



Special Senate Commission to Study Cost
Containment, Efficiency, and
Transparency in the Delivery of Quality
Patient Care and Access by Hospitals

Findings and Recommendations

Report Submitted to the

Rhode Island State Senate

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**Special Senate Commission to Study Cost Containment, Efficiency,
and Transparency in the Delivery of Quality Patient Care and
Access by Hospitals**

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Rhode Island Senate

Special Commission to Study Cost Containment, Efficiency, and Transparency in the Delivery of Quality Patient Care and Access by Hospitals

We are pleased to present these findings and recommendations of the Special Senate Commission to Study Cost Containment, Efficiency, and Transparency in the Delivery of Quality Patient Care and Access by Hospitals. This report represents the best thinking of a distinguished and dedicated Commission whose membership consisted of elected officials, health insurance providers, large affiliated hospitals, smaller community hospitals, healthcare professionals, and experts from throughout state government. Over the course of several hearings, Commission members heard informed testimony, examined current challenges facing the state's hospital system, reviewed best practices, and considered the most reasonable and effective means to reduce and contain cost growth, improve efficiencies, and increase transparency in the process through which hospitals and insurers arrive at reimbursement rates. We consider the Commission's recommendations a crucial first step in slowing healthcare cost growth, improving quality, and empowering healthcare consumer choice.

Ultimately, our study found that hospitals play a vital role in both Rhode Island's health care system and its economy. We further found that inequities currently exist in how hospitals are paid for the care they provide; that public and private insurers pay hospitals differently for similar services; that the 'business' of hospital care is changing; that traditional payment methodologies provide an economic disincentive for hospitals to improve outcomes and that new payment methods are being piloted which may help better align financial incentives; that comprehensive statewide planning of healthcare resources is vital to ensuring the sustainability of Rhode Island's hospitals; that the state does not currently coordinate its healthcare purchasing levers well; and that, with federal healthcare reform, payment reform is both necessary and inevitable.

We are grateful to every member of the Commission for their willingness to take part in these discussions and appreciate the many experts who took time to appear before the Commission and contributed to our understanding of the challenges and opportunities facing Rhode Island's hospital system.

As per the requirements of 2010 S 3021, we offer these findings and recommendations with confidence that we can help improve efficiency and increase transparency in how hospitals care for patients and how they are reimbursed for that care.

Sincerely,

Senator Joshua Miller
District 28- Cranston, Warwick

Senator Roger A. Picard
District 20- Woonsocket, Cumberland

EXECUTIVE SUMMARY

On June 10, 2010, Senate Bill 3021 was read and passed by the Rhode Island Senate creating the Senate Commission to Study Cost Containment, Efficiency, and Transparency in the Delivery of Quality Patient Care and Access by Hospitals. The Commission, chaired by Senator Joshua Miller (District-28, Cranston, Warwick) was authorized to study:

- The establishment of procedures to provide for more efficient administration of healthcare services to citizens of this state;
- The implementation of a more efficient, transparent, and uniform rate-approval process for the purchase of health services;
- The advisability and implementation of a requirement that health insurers pay comparable rates to healthcare providers, in particular, hospitals, for similar services;
- The advisability and implementation of payment methodologies that promote cost containment, efficiency, and transparency;
- The establishment of procedures for the review of provider contracts and rates
- The establishment of a procedure for the disclosure by hospitals of third-party Rhode Island insurance contracts to assure transparency and efficiency; and,
- At its discretion, the development and establishment of a state-based health insurance exchange, as provided under the “Patient Protection and Affordable Care Act”.

The Commission met six times over the past four months: December 15, 2010; January 10, 2011; January 19, 2011; February 9, 2011(public testimony); February 28, 2011; and March 9, 2011, and was charged with presenting its findings and recommendations to the Senate on or before March 31, 2011. This document represents the final report of the Special Senate Commission.

While the Commission process was cooperative and collaborative, with outstanding input and support from all parties, there was not unanimous consent for the findings and recommendations included in this report. We provided each member the opportunity to express their support, objection, or alternative, to each finding and recommendation directly in the report. As described in this document, the Commission’s findings are as follows:

- Preserving the Financial Health of Hospitals is Critical to Rhode Island’s HealthCare System, Economy, and Labor Market
- Inequities Exist in How Hospitals are Paid for the Care They Provide
- Different Payors Pay Different Rates for the Same Service
- The ‘Business’ of Hospitals is Changing
- Current Payment Methodologies May Penalize Hospitals for Improving Patient Health
- Statewide Planning of HealthCare Resources is Vital to the Sustainability of Rhode Island’s Hospitals
- State Government Does Not Coordinate its Purchasing Levers Effectively , and
- With Federal HealthCare Reform, Payment Reform is Necessary and Inevitable

Consistent with these findings, the Commission's recommendations are as follows:

- Monitor and Support the Continued Implementation of OHIC Contract Standards
- Establish a Provider Payment Reform Task Force in Statute
- Effect the Transition Away from Fee-for-Service Payment Model Toward Alternative Payment Models That Promote Efficiency, Effectiveness and Quality of HealthCare
- Monitor and Participate in the Legislative Process on Increased Transparency in the Hospital Rate Setting Process
- Require the Designation of Primary Care Provider
- Promote and Expand Hospital Safe Transitions Programs
- Identify Permanent Funding for the Department of Health All Payor Claims Database (APCD)
- Identify Permanent Funding for the HealthCare Planning and Accountability Advisory Council, and recommit to the goals and findings of the Coordinated Health Planning Act of 2006
- Improve Behavioral Health Interventions
- Explore the Feasibility, Potential Benefits, and Challenges of Interstate Certificate of Need Coordination

Each member of the Commission, along with others who provided testimony, presentations, opinions, and assistance to the Commission, has been instrumental in preparing this document throughout a series of hearings and commission meetings. We thank all members and interested parties for their work with the Commission.

FINDINGS

- **Preserving the Financial Health of Hospitals is Critical to Rhode Island's HealthCare System, Economy, and Labor Market**

The Commission learned of the vital role Rhode Island's hospitals play not only in the provision of quality healthcare to all Rhode Islanders but in the state's economy and labor market as well.

Testimony from the Hospital Association of Rhode Island included the fact that the state's hospitals care for nearly 6,500 patients each day, regardless of their ability to pay. On a given day, the state's hospitals witness 32 births, 92 inpatient surgeries, 201 outpatient surgeries, 345 discharges, 6,150 outpatient visits, and 1,212 emergency visits; providing \$432,100 in *uncompensated* care daily. Beyond providing this direct care, the hospitals supply clinical training and instruction to physicians and to more than 3,300 student nurses each year, as well being responsible for more than \$100 million in research funding throughout the healthcare system.

Beyond the substantial impact Rhode Island's hospitals have on the state's healthcare system, they also play a critical role in one of the state's fastest, and most dependably, growing industries. All together, the state's hospitals provide \$6.1 billion in economic activity annually, providing 20,800 jobs, a total payroll of \$1.7 billion, purchasing \$1 billion in supplies, and spending an average of \$150 million on capital projects annually. Each day, hospitals have a \$16,800,000 economic impact in the state, providing 5% of the state's private sector employment, and accounting for 10% of the state's private sector payroll.

Recognizing that Rhode Island's hospitals serve a critical role in the state's healthcare system, and have an enormous impact on the state and regional economy and labor market, it is imperative that Rhode island work to preserve and protect the financial wellbeing of hospitals in a manner that is consistent with the principles of resource planning and the efficient use and distribution of hospital capacity as outlined elsewhere in this report.

- **Inequities Exist in How Hospitals are Paid for the Care They Provide**

Through testimony and discussion of external studies, such as the January 2010 report by the Rhode Island Office of the Health Insurance Commissioner (OHIC) entitled “Variations in Hospital Payment Rates by Commercial Insurers in Rhode Island”¹, the Commission heard that there is an evident variation in the way hospitals are paid for the inpatient medical/surgical care they provide – hospitals are paid noticeably different for rendering the same or similar service.

While this payment was confirmed, however, its causes, and the data used by OHIC in developing the report, were a point of debate. Some argued that this reimbursement rate disparity constituted ‘unfair treatment’ of providers and was almost entirely the product of the ‘market leverage’ of larger, system-affiliated hospitals over insurers and, equally, the leverage of insurers over smaller, unaffiliated hospitals. These members argued that this disparity ignores important values such as quality and cost effectiveness and that, therefore, much of the difference in reimbursement among providers is unjustified. They point to the afore-mentioned OHIC study as evidence of this fact. The report found that, among the eleven acute care hospitals in Rhode Island², the casemix³ adjusted payment per stay as a percent of Medicare payment⁴ averaged 117% and 149% for hospitals affiliated with the state’s two major healthcare systems, and averaged only 97% for unaffiliated hospitals. In describing these variations, the report further found that ‘there is no evidence that system-affiliated hospitals have relatively higher unreimbursed uncompensated care or teaching costs than unaffiliated hospitals; (that) the three highest paid hospitals have unremarkable Medicaid and Medicare volumes,” and that rather, “there is considerable evidence that the (system-affiliated) hospitals...possess power in particular service markets that gives them negotiating leverage.”⁵ These findings are consistent with those included in the Massachusetts Attorney’s General March 2010 report entitled “Examination of Health Care Cost Trends and Cost Drivers”⁶ which found similar variations in payments among Massachusetts hospitals and stated that these variations “are correlated to market leverage as measured by the relative market position of the hospital or provider group compared with other hospitals or provider groups within a geographic region or within a group of academic medical centers.”⁷

¹ Viewable as of March 2011 at:

<http://www.ohic.ri.gov/documents/Insurers/Reports/2010%20Hospital%20Payment%20Report/2010%20Variations%20in%20Hospital%20Pmt%20Rates.pdf>

² Excluding Bradley, Butler, The Rehabilitation Hospital of Rhode Island, and Eleanor Slater Hospital

³ Casemix adjustment – accounts for the characteristics (age, gender and health status) of the population a health system serves during a given period of time. It is used to adjust the average cost per stay for a given hospital relative to the adjusted average cost for other hospitals to allow for a more accurate comparison.

⁴ Medicare payment levels serve as a common benchmark in payment negotiations nationwide since Medicare payments are public knowledge and are intended to approximate the true cost of care.

⁵ “Variations in Hospital Payment Rates by Commercial Insurers in Rhode Island” Page 4.

<http://www.ohic.ri.gov/documents/Insurers/Reports/2010%20Hospital%20Payment%20Report/2010%20Variations%20in%20Hospital%20Pmt%20Rates.pdf>

⁶ Viewable as of March 2011 at: <http://www.mass.gov/Cago/docs/healthcare/healthcare.pdf>

⁷ Ibid.

Other members refute the OHIC findings, arguing that the disparity among hospital inpatient reimbursement rates was based on incomplete data or simply a reflection of the higher costs that affiliated hospitals incur beyond the traditional care costs of smaller hospitals. They stated that the OHIC report and others like it fail to recognize these justified costs or payments for outpatient services. Among other variables, these costs may be associated with location, the availability of specialized services, hospital licensing fees and disproportionate share hospital (DSH) payments, the volume and quality of care, uncompensated care expenses, research and training costs (which represent an important economic, social, and health benefit to the state) and patient mix. Importantly, they stress that the OHIC report did not capture a ‘full picture’ of hospital finances by focusing only on inpatient care payments and not including outpatient, inpatient psychiatric, rehabilitation, and other important hospital payments. They further point to an alternate study prepared by the same consultant regarding inpatient Medicaid payments for the same period- in this study, two “non-system’ hospitals were paid significantly high than cost (more than 150% above cost)⁸. In addition, it has been documented that federal Medicare pays all hospitals based in Providence and north of the city a higher rate solely because of geographic location. They thus contend that the call for transparency as a way to diminish disparities based on market size is based on false assumptions. Lastly, these members contend that transparency alone, for example the publicizing of negotiated reimbursement rates between hospitals and insurers, would only serve to inflate costs across the healthcare system as lower-reimbursed hospitals simply demand the same rates that highest-reimbursed hospital receive, without any movement in the other direction.

- **Different Payors Pay Different Rates for the Same Service**

Although a direct comparison was not possible given variations in rates paid for type of service, and incomplete access to negotiated contracts between hospitals and insurers, Commission members argued that public payors, such as Medicare and Medicaid, and private payors pay substantially different rates for the same service. In general, members contend that public payers are paying ‘less than cost’ for the care their covered patients receive (it was claimed in testimony that Medicare paid approximately 80% of the cost of care, and Medicaid paid even less) and that private payors have had these costs shifted to them. Private insurers argue that they are both directly responsible for the costs of the care their members receive and, indirectly, a fraction of the costs of care that Medicare/Medicaid patients receive which has been shifted to them. Likewise, hospitals describe themselves as financially ‘squeezed’ from both sides as elected officials look to save money by reducing payments to hospitals from public programs, while insisting that private payors control and contain cost growth on their end.

It is important to mention that State Medicaid officials have recently implemented a new payment methodology for inpatient services paid on a fee-for-service basis that ensures the same rate is paid for the same inpatient service at all hospitals; payments made through managed care plans, however, continue to vary among hospitals. In the development of the new methodology, Medicaid analysis demonstrated that, on average, Medicaid inpatient payment rates were slightly greater than 100% of inpatient hospital cost. The outpatient hospital payments are less than 100%.

⁸ ACS, Medicaid Payment for Hospital Services, December 21, 2009, slide 29

- **The ‘Business’ of Hospitals is Changing**

The ‘business’ of hospitals has changed, and continues to change, significantly. As future demands on *inpatient* care will be influenced by the continued aging of the baby-boomer generation; more than 50% of the care now delivered by hospitals is in the form of *out-patient care* – services which are provided to patients not admitted to a hospital and which do not necessarily need to be offered in a hospital setting. In providing this care, hospitals compete not only with one another, but with countless physicians and other providers who have opened and operate their own independent imaging centers, surgical centers, and other services that were once traditionally offered in hospitals. The changing role hospitals play in the delivery of care has altered the relationship between hospitals, providers, patients, and insurers. This evolution is likely to persist as cost pressures and technology continue to change the role, structure, services and payment methods of hospitals. Additionally, a greater emphasis on primary care, outpatient services, and care coordination of the chronically ill, as both state and federal healthcare reform proposals have recommended, are likely to result in the emergence of new models of care delivery to meet these new demands and opportunities. These new models will require flexibility in administration and reimbursement, however hospitals are large institutions with significant fixed costs that must be covered, community obligations that must be met, and a critical social mission. To survive in this new environment, hospitals must transform how they provide patient care, and payment reform should help facilitate this transition.

- **Current Payment Methodologies May Penalize Hospitals for Improving Patient Health**

Reducing readmissions, preventing hospital acquired conditions, putting greater emphasis on primary and preventative care – each of these approaches is cited nationally as critical to cutting costs and improving healthcare quality, yet each would result in reduced revenue to hospitals under the current fee-for-service payment model. Payors and hospitals are beginning to implement new payment methodologies that align financial incentives with improve safety, care, and quality.

Fee-for-service (FFS) is a payment mechanism wherein a provider is paid for each individual service rendered to a patient. The fewer services, or instances of service, rendered to patients, the fewer payments a provider receives – this system provides an economic *disincentive* to hospitals to improve post-hospital care, or prevent admissions in the first place, since all of these improvements mean less revenue to the hospital, in spite of any savings they may provide in the short term. Despite these financial disincentives, however; hospitals and insurers have nevertheless developed and promoted quality improvement measures and comprehensive patient safety programs and Rhode Island’s hospitals continue to make high quality patient care and safety their number one priority.

Testimony described hospitals' participation in, and insurance companies' promotion of, programs designed to greatly improve successful discharge and transitions of patients out of hospitals, improve preventative and primary care through the use of innovative approaches such as the patient-centered medical home⁹, and reduce intensive care complications and lengths of stay. While improving patient safety and hospital quality remains the mission of all Rhode Island's hospitals, the fact that hospitals *lose* funds for doing so cannot be ignored.

