AMERICAN ACADEMY OF FAMILY PHYSICIANS

Primary Care Spend Toolkit

Rhode Island's Regulator Work on Primary Care Spend

Background

In 2004, the Rhode Island General Assembly passed the Rhode Island Health Care Reform Act of 2004 which created the Office of the Health Insurance Commissioner (OHIC). The OHIC is empowered to regulate the state's health insurance industry to ensure solvency, protect consumers, engage providers and improve the system.

In 2008, OHIC conducted a study of high performing health care systems and their affiliated health plans nationwide, focusing on their levels of primary care spend in their respective state compared to the primary care spend level in Rhode Island. The data showed that primary care spending in Rhode Island, with an average of 5.9 percent of all medical expenditures, was noticeably below benchmark plans in other states, which ranged from a low of 7.1 percent (a Massachusetts HMO) to a high of 14.0 percent (Group Health of Washington State).

Using its authority established under the 2004 law, OHIC established the first set of affordability standards to lower costs and improve quality in Rhode Island in 2009. The affordability standards contained four key components: increase investments in primary care infrastructure, based on studies that have shown that an adequate supply of primary care physicians can reduce health disparities across racial and socioeconomic groups, and improve health outcomes and reduce costs; expand the adoption by primary care practices of the patient-centered medical home ("PCMH") model, based on evidence indicating that a primary care medical home focused on improving care for people with chronic conditions can improve quality and lower costs significantly; standardize provider incentives to adopt electronic medical records systems; and establish a collaborative process to change how providers are paid by reducing reliance on traditional, inefficient fee-for-service payment methodologies.

Specifically, the primary care spend component of the OHIC's affordability standards required health plans to increase the proportion of their medical expenses spent on primary care by one percentage point per year from 2010 to 2014. Each insurer was required to submit a plan to OHIC that demonstrated how the increase was achieved. Insurers were required to show that the primary care increase was accomplished without contributing to an increase in premiums, with an emphasis on innovative contracting and payment and system investment, and not a fee schedule manipulation.

2012 Report - Primary Care Spending in Rhode Island

In September 2012, the OHIC published a report examining the actual and predicted performance of the state's three largest health insurers against their primary care spend targets. The report made four key findings.

Insurance companies were hitting their targets. In 2011, Blue Cross Blue Shield of Rhode Island and United met their primary care spending target and were predicted to do so in 2012. Tufts Health Plan spent roughly the same percentage on primary care as the other two companies in 2011.

Primary care spending was growing while total medical spending was falling. Total primary care spending for commercial members increased by 23 percent while total medical spending fell by 18 percent (2007-2011). In 2011, insurers spent 8 percent of medical claims dollars on primary care, up from 5.4 percent in 2007.

Patient Centered Medical Homes (PCHMs) and other non-Fee for Service (FFS) methods drove the rise in primary care spending. The shift to non-FFS payment supported comprehensive payment reforms across the health care system and reflected rising financial support for innovative medical care delivery, including patient-centered medical homes (PCMHs) and health information technology, the focus of the second and third set of affordability standards. These non-FFS investments were significant because evidence suggests that PCMHs deliver higher quality care and cost savings relative to traditional practices. Preliminary evidence from the RI-CSI, the state's all payer medical home, showed better delivery of preventive care, increased patient satisfaction through enhanced access to providers and staff, and reduced use of high cost services. For example, rates of hospitalization fell 6% when compared with non-PCMH practices.

Primary care spending would continue to grow and future primary care spending would further prioritize non-FFS investments. The report estimated that through 2014, insurers will have spent $65 million more on primary care than they

would have had they not prioritized this investment, with a particular emphasis on non-FFS investments that are more effective, affordable, and contribute to more positive health outcomes.

2014 Report – Primary Care Spending in Rhode Island

In January 2014, the OHIC produced another report on primary care spend which made four key findings.

