Primary Care in Rhode Island

Current Status and Policy Recommendations

December 2023

This report presents the recommendations of the Office of the Health Insurance Commissioner to strengthen primary care in Rhode Island.

STATE OF RHODE ISLAND

Office of The Health Insurance Commissioner

Department of Business Regulation

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December 12, 2023

To the Reader:

A robust and resilient system of primary care is necessary to support the health and well-being of Rhode Islanders. Under Rhode Island law, the Health Insurance Commissioner is directed to discharge the powers and duties of the office to "view the health care system as a comprehensive entity and encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access."[1]

The Office of the Health Insurance Commissioner (OHIC) possesses unique policy and regulatory levers to support a robust system of primary care in the state. Given the mounting challenges facing the primary care workforce nationally and locally, coupled with an ever-changing health care landscape, in February I initiated a process to evaluate and refresh OHIC's strategic use of policy and regulatory levers to support primary care in Rhode Island. This process included a review of national and local trends in primary care, a literature review on the contribution of primary care to health outcomes and health care system performance, and semi-structured interviews with local providers and practice groups, insurers, and other interested parties.

OHIC's research and stakeholder interviews reveal significant challenges facing primary care that are likely to worsen over time. Our findings also reveal strengths that position Rhode Island for successes in meeting these challenges. Given the evidence, I find the need for action compelling and the report that follows outlines specific actions that OHIC will undertake in 2024 and beyond to strengthen primary care. These actions will support OHIC's broader goals of improving the health care system as a whole and promoting affordable health insurance. Where recommended actions are beyond the authority of OHIC to effectuate independently, OHIC will lend its advocacy to those efforts.

OHIC recommends specific actions in the domains of primary care payment, reduction of administrative burden, and targeted incentives to attract and retain primary care providers in the state. The themes we heard most consistently from primary care providers related to workforce capacity, fears about the future trajectory of the workforce due to retirements, and administrative burdens due to utilization review practices and use of electronic health records that lead to clinician burnout.

The supply of primary care providers, and the care teams around them, are essential to meeting the health care needs of Rhode Islanders. Efforts to address primary care provider payment will be necessary to ensure that Rhode Island maintains an adequate primary care workforce in the near term, and it is able to grow the workforce over time. Enhanced primary care payment will be necessary, but not sufficient. Rhode Island must find innovative ways to train more primary care providers, from MDs and DOs to advanced practitioners. A clinician's time is their most valuable resource, and it is a finite resource. Clinician time spent on administrative tasks is time not spent with patients. We aim to address the allocation of clinician time by meaningfully reducing the use of prior authorization and other burdens.

[1] RI Gen. Laws § 42-14.5-2(5).

As readers engage with the content that follows there is one message that I hope remains top of mind. Rhode Island is well-positioned to make headway in addressing these challenges. Rhode Island is poised to make progress because providers, payers, and advocates have been engaged in collaborative efforts to support primary care for over a decade. This history and successful track record of providers, payers, and government working in collaboration to support access to high-quality primary care will serve us well. We will leverage the relationships and good faith between parties to preserve what we have built during these challenging times and to ensure our future progress.

Sincerely,

Cory B. King
Acting Health Insurance Commissioner

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Acronym Glossary

ACO	Accountable Care Organization
AHEAD	Advancing All-Payer Health Equity Approaches and Development
AMA	American Medical Association
APM	Alternative Payment Model
CMS	Centers for Medicare & Medicaid Services
CPC	Comprehensive Primary Care
CPC+	Comprehensive Primary Care Plus
CTC-RI	Care Transformation Collaborative of Rhode Island
EHR	Electronic Health Record
EOHHS	Executive Office of Health and Human Services
FFS	Fee-for-Service
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
MCP	Making Care Primary
MUA	Medically Underserved Area
NCQA	National Committee for Quality Assurance
NESCSO	New England States Consortium Systems Organization
NP	Nurse Practitioner
OHIC	Office of the Health Insurance Commissioner
PA	Physician Assistant or Physician Associate
PCF	Primary Care First
PCMH	Patient-Centered Medical Home
RIDOH	Rhode Island Department of Health
RVU	Relative Value Unit
TCOC	Total Cost of Care
VBP	Value-Based Payment

Executive Summary

The evidence is clear. Primary care is the foundation of an equitable and high-performing health care system. Primary care improves health outcomes and promotes more efficient use of health care resources. A recent report by the National Academies of Science, Engineering, and Medicine (NASEM) defines the nature and impact of high-quality primary care as follows:

> Primary care provides comprehensive, person-centered, relationship-based care that considers the needs and preferences of individuals, families, and communities. Primary care is unique in health care in that it is designed for everyone to use throughout their lives—from healthy children to older adults with multiple comorbidities and people with disabilities. Absent access to high quality primary care, minor health problems can spiral into chronic disease, care management becomes difficult and uncoordinated, visits to emergency departments increase, preventive care lags, and the nation's health care spending soars to unsustainable levels. People in countries and health systems with high-quality primary care enjoy better health outcomes and more health equity.[1]

Primary care delivers outcomes that support the welfare of the public. These public interest outcomes are placed at risk by a deteriorating primary care workforce. The primary care workforce problem is national and local. Enter the keywords "primary care shortage" into a search and you will find stories about capacity issues and constrained patient access in the press in states and localities near and far. The organization and delivery of primary care is changing, both positively and with potential threats. Significant actions must be taken at the national and local levels to ensure that the primary care workforce is adequate to meet the current and future health care needs of Rhode Islanders. This report reviews national and local trends in primary care but focuses on priority action steps that should be taken at the local level, with emphasis on actions that are within the authority of the Office of the Health Insurance Commissioner (OHIC) to undertake independently, or in partnership with other local entities.

Purpose of this Report

The resiliency of primary care in Rhode Island is a top priority of OHIC. Since OHIC's inception and the creation of its first affordability standards in 2010, OHIC has sought to ensure that primary care has a place high on the state's policy agenda. These efforts include the creation of a first-in-the nation primary care expenditure target for commercial health insurers over a decade ago, mandated investments in the patient-centered medical home (PCMH) model, and co-convening of a multipayer initiative called the Care Transformation Collaborative of Rhode Island (CTC-RI) to support care transformation and the adoption of best-practices in primary care delivery.

Changes in the health care landscape, including mounting primary care workforce and capacity challenges, have prompted OHIC to reevaluate its primary care strategy for the purpose of setting a new direction. In February, OHIC engaged Bailit Health to support this reevaluation. OHIC possesses unique policy and regulatory levers to support primary care in the state through its oversight of commercial health insurers. The research and interviews conducted for this report furnish the rationale for action by OHIC and other entities. They also highlight strengths that Rhode Island can build upon to ensure the primary care workforce of the future is sufficient to meet Rhode Island's needs. The essential role of the primary care physician is emphasized, but it is recognized that advanced primary care requires team-based care, and to realistically meet the health care workforce needs of an aging population, multiple clinical types,

[1] National Academies of Sciences, Engineering, and Medicine. 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983., p.3.

notably advanced-practice nurses and physician assistant/associates, must be effectively incorporated into primary care practices. The NASEM report defines high-quality primary care as follows:

> High-quality primary care is the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams who are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities.[2]

Our Key Findings

1. The primary care workforce in Rhode Island is aging, and many providers are contemplating retirement.
2. Primary care is nationally reimbursed and compensated significantly less than most other medical specialties and there is evidence that primary care in Rhode Island is reimbursed at rates that do not support compensation that is competitive with neighboring states.
3. Nationally, and locally, fewer medical students are choosing primary care as a career path. Educational debt and salary differentials are contributing factors.
4. Those medical students who do choose primary care, and are trained in Rhode Island, are not necessarily staying in Rhode Island.
5. Clinician burnout is a key concern facing the primary care workforce and is driving physicians and advanced practitioners to reduce or leave clinical practice. Burnout among clinicians also negatively affects patient care. Utilization review activities, notably prior authorizations, and the challenges of managing a patient panel under workforce constraints that range from doctors to front office staff, exacerbate burnout. OHIC's interviews with primary care providers and practice groups evidenced that the foregoing challenges are impacting the local primary care workforce.
6. Primary care payment, inclusive of reimbursements and supplemental payments, must be sufficient to support a robust care team of clinicians, medical assistants, and front office staff.
7. The local press has done an excellent job amplifying the concerns and experiences of patients in relation to primary care access. Access for new patients is constrained.
8. Rhode Islanders should have reason for optimism that we can address these challenges. Rhode Island has a higher number of primary care providers relative to population than most states and a relatively higher percentage of residents who report a usual source of care. Rhode Island's small size is an advantage because there are fewer barriers to collaboration among decisionmakers and interested parties. Rhode Island has a track record of policy innovation and multi-payer engagement in activities to improve primary care. This history, our relationships, and our infrastructure put us in a position to make headway as we address these challenges.

