Angela Sherwin - Fwd: Primary Care Spend

From: Christopher Koller
To: Mello, Lori; Sherwin, Angela
Date: 1/31/2011 12:23 PM
Subject: Fwd: Primary Care Spend
Attachments: Primary Care Spend

Commissioner Koller:
I am following the development of your office's venture to further the cause of primary care very closely as one of Rhode Island's community pediatricians. I applaud your efforts. Health care reform is happening and it is awesome to witness. The future seems brighter for all citizens as we examine our system of care and take steps to make us all more healthy.
Most critical thinkers and medical economists agree with what we as physicians know; good primary care must be the foundation if our system is to succeed. The problem of course is defining what is good primary care. OHIC's primary care spend proposal correctly looks to support many of the core values of primary care like access, patient empowerment, coordination and cost-efficiency. It also focuses on outcomes by arming the primary care physician with the tools to do our job; infrastructure to house the medical home. This is excellent. However, I need to point out there are really two distinct worlds of primary care, the adult world and the child world. So far in the evolution of the CSI project, pediatricians have been on the outside looking in. The Amercian Academy of Pediatrics is where the term medical home was born yet in today's lexicon children are left out. There is a great deal of money spent on elder care and chronic disease and there is a lot of waste. Pediatricians deal with a different world of the young. Most community pediatricians in Rhode Island have built and maintained "medical homes" for their families all ready.
Many parents and grandparents can not tell you who their primary care physician is but they probably know their childrens' pediatrician's name and phone number. We have same day appointments. We save countless lives everyday with the vaccines we provide. Many are open on weekends for at least urgent care of our patients. We spend hours on the phone coordinating their care. From a policy standpoint it is time to level the playing field. Sure both adult and pediatric physicians would benefit from in-house nurse managers and social workers. But as a state, I think it's important that we value children as much as any other citizen and pediatricians as much as any other physician. My challenge to OHIC would be ensure that the funds for the primary care spend be equally allocated for adult and pediatric physicians. This might sound like an obvious suggestion, but why not include pediatric specific language to the proposal? After reading the Guidance for Primary Care Spend, I just don't see real dollars to aid us in our efforts to keep our children well.
We need better payment by the insurance companies to continue to survive. Pediatrician recruitment in Rhode Island is terrible for one main reason, we get paid the least of any specialty and of any competing state. The medical home we provide in our practices will not longer exist without the pediatrician. Ask any physician who provides medical or surgical care for children and they will tell you the majority of pediatric health care is delivered in the pediatrician's office.
If you except my premise that pediatricians should not be forgotten then you may ask where can the funds be focused to help pediatricians the most. Immunization administration fees are ridiculously low. Weekend care is not paid well. Phone care is completely ignored. Mental health coordination is in shambles. If asked I'm sure the Rhode Island Chapter of the AAP would be more than willing to write-up an addendum to the Guidance.
Respectfully,
Dr.Pogacar

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Thank you for the opportunity to comment on the Office of the Health Insurance Commissioner's Guidance on Primary Spend. Speaking generally, the guidance seems appropriate and likely to be very effective at improving health care, including affordability, in RI. These comments should be taken in that context.

The wording in the guidance rules out all off-site activities, including those intended to improve capacity building efforts. The likely purpose, to prevent various health care stakeholders from attempting to justify unrelated agendas with primary care-related rationales, seems appropriate. The one exception I would encourage you to consider would be off-site services that themselves *are* primary care interventions, defined as services to address problems that are appropriately managed in primary care.

To help with this point, I have attached a first draft of an updated literature review (written for experience by a medical student working with us) of the scientific evidence for behavioral health services treating primary care medical targets.

Specifically, behavioral health treatments, regardless of where they are offered,

- improve medical primary prevention and health promotion,
- improve adherence to medical treatments,
- increase the appropriateness of use of medical treatments,
- improve patients' abilities to cope with their illnesses and treatment,
- directly treat both acute and chronic primary care medical problems, and
- treat comorbid and secondary mental health problems that significantly affect the outcomes of primary care medical problems.

Given the goal of promoting primary care effectiveness and affordability, not specialty services (such as mental health), this point is only relevant because these primary care interventions require providers with behavioral health training and expertise that is often not possible to co-locate in every primary care office. If you do consider treating some primary care behavioral health interventions as primary care services, regardless of setting, I would recommend you require specific standards for communication and collaboration in order for off-site services to be "counted".

Finally, I understand that other providers currently identified as specialists might make similar arguments regarding the primary care importance and impact of their specialty services. Unlike those providers, however, behavioral health providers are credentialed (by BCBSRI, UHCNE, and in the case of psychologists, Medicare) to provide interventions for primary care diagnoses, using the Health and Behavior Procedures (CPT 96150-96155 series). It would be easy to identify which off-site behavioral health services are explicitly designed to address primary care medical problems and which address mental health problems that typically present and are typically treated in the primary care setting.

Thank you for your time and consideration.

Paul

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Impact of LPHC Practice Model on Quality and Cost Effectiveness of Primary Care

Literature Review to Support a LPHC
Student Draft

Douglas Jacobs
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Never has the need for the integration of behavioral health practitioners into the primary care medical setting been as pressing as it is today. Some primary care practitioners refer patients to behavioral health clinicians outside of the practice. A limited number of medical practices have co-located behavioral health clinicians. But very few, if any, medical practices fully integrate behavioral health clinicians as part of the primary care team. Lack of primary prevention, treatment adherence issues, inappropriate use of medical services, insufficient disease support resources for patients, and the prevalence of mental health comorbidities are all major problems reducing the effectiveness of our current primary care system—an integrated team of behavioral health clinicians and primary care practitioners not only effectively addresses these issues to improve health quality, but integration also addresses another crisis: health care cost.

Building on descriptions by Blount, Schoenbaum, Kathol, Rollman, Thomas, O'Donohue, and Peek (2007)[i], the Allied Advocacy Group for Collaborative Care (2002), the Rhode Island Policy Roundtable on Collaborative Care (2003) and Block, Costello & Fine [ii] (2004), the definition of "Integrated Care" for the purpose of this paper and the LPHC are as follows:

> Integrated care is based on the principle that mental, social and physical are indivisible, and accordingly that health care must target the whole person. Integrated services routinely define all healthcare issues in terms of physical, social and behavioral components. The integrated healthcare team includes medical and behavioral providers who mutually design one treatment plan for each person receiving care. Integrated healthcare services are offered

> concurrently by all members of the team as relevant, each addressing every issue for which their perspective and expertise can make a significant contribution. Integrated healthcare interventions are actively coordinated and presented to the patient as a single treatment approach designed to best serve their needs.

Integration of behavioral services into different aspects of the primary care medical setting, and its effect on health care quality and cost, will be the main evidence drawn from the primary care literature. Because very few practices include fully "integrated care" as defined here, most of the evidence drawn from the literature about behavioral health integration is grounded in certain diseases or conditions, certain populations, or certain circumstances. Taken as an aggregate, however, it will be evident why behavioral health clinicians need to be a part of the primary care team.

The escalating cost of healthcare is clearly unsustainable for the national economy. Much of the literature reveals integration as a potential solution, because cost savings are observed when behavioral health practitioners are integrated into the primary care setting. According to a review of 91 studies, in the presence of active behavioral health treatment, patients with diagnosed mental health disorders reduced their overall medical costs by 17% while controls who did not get behavioral healthcare increased costs an average of 12.3%.[iii] In some cases, these reductions in total medical costs are greater than the costs of the behavioral interventions themselves, and the cost of the behavioral intervention is said to be "off-set."

However, the question of whether to incorporate behavioral health clinicians into the primary care setting should be more than a debate solely about "cost-offset," it should be a debate about "cost-effectiveness." Cost-effectiveness refers to the most efficient allocation of resources, without solely focusing on the need to save money. Director for Institute of Health and Productivity Studies at Emory University, Ron Goetzel, states, "Instead of debating whether

prevention or treatment saves money, we should determine the most cost-effective ways to achieve improved population health, and where to focus scarce resources to get the biggest bang for the buck.[iv]" Although some of the behavioral health literature does indeed prove a "cost-offset," not all behavioral health interventions save money. Rather, some of the literature describes behavioral health integration as a more efficient allocation of resources, because behavioral health interventions can improve lives more cheaply than many other medical interventions. It would be insensible to apply the "cost-offset" criterion as a prerequisite for behavioral health interventions, when it is not used in for medical interventions. People are willing to pay for improvements in health status just as they would pay for any other good. As such, demonstrating cost-effectiveness, and not necessarily cost-offset, will be the goal of this literature review.

Several leading national organizations clearly support the incorporation of behavioral health into the primary care medical setting. Given the cost-effectiveness research surrounding behavioral health and primary care, the Health Resources and Services Administration/ Substance Abuse and Mental Health Services Administration [HRSA/SAMHSA], the American Academy of Family Physicians [AAFP], and the Institute of Medicine have all have formally recommended the inclusion of behavioral health practitioners on the primary care team.[v]

Modern medical theories support this notion as well. The biopsychosocial theory of disease asserts that human behavior and organic factors should be treated as two parts of an integrated human system (Engel, 1977). According to this view, effects on biological disorders can be achieved through appropriately targeted effects on personal behavior and experience, relationships, and environmental contexts. The recently proposed "Outcomes Model" is consistent with the biopsychosocial tradition, but includes a measurement paradigm. University of California, San Diego Professor Robert M. Kaplan describes the "Outcomes model" for human

health, which views the human body "as a system that cannot be divided into component parts... Its objective is to treat the person rather than the disease.[vi]" The goal is to extend the duration of life or to improve the quality of life of the patient, rather than just correcting pathology,. This model is built on the behavioral tradition, because behaviors can influence duration and quality of life independent of disease diagnoses. Others, such as Kemeny[vii] (1993) and Siegel[viii] (1985), argue for the importance of the biopsychosocial model, which addresses psychological and spiritual factors for the purpose of improving medical outcomes as well. The prevalent biomedical model continues to offer important medical insights and treatments and to have proponents as a model for guiding the medical system.[ix] Nonetheless, the increasing dominance of the biopsychosocial models as guides for medical care encourages integration of behavioral expertise with biomedical expertise, even if not within individual providers.

In addition to the theoretical support for such an approach, there is ample data to support specific effects that should translate into cost-effective behavioral screening and interventions in a general practice setting. These include evidence for the cost-effectiveness of behavioral health interventions for improving primary prevention, improving adherence to medical treatments, increasing appropriate use and decreasing inappropriate use of medical services, advancing patients' ability to cope with illness and with adverse effects of treatment, and treating comorbid and secondary mental health problems. The following review offers examples of this evidence, rather than trying to present a comprehensive description of what has become a huge literature.[x]

Primary Prevention / Health Promotion

The most prevalent factors leading to premature death are tobacco use, exercise and diet patterns, alcohol abuse, microbial agents, toxic agents, firearms, sexual behavior, motor vehicle accidents, and illicit drug use. These factors account for about half of all deaths, and individual

behavior plays a role in about 86% of these deaths, or 43% of total deaths.[xi] Study authors conclude that, "Our findings indicate that interventions to prevent and increase cessation of smoking, improve diet, and increase physical activity must become much higher priorities in the public health and health care systems." For specific sub-populations the pattern of health risks vary and approaches should take this into account. For example, for employed young adults, obesity and stress are the strongest predictors of health care utilization, so preventatively addressing these issues has the potential to be especially cost-effective.[xii]

Behavioral interventions has been shown to be effective in preventing premature deaths by reducing both acute risk behaviors, such as drug abuse and unsafe sex, and long-term lifestyle risk factors such as physical activity, smoking, and poor diet quality. Behavioral health primary risk prevention strategies can effectively address acute risk factors, an example of which is drug and alcohol abuse. Analyses of 42 schools indicate substance abuse behavioral prevention demonstrates significantly decreased drug use when compared to a control group: 17% vs 24% for cigarette smoking, 11% vs 16% for alcohol use, and 7% vs 10% for marijuana use in the last month.[xiii] Additionally, preventative, client-centered sexual behavior counseling results in an overall reduction in sexually transmitted disease incidence by 30% over six months. The sexual behavior counseling costs are more than off-set by the savings accrued from avoiding infections—if 240,000 people were given brief sexual behavior counseling, approximately 145 new AIDS cases would be prevented, and approximately twenty million dollars would be saved.[xiv] Behavioral interventions also address lifestyle risk factors. Behavioral models are useful strategies for increasing physical activity in the general population,[xv] leading to decreased obesity and heart disease rates. Dietary behavioral interventions to increase consumption of fruit, vegetables, whole grains, nuts, and olive oil (the Mediterranean diet), decrease the prevalence of metabolic syndrome

by 50% when compared to a control group.[xvi]The adoption of appropriate behaviors (before any disease becomes apparent) could increase life expectancy by as much as 10-14 years.[xvii] Behavioral health should be incorporated into the primary care setting because most Americans have at least a few of the behavioral risk factors for chronic disease and premature death, and behavioral health interventions change these risky behaviors.

