

2015

Report of the Working Group for Healthcare Innovation

DECEMBER 1, 2015

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
STATE OF RHODE ISLAND

Executive Summary

It is easier to make it in Rhode Island when everyone has access to high-quality, affordable healthcare. Businesses are more likely to invest here if Rhode Island can offer predictable healthcare costs. Like citizens across the country, Rhode Islanders face unsustainably high and rising healthcare costs and a fragmented care delivery system. Addressing and solving these challenges will provide Rhode Island families and businesses with more opportunity.

Building on the successful and ongoing efforts to reinvent Medicaid, Governor Gina M. Raimondo assembled a group of 41 stakeholders – providers, insurers, advocates, businesspeople, and legislators – and charged the group with proposing solutions to spark innovation across healthcare and achieve healthcare’s “Triple Aim” of **improved health, enhanced patient experience, and reduced per-capita costs**. The Working Group for Healthcare Innovation was charged with developing a plan for a global health spending target, value-based payment reform, access to care, health information technology, population health goals, and opportunities to reduce waste and overcapacity.

This report lays out a set of recommendations to help improve the state’s healthcare system and address high costs while maintaining quality of care. The proposals in this report represent a starting point for achieving the Governor’s ambitious goal to drive reform across the entire healthcare system. This report offers four broad recommendations with specific targets, deliverables and metrics:

- **Recommendation 1:** Create an Office of Health Policy to set statewide health policy goals and oversee effective implementation.
- **Recommendation 2:** Hold the system accountable for cost and quality, and increase transparency through a spending target.
- **Recommendation 3:** Expand the state’s healthcare analytic capabilities to drive improved quality at sustainable costs.
- **Recommendation 4:** Align policies around alternative payment models, population health, health information technology, and other priorities.

Reforming the state’s healthcare system requires partnership, initiative and commitment from all healthcare stakeholders, including private sector payors, providers, publicly funded healthcare systems and advocates, to ensure we keep our focus on improved outcomes, better care and lower cost. While major reforms to the entire industry require efforts driven by private sector and non-governmental entities, leadership and direction from state leaders is essential. Through these recommendations, the Working Group has attempted to put in place a process to build the underlying health infrastructure to help the private sector along the path of reform. Pieces such as a unified health policy office, a comprehensive state health plan, accountability for costs, and improved transparency will help align action across the health system.

These recommendations are presented to the Governor to strengthen the foundation that will move Rhode Island’s healthcare system into the future and ensure that Rhode Island remains a leader in providing affordable, quality health care to all of its citizens.

Table of Contents

Executive Summary	1
Table of Contents	2
Introduction.....	3
The case for change	3
Building from a place of strength	4
Goals of the Working Group.....	6
The Working Group for Healthcare Innovation’s public process.....	9
Recommendations.....	11
Recommendation 1: Create an Office of Health Policy to set statewide health policy goals and oversee effective implementation	12
Recommendation 1.1: Create a single point of health policy within the Executive Office of Health and Human Services.....	12
Recommendation 1.2: Create a comprehensive state health plan.....	13
Recommendation 1.3: Coordinate health policy decisions across the state.....	14
Recommendation 2: Hold the system accountable for cost and quality, and increase transparency through a spending target	15
Recommendation 2.1: Encourage affordable healthcare with predictable costs	15
Recommendation 2.2: Hold payors and providers accountable across the entire healthcare system	16
Recommendation 2.3: Link insurance premiums to the total cost of care.....	16
Recommendation 3: Expand the state’s healthcare analytic capabilities to drive improved quality at sustainable costs.....	17
Recommendation 3.1: Make cost and quality information readily accessible.....	17
Recommendation 3.2: Build the capabilities for cutting-edge health analytics within the state	17
Recommendation 3.3: Encourage an open and transparent healthcare system	18
Recommendation 4: Align policies around alternative payment models, population health, health information technology, and other priorities.....	20
Recommendation 4.1: Move away from fee-for-service towards alternative payment models	20
Recommendation 4.2: Encourage accountability for population health by adopting statewide health goals	22
Recommendation 4.3: Expand and improve usage of health information technology	24
Conclusion	28
Summary of Recommendations	29

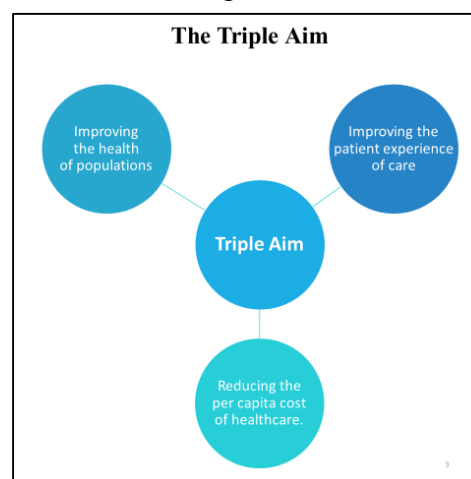
Introduction

Rhode Islanders have access to some of the finest healthcare services in the country, but rising healthcare costs are a major concern. Rhode Island, in line with other northeastern states, has some of the highest healthcare costs in the country. Although cost growth has slowed somewhat during recent years, costs remain at an unsustainable level. Rising healthcare costs put pressure on families, the business community, and the state. Rhode Island's future prosperity will be tied to our ability to create a sustainable, high-quality healthcare system.

Rhode Island has an opportunity to lead by example in healthcare. Building on the successful efforts to reinvent Medicaid and shift Rhode Island's publicly funded healthcare system to pay for value instead of volume, Governor Raimondo launched a public effort to spark innovation across the entire healthcare industry, eliminate waste from the system, and hold down the cost of healthcare.

The Working Group's challenge was to build on this promising foundation. There is enormous opportunity to transform our healthcare system, and in doing so achieve our Triple Aim:

1. Improve the health of those we serve.
2. Enhance the quality of care.
3. Lower per-capita costs.



The case for change

While access to health insurance is improving rapidly due to the Affordable Care Act, healthcare costs remain a major national concern. In the 10 years following 2000, private health insurance costs grew an 85%, with costs for Medicare and Medicaid growing even faster. Out of pocket expenses, including the co-pays and deductibles charged when patients use healthcare services, have also increased, with an average growth of nearly 50% over the same period.¹ Patients are hit on both ends: not only by rising premiums, but also by increased out-of-pocket costs.

Rhode Island is experiencing the same unsustainable healthcare cost growth as the country as a whole. Rhode Island is the 7th most expensive state in the country for medical care, with average per-capita expenses in 2009 of over \$8,300 compared to the national average of \$6,815.² Costs have continued to grow since 2009, with the most recent data showing total per-capita medical expenses of \$8,628 in 2013.³ Rising costs are reflected in rising healthcare premiums. The

¹ Kaiser Family Foundation. 2012. Raw data available at <http://www.cms.hhs.gov/NationalHealthExpendData/>

² Kaiser Family Foundation. *Health Care Expenditures per Capita by State of Residence*. 2009. Available at <http://kff.org/other/state-indicator/health-spending-per-capita/>

³ Health Care Planning and Accountability Advisory Council. *Rhode Island Total Cost of Care Study*. 2015.

average yearly commercial insurance premium for a Rhode Island family has increased from roughly \$9,500 in 2003 to over \$16,000 in 2013, an increase of 70%, or 5.5% annually.⁴

Unsustainable costs are increasingly hurting Rhode Islanders. According to the Rhode Island Department of Health (RIDOH) 2015 Statewide Health Inventory, more than a third of Rhode Islanders don't feel confident they can get medical care they need without being set back financially, and over a quarter feel that they have to pay more for medical care than they can afford.⁵ Many Rhode Islanders who aren't confident they can afford care delay it. In the survey, 30% of respondents had delayed medical care because of its cost at some point. Many of them ended up sicker than they had been originally due to the delay.