In July of 2010, the Office of the Health Insurance Commissioner announced approval conditions for health plan contracts between all commercial insurers and hospitals licensed in Rhode Island (for contracts expiring between July 2010 and June 1, 2011). During his December 15, 2010 presentation before the Commission, Commissioner Christopher Koller explained that these conditions were developed, in part, in recognition of the economic disincentive for hospitals to coordinate care and improve efficiency. Taken from his presentation, the Commissioner described how the "current fee-for-service payment system rewards volume (and) discourages care coordination." As an example, he explained "a good flu season for the rest of us is bad for hospitals."

To address this imbalance, the approval conditions described in the July 2010 OHIC Rate Factor Decision release¹⁰ would require that health plan contract terms with hospitals,

"Utilize unit of service payment methodologies for both inpatient and hospital outpatient services that realign payment to provide incentives for efficient use of health services, and are derived from nationally utilized payment practices other than fee for service"

The Commissioner stated that there appears to be general agreement among providers and health plans concerning the goals that the conditions aim to achieve, although there remains some concern and resistance regarding how the conditions would go about achieving them. Nevertheless, the Commission believes that any deterrents to coordinating care as well as incentives to promote the efficient use of health services should be addressed.

- **Statewide Planning of HealthCare Resources is Vital to the Sustainability of Rhode Island's Hospitals**

The charge of the Special Senate Commission includes ensuring continued access to quality patient care for all Rhode Islanders. Hospitals testified before the Commission that a key element in preserving this access is comprehensive statewide planning of healthcare resources. It was suggested that adequate planning of healthcare assets and capacity across the state would help protect the financial health of hospitals, preserve a comprehensive range of services for patients, and promote the value of fair and equitable access to quality healthcare.

⁹ Patient Centered Medical Home (PCMH) is an approach to providing comprehensive primary care for patients through a personal physician that facilitates partnerships between the patients, their care providers, and when appropriate, the patient's family. Patient-centered medical homes coordinate care and provide a single 'home' that collectively takes responsibility for the ongoing care of the patient.

¹⁰ Office of the Health Insurance Commissioner, July 2010 Rate Factor Decision.
[http://www.ohic.ri.gov/documents/Insurers/Regulatory%20Actions/2010_July_Rate_Decision/2_%20Conditions%20Summary.p](http://www.ohic.ri.gov/documents/Insurers/Regulatory%20Actions/2010_July_Rate_Decision/2_%20Conditions%20Summary.pdf)
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The underlying principle¹¹ in support of statewide healthcare planning is that excess capacity in the healthcare system can result in price inflation and potentially *less* access and *lower* quality. When a hospital cannot fill its beds, or a provider cannot fill his/her schedule, the significant fixed costs associated with healthcare services must be met some other way- often through higher charges for those patients that are served, or reductions in staff and available services. Because healthcare institutions serve a public need and are costly to operate, proponents of healthcare planning contend that it makes sense to limit the development of facilities and equipment so that there is just enough capacity to meet demand, and services are not duplicated nor underutilized.

Several hospitals testified about the need for more proactive statewide planning and control of Rhode Island's healthcare resources, such as through the Certificate of Need process which currently governs hospital and nursing home ownership changes or expansions. They point to the growth of 'free standing' healthcare facilities (laboratory, diagnostic, surgical, and other healthcare services not associated with a hospital) as examples of the risks to the broader healthcare system from insufficient planning. These facilities offer services otherwise available in hospitals, but operate with far fewer 'mandates' than hospitals face- such as the requirement to provide care regardless of a patient's ability to pay, the obligation to accept Medicare and Medicaid recipients, and the requirement to provide free care for uninsured individuals up to 200% of the Federal Poverty Level, among other obligations. 'Free standing' facilities can also choose to provide only the most profitable services, compared to the full array of services that hospitals must offer. To further illustrate the difference between the two settings, hospitals point out that while a free-standing diagnostic center can choose to keep their equipment 'on' only during office hours; hospitals must have this equipment available 24 hours a day, 7 days a week, along with sufficient staff to operate said equipment, and increased maintenance. This significantly increases the costs of this service and equipment to hospitals, yet hospital revenue to cover these costs is reduced due to the availability of duplicate equipment and services in ancillary settings. Better planning of healthcare resources in the state, they contend, would ensure that what the healthcare system 'has' matches what the healthcare system 'needs' and would promote efficiency and the financial health of all service providers. It is important to note, however, that according to the National Conference of State Legislatures, healthcare resource planning and control also has its share of opponents.¹² In particular, the NCSL points to a 2004 report completed by Federal Trade Commission (FTC) and the Department of Justice which claimed that CON programs actually *contributed* to rising prices because they inhibit competitive markets that should be able to control the costs of care and guarantee quality and access to treatment and services.¹³ These findings, however, are disputed.¹⁴

¹¹ National Conference of State Legislatures- Certificate of Need State Laws
<http://www.ncsl.org/default.aspx?tabid=14373>

¹² Ibid.

¹³ 'Improving Health Care: A Dose of Competition' July 2004. http://www.justice.gov/atr/public/health_care/204694.pdf

¹⁴ Glied, Sherry. "Side Effects: A Dose of Competition & Access to Care. Columbia University,
<http://jhppl.dukejournals.org/cgi/content/abstract/31/3/643>

- **State Government Does Not Coordinate its Purchasing Levers Effectively**

A 2008 report by the Lewin Group, commissioned by the Commonwealth Fund¹⁵ found that:

“Given that state governments are typically the largest employer group in any given state, state (employee health plans) are responsible for a large volume of healthcare purchasing. This can yield considerable influence in negotiations with participating health plans and provider groups, in terms of encouraging their participation in quality improvement, cost containment, and related initiatives. In addition, state (employee health plans) may be in a position to combine their quality improvement activities and strategies with other large public and private sector purchasers, including Medicaid, other public programs, and private health plans and employer groups. The combined market leverage of such coalitions can enhance (employee health plans) purchasing advantage and help to coordinate state-level quality promotion activities.”

Taken together, Medicaid enrollees and Rhode Island state employees comprise over 20% of the total state population. State regulation over commercial insurance adds another 40%. Yet despite the state’s influence of over 60% of the healthcare dollars spent in the Rhode Island, policies for payment reform remain disparate and uncoordinated among these various entities. If the state were to coordinate these efforts under a single clear vision for payment reform, it would have established a significant market lever to facilitate change.

- **With Federal HealthCare Reform, Payment Reform is Necessary and Inevitable**

Given its central importance to federal healthcare reform effort, payment reform is not only necessary, it is inevitable. The anticipated strain on hospitals and the broader healthcare system brought about by expanded health insurance coverage, combined with the long-standing cost pressures that hospitals continue to face, will require it. Healthcare reform that improves access to care without addressing reimbursement reform will only exacerbate the health cost crisis. New models of care delivery, reforms in Medicaid and Medicare, incentives for collaborative care, penalties for readmission rates and infection rates, and other significant changes in how healthcare is delivered will mandate changes in how that care is paid for.

Lastly, the Commission seeks to emphasize that Rhode Island is not alone in its healthcare payment study and reform efforts. Whether prompted by federal healthcare reform efforts, or self-initiated, many states have begun to focus on the issue of healthcare payment reform. Neighboring Massachusetts recently completed a comprehensive review of the state’s healthcare payment system and introduced landmark payment reform legislation. Other states including Vermont have convened similar bodies design to study the issue of healthcare payment reform. Rhode Island is far from alone in this undertaking.

¹⁵ http://www.commonwealthfund.org/usr_doc/McKethan_whatpublicemployeehltpanscando_1097.pdf?section=4039

RECOMMENDATIONS

1. Monitor and Support the Continued Implementation of OHIC Contract Standards

Any recommendations regarding cost containment, efficiency, and transparency in the delivery of healthcare should recognize and build upon work that is already underway in Rhode Island. One of the most influential recent developments concerning how healthcare is paid for in the state is the afore-mentioned hospital contract approval conditions announced by the Health Insurance Commissioner in July of 2010. The founding premise for this aggressive approach was that “current health plan contracting with hospitals have not been an effective policy to improve the affordability of commercial health insurance premiums”¹⁶ Consistent with his office’s authority and statutory directive, the Health Insurance Commissioner announced the following¹⁷ approval terms, and accompanying ancillary information, for contracts between hospitals and insurers expiring between July 2010 and June 1, 2011 (list has been abbreviated from the original). The principles of such contracts must:

1 . Utilize unit of service payment methodologies for both inpatient and hospital outpatient services that realign payments to provide incentives for efficient use of health services, and are derived from nationally utilized payment practices other than fee for service.

- Efficiency-based payment methodologies, and their superiority over traditional per-diem arrangements are well documented in publications by the Medicare Payment Advisory Commission. Many of these have either been implemented by Medicare already or are being demonstrated. OHIC’s insurer contracting survey however, documented the lack of their use in Rhode Island.

2. Limit average annual effective rates of price increase for both inpatient and outpatient services to a weighted amount equal to or less than the Centers for Medicare and Medicaid Services (CMS) National Prospective Payment System Hospital Input Price Index for all contractual and optional years covered by the contract.

- The Hospital Input Price Index has been adopted by CMS as an appropriate measure of fair price increases for Medical Services. It was recently adopted by the General Assembly for Medicaid payments to hospitals. Filings with OHIC by the insurers, however, consistently document price increases to hospitals at several multiples of this index. These differences are passed directly onto commercial insurers and raise commercial insurance prices.

3. Provide the opportunity for hospitals to increase their total annual revenue for commercially insured enrollment under the contract by at least additional two percentage points over the previous contract year by improving or attaining mutually agreed-to performance levels for no less than three nationally-accepted clinical quality, service quality or efficiency-based measures.

¹⁶ Office of the Health Insurance Commissioner, July 2010 Rate Factor Decision. Page 1
[http://www.ohic.ri.gov/documents/Insurers/Regulatory%20Actions/2010_July_Rate_Decision/2_%20Conditions%20Summary.p](http://www.ohic.ri.gov/documents/Insurers/Regulatory%20Actions/2010_July_Rate_Decision/2_%20Conditions%20Summary.pdf)
^{df}

¹⁷ Ibid.

- Performance-based opportunities for hospital revenue enhancement are not uncommon, and yet Rhode Island insurers reported they constitute only 0.5% of their payments to hospitals. The appropriate size and content of performance-based opportunities for hospital revenue enhancement should be subject to private negotiation, however the relatively low usage rate of such payment enhancements in Rhode Island has hindered broader payment realignment.

4. Include terms that define the parties' mutual obligations for greater administrative efficiencies, such as improvements in claims and eligibility verification processes, and identify explicit commitments on the part of each.

- Insurers, hospitals, and national studies alike all point to excess administrative costs as a problem. Insurer administrative costs are now rising at rates of insurance premium inflation, several times the rate of general inflation.

5. Include terms that promote and measure improved clinical communications between the hospital and each patient/member's designated primary care physician, specialist physicians, long term care facility, or other providers.

- In October 2010, The RI Primary Care Provider Advisory Committee made recommendations to the DOH concerning opportunities for improvements by hospitals and by primary care practices that would improve the quality and efficiency of care and reduce avoidable emergency room use and preventable inpatient hospital admissions and readmissions. Health insurer contracts are appropriate means to promote these goals.

6. Include terms that explicitly relinquish the right of either party to contest the public release of the any and all of these five specific terms by state officials or the participating parties to the agreement.

- To achieve the goals set forth in OHIC's Affordability Standards, greater degrees of public accountability and transparency for health plan payment terms and conditions with hospitals – similar to those in place for Medicare and Medicaid – are necessary.

Many of the issues regarding cost containment and efficiency that were discussed during Commission testimony are addressed, at least in part, by the OHIC contract conditions. The conditions are not a complete solution, but have the potential to transform how hospitals are paid for the care they provide- placing the focus on outcomes, and not merely inputs. The contract standards, as a whole, lack unanimous support among the Commission; some support the standards but insist that the deciding factors including physician payment reform; others contend that the office lacks the authority to promulgate such rules and that the conditions can not be applied to the largest commercial groups which are self-funded. Further, they argue that the OHIC requirements are on the insurer, but not on the state's hospitals, creating a possible contract impasse; however given their influence over how insurers and hospitals pay for quality care, contain costs, and promote efficiency and transparency, the Commission recommends that the General Assembly closely monitor the effect and impact of the Health Insurance Commissioner's insurer-hospital contract conditions and, with cooperation and input from all stakeholders, offer whatever support may be necessary and appropriate to effectuate the goals of these conditions.

**UnitedHealthcare Comment regarding Recommendation 1 –
Monitor and Support the Continued Implementation of OHIC Contract Standards**

The Office of the Health Insurance Commissioner's (OHIC) hospital-insurer contract conditions provided a level of support to UnitedHealthcare's contracting efforts with hospitals that looked to implement a number of innovative payment methodologies. While the conditions have provided some leverage in negotiations with hospitals, United continues to have some concerns regarding their impact. It is important to note that the conditions are just one component of payment reform. UnitedHealthcare believes that it is critical that payment reform be discussed in a comprehensive manner in order to develop a provider and delivery payment system that will, in fact, improve health care quality and address the issue of increasing medical costs.

In addition, specifically with regard to these conditions, it is important to note that the current conditions do not address the issue of market imbalance among hospitals, an issue that has been presented at a number of commission meetings and in legislative hearings. The conditions codify the current imbalance among facilities going forward which is an issue that should be considered.

2. Establish a Provider Payment Reform Task Force in Statute

To study, guide, implement, and/or support the recommendations of this report, along with Rhode Island's broader payment reform efforts, the Commission recommends the establishment of Provider Payment Reform Task Force within the Executive Branch. This task force will ensure open communication and coordination among all relevant state agencies, allowing the sharing of resources and information, integrating reform efforts, allowing the state to develop a single comprehensive vision for payment reform, and ensuring that the state's disparate interests are moving in harmony toward that vision. The Task Force would be comprised of the Secretary of the Executive Office of Health and Human Services (EOHHS), the state Medicaid Director, the Health Insurance Commissioner, the Director of Administration, the Director of Health, and the Directors of State Employee Purchasing. The task force would be co-chaired by the Health Insurance Commissioner and the Secretary of EOHHS.

As a public body, the Task Force would be subject to all appropriate open meetings and administrative procedure laws. Its charge would include conducting studies to determine appropriate payment levels by payer, hospital, and inpatient/outpatient service type; monitoring payment reform efforts regionally and federally; studying and recommending methods to improve consumer education about healthcare pricing; studying and making recommendations regarding physician reimbursement; and coordinating provider payment reform efforts across Medicaid, public employee plans, and commercial health insurance regulations with the goals of: standardization across payers, coordination with Medicare payment and reform, and improved population health, patient experience of care, and system efficiency. To ensure that key stakeholders are involved in the process, the Task Force would be asked to establish a Provider Advisory Council. The Provider Payment Reform Task Force would be required to provide regular reports to the General Assembly on their efforts.

**UnitedHealthcare Comment regarding Recommendation 2 –
Establish a Provider Payment Reform Task Force in Statute.**

UnitedHealthcare believes it is important to reform the provider payment and delivery system to address the issue of rising medical costs. It is important that these changes are done in a reasoned manner so that they do not create unintended consequences that result in increased costs and providers not being able to adapt to the new payment structures. Along these lines, while we may support an advisory council to provide guidance and monitor payment reform, we do not believe that the government task force proposed in the report is the structure that should be established.

We believe that the suggestion that the responsibility of the task force should include among their responsibilities "determine appropriate levels by payer, hospital and inpatient/outpatient service type" as well as a goal of "standardization across payers" with regard to payment reform has the potential to stifle innovation and create a government rate-setting type structure with regard to hospital payment rates. We do not believe this is the approach the state should move to in addressing payment reform.