Primary behavioral prevention has shown to be particularly effective in preventing Type 2 diabetes. About 23.6 million people in the United States have diabetes, and 95 percent of those with diabetes have type 2 diabetes. The Diabetes Prevention Program, a recent major clinical trial, was aimed at discovering whether diet and exercise or the oral diabetes drug Metformin could prevent the onset of diabetes in those diagnosed with Pre-diabetes. Participants given Metformin reduced their risk of developing diabetes by 31 percent.[xviii] However, participants treated with a lifestyle intervention—intensive behavioral counseling on diet, exercise, and weight loss—reduced their risk of developing diabetes by 58 percent,[xix] nearly twice the effect as Metformin, yet more than 42 million prescriptions for the generic formulations of Metformin were filled in 2009,[xx] while comprehensive behavioral primary prevention strategies are seldom provided. With a full one-fourth of the population 20 years of age and older having pre-diabetes,[xxi] the integration of behavioral health clinicians will allow for the implementation of a behavioral prevention regime to prevent the onset of diabetes in these primary care patients, thus preventing diabetes more successfully than in other primary care settings]

Adherence to Medical Treatment

Behavioral factors often interfere with or can improve patients' success at following through with recommended medical treatments. Doctors often falsely believe that their patients are complying with treatment as ordered,[xxii] but an estimated 50% of patients do not take their medications as prescribed and are said to be nonadherent with therapy.[xxiii] Poor adherence is estimated to cost approximately $177 billion in total direct and indirect (such as lost wages, lowered productivity, and quality of life) costs[xxiv] each year. Adherence is particularly pronounced in patients with chronic conditions; for example, approximately half of patients receiving hydroxymethylglutaryl-coenzyme A reductase inhibitor, a statin class of anticholesterol drug, will discontinue their medication within six months.[xxv] For patients with chronic disease, medical nonadherence is associated with worse health outcomes, higher hospitalization rates, and increased health care costs.[xxvi]

Behavioral interventions targeting medication regimes have shown to significantly increase adherence.[xxvii xxviii xxix] Eight out of thirteen interventions with combined informational and behavioral components demonstrated improvements in adherence measures. The integration of behavioral health clinicians into the primary care team will help address medication noncompliance in a wide range of patients, which is helpful because this problem has proven to be both prevalent and persistent (particularly in those with chronic conditions). The target population of this integrated primary care team will be predominantly adults, so the fact that nonadherence increases by 6.7% per year means that nonadherence should be expected to be pronounced in the patient population.

Appropriate Use of Services

The US health care system is often termed a paradox of excess and deprivation.[xxx] This is represented succinctly by individual utilization of health care services: some patients receive too much healthcare, others don't receive enough, and others are receiving inappropriate treatment altogether.

General medical health plans commonly outsource mental health and behavioral care to restricted provider networks. Under this system, more than 70% of those with mental health or substance abuse problems receive no treatment for their illnesses.[xxxi] In 1996, Although about half of patients with a mental disorder in the previous 12 months received treatment, only 14.3% of those with mental health disorders received care that could be considered consistent with evidence based treatment recommendations.[xxxii] Additionally, about two-thirds of primary care physicians in 2005 reported that they could not get outpatient mental health services for patients, a rate at least twice as high as that for other services.[xxxiii] Integration is viewed as a solution to increasing appropriate use of care. In the federally funded PRISM study, even with "the best referral process imaginable" only 49% of the patients referred to outside behavioral health clinicians became engaged in these services, compared to 71% of patients in practices with integrated mental health services.[xxxiv]

Additionally, integrated care can help decrease inappropriate use of medical care. High health care utilization is extremely costly, and is not necessarily associated with better outcomes.[xxxv] Prevalence of mood disorders is markedly higher in "high utilizers" than a control group,[xxxvi] so it stands to reason that the reduction of mood disorders would decrease over-utilization of healthcare, and lead to cost savings. This is indeed observed. Collaborative protocols in primary care for panic disorder are not only cost-effective, but more than offset their cost in savings on other healthcare.[xxxvii] Psychological treatment for depression is associated with a

decrease in outpatient utilization 1 year post-treatment.[xxxviii] Another study also demonstrated cost savings: when patients with a history of high medical expenditures were identified and treated for depression, their medical utilization cost fell from $13.28 per day to $6.75 per day. When costs for treatment were added, daily service use cost was $12.55 per day, still a net savings..[xxxix] This decrease in high utilization associated with behavioral treatment can be particularly beneficial for businesses as they reap the benefits of lower absenteeism and attrition and increased presenteeism. After 20,000 McDonnell-Douglas Corporation employees were identified as having alcohol, drug, or emotional problems, the corporation decided to hire in-house behavioral counseling services. The users of these services showed a 34-44% decrease in absenteeism and had a 60-80% lower attrition rate, in addition to decreasing medical utilization. The McDonnell-Douglas Corporation saved $4.00 in health costs, absenteeism, and attrition for every $1.00 spent on the in-house behavioral counseling.[xl]

Physicians have identified psychological and emotional problems that are not medical in nature as accounting for as much as two-thirds of their time and of the symptoms presented to them.[xli] Somatization, the appearance of physiological symptoms resulting from psychological distress, is pervasive in the primary care setting, but remains underdiagnosed[xlii] and is notoriously difficult to treat. Behavioral health specialists can employ the "narrative approach," an intensive psychotherapy technique that successfully addresses somatic symptoms. "It mobilizes the patient to accept diagnoses and treatments previously ignored or even refused," says Andre Matalon, who has published several articles on this approach. As such, redirecting patients with these psychological problems to behavioral health clinicians rather than medical providers, could increase the relevance, and therefore cost-effectiveness, of services and decrease unnecessary, unhelpful, or inefficient use of higher-cost physician time.[xliii] These patients, suspicious that their symptoms will be discounted, are likely to not accept a referral to an outside behavioral clinician who is not part of their treatment team. The incorporation of behavioral health practitioners into

the primary care team could overcome this barrier.

Coping with Disease

Illnesses, especially chronic illnesses, often cause significant disruption to patients' lifestyles and thus cause significant distress. Medical treatments can make these effects even worse by causing their own disruptions through "adverse effects" as well as adding the demands of following treatment protocols. Behavioral interventions are particularly effective at helping patients cope with illness and with these adverse effects and, therefore, to improve health and quality of life outcomes. This can increase the efficiency of healthcare by reducing unnecessary demands on medical personnel for assistance with the psychosocial effects and aftermaths of medical disorders and their treatment.

Patient education programs[xliv], supportive group interventions[xlv xlvi] and relaxation training [xlvii] have been shown to improve functioning, reduce depression and anxiety, decrease pain, and increase adherence to treatment for patients with a variety of chronic diseases. Because of the vicious cycle between chronic illnesses and quality of life and emotional functioning,[xlviii] behavioral interventions that help patients cope effectively with these psychosocial concomitants, improving both medical and psychosocial outcomes. All illnesses cause difficulties with psychosocial adjustment, and this aspect of recovery often requires direct attention to improve. [xlix]

Behavioral interventions have shown to be particularly successful in regards to pain management. Pain management programs involve multiple behavioral treatments for various types of pain.[l] Pain can arise either as a result of another disease and condition, like cancer, or be the condition in and of itself, like headaches or back pain. Systematic reviews and meta-analyses of behavioral therapies demonstrate a reduction in pain and improvement in functioning for arthritis,[li] fibromyalgia,[lii] headaches,[liii] and back pain.[liv] The U.S. Headache Consortium has even assigned the highest grade to the strength and quality of the evidence supporting psychological interventions for the treatment of migraine headaches.[lv] Treatment of pain through behavioral

interventions could potentially lead to cost-savings, because the direct and indirect costs of pain are great.[lvi] [lvii] For example, a migraine study reported that participants had headaches on 8.1 work days in 3 months, and demonstrated a 25 to 40 percent reduction in performance on such days. The average evidence-based, behavioral, acute-pain management program costs $17,714, and is shown to lead to cost savings of $1,500 per inpatient visit.[lviii] This means that if more than 12 patients are included in the program, the cost of the pain management program is offset, and large savings are accrued. Integration of behavioral and pharmacological approaches has shown to be particularly effective. Antidepressants produce an early reduction in headache activity,[lix] whereas patients in behavioral pain management programs improve long after cessation of active treatment,[lx] presumably due to continued improvement in behavioral and cognitive pain management skills. Thus the combination of pharmacological and psychological techniques causes relief of pain in both the short and long term.

Behavioral interventions can be effective at reducing biological and psychological side effects of medical treatments. Chemotherapy frequently causes both pain and depression, and behavioral interventions, like hypnosis[lxi] and relaxation therapy,[lxii] can help individuals cope. Additionally, the very act of receiving a cancer diagnosis is marked with pronounced distress,[lxiii] and behavioral health clinicians could help ease this burden. About 35 percent of patients follow a "distress" trajectory following cancer diagnosis, which can lead to loss in physical functioning. In general, primary care physicians and oncologists are likely to under-diagnose psychiatric distress in cancer patients,[lxiv] so the integration of behavioral health clinicians could improve diagnoses of this distress. Behavioral therapy can also determine the success of a surgery. After a percutaneous coronary surgery, a treatment for multivessel coronary disease, patients in behaviorally oriented cardiac rehabilitation programs had significantly lower chances of coronary event recurrence than control patients—30.4 percent compared to 53.7 percent without behavioral therapy.[lxv] Following behavioral therapy, cardiovascular mortality was reduced for this surgery from 14.6 percent to 2.2 percent.[lxvi] In terms of both helping to alleviate side effects of medical treatment and helping

patients to cope with medical treatment, behavioral health clinicians could play a large role in the primary care setting.

Treatment of Mental Health Disorders and Comorbidities

Not only are the majority of visits to medical care providers thought by some to be due to emotional distress rather than medical problems,[lxvii] around half of mental illnesses may be presented to general practitioners rather than to mental health professionals.[lxviii] This is particularly important due to the consistent finding that mental health problems are underdetected, underdiagnosed when recognized, and undertreated when properly diagnosed.[lxix lxx]

The importance of treating psychosocial problems that present either as comorbid to or as the result of medical problems is demonstrated by the effects of ineffectively treated mental health disorders on medical outcome. Depression has been an increasingly prevalent issue in the primary care setting due to the economic downturn.[lxxi] Depression affects length of hospital stay,[lxxii] affects long-term rehabilitation and recovery, [lxxiii] and increases rehospitalization by as much as a factor of three.[lxxiv] Medical illnesses frequently seen in primary care settings, like cardiac disease, chronic obstructive pulmonary disease, and diabetes mellitus, are often worsened by depression, which also increases the risk of rehospitalization for these diseases.[lxxv] Anxiety similarly interferes with functioning in medical patients.[lxxvi] Yet most people, at least in the U.S., have relatively frequent contact with physicians, with over 75% consulting a doctor each year and 95% at least once every 5 years.[lxxvii] Physicians' offices may thus be particularly important locations for the identification of both secondary and comorbid mental health problems, which can be accomplished by behavioral health clinicians. In 2009, the US Preventive Services Task Force released an update recommending screening adults for depression in primary care practice, but only when staff-assisted depression care supports are in place and functioning.[lxxviii] The inclusion of behavioral clinicians would be this support system, and would allow enable the integrated practice to adhere to federal recommendations.

Rates of treatment for mental health conditions have slowly increased from 1990, but these increases have largely been confined to the general medical sector.[lxxix] This is an issue because general practitioners have shown to be relatively ineffective at treating mental health conditions: A large proportion of patients with appropriately diagnosed mental illnesses in the general medical sector do not receive the treatments considered state of the art in psychiatry, or receive inadequate doses or durations of treatments that are appropriate.[lxxx] Other patients are sometimes incorrectly diagnosed by a general practitioner and referred to mental health treatment; about half of those receiving mental health treatment do not meet the criteria for a mental health disorder.[lxxxi] Behavioral health clinicians are specifically trained to recognize and treat mental health conditions, so incorporating them into the primary care team will allow for more accurate diagnosis and treatment of them. Furthermore, when general medical practitioners correctly recognize mental issues and attempt to refer patients to mental health specialists, especially those who practice in other locations, patients too often fail to follow through with these referrals.[lxxxii] Having behavioral specialists routinely assess all primary care patients could thus improve detection and increase the follow through and effectiveness of needed mental health interventions.[lxxxiii] Instead of relying on the primary care practitioner to correctly identify and refer the patient (which the patient might not follow through with) behavioral health clinicians would be part of the primary care team from the onset.

Conclusion from the Literature

Taken as an aggregate, this literature provides justification for the integration of behavioral health clinicians into the primary care team. Brief, relatively inexpensive behavioral health services could improve outcomes and save money on medical costs by advancing the primary prevention of disease, promoting adherence to medical treatments, increasing the appropriateness (and thus cost-effectiveness) of medical service utilization, improving patients' ability to cope with illness and with adverse effects of treatment, and more effectively diagnosing and treating

mental health problems. Although integration of behavioral health clinicians might not have an enormous effect in any one area, there is enough evidence to demonstrate a cumulative effect of significance, in addition to a more cost-effective approach for treating generalized patients. Every aspect of the physician visit can be improved by including a behavioral health clinician: behavioral health clinicians can institute primary prevention efforts from the first meeting to avoid disease in the first place, can aid in the diagnosis and treatment of mental health problems when they arise, can support patients after diagnoses so they can cope with diseases psychologically, and can help patients adhere to treatment plans when they are decided upon. Not only would the patient benefit immensely in terms of the quality of their care, but also most of these integration components have been shown to be cost-effective.