Despite the importance of understanding healthcare costs, the state has not historically tracked statewide total medical expenses. The Health Care Planning and Accountability Advisory Council (HCPAAC) commissioned a total cost of care study to examine total statewide spending on healthcare 2011 through 2013. Going forward, the state will have access to total cost of data through the all-payor claims database.

It is clear that there are no easy solutions to the crisis of health spending, but accurate and up-to-date data is a necessary precondition to solving this problem. A global health spending target is one method of providing transparency and accountability across the healthcare delivery system. With a target, the state and the public would have access to up-to-date information on trends across all payors and providers. A dedicated state entity would analyze the data for opportunities to reduce costs. While the state may ultimately need to consider more prescriptive regulation of health spending, it is critical first to collect the data necessary to evaluate the extent of the problem.

Building from a place of strength

The Whitehouse-Steinberg Compact

In December 2014, a broad coalition of Rhode Island healthcare leaders sent a letter to Governor-elect Raimondo and other state leaders calling for movement on health reform, including the establishment of statewide payment reform goals, statewide progress targets, and statewide tracking metrics.⁶ The group, convened by Senator Sheldon Whitehouse and Rhode Island Foundation President Neil Steinberg, included healthcare leaders from across the payment and delivery system, including providers, payors, and academics.

The group's recommendations fall into four broad categories:

- Statewide payment reform goals
- Statewide progress targets

⁴ Medical Expenditure Panel Survey (MEPS) data for Rhode Island.

⁵ Rhode Island Department of Health. *RIDOH 2015 Statewide Health Inventory*. 2015. Available at <http://www.health.ri.gov/publications/reports/2015HealthInventory.pdf>

⁶ *Letter to Governor-elect Raimondo, Speaker Mattiello, and Senate President Paiva Weed*. 2014. Available at <http://www.whitehouse.senate.gov/news/release/ri-health-care-leaders-send-reform-recommendations-to-raimondo-and-general-assembly-leaders>

- Statewide tracking metrics
- Action steps for state healthcare leaders and policymakers

The group encouraged setting a goal of achieving broad-based payment reform within the next five years. To do this, the group recommended the expansion and development of alternative payment models to reward value and patient-centric care delivery, the expansion of incentives for systems of care that encourage collaboration and sharing of claims data, and the reduction of waste in the healthcare system by reducing administrative overhead and encouraging use of evidence-based best practices. The progress targets included reducing use of traditional fee-for-service payments, collecting necessary data and considering opportunities for cost control, and reducing waste and redundancy.

The Working Group has been guided by the Whitehouse-Steinberg Compact and the leaders who originally set out these goals. Between the Working Group's recommendations and other state health reform efforts, we are well along the path set out in the Compact.

Recent health reform efforts

Rhode Island has some important building blocks already in place as we work to create an improved and more cost effective system:

- Excellent providers who are willing to be our partners in improving the healthcare system.
- A nationally recognized system of primary care providers who can guide patients through complicated health challenges.
- Two Medicare accountable care organizations that are already bringing change to Rhode Island's healthcare system.
- Widespread penetration of patient-centered medical homes (PCMHs) across the state, with 41% of primary care practices participating in a recognized PCMH.⁷
- One of the nation's best health information exchanges in CurrentCare, which is already helping coordinate care and reduce waste across the state.
- Significant expansion in health insurance coverage over the two years, both through Medicaid and private insurance, that lessens the burden on providers of uncompensated care and allows more people to receive care in the right place at the right time.⁸

In addition, recent health reform efforts have brought us closer to the ideal of achieving the Triple Aim:

- An ongoing State Innovation Model (SIM) project which also already made strides bringing the all-payor claims database online, creating a provider directory, and aligning quality measures throughout the state, and which will integrate the 2015 Statewide Health Inventory into a statewide Population Health/Behavioral Health plan.

⁷ RIDOH 2015 Statewide Health Inventory.

⁸ HealthSource RI. *Health Information Survey*. 2015.

- A strong Health Insurance Commissioner’s Office, which has continued work on Affordability Standards, administrative simplification, and alternative payment models.
- A recently-completed Reinventing Medicaid process, which is on track to achieve approximately \$70 million in savings, and which laid out the state’s long-term vision for Medicaid reform.
- Reports covering primary care, behavioral health, hospital capacity, and total cost of care from the Health Care Planning and Accountability Advisory Council.⁹

Goals of the Working Group

In her Executive Order, the Governor asked the Working Group to consider six main health reform goals:

- *A global health spending target*

A global health spending target would set out an acceptable level of growth in total medical expenses across the state each year, based on the model adopted by Massachusetts. The state would likely target the long-term potential growth in gross state product, a measure of growth in the state’s economy, to encourage healthcare to remain a fixed portion of the state’s economy. Payors, providers, and others who exceed the acceptable level of growth without good cause could be held accountable and asked to provide performance-improvement plans. The goal of such a target first and foremost is to provide data about health costs and transparency into health system expenses.

- *Tying healthcare payments to quality*

Rhode Island’s current healthcare delivery system is heavily weighted towards payment models that promote volume of services instead of value. Moving to value-based systems of payment will be essential to allow providers the freedom to use their resources to reduce utilization and improve health. The federal government has announced goals to move 50% of all Medicare payments to alternative payment models by 2018. The Rhode Island Medicaid program has adopted the same goal. Through the SIM process, and in collaboration with the Office of the Health Insurance Commissioner (OHIC), Rhode Island is currently examining opportunities for payment reform across the delivery system.

- *Ensuring all Rhode Islanders have access to care*

Rhode Island has taken massive strides towards improving access to care over the last several years. According to HealthSource RI’s (HSRI’s) Health Information Survey, 95% of Rhode Islanders currently had access to health insurance in 2015, up from 89% in 2012.¹⁰ These improvements have come as a result of expanding eligibility criteria for the Medicaid program and the creation of HSRI, the state’s health insurance exchange. Nevertheless, access problems remain. Access to pieces of the delivery system, such as

⁹ See the Health Care Planning and Accountability Advisory Council website at <http://www.health.ri.gov/partners/advisorycouncils/healthcareplanningandaccountability/>

¹⁰ *Health Information Survey*.

behavioral health and substance abuse treatment, has lagged behind insurance coverage. Rhode Islanders also face increasing costs to use their insurance coverage in the form of co-pays and deductibles. The state's population health plan, being created through the SIM process with RIDOH, will explore options to improve access throughout the delivery system, while OHIC's Administrative Simplification Task Force is evaluating increases to patient co-pays and deductibles.

