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HealthRight

The creative table for health care policy solutions in Rhode Island.

U.S. and Rhode Island Health Care System

A Brief Overview

<http://www.rihealthright.org>

U.S. and Rhode Island Health Care System A Brief Overview

Introduction

This issue brief seeks to provide an overview of the current health care system in Rhode Island within the overall context of the U.S. health care system, look at some strategies to transform the health care system in Rhode Island, raise questions for further discussion, and pose policy recommendations and strategies.

HealthRight was established in 2007 with the following foundational principles:

1. **Healthy Lives:** The purpose of health care is to help all people to achieve healthier lives.
2. **Quality of Care:** All Rhode Islanders should receive health care that is high quality, timely, accessible and affordable.
3. **Consumer Choice and Protection:** The health care system should be designed to maximize consumer choice, protection and control.
4. **Aggregated Payment and Pooled Risk:** All public and private health care dollars should be consolidated into an aggregated public or not-for-profit purchaser of health coverage and/or health care services that pools risk across the state.
5. **Cost Containment:** Costs should be controlled by implementing a coordinated health planning process and restructuring delivery of health care to achieve more equitable and efficient allocation of health care resources in the public interest.
6. **Diversity of Stakeholders:** Involving multiple and diverse stakeholders is the best way to design a health care system that delivers high quality, accessible and affordable care for everyone.

Following eight years of health care conversations, HealthRight is issuing three papers. This paper provides an overall view of the health care system; one addresses cost containment strategies for the health care system; the third discusses access to health care. Together, these three papers raise critical questions and suggest possible paths or solutions to issues facing the health care system in Rhode Island. The following are over-arching themes of the recommendations throughout:

- It is critical that health care financing move away from fee-for-service payment models towards global budgets;
- Vigorous and meaningful health care planning must be at the foundation of the health care system;
- Strong, coordinated regulatory oversight of insurers and health care providers is necessary;
- Consolidated purchasing power, and increased negotiating strength, will be helpful to the three goals above.

U.S. and Rhode Island Health Care System A Brief Overview

Why is it important to look at the health care system?

In the United States, we spend 17% of our gross domestic product (GDP) on health care; the only country that spends more as a percentage of GDP is Tuvalu, at 19.7%.¹ For this high price, one might think the health care outcomes in the U.S. were stellar. However, the U.S. is average or below average in terms of many measures of health.² We can do better.

Health care costs, particularly Medicaid, represent nearly 1/3 of the state general revenue budget, or over \$913 million in SFY 2015.³ In addition, in 2013, the state paid about \$162 million for health care for its employees.⁴ With about 240,000 Rhode Islanders enrolled in Medicaid and 14,000 state employees, the state is among the largest purchasers of health care in the state. Money saved by strategically paying for high quality health care at the right price can be invested in other parts of the state economy, such as schools, roads, or other state infrastructure. Savings or cuts to the health care system must be made with the knowledge and deliberation that the health care and social services is the largest category of private employers in the state, with over 80,000 employees and is a major driver in the state economy.⁵

[see Cost Containment paper at pp. 4-7 for more discussion of health care costs]

COUNTRY RANKINGS	EXHIBIT WS-1. OVERALL RANKING												
	Top 2*			Middle								Bottom 2*	
	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US		
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11		
Quality Care	2	9	8	7	5	4	11	10	3	1	5		
Effective Care	4	7	9	6	5	2	11	10	8	1	3		
Safe Care	3	10	2	6	7	9	11	5	4	1	7		
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6		
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4		
Access	8	9	11	2	4	7	6	4	2	1	9		
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11		
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5		
Efficiency	4	10	8	9	7	3	4	2	6	1	11		
Equity	5	9	7	4	8	10	6	1	2	2	11		
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11		
Health Expenditures/Capita, 2011**	\$3,800	\$4,522	\$4,118	\$4,495	\$5,099	\$3,182	\$5,669	\$3,925	\$5,643	\$3,405	\$8,508		

Notes: * Includes ties. ** Expenditures shown in \$US PPP (purchasing power parity); Australian \$ data are from 2010.
Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund *National Score card 2011*; World Health Organization; and Organization for Economic Cooperation and Development, *OECD Health Data, 2013* (Paris: OECD, Nov. 2013).