Given this evidence, it is not surprising that the Institute of Medicine has formally recommended the inclusion of behavioral health clinicians on the primary care team. What *is* surprising is the general lack of primary care models that include behavioral health clinicians in the primary care setting. The successful, cost-effective demonstration of the Lifelong Personal Health Care pilot project could serve as the necessary evidence for a more widespread acceptance for this model, and ultimately serve as motivation for the creation of more of these integrated practices around the country. In turn, the cost-benefits of these behavioral services could potentially help slow the unsustainable escalation of health care costs, freeing more resources to offer better care to those who need it.

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HealthInsInquiry - Guidance on Primary Spend for Health Insurers

From: Howard Mintz <hmintz@coastaldocs.com>
To: "healthinsinquiry@ohic.ri.gov" <healthinsinquiry@ohic.ri.gov>
Date: 2/3/2011 2:15 PM
Subject: Guidance on Primary Spend for Health Insurers

Howard Mintz
Coastal Medical Bald Hill Pediatrics
315 Commonweatlth Ave
Warwick, RI 02886
615-2299

Here are my comments:

I would first like to address the issue of shifting fee schedules, which was not what was desired. #5 of "Factors Considered", states that the significant salary gap will likely affect the future supply of primary care physicians. Not until this gap is closed, will any of the other changes that will support primary care physicians dramatically change the supply of primary care physicians in Rhode Island.

I would also like to say that I fully concur with the statements of Dr. Pogacar, regarding the issues of pediatric practices. In no other field of medicine will you find offices that are open 7 days a week, seeing patients for same day appointments and coordinating care, keeping them out of expensive emergency rooms and treatment centers.

At the same time, factors making primary care practice frustrating will need to be eliminated. Barriers to care set up by insurance companies make taking care of patients difficult. Try calling an insurance company to get prior authorization for a procedure, having to spend ten minutes on a telephone tree until one can reach an individual who can be of help, which means time that I am unable to spend on real patient care. Insurances are changing formularies without prior notice causing doctors to spend countless time on the phone with pharmacies, and then not having systems in place to easily find an appropriate medication. Denying payment for visits in which the diagnosis is not covered, even if that is the correct diagnosis (such as seeing a child for mouth pain, diagnosing a dental abscess, coding it as such, only to have the visit denied) and having to lie as to the proper diagnosis and wait months in order to get paid. Similarly, it is frustrating when certain codes such as obesity are not paid for, and again forcing us to use inaccurate codes in order to order labs and get paid. With the advent of electronic health records and the ability to track patients, this interferes with our ability to monitor and track patients.

Paying for care to the RiteCare or Medicaid patients at the same rate as the major private insurers would eliminate much of the barrier to care that these patients receive, and hopefully keep them out of the ERs. Even paying for their visits at the Medicare rate would make a significant difference. In addition may of our patients with special needs may have Medicaid or RiteCare as a secondary insurance to help cover things like copays. What happens in reality is that the copay which is submitted to the secondary insurance is denied, because the payment by the primary commercial insurance is more than is covered by RiteCare or Medicaid. So the one's subsidizing these patients is not the secondary insurance, but the Primary care office, again providing us with a disincentive to see them.

Subsidizing phlebotomists in pediatric offices would help insure that pediatric patients had appropriate testing. Internists will order sufficient testing making it worthwhile for commercial labs to place phlebotomists in offices, but pediatricians tend to be conscientious about ordering each blood test thereby being cost effective but not providing the volume needed to support obtaining the specimens in the manner most convenient for the patients. Bringing other ancillary health care providers, such as social workers or nutritionists into the office on a regular basis to work with patients, would bring needed therapy to families and children where they are used to receiving care, and increase their use of these services.

Adequate funding for children's mental health issues should be provided so that there is a sufficient number of Child Psychiatrists to see children with mental health issues. Increased access to child psychiatrists would decrease emergency mental health visits where children are sitting at Hasbro awaiting a bed at a psychiatric institution (for which there are also an inadequate number). Rhode Island produces good child psychiatrists; it's too bad they don't stay.

Howard Mintz

MEMORIAL HOSPITAL
OF RHODE ISLAND

Department of Family Medicine

February 3, 2011

Angela Sherwin
Principal Policy Associate
Office of the Health Insurance Commissioner
State of Rhode Island
1511 Pontiac Avenue, Bldg. 69-1
Cranston, RI 02920

Dear Ms. Sherwin:

Thank you for the opportunity to comment on how OHIC directs insurers to invest in primary care. These standards are a breakthrough for healthcare in Rhode Island and I compliment the OHIC for their forthright and visionary leadership.

One area that appears to be missing from the recommendations is that of **Primary Care Workforce Training.** I suggest that the support of training efforts for primary care physicians training be included, since initiatives at payment reform will likely be unsuccessful if there is no-one to provide these services. Support for expansion of training programs, support for existing programs, and loan-forgiveness for indebted primary care physicians who wish to go into practice in RI are high on the list of needs.

Regarding Item 1:

Money spent by insurers in payments to primary care physicians and primary care practices.

Examples include fee-for-service payments, pay-for-performance incentives, payments for structural changes at the practice (i.e. electronic records), and payments for supplemental staff or supplemental activities not traditionally considered within the scope of primary care (i.e. payments to other providers by the primary care physician).

There is ever increasing research that demonstrates that pay-for-performance is ineffective in the primary care setting for a variety of reasons. Its focus on single or linked measures is insufficient to change practice patterns, it tends to skew practice toward particularistic measures, and penalizes practices in low socio-economic status areas. Structural and integrated changes to practice may be far more effective in improving the health of the population.

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Regarding item 2:

2. Money spent by insurers for services provided by a third party in the primary care setting to either patients or the practice itself.
   Examples include practice training, nurse care managers, behavioral health and pharmacy co-location.

I would like to underline that efforts only be supported if they are co-located in the practices themselves, since significant research has shown that such integration at the practice level is a key component to their success. This is partially covered by the second part of the document, but the language of "integrated into practices" might be helpful.

Thank you again for the opportunity to comment on this important work.

Sincerely,

Jeffrey M. Borkan, M.D., PhD
Professor and Chair
Department of Family Medicine
Memorial Hospital of RI
Warren Alpert Medical School of Brown University

The Rhode Island Foundation

One Union Station, Providence, RI 02903
401 274-4564 ▪ www.rifoundation.org

February 8, 2011

Mr. Christopher F. Koller
Health Insurance Commissioner
State of Rhode Island and Providence Plantations
1511 Pontiac Avenue
Building # 69, Floor # 1
Cranston, RI 02920

Dear Mr. Koller:

Thank you for the opportunity to provide comments on the Office of the Health Insurance Commissioner's (OHIC) Guidance on Primary Care Spending.

We applaud OHIC's efforts to promote a more cost-effective health system that promotes improved outcomes for all Rhode Islanders. OHIC's primary care spending requirements are a critical building block in our state's health improvement efforts.

After reviewing this guidance, we'd like to make several suggestions:

- On the first category of allowed investment, you might consider clarifying that pay-for-performance or bonus payments are not allowed unless they are tied to a well-defined improvement in the functioning of the primary care setting. Doing this would avoid the possibility of rewarding practices that simply shift to providing less care or attracting a healthier patient mix.

  You might also want to consider clarifying that expenditures devoted to behavioral health in the primary care setting are designed to improve outcomes for patients and to advance the integration of primary care and behavioral health care, not simply to move the delivery of behavioral health care into primary care settings from other locations.

- On the fourth factor, concerning loan forgiveness programs, we strongly urge OHIC to incorporate loan forgiveness programs targeted on other primary care practitioners including at a minimum physician assistants, nurse practitioners, and clinical social workers. The Rhode Island Foundation – working with partner organizations including Blue Cross-Blue Shield of Rhode Island, the Rhode Island Area Health Education Center

- (AHEC), the Rhode Island Medical Society, the Rhode Island State Nurses Association, the University of Rhode Island School of Nursing, the Rhode Island Health Center Association, and the Rhode Island Academy of Physician Assistants -- has launched a new component of our loan forgiveness program to provide loan forgiveness awards to physician assistants and nurse practitioners. The initial funding for this program is provided by a grant from The Rhode Island Foundation, but its long-term sustainability will, to a very large degree, depend on funding from other stakeholders including our state's commercial insurers. Attracting new nurse practitioners and physician assistants to the practice of primary care in Rhode Island will potentially be an important driver in providing more cost-effective primary care.

- In the Notes attached to the guidance, you might want to add a note stating that all patient-centered medical home projects qualified under this guidance will be encouraged to coordinate their efforts and to publicly describe their plans to sustain these programs over the long-term. As patient-centered medical home programs beyond the Chronic Care Sustainability Initiative are emerging, it would be beneficial if insurer-funded medical home efforts could be coordinated to ensure that practices do not end up with multiple programs serving members covered by different insurers. Perhaps commercial insurers supporting such programs could voluntarily agree on principles to guide coordination and further development of these efforts.

Thank you for the opportunity to comment on this guidance and your efforts to improve our state's health care system. I would be happy to answer any questions you might have.

Sincerely,

Owen Heleen
Vice President for Grant Programs

OH/es

HealthInsInquiry - Primary Care in Rhode Island

From: "Jose Polanco" <jpolanco@pace-ri.org>
To: <HealthInsInquiry@ohic.ri.gov>
Date: 2/8/2011 12:31 PM
Subject: Primary Care in Rhode Island

As a primary care physician in Rhode Island, I have a few comments I would like to make in response to your email.

I borrowed over $185,000 to become a primary care physician. I then left working for a hospital to open my own practice borrowing another $200,000 to establish a completely wireless, paperless office- everyone came out for the grand opening- the lieutenant governor, mayor, etc. After 3 ½ years of dealing with insurers' barrage of programs to "help" with primary care, I decided to leave the fee-for-service model. Everything went up (except my pay). The insurances would increase our pay by pennies. Not only would it be tiny increases, they'd also take it away from another charge. The paperwork- you know how that goes- give us more busy work so we have more obstacles to ordering any test or prescription that we feel is appropriate for our patients. This model does not work. Health care has been hijacked by insurers and we as a profession have been kept out of the loop. I was so naive- I actually met with some of the insurers to show them how I was saving them money by being bilingual (no need for interpreters)/seeing patients the same day for sick visits (fewer ER visits)/etc., but all they said was- "If you don't like our contracted rates, you can just get out of our contract and our patients can see someone else". Later I find out they pay much higher rates to the guys down the road who have a larger group- regardless of their quality of care. Go figure.

Unfortunately our society, law makers, all the way up to the president, do not see the magnitude and severity of the problem. Requiring everyone to have insurance is not the answer.

One day everyone is going to notice that no one wants to practice primary care, and that day will soon be upon us. I have since joined an HMO model at PACE Organization of Rhode Island caring for a small panel of geriatric patients. I would like to practice primary care in the community the way I originally planned, but current conditions do not allow this.

I wish you luck with this project and hope that America wakes up. Let me know if doctors can unite one day to truly fight for our rights and our patients' rights- I'd be interested in that.

Jose Polanco, MD

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Rhode Island Chapter

Rhode Island Chapter of the AAP
PO Box 20365
Cranston, RI 02920

February 12, 2011

Dear Commissioner Koller,

Thank you so much for highlighting the value of primary care medicine to the health of Rhode Island's citizens with the Affordability Priorities and Standards for Health Insurers. While the current economy is forcing many difficult business decisions, any investment in the promotion of healthy living has a guaranteed return on investment. Unlike the often quick savings found with adult medicine reforms, the financial return for pediatric interventions is often not realized until the patient attains adulthood. It is important to raise this distinction as most insurance business models build on the need to show immediate results. Pediatric investments cannot be judged against this traditional business model, nor is it appropriate to hold pediatric patients and their physicians to this short return standard.

The Centers for Medicare and Medicaid Services reports that the "per person health care spending for the 65 and older population was $14,796 in 2004, which was 5.6 times higher than spending per child ($2,650 in 2004) and 3.3 times spending per working-age person ($4,511 in 2004)." In other words, "in 2004, children accounted for 26 percent of the population and 13 percent of the personal health care spending, while the working-age group, including the baby boomers, comprised the majority of spending (52%) and population (62%). The eldest were the smallest sized group at 12 percent of the population and accounting for the remaining 34 percent of spending." (www.cms.gov/NationalHealthExpendData/04_NationalHealthAccountsAgePHC)

The conclusions from these statistics are two-fold - the costs for children's healthcare are an extremely small portion of the overall healthcare dollar spend. This is most likely due to the overall good health of the pediatric population coupled with comprehensive pediatric standards for medical care. 'Bright Futures', the American Academy of Pediatrics document that dictates the standards of each well baby/well child appointment, is actually preserved in the Affordable Care Act as the standard for preventative pediatric care nationally. Done right, pediatric preventative medicine aims to grow our patients in to healthy adults who will cost less than the current adult statistic of 52% of national healthcare spending. The second conclusion from this financial disparity is that the comprehensive preventative care provided by pediatricians is undervalued by the insurance community.

With my comments I would like to highlight the tremendous value of the quality, comprehensive and cost-saving pediatric medical care delivered by Rhode Island's pediatricians and how support from the Affordability Standards will not only improve this current standard of care but also create new initiatives to benefit our patients and support practice transformation.

The first category – how the Affordability Standards can support the current standard of care.