- *Expanding and improving health IT*

Rhode Island has one of the country's best health information exchanges (HIEs) in CurrentCare, but it is underused. CurrentCare operates statewide and connects to the majority of provider's electronic health records systems. Recently, CurrentCare has completed automatic two-way integration with one of the state's most popular health records systems. With this integration, existing CurrentCare data is automatically included when a provider views a patient's medical record, without any additional intervention by the provider. However, CurrentCare enrollment remains below 50% of Rhode Islanders, including roughly 30% of Medicaid members, and only about 15% of providers access CurrentCare regularly for their patients. The state will take actions to increase the enrollment in and usage of CurrentCare.

- *Improve the health of Rhode Islanders*

The state, through the Department of Health, has defined preliminary population health goals. The goals were created to address three leading priorities: addressing the social and environmental determinants of health, eliminating disparities of health and promoting health equity, and ensuring access to quality health services. Together, the goals are designed to promote healthy living, ensure access to healthy environments, promote a comprehensive health system, and control emergent health hazards. The population health plan will recommend options for achieving these goals, while analyzing and communicating data to improve the public's health. Striving to improve the health of Rhode Islanders through these goals can lead to recommendations that strengthen preventative models. For example, as part of the community health team model, community health workers can serve as a link between the social and environmental factors in the community which often determine health outcomes to the traditional components of the health care system.

- *Reducing waste and overcapacity*

A 2013 study of the state's hospital capacity suggested that the state may have as many as 200 excess hospital beds.¹¹ In addition to hospitals, the state may also have excess

¹¹ Health Care Planning and Accountability Advisory Council. *Hospital Capacity Study*. 2013. Available at <http://health.ri.gov/materialbyothers/HealthCarePlanningAccountabilityAdvisoryCouncilReportToGeneralAssembly.pdf>

capacity in nursing homes.¹² Further, some estimates suggest that up to 30% of healthcare spending could be eliminated without impacting the quality of care by reducing or eliminating excessive administrative costs, unnecessary or duplicated tests, and clinical procedures that do not follow evidence-based practices.¹³

The Working Group for Healthcare Innovation's proposal has attempted to address the challenges laid out by the Governor. In particular, the proposal:

- Sets clear expectations on costs and drives all stakeholders towards progress on a shared goal.
- Disrupts the status quo, which is a fee-for-service model that increases costs with limited accountability for improving patient outcomes.
- Builds a common infrastructure which includes a thoughtful state health plan, transparency around prices, and a thorough analysis of what drives cost.

¹² Working Group to Reinvent Medicaid. *Report of the Working Group to Reinvent Medicaid: Recommendations for a plan for a multi-year transformation of the Medicaid program and all state publicly-financed healthcare in Rhode Island*. 2015. Available at <http://reinventingmedicaid.ri.gov/final-report/>

¹³ *Letter to Governor-elect Raimondo, Speaker Mattiello, and Senate President Paiva Weed.*

The Working Group for Healthcare Innovation’s public process

On July 20, 2015, Governor Gina M. Raimondo issued Executive Order 15-13, which established the Working Group for Healthcare Innovation. Governor Raimondo tasked the group with evaluating a health spending target, among other goals.

Working Group membership	
The Honorable Elizabeth Roberts (Chair), Executive Office of Health and Human Services	E. Paul Larrat, University of Rhode Island College of Pharmacy
Laura Adams, Rhode Island Quality Institute	Peter Marino, Neighborhood Health Plan
Edward Almon, Claflin Company	Linda McDonald, United Nurses and Allied Professionals
Peter Andruszkiewicz, Blue Cross Blue Shield RI	The Honorable Joseph McNamara, Rhode Island House of Representatives
The Honorable Scott Avedisian, City of Warwick	The Honorable Joshua Miller, Rhode Island Senate
Al Ayers, Electric Boat	Alvaro Olivares, Hispanic Outpatient Psychiatric Clinic at Butler Hospital
Timothy Babineau, Lifespan	The Honorable Juan Pichardo, Rhode Island Senate
Steven Brown, RI Dental Association	Donna Policastro, Rhode Island State Nurses Association
Albert Charbonneau, RI Business Group on Health	Albert Puerini, Rhode Island Primary Care Physicians Corporation
Jack Elias, Brown Medical School	Louis Rice, University Medicine
Steven Farrell, United Healthcare of New England	Pablo Rodriguez, Women’s Care
Diana Franchitto, Home & Hospice Care of RI	James Roosevelt, Tufts Health Plan
Louis Giancola, South County Hospital	Samuel Salganik, RI Parent Information Network
Hugh Hall, West View Nursing & Rehabilitation Center	Lester Schindel, CharterCare Health Partners
Jane Hayward, Rhode Island Health Center Association	John Simmons, RI Public Expenditure Council
Steven Horowitz, St. Elizabeth Community	The Honorable Joseph Solomon, Rhode Island House of Representatives
Dennis Keefe, Care New England	Neil Steinberg, Rhode Island Foundation
H. John Keimig, Healthcentric Advisors	Robert Swift, Providence VA Medical Center
Dale Klatzker , The Providence Center	Reginald Tucker-Seeley, RI Commission on Health Advocacy and Equity
Alan Kurose, Coastal Medical Group	Ira Wilson, Brown School of Public Health
Elizabeth Lange, Pediatrician, Coastal Medical	

Executive Order 15-13 further directed that the Working Group should hold public meetings. In compliance with this directive, the Working Group met on four occasions and convened two town hall-style listening sessions.

Working Group meeting dates	Listening session dates
August 19, 2015: Providence College, Providence	September 15, 2015: Buttonwoods Community Center, Warwick
October 7, 2015: Rhode Island College, Providence	October 13, 2015: Juanita Sanchez Educational Complex, Providence
November 4, 2015: Department of Administration, Providence	
December 1, 2015: Department of Administration, Providence	

To facilitate the analysis of a potential global health spending target, the Working Group members and others also participated in a Spending Cap Subgroup. The subgroup met four times to discuss and evaluate a spending target. The Working Group also relied on the assistance of a Provider Advisory Group to gather insights from providers who experience the system daily. The Provider Advisory Group met twice during the process.

Spending Cap Subgroup dates	Provider Advisory Group dates
October 13, 2015: State House, Providence	September 29, 2015: Rhode Island Medical Society, Providence
October 27, 2015: Department of Administration, Providence	October 27, 2015: Rhode Island Medical Society, Providence
November 10, 2015: Department of Administration, Providence	
November 17, 2015: Department of Administration, Providence	

Recommendations

As the Working Group looks towards the future of Rhode Island's healthcare system, we recognize that above all we strive to achieve the Triple Aim of improving the health of Rhode Islanders, enhancing the quality of care, and lowering costs. All of the work of this Working Group has this Triple Aim as the ultimate goal. In this report, the Working Group for Healthcare Innovation sets forth four major recommendations to begin to transform the state healthcare system into a system that is better optimized to achieve these goals. Under each recommendation, we identify a number of specific initiatives for the Governor to consider.

- **Recommendation 1:** Create an Office of Health Policy to set statewide health policy goals and oversee effective implementation.
- **Recommendation 2:** Hold the system accountable for cost and quality, and increase transparency through a spending target.
- **Recommendation 3:** Expand the state's healthcare analytic capabilities to drive improved quality at sustainable costs.
- **Recommendation 4:** Align policies around alternative payment models, population health, health information technology, and other priorities.

