model, during the period July 2010 through June 2011, adhering to the same parameters as for the 2009-2010 expansion.

Standard #3: Mandated EMR Incentive

1. March 2009: The insurer shall commit in writing to the implementation of a physician (primary care and/or specialty care) EMR adoption incentive on or before January 2010 that meets the following standards:
 - a. The incentive must be applied only to practice adoption of EMRs with:
 - i. certification by the Commission for Healthcare Information Technology (CCHITSM)³⁷, and

³⁶ The addition of 15 physician FTEs will increase the patients affected by the program, as a percentage of the total state population from 2.38%, to 3.69%, the latter being the national multi-payer medical home benchmark level that PA will achieve in 2009.

- ii. registry functionality to promote patient tracking in the manner prescribed by NCQA PPC-PCMH standards for a medical home.
 - b. The incentive must be equivalent in value to one or more of the following thresholds.³⁸
 - i. initial payment per physician to subsidize the cost of EMR acquisition, adjusted for carrier market share as follows³⁹; and,
 - 1. BC: \$5,000 or more, up to practice maximum of \$15,000
 - 2. United: \$2,500 or more, up to practice maximum of \$7,500
 - 3. TuftsHP: \$500 or more, up to a practice maximum of \$1,500
 - ii. support for the cost of EMR implementation and operation in the form of pay-for-participation payments equal to \$.60 PMPM or in increased fees, totaling in value at least 3% greater than the insurer's standard fee schedule.
 - c. Carriers may establish an annual cap on program enrollment, at a level not less than 200 new providers per year. This cap will be revisited annually by OHIC.
2. March 2010: The insurer shall demonstrate the implementation of a physician (primary care and/or specialty care) EMR adoption incentive that meets the standards defined above. As part of its rate factor filing the insurer should submit data on the payments made as part of the incentive program.

Standard #4: Fundamental Payment Reform

- 1. March 2009: The insurer shall commit in writing to participate in a state-facilitated process to explore, assess, recommend and adopt reforms to health care service payment in Rhode Island. Participation shall include:
 - a. active engagement as a member of the stakeholder body to be convened by OHIC in coordination with other state governmental entities, and
 - b. provision of non-competitive information to the body to assist it in its deliberations.
- 2. Should the body have convened during 2009, the insurer must have demonstrated participation consistent with the requirements of #1 above.
- 3. March 2010: To be decided

³⁷ CCHIT certification standards for Ambulatory Electronic Health Records can be accessed at www.cchit.org/certify/ambulatory/index.asp.

³⁸ These standards are informed by national analysis and practices by payers in Rhode Island and elsewhere in the U.S.

³⁹ Based on per physician EMR adoption cost of \$33,000, a target of 25% overall subsidy, and market shares of 62.5/32.5/5 respectively.

Appendix B: Primary Care Spend Metric

For the period July 1, 2007 through June 30, 2008, for all fully insured commercial business, all medical payments¹ made to primary care providers² in Rhode Island, regardless of where the member resides. Payments should be reported as both total dollars spent during the time period and as a percentage of total medical payments³ during the time period.

1. Payments defined as paid* claims. Medical payments exclude Rx, lab and imaging services, and are broken out by:

Payment for services: CPT codes, capitation, etc.

Incentive/bonus payments, including both performance and infrastructure payments

All other payments (please explain)

- * Note: Both Tufts HP and BCBSRI prefer to use allowed claims, rather than paid, due to concerns regarding the impact of changing benefit design/increased cost sharing on the "paid" metric. Given this preference, all three carriers provided historical claims both ways – using paid claims and using allowed claims. The data showed that allowed was a few points higher than paid, but that this difference did not change over time, as was anticipated. Based on this finding, the group agreed to use paid claims, but to report allowed claims on an ongoing basis, in case this relationship changed.

2. Primary care providers are inclusive of the following:

- practice type: Family Practice, Internal Medicine and Pediatrics
- professional credentials: Drs of Medicine and Osteopathy, Nurse Practitioners, and Physicians' Assistants

"Dual" providers, i.e., those who deliver both primary and specialty care, are excluded, except in those instances where the specialist is paid on a PCP fee schedule.