**Blue Cross & Blue Shield of Rhode Island Comment regarding Recommendation 2 –
Establish a Provider Payment Reform Task Force in Statute.**

BCBSRI does not support the purpose as described in full. This task force, described as consisting of the EOHHS, the Director of Medicaid, the Office of the Health Insurance Commissioner, the Department of Health, and the state employee purchasing director, could have value, but the purposes most appropriate for such a group should be described in this way:

As a public body, the Task Force would be subject to all appropriate open meetings and administrative procedure laws. Its charge would include monitoring payment reform efforts regionally and federally; studying and recommending methods to improve consumer education about healthcare pricing and quality; and coordinating provider payment reform efforts across Medicaid and public employee plans with the goals of: coordination with Medicare payment and reform and improved population health, patient experience of care, and system efficiency. To ensure that key stakeholders are involved in the process, the Task Force would be asked to establish a Provider and Payor Advisory Council. The Provider Payment Reform Task Force would be required to provide regular reports to the General Assembly on their efforts.

**3. Effect the Transition Away from Fee-for-Service Payment Model
Toward Alternative Payment Models That Promote Efficiency,
Effectiveness and Quality of HealthCare**

The fee-for-service model is a payment mechanism wherein a provider is paid for each individual service rendered to a patient (see page 9). Providers who emphasize wellness and preventative medicine, help individuals manage chronic medical issues, work to significantly reduce hospital readmissions, or make other efforts to improve health and reduce system costs, are not rewarded for these efforts under a fee-for-service model and are, in fact, penalized under

it. Critics¹⁸ of the fee-for-service system contend that it inflates costs, does not improve care, and has become outdated. As described previously, the Health Insurance Commissioner's July 2010 Rate Factor standards¹⁹ would require that health plan contract terms with hospitals utilize payment methodologies other than fee for service. In addition, several hospital contracts in Rhode Island are based, at least in part, on alternative payment methodologies, as are both public programs, Medicare and Medicaid.

Building on these efforts, the Commission recommends expediting the full transition away from fee-for-service payments by requiring, beginning in March 2012, that insurer contracts with hospitals and physicians must include an *optional* alternative payment structure beyond fee-for-service, such as global payments or bundled payments, that will encourage doctors, hospitals, and other providers to focus on overall health, coordinate with and facilitate payment reform projects in federal healthcare reform for Medicare and Medicaid, and improve the efficiency, effectiveness and quality of healthcare delivery. The Provider Payment Reform Task Force would further be asked to monitor the impact and outcome of these efforts, along with any additional costs associated with the transition, with the possibility of requiring a complete transition away from fee-for-service payments by 2014.

4. Monitor and Participate in the Legislative Process on Increased Transparency in the Hospital Rate Setting Process

The issue of disparity in how hospitals are reimbursed for the care they provide was a key focal point for the Commission's discussion. To address this disparity and ensure the hospital reimbursement rates correctly reflect the true cost of care and are not artificially inflated, or deflated, because of the abundance, or lack, of market leverage by a hospital, certain members proposed significantly increasing transparency in the hospital rate setting process. In his presentation before the Commission, for example, Tom Breen of South County Hospital proposed enhancing the Health Insurance Commissioner's regulatory oversight to review, and amend, approve, or decline, contracts between hospitals and insurers if they did not include fair and comparable rates as compared to other hospitals. Under the proposal, the Commissioner would be allowed to publicize these contract comparisons. Supporters of such an approach argue that increased transparency would bring to light any unjustified disparities between hospital reimbursement rates. Advocates further contend that rate transparency would allow for a more 'level playing field' among providers, would encourage efficient use of healthcare resources, would improve quality, and would provide consumers the information they need to make decisions about how and where to spend their healthcare dollars – hospitals requesting large reimbursement increases would have this information public which would mitigate against inflation and compel all parties to make sure their 'numbers' are fair and accurate. They view legislation requiring transparency in the rates set between hospitals and insurers as a matter of treating all hospitals equally and fairly and believe such legislation would provide downward pressure on hospital costs and would result in improving and stabilizing health insurance reimbursement rates.

¹⁸ <http://www.dailyfinance.com/story/is-fee-for-service-what-ails-americas-health-care-system/19311085/>

¹⁹ Office of the Health Insurance Commissioner, July 2010 Rate Factor Decision.

[http://www.ohic.ri.gov/documents/Insurers/Regulatory%20Actions/2010_July_Rate_Decision/2_%20Conditions%20Summary.p
df](http://www.ohic.ri.gov/documents/Insurers/Regulatory%20Actions/2010_July_Rate_Decision/2_%20Conditions%20Summary.pdf)

Opponents of proposed rate transparency measures contend that they are unnecessary, would *raise* and *destabilize* hospital reimbursement rates, and fail to address the real reimbursement challenge facing hospitals, which are the public payers of Medicaid and Medicare. As mentioned previously, some Commissioner members contend that the Health Insurance Commissioner's January 2010 report on rate disparity does not take into account all factors that may influence reimbursement rates and point out that other studies have found that 'overpayment' to hospitals was not a product of market size but rather depended on geographic location. Thus, the call for transparency as a means to diminish disparities based on market size, they contend, is based on false assumptions.

Opponents also argue that transparency alone, for example the publicizing of negotiated reimbursement rates between hospitals and insurers, would only serve to inflate costs across the healthcare system as lower-reimbursed hospitals simply demand the same rates that highest-reimbursed hospital receive, without any movement in the other direction. During his January 10th testimony before the Commission, Domenic Delmonico of Care New England Health System remarked that affiliated hospitals do not oppose transparency but that for transparency to be effective and fair; *all* costs that a hospital faces must be recognized. Disclosing to a public commission what insurers pay the hospitals without taking into account other variables would result in incorrect and misleading conclusions that would raise costs.

Lastly, opponents of currently proposed transparency measures argue that commercial insurers, in some cases, represent less than 30% of a hospital's payer mix and that the biggest 'piece' of the reimbursement 'pie' is Medicare and the second biggest 'piece' is Medicaid, not private insurers. Further, they contend there has been a decades-long cost shift from these public payers to private insurers and that true payment reform to help ensure the financial stability of hospitals should focus on public payers.

As some members of the Commission have strongly endorsed increasing transparency in hospital rate setting, while others have equally opposed such measures – the whole of the Commission neither supports nor opposes legislative efforts to increase hospital rate transparency. Rather, the Commission encourages the continued study and review of the issue and expects that the information contained in this report will help to guide and assist these deliberations going forward. Efforts in the state concerning rate transparency happen as the federal government, as provided in the 2010 Affordable Care Act, begins to offer an “unprecedented level of scrutiny and transparency” over health insurance rates²⁰. During the January 2011 General Assembly Session, legislation has been introduced that would mandate public disclosure of hospital reimbursement rates by insurers. While consensus on this issue is not expected, the Commission expects that its work will inform consideration of this legislation and/or lead to new proposals regarding the issue of rate transparency.

²⁰ 'Shining a Light on Health Insurance Rate Increases' <http://www.healthcare.gov/news/factsheets/ratereview.html>. Accessed on February 24, 2011

**UnitedHealthcare Comment regarding Recommendation 4 –
Monitor and Participate in the Legislative Process on Increased Transparency in the
Hospital Rate Setting Process.**

UnitedHealthcare has been a proponent of consumer-based transparency for some time. We currently provide our members with a significant amount of quality and cost data to our members so that they can make more informed health care decisions. However we have not seen sufficient evidence that hospital contract transparency across payers more broadly has had any impact in reducing health care spending. In fact, we believe that such transparency has the potential to be inflationary by placing pressure for hospitals to demand payments at the highest end of the reimbursement spectrum.

5. Require the Designation of Primary Care Provider

Designating a primary care provider has been shown to greatly improve health outcomes by making such providers the central figure in the delivery and coordination of patient care. Designating a primary care provider and actively participating in one's care with that provider allows the provider to serve as a medical/health care 'home' for patient care - organizing a variety of patient healthcare needs and responsibilities in one physical 'place'; monitoring the 'full picture' of a patient's health in a way that specialized providers can not; and establishing a stronger relationship with the patient to better recognize and respond to their mental, social, and physical healthcare needs. Lastly, countless studies have indicated that improving and expanding primary care is perhaps the most impactful step toward containing healthcare costs.

In proposing this recommendation, the Commission recognizes that, in addition to physicians, other health care professionals, particularly nurse practitioners, can and do provide primary health care to patients and serve as their primary care provider. As demand on the healthcare system increases with the continued implementation of health care reform and the aging of the Rhode Island population, such professionals can be expected to play an even greater role in the deliver of primary care to Rhode Islanders. As such, the Commission considers the term primary care *provider* as meaning any licensed provider with a professional history of providing primary health care services.

To effectively coordinate patient care and contain healthcare costs, it is important for insurers and hospitals to know who a patient considers their primary care provider. Several hospitals, as well as Quality Partners of Rhode Island, testified that identifying and engaging primary care providers in the transition of patients out of hospital care is a critical factor in improving the quality, safety, and value of these transitions and reducing readmissions. In their presentation, Quality Partners specifically mentioned poor communication between providers, including the inability to identify a patient's primary care provider, as a core problem facing care transitions.

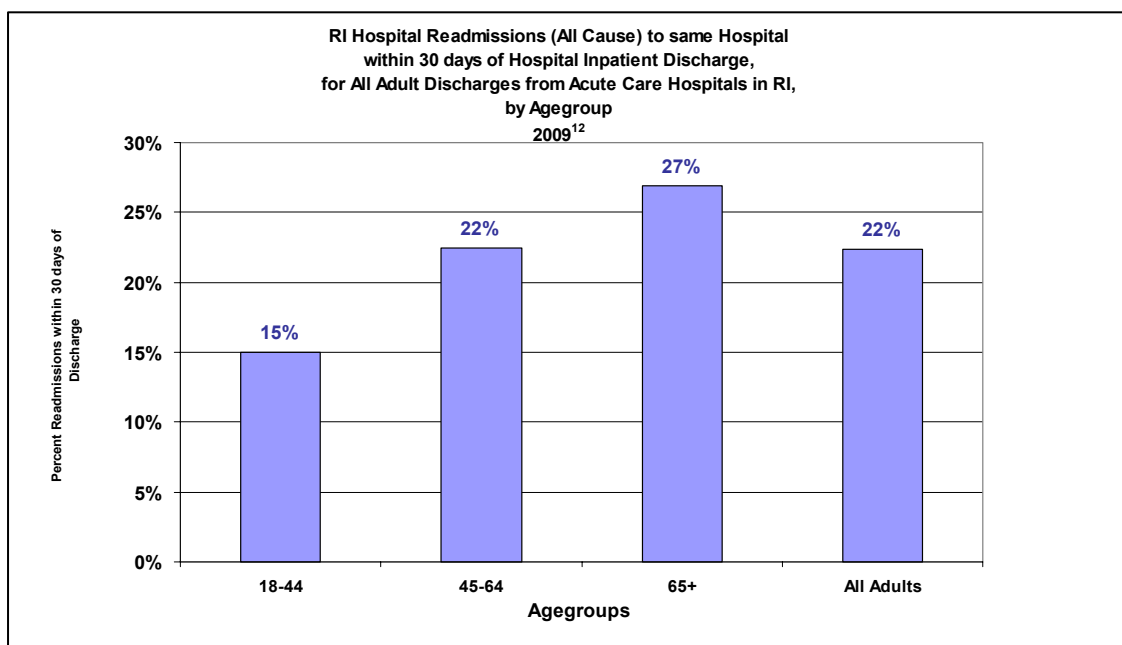
The Commission supports requiring individuals to designate a primary care provider. It is important to note, however, that there are many additional questions that must be answered and considered before full implementation of this recommendation. First, the simple act of identifying a primary care provider does not make this relationship a reality – patients must take responsibility for their own health and work with their primary provider to coordinate this care. There are some instances where a patient may identify a physician or nurse practitioner as their

primary care provider despite having not visited the professional's office in many years; it is unfair, in such an instance, to expect the provider to effectively coordinate the patient's care or answer questions about that patient's health simply because he/she was so identified. Likewise, there are patients who, though they may be active in managing their own care, change their primary care provider frequently; still others receive much of their care from a specialist and may consider the specialist their primary provider, despite the fact that such practices are not designed to function as the afore-mentioned medical 'home' to coordinate disparate patient care. Lastly, while no Commission members oppose the concept of patients having a primary care provider, insurers expressed resistance to listing these providers on the patient's health insurance card, as was proposed in legislation considered during the 2010 session. These insurers cite the same concerns listed previously, as well as the administrative burden of reprinting thousands of membership cards, ensuring accuracy, and keeping provider information up to date.

While these concerns are valid and must be resolved before any legislative or regulatory requirement can take effect, the Commission nonetheless supports the principle of requiring patients to identify a primary care provider, and actively managing their care with that provider. Such a designation across the healthcare system can serve as a potential first step for a gradual transition to a primary care-based insurance product, should the state chose to make such a transition. In recent years, Lt. Governor Elizabeth Roberts has championed legislation that would place this requirement in statute. Commission members Senator Joshua Miller and Senator Roger Picard have expressed interest in introducing similar legislation during the 2011 session. Designating a primary care provider

6. Promote and Expand Hospital Safe Transitions Programs

According to data presented by the Department of Health²¹, over 1 in 5 adults discharged from acute care hospitals in Rhode Island are readmitted within 30 days; for adults over the age of 65, this jumps to almost 30%. The issue of hospital readmissions has become a key point of



²¹ December 15, 2010 – 'Transparency in Healthcare Delivery and Financing, Dr. David R. Gifford, Director- Rhode Island Department of Health. Notes: All Cause Readmissions within 30 days of Discharge to the Same Hospital, RI Residents, Acute care Hospitals Only Source: Hospital Discharge Database, Rhode Island Department of Health

discussion nationally regarding quality, patient safety, and controlling excessive costs.

Quality Partners of Rhode Island presented before the Commission regarding their collaborative effort to improve patient transitions out of hospitals, describing this as an area where there is significant room for improvement and potential for cost savings. A key challenge in current transitions of care is insufficient communication - between the provider and the patient, the patient and the provider, and, perhaps most importantly, among the providers themselves. Quality Partners describes the Safe Transitions project on their website²²:

The Safe Transitions Project furthers Rhode Island's leadership around care coordination, already evidenced by the Continuity of Care Form. The project:

- Focuses on patients' discharge from the hospital to other care settings,
- Promotes cross-setting communication, and
- Ultimately, aims to improve patients' transition experiences, self-management skills, and outcomes.

The project includes patient- and systems-level interventions focused on Medicare patients at high risk for re-hospitalization. These include:

- Providing in-hospital computerized education prior to discharge,
- Coaching patients for 30 days after discharge,
- Working one-on-one with home health agencies, hospitals, and nursing homes to implement best practices, and
- Fostering cross-setting communication.

The project also focuses on community engagement.

The Continuity of Care (CoC) form referenced in the Quality Partner's description is a form developed by the RI Department of Health that is "used to communicate health information and provide for the safe transition of individuals who are transferred from one health environment to another (e.g. from a hospital to a nursing home or to home nursing care; from a nursing home to a hospital). The form provides an important opportunity to ensure high quality services, patient safety, and patient-centered care."²³ The CoC includes important information including medications the patient has been prescribed and their proper use, activities that are allowed or should be avoided after discharge, an analysis of a patient's cognitive skills for caregivers to review, whether the patient has an advanced directive, and other vital care information.

Quality Partners reported that, since its implementation in January 2009, the Safe Transitions project in Rhode Island, limited to at-risk Medicare Fee-for-Service patients within six hospitals (at the program's peak), has thus far achieved documented success in reducing readmissions, and lowering the resultant costs to hospitals. They further report that participating hospitals, insurers, and other providers have given positive feedback on the program and view it as a worthwhile candidate for expansion.

²² Quality Partners of Rhode Island. Accessed: February 8, 2011.
<http://www.qualitypartnersri.org/cfmodules/objmgr.cfm?Obj=CMSContentPage&pmid=1779&mid=1779&cid=161&clear=yes&bc=Safe%20Transitions%20Project%20&bcl=1>

²³ <http://www.health.ri.gov/healthcare/about/continuity/index.php>

In concluding its presentation, Quality Partners offered a series of recommendations, endorsed by their Leadership Advisory Board, for the Commission to consider regarding care transitions. These recommendations included (1) expanding the mandated transmission of the Continuity of Care form to include physicians' offices; (2) convening a commission to identify next steps to create a physician contact information database; and (3) increasing the adoption and measurement of evidence-based best practices.