Recommendation 1: Create an Office of Health Policy to set statewide health policy goals and oversee effective implementation

The Working Group recommends creating a new Office of Health Policy. One common theme in public comments received throughout the Working Group process was the need for better coordination and goal setting across state agencies. The Assembly and other health reform efforts have already set a number of health policy goals, in areas such as value-based payments, population health, quality, and access to care. We expect the Office to work within these existing efforts.

The Working Group does not recommend creating a new office lightly. The Working Group is aware of the possibility of the Office becoming an unnecessary layer in the complex bureaucracy that regulates healthcare. In creating a new office, the state must ensure the Office is able to effectively coordinate policy, so that payors and providers are able to interact with fewer state agencies instead of more.

In line with this principle, the Working Group recommends the following initiatives:

Recommendation 1.1: Create a single point of health policy within the Executive Office of Health and Human Services

The Office of Health Policy should be created within the Executive Office of Health and Human Services (EOHHS) with the mission of establishing a coordinated, data-driven planning and regulatory process; monitoring quality, access and community health outcomes; and ensuring efficiency, accountability and transparency in healthcare delivery and payment.

EOHHS is in the best position to coordinate health policy among healthcare agencies. EOHHS is already charged with coordination across the four major health agencies. The Office of Health Policy would coordinate with OHIC and HSRI, in addition to the agencies under the existing EOHHS umbrella. Beyond coordination, the Office must take a more active role in health policy than EOHHS has taken previously, including the development of a state health plan and coordination of policies such as certificate of need, affordability policy, and hospital conversions, as detailed in Recommendation 1.3. The Office should have a strong data and analytics component, addressed in more detail in Recommendation 3, to allow data-driven decision making.

The Office should be led by a director accountable directly to the Secretary, who will work closely with existing agency policy staff and with department directors listed above who have authority in health policy and regulation. The Office should be advised by an outside stakeholder advisory group with active consumer engagement, which should help define the Office's policy agenda. By creating this stakeholder group, the Working Group hopes that the state can consolidate some existing stakeholder groups. Between agency groups and groups focused on health reform, the state has numerous stakeholder groups focused on health policy, many of which draw the same participants.

We recommend that the Governor's FY17 budget proposal be compatible with the creation of the Office.

Recommendation 1.2: Create a comprehensive state health plan

The Office of Health Policy must develop a comprehensive state health plan to inform its policy alignment decisions, which is likely best served by the ongoing SIM process to create a statewide population health plan. The state already has many existing health planning documents, but it is necessary to combine the existing documents into a comprehensive plan.

- As part of its mission, the HCPAAC has produced studies on different aspects of the health system which are listed below. Each HCPAAC study focuses specifically on one aspect of the health system:
 - Hospital capacity study
 - Primary care study
 - Behavioral health studies
 - Total cost of care study
- The Health Reform Commission, led by then-Lieutenant Governor Elizabeth Roberts, produced the State Health Innovation Plan (SHIP), which defined a strategy and mechanisms for moving Rhode Island’s healthcare delivery system to a value-driven, community-based, and patient-centered system. In particular, the SHIP developed the state’s current reform model based on patient-centered medical home initiatives and focused on a community-centered delivery system.
- The SIM application lays out the process to achieve the model of reform laid out in the SHIP, and is guiding the current SIM work. The SIM is currently developing a population and behavioral health plan in accordance with the federal government’s requirement for this grant.
- The 2015 Statewide Health Inventory is a comprehensive inventory of all healthcare facilities, health services, and institutional health services in the state, with data on the location, distribution, and nature of each healthcare resource. The inventory is extensive, with data covering all aspects of hospitals, outpatient care, primary care, long-term care, and other facilities and centers, as well as a survey of patients. The inventory, through the SIM process, will inform the state’s integrated population and behavioral health plan.
- The Reinventing Medicaid Working Group produced a plan for a multi-year transformation of the Medicaid program and all state publicly financed healthcare in Rhode Island, with the goal of transforming the public healthcare system to one that pays for the outcomes and quality care Rhode Islanders deserve, and that addresses the complex medical and social needs critical to achieving improved health status.

The Working Group believes it is necessary for the state to have a comprehensive health planning document. This need is likely best served by expanding the ongoing process to create a SIM population health plan. The plan should include details on quality metrics, capacity and needs planning, workforce planning, and performance management, in addition to the data from existing health planning resources. While some of these pieces currently exist independently under multiple agencies, others are not addressed at all. For example, OHIC has created some

spending goals for the commercial market through its Affordability Standards, but these are not aligned with goals for the Medicaid program. The population health plan should incorporate these necessary components, and should serve as a guide for the Office of Health Policy.

Such a comprehensive health plan will provide local providers with an understandable framework on which to make investment decisions. During Working Group meetings, several providers expressed uncertainty about whether investments in new outpatient or other facilities would be approved by the state. This comprehensive plan would help the state use its regulatory power, discussed in Recommendation 1.3 below, to efficiently drive the state towards a coherent policy vision. For example, in the case of new outpatient facilities, the plan should clearly identify areas of demand for new facilities, and where those facilities would be best located.

Recommendation 1.3: Coordinate health policy decisions across the state

The Office of Health Policy must align health policy decisions within state agencies with the state health plan and with each other. Although the Working Group has not endorsed the proposition that policymaking must be separated from regulation, we do believe there is benefit to coordinating policy decisions through a common entity to ensure agencies are working effectively toward shared goals.

In addition to coordinating broadly between agencies, the Office must ensure that decisions undertaken in each of the health agencies are aligned with the state health plan. The Office must avoid making healthcare policy decisions based on political considerations, and focus on need and alignment with the state health plan. The state policy goals that the Office should coordinate include, at a minimum:

- Certificate of need
- Affordability policy
- Administrative simplification
- Hospital conversions
- Medicaid reforms
- Capacity studies
- Health planning

The Office should not have a role in oversight or other purely regulatory functions, such as licensure, certification, complaints, and public health programs.

Recommendation 2: Hold the system accountable for cost and quality, and increase transparency through a spending target

The Working Group was formed to evaluate the possibility of a global health spending target for Rhode Island. Several Working Group members expressed concerns with a “hard” spending cap. A hard spending cap could make existing discrepancies in payment rates between providers permanent by limiting rate increases. A hard cap could also have unintended consequences on investment by crowding out the ability of payors and providers to invest in new or underutilized services. Rising spending on behavioral healthcare, for example, may be beneficial if it results in measurable improvements in quality of care with reduced hospital utilization, even if spending on behavioral healthcare grows more quickly than the healthcare system overall. Other pieces of the healthcare system, such as pharmaceuticals, are likely to be outside the control of Rhode Island providers.

After evaluation of various proposals from members, The Working Group recommends encouraging accountability and increasing transparency through a flexible spending target. The target itself should be secondary to the main goal of increasing transparency and accountability for costs and quality in our system. The Office of Health Policy should primarily attempt to understand how and why healthcare costs are increasing, rather than enforce a spending target.

In line with this principle, the Working Group recommends the following initiatives.