K. Davis, K. Stremikis, C. Schoen, and D. Squires, *Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally*, The Commonwealth Fund, June 2014.

U.S. and Rhode Island Health Care System A Brief Overview

History of Health Reform

Some key dates:

- 1939 Employer-based health insurance becomes tax-exempt
- 1969 Medicare and Medicaid established
- 1974 Health Planning Resources Development Act provide funding for health care planning, and many states establish certificates of needs processes.
- 2010 The Affordable Care Act passed Congress
- 2014 HealthSource RI begins selling health insurance; Rhode Island expands Medicaid to include low-income adults without dependent children.
- 2015 Access to insurance has increased in Rhode Island significantly; only 2.7%-5% of Rhode Islanders lack health insurance.

Where is health care in Rhode Island?

The health care system in Rhode Island, as elsewhere in the United States, is a hodgepodge of often uncoordinated access points for consumers/patients who may reasonably be confused about the best, most efficient ways to meet their health care needs. Some places Rhode Islanders get health care include:

- Hospitals, including inpatient, emergency departments, hospital-affiliated primary care and hospital-affiliated specialty care;
- Federally Qualified Health Centers (FQHCs), also known as community health centers
- Private practice – primary care
- Private practice – specialty care
- Ambulatory surgical centers
- Stand alone radiology centers
- Stand alone urgent care centers
- Retail Minute Clinics

Recommended strategy: Streamline access to health care, through primary care practices wherever possible. Create a patient-centered, responsive and coordinated health care system.

Multiple efforts in Rhode Island are moving in this direction. About 30% of Rhode Islanders get their primary medical

care at a practice that is part of the Care Transformation Collaborative (CTC); the State Innovation Model (SIM) seeks to push 80% of care into a value-based care model; the Office of the Health Insurance Commissioner (OHIC) affordability standards will require 80% of primary care in Rhode Island to be provided at a patient-centered medical home. The state is moving in the right direction. These efforts themselves must be aligned and coordinated in order to coordinate the fractured health care system. The patient/consumer voice must be a part of the system redesign efforts.

Behavioral Health Care Access and Integration

Behavioral health care is an important, and possibly underdeveloped, piece of the Rhode Island Health care system. Because of the intricacies and history of health care funding, and the stigmatization of mental health and substance abuse diagnoses, the behavioral health care system has been developed as a separate part of health care in Rhode Island. In addition, a recent report describes behavioral health care needs, and unmet behavioral health care needs, as higher in Rhode Island than in other comparison states.⁶ [See Access To Care paper at pp 6-7 for further discussion.]

There is a move nationally and locally to integrate behavioral health care into primary care, and thus create additional access to behavioral health care for more Rhode Islanders,

U.S. and Rhode Island Health Care System A Brief Overview

particularly those who have episodic or lower level needs for these health care services.

Recommended strategy: All health reform efforts in Rhode Island should consider the best way to develop additional modes of integration and access to behavioral health care services.

Health Care Workforce

Conversations about the health care system must also take a look at the health care workforce. Residency programs are largely financed by Medicare. For years, emphasis in medical training was placed on training more specialists, and on providing hospital-based care. Now that health care needs are moving from hospital-based care to care provided in the community, medical schools and residency programs are changing too. Programs are beginning to train more primary care providers. Training is now occurring outside hospital settings, as well. Programs such as the Teaching Health Center Program provide funding for residency programs based in community health centers. More programs are starting to train more physicians' assistants and nurse practitioners to be a part of primary care medical home teams.

In Rhode Island, it appears that reimbursement and compensation for healthcare providers may be lower than in neighboring states. Recent data released by Wakely show that while the overall cost of care in Rhode Island and Massachusetts is nearly the same, Massachusetts spends more on provider compensation, and Rhode Island spends more on pharmacy and hospital stays.⁷ In addition, a recent survey indicates that Rhode Island is ranked at the bottom of the country in a number of measures, including 44th for average physician salary.⁸ As long as actual or perceived reimbursement for health care providers remains lower than in neighboring states, recruiting and retaining providers in a highly competitive market remains a challenge.

