



The Care New England and Lifespan Proposed Merger: Payment Model Characteristics Necessary to Maximize Affordability and Quality Related to the State of Rhode Island Office of the Health Insurance Commissioner's Statutory Purpose

Executive Summary

This working paper (defined in this context as a document meant to share ideas, serve as a basis for discussion, and elicit feedback) represents an effort by the State of Rhode Island Office of the Health Insurance Commissioner (OHIC) to iterate on and refine three critical payment model structures for the merged entity that would be formed if the proposed merger by Care New England (CNE) and Lifespan is approved. These payment model structures are: comprehensive price caps, quality incentive requirements, and advanced value-based payment (VBP) adoption. Such payment model structures would be aimed at holding the merged entity accountable for improving affordability and improving population health and health equity on a statewide scale in concert with other policies not addressed here. The scope of the discussion in this paper of these payment model structures is limited their applicability to the commercial health insurance market but application to other markets (such as Medicaid and Medicare) deserves consideration as well. Moreover, there are a host of other regulatory guardrails that should be considered pertaining to prohibitions on anti-competitive contract provisions, provider-to-provider affiliation agreements, and oversight of merged entity financial solvency that are not addressed here. This paper is not exhaustive, and we leave it to our able colleagues in state government and elsewhere to fully work out these details. Finally, at the outset of this paper, it is important to note that the office and the paper, consistent with OHIC's previous statements, do not take a position as to whether the proposed merger should be approved because OHIC is not one of the governmental entities responsible for determining this.

This paper follows OHIC's previously published paper, [*The Care New England and Lifespan Proposed Merger: Policy Considerations Related to the State of Rhode Island Office of the Health Insurance Commissioner's Statutory Purpose*](#). Like the previous paper, this paper will assist the health insurance commissioner in strategically assessing how OHIC should carry out its statutory responsibilities in light of the proposed merger and inform the vital public conversation around the proposed merger's implications for the Rhode Island health care system as a whole.

Given these considerations, the proposed merger between CNE and Lifespan presents a host of risks and opportunities. It remains OHIC's position that the risks to the public interest objectives that guide OHIC's work—access, affordability, and quality (which are consistent with OHIC's statutory purpose outlined in [*State of Rhode Island General Laws \(RIGL\) § 42-14.5-2*](#)) are significant and should command careful attention by regulators and the public. This is because, as OHIC also found in its previous paper, the available evidence clearly suggests that hospital consolidation leads to higher prices and that the evidence on the impact of hospital consolidation on the quality of care is mixed.

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Furthermore, it is critical to emphasize that, although this paper discusses payment model structures that would be of particular importance in the event the merger be approved, the paper should not be construed as endorsing any type of assumption that the merger should or should not be approved or will or will not be approved. Again, OHIC is not one of the governmental entities responsible for resolving whether or not the merger should be approved but it is profoundly responsible for advancing access, affordability, and quality in the Rhode Island health care system and the disposition of merger will ultimately have a decisive impact on these public interest objectives.

Regarding comprehensive price caps, OHIC recommends that these should be put into place for the merged entity—if it is approved—to ensure that the risk of monopolistically driven price increases does not occur following the approval. Such price caps should be directly binding on those providers that are within the ownership structure of the merged entity. For administrative simplicity and ease of implementation, OHIC recommends that these price caps should take the form of price caps on annual growth that would limit year-over-year average price increases to no more than the per capita potential gross state product growth or less for the applicable time period, which is consistent with the principle that pricing growth for the merged entity should not exceed overall economic growth for the state.

Regarding quality incentive requirements, OHIC notes that the current acute care hospital measure set covers hospital acquired infections, hospital readmissions, follow-up after hospitalization for mental illness, and patient experience of care. OHIC also curates measure sets to be used by insurers in contracts with other classifications of providers, such as primary care providers and accountable care organizations (ACOs). In addition to ensuring that the merged entity's contracts include meaningful financial incentives for quality performance, the oversight entity charged with overseeing the merged entity should publish quality performance for the merged entity, including performance at the individual hospital and physician group level. To ensure statistically valid measurement, a measure-specific minimum denominator threshold could be adopted for public reporting at the individual hospital level and provider group level.

The prospect of a merger between CNE and Lifespan presents the need and opportunity to accelerate advanced VBP in Rhode Island. A merged entity would account for nearly 80% of the inpatient services market and over 80% of the market for attributed patients, a proxy measure for the physician services market. In effect, an entity of this size and scope would command a critical mass of patients and service volume on which to build more advanced VBP models. This would ensure that the merged entity would face thoughtfully constructed economic incentives to control the total cost of care and set its attention on utilization, mix of services, and prices. Imposing budgetary discipline for total spending is important because price caps, as described above, do not directly address volume.

Regarding advanced VBP adoption, OHIC recommends that the focus for the merged entity should be on adopting advanced VBPs that include an explicit predetermined budget. There are a number of ways that the merged entity could adopt advanced VBPs. Short of full global capitation, which is most feasible within an integrated delivery system and payer structure, the merged entity could build off of existing total cost of care (TCOC) contracts with payers and shift the preponderance of hospital and employed physician services to hospital global budgets and physician sub-capitation.

It is OHIC's position that a permanent regulatory oversight structure must be empowered to oversee the merged entity. Alternative structures have been tentatively proposed by others. OHIC does not take a position on the form and location of the necessary oversight powers within state government. If the merger is ultimately approved on its present track, beyond any conditions of approval, it is also possible that the legislature may choose to provide additional administrative powers and resources to the executive branch to oversee the merged entity.

This paper reviews the payment model structures that could be applied to the merged entity, but it does not offer a blueprint for how to do so from a regulatory perspective. The specific policy features of the regulatory oversight model and the associated legal and human resources necessary to carry out oversight of the merged entity will be conditioned by the form of approval by the relevant state agencies or the legislature. At minimum, it is OHIC's position that the merged entity should be required to fund the costs of state oversight of the merged entity in perpetuity.

In conclusion, it bears mentioning as well that the proposed merger—despite the significant risks it presents for Rhode Islanders and the Rhode Island health care system, also could potentially have a positive impact on the health care system and health outcomes in the state. If approved, the fundamental task of policymakers, regulators, and all stakeholders will be to make extraordinary efforts to ensure that this potential becomes a reality, despite the preponderance of evidence suggesting that this is unlikely to occur. OHIC will continue to track developments around the proposed merger and may update this paper in light of additional information. The office will continually seek to educate the public about the risks and opportunities connected to the proposed merger.