Recommendations and Action Steps

OHIC finds the gathered information regarding the state of the primary care workforce to be compelling and to warrant priority state policy attention. OHIC recommends a series of complementary actions to support and sustain the primary care workforce in Rhode Island. Many actions will extend beyond the authority of OHIC and must include other executive branch agency and legislative action. With this recognition, OHIC identifies the following as necessary action steps:

1. Increase insurer payment for primary care so that it more closely approximates other medical specialties and is more competitive with neighboring states. Increased payments should be achieved through increased reimbursements for evaluation and management and other medical services when provided by primary care providers and through capitated payment arrangements that support team-based, high quality patient panel care. The increase in primary care payment

[2] Ibid.

should be effectuated while constraining total medical spending growth to the State of Rhode Island's per capita cost growth target.

   a. OHIC will amend the agency's primary care expenditure target in 2024 to better align the agency's legacy measurement methodology with emerging consensus definitions of primary care expenditures and establish new targets for commercial insurers that will support achievement of necessary increases in primary care payment.

   b. OHIC will publicly report primary care expenditure data using the new methodology and enforce compliance with the commercial expenditure requirements through prior approval health insurance rate review and other means.

   c. OHIC will work with EOHHS and others to promote the positive role Medicaid can have in this process, similar to the exemplary work EOHHS has done for the primary care of children and adolescents.

2. Obtain commitment by health systems that employ primary care clinicians that increases in primary care payment will transfer directly to the benefit of employed primary care clinicians in the form of compensation and practice supports.

   a. OHIC will engage employed physicians, health systems, and commercial health insurer leadership to discuss ways to ensure that the primary care workforce benefits from these investments directly in the form of compensation and supports within clinical practice.

3. Make significant reductions in the administrative burdens placed on primary care practices and providers more generally by insurer utilization review and administrative requirements.

   a. OHIC's Administrative Simplification Task Force is working to develop recommendations to reduce the burden of insurer administrative requirements, such as prior authorization, on providers generally. The burden of prior authorization is significant and OHIC will take necessary actions to meaningfully reduce the volume of prior authorizations through building consensus and promulgating regulations.

   b. OHIC will convene a structured forum with representation from the provider community and health insurers to engage in dialog about the implications of medical management practices and other administrative requirements.

4. Accelerate the provision of prospective payment opportunities for primary care practices through commercial insurers, using models that generally align with the 2017 OHIC consensus methodology developed in collaboration with stakeholders.

   a. Prospective payment enables practices to support team-based care, expanding the bandwidth of clinicians, and provides more predictable revenue and an incentive for primary care practices to grow their revenue by responsibly taking on more patients.

5. Develop a system for tracking and reporting upon the composition of Rhode Island's primary care workforce.

   a. The Rhode Island Department of Health is leading efforts to develop data systems for tracking and reporting upon the composition of the health care workforce. OHIC supports and will advocate for these efforts.

6. Expand primary care workforce training by Rhode Island higher education institutions and create financial incentives for graduates to remain in Rhode Island upon graduation.

   a. The Care Transformation Collaborative of Rhode Island, which OHIC co-convenes with EOHHS, has undertaken a workforce planning effort and developed proposals to improve

primary care training capacity and retention in the state. CTC-RI's proposals are worthy of serious consideration.

   b. Funding should be dedicated to primary care provider loan forgiveness.

7. Maintain ongoing dialogue with primary care providers in the state to ensure an understanding of the challenges they face, to test new policy designs and to assess the effectiveness of initiatives in support of the primary care workforce.

   a. Accountability structures are critical to ensure progress. OHIC will leverage its existing Payment and Care Delivery Advisory Committee to act as the forum for addressing primary care workforce challenges in relation to the primary care payment recommendations described above.

   b. The state should systematically measure and report on the number and percentage of insured Rhode Islanders who report a usual source of care.

   c. The state should create a public-facing dashboard that presents longitudinal data on the primary care workforce, all-payer primary care expenditures, and patient access to primary care with comparison to external benchmarks where available.

In the report that follows OHIC sought to utilize the most recent data available. Where data are more than two years old it is important to contextualize the findings with reference to current experience. Recent articles in the press convey consumer experiences of constrained access that further evidence the need for action. Moreover, recent discussions between OHIC and practice groups reveal increasing average wait times for appointments, in particular for routine and new patient visits. OHIC will continue to maintain frequent dialog with primary care providers as the recommendations set forth in this report are implemented.

1. Background

1.1 Report Purpose

The resiliency of primary care is a top priority of the Rhode Island Office of the Health Insurance Commissioner (OHIC). Since OHIC's inception and the creation of its first affordability standards in 2010, OHIC has sought to ensure that primary care has a place high on the state's policy agenda. Changes in the health care landscape, including mounting challenges in primary care workforce and capacity, have prompted OHIC to reevaluate its primary care strategy. To this end, OHIC conducted a review of the state of primary care, both within the state and nationally, in collaboration with Bailit Health.

The aim of this report is to present the findings from OHIC's research effort and its recommended actions. The report offers an assessment of the current state of primary care in Rhode Island, considering the broader national context. Importantly, it provides recommendations for future actions to support and strengthen primary care in the state. The recommendations include actions that OHIC can take, as well as necessary actions that other executive branch agencies and the General Assembly can take to support primary care. These recommendations will serve as a guide for OHIC's initiatives, ensuring that Rhode Islanders have access to resilient and effective primary care that adapts to evolving health care challenges.

1.2 Why OHIC Prioritizes Primary Care

OHIC prioritizes primary care because accessible, high quality primary care is the foundation of an equitable, affordable, and high-performing health care system. Primary care is critical for initial patient contact, ongoing health maintenance, care coordination, and a healthy population and workforce. Of great interest to OHIC, primary care services can lead to better health outcomes and lower total health care costs. A higher per capita supply of primary care physicians is associated with improved mortality outcomes, increased life expectancy, increased receipt of preventive health services, and reduced low birth-weight rates.[3,4,5,6,7] Important for health equity, access to primary care may have the largest impact on health in areas with the highest levels of income inequality.[8] Greater primary care availability in a community is also correlated with a decrease in utilization of more expensive types of health services, such as hospitalizations and emergency department visits.[9] Primary care clinicians use fewer tests, spend less money, and protect people from overtreatment more than the subspecialists from whom people seek routine care.[10] Exemplary of primary care's importance, a recent analysis found that addressing basic patient problems in the emergency room costs up to 12 times more than in primary care offices.[11] Overall, primary care providers are central to the well-being of Rhode Islanders, the sustainability of the state's health care system, and economic development.

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[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3108147/

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[5] Starfield B, Shi L, Macinko J. Contribution of Primary Care to Health Systems and Health. *The Milbank Quarterly*. 2005;83(3):457-502. doi:10.1111/j.1468-0009.2005.00409.x.

[6] Basu S, Berkowitz SA, Phillips RL, Bitton A, Landon BE, Phillips RS. Association of Primary Care Physician Supply With Population Mortality in the United States, 2005-2015. *JAMA Internal Medicine*. 2019;179(4):506-514. doi:10.1001/jamainternmed.2018.7624

[7] Yanagihara D, Hwang A. Investing in Primary Care: Why it Matters for Californians with Commercial Coverage. *California Health Care Foundation.* 2022. Available at: https://www.chcf.org/wp-content/uploads/2022/04/InvestingPrimaryCareWhyItMattersCommercialCoverage.pdf.

[8] Shi L, Starfield B, Politzer R, Regan J. Primary care, self-rated health, and reductions in social disparities in health. *Health Serv Res*. 2002;37(3):529-550. doi:10.1111/1475-6773.t01-1-00036.

[9] Kravet SJ, Shore AD, Miller R, Green GB, Kolodner K, Wright SM. Health care utilization and the proportion of primary care physicians. *Am J Med*. 2008;121(2):142-148. doi:10.1016/j.amjmed.2007.10.021.

[10] Phillips RL Jr, Bazemore AW. Primary Care And Why It Matters For U.S. Health System Reform. *Health Affairs*. May 2010;29(5): 876-880. doi:10.1377/hlthaff.2010.0020.

[11] UnitedHealth Group. 18 Million Avoidable Hospital Emergency Department Visits
Add $32 Billion in Costs to the Health Care System Each Year. 2019. Available at: https://www.unitedhealthgroup.com/content/dam/UHG/PDF/2019/UHG-Avoidable-ED-Visits.pdf.

