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Rhode Island's Novel Experiment To Rebuild Primary Care From The Insurance Side

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ABSTRACT Primary care is viewed both as the solution to better health care in the United States and as a threatened institution, beset by poor payment and difficult working conditions. Rhode Island has taken a direct approach to making primary care more effective for patients and more attractive for physicians. In 2009 the state's Office of the Health Insurance Commissioner developed "system affordability priorities" for Rhode Island's commercial insurers, including a directive to almost double the portion of their medical expenses devoted to primary care. Initial plans of those insurers to meet those expectations are now being implemented; this paper describes those plans.

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Rhode Island's original Charter in 1663 granted its residents permission for a "lively experiment," allowing greater religious freedom in a civil society.¹ The phrase, chiseled on the face of the Rhode Island State House, is invoked regularly to embolden lawmakers and citizens to take civic action. It is an apt description for current attempts by state officials to promote delivery system reform by strengthening the state's primary care.

In 2009 the Office of the Health Insurance Commissioner, a small state agency with broad regulatory authority over commercial health insurers, embarked on a process to strengthen and expand primary care in the state. The consensus in Rhode Island, as in much of the country, was that primary care was slowly being starved because of payment policies. There was also agreement that a health care system is only as good as its primary care base. Thus, the obvious answer was that more money needed to be pumped into primary care.

The commissioner's bold step was to do just that. Working with both insurers and providers, the commissioner's office has hammered out a workable format that will rapidly increase funding for primary care doctors to manage

patients' health. Many questions remain about how to do this, such as specifically how and where the funds should be targeted. The experience in Rhode Island, even in the early part of this "lively experiment," deserve national policy attention.

Policy Background

In 2004 the Rhode Island legislature separated health insurance regulation from the Department of Business Regulation and created the cabinet-level Office of the Health Insurance Commissioner. In doing so, it added two new standards to the traditional roles of a health insurance regulator in ensuring health plan solvency and protecting consumers. Specifically, the office was required to hold health insurers accountable for fair treatment of providers, and to direct insurers to promote improved accessibility, quality, and affordability.²

STATUTORY GUIDANCE The explicit statutory direction for "affordability" distinguished Rhode Island from other states. It also gave the Office of the Health Insurance Commissioner the ability to exert influence beyond the normal confines of state insurance regulation. The legislation, however, provided little guidance for interpret-

ing or assessing these new criteria. The office's new authority is also limited to fully insured commercial coverage and therefore excludes Medicare and Medicaid recipients and large self-insured employers, which, under the Employee Retirement Income Security Act (ERISA), are exempt from state regulatory oversight.³

SEEKING AFFORDABILITY After its establishment, the Office of the Health Insurance Commissioner determined that it could most effectively implement the directive to promote improved affordability through a more systematic review of rates charged by insurers. Historically, commercial health insurers in Rhode Island were required to file with regulators the methodologies, or "rate manuals," that they use for calculating rates. They also were required to refile the estimated inflation rates, administrative costs, and profit margins—collectively known as "rate factors"—used in those methodologies whenever those factors changed.

In 2007 the insurance commissioner's office substantially revised this process to make the filing of rate factors annual, consistent across lines of business and insurers, and transparent. More information was collected and made public, and more public input was solicited. In 2008 the office required these rate-factor filings to be accompanied by a description of activities that insurers had undertaken to address the affordability of coverage. These descriptions were also made public to promote awareness and discussion of what the insurers believed were the drivers of health insurance premiums, and what they were doing to address them.

OUTCOMES Unfortunately, these efforts produced only limited results. Publication of projected price and utilization trends by type of provider rendering the service did generate greater public awareness. However, publication of efforts to address affordability resulted in poorly defined, nonspecific lists of ongoing management activities by insurers in areas such as disease management, high-cost case and formulary management, wellness programs, and benefit design. These failed either to engage the provider or purchaser community or to focus on the changes needed to improve system affordability.

REVISITING AFFORDABILITY In response, in the fall of 2008 the insurance commissioner began developing formal affordability standards for commercial health insurers. The goal was to identify a small number of general affordability priorities and to set expectations for health plans, using as the point of leverage the annual rate-factor approval process described above.