Introduction

This working paper (defined in this context as a document meant to share ideas, serve as a basis for discussion, and elicit feedback) represents an effort by the OHIC to iterate on and refine three critical payment model structures for the merged entity that would be formed if the proposed merger by CNE and Lifespan is approved. These payment model structures are: comprehensive price caps, quality incentive requirements, and advanced VBP adoption. Such payment model structures would be aimed at holding the merged entity accountable for improving affordability and improving population health and health equity on a statewide scale in concert with other policies not addressed here. The scope of the discussion in this paper of these payment model structures is limited their applicability to the commercial health insurance market but application to other markets (such as Medicaid and Medicare) deserves consideration as well. Moreover, there are a host of other regulatory guardrails that should be considered pertaining to prohibitions on anti-competitive contract provisions, provider-to-provider affiliation agreements, and oversight of merged entity financial solvency that are not addressed here. This paper is not exhaustive, and we leave it to our able colleagues in state government and elsewhere to fully work out these details. Finally, at the outset of this paper, it is important to note that the office and the paper, consistent with OHIC's previous statements, do not take a position as to whether the proposed merger should be approved because OHIC is not one of the governmental entities responsible for determining this.

This paper follows OHIC's previously published paper, [*The Care New England and Lifespan Proposed Merger: Policy Considerations Related to the State of Rhode Island Office of the Health Insurance Commissioner's Statutory Purpose*](#). Like the previous paper, this paper will assist the health insurance commissioner in strategically assessing how OHIC should carry out its statutory responsibilities in light of the proposed merger and inform the vital public conversation around the proposed merger's implications for the Rhode Island health care system as a whole.

As was addressed in the previous paper, the proposed merger to create an integrated academic health system with Brown University as an affiliated partner promises to be the most consequential development in Rhode Island health care in decades. This is because, as the facts and data for each hospital reviewed in the previous paper show, combining Rhode Island's two largest hospital systems will lead to a substantial increase in inpatient market share among the hospitals with the highest relative prices. Furthermore, given existing business relationships between hospital systems and physician practices, the merged entity will command a significant footprint in the market for physician services. Both of these

facts could have significant implications for health insurance premium affordability and health care quality.

Given these considerations, the proposed merger between CNE and Lifespan presents a host of risks and opportunities. It remains OHIC's position that the risks to the public interest objectives that guide OHIC's work—access, affordability, and quality (which are consistent with OHIC's statutory purpose outlined in [State of Rhode Island General Laws \(RIGL\) § 42-14.5-2](#)) are significant and should command careful attention by regulators and the public. This is because, as OHIC also found in its previous paper, the available evidence clearly suggests that hospital consolidation leads to higher prices and that the evidence on the impact of hospital consolidation on the quality of care is mixed.

In light of such risks, this paper advocates for payment model structures, including comprehensive price caps, quality incentive requirements and performance reporting, and advanced VBP adoption, that could contribute toward improving the probability that the merged entity will maximize affordability and quality if the merger is approved. The paper reviews each of these payment model structures before it turns to a concise treatment of related regulatory considerations and a discussion section.

Finally, it is critical to emphasize that, although this paper discusses payment model structures that would be of particular importance in the event the merger be approved, the paper should not be construed as endorsing any type of assumption that the merger should or should not be approved or will or will not be approved. Again, OHIC is not one of the governmental entities responsible for resolving whether or not the merger should be approved but it is profoundly responsible for advancing access, affordability, and quality in the Rhode Island health care system and the disposition of merger will ultimately have a decisive impact on these public interest objectives.

Comprehensive Price Caps

The Rationale for Price Caps. The challenge that provider price growth poses to affordability is extensively documented in the health economics literature. Chernen, Dafny, and Pany helpfully summarize the situation and the need for policy measures to address it:

The [United States] commercial health insurance sector, where tens of millions of individuals under the age of 65 receive health insurance coverage, uses market-based rather than regulated prices for providers. However, over the last three decades, health care provider markets have become increasingly consolidated and, as a result, there has been a steady increase in prices for care in the commercial sector. [United States] provider prices are high relative to provider prices in other countries and are growing faster than prices in many other [United States] industries. Growth in provider prices has been a primary driver of the growth in commercial health insurance premiums. Ultimately, premium increases are borne by the American public. As a result, the [United States] requires multifaceted regulatory action to address high and rapidly rising prices for care.¹

Furthermore, the relationship between hospital consolidation and rising prices has been extensively documented. As the Medicare Payment Advisory Commission (MedPAC) noted, "The preponderance of

1. Michael Chernen, Leemore Dafny, and Maximilian Pany, *Capping Provider Prices and Price Growth in the US Commercial Health Sector* (New Haven, CT: 1% Steps for Health Care Reform, 2021), 1, <https://onepercentsteps.com/wp-content/uploads/brief-cppagp-210208-1700.pdf>.

evidence suggests that hospital consolidation leads to higher prices. These findings imply that hospitals seek higher prices from insurers and will get them when they have greater bargaining power.”²

In light of these findings, regulatory action in the form of price caps have been proposed that can fundamentally take two different forms:

- **Distributional Price Caps:** This approach caps prices by service category or service at a specific multiple that would be relative to an established benchmark. Such a price cap can be applied to services rendered in-network and out-of-network and providers would not be allowed to contract with payers for or be allowed to accept prices that exceed the established cap. Different methods of selecting the multiple and benchmark are possible including but not limited to using a defined commercial relativity (e.g., 500% of the 20th percentile of the commercial in-network price in a given market) or a defined Medicare relativity (e.g., 150% of the Medicare rate).³ Relying upon commercial prices in a given market assumes that a market-derived benchmark is most appropriate whereas relying upon Medicare prices assumes that a national benchmark is most appropriate.
- **Caps on Annual Price Growth:** This approach caps price growth by service category or service on an annual basis by limiting growth to no more than the growth of an established benchmark. Such a price cap can utilize a range of benchmarks including but not limited to measures of price changes (e.g., the Consumer Price Index) or measures of economic growth (e.g., gross domestic product).⁴ The benchmark can utilize either the chosen measure itself or the measure plus or minus a fixed factor (e.g., plus or minus 1%). Relying upon the chosen measure itself assumes that price growth should optimally converge with the phenomenon quantified by the measure (e.g., inflation or economic output) whereas employing an added or subtracted factor assumes that it is reasonable to permit price growth to exceed or be limited to less than the phenomenon quantified by the measure (e.g., provider prices should be allowed to grow above or below inflation or faster or slower than the economy at least to some degree).