1.3 Brief History of OHIC Primary Care Initiatives

Since its creation in 2004, OHIC has undertaken a series of strategic initiatives aimed at improving the accessibility, affordability, and quality of primary care for Rhode Island residents. This section provides a brief overview of these initiatives. These initiatives have:

1. Responded to or ameliorated many emerging aspects of the crisis of the first decade of this century while laying a foundation for future improvements.
2. Led to the transformation of practices where the majority of Rhode Islanders receive their care in advanced primary care practices, including a growing capacity for integrated behavioral health care and participation in advanced primary care by Rhode Island's Federally Qualified Health Centers (FQHCs).
3. Resulted in regular reporting of OHIC harmonized contractual quality metrics and improvements in their results.
4. Spurred capacity and willingness of practices to participate in shared savings, capitated primary care and other advanced alternative payment programs.
5. Created organizational capacity to bring diverse entities together, obtain grants, introduce innovation, share best practices, and educate through the establishment of a multi-payer primary care initiative.

Care Transformation Collaborative of Rhode Island

In 2008 OHIC and the Executive Office of Health and Human Services (EOHHS) convened the Chronic Care Sustainability Initiative (now, the Care Transformation Collaborative of Rhode Island [CTC-RI]) to support the continuing transformation of primary care in Rhode Island. CTC-RI brings together stakeholders to implement, evaluate and spread effective multi-payer models to deliver, pay for and sustain high-quality, comprehensive, accountable primary care. CTC-RI facilitates the exchange of knowledge and best practices, ultimately leading to improved primary care outcomes and the integration of preventive health measures into primary care settings.[12]

Primary Care Spend Obligation

OHIC directed insurers to increase primary care's share of total medical payments by one percentage point per year from 2010 to 2014. Since 2015, OHIC has directed commercial insurers to annually spend at least 10.7 percent of their medical expenses for all fully insured lines of business on primary care, 9.7 percent of which shall be for direct primary care expenses.[13] The goal of this initiative was to drive increases in primary care investment relative to higher-cost inpatient and outpatient specialty care, thereby stabilizing and sustaining the primary care workforce. Investments emphasized non-claims-based (i.e., non-fee-for-service-based) payments to support practice infrastructure, care management, and incentives for quality performance. These were contingent upon practices transforming to advanced primary care practices.

Supplemental Payments to Designated Primary Care Practices

OHIC recognizes the important role of Patient-Centered Medical Homes (PCMHs)[14] in delivering comprehensive and patient-focused primary care. In 2015, OHIC established a three-part PCMH definition that requires demonstration of practice transformation, implementation of cost management

[12] For further details about CTC-RI and its initiatives, please see https://www.ctc-ri.org/.

[13] OHIC's definition of primary care expenses includes the amount that an insurer spends on payments to primary care providers (i.e., the physician, practice, or other medical provider considered by the insured to be his or her usual source of medical care such as NPs and PAs, but excluding specialty providers) and other preventive and basic health services plus non-FFS investments, including health information technology, PCMH, CurrentCare, incentives to providers, loan forgiveness of training physicians and flu clinics.

[14] PCMH is a model of primary care that promotes accessible, comprehensive, coordinated care and encourages patients and families to be actively involved in health care decisions. The model is patient-focused and looks at prevention, overall wellness and appropriate treatment.

strategies, and clinical quality performance attainment or improvement, and began applying the definition to recognize practices.[15] This multifaceted definition ensures that PCMHs not only focus on enhancing patient experience and quality of care but also on optimizing health care delivery efficiency and effectiveness.

To facilitate PCMH transformation and sustain their operations, since 2016 OHIC has mandated insurers make supplemental payments to designated primary care practices recognized by OHIC as PCMHs. These payments serve as financial support, enabling primary care practices to enhance and sustain their capacity to deliver coordinated and patient-centered care. Practices report to OHIC annually to be considered for PCMH recognition and to be eligible for supplemental payments from insurers.

Prospective Payment Model

In 2017, OHIC convened a Primary Care Alternative Payment Model (APM) Work Group to develop a consensus methodology for a standard primary care APM for the commercial market in Rhode Island.[16] The Work Group agreed that the standard primary care APM model for the commercial market should be a complete capitated payment for specified primary care services while maintaining pre-existing member cost-sharing agreements. OHIC has encouraged adoption of this model and, in 2020, OHIC issued updated Affordability Standards that set specific primary care APM adoption requirements.[17] OHIC updated the consensus methodology 2021 and revised implementation targets in 2023. Today, many practices are participating in local payer or Medicare-led APMs. Primary care APMs provide practices with prospective payment for attributed patients which promotes flexibility in clinical practice and encourages revenue growth through increased empanelment. OHIC believes there is untapped potential for prospective payment when payment amounts are enriched to support practices and team-based care.

Administrative Simplification Task Force

In 2022, OHIC convened its Administrative Simplification Task Force to gather input and recommendations from stakeholders on prior authorization[18] requirements and processes, which OHIC identified as a major challenge for providers and a contributor to provider burnout. Over the course of its initial five meetings, Task Force members developed a problem statement about prior authorization but were unable to come to an agreement on a strategy to reduce the burden that prior authorization requirements and processes have presented to health care providers and patients.[19] Following amendments to OHIC's enabling stature in 2023, and a process of consensus development by CTC-RI, OHIC has reconvened the Task Force and it will continue to meet into 2024 to work towards a targeted 20 percent reduction in the volume of prior authorization as well as other recommendations to address administrative burden.

2. Environmental Scan

2.1 National Trends in Primary Care

Primary care in the U.S. has experienced noteworthy trends in areas such as payment, practice organization, workforce, and access. This section details these changes using the most recent available data and literature. A review of national trends helps contextualize current experience in Rhode Island.

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[15] For further details about OHIC's PCMH definition and requirements, please see: https://ohic.ri.gov/ohic-reformandpolicy-pcmhinfo.php.

[16] For a summary of the Primary Care APM Work Group's process and consensus methodology for primary care capitation, please see: https://www.ctc-ri.org/sites/default/files/uploads/Primary%20Care%20APM%20Work%20Group%20Consensus%20Model%202021%201-25%20update.pdf.

[17] Powers and Duties of the Office of the Health Insurance Commissioner. Available at: https://ohic.ri.gov/sites/g/files/xkgbur736/files/2022-03/230-ricr-20-30-4-final-sos.pdf.

[18] Prior authorization is the prospective assessment of a health care service prior to that service being rendered.

[19] The Administrative Simplification Task Force's Report to the OHIC is accessible at: https://ohic.ri.gov/node/396 (Accessed October 16).

Primary care spending and payment models

Nationwide spending on primary care represents a small percentage of total health care expenditures and has been trending downward. National spending on primary care as a percentage total health care spending has decreased in recent years, from an estimated 6.5 percent of total health care expenditures in 2002 to 4.7 percent in 2019, with decreases occurring in a majority of states.[20,21] This pattern reflects both levels of primary care investment as well as the rapid rate of growth in non-primary care spending.

Primary care nationwide has also been slow to adopt value-based payment (VBP), unfortunately, as there is evidence that practices receiving VBP are more likely to engage in efforts to improve care. Although VBP models have become more common across the U.S. health care system (increasing from 30 to 40 percent of payments between 2016 and 2021), research suggests that primary care providers continue to be paid largely through fee-for-service (FFS) models.[22,23] The Commonwealth Fund's 2022 survey of 1,000 U.S. primary care physicians found that 71 percent of respondents reported receiving any FFS payments, while only 46 percent reported receiving revenue from shared savings (with upside or downside risk), capitation, or population-based payment models.[24] Larger practices, those part of integrated health systems and those in suburban or urban areas were more likely to report receiving revenue from these VBP models.[25]

Physician reimbursement and salaries

Primary care physicians receive lower reimbursement rates than most specialists. The Resource-based Relative Value Scale (RBRVS) reimbursement system has been criticized as contributing to undervaluation of primary care services. Physician reimbursement by many payers is based on relative value units (RVUs) that are applied to each service delivered. While primary care physicians typically focus on delivering cognitive services (Evaluation and Management, E/M), the RVU system tends to assign higher values per unit of time to procedural services which are more often performed by specialists. There are not different E/M codes for primary care compared to specialty care. CMS made increases to the RVUs used to reimburse Medicare E/M work in ambulatory care starting in 2021 after revision and re-valuation upwards of the E/M office visit codes. In 2024 CMS will allow an add-on code to be applied to office E/M to provide supplemental payment for primary care, but it is not limited to primary care.

In terms of starting salary, primary care physicians often earn lower incomes than specialists. Average salary offers for primary care including internists, family medicine physicians, and pediatricians rank at the bottom of medical specialties (see **Table 1**). It is important to note that the average medical school debt is $202,453, excluding premedical undergraduate and other educational debt.[26]

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[20] Martin S, Phillips RL, Petterson S, Levin Z, Bazemore AW. Primary Care Spending in the United States, 2002-2016. *JAMA Intern Med*. 2020;180(7):1019–1020. doi:10.1001/jamainternmed.2020.1360.