Recommendation 2.1: Encourage affordable healthcare with predictable costs

The Office of Health Policy should establish a process to regularly calculate and publish up-to-date figures on total medical expenses for the state. The Office should hold annual cost trend hearings to understand the growth in health expenditures from year to year, which should include both insured and out-of-pocket costs. The Office should include data from all major health plans, including self-insured plans, and all major providers. If cost trends remain unsustainably high across the state’s entire healthcare system, the Office should consider the possibility of further regulation, potentially including a cap on healthcare spending growth.

As part of the cost trend hearings, the Office should establish a non-binding annual target on the growth rate in total medical expenditures, which should apply to all healthcare services provided to Rhode Islanders within the state that are reimbursed through insurance companies. There should be no penalty for exceeding the target either for any individual player or for the system as a whole.

At first, the target should be set to have healthcare costs grow no faster than the long-term overall economic growth rate for the state. The Office should modify the target in future years to align with the goal of encouraging affordable healthcare with predictable costs, taking into account new innovations in care, demographic changes, the growth rate of healthcare costs in nearby states, and other factors that might affect the cost of healthcare.

Recommendation 2.2: Hold payors and providers accountable across the entire healthcare system

The current regulatory structure asymmetrically holds players accountable for rising healthcare costs. For example, payors are subject to a strict rate review process through OHIC, as well as affordability standards, while provider pricing receives less scrutiny, with the exception of OHIC's hospital rate regulation through the Affordability Standards. In designing the annual cost trend hearings, the Office of Health Policy should strive to hold all players in the healthcare system accountable for their results and costs. The Office should publish data on the cost performance of each major provider and use the analytic capabilities described in Recommendation 3 to determine why costs are increasing for each payor and major provider. The Office must consider cost trends in conjunction with existing data on outcomes and quality of care. Although new interventions may appear expensive, they may also be cost effective alternatives to existing therapies.

If an individual payor or provider has caused costs to increase unsustainably during the year without good cause, the Office can hold them accountable by requesting a performance improvement plan. The performance improvement plan should detail why the excessive cost growth occurred and the entity's proposed strategy for reducing costs in future years. The Office should be careful not to hold entities accountable for healthcare costs outside of their control, such as pharmaceutical costs, increases in insurance enrollment, documented demographic changes, and exceptional circumstances such as pandemics.

Recommendation 2.3: Link insurance premiums to the total cost of care

The Working Group believes there should be a tight connection between the growth in insurance premiums and growth in total cost of care. The state has a robust rate review process through OHIC to ensure that insurance premiums are reasonable in light of expected expenses. In addition, the Affordable Care Act imposes a minimum medical loss ratio on health insurance companies of 80% in the individual and small group markets, and 85% in the large group market. In 2014, Rhode Island was one of only four states in which all payors met this minimum threshold.¹⁴

However, total cost of care data shows an increase in the commercial market of 1.4% annually from 2011 to 2013, while premiums grew faster.¹⁵ The Working Group requests that the state issue a report examining the link between premiums and total cost of care by September 2016. If premiums have grown at an unjustified rate compared to costs, the state should consider modifying the rate review process, publishing retrospective cost reconciliations, or increasing the minimum medical loss ratio to ensure there is a tight link between premiums and costs.

¹⁴ CMS News. *Health care law results in \$2.4 billion in consumer rebates on premiums since 2011*. 2015. Full report available at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2014_Medical_Loss_Ratio_Report.pdf

¹⁵ *Rhode Island Total Cost of Care Study*

Recommendation 3: Expand the state’s healthcare analytic capabilities to drive improved quality at sustainable costs.

The primary goal of establishing a spending target should be to establish accountability and transparency within the health system. In addition to reporting on top-level trends, the Working Group urges the state to invest in health analytics. In Massachusetts, the law establishing the spending target also created the Center for Health Information and Analysis (CHIA). CHIA provides the underlying analytic capabilities which power the Massachusetts cost trend hearings and spending target.¹⁶

The Working Group’s goal in proposing this recommendation is twofold. First, the Office of Health Policy should coordinate data across all state health databases and ensure data-driven policy decisions. Second, the Office should regularly analyze data across these databases to provide meaningful information to the public on quality, affordability, utilization, access, and outcomes. By coordinating health data across the state, there may be opportunities to rationalize data collection requirements imposed on payors and providers.

In line with this principle, the Working Group recommends the following initiatives.

Recommendation 3.1: Make cost and quality information readily accessible

As discussed in Recommendation 2, the Office of Health Policy should hold annual cost trend hearings in September of each year to examine results from the preceding year. In these hearings, the Office should publish cost and quality data to understand why costs are increasing, where they have increased, and opportunities to bend the cost curve. In its published data, the Office should break down cost trends for all services into components which reflect the effect of changes in population, utilization, intensity, and pricing.

The Office should break down cost trends to the level of individual major providers and health plans. In order to accomplish this goal, the Office, either itself or through an existing state agency, must have the ability to collect data from hospitals, outpatient facilities, large independent physician associations, and other major providers, including total spending, spending broken down by category, and the use of alternative payment mechanisms.

Recommendation 3.2: Build the capabilities for cutting-edge health analytics within the state

Currently, Rhode Island has health data capabilities within a number of agencies. Through the Center for Health Data and Analysis, which collects, analyses, and disseminates data to drive public health decision making, RIDOH maintains a number of public health databases, including a hospital discharge database, emergency department database, KIDSNET¹⁷, as well as survey

¹⁶ Massachusetts Center for Health Information and Analysis. *Mission & History*. Available at <http://www.chiamass.gov/mission-and-history/>

¹⁷ KIDSNET is Rhode Island’s population-based integrated child health information system. KIDSNET facilitates the collection sharing of preventive health services data to allow timely and appropriate follow-up. KIDSNET also

data such as the Behavioral Risk Factor Surveillance System. These databases are utilized by RIDOH programs, other state and local agencies, community-based organizations, health care providers, and the general public. EOHHS holds Medicaid encounter data, an enormously rich data source cataloging the full claims history for each Medicaid member. OHIC has data on medical expenditures by health plan, as well as reform-minded statistics including the use of alternative payment models and spending on primary care. The state has created a new all-payor claims database (APCD), which has enormous research potential. The state should continue making this data publicly available where it is feasible.

On the other hand, there is no public entity that consistently reviews data from each database with the goals of improving population health, enhancing the patient experience, and reducing per-capita costs. Although pieces of each data source are generally available to the public, some data cannot be released due to sensitivity or small sample sizes. The Working Group believes it is essential for a health analytic capability to exist within the state. The Office, in coordination with existing state resources, should create this capability.

Recommendation 3.3: Encourage an open and transparent healthcare system

The Working Group believes that encouraging cost transparency will be critical to achieving the Triple Aim. Healthcare remains one of the least transparent industries with which consumers have regular contact. As healthcare becomes more complex and patients are increasingly responsible for paying a significant share of their costs, transparency has become even more important. In 2012, 64% of workers nationally had a deductible of \$1,000 or more.¹⁸ Prices for a single procedure can vary greatly, even within Rhode Island, and there is little correlation between prices and quality or outcomes.