3. "Total medical payments" includes all payments made to Rhode Island facilities and providers, regardless of where the member resides.

- This should include Rx, Behavioral Health, lab and imaging services.
- Medical payments should be inclusive of any secondary payer payments.
- Rx payments* should include Rhode Island payments only.
 - Blue Cross will include only those payments made to pharmacies in Rhode Island, plus mail order payments (again, regardless of where the member resides). Rx carve outs will be adjusted by the % of members with pharmacy benefits, and that % will be included in ongoing reporting
 - United will include only those payments for scripts written by RI providers, regardless of where it is filled.

- * Note: There was discussion of the possibility that there would be a growing share of business with Rx carve outs. We agreed that carriers could and should report on this issue on their primary care spend reports, and may report an adjusted spend percentage, reflecting the impact of Rx carve outs.

Appendix C: Public Comment



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March 23, 2009

RE: Public Comment - System Affordability Priorities and Standards for Health Insurers in Rhode Island

*“When we tug on a single thing in nature,
we find it attached to everything else.”*

John Muir

“Why has government been instituted at all?”

*“Because the passions of men will not conform to
the dictates of reason and justice, without constraint.”*

Alexander Hamilton (1788)

The National Association of Social Workers - Rhode Island Chapter promotes any regulatory efforts that moves Rhode Island closer to quality healthcare for all individuals living within Rhode Island borders, regardless of economic or resident status. We also believe that all parties concerned including insurers, providers, government entities, and most importantly consumers, must have their perspective needs met for a healthy and productive healthcare system.

Although this Council’s report is generally aimed at Primary Care Systems, not an area of our expertise, we felt it was important to begin “setting the table” for addiction and mental health services. As social workers, we do not claim expertise in primary health care, however we do believe that social work needs to be more integrated in primary healthcare systems, including associative relationships with primary care physicians. Currently the primary medical fields social workers are largely represented are hospitals, nursing homes, adult day centers community and facility based long term care.

The following comments include areas in which we feel our expertise has something to add to the present discussion. In addition, our comments are related to future discussions regarding addiction and mental health service delivery systems. The format of comments are in direct relationship to the order and format of the OHIC report.

I. *Broad Categories (page 2):*

NASW - RI agrees with the two broad categories outlined in the report:

- **Fair Treatment of Providers**
- **Policies that Promote Improved Accessibility, Quality and Affordability for the RI Health System.**

We also believe that all three parties - insurers, consumers, and the regulatory body, are interdependent and need to be accountable to each other in a formalized process and with measurable benchmarks.

II. *Final Recommendations System Affordability Priorities (page 3).*

1. ***Expand and improve the primary infrastructure in the state - with limitations on ability to pass on premiums.*** To effectively address premiums, the current system of competitive market driven insurance entities may need to be redesigned. Although the free market response to healthcare insurance provision may indeed lower cost in some instances, we believe that there are several flaws and important factors to consider when looking at this system.

The free market system is not a social program and is based on a “highly” competitive model with each entity trying to gain an upper hand on the market. This system may or may not emphasize quality of care and consumer choice as its’ top goal.

- A for profit company, must by mission and law, try to make money for its stock holders. In our opinion, this reason for existence drives many decisions on all levels of service.
- A non profit organization only works if its is driven by a strong mission to provide the highest quality and affordable services and return all funds back into the system of care.
- Government run systems are vulnerable to fluctuations in government revenue conditions.
- Each of the above systems are open to influence by politically driven forces.