[21] Patient-Centered Primary Care Collaborative (Robert Graham Center). Investing in Primary Care: A State Level Analysis; 2019. https://thepcc.org/sites/default/files/resources/pcmh_evidence_report_2019_0.pdf.

[22] Health Care Payment Learning and Action Network. APM Measurement Effort. 2022. Available at: https://hcp-lan.org/apm-measurement-effort/2022-apm/2022-infographic/.

[23] Horstman C, Lewis C. Engaging Primary Care in Value-Based Payment: New Findings from the 2022 Commonwealth Fund Survey of Primary Care Physicians. *The Commonwealth Fund.* April 2023. Available from: https://www.commonwealthfund.org/blog/2023/engaging-primary-care-value-based-payment-new-findings-2022-commonwealth-fund-survey.

[24] Ibid.

[25] Ibid.

[26] Hanson M. Average Medical School Debt. Education Data Initiative. September 17, 2023. Available at: https://educationdata.org/average-medical-school-debt.

Table 1. Starting Salary Offers by Medical Specialty (2020-2021 and 2021-2022) [27]

Medical Specialty	2020/2021 Average Salary Offer	2021/2022 Average Salary Offer	Year over Year Change
1. Orthopedic Surgeon	$546,000	$565,000	3%
2. Cardiologist (Interventional)	$611,000	$527,000	-16%
3. Urologist	$497,000	$510,000	3%
4. Gastroenterologist	$453,000	$486,000	7%
Cardiologist (Non-invasive); counted with #2 above	$446,000	$484,000	8%
5. Radiologist	$401,000	$455,000	12%
6. Pulmonologist/Critical Care	$385,000	$412,000	6%
7. Hematologist/Oncologist	$385,000	$404,000	5%
8. Anesthesiologist	$367,000	$400,000	8%
9. Dermatologist	$378,000	$368,000	-3%
10. Oral Maxillofacial Surgeon	NA*	$368,000	NA*
11. Neurologist	$332,000	$356,000	7%
12. Obstetrician-Gynecologist	$291,000	$332,000	14%
13. Psychiatrist	$279,000	$299,000	7%
14. Hospitalist	NA*	$284,000	NA*
15. Rheumatologist	NA*	$258,000	NA*
16. Internal Medicine (Internist)	$244,000	$255,000	5%
17. Family Medicine Physician	$243,000	$251,000	3%
18. Pediatrician	$236,000	$232,000	-2%
19. Certified Registered Nurse Anesthetist	$222,000	$211,000	-5%
20. Nurse Practitioner	$140,000	$138,000	-1%

*NA – This specialty was not among the top 20 in demand last year; average salary offers are not available.

Practice organization

Nationally, physician practice arrangements have shifted away from private practice and towards larger, employed practices. Between 2012 and 2022, the American Medical Association (AMA) reported that the share of physicians who work in practices wholly owned by physicians (i.e., private practices) dropped by 13 percentage points from 60.1 percent to 46.7 percent.[28] The AMA reported that practice size has also changed, with a continued redistribution of physicians from small to large practices. The percentage of physicians in practices with 10 or fewer physicians fell from 61.4 percent in 2012 to 51.8 percent in 2022.[29] In comparison, the percentage of physicians in practices with 50 or more physicians grew from 12.2 percent to 18.3 percent.[30] There have also been changes in practice type. Forty-two percent of

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[27] AMN Healthcare. Physician Starting Salaries 2022 vs. 2021. August 22, 2022. Available at: https://www.amnhealthcare.com/blog/physician/perm/physician-starting-salaries-by-specialty-2022-vs-2021/.

[28] Kane C. Recent Changes in Physician Practice Arrangements: Shifts Away from Private Practice and Towards Larger Practice Size Continues Through 2022. American Medical Association. July 2023. Available at: https://www.ama-assn.org/system/files/2022-prp-practice-arrangement.pdf.

[29] Ibid.

[30] Ibid.

physicians worked in single specialty practices and 26.7 percent in multi-specialty practices in 2022, reflecting a shift of about 4 percentage points since 2012 from the former practice type to the latter.[31]

Workforce

The U.S. is facing a nationwide shortage of primary care physicians, which is projected to grow given the large portion of the physician workforce nearing traditional retirement age and accelerated retirement due to physician burnout, exacerbated by COVID-19. As of September 2023, the federal government estimated that an additional 17,463 primary care physicians would have been needed to provide a level of care that would have removed the Health Professional Shortage Area (HPSA) designation for areas with primary care shortages.[32] The Association of American Medical Colleges estimates that by 2034 the U.S. will face a deficit of between 17,800 and 48,000 primary care physicians.[33]

Burnout is a key concern in the primary care workforce and is driving physicians to reduce or leave clinical practice. Burnout among physicians also negatively affects patient care, including a two-fold increase in odds for unsafe care, unprofessional behaviors and low patient satisfaction.[34] The Agency for Healthcare Research and Quality defines burnout as a "workplace-based condition where people experience a long-term stress reaction marked by emotional exhaustion, depersonalization and a lack of sense of personal accomplishment."[35] In 2020, 38 percent of physicians in the U.S. reported experiencing at least one of the three dimensions of burnout, with primary care physicians reporting higher rates of burnout than most other types of physicians.[36] The COVID-19 pandemic accelerated the U.S. physician burnout rate; at the end of 2021, nearly 63 percent of physicians reported symptoms of burnout.[37] Among primary care clinicians, 71 percent reported that their burnout or mental exhaustion had reached an all-time high during the pandemic, and one in four primary care clinicians reported they intend to leave practice over the next several years.[38]

There are not enough new physicians entering the primary care workforce to make up for the increases in physicians retiring. Since 2011, the percentage of U.S. trained M.D. physicians who have matched into primary care residency positions has been on the decline.[39] A study of career plans of internal medicine residents from 2019 to 2021 found that fewer than 9 percent of third-year internal medicine residents were interested in primary care.[40] From 2012 to 2020, only about 20 percent of all physicians completing their residency were practicing primary care two years later.[41] In 2020, rates of physicians entering

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[31] Ibid.
[32] Health Resources & Servies Administration. Health Workforce Shortage Areas; October 2023. https://data.hrsa.gov/topics/health-workforce/shortage-areas.
[33] IHS Markit Ltd. The Complexities of Physician Supply and Demand: Projections From 2019 to 2034; 2021. https://www.aamc.org/media/54681/download.
[34] Panagioti M, Geraghty K, Johnson J, et al. Association Between Physician Burnout and Patient Safety, Professionalism, and Patient Satisfaction: A Systematic Review and Meta-analysis. *JAMA Intern Med*. 2018;178(10):1317–1331. doi:10.1001/jamainternmed.2018.3713.
[35] Agency for Healthcare Research and Quality Physician Burnout. November 2023. Available at: https://www.ahrq.gov/prevention/clinician/ahrq-works/burnout/index.html.
[36] Shanafelt TD, West CP, Sinsky C, Trockel M, Tutty M, Wang H, et al. Changes in Burnout and Satisfaction With Work-Life Integration in Physicians and the General US Working Population Between 2011 and 2020. *Mayo Clin Proc*. 2022;97(3):491-506. 10.1016/j. mayocp.2021.11.021.
[37] Shanafelt TD, West CP, Dyrbye LN, et al. Changes in Burnout and Satisfaction With Work-Life Integration in Physicians During the First 2 Years of the COVID-19 Pandemic. *Mayo Clin Proc.* 2022;97(12):2248-2258. doi:10.1016/j.mayocp.2022.09.002
[38] Horstman C, Lewis C. How Primary Care Is Faring Two Years into the COVID-19 Pandemic. The Commonwealth Fund. 2022. Available at: https://www.commonwealthfund.org/blog/2022/how-primary-care-faring-two-years-covid-19-pandemic.
[39] KFF Health News. American Medical Students Less Likely to Choose to Become Primary Care Doctors. July 3, 2019. Available at: https://kffhealthnews.org/news/american-medical-students-less-likely-to-choose-to-become-primary-care-doctors/.
[40] Paralkar N, La Vine N, Ryan S, et al. Career Plans of Internal Medicine Residents From 2019 to 2021. *JAMA Internal Med.* 2023;183(10):1166–1167. doi:10.1001/jamainternmed.2023.2873.
[41] Milbank Memorial Fund. The Health of US Primary Care: A Baseline Scorecard Tracking Support for High-Quality Primary Care. February 2023. Available at: https://www.milbank.org/publications/health-of-us-primary-care-a-baseline-scorecard/ii-workforce-the-primary-care-physician-workforce-is-shrinking-and-gaps-in-access-appear-to-be-growing/.