Working with state staff, consultants, and its Health Insurance Advisory Council, the office pursued an open process to identify ways in

which commercial health insurers could facilitate system improvement. The insurance commissioner's rationale for this process was as follows: (1) Health plan activities can affect medical cost trends. (2) Reasonable alignment of policies and actions by insurers is possible, and is beneficial to achieving systemic goals. Without alignment, health plans' affordability efforts will be limited by the ability and willingness of each health plan to influence change. (3) Communities can identify system priorities. (4) Public discussion of trade-offs and priorities is better than private discussion.

ADVISORY COUNCIL The Health Insurance Advisory Council was established by statute as a group of representatives from small and large employers, providers, and consumers who were to give advice to the commissioner on issues facing the office. The council's work on this issue began with identifying a range of policy options to improve system affordability, placing emphasis on those that were unlikely to be advanced without some degree of state action.

The council also wanted to endorse interventions that had been shown in the research literature to have a demonstrable, favorable effect on medical cost trends.⁴ Most important, any new activities had to be considered to be reasonably within the scope of a health plan's control.

Ultimately, the council grouped these affordability options into three categories: (1) strategies focused on providers: realigning provider payment incentives and practice, beginning with primary care; (2) strategies focused on consumers: changing consumers' behavior and reducing the use of unnecessary services through information dissemination and benefit design; and (3) strategies focused on health system infrastructure: upgrading and simplifying administrative and clinical information processing and analysis functions.

The council eventually recommended that health plans in Rhode Island focus their affordability efforts on provider payment reform, starting with primary care and without adding to the overall costs of care. They recommended the adoption of four priorities for insurers: expanding and improving the primary care infrastructure in the state; promoting the adoption of medical homes based on the Chronic Care Model;⁵ promoting the adoption of electronic health records by physicians; and implementing more comprehensive payment reform.

Rationale For Rhode Island's Approach

The Office of the Health Insurance Commissioner and the council decided to focus health

plan affordability efforts on the delivery system and payment reform for several reasons.

HOLDING INSURERS ACCOUNTABLE First, the commissioner's office thought that health insurers should not be held accountable for items beyond their direct control. For example, payers could not be held solely responsible for reducing regional variations in practice, or increased adoption of certain prevention-focused strategies.

ALTERING PAYMENT SYSTEMS Second, it is relatively simple to alter primary care payment systems. Fee-for-service payment is widely understood to be a major contributor to health care inflation because of its incentive for increased volume of services.⁶ Health plans cannot move from it unilaterally for institutional providers, such as hospital-based specialists, but they can do so readily for the primary care sector.

PHYSICIAN SUPPLY Third, there is compelling evidence that population-based quality and cost measures, both nationally and internationally, are positively correlated with the supply of primary care physicians.^{7,8} Although health plans cannot directly influence primary care supply, they can spend more money on primary care, creating a stronger primary care system that results in either more primary care physicians or more highly compensated ones (which presumably would also influence supply.)⁹

In 2008 Rhode Island insurers spent 5.9 percent of their medical services expenditure on primary care, which compared poorly to benchmark data from other high-performing health

systems identified by the Commonwealth Fund's Commission on a High Performance Health System. For example, Geisinger Health System's health plan in Pennsylvania reported using nearly 9 percent of its total spending on primary care (Exhibit 1).

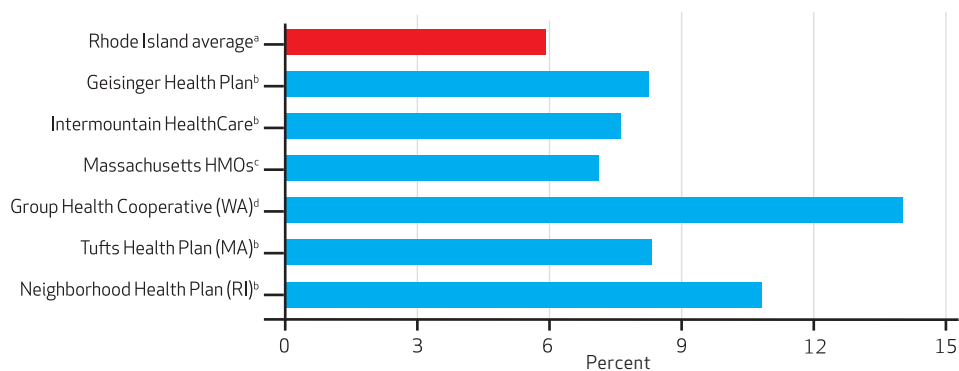
HISTORY OF COLLABORATION In addition to these compelling reasons for reform, another factor facilitated the program: a history of collaboration between insurers and state officials. The Office of the Health Insurance Commissioner and the three commercial insurers in Rhode Island had recently collaborated to implement a multipayer Chronic Care Model medical home initiative, which provided a base for expanding primary care payment reform and coupled reform with practice transformation.¹⁰