Recommended strategy: As we move to a more global payment system, and pay for quality, not quantity of care, Rhode Island should emphasize paying for effective health care. Payers and policy makers should ensure that health care employers have adequate resources and tools to recruit and retain the health care workforce of the future health care system. The health care planning process should help address some of our needs as a state, and can be used as a guideline for training programs. These efforts should be centralized and streamlined.

Current Rhode Island Health Reform Efforts

As a part of our review of the Rhode Island health care system, we attempt below to catalogue the numerous Rhode Island health policy and health care reform efforts.

Recommended strategy: More effort should be made to align the various initiatives, including funding, goals, evaluation, quality measures and advisory groups. Funding sources currently determine what the Rhode Island health care system looks like or how it will innovate or reform. The state should look for opportunities to step back, create a plan, and then seek funding to implement the plan. In a small state like Rhode Island, system alignment should not only be a priority, but it should be possible. Many of the participants in these initiatives overlap significantly, yet some are taking place without sufficient attention or acknowledgement that similar, often parallel efforts are underway. Perhaps the disjointed nature of the health care system is well-illustrated here.

Recommended strategy: Merge all state agency functions that currently regulate insurance or fund or provide health services into one Health Care Authority.

U.S. and Rhode Island Health Care System A Brief Overview

The A-Z list of Rhode Island State Health Workgroups and Reform Efforts

All Payer Claims Database (APCD)

The Rhode Island All Payer Claims Database contains insurance claims information for commercial insurance, Medicare and Medicaid. It is expected that information will be available from the APCD by the end of the year.⁹ This data will allow policy makers and researchers to look at healthcare spending and analyze how the system is working and how it can work better; comparisons to other states will also be possible as multiple states have similar APCD efforts underway.

Care Transformation Collaborative (CTC)

The Care Transformation Collaborative began as a pilot program of 5 practices in 2008 to provide care to patients with chronic illness in a "Patient Centered Medical Home" (PCMH) model of care. There are currently 73 CTC locations throughout the state; about 300,000 Rhode Islanders get their care in a CTC PCMH practice.¹⁰ The goal of PCMH transformation is to provide high-quality primary care that is organized around the needs of the patient.¹¹

CurrentCare

CurrentCare is Rhode Island's central computerized repository for patient information such as prescriptions, lab results, hospital discharge and other pertinent medical information. About half of all Rhode Islanders are enrolled in this opt-in system.¹²

Delivery System Reform Incentive Payment Waiver (DSRIP)

Delivery System Reform Incentive Payment Waivers are Medicaid waivers aimed at improving the health care delivery system by focusing on (1) infrastructure development, (2) system redesign; (3) clinical outcome improvement and (4) population health.¹³ Rhode Island's Reinventing Medicaid effort produced two briefs on whether and how to pursue a DSRIP initiative here,¹⁴ and recommended that the state participate in the DSRIP program.¹⁵ New York and other states have implemented DSRIP initiatives as a tool in Medicaid reform efforts.¹⁶

Health Care Planning and Accountability Advisory Council (HCPAAC)

The Health Care Planning and Accountability Advisory Council is co-chaired by the Secretary of the Executive Office of Health and Human Services and the Health Insurance Commissioner, and is established for the purpose of health care planning in Rhode Island.¹⁷ The council has issued various reports, including a report to the General Assembly in 2013 that addressed two studies, one on hospital inpatient care and the other on primary care.¹⁸ A study on demand for and access to behavioral health care was recently released.¹⁹

Health Equity Zones (HEZ)

With funding from the Centers for Disease Control and Prevention, and in partnership with 11 Rhode Island community based organizations, the Department of Health has created eleven health equity zones to address the social determinants of health and individual community needs with the goal of improving community health.²⁰ [See longer discussion on p 9]

U.S. and Rhode Island Health Care System A Brief Overview

Health Insurance Advisory Council (HAIC)

The Health Insurance Advisory Council meets monthly to advise the health insurance commissioner regarding the needs and concerns of consumers, purchasers and health care providers.²¹

Health Services Council (HSC)

The Health Services Council is tasked with advising the Department of Health regarding licensing of health care facilities and issuance of certificates of need for certain health care services.²² Without a statewide health care plan, there is no solid guidance for the HSC to base its recommendations on, and the HSC has approved all applications that have not been withdrawn for many years. The HSC has recently been reconstituted after a seven month hiatus.