The Commission recommends that the Department of Health expand the regulatory mandate regarding Continuation of Care form transmission to include primary care providers; Quality Partners reports that these providers *want* to be included on this transmission and that such inclusion is considered a best practice in transitions management. The Commission also endorses the creation of a commission to explore the feasibility, potential benefits, and possible challenges, of developing a physician contact database whereby hospitals can quickly identify and locate a patient's primary care provider when such information is not otherwise available. The Commission further supports the continued study of aligning hospital reimbursement with reducing readmission rates and the practices by providers that promote them. Lastly, to encourage the adoption of best practices in discharge planning and transitions by all hospitals, the Commission recommends passage of legislation requiring each hospital operating in the state of Rhode Island to submit to the Director of Health either evidence of the hospital's participation in a high-quality comprehensive discharge planning and transitions improvement project operated by a nonprofit organization in this state; or, a plan for the provision of comprehensive discharge planning and information to be shared with patients transitioning from the hospitals care. Such a plan would be required to contain the adoption of evidence-based best practices including, but not limited to, patient education, coordinated provider communication, and expanded transmission of Continuity of Care forms.

It is important to note that, although no members disagreed with the importance of improving hospital care transitions, some argued that *results*, however they are achieved, are what really matters. A hospital may follow only some of the listed best practices, or try something entirely different, and if this approach results in low readmission rates – the ultimate goal is achieved.

7. Identify Permanent Funding for the Department of Health All Payor Claims Database (APCD)

In 2008, the Rhode Island General Assembly enacted legislation that directed the Department of Health to develop the capacity and infrastructure to produce and disseminate information about the quality and efficiency of Rhode Island's healthcare delivery system by developing and maintaining a "healthcare quality and value database" - in application, this database is referred to as an 'All Payor Claims Database (APCD)'. The data included in this database is intended to provide information and public policy reports about the use and costs of healthcare services in Rhode Island. Nationally, APCDs are statewide public databases that are usually run by state health departments with operational assistance from a contracted third party IT vendor. The data provided to the database represents paid claims to enrollees/members, and is supplied by both commercial insurance carriers and public payors. This data is deidentified to assure confidentiality.

Eleven states have APCDs in different stages of maturity: some have been around for years; others are just starting data intake. 8 are legislatively authorized; 3 are voluntary. At least 8 other states are either moving forward with implementing an APCD, including Rhode Island, or are in the process of reviewing options. All New England states currently have operational APCDs with the exception of Rhode Island and Connecticut.

From a public policy perspective, APCD's can be used to:

- Inform Certificate of Need and Change in Effective Control decisions
- Inform health policy discussions and decisions
- Evaluate the impact of changes, such as payment reform, insurance reform, etc., on quality, costs, and outcomes
- Provide information about the comparative cost and quality of care in various treatment settings
- Inform efforts to improve the quality and affordability of care, and
- Inform efforts to strengthen primary care and chronic care management
- Evaluate the effectiveness of programs designed to improve quality & cost²⁴

Other states use their APCD data to:

- Create baselines for measuring the effects of quality improvement initiatives and public health interventions
- Enable analysis of cost, quality, and utilization
- Promote transparency about health care payment and quality
- Drive tools such as the "Prometheus" payment model that looks at relative use of health care resources
- Derive consumer- friendly information about comparative costs of care, and
- Permit research about health care delivery across different payers and settings

Further, other states *expect* to use their APCD data to:

- Create baselines for measuring the effects of quality improvement initiatives and public health interventions
- Enable analysis of cost, quality, and utilization
- Promote transparency about health care payment and quality
- Drive tools such as the "Prometheus" payment model that looks at relative use of health care resources
- Derive consumer- friendly information about comparative costs of care, and
- Permit research about health care delivery across different payers and settings

Under the Department of Health's statutory authority (R.I.G.L Chapter 23-17.17), the state is partnering with the Rhode Island Quality Institute to develop a statewide APCD using grant funding. Under project funding through the federal Beacon Communities grant, this database is being developed and should be operational in early 2012; however, the enabling statute for the database does not provide funding for its *continued* operation. As such, it is necessary to identify

²⁴ Health Cost Containment and Efficiencies- Brief for State Legislators. National Conference of State Legislators. June 2010

and develop a sustainable funding stream to maintain and operate the APCD and conduct analysis and reports.

Recognizing the vital role a comprehensive all payor claims database can play in monitoring, evaluating and improving quality of care and access to health services, informing policy decisions, and increasing public awareness of key health quality and cost measures, the Commission recommends that the state identify and develop a permanent and sustainable funding source for the All Payor Claims Database that ensures its continued operation and functionality, including resources for public analysis and reports

Blue Cross & Blue Shield of Rhode Island Comment regarding Recommendation 7- Identify Permanent Funding for the Department of Health All Payor Claims Database

BCBSRI is generally supportive of the concept of an all Payers Claims Database. The Commission, however, did not hear substantial information about specific uses of the All Payer Claims Database in Rhode Island. There is potential value that could result from the implementation of an APCD in Rhode Island, but more specifics need to be defined regarding how the data would be used, the costs of the program, the protections for personal privacy, and integration with the Health Information Exchange. The value of the APCD should be analyzed before imposing additional costs on the system, and these costs and work effort should be prioritized against other health system needs (for example, see the suggestion regarding coordinate health system planning).

8. Identify Permanent Funding for the HealthCare Planning and Accountability Advisory Council, and recommit to the goals and findings of the Coordinated Health Planning Act of 2006

Comprehensive statewide healthcare planning was frequently mentioned as a key recommendation among the Commission for containing costs and improving healthcare quality. Rhode Island's current healthcare infrastructure is fragmented, with an array of state departments and offices carrying out healthcare planning, along with a myriad of private efforts, all with a lack of coordination. Because of this lack of coordination, certain healthcare services may be duplicated, over-utilized in some parts of the state, or significantly *under*-utilized in other parts of the state. This failure to match what Rhode Island's healthcare system 'needs' to what the system 'has', and 'where the system has it', fails to improve quality and may significantly raise overall healthcare system costs.

An essential component of health planning is resource allocation. In Rhode Island, much of this allocation is conducted through the Certificate of Need program. Certificate of Need is the process by which the Department of Health engages in a public process to decide whether there is a need for significant expansions in or new healthcare services, facilities, or equipment before offering approval or rejection of such service, facility, or equipment. The program is designed to prevent unnecessary duplication of expensive medical services and equipment; and to promote access, safe and adequate treatment, and quality improvement in healthcare facilities. Funding for the Health Services Council and the Certificate of Need program is eliminated in the Administration's proposed FY 2012 budget.

Another component of strategic healthcare planning includes the accurate assessment and forecasting of healthcare resource needs, particularly hospital ‘bed’ capacity. An interesting dynamic emerged in Commission testimony wherein several parties posited that there is currently an excess supply of hospital beds within the healthcare system, while acknowledging that, as Rhode Island’s population quickly ages and approaches retirement in the coming years, there may be a *shortage* of hospital beds to meet demand. The Commission also hear testimony that countered this assumption, based on advances in technology and other factors. Such variables and uncertainties demonstrate the need for forward-looking comprehensive statewide planning that can sufficiently take into account the current demand and future needs of the state’s healthcare system.

In 2006, the General Assembly passed the ‘Rhode Island Coordinated Health Planning Act’. Among other findings, the Act recognized the need for coordinated data collection and analysis; the need for coordinated and informed healthcare planning; the need for better coordination and cooperation among state departments and agencies involved in healthcare planning; and the need to professionalize the Health Services Council and revitalize the certificate of need process. The Assembly further found that Rhode Island’s small size makes the state “the perfect laboratory to create a unified healthcare system, planned and coordinated with a functioning public/private partnership, with broad representation of all of the healthcare stakeholders.”

The Act establishes the Health Care Planning and Accountability Advisory Council. Among other powers, the Council was authorized to develop and promote studies, advisory opinions, and a unified health plan on the state’s healthcare delivery and financing system. No funding was explicitly supplied for the Council in statute. Rather, the Act authorized the Department of Health to apply for and receive whatever private and/or public funds were available to carry out the goals and requirements of the Act. Recognizing the same aforementioned need for coordinated planning as described in the Coordinated Health Planning Act of 2006, the Commission recommends that the state identify and develop a permanent and sustainable funding source for the Health Care Planning and Accountability Advisory Council and the Health Services Council. The Commission further recommends that the Governor, the General Assembly, and the Secretary of the Executive Office of Health and Human Services and the Director of Health, in their capacities as co-chairs of the Council, recommit themselves to the findings and goals of the Rhode Island Coordinated Health Planning Act of 2006, and promote the development of a comprehensive unified plan for the state’s healthcare delivery and financing system.

9. Improved Behavioral Health Interventions

Through testimony the Commission learned of the state’s costly, and sometimes unnecessary, overreliance on hospital emergency rooms for behavioral health evaluations. In some instances, community-based settings may be more appropriate, less costly, and more effective in delivering such interventions and treatment, yet the state does little to promote such settings as an option in emergency behavioral healthcare.

Two key populations for whom community evaluations may be most appropriate and effective are children, and adults with substance abuse issues. Currently, the Department of Children, Youth, and Families (DCYF) operates the ‘Kids Link’ emergency services hotline which is designed to offer a 24-7-365 (all day, year-round) statewide resource for families to assist them in accessing necessary evaluation and/or treatment services for a child and/or family. Additionally, DCYF regulations for certification of “Mental Health Service Interventions for Children, Youth and Families” include the expectation that licensed crisis intervention providers will conduct evaluations in the community and make referrals to community-based services.

The Commission recommends legislation that realizes the full potential of the ‘Kids Link’ hotline as a tool in promoting the use of community-based evaluations for a child’s mental health, by requiring the hotline to direct families with children in need of behavioral health evaluations to community-based settings unless a hospital emergency admission is voluntarily sought or deemed medically necessary. The goal of any legislative change would be to preserve flexibility in the provision of emergency care, while promoting the concept of community-based settings as ‘option one’ for behavioral care interventions. Doing so can lower costs, improve outcomes, and preserve limited emergency room resources.

While ‘Kids Link’ and the afore-mentioned Mental Health Intervention regulations provide the framework for a more community-based intervention system for children, the Commission was informed that there is little infrastructure in place for developing a similar system for adult mental health or substance abuse interventions. While in the long term, establishing such a comprehensive care system should remain a key priority for the state, a more immediate but still significant change would be the revision of Rhode Island General Law Chapter 23-1.10-10 to allow intoxicated persons, either voluntarily or in police custody, to receive care in *non-hospital* settings with *non-physician* medical staff (still following clearly defined medical protocols); who can then determine the necessity of transferring a person to an emergency room. Rhode Island law currently requires such persons be evaluated in a hospital emergency room, regardless of whether the setting is appropriate or not. As mentioned previously, community-based settings may offer more appropriate and less costly care for substance abuse patients.

The Commission recommends legislation that would amend state statutes pertaining to the treatment of intoxicated persons to make them more flexible by allowing, but not requiring, such persons to be evaluated in community-based settings if such a setting is deemed appropriate.

10. Explore the Feasibility, Potential Benefits, and Challenges of Interstate Certificate of Need Coordination

Established more than 30 years ago by the federal and state governments, the Certificate of Need (CON) program is intended as a way to control healthcare costs by regulating major capital expenditures and managing healthcare service capacity. As described earlier on page 15, Certificate of Need is the process by which the state, or the federal government, determines whether there is a need for any new healthcare services, facilities, or equipment before offering approval or rejection of such service, facility, or equipment. The program is designed to prevent unnecessary duplication of services and promote access, safe and adequate treatment, and quality improvement in healthcare facilities. Arguments for and against statewide healthcare planning systems such as the Certificate of Need program can be read on page 9 of this report.

Research indicates that currently, all New England states, including Rhode Island's immediate neighbors of Connecticut and Massachusetts have some form of Certificate of Need program.²⁵ Given the close proximity of these states and their high population density, some question whether these individual state CON programs can effectively achieve the stated purpose of preventing unnecessary duplication of services and promoting access, treatment, and quality in healthcare facilities, if they operate separately and fail to coordinate their efforts across state lines. A Rhode Island-based healthcare provider, for example, may offer a necessary service that addresses a key healthcare need in a part of the state, yet that service might be duplicated less than a minute down the road in Massachusetts because of a lack of coordination between state Certificate of Need programs and review. No one seeks to relinquish the right of Rhode Island, or any other state, to make its own decisions regarding the distribution of healthcare services and facilities within its borders; however the lack of coordination between Certificate of Need programs and the duplication of health services along state lines are counter to the expressed purpose of the Certificate of Need program. The Commission therefore recommends that the Director of the Rhode Island Department of Health, consistent with his or her statutory authority and responsibilities for healthcare planning and the state Certificate of Need program, study the feasibility, potential benefits, and challenges of an interstate Certificate of Need coordination program, and reach out to his or her counterparts in Rhode Island's neighboring states regarding the matter.

²⁵ National Conference of State Legislatures- Certificate of Need State Laws
<http://www.ncsl.org/IssuesResearch/Health/CONCertificateofNeedStateLaws/tabid/14373/Default.aspx>

**Statement by Lifespan Regarding the Special Commission to Study Cost Containment,
Efficiency and Transparency in the Delivery of Quality Patient Care
and Access by Hospitals**

Lifespan appreciated the opportunity to participate on the Special Commission to Study Cost Containment, Efficiency and Transparency in the Delivery of Quality Patient Care and Access by Hospitals. We believe the Commission attempted in good faith to meet its charge and explore issues that were legislatively outlined. As you know, the Commission was the result of disagreements over various pieces of legislation that have been introduced over the past several years that exposed vast differences of opinions among various hospitals over important issues, especially issues surrounding reimbursement. We applaud the efforts of Senators Miller and Picard to tackle these difficult issues with a sense of fairness and openness. We would also like to acknowledge the work of Senate Policy Analyst Robert Kalaskowski and his evenhanded accounting of the discussions that ensued throughout the course of the Commission's work; it is no small task to capture the opinion and points of view that are debated and discussed in a legislative commission format.

Throughout the proceedings, each member, quite naturally, brought different and unique insights to the issues that were covered and the tone and decorum were respectful. However, we were somewhat dismayed that a draft report was presented to the Commission members before any discussion ensued about directional findings and the scope of the report. Despite this misgiving, people were given time to state concerns and express opinions.

In reviewing the draft report and deliberating over its content and findings, Lifespan has concluded it cannot fully endorse many of the Commission's recommendations. We do agree with several policy directions outlined in the report. For instance, we support a movement away from fee for service payments to alternative payment methods. Additionally, while we agree in concept with individuals identifying primary care providers to increase care coordination, we are concerned about the mechanism to achieve that goal. Further, we support continued efforts to promote and expand safe transitions programs, and our hospitals are already involved in such programs and we will continue to participate in pilots in this area. Finally, we support the recommendation to identify permanent funding for the Department of Health All Payer Claims Database.

Nevertheless, our main discomfort and concern rest in what appears to be a central premise (and persistent discussion around this point) that long simmering differences among various hospitals within the state can be addressed by rectifying the perceived inequities of the current reimbursement levels among hospitals—without regard to size, service mix, academic reach and major differences in the safety net function provided by hospitals. Moreover, despite considerable discussion, the report's recommendations will do little to alter the current financing structure of hospitals struggling to confront dwindling inpatient census, while, at the same time, facing major upheavals in payment methodologies emanating from private and public payers. The market is extremely fluid and dynamic, yet the report suggests we can wait while we develop a more strategic state planning process. We are concerned that, as we wait for a plan, providers in other states will act, placing us at an even greater competitive disadvantage.

There was also scant discussion around the relationship between volume and payment dynamics; increasing reimbursement levels without a concomitant increase in volume will do little to improve a hospital's financial performance. This factor is exacerbated by a population that is not growing, as most hospitals are essentially (aside from importing patients from neighboring states) competing for the same patient base. Moreover, there was also, in our opinion, a noticeable lack of investigation surrounding the accelerating pace of change confronting the hospitals in Rhode Island, at a time when cost stabilization and affordability are the major preoccupation of employers and individuals. State and municipal governments are also struggling with major budgetary concerns surrounding health care costs.