Moreover, with guidance from the state-designated Regional Health Information Organization, the Rhode Island Quality Institute, and the Department of Health, Blue Cross Blue Shield of Rhode Island was offering a number of incentives to practices to use electronic health records. UnitedHealthcare was preparing to introduce a similar incentive. The subsequent introduction of federal funds through the Health Information Technology for Economic and Clinical Health (HITECH) provisions of the American Recovery and Reinvestment Act (ARRA) of 2009 strengthened these incentives.

Finally, all players recognized that there was not yet the necessary level of consensus and political support to undertake a payment reform

EXHIBIT 1

Primary Care Spending As A Percentage Of Total Medical Spending, Rhode Island Average (Baseline) And Benchmarks From Six Large Insurers



SOURCES Office of the Health Insurance Commissioner, Rhode Island; and various other sources (see below). **NOTES** The Rhode Island average is the mathematical average of the two largest commercial insurers in the state, Blue Cross Blue Shield of Rhode Island and UnitedHealthcare of New England. The Rhode Island target is 10.9 percent, which is the current rate plus five percentage points, as set in affordability standards. ^aPlan-specific spending rates are greatly influenced by membership mix. ^bSource: Self-reported by insurers. ^cSource: Oliver Wyman Study, 2008 Sep, based on commercial, fully insured health maintenance organizations (HMOs) only. Primary care includes obstetrics/gynecology; excludes pay-for-performance. ^dSource: Wagner EH, director of the MacColl Institute for Healthcare Innovation, Center for Health Studies, Group Health Cooperative. Group Health Cooperative is a group-model HMO with owned facilities, like Kaiser Permanente.

initiative on a larger scale. Insurers, physicians, and regulators agreed that primary care reform would be difficult enough, especially as the threat or promise—depending on one's point of view—of federal health reform loomed.¹¹

Developing Regulatory Standards

Once these priorities were agreed upon, specific standards were needed to set expectations and allow for assessment. To this end, the Office of the Health Insurance Commissioner staff gathered data and input from Rhode Island insurers, advice from an expert panel assembled by the Commonwealth Fund, and data and experience from outside Rhode Island.

PROCESS The council reviewed multiple rounds of standards during the development process and solicited public testimony on them. The insurers were generally supportive of the areas selected for focus in the affordability standards, and they provided data, feedback, and recommendations during the development process. The iterative nature of the standards development, the participation of insurers, and the knowledge that standards would be consistently applied all added to their acceptability. Four key standards emerged.

► **STANDARD ONE:** First, each insurer's proportion of medical expense to be allocated to primary care for the twelve months starting 1 January 2010 was to be one percentage point higher than actual spending for the twelve months starting 1 January 2008. This proportion was then to increase by one percentage point per year for five years. At the end of 2014, on average, 11 percent of commercial insurers' medical expenses were to be devoted to primary care.

Each insurer was required to submit a plan to the Office of the Health Insurance Commissioner each year that demonstrates how the increase will be achieved. An insurer must show that the increase will be accomplished without contributing to growth in premiums. There was to be an emphasis on innovative contracting and payment, as well as primary care system investment, not merely fee-schedule manipulation—that is, simply changing rates of reimbursement for specific diagnosis and management codes. Insurers' plans are to be subject to public review and discussion.

► **STANDARD TWO:** Second, insurers were required to support an expansion of the medical home initiative mentioned above that was based on the Chronic Care Model. The formal name for this is the Rhode Island Chronic Care Sustainability Initiative. Support was to start in July 2009 and continue through June 2010, with an increase of at least fifteen full-time-equivalent

primary care physicians to be hired by practices participating in the initiative by the end of the period.