HealthSource RI Advisory Board

An advisory board for the state's health insurance exchange is expected to be reconvened in the near future.

Integrated Care Initiative (ICI)

The state's program for residents eligible for both Medicare and Medicaid, the Integrated Care Initiative (ICI) has a consumer advisory council.

Medicaid Consumer Advisory Committee (CAC)

Representatives of insurers, Medicaid, consumer advocacy organizations, provider organizations and consumers meet monthly to address operational issues in the Rhode Island Medicaid program.

Medicaid Waiver Taskforce

A taskforce to advise EOHHS on the global 1115 Medicaid waiver was established when the waiver was approved by the General Assembly. The group, which meets monthly, has had many names, including the Global Waiver Taskforce and the EOHHS Partners Taskforce.

Medical Care Advisory Committee (MCAC)

Health care providers meet monthly and serve in an advisory capacity to Rhode Island Medicaid.²³

The Office of the Health Insurance Commissioner (OHIC)

The Office of the Health Insurance Commissioner is responsible for approving insurance rates and has instituted a number of regulatory requirements that address increasing cost of health insurance. In 2009, OHIC instituted a primary care spend requirement²⁴ (which helps fund CTC) and recently issued requirements for affordability standards, which will push more providers to practice in Patient Centered Medical Homes, as by 2019 insurers will be required to certify that 80% of their providers are in PCMH practices.²⁵

U.S. and Rhode Island Health Care System A Brief Overview

The Affordability Standards have established two additional committees, the **Advisory Committee on Alternative Payment Methodologies** and the **Advisory Committee on Care Transformation**. At first glance, it appears that these efforts overlap in content and substance with the activities of the SIM and CTC. It is crucial that these efforts be aligned and, if possible, combined.

Administrative Simplification Workgroup

This group, established by statute and convened by the Office of the Health Insurance Commissioner (OHIC), seeks to simplify eligibility, billing and appeals processes across insurers.²⁶

PCMH Kids

PCMH Kids is a new initiative to extend CTC-like Patient Centered Medical Home (PCMH) transformation to pediatric practice.

Reinventing Medicaid

Governor Raimondo established the Reinventing Medicaid working group in February 2015. The group issued two reports. The first made immediate recommendations for the state budget.²⁶ The second made more long-term, structural recommendations regarding the state Medicaid program.²⁷

State Innovation Model (SIM)

The vision of the RI SIM is “to achieve measurable improvement in health and productivity of all Rhode Islanders, and achieve better care while decreasing the overall cost of care . . . by transition[ing] from a disparate and health care provider and payer-centric environment to an organized delivery and payment system that is outcomes-oriented and person-centric.”²⁸ Rhode Island has received a \$20 million grant from CMS to implement this vision over four years. The Healthy Rhode Island Steering Committee is the group tasked with advising the state in the SIM effort.

Working Group on Healthcare Innovation

This group was established by executive order on July 20, 2015 to continue the work of Reinventing Medicaid, with a portfolio expanded to include the whole health care system. The group’s mission overlaps with a significant number of ongoing efforts, including the SIM and the HCCPAC. The executive order requires the group to “coordinate the work of other health care reform efforts in the State and shall serve as the primary coordinating body for all health care reform efforts ongoing within Rhode Island government.”²⁹

U.S. and Rhode Island Health Care System A Brief Overview

Health is more than health care

Health reform efforts often focus on the cost of health care. Some also look at the health delivery system. All of this is important, but health care only impacts a small part of a person's overall health.³⁰ Genetics, lifestyle, environmental factors, socioeconomic status all have significant impact on individual and community health. For example, a recent study found that hospital admissions for hypoglycemia increased for low-income patients at the end of the month. It was noted that food stamps often do not last the whole month, and the inability to access healthy food at the end of the month might be an important driver of the observed health inequities.³¹

Recommended Strategy: Rhode Island should implement policies that support healthy lives such as those below. In addition, every health policy and health reform committee should be asking "how does what we are doing lead to healthier Rhode Islanders?" Healthier communities and healthier people will lead to lower-cost health care and more affordable health insurance. Increasing health is one way to bend the health care cost curve. All of Rhode Island's health reform initiatives should consider making strategic investments that will improve the health of communities.