Any healthcare system that relies on an insurance base funding scheme, must make decisions on how to handle for-profit, not-for-profit, and government insured services and maintain control through an enhanced regulatory process. This includes the rate review process. Rhode Island has a mix of all the above entities for health insurance provision and, in our opinion, the failure to overcome obstacles faced in each system has resulted in our current largely unplanned and sometimes inadequate healthcare system of care. A basic agreement of all who choose to remain involved, in our opinion, should be driven by one value: **All people living within our borders should have the healthcare services and options they need.**

2. ***Spread Adoption of the Chronic Care Model-Style Medical Home.*** NASW - RI does not have enough information or experience in this area to comment. However, we assume that the Chronic Care Model - Style Medical Home refers to physical illness only.

Concerning mental health services, a major entity responsible for the “medical” assessment

for many people is the consumer themselves. Unless incapacitated by their issue, the consumer is in the best position to relay information about their symptoms and condition to the mental health practitioner who then in turn arranges and/or provides services. The ultimate assessment of success is determined by the consumer. It would not be acceptable by the social work profession to have a non-mental health professional make decisions about types or range of services. In essence, when possible and within reasonable costs, the consumer should determine most of their services unless proven ineffective or impossible due to the consumer being judged legally not competent or a danger to self or others. In other words, the “medical home” lies in close proximity to the client.

3. ***Standardized EMR Incentives.*** NASW - RI has been a strong advocate of patient/consumer electronic records as long as participation is voluntary by the consumer. Besides serving on several Rhode Island Quality Institute committees looking at electronic records and testifying in the Rhode Island House and Senate regarding funding for a statewide electronic record system, this writer has many personal and professional anecdotal stories where electronic records could have reduced a great deal of pain and aggravation by consumers and actually saved considerable funds due to unnecessary hospitalization and duplication of services. It would be logical that standardization of incentives would benefit providers, insurers and consumers.
4. ***Work Toward Comprehensive Payment Reform Across the Delivery System.*** NASW - RI does not have the knowledge base or experience to comment on payment structures regarding primary care and other physical medical treatment. Even though by law, our organization can not enter into discussion regarding specific rates, we can shed light on critical issues including payment of professionals in relation to service access. We are a strong advocate of increasing medicaid and other publically funded healthcare services to standard commercial rates. This greatly increases choices of service providers particularly for people with government funded healthcare. NASW - RI is also committed to true mental health parity in regards to access to treatment and payment of providers.

III. Rate Review Process (page 4)

Regarding the Rate Review Process, NASW - RI fully supports the four areas identified to help determine fair rates.

1. Solvency

Regardless of who is providing the insurance service, it goes without saying that the entity needs to be solvent. Providing the entity is “running a tight ship” consideration of rate increases or decreases need to be looked at through the scope of solvency.

2. Consumer Protection

The consumer is the reason for any healthcare entity to exist, regardless of corporation status. In the ideal world, there would be no need for consumer protection regarding these services. However, we do not exist in an ideal world. Profit making corporations need to figure out how to balance their

need to make a profit and the service provided to consumers. Non - profit entities need to balance running their business efficiently and providing the service to the consumer. Government entities need to balance government revenue potential and the will of the people with providing promised services and in some cases the provision of “last resort” services. In the opinion of NASW - RI, we can not provide full “consumer protection” until all who need healthcare are able to receive it both in quality measures and timely provision.

3. Fair Treatment of Providers

How much is enough? What is too little? These are two very complicated questions that need to be vetted both in the private market and in the public domain. From a mental health professional point of view, how much payment is guided by several factors. Most mental health services are provided on a one to one bases and for most private practitioners in hourly increments. Each private practitioner is a small business person responsible to pay rent, pay employees if they exist, maintain healthcare and liability insurance, etc. Rates need to take these factors into consideration. Other “provider fair treatment” issues include required paper work, methods of how services are evaluated, ease of qualifying for payment from insurance companies, prompt payment and other smaller but important factors.

4. Health Plan Policies to Improve Affordability, Quality and Accessibility of Medical Care.

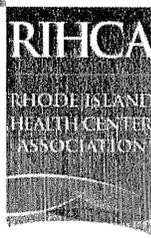
This is a complicated area due to the many variables relating to affordability, quality and accessibility. Any change in one area, generally affects the other areas and it is also guaranteed that there are trade offs when making these changes. The only way to make these changes effectively is to provide transparency and to keep primary goals in mind. There are many social and economic factors that affect how health programs are implemented. We stress again that the main goal is to provide quality and effective healthcare services to all people living in our borders. We realize this is not attainable right now, but we believe it needs to be part of every discussion and decision that involves healthcare.