1. Afterhours telephone calls
2. Email communication
3. Provision of sick and well child care at the same office visit
4. Developmental screening
5. Vision screening
6. Hearing screening
7. Postpartum Depression screening
8. Evening, weekend and holiday office hours
9. Office used in an emergency
10. Vaccine administration
11. Care coordination

According to the AAP Access Principles, "all health plans should have payment rates that assure that children receive all recommended and needed services." Currently, Rhode Island health insurance payments fail to fulfill this Access Principle for all recommended pediatric services. Unlike preventative adult medicine visits, the pediatric visit is full of separate screenings and services (hearing, vision, development, mental health) that are important but time-consuming. While each of these screens is reported to the insurer with a separate CPT code that has value, currently most of these services in Rhode Island are not paid individually. Rather, the insurers consider them 'bundled' in the well child care payment. With the Affordability Standards, I ask that the insurers pay pediatricians for the entire work of each well child visit. To be clear, I am not asking for a raise in fee-for-service payments, but rather payment of fees for the service that is already provided to the state's children.

If line-item payments are too onerous for the Affordability Standards, another option may be to respect the work and cost-savings of these screens with one global payment that is added to each well child visit payment. Consider it a "Bright Futures" payment that fairly compensates pediatricians for the sum value of this standard care. In the same fashion, a fair per-member-per-month payment could compensate for the cost savings and value of emergency and afterhours office access as well as telephone advice. Either way, the current system for compensating pediatricians for the proper value of these eleven points is unsustainable and needs to change.

The second category – how the Affordability Standards can support new pediatric initiatives.

1. Co-location of services – nutrition, mental health, pharmacy, parent consultants, lactation consultant
2. Group office visits – prenatal consults, behavior, breastfeeding, obesity, asthma, tobacco cessation, etc.
3. Comprehensive obesity treatment care
4. Normal camp experiences for children with chronic illnesses – congenital heart disease, cancer, diabetes, asthma
5. TALC – The Adolescent Leadership Council
6. Workforce recruitment and retention – loan forgiveness
7. Electronic Health Record attainment and connection to KIDSNET
8. Medical Home

With your indulgence, at the bottom of this letter I have provided the details to support each of my recommendations. To be clear, the pediatricians of this state are dedicated professionals who care tremendously for the health of Rhode Island's children. As the work of healthcare reform gains momentum, it is incumbent on all of us to make sure that the youngest of our citizens have a continued voice at every table that will affect their lives. Pediatricians speak with strongest voice for our patients, but we cannot do it alone, and we cannot do it without initiatives that are specifically targeted to support our offices and our patients. One day, our patients will grow up to be adults. With the commitment of the Affordability Standards to the pediatric needs listed in this letter, the pediatricians of this state will have the tools necessary to successfully transition their patients to the adult physicians as healthy, productive citizens who are the realization of cost efficient health care.

Thank you for your consideration and your hard work on behalf of all Rhode Islanders.

Sincerely,

Elizabeth B. Lange MD

Elizabeth B. Lange, MD FAAP
Immediate Past President, Rhode Island chapter of the American Academy of Pediatrics
Pediatrician, Waterman Pediatrics/Coastal Medical, Inc.

Afterhours telephone calls: The mainstay of pediatric care is the accessibility of a pediatrician by phone afterhours. In recent years, the consumer demand for afterhours access to the pediatrician has been increasing for a multitude of reasons – increased consumer demands for free healthcare due to increased out-of-pocket medical expenses with higher copays, higher deductibles and higher premiums, higher percentage of two employed parent households, increased consumer expectations for access to care and increased "connectivity" via cell phones and web-based communication. The 3am croup attack, the 11pm fever to 104, the listless vomiting child at 5am – as parents, we have all accessed our pediatrician after hours at one point or another. In fact, in 2008 the AAP Section on Telephone Care reported that 30% of pediatric care is provided by non face-to-face methods, primarily by telephone. Most of these calls involve reassurance and education, and most of these interactions have prevented unnecessary emergency room visits.

In a survey published in Pediatrics 2007 (119;e305-e313), parents who called the Pediatric After-hours Call Center at the Children's Hospital of Denver were asked "What would you have done if you could not have called our call center this evening/today?" With a 77.8% response rate (n=8980), 46% of parents said they would have gone to an emergency department or urgent care facility. Of this 46% of parents, only 13.5% subsequently were given an urgent disposition by the call center. Of the 21% of parents who would have treated their child at home, 15% of these cases were given an urgent disposition by the triage nurses. Assuming that all callers followed the advice provided, the estimated savings per call, based on local costs in that year (CO, 2007) was $42.61 per call. Savings based on Medical Expenditure Panel Survey national payment data were $56.26 per call. The bottom line is that afterhour calls play a vital role in the overall health of our patients, and cost containment of healthcare dollars. In an assessment of daytime office telephone calls, another study of Colorado office practices estimated the cost of in-office telephone triage to be $6750 per physician per year (Pediatr Ann.2001:30:256-267).

And yet there is tremendous medical liability with providing telephone medical care. In the Physician Insurers Association of America's database of closed malpractice claims for 1985-2006, of the 817 claims involving telephone medicine, one third of these (272) resulted in a payout to the plaintiff. Pediatrics accounted for 12% of the claims but nearly 16% of the indemnity dollars. In fact, the average indemnity payment for a pediatric telephone claim ($282,630) was higher than the average indemnity payment for general pediatric claims paid during the same time period ($261,901) and higher than the average indemnity for all telephone claims ($272,327). Even more concerning is that of the four primary care specialties representing three-quarters of all telephone claims, pediatricians had the highest percentage of paid claims (41%). In contrast, the rate of payment for all pediatric claims in the PIAA database during the same time period was 28%.

The American Academy of Pediatrics published a policy statement in October 2006 supporting payment for telephone care. A copy of this statement was mailed at the time to the national medical directors of all the health insurers. The 2008 CPT included several well-described new codes for non-face-to-face services (telephone care and on-line medical services) and the Center of Medicare and Medicaid Services valued these codes with RVUs (relative value units). And yet no Rhode Island insurer currently supports payment for afterhours telephone care. No other profession (accountant, lawyer) is expected to provide telephone advice and counsel for free. The cost savings of pediatric telephone care to the insurer are clear, the benefits to the patients are

tremendous, the support of the medical home mantra is achievable, the liability to the pediatrician is very real, and the coding and payment structure as well as a policy statement are already in place – payment to primary care physicians for afterhours telephone care is the perfect and most necessary place to start applying the Affordability Standards.

Electronic communication: This discussion is similar that for telephone communication. In the current fee-for-service office environment, there is no paid protected time built in to the schedule in which to answer patient emails. And yet, for all the aforementioned reasons (higher out of pocket medical expenses, busier lives, increased worldly electronic connectivity, 24/7 business cycle) as well as the advent of patient portals, many patients are demanding electronic access to their physician. In order to support the overhead necessary for this new form of physician-patient communication, the medical offices need financial support in order to provide the confidential patient portal access as well as the compensated physician time to respond to patients in this medium. With support from the Affordability Standards, primary care physicians can better meet the needs of our patients in a fashion that is best for appropriate office care.

Provision of sick and well child care at the same office visit: For many reasons, pediatricians often are called upon to treat an illness, to perform a procedure or to address a significant medical concern at a well child appointment. Put another way, due to patient circumstance of that day, the physician is providing two separate services at one visit. For example, the two month old well child visit in which the baby is wheezing from a bad cold, the seven year old child where the majority of the well visit is spent discussing the child's inattention at school, poor self esteem and a treatment plan is initiated for an ADHD evaluation, or the parent who waited until the child's well visit to show the doctor a growth on the patient's foot, which is a wart that requires in-office treatment. Again, in this era of high deductible insurance plans and two working parent households, by necessity many families are bundling all of their concerns in to the well child visit. By accommodating the patient/family's needs at this one visit, the pediatrician is providing efficient, timely and thorough care, as well as saving the family an additional copay and additional time out of work/school for averted second office visit. From an office schedule point of view, the extra time the pediatrician has dedicated to this family usually extends beyond the appointment time, resulting in a back-up of office schedule.

The CPT recognizes this work with the -25 modifier. When added to the medical claim, this tells the health insurance company that two separate but identifiable services have been provided at that visit. As of this writing, not all of Rhode Island's insurers recognize the value of this added diagnosis and treatment, and will deny payment for the second office visit, instead bundling the payment with that of the well child visit. For those insurers that value the second diagnosis, the payment is 50% that which would be paid if the family had the problem addressed at a second appointment. Unfortunately, 50% payment is the national trend at this time even though the physician still applies 100% work to the second medical concern that is raised by the family. Due to the obvious cost savings and patient-friendly nature of the two diagnosis visit, not to mention the office schedule disruption, I ask that the Affordability Standards be applied such that every Rhode Island insurer must value the second diagnosis code with payment at 50%, or higher as national trends dictate.

Developmental Screening: Due to the increasing rates of autism, and the fact that early identification of developmental problems and initiation of treatment plans results in better

pediatric outcomes, the American Academy of Pediatrics has a policy statement that recommends that developmental surveillance be incorporated at every well-child visit and that screening tests be administered at regular intervals, including at a newly added 30-month well child visit. This developmental screening schedule is included in the AAP well-child guidelines book called "Bright Futures", which was written in to the Affordable Care Act of 2010 as the national standard for pediatric care. The work of developmental screening has been valued with a CPT code. As of this writing, most Rhode Island insurance company policies are to be commended for supporting these developmental screening and 30-month visit recommendations. However, not every policy that covers Rhode Island's children values these standards. I ask that the Affordability Standards be applied so that every child has access to the appropriate standard of care developmental assessments and 30-month well child visit in the medical home. (Parenthetically, the Commonwealth of Massachusetts lost a lawsuit in which one of the plaintiffs' major points was the inadequacy of behavioral and mental health screenings and treatment for children in MA. As a result, MassHealth mandated that all children age birth to 22 years receive appropriate developmental screenings at their well child appointments. Further, MassHealth pays pediatric providers to perform these screenings. In an effort to avoid a two-tiered system, the private insurers have likewise agreed to pay for these screenings at the appropriate well child visits.)

Vision Screening/Hearing Screening: In a similar fashion, the AAP Bright Futures standards recommend that children have their vision screened at ages 3, 4, 5, 6, 8, 10, 12, 15, 18 and hearing screened at ages 4, 5, 6, 8, 10. It is well known that children who unable to see or hear well are at risk for speech and language delays as well as educational and behavioral challenges, all of which can negatively impact a child's life. With a successful screening program in the medical home, pediatricians are able to limit specialist referrals to only those children who do not pass the office test. The CPT has a code for each of the vision and hearing screening tests which is submitted to the insurer at the appropriate visits. As of this writing, most of the Rhode Island insurers do not recognize these separate CPT codes, rather bundling this care in with the payment for the well child visit. This practice is a disservice to the standard pediatric care and disconnected from the standard of adult medicine in which most adults only receive vision screening at an eye care provider's office and not in the medical home. This additional office visit for adult medicine is another expense that is avoided by the pediatric office vision and hearing screening standards. I ask that the Affordability Standards be applied to vision and hearing screening such that the work performed is valued as a separate payment.

Postpartum Depression screening: Many studies from infancy through adolescence show that a mother's depression affects her children adversely. Mothers with depressive symptoms are more likely to seek urgent care for their young children and to utilize more health services and are less likely to limit television watching, to read to their child and to implement safety measures. Over time, children raised in a home with a depressed parent are more likely to develop behavioral problems and depression. (Pediatrics 2006 vol 118 no 1). Postpartum depression (PPD) is the most common complication of childbirth, affecting at least 15% of women. The March of Dimes calls it the biggest threat to the health of a newborn. Due to the frequency of newborn office visits, pediatricians are uniquely positioned to screen mothers for PPD, which is why Bright Futures has added this screening as the standard to the 1, 2 and 6-month well baby visit and is represented by its own CPT code. Rhode Island has a terrific PPD treatment program at Women and Infants Hospital so that any new mother who screens positive at the pediatrician's office is easily referred to this program. Currently no Rhode Island insurers separately value

this important standard of care screening. I ask that the Affordability Standards be applied to PPD screening.

Evening, weekend and holiday office hours: Medical care provided in the medical home is the most cost efficient and cost savings care. To this end, to the best of each office's ability, pediatricians provide extended hours to accommodate our patients' needs. As many of the adult physician practices are now adopting the Medical Home model, they realize how difficult it can be to supply office staff who will work each weekend and holiday day as well as evening hours. These are overtime hours for the employees and family time for everyone. However, medical appointment availability for acute illness outside traditional office hours is a tremendous service to our patients as well as an insurance cost savings. This standard also allows the emergency rooms to be more available for true emergencies. Each Rhode Island insurer has evaluated their own claims data to ascertain how many patients are cared for afterhours in the medical home, and each insurer knows the specific cost savings of this care to their business. In an informal pediatric poll a few years ago, RIAAP determined that the pediatric offices around the state cared for 200-400 children in their offices each weekend. Stated another way, by opening their offices on the weekends and holidays, Rhode Island's pediatricians prevented the majority of 200-400 children from needing to seek medical care in the emergency department or walk in. These are very expensive places to receive non-emergent medical care. While many of the insurers recognize the 99050 afterhours code for weekend care, many do not recognize its use for evening hours, nor do they recognize the 99051 code for planned evening clinics. I ask that the Affordability Standards require the insurers to recognize the value of the CPT codes for medical care delivered during non-traditional office hours (evenings and weekends/holidays) and to develop new payment plans that incent/reward primary care offices to remain open for office visits for these hours.