primary care differed substantially across states, with higher percentages of new primary care physicians in western and rural states (e.g., Maine and Alaska).[42]

Amid the physician shortage, nurse practitioner (NP) and physician assistant/associate (PA) roles are growing, helping fill gaps in the primary care physician workforce. A 2021 report from the National Academies of Sciences, Engineering and Medicine estimated that between 24 percent and 39 percent of NPs practiced ambulatory primary care and the Bureau of Labor Statistics reports that NPs are the fastest growing profession in the U.S.[43,44] The American Association of Physician Associates estimates that 20 percent of practicing PAs are working in primary care.[45]

Access

Primary care access in the U.S. is lagging, especially in underserved communities. Many Americans do not have an ongoing primary care relationship. In 2021, 17 percent of adults did not have one (or more) person they thought of as their personal health care provider and 27 percent of children had no usual source of care (or used the emergency department or hospital as their usual source of care).[46]

About 100 million Americans live in Health Resources and Services Administration-designated primary workforce shortage areas.[47] Another way of measuring equitable primary care access is measuring the number of primary care physicians per 100,000 population in medically underserved areas (MUAs). An MUA is an area designated by the HRSA as having too few primary care providers, high infant mortality, high poverty levels, or a large elderly population. As of 2020, there were approximately 55.8 primary care providers per 100,000 people in MUAs, well below the rate of 79.7 primary care physicians per 100,000 in areas that are not MUAs.[48]

PCMH adoption

Starting in 2007, primary care began receiving heightened national health policy attention, driven in large part by the emergence of the PCMH model. Rhode Island was at the forefront of this movement, with the state actively promoting and implementing the PCMH model as a way to promote team-based, coordinated care with a focus on quality and cost containment. The PCMH model quickly gained national recognition, leading to broader adoption (The National Committee for Quality Assurance [NCQA] reports that 25 public sector medical home initiatives across 22 states require or incentivize NCQA's PCMH Recognition).[49] However, in the years that followed, attention began to shift towards other models, most notably Accountable Care Organizations (ACOs) and total cost of care (TCOC) models. This shift reflects the evolving understanding that while primary care is essential, a comprehensive approach that considers the entire health care system is necessary to improve quality and control costs.

Centers for Medicare & Medicaid Services (CMS) Initiatives

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[42] Ibid.

[43] National Academies of Sciences, Engineering, and Medicine. The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity. National Academy of Medicine; 2021.

[44] U.S. Bureau of Labor Statistics. Fastest Growing Occupations. Occupational Outlook Handbook. September 8, 2022. Available at: https://www.bls.gov/ooh/fastest-growing.htm.

[45] American Academy of PAs. PAs as Primary Care Providers (PCPs). February 2023. Available at: https://www.aapa.org/download/81294/?tmstv=1698700854.

[46] Milbank Memorial Fund and the Physicians Foundation (Robert Graham Center). The Health of US Primary Care: A Baseline Scorecard for High-Quality Primary Care; February 2023. https://www.milbank.org/publications/health-of-us-primary-care-a-baseline-scorecard/.

[47] Health Resources and Services Administration. Health Workforce Shortage Areas. October 2023. Available at: https://data.hrsa.gov/topics/health-workforce/shortage-areas.

[48] Milbank Memorial Fund and the Physicians Foundation (Robert Graham Center). The Health of US Primary Care: A Baseline Scorecard for High-Quality Primary Care; February 2023. https://www.milbank.org/publications/health-of-us-primary-care-a-baseline-scorecard/.

[49] National Committee for Quality Assurance. PCMH as Public Policy. Available at: https://www.ncqa.org/public-policy/pcmh-public-policy-trends/.

The federal government has led multiple efforts to support value-based primary care payment models and enhanced care delivery.

- CMS' Comprehensive Primary Care (CPC) Model and the subsequent Comprehensive Primary Care Plus (CPC+) Model included prospective care management fees and the opportunity to earn shared savings or payments for performance in addition to usual payment. Thirty-five Rhode Island practices participated in CPC+, which ran from 2017 through 2021.[50]
- CMS' Primary Care First (PCF) model includes two cohorts of participating practices (Cohort 1 began in 2021 and Cohort 2 began in 2022) each with a five-year performance period. Under PCF, practices must meet quality standards in order to be eligible for a performance-based adjustment to their primary care model payments. Thirty-five Rhode Island practices are participating in PCF.[51]
- CMS announced a new voluntary primary care model in June 2023 – the Making Care Primary (MCP) model – that builds upon the CPC, CPC+, and PCF models.[52] The MCP model is a 10.5-year multi-payer model that aims to help primary care physicians gradually adopt prospective, population-based payments while building infrastructure to improve behavioral health and specialty integration and drive equitable access to care.[53] CMS selected eight states to participate in the MCP model (Rhode Island is not one of these states).[54]
- CMS announced a new ten-year, voluntary, state TCOC model in September 2023 – the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model – which includes a primary care component. Primary Care AHEAD will align with ongoing Medicaid transformation efforts within each participating state and primary care practices participating in the model will receive a Medicare care management fee to meet transformation requirements for person-centered care.[55]

2.2 Rhode Island Trends in Primary Care

Rhode Island experiences many of the same challenges as the rest of the country in terms of primary care investment and provider supply, with some unique and more favorable trends. It also faces some challenges related to regional competition for clinicians and staff.

Primary care payment

Multiple definitions of primary care spending exist domestically, making cross-state comparisons of primary care spending challenging. This is further complicated by the fact that a significant percentage of payments to primary care practices are made through non-claims-based methods. However, two recent claims-based analyses suggest that Rhode Island is doing better than some, but not all neighboring states, in terms of primary care spending as a percentage of total medical expense:

- 2020 New England States Consortium Systems Organization (NESCSO) report: In the New England states – Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont – 2018 all-payer combined primary care claims payments as a percentage of total medical payments was 5.5 percent using the narrower definition of primary care spend favored by

[50] Centers for Medicare & Medicaid Services. Comprehensive Primary Care Plus. Available from: https://www.cms.gov/priorities/innovation/innovation-models/comprehensive-primary-care-plus.
[51] Centers for Medicare & Medicaid Services. Primary Care First Model Options. Available from: https://www.cms.gov/priorities/innovation/innovation-models/primary-care-first-model-options.
[52] Centers for Medicare & Medicaid Services. Making Care Primary (MCP Model). Available from: https://www.cms.gov/priorities/innovation/innovation-models/making-care-primary.
[53] Ibid.
[54] The eight states are Colorado, North Carolina, New Jersey, New Mexico, New York, Minnesota, Massachusetts and Washington.
[55] Centers for Medicare & Medicaid Services. States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model. Available from: https://www.cms.gov/priorities/innovation/innovation-models/ahead.

OHIC.[56,57] Rhode Island ranked 3rd of the six states for commercial market primary care claims spending as a percentage of total medical spending using the report's narrow definition (6.0 percent), 5th of five states for Medicare Advantage and Medicare FFS spending (4.9 percent and 2.9 percent) and 5th of five states for Medicaid spending (5.4 percent). The limitation of the NESCSO report is that it does not systematically account for non-claims-based payments to primary care. Medicare Advantage issuers and Medicaid in Rhode Island make substantial non-claims-based payments to primary care to support PCMH and ACO activities.

- 2023 Bailit Health Analysis: Bailit Health collected 2021 payer-reported primary care spending data from Rhode Island and Connecticut using similar methodologies. Bailit Health found that in 2021, Rhode Island's commercial market primary care claims spending as a percentage of total medical spending (not including long-term care) was 4.8 percent, compared to Connecticut's 3.9 percent. This analysis employed an accounting methodology that is different than the existing methodology used since 2010 to assess performance against the Rhode Island fully insured primary care expenditure target.

OHIC also evaluated differences in Medicare reimbursement for select physician evaluation and management services between Rhode Island and neighboring states. Medicare is the largest payer for health care services. As the largest payer, the Medicare Physician Fee Schedule (PFS) is an important benchmark against which commercial reimbursement rates are measured and frequently established. OHIC evaluated reimbursement rates for office-based and facility-based evaluation and management (E&M) services for the following new patient (99202 - 990205) and established patient (99211 - 99215) code sequences from the 2023 PFS. These are service codes that account for the preponderance of billing by primary care providers.