We applaud the Commissioner’s Office and the Council in their effort to delve into a very intensive process and are generally encouraged by their work output and sincerity in looking at the insurer rate review process. We are confident in both the people involved and in the process. If I can be of any help, please do not hesitate to contact me, especially on issues related to full healthcare coverage and mental health services.

Sincerely,

Rick Harris, LICSW
Executive Director

235 Promenade Street | Suite 104
Telephone: 401-274-1771



Providence, Rhode Island 02908
Facsimile: 401-274-1789

March 24, 2009

Christopher F. Koller
Health Insurance Commissioner
1511 Pontiac Ave, Building #69 first floor
Cranston, RI 02920

Dear Commissioner Koller,

I write today on behalf the Rhode Island Health Center Association and its members, Rhode Island's ten community health centers, to comment on the draft report, "System Affordability Priorities and Standards for Health Insurers in Rhode Island," and to commend the Health Insurance Advisory Council and the Office of the Health Insurance Commissioner for this good and important work.

Rhode Island's ten community health centers are a critical element in the state's health care landscape. Serving 112,000 Rhode Islanders annually, the community health centers provide comprehensive, high quality primary and preventive care to some of Rhode Island's most vulnerable populations. About 42% of our patients are publicly insured, and 28% are uninsured.

The health centers are leaders in primary care in Rhode Island. We are active proponents of the medical home model of care, participants in the Rhode Island Chronic Care Sustainability Initiative and the Rhode Island Chronic Care Collaborative, and early adopters of electronic medical records. Because of this, we were particularly pleased to see the four proposed priorities of the Health Insurance Advisory Council, and write in support.

Priority 1: Expand and improve the primary care infrastructure in the state – with limitations on ability to pass on premiums.

The Rhode Island Health Center Association wholeheartedly endorses this effort. A rebalance of spending from the insurers is an innovative attempt to begin to address the problem filling available primary care positions in Rhode Island, and the need to increase primary care. Primary care is a relatively inexpensive investment in the health of our state. The data cited in the report regarding the cost savings we could expect by increasing the proportion of primary care providers is quite convincing. Of course, this is one piece of the larger puzzle regarding how to increase primary care in Rhode Island. The continuing difficulty recruiting primary care providers is highlighted in an article yesterday in the Providence Journal, "Most of Brown's medical school grads plan specialty practices," (March 23, 2009). Clearly, the problem of access to primary care providers is one that we will be facing for some time to come. RIHCA is glad to see the important work that OHIC is doing to address this key issue.

Priority 2: Spread Adoption of the Chronic Care Model Style Medical Home

Rhode Island's community health centers are leaders in the move to medical home models of care for patients with chronic health issues. Thundermist Health Center is one of the five CSI-RI sites through the Rhode Island Chronic Care Sustainability Initiative. In addition, all of our health centers participate in the RI Chronic Care Collaborative (RICCC) as well. The goal of RICCC is to assist providers in developing processes and initiatives to better manage and improve the quality of care for their patients with chronic diseases. The health centers' commitment to quality primary care, and the success of the demonstration project leads us to support the initiative for expansion to more patients and more sites.