It is important to note that these two forms of price caps are not mutually exclusive but rather represent two different approaches that can be employed separately or together.

Existing Rhode Island Use of Price Caps. In Rhode Island, as was noted in OHIC’s previous paper, the office currently has in place a set of Affordability Standards which systematize the expectations and regulatory requirements that commercial health insurers must follow to demonstrate their efforts to improve affordability. Among these requirements is a hospital rate increase cap. [230-RICR-20-30-4.10\(D\)\(6\)\(e\)](#) specifies that OHIC limits the inpatient and outpatient hospital average rate increases that insurers can grant hospitals to no more than the United States All Urban Consumer All Items Less Food and Energy Consumer Price Index (CPI-U) percentage increase plus 1%. The method of computation for the CPI data is determined by the health insurance commissioner annually by drawing upon published United States Department of Labor data and applying methodologies that are relevant to a given time period’s specific circumstances. Insurers and hospitals can negotiate an average rate increase up to, but not exceeding, the rate cap. Any increase above the rate cap must receive the prior approval of the health insurance commissioner.

2. Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington, DC: Medicare Payment Advisory Commission, March 2020), 498, http://medpac.gov/docs/default-source/reports/mar20_entirereport_sec.pdf.

3. Michael Chernew, Leemore Dafny, and Maximilian Pany, *Capping Provider Prices*, 3.

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The Rhode Island approach has been effective. In the February 2019 issue of *Health Affairs*, researchers examined the impact of Rhode Island’s Affordability Standards and found that the rate cap and the mandated use of unit of service payment methodologies (such as diagnosis-related groups for most medical and surgical services) were the key policies implemented as part of the Affordability Standards driving the observed relative reduction in commercial health care spending compared to the control group.⁵ Specifically, the authors concluded: “State regulators in Rhode Island achieved among the largest total health care spending changes observed from payment reforms to date.”⁶

The previous paper also explained the reasons why OHIC sees additional action as necessary to address the risks to affordability from higher prices that could materialize after the proposed merger of CNE and Lifespan, despite the success of the current OHIC rate cap as a critical regulatory guardrail. Of these reasons, the most significant are: (1) professional prices are not included in the rate cap, leaving these prices vulnerable to the exercise of market power by the merged entity and (2) the rate cap itself could be overridden statutorily in the future, leaving the consumers and employers vulnerable to unregulated price increases for even inpatient and outpatient prices. The imposition of comprehensive price caps that are directly binding on the merged entity would constitute additional action that has the potential to address these risks if the merger is approved.

Application of Price Caps to the Merged Entity if Approved. Comprehensive price caps should be put into place for the merged entity—if it is approved—to ensure that the risk of monopolistically driven price increases does not occur following the approval. Such price caps should be directly binding on those providers that are within the ownership structure of the merged entity. For administrative simplicity and ease of implementation, OHIC recommends that these price caps should take the form of caps on annual price growth that would limit year-over-year average price increases to no more than the per capita potential gross state product growth or less for the applicable time period, which is consistent with the principle that pricing growth for the merged entity should not exceed overall economic growth for the state.

The service categories to which the price caps would apply would include: inpatient hospital, outpatient hospital, professional, and ancillary. Careful consideration should be given to exempting a select subset of services within these service categories from the price caps if analysis can demonstrate that doing so is highly likely to be associated with improved health system performance both in terms of cost and quality. Prescription drug prices would not be subject to these price caps because there is presumed to be a limited ability of the merged entity to control them and broader policy actions beyond the scope of this paper (e.g., reference pricing or unsupported price increase penalties) are necessary to address them at the federal and/or state level.

Finally, an important advantage of employing a price cap methodology for the merged entity that focuses on annual price growth rather than a price cap methodology that focuses on prices relative to an established benchmark is that Rhode Island already has successful experience doing so on a smaller scale through the OHIC hospital rate cap. This experience can be built upon and leveraged even if by itself it is not a substitute for the type of comprehensive approach to mitigate price growth that is outlined here.

Quality Incentive Requirements

The Rationale for Quality Incentive Requirements. The literature reviewed in OHIC’s previous working paper found that provider consolidation was empirically shown to increase prices, even when the

5. Aaron Baum et al, “Health Care Spending Slowed After Rhode Island Applied Affordability Standards to Commercial Insurers,” *Health Affairs*, 38, no. 2 (February 2019): 237. <https://doi.org/10.1377/hlthaff.2018.05164>.

6. Aaron Baum et al, “Health Care Spending Slowed,” 244.

transactions in question escaped or passed antitrust scrutiny. Therefore, the recommendation that price caps form the basis of how the merged entity contracts with insurers and is paid is a foundational payment model structure that must be embedded in the regulatory oversight model for the merged entity. On the important matter of health care quality, the literature on mergers and acquisitions fails to prove conclusively that health care quality is improved by consolidation. In fact, some studies have found that quality suffers when there is less competition. In the section that follows, OHIC describes a payment model structure to leverage health care pricing as a means of constructing meaningful financial incentives for quality performance. This builds on existing OHIC regulatory requirements for insurers. In addition to this, OHIC recommends public reporting of quality performance by the merged entity and the thoughtful prioritization of quality measures based on measurable health equity gaps.

Existing Rhode Island Use of Quality Incentives. OHIC regulatory requirements make annual hospital inpatient and outpatient price increases partially contingent on quality performance. This introduces financial risk within the fee schedule and is intended to motivate excellence in quality performance. Additionally, OHIC regulatory requirements specify the clinical quality measures that must be used in contracts between acute care hospitals and insurers. Currently, OHIC mandates six core clinical quality measures and allows market participants to include up to seven additional menu measures at their mutual discretion. The current measures for 2022 are listed in Table 1 in addition to measures that are currently under development and expected to be deployed in future years.