Office Used in an Emergency: There is never a dull moment in primary care medicine. While the schedule is set in the morning, the plan is quickly derailed when a patient who fell off the monkey bars needs an urgent evaluation for a possible broken arm, or a patient with acute abdominal pain might have appendicitis, or an asthmatic is having difficulty breathing. In pediatrics we call these "come alongs," patients who need acute assessment and care outside the normal office schedule. Their care is among the most important that we can deliver, because often times we can avert an emergency room visit, but it comes at the expense of a disrupted and derailed office schedule. The CPT has a code to recognize this disruption and work, but the Rhode Island insurers do not recognize this code. In fact, one insurer has previously stated that they cannot pay this code since some physicians were caught over-utilizing it. This is a disservice to all the pediatricians who were applying this code correctly. In any given pediatric office, this properly identified situation arises only a few times per week or less. I ask that the Affordability Standards include emergency office care in the payment formula.

Vaccine administration: Preventative vaccinations are one of the biggest health achievements of the last century. Pediatric vaccines have saved more lives than any other single medical treatment, resulting in tremendous cost savings to the healthcare system. The vaccines of today are so good that many of us have either forgotten or never even seen serious illnesses such as pertussis, meningitis, chicken pox, measles, and tetanus. Coupled with the belief by some that vaccines cause autism, many families require significant counseling time to discuss their concerns about the current vaccine schedule.

The 2011 CPT recognizes this time with new vaccine administration codes. While the experience with the new codes and their values is just 6 weeks old, I ask that the Affordability Standards protect the intent of these new codes - to value the incredible time consumption necessary to properly counsel families about the value of vaccines with payment equal to or above the Medicare rate. In recent years Rhode Island has significantly slipped as a national leader in overall pediatric vaccination rates. Not only is this embarrassing in a state our size, but it also means that our undervaccinated population is at risk of contracting vaccine-preventable diseases. Nationwide there have been recent outbreaks of measles, meningitis and pertussis due to populations of unvaccinated children. Unless we turn around our rates of pediatric vaccination, Rhode Islanders are at risk for a similar outbreak.

One of the many barriers to improved vaccination rates is the insurance company payment for vaccine administration. I ask that the Affordability Standards require Rhode Island health insurers to support the new 2011 CPT vaccine administration codes with payment of at least 100% Medicare rates. While these standards apply to the commercial insurers, I would like to note that the state Medicaid plan pays woefully below cost for vaccine administration (currently 52% Medicare). This has been brought to their attention with no changes planned at this point. Without a state supported vaccine clinic, Rhode Island's children can only receive their vaccinations in the medical home. Therefore, it is disappointing that the state Medicaid plan expects pediatricians to deliver this important health prevention service at below cost.

Care Coordination: This has become the buzz-word in the Patient-Centered Medical Home model. Before these standards were written, a few pediatricians utilized the care plan oversight CPT codes (99339, 99340) to represent their recurrent physician supervision of a complex patient or a patient who requires multidisciplinary care and ongoing physician involvement. These codes are not face to face and reflect the complexity and time required to supervise the care of the patient. The codes are reported based on the amount of time spent per calendar month. The CPT specifically describes the appropriate use of these codes. While this applies to very few pediatric patients across the state, it is a valuable code for those who qualify. Therefore, I ask that the Affordability Standards maintain the value of this service.

Co-location of services: As with adult medicine, co-location of services enhances patient satisfaction and elevates the level of care provided to that patient. In pediatrics, there is tremendous value and convenience in meeting with consultants in the medical home. Due to our population size, one consultant may be accessible to multiple medical homes. There are many successful models of mental health-primary care liaisons but the costs of co-location are prohibitive to most practices. The National Survey of Children's Health noted in 2007 that 24% of Rhode Island children age 2- 17 who needed mental health services did not receive them. Certainly, a mental health-pediatric co-located practice should overcome this concerning statistic. Ongoing grants from the Affordability Standard spend can remove this financial barrier, thus improving care for our patients. Likewise, placing a nutritionist in a pediatric office has tremendous value. A pediatric nutritionist's schedule will fill pretty quickly with patients who struggle with eating

disorders, obesity, stubborn and finicky eating habits, as well as petite former premature babies.
For families with a sick child, a trip to the pharmacy can be difficult. Therefore, a co-located pharmacy in medical office buildings will ease this burden and improve the likelihood that the prescription will be filled and taken as directed.
The Rhode Island Department of Health has compelling data to show that co-located parent consultants, with their specific expertise, have reduced the average annual healthcare costs for children with special health care needs.
Finally, breastfeeding is the best source of nutrition for babies – it is cost effective, environmentally sound, immunologically protective and medically advantageous. Babies who are breast fed have a lower risk of allergies as well as obesity, not to mention the health benefits to the nursing mother. However, only 75% of women initiate breastfeeding at birth and only 13% are still exclusively nursing at 6 months. The best ingredient for breastfeeding success is a strong support network, both from family, friends, work and physician. Co-locating a lactation consultant in the pediatric practice values one of these supports and there are successful models of this care to emulate.

Group office visits: Many healthcare questions and coordination of care are best addressed in a group setting where patients and parents can learn from each other as well as from the professional healthcare presenter. Support for group office visits by the Affordability Standards will achieve better health outcomes and health care cost savings.

Obesity Treatment: Obesity is a tremendous issue across all patient ages. Nearly one in six Rhode Island children entering kindergarten and one in five children entering seventh grade during the 2008-2009 school year were obese (KIDS COUNT 2010) However, obesity prevention is one of the many valuable 'touchpoints' of pediatric care, the eighteen – twenty year return on investment. With the right support system, access to quality nutritional education and a personalized exercise plan, early childhood eating habits children will grow at an normal pace and will not grow up to become an obese adult with multiple expensive health issues. The insurers have already recognized the healthcare expense attributed to our state's obesity epidemic and they have made some great strides at providing patient education and support (Shape Up, JOIN). I ask that the Affordability Standards be applied to redouble this effort within the insurers and to collaborate with the obesity prevention and treatment work already provided in the medical home. This is another opportunity for a group office visit. There are some very successful models of this care already ongoing in our state that can be expanded with the Affordability Standards.

Normal camp experiences for children with chronic illnesses: At first blush, this may sound like a frivolous application of the serious standards at hand. However, for children who live with chronic illnesses such as diabetes, asthma, congenital heart disease, autism or cancer, nothing is frivolous about their lives and nothing in their daily lives is normal for a child. Their medical needs preclude participation in traditional summer camps. Rhode Island is lucky in that there are dedicated medical professionals and community volunteers who value the normalcy of childhood enough to provide summer camps for these special children. The camps are staffed by medical professionals who are prepared for any emergency so the children are free to be children. And the parents are free to let go of their special child for a few hours, knowing that they are safe at this well prepared camp. As you can imagine, the funds to support such a specialized endeavor are tremendous and dependent on camper tuition as well as philanthropy, not to mention the donations of medical personnel time. While not a traditional view of the Affordability Standards spend, I submit that the patient experiences and the subsequent health benefits

from these experiences at the special camps far exceeds the costs of maintaining this camp, and completely falls under the rubric of "an investment in improved healthcare."

The Adolescent Leadership Council (TALC): By the same token, the TALC program is an initiative of Hasbro Children's Hospital's Child and Family Psychiatry program that is based on a nationally successful model of bringing together teenagers who live with chronic illness with students from area colleges who are medically similar in an effort to enhance disease education and to share the highs and lows of living with chronic illness. The meetings are lead by child psychiatrists and child psychiatry residents who work with the young adults as well as their parents. For the participants and their families, this program is a life-line to normalcy and understanding in place where all feelings are safe and validated. Again, TALC is not a traditional view of the Affordability Standards, but this program greatly enhances the health and well-being of these teenage patients.

Workforce recruitment and retention – loan forgiveness: Paul Howard, director and senior fellow at the Manhattan Institute's Center for Medical Progress, wrote, "Unless trends change soon, a lack of primary-care providers would endanger the nation's well being and drive up healthcare costs." Several studies have documented the fact that few medical residents are choosing primary care, and are instead opting for more lucrative specialties. Consequently, the "American Medical Association is predicting a shortage of up to 44,000 primary-care physicians by 2025." A 2006 American College of Physicians study maintained that one of the key drivers of the "impending collapse of primary care" besides medical student debt is "inadequate and dysfunctional payment policies" for primary care providers. With few students in the primary care educational pipeline, the physicians of today feel the threat of extinction. For those who are graduating in primary care, their commitment to lifestyle may mean that two graduates will be required to replace one aging primary care physician.

Due to current workloads, insurance payments and malpractice laws, it is very difficult to recruit primary physicians to work in Rhode Island. A key cornerstone of the Affordability Standards for this year must include significant support for primary care physician education, with loan forgiveness programs as well as student stipends, and primary care recruitment/employment. To achieve the latter, salaries must be competitive with neighboring states. This can be accomplished with improved office payments for services (E/M codes), improved practice supports (EHR, practice management support) and improved work hours (support for a pediatric-specific walk in, overnight nurse triage programs.)

Electronic Health Record attainment and connection to KIDSNET: EHRs are the face of modern medicine due to the expected cost savings from improved healthcare and health coordination, as well as reduction in duplicative services. However, all of these savings are realized by the insurers, the patients and the "system" with no appreciable savings directed to the physician. And yet, the cost to obtain and to maintain the expensive computer systems is borne by the primary care provider. While there are supports in place to assist pediatricians with obtaining an office EHR (RI Quality Institute, the REC) this assistance does not nearly cover the full cost of the installing and maintaining a comprehensive computer system. Furthermore, most pediatricians in Rhode Island will not qualify for the federal funding that is available to support EHR implementation. The Affordability Standards can be well applied to support primary care physicians with the costs of implementation and maintenance of an electronic health record, either through an enhanced fee schedule or direct grants/subsidies. For our state vaccine program it is a requirement that the pediatricians report the patient vaccine administration dates to the

statewide database called KIDSNET. To fully transfer this data electronically requires many EHR companies to write a patch program which is an added office expense. This is another place where the Affordability Standards can support the acquisition of EHR capabilities for the office.

Medical Home: As is well known, the 1967 American Academy of Pediatrics concept that the pediatrician should be the central location for coordinating a child's medical record has been expanded to become the Patient Centered Medical Home Principles. This set of principles was adopted in 2007 by four leading medical organizations and has become the cornerstone of practice transformation, including the local CSI project and the proprietary medical home projects. The standards outlined in the formal Principles are lofty but attainable with proper support. Due to many factors, the bulk of the cost savings in this model are achievable with adult patients. However, I challenge the Affordability Standards to continue to work with the pediatricians of this state to write medical home standards that reward the current savings achieved by comprehensive pediatric care as well as reward any mutually beneficial initiatives which achieve new savings. One methodology would be to link the new Rhode Island pediatric-specific standards to the pediatric Meaningful Use targets. The National Survey of Children's Health reports in 2007 that only 63.6% of Rhode Island children age 0-17 receive health care that meets the AAP's definition of a medical home. I am confident that this number can be greatly improved if the Affordability Standards are applied to pediatric care in Rhode Island as is outlined in this comment.

Thank you for your dedicated attention to the health and well being of our state's children and their doctors.

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Rhode Island Business Group on Health

Promoting a better Healthcare delivery system

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February 15, 2011

Mr. Christopher Koller
Rhode Island Health Insurance Commissioner
1511 Pontiac Avenue, Building 69-1
Cranston, RI 02920

RE: Guidance on Primary Spend for Health Insurers

Dear Commissioner Koller:

On behalf of the Rhode Island Business Group on Health (RIBGH) and our affiliate organization, The Worksite Wellness Council of Rhode Island (WWCRI), we are providing you with our perspective on the proposed "Guidance on Primary Spend for Health Insurers" (the Guidance) prepared by your office for public comment. RIBGH and WWCRI continue to support your office's efforts to promote primary care in Rhode Island including increasing the amount spent by health insurers on primary care by five percentage points from 2010 to 2014.

While we agree with and support the four specific investments described in the Guidance that would meet the requirements of acceptable primary care spending by health plans, we are particularly concerned about significantly increasing the rate of adoption of Electronic Medical Record systems (EMRs) by primary care practices in Rhode Island. It is well documented that EMRs, when properly and meaningfully used, improves quality and reduces the cost of healthcare by increasing practice efficiency and reducing medical errors and unnecessary tests and procedures. We believe that achieving the widespread adoption of EMRs in Rhode Island is essential to seeing meaningful results from the additional primary care investments by the health insurers. We are also concerned that many primary care practices have been delaying their purchase of EMRs due to financial constraints. Therefore, we recommend that the OHIC consider additional language in the final version of the Guidance to emphasize that providing financial assistance for the adoption of EMRs is a desired primary care investment.

Thank you for the opportunity to comment on the proposed Guidance.