Much of the preoccupation with hospital reimbursement dynamic is based on the Office of the Health Insurance Commissioner (OHIC) report on hospital financing. Shortly after its publication, we identified several major methodological flaws and incorrect policy statements that were part of the report findings—among them a reliance on a small sample of inpatient data; excluding outpatient activity; ignoring the revenue associated with academic programs; and a finding that there was no evidence that Lifespan hospitals' provide a disproportionate level of uncompensated care services in Rhode Island. (This OHIC finding is in fact disputed by studies published by the Department of Health which clearly demonstrate such disparities). Moreover, some hospitals currently receive global payments from insurers that were not implemented at the time of the OHIC study. Also, the study is silent on whether or not it examined the possibility that some hospitals have received payments over the years by insurers that augmented their contract terms. If they have indeed occurred and were not acknowledged, this fact could distort and alter payment differentials. Seemingly unaccounted for are payments made by local insurers to out of state hospitals; care migrating across state lines is not only likely to be more expensive (and should be included in the study) but also represents a lost economic opportunity for the state.

Our objective here is not a point by point refutation of that study; rather, we merely wish to emphasize that there are many factors that account for the current hospital reimbursement system in Rhode Island and this study, in our opinion, did not capture those complexities and distortions satisfactorily enough to draw consistent conclusions and make fair policy decisions.

That said, we do agree that the current system of health care financing has set us on a course of unsustainable expenditures that cannot be maintained and that the fee for service payment system must change. Rhode Island's per capita health care expenditures are among the highest in the nation and our health insurance premiums are likewise among the highest. (It is interesting to note that, as the Commission heard in testimony, one of the major tenets of the Massachusetts Health Care Quality and Cost Council is to reduce per capita expenditures in Massachusetts.) These factors, among others, led Lifespan to sign its most recent Blue Cross contract with terms consistent with the parameters outlined by the OHIC, despite our own misgivings about the regulatory legitimacy of those directives. We recognize that costs stabilization, improved quality and access and a balanced delivery system are prerequisites in redesigning care in Rhode Island.

In our opinion, a number of inescapable facts surrounding Rhode Island's hospital system had not been adequately addressed or acknowledged during the Commission's deliberations that have exacerbated hospital performance in Rhode Island. There has been a substantial drop in inpatient hospitalizations and patient days across the across the state. In fact,

hospital discharge data show that, over the past four years, utilization has declined to the point that **more than 120 beds have been essentially removed from the system**. We see no signs this trend will abate, as affordability issues, health care reform initiatives (both state and federal) and system reengineering contribute to a continuing reduction in bed need across the state. (This change in demand will cause the average cost per unit of service to rise most especially in hospitals which already have low volume, unless there is a change in hospital capacity across the state.)

A review of the sizable number of Ambulatory Sensitive Conditions (conditions that if identified and treated earlier in out-patient settings would avoid hospitalization) that are treated in hospitals in Rhode Island suggest a substantial number of admissions and patients days are likely to be eliminated; these reductions do not take into account days lost to changes in Medicare's readmission payment policies. In addition, lengths-of-stay in Rhode Island hospitals are higher than many states and a large variability in levels of intensity of end-of-life resources are clearly evident in our hospitals. Likewise, emergency department volume is vulnerable to redirection with different incentives and alternative care models.

Equally important, the lack of size of many hospitals in our state places them at a distinct disadvantage in the context of declining utilization. The *perceived* need to sustain the entire hospital infrastructure with a relatively low average daily census is inherently expensive since hospital fixed costs are very high. A number of hospitals have average daily census figures of less than 80 patients per day. Yet each supports a sizable infrastructure that not only requires maintenance but upkeep and physical plant enhancements to remain current, which could further exacerbate and increase future hospital fixed costs systemically in Rhode Island. Finally, some hospitals have substantial debt and adopted financing strategies that additionally burden their margins and overall financial sustainability. We also feel compelled to point out that hospital management and boards made decisions regarding programmatic and infrastructure expansions and enhancements that contribute to their current financial and operational performance (let alone the decision made regarding whether they should remain stand alone or merge to gain efficiencies and other potential benefits). We presume they were cognizant of the long-term affordability and sustainability challenges at the time the program initiatives, expansions and financing option were recommended and executed.

It is also important to note that there exist vast differences in size, complexity, service mix and academic depth that account for costs and payment differentials. Unique services available at Rhode Island Hospital serve, in effect, a public utility function; they exist only there and serve the entire state—the most obvious of which is its Level 1 trauma service designation. Of course, there are other examples, such as transplant services and the sizable number of high intensity beds (exceeding the total number of staffed beds in many community hospitals). Supporting over 550 academic residents, its teaching programs not only provide needed clinical services to patients without the ability to pay, but anchor the knowledge economy in the state through its academic faculty that attracts over \$80 million yearly in research funding and support over 850 research employees. Additionally, Rhode Island Hospital makes substantial investments to support and nurture these activities.

We think it is important to note that, at a time the state is interested in growing a knowledge economy to help anchor its economic revitalization strategy, Lifespan affiliated academic institutions are key players in any attempt to expand and enhance the knowledge district. No

state has a robust life sciences enterprise without the presence of a thriving and successful academic medical complex. Working with our academic partner Brown University and our growing relationship with the University of Rhode Island, we are anxious, despite increasing financial pressures, to continue to nurture this enterprise as an essential component to economic resurgence in our state.

Rhode Island Hospital also disproportionately serves patients in Rhode Island without health insurance. Only two hospitals in the state provide more services to uninsured and self pay patients than the market share of hospital services they represent. Rhode Island Hospital represents approximately 27.5 percent of Rhode Islander's use of in state hospitals, but provides care to about 44 percent of Rhode Islanders who are uninsured or self pay. In FY 2010, Rhode Island Hospital's estimated costs for providing uncompensated care totaled approximately \$68 million. (System wide, in FY 2010 Lifespan provided approximately \$92 million in uncompensated care at cost.)

In addition, payer mix also impacts profitability and there are likewise differentials in this category that account for reimbursement variability across the state. Simply put, the greater the percentage of patients a hospital serves that are covered by governmental payers (which are not covering the cost of care) or uninsured and self pay, the greater the need for payment from commercial payers to cover the shortfalls. Without a thorough and exhaustive examination of all these factors, discussion surrounding payment parity ignores major factors and distortions in our current reimbursement environment. The disproportionate role Rhode Island Hospital plays as the major safety net institution in Rhode Island (in a state with no publicly funded acute care hospitals) is central to this discussion.

In closing, we respectfully point out that much of what was discussed and recommended will not alter the current system of care and its basic financing methodology. As we pointed out in the beginning of our comments, quite a few, in our view, simply reinforce the status quo—at a time when Medicare and other payers are driving serious changes in care delivery and value based purchasing methodologies. Moreover, while we conceptually endorse a more active state planning process, regional forces and opportunistic provider groups are moving quickly to execute strategies to increase their penetration into Rhode Island--while physician alignment efforts and Accountable Care Organization creation in our region could make penetration by Rhode Island based health care organizations more difficult in Massachusetts and Connecticut. These factors—together with Certificate of Need programs in Connecticut and Massachusetts that are more flexible and liberal than our current program—constrain our ability to respond prudently yet quickly enough to remain competitive. We have serious reservations about the possibility that states with different regulatory frameworks that advantage their providers will relinquish their prerogatives.

Health care in Rhode Island is at a major crossroad. Driven by unsustainable costs and high utilization rates, new paradigms of care are needed. There are pilots programs and other initiatives actively underway across our state in search of workable solutions to the cost/quality imperative. Increased payments for primary care providers; innovative chronic care management programs; improved communication by providers across the care continuum; and a movement away from fee for service to payments based on prevention, episodes of care and other patient centered approaches—all will help to redefine and reshape our delivery system. But these developments will, in our opinion, call for a greater integration of care than has historically

characterized the model in our state, if we are to eliminate waste and inefficiency and manage quality more effectively across the care continuum. We will also need to make critical choices about a hospital infrastructure that is essential to deliver cost effective, high quality care—while simultaneously aiding the state in achieving its economic goal of enhancing its knowledge economy—without threatening the economic competitiveness of other sectors of our economy and undermining state and local budget stability.

We look forward to continuing to work with members of the General Assembly as we confront major decisions along the path to an affordable, rational and sustainable delivery system. Further, we look forward to working with the Rhode Island Healthcare Reform Commission and the Executive Office of Health and Human Services as many of the issues discussed during the Commission continue to be debated and explored.

STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2010

SENATE RESOLUTION

**CREATING A SPECIAL SENATE COMMISSION TO STUDY COST CONTAINMENT,
EFFICIENCY, AND TRANSPARENCY IN THE DELIVERY OF QUALITY PATIENT CARE
AND ACCESS BY HOSPITALS**

Introduced By: Senators Miller, Algieri, and Sosnowski

Date Introduced: June 10, 2010

Referred To: Senate read and passed

- 1-1 RESOLVED, That a special senate commission be and the same is hereby created
- 1-2 consisting of seventeen (17) members: three (3) of whom shall be members of the Senate, not
- 1-3 more than two (2) from the same political party, to be appointed by the President of the Senate;
- 1-4 two (2) of whom shall be representatives from community hospitals, to be appointed by the

1-5 President of the Senate; two (2) of whom shall be representatives of hospitals affiliated with an
1-6 academic medical center that is part of a major health care system, to be appointed by the
1-7 President of the Senate; four (4) of whom shall be representatives of each of the four health
1-8 insurance providers licensed in the State of Rhode Island, to be appointed by the President of the
1-9 Senate; one of whom shall be the health insurance commissioner, or his or her designee; one of
1-10 whom shall be the director of the Department of Health, or his or her designee; one of whom shall
1-11 be the director of Human Services, or his or her designee; and two (2) of whom shall be
1-12 physicians licensed to practice medicine in Rhode Island, one to be appointed by the President of
1-13 the Senate; and one of whom shall be a registered nurse, to be appointed by the President of the
1-14 Senate. The commission shall have two (2) co-chairs from among its members, to be appointed
1-15 by the President of the Senate.

1-16 In lieu of any appointment of a member of the legislature to a permanent advisory
1-17 commission, a legislative study commission, or any commission created by a general assembly
1-18 resolution, the appointing authority may appoint a member of the general public to serve,
1-19 provided that the majority leader or the minority leader of the political party which is entitled to
2-1 the appointment consents to the appointment of the member of the general public.

2-2 The purpose of said commission shall be to study:

2-3 (1) The establishment of procedures to provide for more efficient administration of health
2-4 care services to citizens of this state, the implementation of a more efficient, transparent, and
2-5 uniform rate-approval process for the purchase of health services, in particular, health services by
2-6 hospitals, and the control of rising costs of health care in this state, including the costs of the
2-7 provision of health insurance benefits by employers, and the out-of-pocket costs of health
2-8 services to persons residing in this state;

2-9 (2) The advisability and implementation of a requirement that health insurers pay
2-10 comparable rates to health care providers, in particular, hospitals, for similar services to improve
2-11 the efficiency and effectiveness of communications among insurers and providers, to minimize

2-12 rate disparity among providers, to restore competitive balance and improve competition in the
2-13 markets for health care services in this state, and to assure the fair treatment of all health care
2-14 providers, in particular, hospitals, of similar services and the availability of cost-effective health
2-15 care services in this state;

2-16 (3) The advisability and implementation of payment methodologies that promote cost
2-17 containment, efficiency, and transparency, including global payment reimbursement for total care
2-18 per patient, rather than inequitable reimbursement and other unfair payment terms that adversely
2-19 affect quality patient care and access by reducing the resources that health care providers can
2-20 devote to patient care;

2-21 (4) The establishment of procedures for the review of provider contracts and rates, in
2-22 particular hospital provider contracts and rates, to determine if: (i) The proposed terms are
2-23 reasonable, fair, and equitable, and the rates set equitably among all hospitals without undue
2-24 discrimination or preference; and (ii) The aggregate reimbursement rates of the hospital are
2-25 related reasonably to the aggregate costs of the hospital, considering such standards, measures,
2-26 and guidelines that are relevant, each weighted as appropriate, including without limitation: (A)
2-27 Per diem payment; (B) Payment per stay; (C) Case mix adjusted payment per stay indexed to
2-28 average payment; (D) Case mix adjusted payment per stay indexed to Medicare payment; (E)
2-29 Cost per adjusted discharged; (F) Uncompensated care; (G) Teaching costs; (H) License fee
2-30 imposed by the Department of Health or other agency; (I) DSH payments; (J) Innovative
2-31 methodologists; and (K) Any publicly reported quality measures such as Department of Health
2-32 licensure surveys, CMS Core Measures, and patient satisfaction surveys;

2-33 (5) The establishment of a procedure for the disclosure by hospitals of third-party Rhode
2-34 Island insurance contracts to assure transparency and efficiency;

3-1 At its discretion, the Commission may also study:

3-2 (6) The development and establishment of a state-based health insurance exchange, as
3-3 provided under the “Patient Protection and Affordable Care Act,” H.R. 3590, signed into law

3-4 March 23, 2010, and as modified by the “Health Care and Education Reconciliation Act,” of
3-5 2010, H.R. 4872, to ensure Rhode Island is prepared to create and operate a state-based health
3-6 insurance exchange, as required by such acts, by 2014.

3-7 In making its examination and investigation, the commission shall consult with the
3-8 Rhode Island Department of Health, the Rhode Island office of the health insurance
3-9 commissioner, the Rhode Island Department of the Attorney General, the Rhode Island
3-10 Department of Human Services, health care economists, and other individuals or organizations
3-11 with expertise in state and federal health care payment methodologies and rates. The commission
3-12 shall use data and other information gathered in the course of such consultations as a basis for its
3-13 findings and recommendations.

3-14 The commission shall also consult with a reasonable variety of classes of individuals and
3-15 organizations likely to be affected by its recommendations, including without limitation, the
3-16 Hospital Association of Rhode Island.

3-17 Forthwith upon passage of this resolution, the members of the commission shall meet at
3-18 the call of the President of the Senate and organize, and thereafter, shall meet regularly with all
3-19 due diligence to carry out its purpose and finalize its recommendations as soon as practicable.
3-20 The first meeting of the commission shall be held no later than September 15, 2010. Vacancies in
3-21 the commission shall be filled in like manner as the original appointment.

3-22 The members of the commission shall receive no compensation for their services.

3-23 All departments and agencies of the state shall furnish such advice and information,
3-24 documentary and otherwise, to said commission and its agents as is deemed necessary or
3-25 appropriate to facilitate the purposes of this resolution.

3-26 The Joint Committee on Legislative Services is hereby authorized and directed to provide
3-27 suitable offices and staff for the commission; and be it further

3-28 RESOLVED, That the commission shall report its findings and recommendations to the
3-29 clerk of the Senate on study purposes (1) through (5) no later than March 31, 2011, and on

3-30 optional study purpose (6) no later than May 31, 2011, and the commission shall expire on
3-31 December 31, 2011.

Special Senate Commission to Study Cost Containment, Efficiency, and Transparency in the Delivery of Quality Patient Care and Access by Hospitals

First Meeting Summary (not intended as official minutes) – December 15, 2010

Senate President M. Teresa Paiva Weed welcomed the Commission membership and thanked them all for their participation. She pointed out the wide range of interests represented on the Commission and expressed confidence in the Commission's ability to produce worthwhile recommendations. The President appointed Senator Joshua Miller as Chair of the Commission.

Chairman Joshua Miller thanked the President for her remarks and outlined the history and purpose of the Commission. He shared his goal of meeting at least five times before March. The Chair also thanked the Commission for their willingness to participate.

- **Health Insurance Commissioner Christopher Koller** presented on recent OHIC efforts to improve efficiency in rate setting and health services purchasing (Presentation included in addendum)
- **Dr. David Gifford, Director, RI Department of Health** presented on the Department of Health's All-Payer Database (Presentation included in addendum)
- **Edward Quinlan, Executive Director, Hospital Association of Rhode Island** presented on how Hospital Rates are Set and the process by which Hospitals are reimbursement (Presentation included in addendum)

The next hearing of the Commission was discussed and scheduled.