The Working Group encourages the Governor to consider all possibilities to increase price transparency. In particular, we recommend the state publish data on the relative disparities in reimbursements for the same services between providers. According to a 2012 OHIC Hospital Payment Study, commercial payors paid the highest-paid hospitals twice as much as the lowest paid hospitals in some cases, even after adjustments for case mix.¹⁹ The Office of Health Policy should use APCD to publish an annual index of average reimbursements for common procedures across all hospitals.

The state should also consider policies to facilitate consumer access to price information through policies such as requiring payors and providers to give binding price estimates to consumers upon request. It is understood that the estimates can change in the case of unexpected complications, but it is unacceptable for patients to be unaware of their bill until after a procedure has been performed. The Working Group understands the difficulty of implementing

serves as Rhode Island's childhood immunization registry for children up to age 19 and links data across ten different public health programs.

¹⁸ Kaiser Family Foundation. *2012 Employer Health Benefits Survey*. 2012. Available at <http://kff.org/report-section/ehbs-2012-section-1/>

¹⁹ Office of the Health Insurance Commissioner. *Hospital Payment Study*. 2012. Available at <http://www.ohic.ri.gov/documents/Hospital-Payment-Study-Final-General-Dec-2012.pdf>

binding price estimates given the complexity of healthcare billing and recommends the policy phase in over several years.

Recommendation 4: Align policies around alternative payment models, population health, health information technology, and other priorities

The state must ensure its other health policies are aligned with the direction of reform. Use of alternative payment models, population health goals, and health information technology are the most important components. The state should also consider making strategic investments where necessary to improve the health of Rhode Islanders, and to subsequently reduce costs, such as in wellness, telemedicine, end-of-life care, health IT, and workforce development. In addition, the state should consider using the state employee health plan as a model of healthcare innovation for other employers. There may be opportunity to allow interested municipalities to enroll their employees in the plan to expand its reach.

In line with this principle, the Working Group recommends the following initiatives.

Recommendation 4.1: Move away from fee-for-service towards alternative payment models

Fee-for-service payment remains the dominant method of healthcare reimbursement in Rhode Island, but use of alternative payment models (APMs) is beginning to expand. Data collected by OHIC shows that 24% of commercially-insured payments were made through an alternative payment model in 2014.²⁰ This baseline has been achieved due to efforts over the last five years during which Rhode Island's health insurers, healthcare providers, and policymakers have laid the foundation for the transition to alternative payment models that reward value and support a coordinated system of care.

This foundation includes:

- Multi-payor efforts to fund health information technology infrastructure, such as the state's Health Information Exchange, CurrentCare. To date, CurrentCare has enrolled nearly half of Rhode Islanders and is aimed at improving the flow of health information across providers and care settings.
- Efforts to support team-based primary care through patient-centered medical homes PCMHs that have positioned providers to work as part of a system of care. The multi-payor Care Transformation Collaborative and efforts by Blue Cross Blue Shield of Rhode Island have resulted in over 40% of primary care providers working in a PCMH.²¹
- Contracts between private payors and providers that link payments to the quality of care and encourage total cost of care accountability for attributed populations.
- Medicare alternative payment model initiatives, such as the Medicare Shared Savings Program and the Bundled Payments for Care Improvement Initiative.
- OHIC standards around healthcare payment and contracting. These standards define APMs and set specific binding targets for percentage of payments, require commercial

²⁰ While 24% of commercial payments were made through an alternative payment mechanism, only 1.5% of total dollars flow through something other than fee-for-service.

²¹ *RIDOH 2015 Statewide Health Inventory*.

payors to have quality improvement programs in place with hospitals, and tie hospital rate increases to performance.

- Strong primary care infrastructure through OHIC regulation requiring payors to increase primary care investments and encouraging PCMH adoption. A strong primary care foundation can provide the basis for a coordinated system of care that extends into the community and promotes the use of APMs.

Proposed strategy to achieve APM goals

Current initiatives through the Centers for Medicare and Medicaid Services (CMS) and the Healthcare Payment Learning and Action Network emphasize the importance of reaching a “critical mass” of payors engaged in payment reform to ensure that the financial incentives of value-based payments are strong enough to support system transformation.²²

To reach this critical mass, the Working Group recommends Rhode Island’s public and private payors coalesce around a set of measurable and achievable targets for use of APMs and value-based payments that align with Medicare and SIM targets of having 50% of payments under an APM and 80% of payment linked to value by the end of 2018.²³

Work is already underway at Medicaid and OHIC to drive Medicaid Managed Care Organizations (MCOs) and commercial payors toward these targets. The following additional activities should be undertaken to support system transformation and align policy direction and regulatory standards to meet these targets and maximize the impact of the numerous initiatives underway in Rhode Island.

Next steps to reach the targets

1. Build the infrastructure for success by maximizing the potential for provider success under payment reform and ensuring required infrastructure is in place.
 - Continue to make multi-payor investments in health information technology infrastructure with the goal of having 90% of Rhode Islanders enrolled in CurrentCare by 2018. Continue to encourage and support provider use of CurrentCare and its provider tools.
 - Support the use of data and analytics, such as the APCD and clinical registries, to give providers actionable information that will allow them to effectively and efficiently manage their patient panels, including standardized high-risk patient lists.
 - Provide technical assistance and infrastructure support to primary care practices to build and sustain effective coordinated care processes across the healthcare system, including extension into the community, through programs such as RIQI’s practice

²² Rajkumar R, Conway P, Tavenner M. CMS – Engaging Multiple Payors in Payment Reform. JAMA. 2014; 311(19): 1967-1968.

²³ Whereas most payment models with incentive payments will qualify as payments linked to value, alternative payment models must define and evaluate cost performance relative to a “budget”. Providers are rewarded for managing costs below the budget, so long as quality performance is acceptable, by retaining some of the savings. Providers may also be responsible for some of the costs that exceed the budget

- transformation support. Special attention should be focused on small primary care practices that are not currently engaged in practice transformation and on building competencies among primary care providers and specialists to participate in APMs.
2. Foster better alignment across state agencies by aligning existing policy and regulatory efforts around care transformation and payment reform.
 - Align the Medicaid MCO procurement strategy and commercial insurer transformation standards with regard to APM definitions and targets.
 - Leverage the Office of Health Policy and the SIM process to align state agency policy and regulatory efforts.
 3. Foster better alignment with community partners by ensure that consumers, employers, providers, and payors continue to have a voice in system reform.
 - Continue to convene stakeholders to address and respond to challenges that arise as we transform care delivery and reform payment to improve population health outcomes.
 - Ensure consistency and coherence in value-based payment arrangements by developing common market rules governing APM contracts, such as consistent patient attribution and risk adjustment methodologies.
 - Create a Quality Measure Guiding Committee, including payors, providers, advocates and others, upon completion of the aligned measure set process being conducted under the SIM grant to act as steward of the aligned measure set over time.

Recommendation 4.2: Encourage accountability for population health by adopting statewide health goals

Population health is defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group, as measured by health status indicators.²⁴ Population health outcomes are the product of multiple determinants of health including social factors, environmental factors, the distribution of disparities in the population, medical care, public health policy, genetics, and behaviors. Focusing on population health provides an opportunity for healthcare delivery systems, state agencies, community-based organizations, and others to work together to improve health outcomes in the communities we serve.