Highlight: Health Equity Zones

With funding from the Centers for Disease Control and Prevention, and in partnership with eleven Rhode Island community based organizations, the Rhode Island Department of Health has created eleven health equity zones to address the social determinants of health and individual community needs with the goal of improving community health.³² The Health Equity Zones in Woonsocket and West Warwick seek to build a safer communities that promote healing modeled after the Tarpon Springs, Florida initiative to transform into a "trauma-informed community" that is aware of and has institutions focused on how childhood

trauma impacts adult life and communities.³³ Several initiatives in Providence will address access to healthy food, healthy housing, opportunities for physical activity, and job skills. The North Providence school department will partner with community organizations to focus on the health and wellbeing of children and families in one neighborhood. Newport, Bristol, Pawtucket/Central Falls and Washington County also have set up health equity zones.

In some ways these programs build on the success of the community health teams started by CTC in Rhode Island in Pawtucket/Central Falls, and South County. These are modeled after the successful community health teams in Vermont.³⁴ The Health Equity Zone model also has its roots in the successful and well-known Harlem Children's Zone, where intensive resources were focused on one square mile of Harlem and health and educational outcomes improved.

Highlight: Healthy Housing

External forces that impact health, have the potential to improve health and save costs to the health care system. For example, paying for safe housing is an efficient investment that saves money in the health care system. Hennepin Health, a Medicaid ACO in Hennepin County, Minnesota, has found that providing housing and job resources to patients has created savings in medical costs by way of decreased emergency department visits and hospital admissions; **one hospital day averted pays for one month of housing.**³⁶ Rhode Island has plans to institute a pilot housing first program within Medicaid, to provide services to support housing for Rhode Islanders enrolled in Medicaid who are at risk of homelessness.³⁷ This is a step in the right direction. While Medicaid will not pay directly for housing, it may be possible for Medicaid ACOs, MCOs or other entities to pay directly for the housing itself. The positive outcomes reported by Hennepin Health and others are for providing the actual

U.S. and Rhode Island Health Care System A Brief Overview

housing. Housing is much less expensive than hospitalization, and a good investment in health for some at-risk patients.

Where are the patients in the policy conversations?

In many policy discussions regarding health care, health reform, and even patient-centered medical homes, the patient is missing from the conversation and from consideration. How can patients' own health care needs be adequately and responsively addressed? What do patients want? What do patients need? How can policy makers keep the patients who are served by the health care system in the forefront of their minds when making decisions that will transform the health care system?

Many national organizations are looking at ways to engage patients in individual and policy discussions regarding their health care. One definition of patient engagement is "[a]ctions people take to support their health and benefit from their health care."³⁸ Many PCMH care transformation models, including the RI CTC, spend time thinking about how to make health care practices more patient-centered, and might have patients serve on advisory committees.³⁹ There are many useful resources available to help health care providers, whether hospitals or primary care providers, design and implement productive and engaged patient advisory boards.⁴⁰

Patient engagement is also necessary at the policy level. However, there are many obstacles to patient participation in policy conversations. In Rhode Island alone, there are well over a dozen different meetings where a member of the public could participate and comment on the future of health care. Even for a very engaged member of the public, it is difficult to determine where one's time and energy would best be spent. Consumer advisory committees are one strategy to create a space reserved for consumer input. Rhode Island should

consider investing time and effort in reengaging consumers in these efforts. There are resources available that might be helpful in designing ways for meaningful consumer input.⁴¹

In addition to consumer advisory committees, Rhode Island state government has implemented a few initiatives to encourage patient participation in health care conversations. First, the Department of Health has put out a survey that patients can use to provide input regarding their experience of the health care system and is available here: https://yalesurvey.qualtrics.com/SE/?SID=SV_0MTnfZXsjylcddr&Q_JFE=0 In addition, town-hall style meetings have been held and publicized in conjunction with the Reinventing Medicaid and Healthcare Innovation efforts. These are important, but more can be done to ensure that patient input is front and center when the state redesigns the health care delivery system.

Recommended strategy: Rhode Island health reform efforts should make a space at the table for consumers. Every health policy taskforce, commission, or working group should continue to actively seek out input from organizations representing patient consumers, and also consider whether and how to create room to hear from patients who are not professionally involved in health policy.