The PFS varies by locality. The PFS for the states of Rhode Island and Connecticut is not geographically differentiated within the state. The PFS for Massachusetts is differentiated by county, with one set of rates for Metropolitan Boston (Middlesex, Norfolk, and Suffolk counties) and one set of rates for the rest of the state. OHIC calculated the percent variance (Rhode Island rate/comparator rate) between the 2023 Medicare PFS for Rhode Island and Connecticut, Metropolitan Boston, and the rest of Massachusetts. Medicare reimbursement for office visits in Rhode Island is lower than reimbursement in Connecticut (-3.6% average percent variance), Metropolitan Boston (-7.7% average percent variance), and the rest of Massachusetts (-0.4% average percent variance). Facility-based reimbursement rates, which are paid when E&M services are provided by a physician in a hospital or ambulatory surgical center, follow are similar pattern of geographic variation. **Table 2** shows the 2023 rates by code and geographic area.

[56] The New England States' All-Payer Report on Primary Care Payments. New England States Consortium Systems Organization (NESCSO); 2020. Available from: https://nescso.org/wp-content/uploads/2021/02/NESCSO-New-England-States-All-Payer-Report-on-Primary-Care-Payments-2020-12-22.pdf.

[57] NESCSO's narrow definition included selected claims payments for general practice, family medicine, pediatrics, internal medicine, nurse practitioner, and physician assistant. The narrow definition excludes OB/GYN services.

Table 2. Medicare Physician Fee Schedule Comparison for Select Office-Based E&M Visits

		Rhode Island	**Connecticut**	**Metro Boston**	**Rest of Massachusetts**
HCPCS Code	**Short Description**	**Non-Facility Price**	**Non-Facility Price**	**Non-Facility Price**	**Non-Facility Price**
99202	Office o/p new sf 15-29 min	$75.05	$77.93	$81.64	$75.42
99203	Office o/p new low 30-44 min	$115.93	$120.27	$125.10	$116.22
99204	Office o/p new mod 45-59 min	$171.91	$177.89	$184.64	$172.29
99205	Office o/p new hi 60-74 min	$226.82	$234.61	$243.26	$227.25
99211	Off/op est may x req phy/qhp	$24.24	$25.32	$27.00	$24.49
99212	Office o/p est sf 10-19 min	$58.68	$60.96	$63.97	$58.99
99213	Office o/p est low 20-29 min	$93.45	$96.80	$101.03	$93.82
99214	Office o/p est mod 30-39 min	$132.10	$136.70	$142.46	$132.58
99215	Office o/p est hi 40-54 min	$184.99	$191.25	$198.97	$185.58

Medicare establishes physician reimbursement using relative value units (RVUs) for work (service relative time and intensity), practice expense (based on practice costs like rent, staffing, and supplies), and malpractice (based on the cost of malpractice insurance). These RVUs are adjusted by geographic practice cost indices (GPCIs) that account for geographic variation in the cost of practicing medicine. The resulting GPCI-adjusted RVUs are multiplied by a conversion factor to set the specific rate of reimbursement.[58] Variations in Medicare reimbursement across states are functionally determined by variation in these inputs.

Commercial insurers often, though not always, pay above the Medicare PFS. There is limited current data in the public domain on commercial insurer reimbursement for primary care services across states. A Millman report from 2019, that employed data from commercial PPO plans during the time period 2013 - 2017, found that Rhode Island primary care office visits tended to be reimbursed above Medicare rates, but below the percentages of Medicare that were paid to primary care providers in Connecticut and Massachusetts.[59]

Commercial insurer reimbursement often varies by practice and practice group, with some practices negotiating higher reimbursement rates than others, or earning higher reimbursement rates through demonstration of quality performance or advanced primary care structures. Ultimately, factors beyond reimbursement rates influence provider compensation, such as the availability and magnitude of performance-based payments, but reimbursement rates tell an important part of the story.

Practice organization

The vast majority of Rhode Island practices are affiliated with an ACO or Accountable Entity (AE). Of the 182 practices that OHIC assessed for PCMH recognition in 2022, 32 percent were affiliated with Integra Community Care Network, 19 percent were affiliated with Prospect CharterCARE, and 18 percent were

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[58] How to Use the PFS Look-Up Tool. Medicare Learning Network, MLN901344 April 2023., pp. 6-7. https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/how_to_mpfs_booklet_icn901344.pdf

[59] Milliman Research Report. Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement. November 19th, 2019. See Appendix C-4. https://www.milliman.com/-/media/milliman/importedfiles/ektron/addictionandmentalhealthvsphysicalhealthwideningdisparitiesinnetworkuseandproviderreimbursement.ashx

affiliated with Lifespan. The remaining 24 percent of ACO/AE-affiliated practices were associated with Coastal Medical, Integrated Healthcare Partners, Providence Community Health Centers or Thundermist Health Center. Only 8 percent of submitting practices were not affiliated with an ACO or AE. Of note for practice organization in Rhode Island, Coastal Medical (previously Rhode Island's largest independent primary care group) was acquired by Lifespan) in 2021.

OHIC's PCMH data also suggest that the majority of Rhode Island primary care practices are small (five or fewer clinicians), and the majority of Rhode Island clinicians work in small or mid-sized practices. OHIC collects practices' Physician National Provider Identifier (NPI) numbers (reflecting MDs, DOs, PAs and NPs) as a part of its PCMH recognition assessment. In 2022, 75 percent of practices that OHIC assessed for PCMH recognition had five or fewer clinicians, 19 percent had between six and ten clinicians, and only 6 percent of practices had more than ten clinicians (see **Table 3**). Forty-two percent of clinicians worked in practices with five or fewer other clinicians, 33 percent of clinicians worked in practices with between six and ten other clinicians and 26 percent of clinicians worked in practices with more than ten other clinicians (see **Table 3**). OHIC analysis in prior years indicated that those Rhode Island practices that do not seek PCMH recognition are all small, indicating that the percentage of practices that are small and the percentage of clinicians that work in small practices are even higher than 75 and 42 percent, respectively.

Table 3. Estimated Rhode Island Practices and Clinicians by Practice Size

Practice Size	Estimated Percentage of Practices by Size	Estimated Percentage of Clinicians by Practice Size
Small Practice (1-5 PCPs)	75%	42%
Mid-Sized Practice (6-10 PCPs)	19%	33%
Large Practice (>10 PCPs)	6%	26%

Data Source: OHIC analysis of 2021-2022 PCMH practice data.

Workforce

According to CMS' National Plan and Provider Enumeration System, as of September 2023 Rhode Island ranked fourth out of all states in the U.S. in terms of number of active primary care providers[60], with 301.5 active primary care providers per 100,000 population, compared to 232 nationwide.[61] HRSA data suggest that Rhode Islanders may have more equitable access to primary care than other states. HRSA data show that as of 2020 there were approximately 138.9 primary care providers per 100,000 people in Rhode Island medically underserved areas (MUAs) (compared to 55.9 nationally), well above the 79.1 primary care physicians per 100,000 in Rhode Island areas that are not MUAs (compared to 79.9 nationally).[62] Provider counts possess one notable limitation. That is, one provider may not represent one full time equivalent, as some providers may practice part-time.

Although Rhode Island may be faring better than some parts of the country, Rhode Island's primary care workforce shortage is still cause for significant concern. The primary care provider to population ratio cited above has declined the last two year. Furthermore, data published in the past decade offer valuable insights into the problem. In 2019 alone, Rhode Island experienced a net loss of 14 primary care physicians per 100,000 population, or 4 percent of its primary care physician population.[63] Rhode Island

[60] This data defines primary care providers as general practice, family practice, obstetrics and gynecology, pediatrics, geriatrics, internal medicine, physician assistants and nurse practitioners.
[61] America's Health Rankings. Primary Care Providers in Rhode Island. Available at: https://www.americashealthrankings.org/explore/measures/PCP_NPPES/RI.
[62] Milbank Memorial Fund and the Physicians Foundation (Robert Graham Center). The Health of US Primary Care: A Baseline Scorecard for High-Quality Primary Care; February 2023. https://www.milbank.org/publications/health-of-us-primary-care-a-baseline-scorecard/.
[63] Primary Care Collaborative. Health is Primary: Charting a Path to Equity and Sustainability. November 2023. Available at: https://thepcc.org/sites/default/files/resources/pcc-evidence-report-2023.pdf.

is expected to have a deficit of almost 100 primary care providers by 2030.[64] As of 2018, about 44 percent of Rhode Island family physicians were over the age of 55 and nearing retirement age.[65] Rhode Island is also losing the new physicians it trains to other states. There are two family medicine residency training programs in Rhode Island. Between 2011 and 2017, Rhode Island produced a total of 87 family physicians from its two family medicine residency training programs; of these, 38 (44 percent) stayed in-state.[66] During this time period, the loss of state-trained family physicians was partially offset by the in-migration of 26 family physicians trained in other states.[67] Statements from primary care providers in the press and in conversations with OHIC (summarized later in this report) paint a picture of a primary care workforce that is stretched thin and is unable to provide care to all the patients who need it, particularly for new patients.[68]

Finally, we note that there is no consistent and comprehensive data source on the Rhode Island primary care workforce, making it difficult to assess the current state of primary care workforce shortages. Such a resource would promote better understanding and would allow for tracking the impact of strategies to strengthen the workforce. While Rhode Island ranks relatively high among states in terms of provider to population ratios, these figures do not convey information about how the provider workforce is allocated between patient care and non-patient care activities. To garner a better sense of how the provider workforce is allocated, OHIC is working with a researcher to utilize data from the All-Payer Claims Database to assess practicing clinical FTE counts and panel sizes.