As one of many agencies responsible for the health of the population, the Rhode Island Department of Health’s mission is to “protect and promote the health of all Rhode Islanders.” RIDOH used the Centers for Disease Control and Prevention’s Healthy People 2020 as a guide and framework to establish population health goals for the state. Success in achieving improvements in population health will require a strong partnership with the community, including direct connections with consumers whose healthcare outcomes can be improved by community health workers serving as part of community health teams. Other key partners include payors, providers, community-based agencies, and consumers. The statewide integrated

²⁴ Kindig, D.A. and G. Stoddart “What is Population Health? American Journal of Public Health, Vol.93, 2003, p.3669.

population and behavioral health plan will be an integral component to achieving the goals of the Working Group.

Process for selecting population health goals

In early 2015, RIDOH developed a set of three leading priorities that redefined how the department functions and engages with other state agencies, community partners and the people of Rhode Island. This new vision recognizes that while Rhode Island has made strides in achieving goals for Healthy People 2010, disparities still persist and for the first time in the modern era, the next generation has a lower life expectancy than the current generation.

- The first leading priority is to address the social and environmental determinants of health in Rhode Island. Achieving and maintaining good health is determined by the communities, schools, worksites, child care, healthcare systems, and environments that people are a part of. Creating healthier, equitable places, must be done by multiple organizations, state agencies, and community members working together.
- The second leading priority is to eliminate the disparities of health in Rhode Island and to promote health equity. The poorer health status experienced by vulnerable populations (e.g. the very young or very old, racial and ethnic communities, people with disabilities, homeless or incarcerated populations, and people with low socio-economic status or without a high school degree), includes higher mortality and poorer overall health, which is measured by incidences of chronic and infectious diseases, maternal and child health indicators, and behavioral risk factors. RIDOH will focus on eliminating unacceptable differences in health outcomes while ensuring that every Rhode Islander will achieve his or her maximum level of health.
- The third leading priority is to ensure access to quality health services for Rhode Islanders, including vulnerable populations. Disparities in access to medical and other health resources that extend into the communities where people live persist as a part of everyday life and our most vulnerable populations deserve a coordinated health system that is responsive to their unique needs. The state must incorporate models such as community health teams with community health workers that extend into the homes and environments where health outcomes are most impacted; and must also monitor the comprehensiveness, continuity, and quality of our healthcare system, the adequacy of health networks and of our safety net infrastructure, and alignment with the overall healthcare reform efforts in our state.

With these three leading priorities as the framework, RIDOH identified the top five health strategies to successfully support the implementation of the leading priorities. Under each strategy, RIDOH identified a core set of population health goals along with specific metrics and targets for each.

Strategy 1: Promote healthy living through all stages of life

1. Reduce the burden of obesity in Rhode Island children, adolescents, and adults.
2. Reduce the proportion of Rhode Islanders with chronic illness, such as diabetes.

3. Promote maternal and child health.
4. Promote Senior Health to support independent living.

Strategy 2: Ensure access to safe food, water, and healthy environments in all communities

5. Increase access to safe, healthy, affordable food.
6. Increase compliance with health standards in recreational and drinking water supplies.
7. Reduce the burden of environmental toxic substances in Rhode Island.

Strategy 3: Prevent, investigate, control, and eliminate health hazards and emergent threats

8. Reduce the burden of sexually transmitted infectious diseases, such as HIV in Rhode Island.
9. Reduce the burden of substance abuse in Rhode Island.
10. Increase the capacity of emergency response and prevention in community settings.

Strategy 4: Promote a comprehensive health system that a person can navigate, access, and afford

11. Improve access to care including physical, oral, and behavioral health systems.
12. Improve healthcare licensing and complaint investigations processes.

Strategy 5: Analyze and communicate data to improve the public's health

13. Encourage Health Information Technology adoption among Rhode Island healthcare providers as a means for data collection and quality improvement.
14. Enhance and develop public health data sets to support public health surveillance and action.
15. Develop and implement standards for data collection to improve data reliability and usability.

Recommendation 4.3: Expand and improve usage of health information technology

Health information technology (HIT) infrastructure serves as an essential tool to collect healthcare information and drive effective policy, transition to value based purchasing and achieve the Triple Aim. Health IT enables numerous critical functions, including assessing public health, informing clinical decisions through comprehensive information at the point of care, providing safe and effective transitions of care, measuring the quality and cost of care, determining payment under value-based models, and engaging patients in their own health and care.

Rhode Island's state government, in partnership with the community, has been at the forefront of creating a health information and technology backbone to support the state's transition to value-based care. While a significant time, energy, and dollars have been dedicated to building HIT infrastructure, there are additional infrastructure components that are needed in order to support necessary functions in a coherent, streamlined, and cost-effective manner

The state of health IT in Rhode Island

Electronic Health Record Adoption: Rhode Island continues to promote the adoption of electronic health records (EHRs). EHRs are an essential tool for providers and a foundational

component of the state's HIT strategy. The RIDOH 2015 Statewide Health Inventory indicated strong overall EHR adoption rates, with 85% of primary care practices, 90% of hospitals, 60% of behavioral health clinics, 55% of outpatient specialty practices, 80% of nursing facilities, 45% of home health agencies, and 25% of assisted living residences using EHRs.²⁵ While the most dominant EHRs in the state are Epic and eClinicalWorks, there are approximately 50 different EHRs are being used in the state.

The inventory also asked about availability of reporting software. While hospitals had reporting capacity matching their EHR adoption, only 20% of primary care practices had reporting software and other types of facilities had even lower rates of reporting software availability. Improving report generation will be critical to undertaking population health management, high risk case identification, and aggregation of clinical and claims data.

CurrentCare, Rhode Island's Health Information Exchange: Rhode Island's Health Information Exchange, known as CurrentCare, has been operational since 2010 and is administered by the Rhode Island Quality Institute. CurrentCare is structured as an opt-in centralized HIE service where patients choose to have all of their information shared to create a longitudinal healthcare record across healthcare entities made available to designated healthcare providers. To date there are 480,000 lifetime enrollments in CurrentCare (approximately 48 % of the state's population). The data sent to CurrentCare includes:

- Hospital admission, discharge and transfer data
- Laboratory results
- Continuity of Care Documents, which include information such as allergies, diagnoses, and prescriptions
- Summaries from home health
- Dispensed medications
- Diagnostic imaging reports

The aggregation of healthcare information across healthcare organizations allows providers to access an integrated and longitudinal view of their patients' core healthcare records. Today there are approximately 377 practices, 18 long term care facilities and 17 behavioral health sites that have been trained to use CurrentCare's online portal. Results of the RIDOH inventory indicated that 68% of Rhode Island primary care physicians have access to the CurrentCare viewer. Additional physicians have access through an automatic link with their EHR.

CurrentCare can also provide hospital alerts. These alerts uses hospital admission, discharge and transfer data to notify a provider that their patient has been admitted to, or discharged from an emergency department or acute hospital in the state. Currently there are 223 practice sites that are enabled to receive hospital alerts.