U.S. and Rhode Island Health Care System A Brief Overview

Health care planning

What should Rhode Island's health care system look like? How many doctors, nurses, hospital beds, and MRIs do we need in Rhode Island? How can we design the future health care system based on these needs, given the current realities of the health care system we have today? Different groups study the health care system and make recommendations, which often sit on a desk, or on a website somewhere, collecting dust and are not implemented. The Health Care Planning and Accountability Advisory Council (HCPAAC) reports in recent years contain important information for the health care planning process. The Rhode Island Department of Health is undertaking a health care planning process, in conjunction with the SIM and HCPAAC, to produce a report of the current statewide inventory of health care services. The Director has stated that this inventory will inform the state's first health planning process, which in turn will inform the decisions of the Health Services Council when making determinations on applications for certificates of need.⁴²

A very brief history of health systems planning

The "Health Planning Resources Development Act" of 1974 provided funding for states to engage in health care planning, and many states enacted Certificate of Need (CON) legislation requiring approval of hospital and nursing home construction and purchase of expensive new technology, such as MRIs. The federal funding, and the mandate, was repealed in 1987.⁴³ Rhode Island, like many states, continues to have a CON requirement. However, without federal funding, until very recently there was little or no effort or ability to engage in statewide health care planning. Without a state health care plan, there is nothing to guide decisions on CON applications. With the work of HCPAAC and the SIM, Rhode Island should soon have a working health care plan to guide decisions of the Health Service Council.

Recommended strategy: Vigorous and meaningful health care planning must be at the foundation of the health care system. Rhode Island's state health care plan should make specific recommendations regarding needed health care services for the state, and should stick firmly to them. For example, the state has determined that there is an excess of about 200 staffed hospital beds.⁴⁴ The reconstituted HSC should be given a vigorous mandate and operate in accordance with a well-reasoned health care plan.

Recommended strategy: Health care planning should be fully funded, and the efforts of HCPAAC, SIM, the Department of Health, OHIC, HSC and others should be well-coordinated, if not combined in a central health authority.

Conclusions: Why is health reform so difficult?

As technology, pharmacy and the practice of medicine have advanced, more procedures and conditions previously requiring hospitalization can be done in an outpatient setting or with much short hospital stays. Capital investments in technology such as MRIs and other imaging tools in settings outside the hospital, and outpatient surgi-centers create lower costs for individual tests and procedures, but create overcapacity in the overall health care system.

Our nation and state has spent decades, even a century, investing in a hospital-based health care system. Almost all physicians practicing today trained in a hospital setting. Hospitals have become inextricably woven into the fabric of their communities. They are often among the largest employers and a favorite for local philanthropy and volunteerism.

In Rhode Island, as elsewhere, we are also seeing duplication of services, with each hospital system seeking to provide a full range of services even where the market may not require

U.S. and Rhode Island Health Care System A Brief Overview

additional capacity. Had the state had a well-considered health plan, and used it to determine how much health care is necessary to be available and where, we would not see the same kind of duplication that exists today. In addition, this duplication does not serve Rhode Islanders well, as it means each provider and hospital is performing fewer services each year, and many procedures are of better quality when the provider and the hospital performs an adequate number to maintain skills.⁴⁵ Future hospital mergers within the state might effectively reduce duplication of services and help consolidate resources in a way that makes more sense for Rhode Island.

Consolidation of health care services may be beneficial to the health care system, but it must be done with adequate, strong regulatory oversight to prevent price increases that may result from less competition. **State health planning and regulation is imperative, should be funded, and must be coordinated.**

Federal regulation of pharmacy pricing is also an important way to control escalating healthcare costs. Without this needed oversight, we have seen drug pricing escalate, sometimes exponentially.⁴⁶

More regulatory and purchasing activities such as these can help improve health care and decrease the cost. We have seen that Medicare decisions to stop paying for hospital errors and readmissions have reduced instances of both. Hurdles exist, particularly in the political will to impose such controls, which may be a reflection of entrenched financial interests. For example, when Medicare part D passed to pay for medication for Medicare beneficiaries, the government was specifically prohibited from acting as a purchaser with negotiating power in the market and cannot negotiate for lower prices on behalf of Medicare beneficiaries (and the taxpayers who foot the bill).