Table 1: Acute Care Hospital Measures

#	Measure Name	NQF	Steward	Source
Core Measure Set (6)				
Hospital (6)				
1	CAHPS Survey, specifically HCAHPS	0166	AHRQ	Survey
2	Catheter-Associated Urinary Tract Infection (HAI-2)	0138	CDC	Clinical
3	Central Line-Associated Blood Stream Infection (HAI-1)	0139	CDC	Clinical
4	Clostridium Difficile (C.diff.) Infections (HAI-6)	1717	CDC	Clinical
5	Follow-Up After Hospitalization for Mental Illness (7-Day)	0576	NCQA	Claims
6	Hospital-wide Readmit (READM-30-HOSP-WIDE)	1789	CMS	Claims
Menu Measure Set (7)				
Hospital (7)				
1	Cesarean Rate for Nulliparous Singleton Vertex (PC-02)	0471	TJC	Claims
2	Elective Delivery Prior to 39 Completed Weeks Gestation (PC-01)	0469	TJC	Claims/ Clinical
3	Follow-Up After Emergency Department Visit for Mental Illness	3489	NCQA	Claims
4	Follow-Up After Emergency Department Visit for Substance Use	3488	NCQA	Claims
5	Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure - HAI-3: SSI: Colon - Surgical Site Infection for Colon Surgery and HAI-4: SSI: Hysterectomy - Surgical Site Infection for Abdominal Hysterectomy	0753	ACS-CDC	Clinical
6	Methicillin-resistant Staphylococcus Aureus Blood Infections (HAI-5)	1716	CDC	Clinical
7	Severe Sepsis and Septic Shock: Management Bundle (SEP-1)	0500	HFH	Clinical
On Deck Measure Set (1)				
Health Equity (1)				

#	Measure Name	NQF	Steward	Source
1	The following measure, stratified by race, ethnicity, and language (REL): <ul style="list-style-type: none"> Hospital-wide Readmit <i>(Move to Menu Set when CMS publishes stratified data)</i> 	NA	NCQA/OHIC	Clinical
Developmental Measure Set (1)				
Social Determinants of Health (1)				
1	Social Determinants of Health Screening	NA	RI EOHHS	Survey

Application of Quality Incentive Requirements to the Merged Entity if Approved. The current acute care hospital measure set covers hospital acquired infections, hospital readmissions, follow-up after hospitalization for mental illness, and patient experience of care. OHIC also curates measure sets to be used by insurers in contracts with other classifications of providers, such as primary care providers and accountable care organizations (ACOs). In addition to ensuring that the merged entity's contracts include meaningful financial incentives for quality performance, the oversight entity charged with overseeing the merged entity should publish quality performance for the merged entity, including performance at the individual hospital and physician group level. To ensure statistically valid measurement, a measure-specific minimum denominator threshold could be adopted for public reporting at the individual hospital level and provider group level. The merged entity should be required to provide the necessary data from its electronic health record.

Health equity is an important goal of public policy. The Rhode Island Foundation's November 2021 report, [Ensuring the Integrated Academic Health System Benefits All Rhode Islanders: Recommendations from the Integrated Academic Health System Community Input Committee](#), recommended that "the central goal of the [Integrated Academic Health System (IAHS)] must be to reduce and eliminate disparities in health care and health among its patients. Achieving this goal will necessitate the IAHS focusing on what happens both within its walls and in the community."⁷ A health equity lens can be integrated into quality measurement, measure selection, and the system of rewards and penalties that comprise quality incentive programs within provider contracts. OHIC's current processes can be leveraged toward this end. During the 2021 review of the aligned measure sets OHIC and the Quality Measure Alignment Review Committee employed a Race, Ethnicity, Language, and Disability approach to the assessment of the quality measures to guide measure selection decisions. Consistent with this practice, and the Rhode Island Foundation report, the agency charged with oversight of the merged entity should evaluate opportunities for remediation of health disparities by examining and prioritizing quality measures for which there are observable disparities when the underlying data are stratified by race, ethnicity, language, and disability. The priority measures can be made known to OHIC and the Quality Measure Alignment Review Committee each year to ensure their inclusion in the core measure sets. Priority measures can then leverage the pool of incentive dollars to drive change through the mechanism of health care payment. This will ensure that health equity considerations become embedded in the business model for health care and are not left to ancillary philanthropic endeavors.

Quality incentive requirements can work in tandem with price controls, as the current state of commercial market regulation and contracting proves. Furthermore, quality incentive requirements also can, and should, form part of any advanced VBP models, which are discussed in detail in the next section.

7. Rhode Island Foundation, *Ensuring the Integrated Academic Health System Benefits All Rhode Islanders* (Providence, RI: Rhode Island Foundation, November 2021), 26-27, https://assets.rifoundation.org/images/News-Publications/RIF_HealthReport_2021_v7F_DIGITAL.pdf.

Advanced VBP Adoption

The Rationale for Advanced VBP Adoption. If the merger is approved, the merged entity should be required to abide by price controls and quality performance incentive structures. A permanent regulatory oversight structure should be empowered to examine and publicly report merged entity market conduct and quality performance to ensure that the merged entity abides by these guardrails. Beyond these minimally necessary guardrails, it is OHIC’s position that the merged entity must be set on a course to tie a significant percentage of its revenue to budget-based payment models over time. Unlike price controls and incentive structures for quality performance, which as described above can be formulated by regulators to directly condition the merged entity’s market conduct, the shift to budget-based payment models (what we refer to as advanced VBP) will require investment and operational changes by insurers, in addition to the providers comprising the merged entity. Given the scope of coordination between market participants necessary to achieve the shift toward budget-based payment models, this section outlines the object of this coordination but leaves it to other policymakers to determine the how. OHIC is ready to participate collaboratively in related activities should they occur.

The model by which the merged entity is paid for the provision of health care services is important. Payment models form the basis of economic incentives motivating behavior and can be empirically and logically related to certain outcomes of value to the public, such as efficiency and quality. The Rhode Island Foundation report recommended that the merged system “target 80% of its patient population to be in value-based payment models within five years of the merger.”⁸ In this section, we build on the Rhode Island Foundation’s recommendation and set forth facts about the present state of VBP models in the Rhode Island market, with a focus on the commercial market, and describe different types of payment models that could be applied to the merged entity given its potential size and breadth of service offerings.

It is important to note at the outset that VBP models take time to implement. While CNE and Lifespan are presently engaged in value-based payment models, if the merger is approved, it will be important that expectations be placed on the merged entity to adopt VBP structures beyond their present state. These new models should employ meaningful predetermined budgets for defined sets of services with financial risk, align financial incentives between hospitals and physicians around efficient use of services, and support revenue predictability for the merged entity.