This program, also initiated by the Office of the Health Insurance Commissioner, is a voluntary, multipayer initiative started in the fall of 2008. In the program, all health plans pay a selected group of primary care sites the same amount per member per month and a supplemental amount for nurse care managers. In return, participating physicians agree to achieve certain levels of accreditation in the National Committee for Quality Assurance's (NCQA's) patient-centered medical home standards, to learn collaboratively how to implement changes in their practice structures and processes for the care of chronically ill patients, and to measure their performance. These agreements are commemorated in a common contract between each plan and each site. It involves all commercial and Medicaid carriers but not traditional fee-for-service Medicare.¹² The initiative is still relatively small, as it is designed as a pilot project through which state leaders can learn what works in developing medical homes. However, the new standard requires the insurers to commit to doubling the size of the project and extending its duration.

► **STANDARD THREE:** The third standard required that by 1 January 2010, insurers demonstrate the implementation of an incentive program for physicians to adopt electronic health records that meet certain standards. Those standards include initial payments per physician of \$500–\$2,500 per insurer, depending on insurers' market share; and ongoing financial support to a practice for the cost of electronic health record implementation, with support equivalent to at least 3 percent of the insurer's standard payments to the practice.

► **STANDARD FOUR:** The fourth standard simply required insurers' participation in the ongoing discussion about comprehensive delivery system payment reform in Rhode Island. This included active engagement as a member of the stakeholder body to be convened by the Office of the Health Insurance Commissioner in coordination with other state entities. The standard also required insurers to provide certain noncompetitive information to the body, such as the structure of basic payment arrangements and areas of contractual performance incentives, to assist it in its deliberations.

BEYOND PAYMENT INCREASES One further issue is worth noting. It was the general opinion of the council that increases in primary care payments were necessary, but that simply increasing fee-for-service payments would not be sufficient to meet the standard. The council made no specific recommendations about alternative pay-

ment programs; rather, it referred to models in the literature and in practice in other communities, including pay-for-performance incentives, case management fees, and carefully conceived risk-sharing mechanisms.

The standards lent themselves to explicit measures, and the council recommended a set of evaluation metrics, with plans to assess performance each year and to report results publicly. These include total and ambulatory care-sensitive emergency room admissions and inpatient readmissions; changes in primary care and specialty physician supply; insurance premium trends; and primary care physician satisfaction.

Implementation Now Under Way

The exciting aspect of Rhode Island's latest "lively experiment" is that it is not a series of mandates to do pilot studies, or promises of funding years hence. It is under way in 2010, with insurers and primary care physicians working hard to develop new practice models. This vigor, and, we hope, rigor, is based on the fact that the Office of the Health Insurance Commissioner has ensured that rate increases will be predicated on compliance with the program.

The increase in primary care spending is critical. The amount spent on primary care for the fully insured commercial population for 2009 was estimated to be approximately \$52 million. Therefore, to get from 5.9 percent to 6.9 percent of overall expenditures on health care, the additional primary care spending was estimated to be \$11 million in 2010, factoring in overall health care inflation. Similar increases would be \$24 million in 2011 and \$39 million in 2012, in terms of additional primary care expenditures on the 2009 base.

PROVIDERS' REACTIONS As might be expected, the primary care community is enthusiastic. Al Kurose, who leads the largest primary care practice in the state, Coastal Medical, notes that primary care practices are energized by these changes in payment, which they believe truly enhance their ability to manage care.¹³

These sentiments are corroborated by Yul Ejnes, who works with Kurose and is a member of the Board of Regents for the American College of Physicians.¹⁴ Ejnes says that although not all primary care physicians are completely informed about the Office of the Health Insurance Commissioner-inspired changes in primary care reimbursement, those who are aware are excited. He also points out that the reforms are occurring at the same time that insurers have begun to review differences between Rhode Island's primary care payments and payments in other

states—with an eye to reducing disparities in rates of payment.