Conclusion

We already have a health care system. It is tremendously inefficient, and difficult to change in part because of entrenched interests, but also because it is familiar. However, nearly everyone who has interacted with the health care system has encountered a harried primary care provider, difficulty scheduling an appointment, or trouble understanding how much a minor surgery will cost with their insurance. The system, familiar as it may be, is not working. It is too expensive and it does not give us the best outcomes, even for the high price we pay. We must come together to make real change to rebuild a health care system here in Rhode Island that will be a model of efficiency and health.

For these reasons, we recommend the following:

- Health care financing must move away from fee-for-service payment models towards global budgets;
- Vigorous and meaningful health care planning is required in order to ensure that the health care system is reflective of state health care needs
- Strong, coordinated regulatory oversight of insurers and health care providers is crucial;
- Consolidated purchasing power, and increased negotiating strength, possibly through a strong health insurance exchange, will be helpful to the three goals above.

Rhode Island is well on its way to achieving these recommendations. The State Innovation Model and OHIC's affordability standards are moving the state away from payment for services towards payments for outcomes. The state should use the SIM as the focal point for health reform efforts, and all other efforts should be coordinated through and under the auspices of the SIM.

U.S. and Rhode Island Health Care System A Brief Overview

Works Cited

- 1 Health Expenditure, total (% GDP), The World Bank, 2011-2015.
- 2 See, e.g., Davis, Karen, et al., "Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally", The Commonwealth Fund, June 2014.
- 3 *Reinventing Medicaid*, initial report, May 1, 2015, p.5. Rhode Island 2016 State Budget submission document at p. 15; See also Kaiser Family Foundation at <http://kff.org/other/state-indicator/distribution-of-general-fund-spending/>
- 4 Pew, State Employee Health Care Report, September 2014, p. 42.
- 5 Rhode Island Department of Labor and Training, Rhode Island Employment Trends and Workforce Issues, 2014.
- 6 Truven Consulting, Rhode Island Behavioral Healthcare Project Demand Report, September 2015.
- 7 See <http://www.governor.ri.gov/documents/press/20151007%20Working%20Group%20for%20Healthcare%20Innovation%20vF.pdf> at 59.
- 8 The March 2014 report is available here:
http://www.ohic.ri.gov/documents/OHIC_Final_Admin_Simp_Report_to_GA_3_27.pdf
- 9 <http://www.health.state.ri.us/partners/collaboratives/allpayerclaimsdatabase/>
- 10 <https://www.pcmhri.org/>
- 11 See, e.g., <http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx>
- 12 <http://www.currentcareri.org/Home.aspx>
- 13 "An overview of delivery system reform incentive payment waivers," Issue Brief, Kaiser Family Foundation, Sept. 29, 2014.
- 14 DSRIP and federal authority brief - Reinventing Medicaid; Delivery System Reform Incentive Payments (DSRIP) brief.
- 15 Reinventing Medicaid, final report, July 8, 2015, p. 24.
- 16 "An overview of delivery system reform incentive payment waivers," Issue Brief, Kaiser Family Foundation, Sept. 29, 2014.
- 17 R.I.G.L. 23-81-3.1.
- 18 Report to General Assembly, Health Care Planning Accountability Council, May 7, 2013.
- 19 Truven Health Analytics, Rhode Island Behavioral Health Project Final Report, Sept. 15, 2015.
- 20 <http://www.health.ri.gov/projects/healthequityzones/>
- 21 <http://www.ohic.ri.gov/ohic-hiac.php>