Special Senate Commission to Study Cost Containment, Efficiency, and Transparency in the Delivery of Quality Patient Care and Access by Hospitals

Second Meeting Summary (not intended as official minutes) – January 10, 2011

Chairman Joshua Miller welcomed all Commission members and guests and explained that tonight's hearing would focus on ideas and strategies for cost containment in hospitals, presented by insurers and healthcare providers. Before these presentations, the Chairman welcomed Elena Nicolella, Medicaid director, to present on the Medicaid Hospital Payment Study Commission Final Report.

Elena Nicolella, Medicaid Director, presented on the Medicaid Hospital Payment Study Commission Final Report and its recommendations for changes and adjustments to how Medicaid reimburses hospitals in Rhode Island (Presentation included in addendum). Points of discussion included whether Medicaid should pay for Graduate Medical Education expenses and what the appropriate role is for the state regarding graduate medical education. Director Nicolella mentioned the lack of transparency as an important issue in cost containment as well as the desire of the Medicaid office to pay similarly for similar care. She lastly mentioned the costs of uncompensated care for undocumented immigrants, and the state's overreliance on supplemental payments, as items for further discussion.

Chairman Miller asked whether the Director could comment on how the Commission process went, considering the similarities between the Senate Hospital Commission and the Medicaid Payment Commission?

Director Nicolella remarked that the Commission was challenged by a short time frame; however this time frame was also an opportunity to keep everyone focused on the desired outcomes of the Commission.

Domenic Delmonico, Care New England, presented on CNE's efforts and strategies for cost containment as well as cost containment recommendations for the Commission to consider (Presentation included in addendum). He explained that the 'Free Standing' issue is a significant challenge facing hospitals – as independent labs and medical centers, which are *not* required to provide charity care, get better payer rates and a (generally) healthier clientele, do not have to comply with a fraction of the regulation required of hospitals, and attract patients from hospitals. In the short term, these entities may lower costs to the broader healthcare system, but in the long term, these costs are raised significantly. Mr. Delmonico encouraged the Commission to envision what the state healthcare system should look like in 5-10 years and emphasized the need for statewide healthcare planning. He further recommended that the state require quarterly publicized reporting of hospital productivity, a 3-year plan to study state 'hospital bed' need and reduce/adjust the number of beds to fit that need, and a freeze in the number of ancillary 'free standing' providers in the state to allow the system to 'catch up' with its patient population. He further recommended the re-establishment of the OHIC payer-provider workgroup, and encouraged the state to officially accept or reject the graduate medical education provided in Rhode Island, and respond with actions appropriate to that decision. He further encouraged the

Commission to hold a meeting at, or tour, one of the state's hospitals to gain a perspective on what all these discussions really mean.

Chairman Miller asked, beyond a freeze on the number of free standing providers, were there any other recommendations from throughout Rhode Island or across other states, on addressing the 'free standing' issue?

Mr. Delmonico responded that a freeze remains the best approach but does not have to be a singular approach – a freeze could be coupled with strong service and performance requirements for hospitals on these services to ensure access and quality remains as the growth of these free standing services is halted. The freeze would not have to be permanent.

Christopher Koller asked to expand on the concept of transparency in hospital costs and payments.

Mr. Delmonico responded that transparency itself is not the issue, but that all costs a hospital faces must be recognized. Hospitals are seeing reductions from all sides and have nowhere to 'shift' the countless additional costs that hospitals face beyond direct care. A statewide plan is something that squares well with this issue, but would again require that all costs the hospital faces be recognized. Simply requiring transparency itself would offer no help and would simply have an inflationary effect.

Dr. Anton Dodek, Tufts Health Plan presented to the Commission on Tufts multi-faceted approach to controlling costs (Presentation included in addendum). Tufts shares the six-point goals as put forth by the Health Insurance Commissioner as a means for cost containment, and envisions a network strategy that delivers cost effective, high quality care. Contract negotiations are flexible and are designed to incentivize performance, best practices, and optimum use of medical care. Going forward, Tufts anticipates plan designs will evolve and include a greater focus on engaging members in the delivery of medical care. Future approaches and opportunities for Rhode Island to consider include the development of Accountable Care Organizations (ACOs), as provided for in healthcare reform, increased utilization of pay-for-performance including quality metrics, and use of global payments / risk-sharing arrangements.

Dr. Augustine Manocchia, Blue Cross & Blue Shield of Rhode Island (BCBSRI), presented to the Commission on BCBSRI's cost control activities. Dr. Manocchia focused on Blue Cross's support for the state Safe Transitions project, BCBSRI's Case management "transitions of care" project at Rhode Island Hospital and Miriam hospital, and BCBSRI's Patient Centered Medical Home program, which is designed to improve care of the chronically ill and reduce need for inpatient/ER care/readmissions. Dr. Manocchia further explained BCBSRI's efforts in providing onsite nurse practitioners at selected, high volume, skilled nursing facilities to reduce readmissions; as well as an intensified onsite inpatient utilization review, and ICU Collaborative support which has resulted in reduced complications, and shorter ICU lengths of stay. Lastly, Dr. Manocchia described BCBSRI's ongoing movement toward DRG payment/Case rates. BCBSRI's recent contract extension with a major hospital group complies with the Office of the Health Insurance Commissioner's contracting conditions developed in July 2010.

Ken Belcher, Roger Williams Hospital, Charter Care Health Partners, presented on cost containment and savings within Charter Care Health Partners (Presentation included in addendum). Mr. Belcher explained that the affiliation between Roger Williams and St. Joseph's made clear financial sense and allowed two to increase efficiencies and reduce overall system costs. He described how the potential savings from the affiliation was originally estimated to be roughly \$20 million, but has since increased greatly, and continues to grow. Examples of areas where consolidation has lead to increased efficiencies and cost savings include human resources, purchasing, accounting, billing, IT, facilities, security, and housekeeping, in addition to economies of scale in the purchasing of supplies, negotiating of contracts, and health insurance. Mr. Belcher further endorsed the principles of the Community Hospital Task Force which recommended all hospitals be placed on a level playing field and collaborate, rather than compete.

Chairman Miller asked how Charter Care benchmarked costs to determine 'acceptable' costs and growth or decline?

Mr. Belcher responded that Charter relies on an outside firm that was previously contracted at Roger Williams Hospital to determine reasonable costs against which the hospital can measure their performance in lowering costs and improving quality.

Chairman Miller asked whether CharterCare Partners had any advice or recommendations for public officials to consider?

Mr. Belcher emphasized that openness and transparency is critically important.

Due to time constraints, the remaining hospitals and insurers who had not yet presented were invited to present at the Commission's next meeting. The date and time of the next meeting of the Commission was discussed.

Special Senate Commission to Study Cost Containment, Efficiency, and Transparency in the Delivery of Quality Patient Care and Access by Hospitals

Third Meeting Summary (not intended as official minutes) – January 19, 2011

Chairman Joshua Miller welcomed all Commission members and guests and explained that tonight's hearing was a continuation of the Commission's previous meeting focusing on cost containment in hospitals, presented by insurers and healthcare providers. The Chair also informed the Commission that Quality Partners of Rhode Island would be presenting on their collaborative efforts in improving hospital quality, patient safety, and value.

Mark Montella, Lifespan, presented on Lifespan's efforts and achievements in containing costs and improving efficiency (Presentation included in addendum). He began by providing a brief history of Lifespan, beginning with the 1994 merger of Rhode Island Hospital and The Miriam Hospital. When these systems combined, there were significant cost savings through the consolidation of corporate services such as human resources, legal, IT, and others. Benchmark analysis found that Lifespan's administrative costs were performing above the 85th percentile of like-sized institutions.

Lifespan has made substantial investments in health information technology which, nationally, is viewed as a key method in containing costs and improving care. In 2010 the Department of Health issued a draft report on hospital costs, Lifespan disagree with some of the methodologies in this report and asked Ingenix to run the data again using different methodologies- the results of this second review indicated that Rhode Island's hospitals, based on median cost per discharge, were some of the lowest in the country; he further mentioned that neither Rhode Island Hospital nor The Miriam Hospital were the most expensive. While Lifespan's hospitals are cost competitive, Mr. Montella pointed out the significant uncompensated care costs facing Lifespan's hospitals and all Rhode Island hospitals. Lifespan's hospitals are a significant workforce and economic engine to the state as well as a key component of the knowledge economy. The system has signed a new contract agreement with Blue Cross & Blue Shield of Rhode Island that reflects the Health Insurance Commissioner's contract conditions. Regarding areas of concern going forward, Mr. Montella explained that Rhode Island ranks highest in the region for 'ambulatory sensitive conditions' – or those services that do not necessarily require hospital admission, and if the state makes a concerted effort to move these conditions out of the hospitals, the hospitals would stand to lose revenue. He further highlighted the challenges of using bundled payments that do not pay for readmissions or hospital acquired conditions. Lastly, Mr. Montella explained that end-of-life care is a significant cost driver, and that budget concerns at the state level will continue to place additional stress on hospital budgets.

Health Insurance Commissioner Chris Koller asked for further information on the cost benchmarking issue.

Mr. Montella responded that a priority should be an agreement on how to benchmark costs across hospitals. The Department of Health used a different methodology than Lifespan relies upon and, in Mr. Montella's opinion, excluded a number of important measures and variables. It would be best to agree on an approach and matrix across

hospitals and define how a benchmarking study should look for statewide comparisons. He remarked that Ingenix was a thorough and reputable provider.

Chairman Miller asked whether there was any economic health benefit to focusing on transparency in health quality measures or whether this is best left to the hospitals for self-improvement?

Mr. Montella remarked that the drive toward transparency in hospital quality has been beneficial for consumers and hospitals.

Ken Belcher, Charter Care Health Partners, remarked that there is a need for strategic planning for healthcare quality. Transparency in healthcare quality is important, but transparency of cost is equally important. The state must know the cost per case of each hospital to align system resources properly. If hospitals were to agree on benchmarking formatting and formulas, there would need to be uniformity on what costs *should* be.

Mr. Montella remarked that the state should have a shared acknowledgement of the value of having academic medical institutions in the state. He commented that he is aware of no city with a ‘life sciences corridor’ such as that proposed by the city of Providence, that is not ‘anchored’ with an academic medical center.

Chairman Miller mentioned that previously some had commented Rhode Island had ‘too many’ hospitals beds. Yet in Mr. Montella’s presentation we saw that the elderly population is expected to increase greatly in Rhode Island over the next few years, necessitating *more* hospital beds. Is it wise, then, to simply hold onto these beds until the demand inevitably arrives?

Mr. Montella responded that this demonstrates the need for forward-looking health planning. He further remarked that most Medicare spending occurs during the last 6 months of life.

Ken Belcher, Charter Care Health Partners, commented that many studies have looked at the impact of the baby boomer population on hospitals, which represents a major influx of needed inpatient beds. He further remarked that, in his opinion, care is more costly in a setting such as Rhode Island Hospital than in community hospitals, so that any future planning may want to concentrate on increasing community beds.

Tom Breen, South County Hospital, presented on cost containment and efficiency efforts within South County Hospital. He began his presentation by displaying a map of the location of hospitals throughout Rhode Island, noting that South County is uniquely placed in relation to its peers. He described some of the steps South County Hospital had taken in reducing costs to address their current financial challenges, including a wage freeze, a frozen defined benefits plan, a salary reduction for select employees, increased employee health insurance contributions, and other reductions. He outlined a number of efforts underway to better utilize hospital resources and reduce costs including the patient-centered medical community, a concerted effort to reduce readmissions, and increased focus on quality metrics. The problem is that as the state moves toward these efforts, hospitals are paid less in a Fee-for-service environment. Thus it is important that the reimbursement system catch up with these healthcare quality efforts. He

pointed out the absence of payment for quality measures and efficiency improvements complicate hospitals in existing payment mechanisms. Mr. Breen discussed the Commission's charge and emphasized the importance of fair treatment for all providers. Payors and providers should promote efficiency yet payments are still 'shrouded in secrecy'.

Mr. Breen presented recommendations on behalf of South County Hospital. SCH would like to see enhanced regulatory oversight embedded within the Office of the Health Insurance Commissioner. Under this recommendation, all payer-provider contracts would be filed with the Commissioner within 30 days; the Commissioner will develop methods to compare reimbursement rates across providers as well as consistent metrics regarding quality, efficiency, rate fairness, and payment incentives. If any contract fails to meet these standards, the Commissioner would have the authority to invalidate contracts, and/or invalidate specific provisions of the contract, and/or arbitrate disputes (through binding arbitration). Mr. Breen remarked that additional resources would need to be made available to the Office of the Health Insurance Commissioner to meet these new obligations.

Chairman Miller commented to Mr. Breen that some parties, particularly legislators, not privy to this Commission's work, may associate the term 'binding arbitration' with things that have little to do with the Commission's work.

Beverly Jane Perry, United Health Care, remarked that when discussing cost containment, it is important to focus on those instances in which the *payor* can have a direct effect. For example, United can have an impact through payment methods that allow cost reductions to accrue *without 'punishing' the provider*. Items such as case rate, and DRG rate reimbursements can move in this direction and United has been successful in converting from per diem to per case reimbursements. Ultimately, the focus is on what reimbursement methods can help deliver the best care for the patient. Ms. Perry further discussed performance-based contracting; paying facilities and physicians through performance-based contracts that align with the Health Insurance Commissioner's (OHIC) conditions. Ms. Perry noted, however, that while the OHIC conditions align with United's concerns on affordability, they fail to consider disparities among facilities. Ms. Perry agrees that the ability to address such disparities may be through pay for performance.

Ms. Perry explained that United Healthcare has been a proponent of consumer-based transparency for some time; but has not seen sufficient evidence that consumer-based transparency, nor transparency across payors more broadly, has had any impact on healthcare spending. She mentioned the example of New Hampshire, where there is comprehensive health price transparency, yet consumer choice is largely the same as in states without.

Mark Reynolds, Neighborhood Health Plan on New England, presented on current cost containment and quality improvement efforts at Neighborhood Health Plan, along with recommendations for the Commission to consider. Mr. Reynolds began by stating the Neighborhood is a bit different from the other insurers around the table as it only serves the Medicaid population and is not a commercial insurer, thus it has a different relationship with hospitals. Regarding current cost containment initiatives, Mr. Reynolds explained that Neighborhood participates in the Transitions of Care program which entails an enhanced discharge planning & coordination which is focused on those members with the highest probability for readmission. Neighborhood also participates in the 'Transitions Home Program', a partnership with Care New England/Women and Infants Hospital for high risk neonatal babies which provides intense follow-up in home and clinics and emphasizes education and self-care to

reduce unnecessary ER and admissions. Neighborhood also participates in the Department of Human Services' Communities of Care program for payers for members with highest emergency room utilization. Neighborhood also relies on 'co-location' which places medical providers in behavioral health sites, creating medical homes that increase treatment compliance and reduce ER use and hospital admissions. Other initiatives include a new community-based adult crisis stabilization service which serves as diversion and step down from inpatient behavioral health and medical board admissions; co-location coordinated case management between health plan behavioral health case management and DCYF case workers for improved discharge planning and placement for children in DCYF custody; and efforts to identify opportunities to increase access to community-based outpatient services as an alternative to hospital facility-based settings.

Neighborhood Health Plan supports the DHS payment proposals but would recommend that these proposals, over time, help to level the playing field among providers while better consider severity. Neighborhood further recommends that all hospitals adopt Quality Partners' Safe Transitions best practices and provide a continuity of care document upon discharge. For specific legislative recommendations, Neighborhood emphasized mandating that child emergency evaluations be performed in a setting other than ER, this promotes the use of appropriate diversionary services in community and avoids unnecessary medical and behavioral ER evaluation costs; and mandating that adults identified with behavioral health concerns also be evaluated in community-based settings rather than in a hospital ER as is currently required in Rhode Island. Lastly, Neighborhood recommends the development of alternative settings to reduce hospital spending by creating residential beds in the community for people with substance abuse and restructuring skilled nursing facility payments to encourage more options for people in need of chronic care.