KIDSNET: RIDOH maintains a separate public health information database for its pediatric population called KIDSNET. Operational since January 1, 1997, KIDSNET captures public health information on all children born in the state. The database was developed to ensure that all

²⁵ RIDOH 2015 Statewide Health Inventory.

Rhode Island children receive the right preventive care at the right time. It includes an immunization registry as well as information from vital records, newborn screenings, WIC, the lead poisoning prevention program, early intervention, and home visiting. Much like CurrentCare, KIDSNET has a web portal that allows providers to look up any of the above information on their patient but, unlike CurrentCare, it includes data on all children and does not require individuals opt-in.

Prescription Monitoring Program: RIDOH maintains the state Prescription Monitoring Program (PMP). The PMP includes records of all Schedule II, III, and IV medications dispensed to Rhode Island residents for outpatient care. Prescribers and pharmacists log into the PMP before prescribing certain medications to check for possible abuse.

All-Payor Claims Database: The state is nearing completion of its all-payor claims database. A partnership between RIDOH, EOHHS, and OHIC, the APCD contains de-identified eligibility records, medical claims, pharmacy claims, and provider data. The APCD will allow for:

- Longitudinal tracking of de-identified claims across insurance carriers.
- Robust reporting and analysis to aid and improve the calculation of risk scores.
- Measuring utilization and spending.

Unified Health Infrastructure Project (UHIP). Rhode Island is building a single integrated eligibility system technical platform known as UHIP that will support the health insurance exchange, Medicaid eligibility, and other state human service program eligibility.

Future vision for health IT

Rhode Island has already implemented several state-of-the-art health IT systems which give healthcare providers the data to make informed decisions for their patients and give policymakers the data to make better policy decisions. As the state shifts to a system of care based on value, there will be a greater emphasis on the need for and use of health information technology components that are integrated and interoperable, provide real time analytics, and support patient engagement strategies. More specifically the five year vision for health information technology capacity in the state includes:

1. **Complete EHR adoption:** While the state's rates of EHR adoption have been increasing, the state should establish a goal of 100% EHR adoption rate for all primary care providers, behavioral healthcare clinics, hospitals, outpatient specialty clinics and long term care facilities.
2. **Streamline infrastructure:** Providers can provide better, cost-effective care if they have access to complete clinical, claims, and quality data at the point of care. When multiple providers are attempting to coordinate the care of an individual, technology that allows for information sharing and tracking of critical health factors is a necessity. This function is currently provided with a myriad of systems: CurrentCare, KIDSNET, PMP, ad-hoc point-to-point interfaces, and private information provided by each payor.

In order for providers to be able to incorporate this data into their daily workflow, it should be made available through their own EHR. Providing the ability to integrate several statewide databases both with each other and with CurrentCare will produce resource and

cost savings for providers. Achieving this vision of greater interoperability, more streamlined infrastructure, and a reduced number of point to point connections may require changes to the current legal and regulatory basis upon which these systems were built.

3. **Examine opportunities to move towards a centralized analytic platform:** As value-based payment models are implemented, provider organizations will need timely, accurate, and standard information about their patients to better manage the cost and quality of care they are delivering to their patient population. To date, it has been challenging to use EHRs to generate quality measures. Yet EHR data, if documented consistently and aggregated properly, can be the best source of accurate and timely information for large numbers of patients. Providers not only need data that are complete and organized, but also the analytic expertise to understand that data in a meaningful, actionable way.

Providers would benefit from a shared quality reporting and measurement platform with centralized analytic capabilities. This approach would help address the lack of current analytical tools while also reducing the necessity of large financial investments from each provider. Such a shared platform should be linked to the common provider directory to allow data to be analyzed at the practice, organizational, or payor level.

4. **Engage patients:** Consumers are better patients when they can easily access their own healthcare records, provide supplemental health information, and find cost and quality data. Engaging patients in their health requires an effective patient interface, supported by technology. Currently, patients are burdened by fragmented healthcare record across multiple providers and patient portals. The state should encourage the development of a common platform for patient engagement.

Conclusion

Rhode Islanders already have access to some of the finest healthcare services in the country, and we hope to build on that success. Like healthcare systems throughout the country, Rhode Island's healthcare delivery system faces costs which are rising unsustainably. Rising healthcare costs hurt families, businesses, and the state. Rhode Island will be more attractive for business investment here if we have affordable and predictable healthcare costs. Nevertheless, transforming Rhode Island's healthcare system will be a process which takes many years. This document, in combination with all of the health reform efforts in the state, should be seen as the starting point for transformative reform.

The Working Group for Healthcare Innovation is thankful to the providers, advocates, and stakeholders who participated in the Working Group's public sessions and subgroups. The Working Group's recommendations have benefited from the direct and candid exchange of data, ideas, and challenges. Not every member of the Working Group agrees with every recommendation in this report; some of these recommendations represent difficult compromises. We are united by a belief and understanding that transformative change is never easy and that tough choices are necessary to lay a strong foundation for any kind of sustainable reform. We also share a belief that the state's current healthcare payment and delivery system must be improved.

We have proposed four recommendations designed to move the program towards achieving the Triple Aim of improved health, enhanced patient experience, and reduced per-capita costs. Although our recommendations focus on state action, it is clear that health reform will hinge upon reform in the private sector as well. We hope that these recommendations will spark innovation across the health system.

- **Recommendation 1:** Create an Office of Health Policy to set statewide health policy goals and oversee effective implementation.
- **Recommendation 2:** Hold the system accountable for cost and quality, and increase transparency through a spending target.
- **Recommendation 3:** Expand the state's healthcare analytic capabilities to drive improved quality at sustainable costs.
- **Recommendation 4:** Align policies around alternative payment models, population health, health information technology, and other priorities.

The diverse group of stakeholders who have gathered through this process represent a wealth of expertise and perspectives and they must remain engaged with the difficult task of implementing and continuously improving our reform efforts. This is an exciting time for health reform, with a number of innovative approaches being pioneered across the country. We hope to see Rhode Island at the forefront.

Summary of Recommendations

Working Group for Healthcare Innovation
Recommendation 1: Create an Office of Health Policy to set statewide health policy goals and oversee effective implementation.
Recommendation 1.1: Create a single point of health policy within the Executive Office of Health and Human Services.
Recommendation 1.2: Create a comprehensive state health plan.
Recommendation 1.3: Coordinate health policy decisions across the state.
Recommendation 2: Hold the system accountable for cost and quality, and increase transparency through a spending target.
Recommendation 2.1: Encourage affordable healthcare with predictable costs.
Recommendation 2.2: Hold payors and providers accountable across the entire healthcare system.
Recommendation 2.3: Link insurance premiums to the total cost of care.
Recommendation 3: Expand the state's healthcare analytic capabilities to drive improved quality at sustainable costs.
Recommendation 3.1: Make cost and quality information readily accessible.
Recommendation 3.2: Build the capabilities for cutting-edge health analytics within the state.
Recommendation 3.3: Encourage an open and transparent healthcare system.
Recommendation 4: Align policies around alternative payment models, population health, health information technology, and other priorities.
Recommendation 4.1: Move away from fee-for-service towards alternative payment models.
Recommendation 4.2: Encourage accountability for population health by adopting statewide health goals.
Recommendation 4.3: Expand and improve usage of health information technology.