U.S. and Rhode Island Health Care System A Brief Overview

Works Cited

- 22 <http://www.health.ri.gov/partners/councils/healthservices/>
- 23 <http://www.eohhs.ri.gov/ReferenceCenter/NoticesMeetingAgendas/MedicalCareAdvisoryCommitteeMCAC.aspx>
- 24 Koller, Christopher, et al. Rhode Island's Novel Experiment To Rebuild Primary Care From The Insurance Side, *Health Aff* May 2010 vol. 29 no. 5 941-947.
- 25 <http://www.ohic.ri.gov/documents/Press-OHIC-Adopts-Standards-Improve-HCPDS.pdf>
- 26 <http://static1.squarespace.com/static/54e689e7e4b01dbc2505f118/t/5543e6f5e4b0125980d0058d/1430513397401/Initial+Report+of+the+Working+Group+to+Reinvent+Medicaid.pdf.pdf>
- 27 http://static1.squarespace.com/static/54e689e7e4b01dbc2505f118/t/559fe3f6e4b0567a6dd35c43/1436541942435/Report_Final_Reinventing+Medicaid+Second+Report+FINAL.pdf
- 28 <http://www.eohhs.ri.gov/SIM.aspx>
- 29 www.governor.ri.gov/documents/orders/ExecOrder_15-13_07202015.pdf
- 30 Various studies assign medical care responsibility for 10-20% of a person's overall health, with other determinants such as genetics, social circumstances, behaviors, and environment having significant impact on health. See, e.g., "Health Policy Brief: The Relative Contribution of Multiple Determinants to Health Outcomes," *Health Affairs*, August 21, 2014.
- 31 Seligman, et. al, "Exhaustion Of Food Budgets At Month's End And Hospital Admissions For Hypoglycemia," *Health Affairs*, January 2014 33:1116-123.
- 32 <http://www.health.ri.gov/projects/healthequityzones/>
- 33 Salit, Richard, "The Health Divide," *Providence Journal*, Sept. 19, 2015 at A10. See <http://www.peace4tarpon.org/> for more information about the Tarpon Springs initiative, which notes that interpersonal violence such as abuse, rape and domestic violence; social violence such as war and terrorism; chronic social stressors such as racism and poverty and historical trauma like genocide and slavery impact the health and well-being of individuals and communities.
- 34 "Vermont's Blueprint For Medical Homes, Community Health Teams, And Better Health At Lower Cost," *Health Affairs*, March 2011 vol. 30 no. 3 383-386.
- 35 "Whatever It Takes: A Whitepaper on the Harlem Children's Zone," April, 2014.
- 36 Editorial Board, "Hennepin Health is delivering health care innovation," *Star Tribune*, Aug. 21, 2014; see also Sandberg, et al. "Hennepin Health: a safety-net accountable care organization for the expanded Medicaid population," *Health Affairs*, Nov. 2014. 33:1975-84.
- 37 Initiative 7 in the preliminary report of the Working Group to Reinvent Medicaid calls for "EOHHS [to] implement an innovative home and health stabilization program that targets Medicaid beneficiaries who have complex medical or behavioral health conditions and are either homeless, at risk for homelessness or transitioning from high-cost intensive care settings back into the community." Initial Report at 15. For a more complete list of ongoing housing initiatives in healthcare context, see this chart at the State Reform website: <https://www.statereform.org/health-housing>

U.S. and Rhode Island Health Care System A Brief Overview

Works Cited

- 38 "Here to Stay: What Health Care Leaders Say About Patient Engagement," Center for Advancing Health, 2014.
- 39 Maurer M, Dardess P, Carman, KL, et al. Guide to Patient and Family Engagement: Environmental Scan Report. (Prepared by American Institutes for Research under contract HHS 290-200-600019). AHRQ Publication No. 12-0042-EF. Rockville, MD: Agency for Healthcare Research and Quality; May 2012.
- 40 See, e.g. Agency for Healthcare Research and Quality, Guide to Patient and Family Engagement in Hospital Quality and Safety; Robert Wood Johnson Foundation, Engaging Patients in Improving Ambulatory Care.
- 41 See, e.g., Community Catalyst, Meaningful Consumer Engagement: A Toolkit for Plans, Provider Groups and Communities: A Toolkit for Plans, Provider Groups and Communities.
- 42 See Letter from the Director, HealthConnection, August 2014.
- 43 <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>
- 44 Health Care Planning and Accountability Advisory Council, report to Rhode Island General Assembly, May 7, 2013, p. 4.
- 45 See, e.g., Sternberg, Steve and Geoff Dougherty, "Risks are High at Low-Volume Hospitals," U.S. News and World Report, May 18, 2015.
- 46 See, e.g., Pollack, Andrew, "Drug goes from \$13.50 a Tablet to \$750, Overnight," The New York Times, Sept. 20, 2015; Mohny, Gillian, "Generic Drug Price Sticker Shock Prompts Probe by Congress," ABC News, Nov. 21, 2014.

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