The Purpose of Payment Reform. Payment reform involves the formulation of meaningful provider economic incentives to promote the efficient delivery and use of services and to establish conditions for technical innovation in the provision of care while maintaining or improving performance on measures of health care quality. Payment reform can also be leveraged to address provider revenue predictability and financial stability in some cases. The FFS payment system does not promote efficiency and has not been shown to maximize quality performance. These observations inevitably call into question the value that patients and purchasers of health services derive from the prevailing FFS payment system. VBPs, an alternative to traditional FFS, possess explicit features designed to improve value. In this paper OHIC defines VBP as a payment model that, at minimum, includes explicit financial rewards and/or penalties for performance on predefined measures of efficiency (i.e., cost) or quality. OHIC adds the adjective “advanced” to the phrase “value-based payment” to denote payment models that employ a predetermined budget for a defined patient population and/or set of services.⁹

8. Rhode Island Foundation, *Ensuring the Integrated Academic Health System*, 27

9. The phrase “advanced value-based payment” as used herein is treated as an equivalent to the phrase “alternative payment model,” as the latter appears in OHIC regulation and the national discourse around payment reform. Both phrases

Different types of payment models fall under the rubric of advanced VBP. As stated, a key feature of each is the use of a budget. The budget may be calculated for a defined patient population and/or set of services and tailored to different provider types, such as hospitals and professional providers. Payments can be made upfront as lump sums or FFS payments over the contractual performance period could be retrospectively reconciled to the predetermined budget. Examples include population-based total cost of care models (such as the Medicare Shared Savings Program), episode-based payments (such as payment for joint replacement), and sub-capitation (such as prospective payment for primary care services).

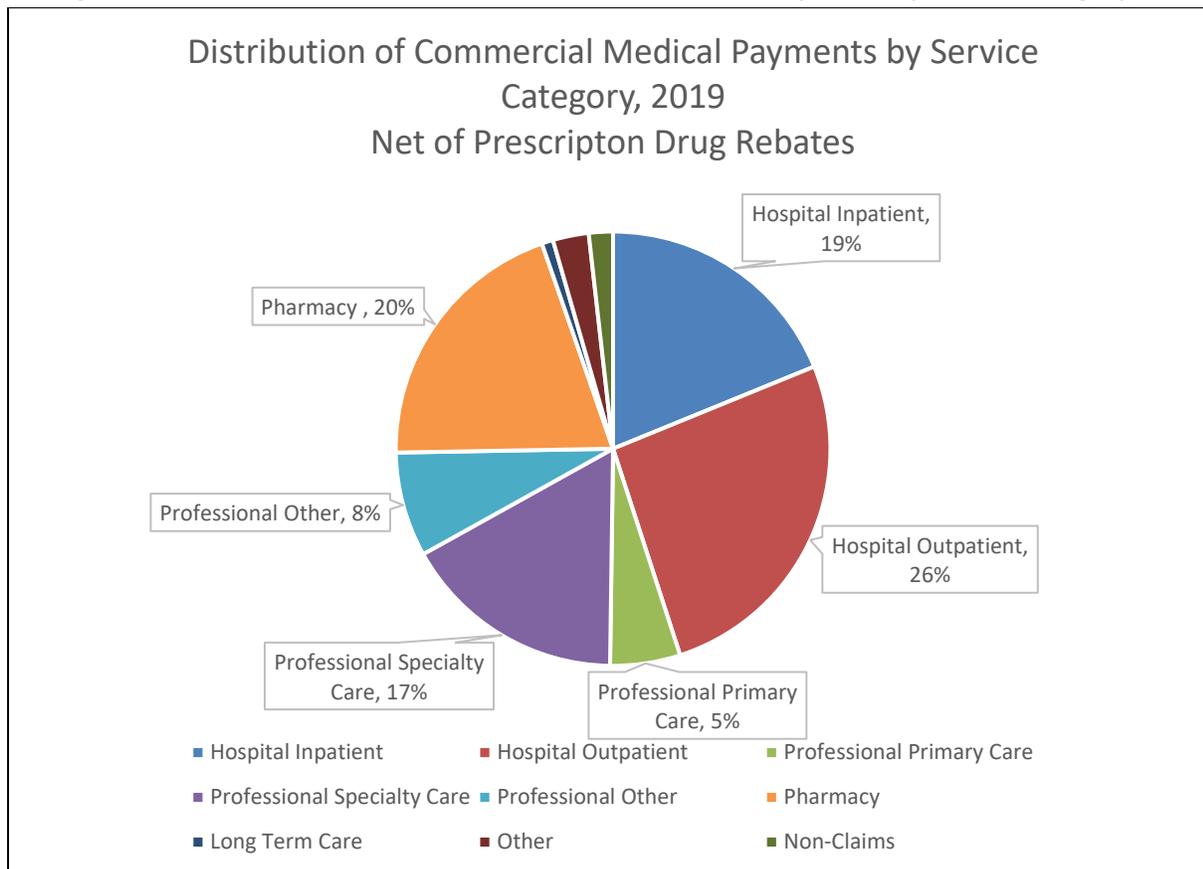
The Present State of Advanced VBP in Rhode Island. The dominant advanced VBP model in the Rhode Island market is a patient attribution based TCOC model that is retrospectively reconciled to the budget based on performance period FFS billing. These models offer upside gainsharing opportunities for providers, in the event that savings relative to the budget are achieved and may include downside risk if patient expenses exceed the budget. In the commercial market, 47.7% of Rhode Island resident member months in 2019 were attributed to providers who are part of accountable care organizations that operated under these payment models. For Medicaid and Medicare Advantage the figures are, 66.4% and 65.5%, respectively. The shift toward TCOC payment models with upside and downside risk has been encouraged by the Centers for Medicare and Medicaid Services (CMS). Historically, OHIC has informed its VBP policy strategy and regulatory approach for commercial payers on the goals set forth by the Medicare Program in 2015.¹⁰ Other, more limited scope of service, payment models exist in the market, but they account for a small percentage of total medical payments.

In the commercial market in 2019, hospital inpatient and outpatient services accounted for 45% of medical payments. Pharmacy was the next largest category (20%) followed by professional specialty care (17%). To succeed under TCOC models for commercial populations, providers need to find efficiencies in these categories of service.