H. John Keimig and Rosa Baier, Quality Partners of Rhode Island (QPRI), presented on Quality Partners' collaborative efforts to improve quality, patient safety, and value in hospitals. The presentation began by providing a history of QPRI, its partnerships with healthcare providers, and its funding streams. Mr. Keimig and Ms. Baier demonstrated how QPRI partners with hospitals on monitoring, reporting, and improving on quality indicators. Regarding recommendations for improved reporting, Mr. Keimig and Ms. Baier encouraged the continued funding of the reporting legislative mandate, and, if possible, an increase in this funding, along with further assistance for the all-payer claims database. The presentation turned toward QPRI's focus on care transitions, where there is significant room for improvement and potential for cost savings. One major problem facing current transitions of care is insufficient communication, whether it be between the provider and patient, patient and provider, or among providers themselves. The presentation outlined the design, function, and 'learned' experience of the Safe Transitions program to date. There are a variety of causes for readmissions many of which focus on the need for complete and accurate information among and between providers and patients. Approaches to reduce readmissions include interventions, such as coaching, to help patients manage their care, follow discharge advice, follow-up with primary care providers, and make certain that medication is taken timely and appropriately. A study found that coaching can reduce the odds of a hospital readmission by 34%, with instances of readmission decreasing as the number of 'coaching' minutes increased. Recommendations for the Commission to consider regarding care transition include: Expanding the mandated transmission of the Continuity of Care form to include physicians' offices; convening a commission to identify next steps to create a physician contact information database; and increasing the adoption and measurement of evidence-based best practices.

Special Senate Commission to Study Cost Containment, Efficiency, and Transparency in the Delivery of Quality Patient Care and Access by Hospitals

Fourth Meeting Summary (not intended as official minutes) – February 10, 2011

Chairman Joshua Miller welcomed all Commission members and guests, explaining that the afternoon's hearing would include public testimony from any and all interested parties. He remarked that the Commission sought from the start to keep this an open process and has extended an open invitation to anyone who wished to comment or share their input.

Dr. Matthew J. Smith, East Greenwich Spine & Sport, Inc. thanked the Chairman for the opportunity to address the Commission and introduced himself as a champion for integrated care delivery for the most expensive chronic condition: spine pain.

He remarked that collaboration around service lines will fall under the framework of Accountable Care Organizations, which will be a coalition of hospitals and their medical staff. In the 1990's, Managed Care Organizations (MCO's), Independent Practice Associations (IPA's) and Physician Hospital Organizations (PHO's) attempted similar integration. Between 1998 and 2002, 147 physician organizations closed or went bankrupt in California alone, while those that survived achieved integrated, high value care – Dr. Smith reviewed the characteristics of those groups that failed and those that did not.

The following characteristics were common to the groups that failed:

- **Size**--Undercapitalization lead to an inability to be consistently profitable. Financial solvency standards for risk-bearing organizations were not met.
- **Misalignment of incentives**--PHO's and IPA's entered into capitation agreements but appeased their physicians with fee-for-service remuneration. Lack of coordination of contracts lead to an aggregation of pieces with no incentive to work collectively.
- **Payment reform without practice reform**--MCO's imposed utilization review processes in an attempt to change practice patterns. Administrative burden and misgivings increased but the cost of chronic care was not contained.
- **Regulations**--requirements for JCAHO standards lead to inefficiency and increased cost burden of providing ancillary and outpatient services in facility settings.
- **More regulations**--Inflexibility of contracts did not allow compensation to be adjusted for changes in patient volume or overhead. The inability to generate revenue from ancillary services fostered a negative atmosphere.
- **Mistrust**--Physicians were not invited into the process from the initial strategic vision to the governance of the organization. The perception of patients and doctors was that clinical and organizational decision making occurred for commercial benefit. Physician productivity declined.

In contrast, the successful groups shared different characteristics:

- **Consensus**. There was strategic clarity with a shared vision between physicians and hospital administrators.
- **Fairness**. An environment of trust and respect was fostered by creating an organizational structure based on collective leadership.

- Patient-centeredness.** Physicians retained autonomy over patient care decisions and management of their practices.
- Joint ventures**--Provision of outpatient and ancillary services could occur in a more efficient setting.
- Incentives**--Physicians were rewarded for collaboration and outcomes. Exclusions and alternatives necessary to overcome regulatory restrictions from Stark and Anti-Kickback legislation were maximized.
- Practice reform concurrent to payment reform**--The costs of chronic disease were managed through comprehensive transformation of care delivery. Through coordinated disease management, care teams, pharmacy management and investment in prevention, emergency room usage was decreased, unnecessary admissions and rehospitalizations were reduced and post-hospital care costs were controlled.

Dr. Smith recommend that the relationships among the parties in the Commission be formalized into a Regional Healthcare Resource Authority. He explained that two main charges await this collaborative. The first is integration: to oversee accountable care organization arrangements between payors, hospitals and providers; to provide guidance on safe harbors from regulatory restrictions to incentivize all stakeholders; to assist in the establishment of fair evidence-based care rates; to protect patients during implementation of standardized clinical decision making Algorithms; to provide support for accreditation of ACOs, PCMHs, Interdisciplinary Spine Pain Centers, etc; to coordinate interoperability of information systems; and to replace the process of prior authorization for individual requests with a uniform utilization review approach based on periodic audits of service lines accepted by all payors.

Dr. Smith remarked that integration leads to accountability, which would be the second charge for the proposed regional leadership.

Dr. Smith spoke about the knowledge economy and the importance of a research department capable of writing grant applications, designing comparative effectiveness research, obtaining IRB approval, collecting standardized clinical data into formal registries, analyzing data and reporting on clinical effectiveness; organizational compliance; and cost utility measures. Dr. Smith remarked that Rhode Island can successfully accomplish many of these functions, as demonstrated by the recent landmark work of Quality Partners. However, the failure to keep the data analysis from the Patient Centered Medical Home pilot study in Rhode Island highlights the need for improvement.

Dr. Smith concluded that ‘with privilege comes responsibility’ and that, by way of the recognition awarded to Rhode Island, the state has been challenged to coordinate for the better. He believes an effective Regional Healthcare Resource Authority will legitimize Rhode Island’s role as a leader to an era of high-value healthcare.

Charles Kinney, President and C.E.O, The Westerly Hospital began his testimony by stating that over the last 50 years the United States has struggled with the competing issues of availability, accessibility and cost- but for the next few years it seems cost will be the only focus.

Mr. Kinney pointed out that many are calling for a State Health Plan to guide decisions but, while health planning has been viewed as an ideal for years- it was tried in the late 60’s and early 70’s to no avail.

Mr. Kinney pointed out that the healthcare business model has changed (and joked that he ‘checks under his car’ for what he was about to say):

- Hospitals are no longer the center of the healthcare system
- Just because hospitals have assets and history does not mean they are still necessary to the health of their community. There may not be a need for every hospital as they now exist. While many may be significant to their local municipality, they may not be significant to the regional system of care.
- Many of the members of the medical staff no longer need the hospital for their practice
- Some members of the hospital staff have opened competing imaging centers, surgi-centers etc and now provide services in non-hospital settings that were traditional hospital services. Hospitals no longer own that business.
- More than 50% of hospitals business is Out Patient care, which could be provided outside the hospital
- The disjointed reimbursement system between physicians, hospitals and other providers is anachronistic- it would be comparable to having a child in college receive a bill not only from the school, but also from every professor, a separate bill from the dormitories, another from the cafeteria service etc.
- When considering the cost incurred by individual hospitals to deliver care, the “economies of scale” of “larger” facilities decline after a certain size. According to both the RI Dept of Health draft report of 2008 hospital costs and the model modified by Lifespan (based upon Ingenix data demonstrate the lowest cost hospitals to be Westerly, Newport, Landmark and or South County, depending upon which analysis one accepts. The fact is that they are all community hospitals.

Mr. Kinney described a number of problems that hospitals face including:

- An inadequate number of primary care physicians
- A decline in the number of physicians in certain specialties
 - Many MD’s no longer come into the hospital leading to a lack of an integrated medical staff
 - Physicians are declining and/ or seeking payment for on-call
 - Occupancies are in decline as more business shifts to the out-patient setting
- Many reports have documented that more than 20% of all ancillary tests are not medically necessary but are done for defensive medicine purposes
- There will be limited access to capital markets due to the poor operating margins in RI and what will be available will be quite expensive.

Mr. Kinney explained that the current healthcare financing system in Rhode Island is *dysfunctional*:

- Medicare pays hospitals approximately 80% of costs of care
- Other government payers also pay significantly less than the cost of care
- Cost shifting to commercial payers is drying up as insurers respond to the demands of employers and the self insured
- The RI Insurance Commissioner is trying to minimize cost shifting through regulation
- In RI, hospitals pay huge license fees and receive some DSH payments. This system is now more of a money generator for the state, as more hospitals become “net payers” into the system. Under federal healthcare reform DSH will cease as a

federal program in 2 years begging the question of where will the state find the replacement money.

- The uncompensated care of hospitals continue to grow as a percent of revenue
- Those hospitals which put their fee increases from insurers in the outpatient vs. inpatient may find themselves not price competitive under a transparency model.
- The current system for negotiating rates with commercial payers favors the systems vs. independent hospitals. He contends that there are no reasons other than their market strength for the significant difference in rates.

Mr. Kinney commented that the focus on overutilization of emergency rooms is a “false god”. A PCP office is open 40 hours per week, 24% of weekly hours. Those hospitals who do well under the existing system will fight to the death to keep it, while others who are not doing well are far more enthusiastic in their support for a new system

- Over the next decade, the existing fee for service system of reimbursement will decline as the primary payment methodology. New reimbursement systems will be more physician driven and include elements of risk- both performance risk and utilization risk. All are designed to reduce payments to hospitals. Utilization risk programs include Medical Home, Payments for Episodes of Care, HAI and Readmission Denials. Performance risk includes Bundled Payments, Value Based Purchasing, Accountable Care Organizations, and other to be defined / devised risk based arrangements.
- Physicians can move faster than hospitals and may develop these new models of care and hospitals will be “downstream” vendors to the physician enterprise.
- To respond is a delicate act of timing- one cannot be too slow nor too fast in adopting new methodologies
- In summary, our core business is declining, more than half of our business can be provided elsewhere, the majority of our physicians do not need us, and the payment system is inequitable.

Mr. Kinney suggested that RI have a transitional hospital reimbursement system for a minimum of 5 years and a maximum of 10 years, while hospitals adapt or change their mission for their bricks and mortar

- There needs to be a consistent base rate reimbursement system for all hospitals
 - Rebase the inpatient and outpatient rates to be price competitive and reflect the cost of care
 - Added to this are adjustments for
 - Direct Medical Education
 - Uncompensated Care (net of bad debt and DSH payments)
 - Case mix
 - Patient Satisfaction
 - Predetermined Quality Measures, which focus on outcome and not just process (this may be different among hospitals, but the same for hospitals among the payers)
 - Compliance with appropriate transitions of care programs
 - Other creative arrangements which may be tried on an individual hospital basis
 - Cost effectiveness

- Medicaid payments, ideally, should be the same as commercial carriers, but realistically should be no less than Medicare
- Emergency room reimbursement rates should be more widely spread to reflect the level of care. The level 1 and 2 visits should approximate Urgent Care Centers, while the upper levels should increase to reflect the time and resources needed. The level 1 and 2 visits should have a lower co-pay to better reflect urgent care centers co-pay.
 - DSH as a program needs to be restructured to reduce the number of net-payers
 - The billing systems and payment rules for commercial carriers should be consistent for ease of billings. This is not just forms, but includes all aspects of claims approvals and denials.
 - Real tort reform needs to occur, establishing a malpractice “binding arbitration types” court is preferred.
 - The Health Insurance Commissioner should be empowered to fine commercial insurers and order payments to providers for unfounded patterns of denials by the insurance carriers.
 - Results for the reduction of readmissions and Hospital acquired infections should be rewarded on a 50/ 50 basis.
 - Reimbursement for Mental Health should be increased to cover the cost of care.
 - All rates should be transparent to ensure consistency with the above principles
 - Insurance companies should provide on line access to the most common elective procedures so subscribers can make price decisions.
 - CON should allow hospital to provide swing beds (acute/ SNF) for hospitals seeking them, through an administrative approval process.

Building on Mr. Kinney’s comments, **Dr. David Gifford, Director of Health**, remarked that the reimbursement model should allow physicians to have a say in how care is delivered – this is not to say that doctors should simply be put ‘in charge’ of the building, but physicians and administration must work together with each side having a voice.

Mark Montella, Lifespan, disagreed with Mr. Kinney that some hospitals would ‘fight to the death’ to preserve the current system. He remarked that Lifespan does not consider the current model sustainable and agrees that the state must redesign the system. He agrees that there must be more alignment between physicians and administrators but also pointed out that there is a lack of alignment between regulators on the state and federal level.

Charles Kinney remarked that one of the biggest issues is the balkanization of medical staff. Collegiality among staff seems gone and it is difficult to align interests.

Ken Belcher, CharterCare, agreed that the focus must be a physician-driven system.

Domenic Delmonico, Care New England, commented that a key hurdle to moving toward a primary care-driven system is consumer choice. In Rhode Island, consumers do not want their care options limited, even if we can ensure them it would mean improved care and better outcomes. Employers and employees want choice – the question is how we can arrive at a system that is primary care-driven, but still promotes choice.

Mark Montella added that studies indicate that hospital employees and other healthcare workers are often ‘frequent users’ of healthcare services. In most states, hospitals and healthcare systems are surrounded by other industries as large or larger. In most Rhode Island communities, healthcare is the largest employer – with countless employees who can be categorized as ‘frequent users’

Dr. Augustine Manocchia, Blue Cross & Blue Shield, commented that, over the last few years, there has been a significant infusion of dollars for primary care due to OHIC guidelines on primary care spending. This may help the transition in a few years. More importantly, consumer engagement is key – consumers need to know that primary care is critical and can lead to better health.

Chairman Joshua Miller remarked that consumer engagement is indeed important, and a challenge. For most people, health insurance is a card in their wallet or purse. They do not think about their health spending or care until there are a user. Incentives do not necessarily mean much to them.

George Pasquarello, DO, FAAO Director of Corporation, East Greenwich Spine & Sport, Inc. began his testimony by stating that the pre-authorization process for imaging increases the referral rate to specialists, thus delaying medical diagnoses and treatment opportunities. He also noted that the pre-authorization process for medications increases the administrative burden for physicians while also decreasing the time spent on direct patient care.

- The delay can be shortened by using a Patient Centered Medical Home Model, which can offer Primary Care Providers with a better ability to provide comprehensive care to patients, including the ordering of diagnostic imaging.
- The Patient Centered Home model can also offer PCPs a better ability to provide comprehensive care for patients, including decision making for medication management

Dr. Pasquarello contended that the fee-for-service model rewards procedure-driven practices and penalizes conservative management for chronic disease states

- Several alternative payment models such as shared savings, capitation and risk sharing would allow physicians the opportunity to individualize care and be rewarded for efficiency and quality

Dr. Pasquarello described RI as a “less desirable practice environment for physicians” due in part to the current reimbursement structure. He observes that the Health Insurance Commissioner is directing a 10% increase in spending for primary care, and notes that this amount can potentially be directed toward the Patient Centered Medical Home model to improve access to the quality care of chronic disease states in both the inpatient and outpatient arenas.

Dr. Augustine Manocchia, Blue Cross & Blue Shield, asked Dr. Pasquarello to clarify his contention that doctors were increasing their referrals to specialists because of imaging preauthorization.

Dr. Pasquarello responded that his peers have remarked it is too difficult to obtain a preauthorization for imaging services for a primary physician and that is simpler

to refer the patient to a specialist. As a specialist, Dr. Pasquarello often receives referrals and will ask ‘why have you been referred to me?’, the patient responds ‘because you can order an MRI and my doctor cannot.’