Sincerely,

J. Michael Vittoria
President
RI Business Group on Health

HealthInsInquiry - Comments re: proposed Primary Care Spend

From: Ailis Clyne <ailisc@yahoo.com>
To: <HealthInsInquiry@ohic.ri.gov>, <HealthInsInquiry@ohic.ri.gov>
Date: 2/16/2011 10:17 PM
Subject: Comments re: proposed Primary Care Spend

As a pediatrician who has been training and practicing pediatrics in this state for 15+ years, I would like to comment on the proposed primary care spending recommendations as offered by OHIC. I don't feel that I am out of line in saying that the pediatric providers are a bit ahead of our adult medicine colleagues in adopting the medical home model of primary care. We provide access and care seven days a week and have for decades. Contrary to the OHIC statement, fee-for-service reimbursement in pediatrics does not come "at the expense of care coordination." That's what we do: CARE COORDINATION!!!. Every day, seven days a week, 365 days a year. And believe me, our reimbursements do not come close to compensating for the time involved in care coordination. You will not see short term cost savings in any area of pediatrics (except possibly with asthma ER visits and hospitalizations--for which there are programs/studies underway to address). What you will see in the next two decades is an exodus of pediatricians from this state if reimbursement for our services does not become competitive with surrounding states.

My proposal:

50% of the primary care spend should go to increasing the fee schedule for all services rendered in the primary care setting. (So we can keep a roof over our practices and maintain our expensive EMRs...NOT drive fancy cars)

50% of the primary care spend should go towards establishing a REAL outpatient quality improvement organization which focuses on supporting primary care doctors in efforts to improve the quality of care they provide to their patients. These comprehensive services should be provided to primary care providers FREE OF CHARGE and include:

1) Thorough research of the existing literature to identify best practices in providing cost efficient services within a medical home
2) Development of user friendly programs to implement best practices
3) Assistance with QI projects and data collection
4) Creation of a uniform set of quality measures to be tracked and supported by all insurers

The bottom line is that improving the quality of primary care in this state depends on maintaining a supply of primary care providers and supporting existing providers in providing higher quality more cost effective care where possible.

Thank you for considering these comments,
Ailis Clyne MD

Rhode Island
Primary Care Physician Advisory Committee

"Advising the Rhode Island Department of Health on programmatic and policy issues that support primary care in Rhode Island."

February 17, 2011

Mr. Christopher Koller
Health Insurance Commissioner
State of Rhode Island
Office of the Health Commissioner
1511 Pontiac Avenue
Building 69, Floor 1
Cranston, RI 02920

Dear Commissioner Koller:

We are writing to you as Chair and Immediate Past Chair of the Primary Care Physician Advisory Committee (PCPAC) to the RI Department of Health. This letter is in response to your request for feedback on OHIC System Affordability Standards for Health Insurers. PCPAC recognizes that an effective primary care system requires a significant investment in infrastructure, including reform of payment systems that encourage and support investments in primary care. These investments must be made at the level of primary care practices and should be aligned across health plans to maximize the impact on the quality and capacity of primary care services in Rhode Island. The following is a summary of the suggestions and concerns raised by PCPAC members when the standards were initially introduced and in response to your December 2010 presentation to PCPAC:

- Payment should be provided for patient-centered care coordination, after hours access, and phone and e-mail contact with patients.
- Increased funding for interdisciplinary primary care teams is needed for primary care providers to provide patient navigation and self-management support.
- The percentage of required primary care spend that can be met by fee-for-service increases should be capped in order to direct more funds into alternative payment methodologies, practice transformation and additional support for implementation of the patient-centered medical home.
- A portion of investments should be dedicated to primary care provider training, recruitment, and retention.

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- While the beneficiaries of primary care spend should be primary care practices, targeting investment into systems to improve communications between primary care providers and hospitals will be productive.

We trust that this feedback will be useful as you finalize OHIC's System Affordability Standards for Health Insurers. We look forward to ongoing dialogue with your office as we continue to work together to improve the primary care system in Rhode Island.

Sincerely,

Elizabeth B. Lange MD

Elizabeth Lange, MD, FAAP
Chair, PCPAC

Tom Bledsoe MD

Thomas Bledsoe, MD, FACP
Immediate Past Chair, PCPAC

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February 17, 2011

Christopher Koller
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Re: Public Comment on "Guidance on Primary Spend for Health Insurers"

Dear Mr. Koller:

I would like to thank the OHIC for this opportunity to comment on this important issue to the health of the Rhode Island community.

The "primary care spend" of the Rhode Island Affordability Standards is an important step to increasing quality and decreasing the cost of health care in our state. The Rhode Island Chapter of the American College of Physicians (over 700 physician members) advocates for a further expansion of the "primary care spend" for the following reasons:

- Primary care medicine should be at the "center" of the health care delivery system with a "team" approach to the care of patients. Primary Care diagnoses and treats acute, chronic and complex medical problems and is also the collector, collator, reporter and analyzer of important health care data to improve the quality of care.

- The CSI-RI Patient Centered Medical Home project, the Beacon grant, the build out of the Health Information Exchange and the adoption of electronic health records with "Meaningful Use" requirements, give structure to the work of improving quality and decreasing costs. This work is only possible with practice redesign in the form of infrastructure build out and added personnel. Specific requirements include:

  a) The cost of office personnel to enter and maintain data entry functions into fields within the electronic health record (EHR).
  b) The time required to collate and analyze data (i.e. Hemoglobin A1C measurement in diabetic patients) on multiple chronic diseases on a continuing basis.
  c) The cost of periodic software and hardware updates to the EHR
  d) The cost for development and maintenance of "patient portals" for communication of health information with patients to help them better manage their health.
  e) The cost of personnel needed to follow patients after visits to the emergency room, post hospitalization and rehabilitation.
  f) The cost of increased access to care with extended office hours in the evenings and weekends.
  g) The cost of seeking "Prior Authorization" for advanced medical imaging.
  h) The cost of a "patient kiosk" registration for collection of demographic and medical history.
  i) The cost of ancillary medical personnel such as Nurse Practitioners, Physician Assistants, behavioral therapists and pharmacists to provide comprehensive care.

- The support received through the "Primary Care spend", the CSI-RI PCMH pilot project, the Meaningful Use incentive payments and the Beacon grant only partially off set the above added costs. The payment structure needs to provide added funding to continue to truly provide primary care centered, comprehensive and longitudinal care for our patients.

- Primary care medicine has been "in crisis" for several decades at a local and national level. The passage of the Affordable Care Act of 2010 will result in 30 million more insured, in addition to a changing demographic of health care needs for the adult population. If the payment disparity in medicine is not corrected, there will be further disparities in the supply and demand for primary care services. The income gap between primary care and sub-specialty and other specialty care is not meaningfully closed with the current payment structure. The difficulties of maintaining and recruiting primary care to Rhode Island are well known and documented over several decades.

- The CSI RI pilot project, Meaningful Use, the Beacon Grant may help fund some of the above changes in practice design but do little to create a fair and equitable income for primary care.

The RI-ACP Chapter strongly recommends a further increase in the "Primary Care spend" to continue to close the "income gap" to supply an adequate physician workforce and create a truly robust and healthy patient centered health care system with high quality, cost efficiency and improved public health.

Sincerely yours,

Nitin S. Damle MD FACP
Governor
Rhode Island Chapter of the ACP

HealthInsInquiry - Public Comment on Primary Spend

From: G Alan Kurose <akurose@coastaldocs.com>
To: "'HealthInsInquiry@ohic.ri.gov'" <HealthInsInquiry@ohic.ri.gov>
Date: 2/17/2011 3:09 PM
Subject: Public Comment on Primary Spend
CC: G Alan Kurose <akurose@coastaldocs.com>

Wednesday, February 16, 2011

Dear Commissioner Koller,

I am writing to advocate a cap on the allowable percentage of the primary spend that health insurers can meet through increases in fee for service payments.

As you know, Coastal Medical provides care to over 100,000 Rhode Islanders, and I am writing to you today in my capacity as president and CEO of that organization. I am proud of the altruistic spirit and commitment to clinical excellence I see in so many Coastal physicians. However, over the last 16 years at Coastal, we have also learned the value and importance of aligning financial incentives to influence physician behavior. We now have 16 NCQA level 3 recognized medical home offices, and our success to date in EMR adoption and PCMH practice transformation is due in part to **careful alignment of financial incentives with desired process changes in our practices.**

PCPAC held extensive deliberations to consider the primary spend in August, 2009. **The majority of PCPAC members did not feel that across the board fee schedule increases by themselves would be an effective mechanism for achieving the stated goals of the affordability standards.** PCPAC echoed that same sentiment at 7:30 AM today. It is recognized that the prevailing fee for service system rewards providers for "producing" a high volume of patient visits, and enhancing fee for service payments perpetuates this "perverse" system of rewarding unwanted behaviors. There is no incentive for quality or efficiency.

Organizations such as the Patient Centered Primary Care Collaborative (PCPCC) are bringing us a steady stream of emerging data from diverse groups across the country that are demonstrating enhanced quality and reduced costs with implementation of coordinated care and a PCMH model. CSI shows promise of yielding similar results, and the practices there are bringing a loud and clear message in their requests for funding to support integration of CDOE's, nutritionists, Pharm D's, and others into the care teams working in their evolving medical home practices.

RECOMMENDATION: Among the allowable investments, there *should be* identified priorities. OHIC should cap the percentage of "primary spend" that can be met by fee-for-service rate increases, and reduce that cap percentage over time. This will force greater investment in PCMH practice transformation and medical home resources, with the goal of improving the quality and reducing the cost of the care delivered.

On behalf of all Coastal providers, I wish to acknowledge with gratitude the critical support that the affordability standards have brought to our professional endeavors in general and our practice transformation work in particular. Thank you.

Al Kurose, M.D.
President and CEO, Coastal Medical

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

RIHCA
RHODE ISLAND HEALTH CENTER ASSOCIATION

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

February 17, 2011

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

Dear Commissioner Koller,

I write today on behalf of the Rode Island Health Center Association (RIHCA) and its members, Rhode Island's ten community health centers, in response to your invitation for comments on the draft guidance on primary spend requirements for health insurers. The community health centers are very supportive of the Health Insurance Commissioner's focus on increasing spending on primary care as a proportion of overall health care. This is good policy and a good way to help control health costs.

Rhode Island's ten community health centers are a critical element in the state's health care landscape. Serving over 120,000 Rhode Islanders annually, the community health centers provide comprehensive, high-quality primary and preventive care to some of Rhode Island's most vulnerable populations. In a state with no county health departments and no publicly run health clinics, Rhode Island's community health centers are the de facto public health infrastructure for primary care. The community health centers are acutely aware of the need for accessible, affordable primary care in Rhode Island, and your office's efforts to support primary care in the state are much appreciated.

RIHCA supports the draft primary care spend guidance. We agree that primary care spending is best done in the primary care setting, and that insurers' plans for an increased primary care spend should be focused specifically on supporting primary care providers. Money spent in payments to primary care practices, for third parties providing services directly to primary care practices, to support patient centered medical homes and on loan forgiveness for primary care providers are all helpful and supportive of strengthening the primary care network in Rhode Island. We also agree that money spent on activities of non-primary care providers and for general health system capacity building (as differentiated from specific EHR implementation efforts at primary care practices) should not count towards the insurers' primary care spend requirements.

RIHCA would like to comment specifically on the proposed allowance of money spent by insurers in support of multi-payor collaboration for primary care, including the All Payor Patient Centered Medical Home Project (CSI-RI). RIHCA supports the multiple state-wide efforts to bring the patient centered medical home (PCMH) model of care to practices throughout Rhode Island. RIHCA has been on the CSI-RI steering committee from the start, and one of our health centers is a practice included in CSI-RI. In addition, all of the community health centers participate in the Rhode Island Chronic Care Collaborative and many are participating in

Beacon. Many of our community health centers are pursuing certification as a medical home through NCQA.

RIHCA believes the medical home model of care is good for patients, good for practices and good for state health policy. We also think that it is important that any new programs developed to promote this model of care, and any further expansion of current programs, include any practice that meets a specified list of criteria. That is, expansion and development of medical home programs should be an open and inclusive process. In addition, we would like to see CSI-RI expand state wide, and to include all practices that meet certain objective criteria. The medical home model of care is the wave of the future, and we hope that OHIC, through the primary care spend and other initiatives, helps promote this model through an inclusive process.

Thank you very much for taking a leadership role in controlling increasing health care costs and in promoting the importance of primary care in Rhode Island. RIHCA looks forward to working together with OHIC as we address the same concerns in the coming years.

Sincerely,

Jane A. Hayward

Jane A. Hayward
President and CEO

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Rhode Island Chapter

Rhode Island Chapter of the AAP
PO Box 20365
Cranston, RI 02920

President
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Hasbro Children's Hospital
593 Eddy Street Room
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Phone: 401/444-7987
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February 16, 2011
To: The RI Health Insurance Commissioner
RE: Guidance on Primary Care Spend for Health Insurers, Comments from The RI Chapter of the American Academy of Pediatrics

Dear Commissioner Koller:

We would like to begin by commending your office for its bold regulatory proposal to increase investment in primary care by RI's health insurers. As pediatricians, we recognize the value of primary care in prevention of illness and promotion of healthy children and youth. We also are the torch-bearers for true medical homes, medical care that is family-centered, comprehensive, compassionate, continuous, coordinated, and culturally effective. The pediatric medical home is for all children and youth rather than only for those with chronic illness. However, because it is meant for all children, because the return on the investment requires a much longer timeline than does chronic care management in older adults, and because children's health care is not the cost driver that adult care is, to date the primary care medical home investments in Rhode Island have neglected children. We understand that health insurers need to see outcomes that show improved quality of care and lower cost of care. We believe investing in children's primary care can deliver both of these but it will take a longer time to reap the benefits. However, if pediatricians and family doctors can get children to early adulthood as healthy, non-obese, non smoking, mentally healthy and physically fit, sexually healthy and fully immunized, we can effectively drive down the cost of health care and improve the health of the community. **We respectfully request that you consider requiring 25% of the primary care spend be dedicated to primary care for children and youth. (This is roughly in proportion to the population of primary care recipients in the state.)**

Plans can be encouraged to create children's health demonstration projects with pediatricians and family doctors in much the same way they have partnered with internal medicine doctors to build medical home demonstration projects.