INSURERS' REACTIONS Of course, a good deal of the change in practice will be dictated not by physicians' innovation, but by what insurers will support with the new funds. As noted above, the initiative relies heavily on transparency. As part of this, the major insurers must detail how they plan to spend additional funds. The development of these plans presents challenges for the Office of the Health Insurance Commissioner and other stakeholders. For example, how much diversity should there be among the insurers' plans? What latitude should insurers be given to develop new ideas?

Blue Cross Blue Shield of Rhode Island and UnitedHealthcare are the dominant commercial insurers for the fully insured in Rhode Island. As Appendix Exhibits 1 and 2 reveal,¹⁵ they are pursuing slightly different approaches.

► **BLUE CROSS BLUE SHIELD OF RHODE ISLAND:** Blue Cross Blue Shield of Rhode Island is putting 50 percent of the total funds it is now required to add to primary reimbursement into support for the primary care medical home. This includes both the all-payer initiative and a larger independent strategic effort by the insurer. Blue Cross Blue Shield of Rhode Island has a specific view of the medical home as focused on members with complex medical needs and substantial annual medical costs. Payment in Blue Cross Blue Shield's own medical home project will go to support case managers in physicians' offices, with an additional per member per month payment to the physician or practice. The insurer will also fund a pay-for-performance program as part of the patient-centered medical home initiative.

A significant part of Blue Cross Blue Shield of Rhode Island's support also goes to the adoption and enhancement of electronic health records. Although this represents only 10 percent of the total funding that Blue Cross is putting into increased primary care reimbursement, it is money that primary care physicians will likely be able to use in a more flexible way than similar dollars coming through the federal government as part of the new subsidies for electronic health records.¹⁶ In addition, another 5 percent of the funds would go to specialists to help them purchase electronic health records and therefore better coordinate with primary care physicians.

Blue Cross Blue Shield is also attempting to promote integration across the health care system. There will be funds available to develop accountable care organizations, so that small practices will be encouraged to merge with larger ones. Hospitals will be encouraged to undertake care coordination with physicians'

offices. A pay-for-performance program will support rational and cost-effective pharmacy use, as well as quality improvement activities. And finally, behavioral health gets a boost through funding of behavioral health specialists, who will be located at primary care offices.

Less of Blue Cross Blue Shield's funding will be used for direct increases in primary care reimbursement. Gus Manocchia, the chief medical officer for Blue Cross Blue Shield, notes that the insurer has been working independent of the commissioner's office initiative to improve primary care in Rhode Island—for example, by raising payment to achieve compensation parity with primary care providers in Massachusetts.¹⁷ All the same, Manocchia says, payment directives will in a few years lead to substantial increases in physician payments—and Blue Cross officials believe that much of this investment should go to practice improvements.

One point of debate is likely to persist going forward. Many primary care providers and health policy analysts continue to suggest that the only way to resolve the crisis in primary care is to substantially increase the pay for internists, family practitioners, and pediatricians. But at this point, the Office of the Health Insurance Commissioner and insurers have not promoted this approach. Rather, the advisory council made payment reform—not fee enhancement—the core of its affordability priorities. Substantial additional monies will flow to primary care as a result of this initiative—and presumably into physicians' pockets—but the Office of the Health Insurance Commissioner and its council are clear that funds must be used for improved capacity to provide primary care to patients, not simply higher payment for continuing to deliver the status quo.

► **UNITEDHEALTHCARE:** UnitedHealthcare's investment plan also supports the medical home. The company estimates that 25 percent of the increase it will fund will go directly to expand the chronic care sustainability initiative. Another 13 percent will pay for electronic health records. In the same category of structure and process incentives, an advisory group of physicians and employers will help UnitedHealthcare define other areas of support, such as forgiveness of loans to primary care practices that have open practices for primary care patients. Neal Galinko, the UnitedHealthcare medical director in Rhode Island, states that all of this spending is in line with United's national effort to support primary care.¹⁸

More UnitedHealthcare money goes directly to primary care providers than in the Blue Cross Blue Shield plan. A quarter of the dollars will be in a pay-for-performance program based on

quality and efficiency measures, with money for both top performers and biggest improvements. Another 5 percent will support incentives for after-hours care. Yet another quarter will be devoted to fee schedule improvements where United's fees trail the market. Galinko is interested in understanding how these reforms will be associated with performance improvement as data are collected over the next two years.