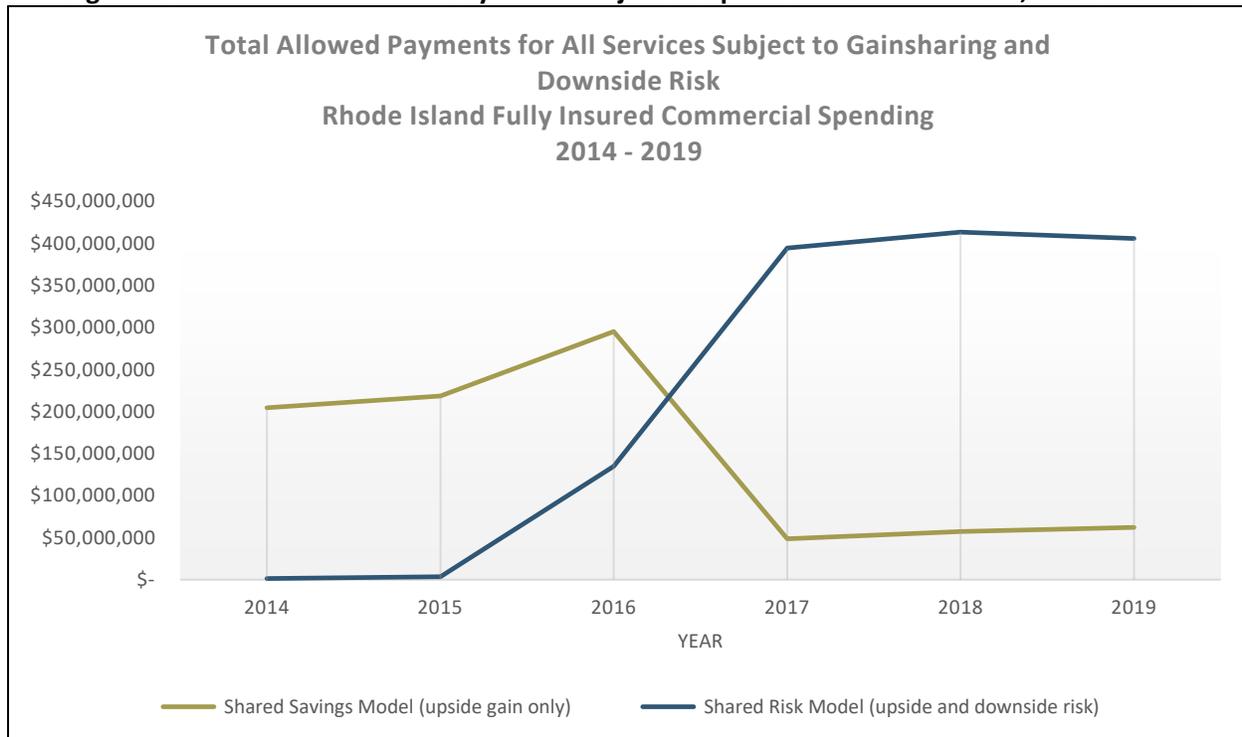
capture payment models that employ a budget. The phrase “value-based payment” defines a broader universe of payment models, of which budget-based payment models are a subcategory.

10. Sylvia M. Burwell, “Setting Value-Based Payment Goals: HHS Efforts to Improve U.S. Health Care,” *New England Journal of Medicine*, 372 (March 2015): 897-899. <https://doi.org/10.1056/NEJMp1500445>.

Figure 1: Distribution of Rhode Island Commercial Medical Payments by Service Category, 2019



Two observations about the design of existing TCOC models in Rhode Island are worthy of note. First, these models are configured on top of an FFS billing chassis—meaning that during the performance period, providers bill FFS and the incurred expenditures for the attributed population are compared to the predetermined “budget target” through a retrospective reconciliation process at year end. Second, all TCOC contracts include gainsharing opportunities (sometimes referred to as “shared savings” or “upside risk”) and some contracts include downside risk, or the potential for the provider to incur losses if expenses exceed the population budget target. The commercial market has seen a shift toward the inclusion of downside risk in TCOC contracts since 2016, with the majority of commercial medical expenditures under TCOC contracts subject to downside risk. However, the shift toward downside risk in TCOC contracts depicted in Figure 2 does not convey important facts about the contracts, such as the magnitude of risk assumption within the contracts or the distribution of contracts across market participants. Both vary across insurers and providers.

Figure 2: Rhode Island Allowed Payments Subject to Upside and Downside Risk, 2014 to 2019

Two implications can be drawn from these observations about the present state of advanced VBP in the market. First, while TCOC payment models have been deployed on a broad scale, the reliance on FFS as the underlying mechanism for health care payment has not been meaningfully diminished. As described below, the continuance of FFS as the underlying payment model can create misaligned incentives between providers within ACOs and not fundamentally shift patterns of practice. Second, the strength of the incentive to contain costs for the attributed population under TCOC contracts is a function of the opportunity to share in savings and avoid losses. Potential losses under these contracts are capped at a contractually defined percentage of the budget target (per member per month or PMPM). Mathematically, the potential maximum loss under a given contract can be calculated as a function of the size of the attributed population, the PMPM budget target, and the following contract parameters: risk exposure cap, minimum loss rate, and risk sharing rate. Summing the potential maximum losses across all TCOC contracts for a given provider entity, yields an aggregate potential loss pool. The design of existing contracts invites the following questions:

1. Does the size of the potential savings and loss pools under these contracts represent quantities of risk sufficient to motivate behavior change and truly mitigate volume incentives?
2. Are the incentives under TCOC models sufficient to drive improvements in efficiency, especially in light of the configuration of providers, i.e. professional providers and hospitals, within the ACO? Are refinements necessary to better align incentives?

Advanced VBP in the Context of the Proposed Merger. The prospect of a merger between CNE and Lifespan presents the need and opportunity to accelerate advanced VBP in Rhode Island. A merged entity would account for nearly 80% of the inpatient services market and over 80% of the market for attributed

patients, a proxy measure for the physician services market. In effect, an entity of this size and scope would command a critical mass of patients and service volume on which to build more advanced VBP models. This would ensure that the merged entity would face thoughtfully constructed economic incentives to control the total cost of care and set its attention on utilization, mix of services, and prices. Imposing budgetary discipline is important because price caps, as described above, do not directly address volume.

In fact, there is some evidence from experience in Maryland, where the nation's longest standing hospital rate setting regime exists, that hospitals increased volumes while under strict price controls. This evidence motivated policymakers in Maryland to adopt a global budget payment structure for hospitals. The Maryland experience with advanced value-based payment will be described below. Given that the proposed merger constitutes a combination of hospital systems, and that hospital inpatient and outpatient spending together account for the largest share of total medical spending, OHIC now dedicates significant space to a discussion of advanced VBP for hospitals below. It begins with a conceptual overview of hospital global budgets followed by a description of specific hospital global budget initiatives. Hospital global budgets can be designed to fit with existing TCOC models in the market and offer strengthened incentives to manage total spending and revenue predictability.