1. One way to invest in child health would be to examine the ways in which pediatricians and family doctors are paid for providing comprehensive preventive services according to Bright Futures, the ACA-specified preventive services guidelines for children and youth. This is an important schedule of periodic comprehensive screenings, counseling, testing and examinations that forms a high quality set of preventive services for child health but requires re-tooling of traditional well child visits and is currently not being paid.

2. We suggest pursuing evidence-based successful models for transforming child health services, in particular, The Vermont Child Health Improvement Partnerships might be an excellent investment. Creating RI Child Health Improvement Partnerships would support

pediatricians to improve quality in the office setting.

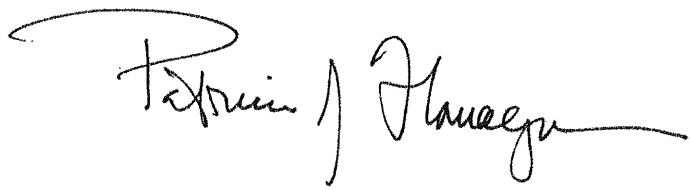
3. A third idea would be supporting Community Health Teams that could provide wrap-around coordination services for multiple practices. Most pediatric practices can not support a nutritionist or a psychologist or social worker but could share these services regionally if the infrastructure were in place.

The RI AAP and our 340 pediatrician members would be very interested in working with youroffice and with the payers to further define an approach to supporting primary care transformation in RI.

Increasing the investment in primary care for children will benefit all Rhode Islanders.

Thank you.

Sincerely,



Patricia Flanagan MD
President,
RI Chapter American
Academy of Pediatrics

February 18, 2011

Mr. Christopher Koller
Health Insurance Commissioner
State of Rhode Island

Dear Mr. Koller:

I writing to you in my capacity as co-chair of the Steering Committee for CSI RI/Beacon, (Rhode Island's nationally prominent all-payor patient-centered medical home demonstration project now also leading Rhode Island's Beacon Community) in response to your request for feedback on your document entitled "Guidance on Primary Care Spend for Health Insurers."

We applaud your efforts over the years to help the Rhode Island health care delivery system to become more effective and efficient and agree with your premise that a more robust primary care infrastructure is critical to that mission.

Under the category of "Guidance for Primary Care Spending," we feel it is important to include efforts to assist primary care practices with panel management, specifically focusing on practice wide quality improvement efforts. Additionally, we believe that supportive services such as nurse care managers, behavioral health providers, nutritionists and pharmacists are most effective if co-located within the primary care practice. Support for infrastructure to allow the location of these services within the practices or in a community-based facility (for example, as a home for a "community health team") that would be capable of servicing a number of smaller practices should also be supported.

The contents of this letter have been discussed with and endorsed by other members of the steering group for the CSI project, a broad coalition of stakeholders engaged in reforming and refinancing primary care delivery in our state. The members of this steering group are listed on the attached page.

Our group recognizes that a robust and effective primary care system is critical for the success of this effort and that primary care has been under-resourced for many years. The fee-for-service payment system in particular has been detrimental; paying primary care physicians only for seeing many patients for a very short time each has not yielded the quality results that the people of Rhode Island or those who purchase medical care here deserve. We believe that a robust and active primary care system requires a substantial investment in infrastructure in that system, both in human capital and in technology, and more generally a shift towards more innovative payment strategies and away from "enhancements" to a fee-for-service system.

The kinds of activities that your office defines as "primary care spending" should include the following:

- *Investment in technological infrastructure* in primary care practices. Too many of our primary care practices are not yet effectively using electronic health records. Growing evidence suggests that the ability to track and manage the health of a practice's patients at

a systems level is critical and this requires effective integration and tracking of medical information at the practice level. Ideally, this would also support data analysis to assist primary care practitioners in assessing the effectiveness and efficiency of hospitals and subspecialty colleagues

- *Rewards for effective clinical practice at the practice or population level* outside of payment based simply on number of patients seen per day. While "simple" adjustments to a fee schedule favoring primary care may be helpful in making primary care a more attractive career choice (see below), there is concern voiced by many of our number that more fundamental payment reform is indicated. A hard cap on the percentage of "primary care spend" that could be used to increase fee-for-service rates might be one way to signal to purchasers, payors and the public that this is a time for creative thinking. Some but not all of our members feel that such a hard cap should be instituted with incremental reduction in the percentage of the increased primary care spend being used for fee-for-service rate increases over the life of your plan

- *Development of other innovative financing mechanisms* should also be supported, specifically those tied to population health and effective and efficient primary care. We agree that these should be tied to your 4 "standards of success," namely a) overall commercial health insurance premium trend, b) inpatient admissions, c) preventable ER visits and admissions, and d) primary care physician to population ratios and patient satisfaction

- *Support for allied health practitioners* critical to the success of the patient centered medical home fully integrated and co-located with the primary care practitioner (including but not limited to nurse care managers, behavioral health providers, nutritionists and pharmacists). A patient-centered medical home requires a physician-led team to deliver patient-centered care effectively. Such integration may require structural changes to practice physical facilities and even affiliation of smaller practices into somewhat larger groups to facilitate sharing of resources. Investment in these kinds of changes should also be supported.

- *Support for Primary Care Practitioners to function as teachers and preceptors* to assist in the diffusion of training (to medical students, residents, pharmacy students, students in colleges and trade schools) as well as *support for training of Primary Care Practitioners* through collaborative learning opportunities, on-site coaching, web-enabled learning and planning and execution of learning sessions. *Efforts to coordinate all of the statewide efforts in practice transformation* should also be supported. Our workforce should be fully trained to function in this new environment

- *Continued funding* of the All Payor Patient-Centered Medical Home project. The transformation of the primary care infrastructure in Rhode Island is too important to be left to competitive market forces, forces which have resulted in the current fragmented and dysfunctional medical "system." Our coordinated and cooperative community effort is seen across the country as a model for system transformation. Continued investment in this project by payors should be especially encouraged. Additional investment leading to growth of the All Payor project should certainly qualify as a "Primary Care Spend"

A career in primary care has unfortunately been seen as far less attractive than other specialty medical careers and we and others have discussed at length the impending workforce crisis in primary care. We believe that for Rhode Island to have an effective and efficient primary care delivery system, a career in primary care in Rhode Island must be seen as attractive relative to a career in primary care in other locations and even relative to a career in a medical subspecialty. In order to attract and retain the "best and the brightest" for primary care in Rhode Island, these disparities must be addressed.

Please note that United HealthCare, an active participant in CSI RI, has ***not*** endorsed the content of this letter.

Sincerely,

Thomas A. Bledsoe MD FACP
Co-chair CSI RI/Beacon Steering Group

Governor St. Primary Care Center, University Medicine
285 Governor St
Providence, RI 02906

CSI-RI and Beacon Steering Committee

Member	Organization	Title
Participating Practices and Hospitals		
Thomas Bledsoe, MD (Co-Chair)	University Medicine – Governor St. Primary Care Center	Physician
	Rhode Island Chapter, American College of Physicians	Governor-Elect
Russell Corcoran, MD	South County Hospital Patient-Centered Medical Community Steering Committee	Chair
Jeff Borkan, MD	Memorial Hospital of Rhode Island	Physician-in-Chief, Department of Family Medicine
	Warren Alpert Medical School, Brown University	Chair, Department of Family Medicine
Jerry Fingerut, MD	Blackstone Valley Community Health Care	Medical Director
Louis Giancola	South County Hospital Healthcare System	President and CEO
G. Alan Kurose, MD	Coastal Medical, Inc.	President and CEO
Maria Montanaro	Thundermist Health Center	President and CEO
Al Puerini, MD	Family Health and Sports Medicine	Physician
	Polaris Medical Management	President and CEO
	Rhode Island Primary Care Physicians Corporation	President
Kenneth Sperber, MD	Hillside Avenue Family and Community Medicine	Physician
Purchasers		
Domenic Delmonico	Care New England	Senior Vice President, Managed Care Contracting and Network Management
Howard Dulude	Rhode Island Business Group Health	Officer/Representative
	Lifespan	Director, Health and Benefits
Health Plans		
David Brumley, MD	Tufts Health Plan	Senior Medical Director
Neal Galinko, MD	UnitedHealthCare of New England	Medical Director
Mack Johnston, MD	Neighborhood Health Plan of Rhode Island	Chief Medical Officer
Gus Manocchia, MD	Blue Cross Blue Shield of Rhode Island	Medical Director
State Agencies		
Dona Goldman	Rhode Island Department of Health	Chronic Disease Director
Ellen Mauro	Office of Institutional and Community-Based Services and Supports, Rhode Island Department of Human Services	Administrator
Elena Nicolella	Rhode Island Department of Human Services/Executive Office of Health and Human Services	Medicaid Director
Amy Zimmerman	Rhode Island Department of Health	Chief, Health Information Technology
Technical Experts		
Laura Adams	Rhode Island Quality Institute	President and CEO
Chris Campanile, MD, PhD	Hillside Avenue Family and Community Medicine	Physician
	Quality Partners of Rhode Island	Clinical Advisor
Gary Christensen	Rhode Island Quality Institute	Chief Operating Officer and Chief Information Officer
Mary Evans	Rhode Island Health Center Association	Senior Director, Operations and Clinical Support
Charles Hewitt	Rhode Island Quality Institute	Director, Health Information Exchange Program Management
Lynn Pezzullo	Quality Partners of Rhode Island	Senior Program Administrator

Lifespan

February 18, 2011

Christopher Koller
Rhode Island Health Insurance Commissioner
1511 Pontiac Avenue, Building 69-1
Cranston, RI 02920

External Affairs

The Coro Building
167 Point Street
Providence, RI 02903

Tel 401 444-3720
Fax 401 444-2201
Email mmontella@lifespan.org

Mark Montella
Senior Vice President

Dear Commissioner Koller,

Respectfully we submit the following comments on OHIC's proposed "Guidance on Primary Spend for Health Insurers" (the Guidance).

Lifespan supports OHIC's efforts to improve the healthcare delivery system in Rhode Island and to promote primary care.

To obtain further clarification on the following would be helpful:

1. What is the definition of a primary care provider?
2. What is the definition of a primary care setting? Does it include for example a primary care clinic in a hospital?

We encourage the consideration of the following to be included in the section "Guidance for Primary Care Spending".

1. Money spent by insurers in payments to primary care physician and primary care practices.

   Examples include fee-for-service payments, pay-for-performance incentives, payments for structural changes at the practice (i.e electronic records) ...

   We encourage the Inclusion telemedicine and remote patient monitoring as examples of payments for structural changes at the practice. These products and services are critical to the success of primary care physician's management of patients with long-term chronic illnesses as well as improve patient's independence, health and well-being.

Referring to the section "Absent compelling evidence from a requesting health insurer, the following items are **not** considered primary care for the purposes of the Affordability Standards:"

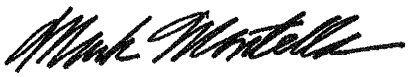
1. Money spent by insurers to non-primary care providers for services or activities outside the primary care setting...

   Does this include telephonic or electronic programs and services aimed at increasing or improving compliance with drug regiments, physician call reminder systems, off-hour nurse

triage call centers or other similar disease management or chronic care disease management tools that support PCPs given that a number of these services are not actually performed in the primary care setting and administered by non primary care providers?

Thank you for the opportunity to provide feedback on OHIC's "Guidance on Primary Spend for Health Insurers" (the Guidance).

Sincerely,



Mark Montella
Senior Vice President

Department of Health

Three Capitol Hill
Providence, RI 02908-5097

TTY: 711
www.health.ri.gov

February 18, 2011

Mr. Christopher Koller
Health Insurance Commissioner
State of Rhode Island
1511 Pontiac Avenue #69-1
Cranston, RI 02920

Dear Commissioner Koller:

Thank you for the opportunity to provide feedback on the proposed "Guidance on Primary Spend for Health Insurers." The Department of Health (HEALTH) believes that aligning targeted investments in primary care is necessary in order to optimize the impact of the Affordability Standards established by your office. Enclosed, please find specific feedback related to money spent by insurers in payments to primary care physicians and primary care practices, for services provided by a third party in the primary care setting, in support of multi-payor collaboration for primary care, and to perform quality improvement tasks.

HEALTH looks forward to continued collaboration with your office to assure the highest quality of primary care services for all Rhode Islanders and a model practice environment for primary care providers and supportive workforces.