Priority 3: Standardized EMR incentive

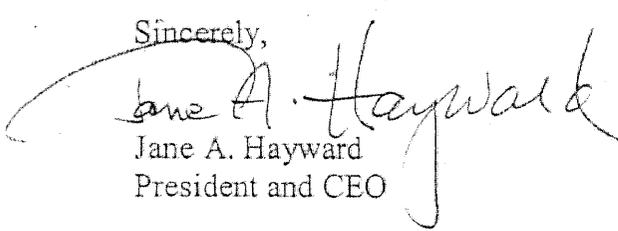
The community health centers support the initiative to incentivize transition to EMRs for all providers. The health centers have been in the forefront of this transition. Six of our ten health centers are currently using EMRs, and a seventh will begin shortly. The others are in the planning stages. In addition to funds for the transition, money is needed for the maintenance and expansion of EMR systems. EMR is a tool to support effective and efficient practice. We believe that the greatest benefit of EMR systems is the potential they have to increase quality care. The health centers continue to benefit from our partnerships with each of the insurers, and support efforts to increase incentives to transition to EMR and to maintain systems.

Priority 4: Work toward comprehensive payment reform across the delivery system

Since one of our goals as community health centers is to focus on prevention and good health outcomes, we support efforts to create new ways for payment that recognize these goals. Fee for service payment structures have a bias towards procedures and additional patient visits. Further study of this issue is necessary, and RIHCA looks forward to learning from the Advisory Council's study.

In conclusion, the Rhode Island Health Center Association, and our ten member community health centers, support the work of the Health Insurance Advisory Council and the Office of the Health Insurance Commissioner, and look forward to working together on the proposed initiatives.

Sincerely,


Jane A. Hayward
President and CEO

From: <ksperber@hillsidefamily.com>
To: <lmello@ohic.ri.gov>
Date: 3/24/2009 2:19:14 PM
Subject: Affordability Standards

I'm writing in response to the call for public comment on the proposed Affordability Standards. I have only one specific comment to put into the mix. The Standards mention fair treatment of providers. We are routinely "reimbursed" for covered services such as vaccinations at less than their actual cost. It is not at all fair for a vaccine which costs \$30 per dose to be "covered" but only reimbursed \$25 per dose. This is commonplace and is practiced by nearly all payors. We can provide a detailed analysis showing this practice if it would be helpful.

Ken Sperber, MD
Hillside Family Medicine

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March 24, 2009

Christopher Koller
Health Insurance Commissioner
Department of Business Regulation
1511 Pontiac Avenue
Cranston, RI 02920

Dear Mr. Koller:

I am writing in support of your draft standards "system Affordability Priorities and standards for health insurers in Rhode Island." In particular I support the four priorities outlined in the document (expand primary care, adopt the chronic care model-style medical home, utilize EMR incentives, and participate in payment reform). I also agree with the methodology used to identify these four priorities.

With respect to the first priority specifics, I support the increase to 10.9% of the commercial medical spend in RI for primary care. For all the reasons outlined in your document, this is one of the best actions that can be taken to improve the health of Rhode Islanders. The metrics also seem reasonable for measuring primary care infrastructure.

The second priority is also integral to the first priority. While increasing the supply and availability of primary care it is important to improve the public's health and decrease costs, it should be tied to reform of the delivery of primary care. The chronic care model and medical home model both have been shown to better meet the needs of the current population seeking medical care. However, the current reimbursement system does not adequately support this mode. Thus, the addition of a PMPM payment that is linked to these models is important. While, metrics tied to chronic disease practices or outcomes are important I would suggest that you might add one or two structural measures that support the chronic care or medical home model.

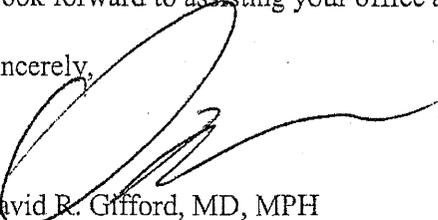
The third priority to create incentives for EMR adoption links well with the current national HIT efforts in the stimulus package and ongoing efforts in the State to shift from a paper medical record to an electronic medical record. While the incentive of any one provider would be inadequate, collectively the incentives you outlined with the incentives from the Federal government in the stimulus package should be adequate to help physicians adopt EMRs.

The fourth priority is linked to the previous three and equally important. Much of the problems in the current medical care delivery system can be linked to the payment methodology. Reform in payment methodology, which the first three priorities represent first steps toward payment reform, is necessary to improve the health of Rhode Islanders and to lower costs.

