




OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

MEMORANDUM

TO: STEPHEN FARRELL, UNITED HEALTHCARE OF NEW ENGLAND
JAMES PURCELL, BLUE CROSS & BLUE SHIELD OF RHODE ISLAND
MARK REYNOLDS, NEIGHBORHOOD HEALTHPLAN OF RHODE ISLAND

FROM: CHRISTOPHER KOLLER 

DATE: MAY 21, 2008

Background

The Office of the Health Insurance Commissioner has, as one of its statutory purposes, the charge of “encouraging policies and developments that improve the quality and efficiency of health care service delivery and outcomes” (RIGL 42-14,5-2). One area that has been the topic of increasing attention locally and nationally is the ability of a well designed primary care infrastructure and “medical home” to reduce costs and improve quality for populations, and the recognition that the existing models for physician compensation by health plans do not provide sufficient incentives for the development of patient centered medical home model.¹ Because of the fractionated nature of payment sources for a typical primary care physician, it is highly unlikely that a change in any one payer’s payment policy, however much it may be in the public interest, would be sufficient to change the actions of a primary care physician. However, if a sufficient proportion of a physician’s practice were to be paid in a way that supported a different practice structure and behavior, such change would more readily occur. Since restructured primary care may well be desirable public policy, this creates an opportunity and need for collective, narrowly focused, state-sponsored action by private parties in the public interest.

¹ See, e.g. Joint Principles of the Patient Centered Medical Home supported by American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), and American Osteopathic Association (AOA)

MEMORANDUM

Development of Pilot Project

For over a year, with technical assistance, the Office of the Health Insurance Commissioner has been convening representatives from primary care practices and health plans to discuss the concept of a “patient centered medical home”, its ability to improve the care for chronically ill populations, its structural components in a practice, and the estimated costs and benefits of implementing these components in a given practice. The explicit goal of the “Chronic Care Sustainability Initiative” has been a pilot all payer project, encompassing a common set of structural standards and interventions for developing a patient centered medical home in these practices, a consistent payment methodology across payers for implementing these standards and interventions, and a consistent set of monitoring tools measuring their effect. OHIC has been actively overseeing these discussions, including but not limited to identifying and reviewing contractual terms, overseeing pricing discussions and resolving differences of opinion between parties.

Implementation of the Initiative

A start of the pilot of Pilot Project is anticipated presently. This will be commemorated with individual provider contracts between participating providers and health plans, based on a common template developed with state participation and oversight. After this the parties will continue to meet to implement all phases of the project. OHIC will continue to oversee and actively oversee the collective activities of the parties in the project, and resolve any differences of contractual interpretation. At the end of the project – currently anticipated to be two years from commencement - payers and participating physicians will make individual decisions about whether and under what terms

cc: Deidre Gifford