Access

Rhode Island reports lower rates of adults and children without a usual source of care than the U.S. In 2021, 10 percent of Rhode Island adults and 24 percent of Rhode Island children reported not having a personal health care provider, compared to 17 percent of adults and 27 percent of children nationally.[69] This is in part due to the high rate of health insurance coverage in Rhode Island as well as a strong FQHC system. Despite this, disparities exist among Rhode Island adults by race, ethnicity, education, and socioeconomic status. For example, in 2021, 24 percent of Hispanic adults, 18 percent of adults in the lowest income bracket, and 22 percent of adults without a high school degree reported not having a usual source of care (compared to 7 percent among White adults, 6 percent among adults in the highest income bracket and 9 percent among adults with some post-high school education).[70] This suggests that access to a primary care provider is still not equitably distributed within the state.

PCMH adoption

Rhode Island has actively promoted and implemented the PCMH model for over a decade. In 2016, OHIC mandated commercial health insurers to make supplemental payments to designated primary care practices recognized by OHIC as PCMHs. As of 2023, 181 practice sites in Rhode Island are OHIC-recognized PCMHs, 79 of which have OHIC-recognized behavioral health integration activities. The PCMH and IBH models of care delivery represent team-based, advanced primary care.

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[64] Care Transformation Collaborative of Rhode Island. New CTC-RI task force addressing primary care workforce crisis; May 2023. Available from: https://ctc-ri.org/05/23/2023/new-ctc-ri-task-force-addressing-primary-care-workforce-crisis.

[65] Petterson S, Wilkinson E, Kessler AC, Stone C, Bazemore A. The State of Primary Care Physician Workforce. The Robert Graham Center. 2018. Available at: https://www.graham-center.org/content/dam/rgc/documents/maps-data-tools/state-collections/phys-workforce/Rhode-Island.pdf.

[66] Petterson S, Wilkinson E, Kessler AC, Stone C, Bazemore A. The State of Primary Care Physician Workforce. The Robert Graham Center. 2018. Available at: https://www.graham-center.org/content/dam/rgc/documents/maps-data-tools/state-collections/phys-workforce/Rhode-Island.pdf.

[67] Ibid.

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

[69] The Commonwealth Fund. Adults with a usual source of care. Available from: https://www.commonwealthfund.org/datacenter/adults-usual-source-care.

[70] Rhode Island Foundation, Health in Rhode Island. Adults without a usual source of care. Available from: https://healthinri.com/data/adults-without-a-usual-source-of-care.

2.3 Rhode Island Stakeholder Interview Themes

OHIC and Bailit Health conducted a series of semi-structured interviews with providers, payers and patient advocates to inform OHIC's new vision for primary care in Rhode Island. During the interviews, OHIC and Bailit Health asked interviewees to reflect on OHIC's prior primary care initiatives, share the biggest challenges to Rhode Island primary care from their perspectives, and recommend actions that OHIC should consider taking to support and sustain primary care in Rhode Island. The list of interviewees can be found in Appendix A. The themes that emerged from the interviews are summarized below, organized by stakeholder group.

2.3.1 Provider Perspective

Workforce: Workforce challenges were the chief concern described by primary care practices in OHIC's stakeholder interviews. Physicians were concerned about the lack of urgency or even dialogue about the primary care physician shortage. Interviewees cited examples of at-risk patients who were unable to access primary care, and the health consequences to them of not doing so. Others described an "existential threat" to primary care and predicted a full crisis within five years without significant action. Specific workforce challenges cited in the interviews were:

- More primary care physicians are retiring than are being replaced.
- Workforce shortages create burnout, which then leads to further shortages.
- Pay for primary care is non-competitive, both compared to other medical specialties and to primary care pay in neighboring states.
- Workforce shortages in primary care are not only a problem for physicians, but for advanced practitioners and medical assistants too.
- Rhode Island is not retaining the physicians who train in the state.
- Workforce shortages are a barrier to delivery of team-based care.

Payment Models: Practices cited two discrete difficulties relating to insurer payment models. A subset of interviewees felt that lack of adoption of primary care capitation was a burden because capitation provides practices with financial flexibility to reconfigure their practice teams, support team-based care and to increase primary care physician compensation. Practices identified one commercial payer (BCBSRI) and Medicare as the only payers presently offering primary care capitation in Rhode Island. Other interviewees stated that the delayed distribution of ACO shared savings payments was problematic because payments were made up to a year after the performance period ended, and the amounts were unpredictable. One practice explained that the latter impeded its practice from making investments in innovative processes to improve care delivery.

Prior Authorization and Other Administrative Burdens: Insurer prior authorization was described as "an annoyance" by one physician, and more harshly by other interviewees. Practices reported that the burden, while not new, has worsened over time and, in some instances, is a barrier to delivering efficient and effective patient care. Multiple practices were grateful for OHIC's recent work on prior authorization through its Administrative Simplification Task Force but at least one practice did not think OHIC's current work went far enough to address the issue. Referral authorizations, prescription refills sent to PCPs who respond in contrast to non-responding specialist prescribers, various forms and approvals, are all daily tasks that add to the burden.

Electronic Health Record Documentation Demands: Physicians expressed a common concern that Electronic Health Records (EHRs) have led to a shift in their roles, with one physician characterizing primary care providers as "clerks/typists" due to the extensive data entry and navigation requirements. Furthermore, providers were notably troubled by the substantial uncompensated time needed to respond to patient portal messages within the EHR, which can increase workload and stress. Document management is a burden. The EHR has a special role in burnout, expanding the workday well past the office hours, distracting clinicians during patient encounters, and changing frequently with each new update bringing both improvements and new glitches. While acknowledging the necessity of digitized health records, providers emphasized the ongoing need to optimize these systems to better align with their workflow and patient-care responsibilities.

Lack of Specialist Engagement: Several interviewees expressed concerns regarding the role of specialists, particularly in the context of health care spending growth and the success of the ACO model. They pointed out that specialist services often come at a higher cost, and the extensive use of specialized procedures and treatments can significantly contribute to the overall increase in health care expenditures. Providers also noted that many specialists appeared to lack a genuine interest or financial incentive to collaborate and coordinate effectively with primary care practices on patient care or cost reduction.

2.3.2 Payer Perspective

Workforce Challenges: The insurers recognized the workforce shortage in primary care. The insurers emphasized what they saw as the pivotal role that VBP models and team-based care can play in addressing these workforce shortages. Moreover, the insurers highlighted the need to incentivize providers to adopt VBP models by linking them to infrastructure improvements, technology integration, and competitive compensation, especially for recruiting new physicians. One insurer shared how it monitors stinting measures to ensure that patient panels are not being expanded at the expense of patient care. Overall, the insurers expressed a commitment to working collaboratively with primary care practices to help them navigate the evolving health care landscape and ensure that workforce challenges are effectively addressed to provide quality care to patients.

Payment Models: Insurers shared that primary care capitation, which providers used to regard with reluctance, has gained support from providers, particularly large practice groups. One insurer shared that it has made progress on primary care capitation in the commercial market: however, less so than in the Medicare Advantage market. An insurer suggested bringing transparency to shared savings payments to ensure primary care providers are seeing the rewards of their performance, ideally through salary support to assist with the current workforce challenges.

Prior Authorization: Insurers either did not raise prior authorization as a challenge facing primary care providers or expressed a more positive perspective of prior authorization processes than the primary care physician interviewees. One insurer described its proactive approach to addressing prior authorization challenges, monitoring denials, and providing targeted outreach to resolve issues when specific offices face high denial rates. The insurers viewed OHIC and CTC-RI’s prior authorization initiatives favorably.

Technology Challenges: The insurer interviewees recognized the substantial technology challenges that many primary care providers are facing. The insurers acknowledged that not all providers are equally equipped or comfortable with capturing and transmitting data electronically, especially small independent providers, which is a burden that needs to be overcome if these providers are to participate in VBP. The insurers emphasized the need for continued support and resources to help practices overcome these technology-related obstacles and ensure they can adapt to the evolving health care landscape.