Dr. Manocchia replied that he would be happy to sit down with Dr. Pasquarello and his team about this issue. This does not sound like a fair or accurate concern; Dr. Manocchia pointed out that Blue Cross has only a 6% denial rate for high-end imaging and 99% of preauthorization decisions are made within 48 hours. He further remarked that there is no difference between a request made by a specialist or a primary care provider.

Dr. Roanne Osbourne commented that the issue may not necessarily be the preauthorization process but that the volume of patients a primary care provider must see to ensure they are covering costs is so large they do not have time to spend on processes such as obtaining preauthorizations that do not add value or offer direct care to patients. It is simply easier and faster to refer the patient to a specialist.

Beverly Jane Perry, United Healthcare, commented that many insurance providers require preauthorization to prevent improper or over-utilization

Dr. Pasquarello, in response to this statement, brought up how, during last year’s federal healthcare debate, he heard President Obama remark that one way to limit costs is to prevent doctors from ‘ordering unnecessary tests.’ He was surprised by this comment and told the Commission that his association conducts a monthly education series about when to order MRIs and other tests.

Dr. David Gifford, Director of Health, remarked that preauthorization is a tool that can, and should, be used for the right purposes – if it is used as a cost control, that is wrong; if it is used to monitor and limit exposure to testing; that is correct. Preauthorization, like co-pays, and other limits and requirements are to serve as a counter to the fundamental incentive and desire to do more testing. Dr. Gifford proposed allowing insurers to utilize a more narrow range of providers to help ‘loosen’ preauthorization standards. There is a huge difference in cost among a variety of testing providers ; if insurers could limit their networks to less expensive providers- the ‘cost savings’ could help pay for and facilitate less preauthorization requirements.

Senator Roger Picard remarked that a key question remains how can you convince consumers that care that is cheaper is actually better?

Matthew DiMatteo, Arcadia Solutions thanked the Commission and Chair for the opportunity to testify. He introduced himself as a born and raised RI resident who has received nearly 100% of his healthcare within Rhode Island; much of which has been provided by some of the stakeholders on the Commission. Mr. DiMatteo remarked that he works in the healthcare industry as a member of Arcadia Solutions. Arcadia is a healthcare consultancy that has been, and is currently, engaged in projects that cross both the payer and provider spaces here in RI and elsewhere. Many of Arcadia employees work and reside in Rhode Island. The company has an interest in the charge of this commission and any outcomes that may result from it.

Arcadia applauds the committee's dedication to the RI stakeholders, and is in agreement that more efficient administration of healthcare services, increased communication between insurers and providers, and transparent payment methodologies will ultimately improve the costs and the level of care provided to patients in Rhode Island. Mr. DiMatteo remarked that his company is thrilled to see this level of collaboration among stakeholders for the betterment of the population that it serves. The company encourages the enhancement of this collaboration that members of this commission are beginning to undertake, and where appropriate, offered technical advisement to help reach these goals.

Special Senate Commission to Study Cost Containment, Efficiency, and Transparency in the Delivery of Quality Patient Care and Access by Hospitals

Fifth Meeting Summary (not intended as official minutes) – February 28, 2011

Chairman Joshua Miller welcomed all Commission members and guests. He remarked that this evening's meeting will focus on the issue of rate transparency. He pointed out that in recent year's there have been several legislative initiatives focusing on the issue of rate transparency and that these approaches will serve as the starting point of the discussion. He mentioned that Massachusetts has unveiled a far-reaching legislative package that would significantly increase government oversight over rate setting in that state; and pointed out that the federal government has been promoting new levels of scrutiny and transparency nation-wide over rate setting. The Chair recognized and thanked Domenic Delmonico of Care New England and Ken Belcher of Charter Care Group for agreeing to open and facilitate the Commission's discussion on rate transparency. He also thanked Mike Ryan of Memorial Hospital and commission member Dr. Roanne Osborne for offering to present before the Commission.

Mike Ryan, Memorial Hospital of Rhode Island described Memorial's mission of maintaining an integrated delivery system of care throughout the continuum. In addition to inpatient and outpatient services Memorials offers rehabilitative, home care, family and primary care, and emergency and urgent care. Urgent care services are provided at Notre Dame Urgent Care center in Central Falls. Memorial Hospital is also a key center of medical education and research. Its association with Brown University Alpert Medical School currently trains 70 residents and 11 fellows in medicine. The hospital is also responsible for over \$6.5 million in research grants. Mr. Ryan described the greatest challenge in hospital finance as covering the cost of uninsured. Estimated uncompensated care charges for the Hospital in 2011 will be \$23,300,000; the cost of uncompensated care in 2011 is estimated to be \$9,800,000. State disproportionate share funding to Memorial for 2011 is \$105,304, however proposed RIte care cuts to Memorial stemming from last session's 'Article 20' will be \$1,000,000. Mr. Ryan described the state's prior experience with programs that are similar to Accountable Care Organizations and population based payments. Mr. Ryan presented a sample balance sheet for a hospitals under a per-member, per-month payment system. Regarding recommendations for the Commission, Mr. Ryan recommended that the state insure reimbursement parity and recognize that medical education is vital to the state's health care system and requires appropriate funding. He further recommended that the healthcare system reward hospitals that emphasize primary care, outpatient, and homecare services in addition to inpatient care.

Domenic Delmonico, Care New England, discussing the issue of cost transparency, commented that state already has an effective model in the form of Workers Compensation, whereby the state can ask a carrier 'how long and how much it took to get a client from injury back to work' and they can respond '\$2,700 and 41 days'. Such a model doesn't fit chronic treatment, but it can fit acute instances. Insurance system reform would be required.

Mark Montella, Lifespan, remarked that it seems difficult to 'translate' an effective worker's comp program to health insurance. In regards to risk-based reimbursement, Mr.

Montella commented how population pools must be big enough so that hospitals and insurers have sufficient 'healthy' members to cover the sick. A target figure of 150,000 has been mentioned as necessary to sufficiently spread risk. Regarding the emphasis of primary care- the issue remains that customers like choice, and the challenge will be for insurers and employers to convince customers to move toward primary care-managed health plans.

Commissioner Chris Koller asked whether Memorial made any efforts to divert patients to urgent care, as provided at the Notre Dame Urgent Care, than in emergency rooms.

Mike Ryan responded that the hospital does indeed encourage patients to utilize urgent care whenever possible.

Dr. Gary Bubly, Rhode Island Medical Society, remarked that lots of attention has been paid to the 'unnecessary' use of emergency room care as driver of millions of dollars in costs. Hospitals do not speak of these expenses as .7% or .8%, which Dr. Bubly contends is accurate; rather they see it as a primary cost driver as they emphasize the need to divert to primary care.

Commissioner Koller commented that the question is how to get from 'A' to 'B' given the fracture payment system in place. He wondered whether there may be some benefit to a state based public policy that is coordinated with Medicare as there is an ability to innovative under Medicare that may be underutilized.

Mark Montella, Lifespan, commented that the goal of everyone on the Commission is to come up with a care delivery system that works. In regards to emergency room usage, he pointed out that in California, that has pretty substantial reporting requirements, there are some pretty well known and well managed health care plans that still have high ED utilization.

Dr. Roanne Osborne presented to the Commission seeking to provide a family physicians perspective on the work of the Commission. She emphasized the important role that primary care, expanding access to primary care, and coordination will play in containing health care costs. Dr. Osborne pointed out that up to 21% of Emergency room visits could have been seen in primary care offices. She recommended moves to increase hours of operation of primary care offices and utilize data to find out which areas of the state are in the greater need of primary care physicians. She further emphasized the role of primary care doctors in discharge planning. A significant issue remains the parity of reimbursement between primary care doctors and specialists. Primary care salaries are simply not attractive to medical students; between 2008-2010 only 40% chose primary care. In Massachusetts the starting salary for a primary care physician is between \$10-\$15,000 higher than in Rhode Island. According to a RIAFP poll, 53% of primary physicians surveyed remarked they would work outside of Rhode Island if they could. Dr. Osborne emphasized that expanding access to health insurance will require the state to increase the supply of primary care providers – in Massachusetts, where coverage has already been expanded greatly- the average wait for primary care in the city of Boston is 29 days. Rhode Island must address the issue of retaining primary care physicians in the state.

Dr. Osborne stressed the need for hospital collaboration. She remarked that hospitals can achieve cost savings by joining together for purchasing supplies and contracted work. She further recommended data analysis to determine if and where services may be underutilized. In summary, she emphasized the need to increase the availability of primary care providers; primary care office hours; and coordination between primary care physicians and other providers in discharge planning. She further stressed the issue of remuneration parity between primary care physicians and specialists, the need to retain primary care physicians, and the importance of collaboration between hospitals.

Domenic Delmonico, Care New England & Ken Belcher, Charter Care Partners, lead and facilitated the Commission's discussion regarding the issue of public reporting and transparency for Rhode Island's healthcare delivery system.

Mr. Delmonico described the goals of public reporting and transparency as helping patients make informed choices, helping providers improve quality through benchmarking, encourage payers to reward quality and efficiency, inform policymakers, and promote competition. One critical consideration, however, is that variables must be recognized and factored into any transparency efforts – the definition of 'fair' hospital reimbursement should include items such as non-operating income supports, insurer funding and agreements that may not be reflected in service payments, uncompensated care and DSH arrangements, academic medicine and research costs, and the Medicare Average Wage index. Other concerns include who will gather, store, and maintain data, how will the state educate and enough consumers to use this information, and how can we be sure that the information does not lead to inaccurate conclusions. Importantly, Mr. Delmonico stressed that any effort around transparency cannot go the way of previous efforts around hospital quality and reporting; whereby they receive lots of attention when launched, then are gradually ignored, funding dries up, and they are relegated to an obscure website with no direction on how to utilize them (supports of such programs counter that they are 'alive and well' and are functioning as designed despite budget cuts). Pointing out successful recent efforts in the state of Minnesota, Mr. Delmonico recommended establishing a Reporting and Transparency Task Force and charging it with explicit deliverables and timelines. This body would consider and address all critical variables that must be dealt with, and study best practices of other states, before making a recommendation to the General Assembly regarding transparency. He further added that any efforts on transparency must accompany a commitment to healthcare planning, which is also a pressing issue.

Mark Montella, Lifespan remarked that it seems the Commission is discussing operationalizing something that already exists in statute- the Health Insurance Commissioner (OHIC) already has the authority to publish information about hospital cost and quality; and a good deal of the other powers we are discussing also already exist in statute. One issue is that some of OHIC's authority is in statute, others are in regulation. .

Mr. Belcher remarked that there is a bit more common ground on the issue of transparency than many may think. He echoed Mr. Delmonico's contention that transparency alone is not enough and must be accompanied by sufficient planning and full recognition of appropriate variables such as medical education, complex populations, and 24 hour access to specific services. He described the current discussion as one between 'Haves' and 'Have nots' - larger hospital systems

with market leverage in negotiations; and small hospitals without such leverage. He discussed the controversy last year in Massachusetts around reimbursement levels for Partners Healthcare and the issue of leverage that the reporting brought to light. He also pointed out that transparency, when implemented correctly, is a good thing; he commended the Health Insurance Commissioner for developing last year's report which was criticized by some. While Mr. Belcher acknowledged that the Commissioner himself has stated the report is incomplete, it was important in starting the discussions that the Commission is having today. To move the state healthcare system forward the state must recognize and address the level of disparity among institutions. He pointed out that the Community Hospital Task Force, launched in 2007 by Lt. Governor Elizabeth Roberts and Governor Donald Carcieri, issued two recommendations – that hospitals should collaborate with each other and that hospitals should operate on a 'level playing field'. He remarked that hospitals have begun to collaborate, and pointed out to the existence of Charter Care through the merger of Roger Williams Medical Center and St. Josephs' Health System; but that there is not currently a level playing field for hospitals. To ensure a level playing field, hospitals need to be able to recruit and retain good doctors, but if reimbursements continue to lag that becomes more and more difficult.

Mr. Belcher remarked that any transparency and public review mechanism does not necessarily need to have 'fixed' rates or figures. Perhaps OHIC could be granted the authority to review contracts and recommend an acceptable 'range' of reimbursement taking into account all relevant factors. Mr. Belcher agrees that all Commission members desire a strong statewide health system with consistent quality.

Chairman Miller mentioned that legislation introduced this session which Mr. Belcher and Mr. Delmonico remarked they could not support as it was too 'simple' was a placeholder and that he expects the bill to be amended or that other legislation will be introduced stemming from the work of the Hospital Commission. He remarked that he agreed that no approach should be limited just to reimbursement rate transparency and that there should be factors that recognize costs, teaching responsibilities, demographics, etc.

Charles Kinney, Westerly Hospital, remarked that transparency is not limited to broad hospital negotiations and asked the Commission to imagine an individual with a \$5000 deductible health insurance plan. This individual needs to know how to best spend his/her health care dollars based on cost and quality. Perhaps in the near-term, the state should require insurers to list on their website what they reimburse each hospital for X number of common services.

Domenic Delmonico remarked that such a proposal has merit, but where would the state draw the line- for example, cholesterol testing can be considered 'common' and would be easy to administer, but what about more complicated surgeries or tests? And what about procedures that some hospitals do not offer at all? Perhaps such a list could be hospital-specific?

Commissioner Koller commented that there are two customers for the transparency and information the Commission is discussing. Yes, consumers with high deductible health plans need to know how to spend their health care dollar, but disclosing the

reimbursement of the ‘top 20’ procedures does not get after what Mr. Belcher described as the “haves/have nots” issue.

Mark Montella, Lifespan, commented that he is not sure that, in principle, anyone opposes the concept of transparency. But discussions such as the ‘high deductible’ issue is ‘nibbling around the edges’. He stressed that the Partners issue in Massachusetts does not reflect how all providers negotiation and there is no guarantee such behavior is occurring in Rhode Island. Any efforts regarding transparency appear to be pre-emptive to prevent a ‘Partners’ situation in Rhode Island, but the comparisons to the ‘Partners’ situation is limited in Rhode Island. And if Rhode Island wants to look forward and transform its health care system- payment is only one side of the equation.

Ken Belcher responded that there is imbalance in the hospital system, that hospitals are not on a level playing field, and that Rhode Island lacks a coordinated system of care.

Mr. Montella responded that he does not quite know what a ‘level playing field’ means considering the differences in cost and quality among hospitals.

Tom Breen, South County Hospital recommended that the Commission remain focused on the issue of transparency and fairness. The Commission cannot assume that all things will simply work themselves out and has to start getting specific on how we will promote transparency in such a way that recognizes variables but also safeguards against the ‘Partners’ issue. Perhaps the state should give authority to OHIC to measure contracts within a range.

Mr. Montella emphasized that transparency measures, even ones that adequately recognize factors such as DHS payments, populations, teaching costs, etc. would still fail to acknowledge the fact that every hospital board and management decision ever made accumulate and result in where hospitals find themselves today. Transparency unfairly ignores ‘good’ management decisions and ‘poor’ management decisions that are imbedded in each hospital’s financial position.

Chairman Miller remarked that the broader discussion here concerns the state’s responsibility to decide what information should be private and what should be public in hospital negotiations and what is in the best interest of Rhode Islanders – these deliberations should reflect the fact that the state has a responsibility to contain costs and ensure access to quality care throughout the state.

Special Senate Commission to Study Cost Containment, Efficiency, and Transparency in the Delivery of Quality Patient Care and Access by Hospitals

Sixth Meeting Summary (not intended as official minutes) – March 9, 2011

Chairman Joshua Miller welcomed all Commission members and guests. He invited Jessica Moschella, Administrative Director of the Massachusetts Health Care Quality and Cost Council to present before the Commission on the Massachusetts Council's work and her state's perspective on payment reform.

Jessica Moschella, Administrative Director of the Massachusetts Health Care Quality and Cost Council presented before the Commission on the history, goals, structure, and work of the Massachusetts Health Care Quality and Cost Council (presentation included in addendum)

The Commission membership discussed the findings and recommendations of the Commission as well as the content and structure of its final report.