Insurers were still hitting their targets. In 2012, BCBSRI and United met or exceeded their primary spending targets. In 2012, insurers spent 9.1 cents of every fully insured commercial medical dollar on primary care services; this was an increase of nearly 3.5 cents from 2008.

Primary care spending was continuing to rise. Spending on primary care grew 37 percent from 2008 to 2012, while total medical spending fell 14 percent. In 2012, the market spent $7 million more on primary care than it did in 2011. Insurers spent more money on primary care even as their spending on all other services had fallen. Annual primary care spending rose by $18 million from 2008 to 2012 while annual total medical spending dropped $115 million during the same time.

Non fee-for-service (non-FFS) investments continued to increase. Insurers continued to invest in non-FFS methods, particularly Patient Centered Medical Homes, as well as investments in health information technology, practice transformation, and loan repayment programs, to drive their primary care spending. Of the $65 million spent on primary care in 2012, nearly $22 million (34 percent) funded non-FFS projects. BCBSRI's proportion of primary care spending dedicated to non-FFS investments were 3.5 times higher than it was in 2008. United's 2012 investments in non-FFS was 15 times greater than it was in 2008. BCBSRI and UHC project non-FFS investments accounted for 45.7 percent and 47.3 percent, respectively, of primary care spending in 2014. Tufts, however, was the only insurer to report a decrease in non-FFS investments, falling 0.3 percent from 2011 to 2012 and 1.8 percent in 2013.

The study concluded that *the future of primary care in Rhode Island was promising*. Investments in both fee schedules and non-FFS methods bolstered the state's primary care delivery system. Because off the affordability standards, primary care saw additional investment from the commercial insurers of $64 million since 2010. Raising the portion of premium dollars spent on primary care supported the state's transition into a system of value-based care. These investments strengthened both the primary care system and the medical delivery system generally. They helped clinicians keep people well and out of more intensive care. They augmented the state's health IT system and enabled primary care practices to coordinate the care their patients receive from specialists, hospitals, and home health care. The aggregate value of these investments was clear, though OHIC continued to monitor whether the affordability standards met evolving market needs.

2015 Regulation

In the 2014 assessment of the affordability standards implementation, OHIC concluded that much of the non-fee-for-service expenses were directed to services, that while beneficial to primary care providers, were not providing a direct benefit to capacity building within primary care practices – a function considered essential for care transformation in health care. OHIC also found that the current level of total primary care spend (10.6 percent) was generally in line with the benchmarks identified in 2009. Because of these findings, OHIC decided to focus the revised affordability standards to retain the current rate of primary care spend for future periods until more updated benchmarking data could be developed and promote direct support for primary care practice infrastructure to support practice transformation.

To implement these goals, OHIC developed definitions for direct and indirect primary care expenses and set minimum funding standards for direct spending. The new affordability standards required health insurers to maintain the level of spending of at least 9.7 percent of annual medical expenses on direct primary care and at least 1 percent on indirect primary care (for a total of 10.7 percent). Direct primary care payment was defined as that which directly benefits primary care practices and providers. Indirect primary care payments were defined as those payments that help primary care practices to function as PCMHs and included support for Rhode Island's Chronic Care Sustainability Initiative and CurrentCare (the state's health information exchange).

What's Next in Rhode Island?

The Care Transformation Advisory Committee adopted its 2019 Primary Care Transformation Plan in January 2019 to achieve the new affordability standards requirement stating that, no later than December 31, 2019, 80 percent of the primary care practices contracting with the Health Insurer are to be functioning as Patient-Centered Medical Homes (PCMHs). Furthermore, the Committee was also tasked with putting forward an Alternative Payment Methodology Plan to encourage the transition away from fee-for-service into alternative payment methodologies to save on cost and improve quality outcomes.

The Care Transformation Advisory Committee argued that a strong primary care infrastructure is a vital element of a health care delivery system that supports affordable health care coverage. To revolutionize how primary care is delivered in Rhode Island, statewide PCMH transformation and continued movement away from fee-for-service is crucial.