Hospital Global Budgets in Concept. A global budget for hospital services provides a prospectively determined amount of funding for a defined set of hospital services for a specified period of time (typically one year).¹¹ Stated differently, "a hospital global budget caps the amount of revenue a facility can receive during the course of a given year, regardless of the number of patients treated or the number of services provided to those patients."¹² Hospital global budgets must clearly define of the services that are included within the budget and the specific population(s) whose care is reflected in the pool of services that underly the budget calculation. Services could be limited to facility inpatient and outpatient services or could include employed professional services in addition to facility services. Methods for calculating the base budget and updating the budget to account for changes in reasonable provider input costs, expected changes in utilization, and shifts in market shares and demographics must be explicitly defined. Experts on hospital global budget design emphasize that these payment models must be complemented by robust measurement of health care quality and patient access to ensure that budget constraints are not achieved at the expense of necessary patient care. There is no single blueprint for operationalizing hospital global budgets and policymakers can exercise discretion over the various design features of the global budget to accommodate local concerns and policy objectives. Two such objectives should be incentives for efficiency and model design structures that support provider revenue predictability and financial stability.

Payment reform is about economic incentives. A hospital global budget transfers financial risk from the payer to the hospital through the mechanism of the budget constraint. Under the budget constraint, hospital managers face incentives to reduce the unit cost of services and/or reduce the volume of services to stay within the budget. This is in contrast to the incentive structure confronted under a system of FFS reimbursement (including FFS with price controls) where there is little incentive to promote efficient utilization; perhaps the opposite. From the hospital management perspective, hospital global budgets ensure that incentives for efficient use of services are endogenous features of the payment model for

11. Robert A. Berenson, Suzanne F. Delbanco, Divvy K. Upadhyay, and Roslyn Murray, *Payment Methods and Benefit Designs: How They Work and How They Work Together to Improve Health Care* (Washington, DC: The Urban Institute, 2016), 31, https://www.urban.org/research/publication/payment-methods-how-they-work/view/full_report.

12. Robert Murray, *Toward Hospital Global Budgeting: State Considerations* (Princeton, NJ: State Health and Value Strategies, 2018), 2, https://www.shvs.org/wp-content/uploads/2018/05/SHVS_-_Global-Hospital-Budgets_FINAL.pdf.

hospitals.¹³ In the absence of hospital global budgets, patient attribution based TCOC models with hospital systems and insurer-based medical management policies may create incentives for efficient utilization, but these structures are exogenous to the payment model for hospital services.¹⁴ This exogeneity sustains a misalignment of incentives between hospitals, physicians operating under accountable care models, and insurers. As Murray (2018) notes, “hospitals with high fixed costs find volume reductions (which are key to meaningful population-based cost control) unattractive from a financial perspective. Payment model researchers have observed that reductions in unnecessary hospitalization, readmissions or shifting of care to less costly ambulatory settings represent lost hospital revenue and thus result in reduced profitability.”¹⁵ This implies that the existing reliance on patient attribution-based TCOC contracts with hospital-based ACOs may be an inherently flawed strategy to control spending by itself.

A hospital global budget could yield several outcomes that are worthy objectives of public policy and desirable to market participants in light of the proposed merger:

- **Meaningful Cost Containment:** Hospital inpatient and outpatient services comprise roughly 45% of total commercial medical spending and 40% of total medical spending across all payers. A hospital global budget places a direct incentive for cost control on the largest components of health care spending.
- **Predictability of Annual Revenue for Hospitals:** A hospital global budget could provide more certainty for financial planning and business operations because it is a known quantity at the beginning of the fiscal year.
- **Predictability and Stability in Annual Hospital Expenses for Insurers and Self-Insured Purchasers:** Health insurers and other health care purchasers could benefit from more predictable and stable hospital expenses.
- **Incentives for Innovation:** Technical innovations in care delivery may be garnered from hospital global budgets, such as improved coordination between hospitals and physicians, investment in care management resources, and investments in prevention and wellness in the community.

Experts note that hospital global budgets have potential shortcomings that must be addressed through program design. Several of these are enumerated by Murray (2018). A few are described below:

- Murray (2018) notes: “With their strong incentives for cost reduction, [global budgets] can [...] encourage an under-provision of services and skimping on quality.”¹⁶ These weaknesses can be mitigated through robust quality measurement and the application of performance-based financial rewards or penalties. Quality measures can be derived from existing sources and performance can be compared to national benchmarks. Furthermore, measures that evaluate access to care, such as wait times and utilization of non-hospital providers, can be employed as well. Public reporting of hospital performance with sufficient denominators will add a level of public transparency and accountability.
- Murray (2018) also conjectures that global budgets may “induce hospitals to shift services to non-hospital providers in their area.” This could lead to higher health care expenditures due to the

13. One might claim that inpatient Diagnosis-Related Groups (DRGs) and outpatient Ambulatory Payment Classifications (APCs) are examples of hospital payment models in which incentives for efficient utilization is endogenous to the payment model. This is true to an extent. DRGs and APCs encourage efficiency within the encounter or stay but they do not encourage global efficiency in terms of the volume or mix of encounters and stays for a population.

14. Medical management policies are insurer-directed, unless delegated to the provider. Patient attribution based TCOC models are superimposed on existing payment systems and rely on loose budget constructs with defined rules for calculating and distributed savings and losses.

15. Robert Murray, *Toward Hospital Global Budgeting: State Considerations*, 4.

16. Robert Murray, *Toward Hospital Global Budgeting: State Considerations*, 3.

concurrent payment of the global budget and the FFS payment to the non-hospital provider. This weakness can be mitigated through analysis of patient shifting and deduction of those payments from the global budget.¹⁷

- Hospital global budgets transfer financial risk from the payer to the hospital through the mechanism of a budget constraint. Hospitals may not be ready to manage significant downside risk. Murray (2018) notes that hospitals can undertake strategies to mitigate downside risk, such as the purchase of stop-loss insurance.¹⁸
- Hospital financial incentives under global budgets may be misaligned with physician financial incentives if the latter are paid on a volume driven FFS model. This is a variation on the misalignment of incentives that exists in the Rhode Island market currently. Under existing patient attribution based TCOC models, all providers are paid on an FFS basis, but the incentive to generate savings confronted by the ACO is not complemented by a similar incentive on the hospitals that are constituent parts of the ACO.

Conceptually, hospital global budgets will be most effective when conducted on an all-payer basis because all-payer engagement rationalizes payments for the hospital(s) operating under the global budget. Therefore, coordination among market participants, including private and government payers is critical. Whether this coordination can be engendered through informal convention or whether formal statutory measures are a necessary precondition is a matter beyond the scope of this paper.

Hospital Global Budgets in Practice. History and current models in other states offer a number of instances of hospital global budget models in practice. This section briefly reviews a few of these cases and points interested readers toward resources on each program that may be of interest to policymakers in Rhode Island. Additionally, OHIC recently hosted a public educational webinar [Hospital Global Budgets: An Introduction](#). A recording of the webinar is available [here](#).