Sincerely,

David R. Gifford, MD, MPH
Director
401-222-2232

Feedback from the RI Department of Health
OHIC Proposed Guidance for Primary Care Spending

1. Money spent by insurers in payments to primary care physicians and primary care practices *Examples include fee-for-service payments, pay-for-performance incentives, payments for structural changes at the practice (i.e. electronic records), and payments for supplemental staff or supplemental activities not traditionally considered within the scope of primary care (i.e. payments to other providers by the primary care physician).*		
Topic	**Recommendation**	**Additional Information**
Pay-for-performance	**Allow commercial insurers to allocate a portion of their primary care spend for payment incentives to providers/practices that demonstrate regular use of KIDSNET (Rhode Island's confidential, computerized, child health information system), enrollment of their patients into the HIE (i.e. current*care*), and regular use of the HIE once operational (both sending data to the HIE as well as accessing data from the HIE).**	
Adult Immunization	**Insurers should provide coverage for all ACIP-recommended adult vaccines and consider administration fees provided by Medicare Part B to be the minimal standard for vaccine administration reimbursement.**	CDC's Advisory Committee on Immunization Practices (ACIP) recommendations for adult and childhood vaccines represents the standard of care for vaccination practice in the US. The Department of Health supports the National Vaccine Advisory Committee recommendation that the insurance industry move toward first-dollar coverage for all vaccines recommended by ACIP.
Definition of "supplemental staff"	**"Supplemental staff" should explicitly include qualified Resource Specialists, Chronic Disease Educators, Community Health Workers, and Patient Navigators who deliver evidence-based interventions.**	

2. Money spent by insurers for services provided by a third party in the primary care setting to either patients or the practice itself. *Examples include practice training, nurse care managers, behavioral health and pharmacy co-location.*		
Topic	**Recommendation**	**Additional Information**
Recommendations to reduce pediatric asthma ED and hospitalization costs in RI	Align reimbursement policies with the evidence-based asthma standards of care developed by the 2007 NHLBI National Asthma Education and Prevention Program (NAEPP), *Guidelines for the Diagnosis and Management of Asthma.* Specifically, **commercial insurers should provide reimbursement for:** • **Home Management through home-based asthma education and home assessment for pediatric patients with moderate and severe persistent asthma symptoms, when prescribed by the primary health care provider.** • **Supplies for patients with moderate and severe persistent asthma symptoms, tailored to patient need, to reduce exposure to asthma triggers in the home** (e.g., mattress covers, integrated pest management, HEPA vacuums and filters).	The published literature provides strong evidence that asthma education and home-base environmental trigger interventions are cost effective aspects of clinical asthma management, especially when targeting high risk patients who tend to use health care services frequently. In December 2009, the US Centers for Disease Control and Prevention released findings of a thorough review of the literature on the *Economic Evaluation of Home-Based Environmental Interventions to Reduce Asthma Morbidity*. Findings included: • Studies with satisfactory program cost information report the range of program costs from $231 to $1,720 per participant. • Cost benefit studies show that positive returns on investment with a benefit-cost ratio of 5.3-14.0. • Cost effectiveness studies show that costs per symptom-free day (recommended economic indicator for asthma) range from $12-$57 per symptom free day, and could be lower if all direct and indirect costs (productivity) were included. • Studies summarized above provided home-based visits which included education on asthma self-management as well as environmental home-based trigger reduction services such as environmental assessments, remediations, and supplies. Studies focused on children with moderate to severe asthma. The types of home visitors included: nurse, respiratory therapist, asthma educator, sanitarian/housing officer, and/or community health worker. The initial home-based asthma education should be provided by a Certified Asthma Educator. The initial home assessment and follow-up visits to help families access and assist in coordination of environmental services to reduce asthma triggers (e.g., cockroaches, mold/moisture) in the home can be provided by a Resource Specialist trained and certified to provide such services. Three to five home visits have been found to improve outcomes.

Definition of "services provided by a third party"	**"Services provided by a third party" should explicitly include those services provided by qualified Resource Specialists, Chronic Disease Educators, Community Health Workers, and Patient Navigators who deliver evidence-based interventions.**	Examples of evidence-based interventions include, but are not limited to, Stanford Chronic Disease Self-management Training/Living Well RI, home-based services delivered by Certified Asthma Educators, and services provided by Parent Consultants under the Pediatric Practice Enhancement Project.

3. Money spent by insurers in support of multi-payor collaboration for primary care, including the All Payor Patient Centered Medical Home Project.		
Topic	**Recommendation**	**Additional Information**
PCMH Projects	**PCMH activities and investments must equally benefit pediatric providers and incentivize pediatric patient-centered medical homes.**	
Coordinated PCMH Training	**1) Specify a minimal amount of each commercial insurer's primary care spend that must be dedicated to supporting training opportunities for pediatric and adult primary care providers to engage in PCMH adoption.** **2) Align training opportunities for providers/practices engaged in PCMH adoption by requiring insurers to fund PCMH training programs (e.g. Learning Collaboratives, best practice training) that are approved by a coordinating body that minimally includes representation from CSI-RI, BCBSRI medical home initiative, RICCC/Department of Health, Memorial Hospital, health plans, and the Beacon Community Project.**	

4. Money spent by insurers to support loan forgiveness programs targeting new Rhode Island primary care physicians.		
Topic	**Recommendation**	**Additional Information**
	(No recommendations)	

Other		
Topic	**Recommendation**	**Additional Information**
Quality Improvement	**Invest in coordinated quality improvement activities including setting quality improvement goals, developing measures, and in support of public reporting of primary care measures by the Department of Health.**	

Blue Cross Blue Shield of Rhode Island

500 Exchange Street, Providence, Rhode Island 02903-2699
(401) 459-1000 www.BCBSRI.com

From: Blue Cross & Blue Shield of RI
500 Exchange Street
Providence, RI 02903-2699

To: OHIC
1511 Pontiac Ave. #691
Cranston, RI 02920
HealthInsInquiry@ohic.ri.gov

Re: BCBSRI comments: "Guidance on Primary Spend for Health Insurers "

Thank you for the opportunity to comment on the Guidance of how "primary care" should be defined for the purposes of compliance with the primary care spend component of the OHIC Affordability Standards and for assessing compliance with the standard.

BCBSRI continues to remains committed in its support of ensuring sustainability of primary care in RI. We view and believe we have demonstrated through significant financial support that the primary care physician (PCP) is the critical linchpin in the overall management and delivery of high quality affordable care for the residents of the state.

BCBSRI shares OHIC's perspective that there should be investment in improved capacity and care and support those items 1 - 4 in the Guidance Document as meeting the definition of primary care for the purposes of the Affordability Standards. In particularly we commend the recognition that the support should and must extend past monies and compensation paid directly to the PCPs. As noted in Item 2., "Money spent by insurers for services provided by a third party in the primary care setting to either patients or the practice itself. *Examples include practice training, nurse care managers, behavioral health and pharmacy colocation."* As an insurer, we find it critical in our ability to meet the required targets that we can extend the accounting of the spend beyond that directly paid to the practices. We support the inclusion of our investment for the practices in content experts and provision of resources that have expertise in effective primary care delivery models. Improvement in the primary care team's efficiency and ability to move members' through the continuum of care increases their capacity to see more members and directly improves the overall member experience.

However, we strongly disagree with the recommendation that money spent by insurers for health system capacity building, such as data reporting should not be included in the spend. We strongly believe that understanding the cost drivers, use of evidence based medicine (EBM), exchange of information and population management are essential to drive affordable high quality care. This simply can not be done without information and strong health information technology (HIT). The current CSI initiatives, RI Quality Institute (RIQI), including that fact that RI was only one of six states to be awarded a demonstration contract from the Agency for Health Care Quality and Research to fund an effort to design and develop a statewide Health Information Exchange, as well as a number of other local and national efforts centered on expanding the sharing and use of data.

Blue Cross Blue Shield of Rhode Island

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Also as noted in the Guidance document, the financial capacity that sits in the non-primary care settings and need to realign current investments to help build stronger primary care, can not be ignored in this effort. Understanding the high quality and efficient specialty care providers is critical in the affordability equation. But it has to be done in a smart and fact-based manner. This again takes significant analytical resources and infrastructure. The primary care physicians in their quest to provide the best care for their patients look to us as to who these providers are. Without significant risk adjusted information, we can't respond. It takes more than simply claims data to do this appropriately and to reward the right behaviors through the alignment of incentives with the high quality providers – not simply the biggest.

BCBSRI can't support this extremely costly but critical work of realigning health care expenditure and still meet the current pressures on premium without recognition of the costs noted as part of our affordability spend requirements. We believe that while OHIC has captured critical componets of the spend in the four items listed, by leaving out reporting, HIT and efforts to align high quality efficient providers, we will not complete the job in the most effective and sustainable manner. Thank you very much for the opportunity to respond.

Neighborhood Health Plan of Rhode Island

February 18, 2011

Office of the Health Insurance Commissioner
1511 Pontiac Ave. #69-1
Cranston, RI 02920

Dear Commissioner Koller,

Neighborhood Health Plan of Rhode Island commends the Office of the Health Insurance Commissioner for its efforts to improve the affordability and quality of the health care system. We recognize the important work being accomplished in this office through the Chronic Care Sustainability Initiative, the All-Payor Medical Home initiative, the potential for regulatory efforts to improve affordability, and the desire to see an alignment in strategies between commercial coverage regulation and public health care programs.

Central to this vision, OHIC has proposed a set of Affordability Standards that would give the Commissioner tools to reform health care spending in Rhode Island and move our system toward a greater emphasis on primary care. In particular, the Affordability Standards require commercial insurers to increase the percentage of medical spending on services defined as "primary care" by one percentage point per year between 2010 and 2014, resulting in a total spend in the commercial coverage market of 10.9 percent.

The following is Neighborhood's response to OHIC's request for comments on the proposed definition of primary care. The order of our comments matches the two page document to which we are responding. We took into consideration other materials from your office, including the May 19, 2009 Issue Brief, the October 2010 Power Point presentation to HIAC, and the proposed changes to OHIC Regulation Two.

Overall, we offer three major categories of comments. First, we believe a stronger emphasis on the experience of the patient should be included in the evaluation metrics in order to be sure that realigning medical spend actually results in positive health outcomes and improved patient interaction with the medical system. Second, we looked carefully at the metrics for evaluating success of the use of the Affordability Standards, and offer some thoughts on the selection and use of these metrics. And, third, we ask that the definition of primary care spending include room for primary care work done by providers, both at traditional and innovative locations, not commonly considered as part of the primary care universe. These three general themes are woven in throughout our comments.

Response to "Factors Considered"
OHIC is to be congratulated for defining system evaluation measures. These measures should define and drive decisions on what investments support the Affordability Standards.

- Neighborhood recommends that acceptable primary care expenditures should be tied directly to efforts to improve the four metrics enumerated in Factor 2.
- We suggest that impacting medical trend and commercial coverage premium is an overarching goal to which the other metrics are aligned.
- In the use of annual surveys to measure the success of this initiative, we suggest including a survey of patient satisfaction around their experience with the health care system, including issues of access, quality and effectiveness of care. Increasing primary care spend should have the aim of improving health outcomes for the member. As such, it is paramount to include the member's voice in any analysis of the success of this initiative. (Response to Slide 11)

- The annual survey of PCP satisfaction should be designed to emphasize physician's satisfaction with non-financial aspects of their practice, including responsiveness of carriers, flexibility in services and rewards for innovative (and demonstrably effective) new models of care. (response to Slide 11)

Response to "Guidance for Primary Care Spending"
Neighborhood recommends the following investments be considered:

Investments that recognize the patient

- Incentives to increase access to primary care services for members; examples include payment to providers for offering night and weekend hours. This would not only improve the experience of the member, but could positively impact the rate of use of emergency departments.
- Allowing for incentives for wellness programs engaged by the member
  - Asthma management, weight loss, smoking cessation etc.
- The inclusion of primary care providers in innovative, non-primary care settings; for example, a PCP at a Community Mental Health Center

Investments that augment and support primary care

- Home care services, services at adult day care, and other congregant centers should be included
- Mental health services in the definition of primary care
  - Mental health services can have a profound impact on the prevention of more significant health issues. Also, some patients rely on their PCP for mental health services
- Efforts to expand patient access to primary care should be included in the list of acceptable investments. If this is added to the other named investments, the Standards would be supported by the cornerstone of Medical Homes: panel management supported by thorough/impactful information, by barrier-less patient access, and by team-based care.

Investments that support primary care in innovative settings

- Allowing flexibility in the standards for carriers with different population mixes
  - For example, carriers providing coverage to members in nursing homes may have a unique set of services and providers that should be included as primary care

Moving away from a "volume based" reimbursement system

- Development and piloting of alternate financing/reimbursement mechanisms should be included in acceptable work

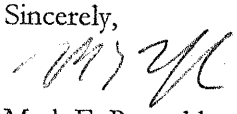
Patient Centered Medical Homes

- Work supporting the construction of PCMH should not be limited to *all*-payor collaborations. Plan-specific work should be accepted, providing it aligns with the Standards and the CSI/Beacon collaboration
- Efforts to expand patient access to primary care should be included in the list of acceptable investments. If this is added to the other named investments, the Standards would be supported by the cornerstone of Medical Homes: panel management supported by thorough/impactful information, by barrier-less patient access, and by team-based care.
- Plan-specific work directly tied to moving the system evaluation measures should be included. One example is Plan investment in Transitions of Care programs that are reducing readmissions.

Neighborhood recognizes that the desire to deliver meaningful results requires a long-term vision. We encourage OHIC to consider both the immediate measurable effects, and the changes that may take place over a longer time frame. Metrics and goals related to a multi-year vision should be included.

Neighborhood appreciates the opportunity to comment on the Affordability Standards. If you have any questions relating to this issue, or any others, please don't hesitate to contact us.

Sincerely,



Mark E. Reynolds
President and Chief Executive Officer