I think these standards are long overdue and extremely important to improving health and lowering costs and as such, consistent with the intent and authority of the enabling legislation creating the Office of The Health Insurance Commissioner.

I look forward to assisting your office adopt and implement these standards.

Sincerely,



David R. Gifford, MD, MPH
Director

Chris/Rick:

A last minute customer conference call was scheduled for 3:30p this afternoon. It is doubtful that this will wrap up any earlier than 5:00p and I will most likely be unable to attend tonight's meeting.

A few quick comments:

I'm concerned about the Impact Assessments with respect to the "freshness" of the data. More current data will provide the most valuable tool but if we're using three yr old reports, we cannot assess our decisions until too late. There must be some data that is available real time that gives us the indications we need. I'd be happy to reach out to the carriers myself if you think it might help.

Some recent news from MA seems to indicate that the state is struggling mightily with cost containment. One piece suggested that the state ignored that critical piece from the outset and is now forced to deal with the inflation. Is it still too soon to use MA as a contrary benchmark? If they truly are failing to contain costs (and possibly even accelerating inflation), we may want to look at comparisons from our proposals to what may exist in the MA system.

Apologies for the late notice.

Roland

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March 24, 2009

Christopher F. Koller
Health Insurance Commissioner

Dear Mr. Koller:

My name is Dr. Charles Cronin and I am a Board Certified Internist practicing primary care in Rhode Island. I would like to commend you on your efforts to improve the healthcare environment in Rhode Island, particularly as it pertains to primary care. As you well know, primary care is in extremis in Rhode Island. With increasing overhead costs, poor reimbursement and the inability to negotiate with the Providers, it is a difficult and frustrating environment to practice in.

Over the last several years, I have had a continual decline in revenue, which can be attributed to the practices of the Insurers in Rhode Island. For every initiative they put forward in the name of curtailing health care cost, comes more time and money by the physician. Prior authorizations for medications to imaging studies have required many offices to dedicate or hire staff to handle the increased workload.

Good primary care can save the healthcare system millions of dollars in Rhode Island alone. However, with this toxic environment, it cannot be achieved. As recently cited in the Providence Journal, medical students are not choosing primary care. How can a state that grossly underpays their primary care physicians compared to its neighbors and the rest of the country, retain and attract primary care physicians? The answer is obvious, we can't.

Again, I applaud your efforts. Rhode Island can be a leader in healthcare reform if we choose to.

Sincerely,

Charles L. Cronin III, D.O.
Diplomat, American Board of Internal Medicine

348 Gleaner Chapel Road
Scituate, Rhode Island 02857

March 24, 2009

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

Dear Mr. Koller,

Thank you for providing the opportunity for public comment on system affordability priorities of the Office of the Health Insurance Commissioner.

I am writing, specifically, to applaud those priorities.

Recent work at the Robert Graham Center, the Dartmouth Center for Clinical Effectiveness, at Johns Hopkins, Harvard, and elsewhere has shown the value of a strong primary care infrastructure in controlling health care cost, and improving quality.

States with more family physicians per ten thousand population have health care costs that are 10 to 25 percent less than states with fewer family physicians, and have improved measured population health. Nationally, Rhode Island ranks in the lower third of the country for the number of family physicians per ten thousand population, and in the upper third for health care costs.

Recent studies at the Robert Graham Center help us to understand why that is the case. Emergency room utilization, and hospital utilization, is lowest where there are more family physicians.

We have also studied the impact of community health centers and group practices. Community Health Centers and group practices are associated with the lowest health care cost, an effect which exists at all patient income levels.

The system affordability priorities being presented to day will help Rhode Island build the primary care infrastructure needed to improve quality and reduce cost, two directions critically necessary if we are to resuscitate Rhode Island's wounded economy.

I am sorry I cannot be there in person to offer this testimony myself. Please let me know if I can provide you with more information or testimony.

Respectfully Submitted,

Michael Fine, M.D.
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End Notes

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