2.3.3 Consumer Advocate Perspective

OHIC interviewed two representatives from a consumer advocacy organization that serves a broad range of Rhode Islanders, who highlighted several challenges and opportunities for primary care in Rhode Island:

- Timely access to primary care is increasingly difficult for consumers, especially for consumers on Medicaid and patients who are non-English speaking.
- Fragmented care is a concern, especially for children with special needs and patients seeking behavioral health care.
- CMS has finalized payment for Community Health Integration, Principal Illness Navigation. Allowing providers to bill Medicare for community health integration services conducted by community health workers may have an impact on Rhode Island Medicaid and commercial primary care payment in the future.

- Rhode Island would benefit from an additional medical school to produce primary care physicians.

Finally, the Rhode Island media has documented waning accessibility to primary care being experienced by consumers with all types of insurance. Articles over the past year have aptly amplified the voice of everyday Rhode Islanders and helped raised awareness about the need for action.

3. Key Findings

OHIC's review of national and local trends in primary care, interviews with local stakeholders, and assessment of local media yield the following key findings:

1. The primary care workforce in Rhode Island is aging, and many providers are contemplating retirement.
2. Primary care is nationally reimbursed and compensated significantly less than most other medical specialties and there is evidence that primary care in Rhode Island is reimbursed at rates that do not support compensation that is competitive with neighboring states.
3. Nationally, and locally, fewer medical students are choosing primary care as a career path. Educational debt and salary differentials are contributing factors.
4. Those medical students who do choose primary care, and are trained in Rhode Island, are not necessarily staying in Rhode Island.
5. Clinician burnout is a key concern facing the primary care workforce and is driving physicians and advanced practitioners to reduce or leave clinical practice. Burnout among clinicians also negatively affects patient care. Utilization review activities, notably prior authorizations, and the challenges of managing a patient panel under workforce constraints that range from doctors to front office staff, exacerbate burnout. OHIC's interviews with primary care providers and practice groups evidenced that the foregoing challenges are impacting the local primary care workforce.
6. Primary care payment, inclusive of reimbursements and supplemental payments, must be sufficient to support a robust care team of clinicians, medical assistants, and front office staff.
7. The local press has done an excellent job amplifying the concerns and experiences of patients in relation to primary care access. Access for new patients is constrained.
8. Rhode Islanders should have reason for optimism that we can address these challenges. Rhode Island has a higher number of primary care providers relative to population than most states and a relatively higher percentage of residents who report a usual source of care. Rhode Island's small size is an advantage because there are fewer barriers to collaboration among decisionmakers and interested parties. Rhode Island has a track record of policy innovation and multi-payer engagement in activities to improve primary care. This history, our relationships, and our infrastructure put us in a position to make headway as we address these challenges.

4. Recommendations

OHIC finds the gathered information regarding the state of the primary care workforce to be compelling and to warrant priority state policy attention. OHIC recommends a series of complementary actions to support and sustain the primary care workforce in Rhode Island. Many actions will extend beyond the authority of OHIC and must include other executive branch agency and legislative action. With this recognition, OHIC identifies the following as necessary action steps:

1. Increase insurer payment for primary care so that it more closely approximates other medical specialties and is more competitive with neighboring states. Increased payments should be achieved through increased reimbursements for evaluation and management and other medical services when provided by primary care providers and through capitated payment arrangements

that support team-based, high quality patient panel care. The increase in primary care payment should be effectuated while constraining total medical spending growth to the State of Rhode Island's per capita cost growth target.

   a. OHIC will amend the agency's primary care expenditure target in 2024 to better align the agency's legacy measurement methodology with emerging consensus definitions of primary care expenditures and establish new targets for commercial insurers that will support achievement of necessary increases in primary care payment.
   b. OHIC will publicly report primary care expenditure data using the new methodology and enforce compliance with the commercial expenditure requirements through prior approval health insurance rate review and other means.
   c. OHIC will work with EOHHS and others to promote the positive role Medicaid can have in this process, similar to the exemplary work EOHHS has done for the primary care of children and adolescents.

2. Obtain commitment by health systems that employ primary care clinicians that increases in primary care payment will transfer directly to the benefit of employed primary care clinicians in the form of compensation and practice supports.
   a. OHIC will engage employed physicians, health systems, and commercial health insurer leadership to discuss ways to ensure that the primary care workforce benefits from these investments directly in the form of compensation and supports within clinical practice.
3. Make significant reductions in the administrative burdens placed on primary care practices and providers more generally by insurer utilization review and administrative requirements.
   a. OHIC's Administrative Simplification Task Force is working to develop recommendations to reduce the burden of insurer administrative requirements, such as prior authorization, on providers generally. The burden of prior authorization is significant and OHIC will take necessary actions to meaningfully reduce the volume of prior authorizations through building consensus and promulgating regulations.
   b. OHIC will convene a structured forum with representation from the provider community and health insurers to engage in dialog about the implications of medical management practices and other administrative requirements.
4. Accelerate the provision of prospective payment opportunities for primary care practices through commercial insurers, using models that generally align with the 2017 OHIC consensus methodology developed in collaboration with stakeholders.
   a. Prospective payment enables practices to support team-based care, expanding the bandwidth of clinicians, and provides more predictable revenue and an incentive for primary care practices to grow their revenue by responsibly taking on more patients.
5. Develop a system for tracking and reporting upon the composition of Rhode Island's primary care workforce.
   a. The Rhode Island Department of Health is leading efforts to develop data systems for tracking and reporting upon the composition of the health care workforce. OHIC supports and will advocate for these efforts.
6. Expand primary care workforce training by Rhode Island higher education institutions and create financial incentives for graduates to remain in Rhode Island upon graduation.
   a. The Care Transformation Collaborative of Rhode Island, which OHIC co-convenes with EOHHS, has undertaken a workforce planning effort and developed proposals to improve primary care training capacity and retention in the state. CTC-RI's proposals are worthy of serious consideration.
   b. Funding should be dedicated to primary care provider loan forgiveness.
7. Maintain ongoing dialogue with primary care providers in the state to ensure an understanding of the challenges they face, to test new policy designs and to assess the effectiveness of initiatives in support of the primary care workforce.
   a. Accountability structures are critical to ensure progress. OHIC will leverage its existing Payment and Care Delivery Advisory Committee to act as the forum for addressing

primary care workforce challenges in relation to the primary care payment recommendations described above.

b. The state should systematically measure and report on the number and percentage of insured Rhode Islanders who report a usual source of care.
c. The state should create a public-facing dashboard that presents longitudinal data on the primary care workforce, all-payer primary care expenditures, and patient access to primary care with comparison to external benchmarks where available.

5. Conclusion

The importance of a robust and adequate supply of primary care to an equitable and high-performing health care system cannot be overstated. The research and interviews that OHIC conducted to inform this report made it abundantly clear that primary care workforce shortages, payment challenges, and administrative burdens are reaching a critical juncture. This report provides a foundation for understanding the state of primary care in Rhode Island, within a national context, and outlines a roadmap for OHIC and other stakeholders to pursue to ensure that the state's residents have access to resilient and effective primary care as the health care landscape continues to evolve.

Appendix A: Stakeholder Interviewee List

Interviewee Name	Interviewee Affiliation
Andrea Galgay	Rhode Island Primary Care Physicians Corporation
Cathleen Newman	Blue Cross and Blue Shield of Rhode Island
Chris Bush	Blue Cross and Blue Shield of Rhode Island
Christopher Ottiano, MD	Neighborhood Health Plan of Rhode Island
Debra Hurwitz, RN	Care Transformation Collaborative of Rhode Island
Doreen Carlin-Grande	Neighborhood Health Plan of Rhode Island
Edward McGookin, MD	Coastal Medical
Elena Nicolella	Rhode Island Health Center Association
Elizabeth Lange, MD	Care Transformation Collaborative of Rhode Island
Hub Brennan, MD	Drs. Brennan, Cronin & Associates
Linda Cabral	Care Transformation Collaborative of Rhode Island
Manuel Ortiz	RIDOH Office of Primary Care and Rural Health
Maria Stump, MD	Co-Chair, RIDOH Primary Care Physician's Advisory Committee
Michele Troilo	Neighborhood Health Plan of Rhode Island
Michelle Anvar, MD	Brown Medicine
Noah Benedict	Rhode Island Primary Care Physicians Corporation
Pano Yeracaris, MD	Care Transformation Collaborative of Rhode Island
Patricia Flanagan, MD	Care Transformation Collaborative of Rhode Island
Paul Larson, MD	Lifespan Physician Group
Peter Hollmann, MD	Brown Medicine
Richard Glucksman	Blue Cross and Blue Shield of Rhode Island
Sam Salganik	Rhode Island Parent Information Network
Shamus Durac	Rhode Island Parent Information Network
Tom Bledsoe, MD	Brown Medicine
Warren Licht, MD	Brown Medicine