February 9, 2011

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

Thank you Mr. Chairman for the opportunity to address the Commission. My name is Matthew Smith; I am a physician in East Greenwich. I am a champion for integrated care delivery for the most expensive chronic condition: spine pain. While investigating the feasibility of restoring value to this service line, I uncovered challenges which are relevant to this Commission’s charge.

Collaboration around service lines will fall under the framework of Accountable Care Organizations, which in most cases will be a coalition of our 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. Before presenting my recommendation, I will review 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. The 147 vanquished covered 4.1 million lives; 28,000 lives per group. Kaiser Permanente in Northern California alone had 3 million members at the time.

• **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. Without buy-in, physicians undermined the process.

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. Shared governance was assured in the bylaws through the use of reserve powers and class voting to protect the interests of all stakeholders.
• 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 re-hospitalizations were reduced and post-hospital care costs were controlled.

With these observations in mind, I recommend that the relationships among the parties at this table be formalized into a Regional Healthcare Resource Authority. Two main charges await this collaborative. The first is integration:

• Oversee ACO arrangements between payors, hospitals and providers. Facilitation of communication in these historically complex relationships will be necessary to assure the transparency and trust needed to respect all parties’ interests as difficult topics such as risk-sharing are addressed.
• Provide guidance on safe harbors from regulatory restrictions to incentivize all stakeholders.
• Assist in establishment of fair evidence-based care rates
• Protect patients during implementation of standardized clinical decision making algorithms
• Provide support for accreditation of ACO’s, PCMH’s, Interdisciplinary Spine Pain Centers, etcetera
• Coordinate interoperability of information systems
• 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.

This leads to accountability, the second charge for our regional leadership.
A cornerstone of the knowledge economy will be 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: 1. clinical effectiveness, 2. organizational compliance and 3. cost utility measures. Clearly, 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 our own state highlights the need for improvement. The effectiveness of the research department should not be hampered by continued fragmentation of resources in an environment of competing interests.

In conclusion, with privilege comes responsibility. By way of the recognition awarded to Rhode Island, we all have been challenged to coordinate for the better. An effective Regional Healthcare Resource Authority will legitimize Rhode Island’s role as a leader to an era of high-value health care.

Matthew J. Smith, MD
ABPM&R, AANEM, ABIME
Chair, East Greenwich Spine & Sport
President, Rhode Island Pain Society