Discussion

The Rhode Island initiative is striking: compared to other programs around the country, it is causing a real shift of expenditures from other parts of the health care system to primary care. Other states are engaged in various medical home trials in which insurers—separately or convened by state governments—are investing limited funds in practice changes. Many health insurance executives are not certain that these programs will actually improve care or lower costs. In most cases, though, insurers make the key funding decisions.

THE RHODE ISLAND DIFFERENCE Rhode Island has clearly taken a different course. Satisfied that the health services research literature demonstrates that stronger primary care leads to better overall health care, and cognizant of the fact that recruiting physicians to Rhode Island primary care is increasingly difficult because of poor overall payment, the state has used existing regulatory authority and created new policy—concentrating on the proportion of health care dollars supporting primary care practice.

The approach is admirably simple: Estimate current expenditures, then force the limited number of commercial companies in the fully insured marketplace, over which the state's insurance commissioner has direct control, to boost payments and identify what is being supported. It is, in effect, attempting to redress the Medicare's resource-based relative value scale (RBRVS) valuation process, which had the unintended effect of devaluing primary care. It also bypasses the usual approach of contractual negotiations between private health plans and providers, which reward provider size and market share, as opposed to high-quality care—especially high-quality primary care.

WEAKNESSES Inevitably, this approach has weaknesses. There is no formal study of the merits of the program; this would likely have required a complicated randomization process in a pilot format. Medicare and Medicaid, the large governmental payers, are not participating for their fee-for-service providers; nor are self-insured employers directly, because their regulation by the state is preempted by the federal

ERISA law. So Rhode Island's program is in effect applying to only part of the payment that most physicians receive.

The program is also only a partial solution within the context of the overall health care system, in that there is no real involvement of hospitals. Although much medical care in Rhode Island is provided by hospitals and hospital-affiliated groups, there is not much integration of primary care physicians into these systems. So primary care physicians, and insurers, are largely making their decisions independent of any integration between hospitals and physicians. Such integration is central to the concept of accountable care organizations, which many see as the centerpiece of real health reform. Rhode Island therefore does not exemplify how primary care expansion would contribute to the accountable care organization concept.

Nor is there any aspect of the program that supports primary care training. Although some of this increased primary care spending could go to expanding the pipeline of primary care physicians, it does not support new residency slots. Finally, the dollars for the boost to primary care must come from somewhere else—in all likelihood, from payments to specialists and to hospitals. But thus far, those groups have raised few if any objections.

BETTING ON THE MEDICAL HOME Essentially, the Rhode Island initiative is a bet on the medical home, and on different and higher primary care payments, to improve the effectiveness of medical care in the state. From what we know, it is a reasonable bet. But the state and insurers are committed to gathering data that will determine if there are real improvements.

The success of the program thus far may lie in

its strong advisory structures, and its location in a small state where the major decision makers among physicians, hospitals, and insurers can, and do, meet frequently. It is also a transparent program, which allows ongoing debate and, if necessary, midcourse adjustments. These appear to be key to gaining consensus in Rhode Island.

POLICY DIRECTIONS With the new money comes responsibility for the state, insurers, and primary care providers. A public priority-setting process must be developed to help guide, react to, and coordinate insurers' proposals for how the money is best spent. Although initial resistance was not great because of the public process and the engagement of stakeholders, the continued success of the project is dependent upon the availability of resources for implementation and evaluation, and of political support. Perhaps most important, a change in the commissioner or a larger executive branch administration change could threaten future prospects.

Primary care leadership and infrastructure must be developed to take advantage of new funds. These capacities must continue to grow as the required spending amounts increase. Incentives and market forces must be aligned so that a stronger primary care infrastructure actually meets the needs of patients and consumers. And other providers in the system have to figure out how to adapt to an environment where more care is overseen by a strengthened primary care infrastructure.

These challenges all follow from a fundamental prioritization of resources for primary care. For this alone, Rhode Island's "lively experiment" is unique, and worthy of ongoing attention from policy makers. ■

NOTES

- 1 A copy of the Charter granted to Roger Williams by King Charles I is on public display at the Rhode Island State House.
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- 15 The online Appendix can be accessed by clicking on the Appendix link in the box to the right of the article online.
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