To: Rhode Island Health Plans
Health Insurance Advisory Council

From: Christopher F. Koller, Health Insurance Commissioner

Date May 12th, 2011

Re: Decision on Interpretations of Primary Care Spend Guidance

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Several policy issues have been brought before OHIC as the health insurers have developed their primary care spend plans for 2011. OHIC released initial "Guidance for Primary Care Spend for Health Insurers" in March 2011. Since the guidance was released, additional issues have been brought before OHIC for consideration. After consulting with the Health Insurance Advisory Council and the insurers in April of this year, I am making the following interpretations on these additional issues raised. For documentation purposes, this memorandum should be considered an addendum to the "Guidance for Primary Care Spend for Health Insurers".

Issue One: Applicability of 25% standard for non fee-for-service portion of primary care spend in 2011.

The health insurers have made a persuasive argument that they were not given adequate time to prepare for this standard, as the Primary Care Spend Guidance document was released in March of 2011, three months into measurement year. Accordingly, they will not be held to the 25% standard in 2011. For 2012, the previously articulated standard of 30% remains. Exemptions to that standard will be made only if the insurer can demonstrate that its fee schedules would have to be reduced to achieve this standard.

Issue Two: Inclusion of expenses for flu clinics as part of primary care spend

Flu clinics are immunization events held in non-physician settings. Health plans often pay for members who receive covered immunizations there. OHIC supports the public health goals of immunization and has no policy position on where those immunizations are best administered. As consistently articulated, the goal of the primary care spend standard is to achieve primary care payment reform and strengthen the primary care infrastructure, with the desired outcomes of fewer unnecessary hospitalizations and emergency room admissions, lower premium trends and more numerous and more satisfied primary care practitioners. While flu clinics may contribute to the desired outcomes, so do many other things which are not associated with primary care spend, such as hospital payment reform, inpatient quality of care initiatives, and wellness promotion efforts; therefore, OHIC cannot justify inclusion of this particular category of spending outside the primary care setting as a primary care spend.

Issue Three: Inclusion of expenses for data reporting to primary care providers as part of primary care spend

The insurers and primary care physicians have made compelling cases that primary care physicians will not be able to achieve the goals identified above without information on services provided outside primary care offices to the populations for whom they are

responsible. Information on these services rests in many settings – the other providers, the insurers themselves, and in some cases in some sort of central repository. Often, however, the information can also be of strategic value to the owner or manager of the information – for increasing business, for obtaining competitive information or for negotiating advantage. OHIC believes that such medical information fundamentally should be deemed the "property" of the patient themselves, not any provider or insurer. As a corollary, aggregations of the data and information should be primarily for public purposes, not private ones. These are admittedly vague standards and need some sort of practical interpretation. Accordingly, OHIC has determined that expenses by insurers spent to make clinical and utilization information available to primary care physicians should be considered part of a primary care spend definition, so long as those expenses meet the following criteria:

1. The expenses are for data reporting projects approved by a representative consortium of primary care physicians organized for the purposes of practice improvement, such as the CSI/Beacon projects.
2. "Data reporting" refers to any effort to aggregate clinical, claims or enrollment information possessed by health plans and to analyze and transmit this information to groups of primary care providers. Third party efforts to promote electronic health record adoption by primary care physicians or the direct exchange of clinical information between providers are not considered "data reporting".
3. The resulting aggregated data are used primarily for the purposes of quality improvement, care coordination and practice management, not private negotiation.
4. Resulting analyses are publicly available under disclosure methods agreed to by all parties.
5. The expenses to be allowed are those directly incurred by the insurer or a contractor for these projects - not for allocated insurer administrative costs - and there is sufficient documentation of the expenses by the insurer.

OHIC recognizes that these are working criteria that may have to be further developed, and pledges to be responsive to insurer requests for interpretation or clarification.