Maryland: The All-Payer Model. Maryland offers the most notable current example of the use of hospital global budgets on a statewide scale. Maryland has conducted all-payer hospital rate setting since the 1970s. Under this arrangement, Maryland hospitals were waived from the Medicare Prospective Payment System. While rate setting (a form of price control) is effective at limiting increases in unit cost, Murray (2018) has noted that in the early 2000s Maryland “hospitals increased their patient volume, and the state was consistently in the top 10 nationally in expenditures per Medicare beneficiary.”¹⁹ In 2014, Maryland executed a multi-year agreement with CMS to limit hospital inpatient and outpatient expenditure growth per capita to the state’s 10-year annual growth rate in gross state product, meet cost savings targets, reduce readmissions and hospital acquired infections, and improve other aspects of quality and population health. Under the demonstration, which is known as the Maryland All-Payer Model, Maryland’s 46 hospitals adopted all-payer global budgets that account for approximately 95% of annual hospital revenues.

In 2019, the Medicare demonstration was extended and rebranded as the Maryland Total Cost of Care Model. The Total Cost of Care Model builds on the All-Payer Model. Specifically, under the Total Cost of Care Model, the foundation of hospital global budgets is enhanced by two programs designed to invest in aligned incentives between hospital and non-hospital providers. The Care Redesign Program grants incentive payments to non-hospital providers who partner with hospitals on care redesign activities that

17. Robert Murray, *Toward Hospital Global Budgeting: State Considerations*, 3.

18. Robert Murray, *Toward Hospital Global Budgeting: State Considerations*, 3.

19. Robert Murray, *Toward Hospital Global Budgeting: State Considerations*, 6.

improve quality and the Maryland Primary Care Program invests in primary care practice transformation to better manage care and reduce the rate of hospitalization.²⁰

The [Health Services Cost Review Commission](#) (HSCRC) is the state agency responsible for hospital rate setting and oversight of the Maryland All-Payer Model and Total Cost of Care Model demonstrations. It sets an annual budget for each hospital such that “each hospital’s total annual revenue is known at the beginning of each fiscal year. Annual revenue is determined from an historical base period that is adjusted to account for inflation updates, infrastructure requirements, population driven volume increases, performance in quality-based or efficiency-based programs, changes in payer mix and changes in levels of [uncompensated care]. Annual revenue may also be modified for changes in services levels, market share shifts, or shifts of services to unregulated settings.”²¹

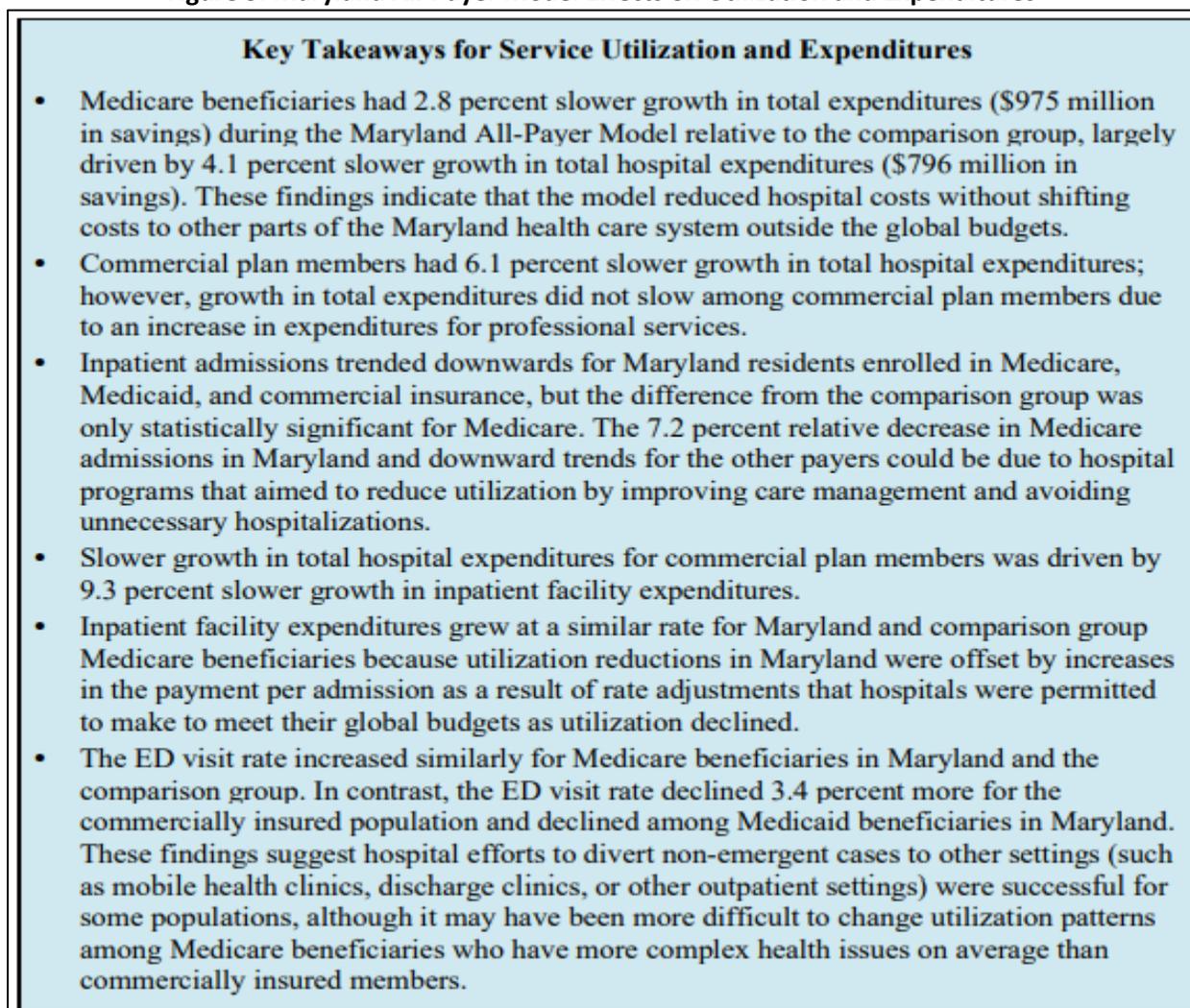
The hospital global budgets utilize the existing all-payer rate setting infrastructure. FFS payments continue as the basis for transacting health services business between Maryland’s hospitals and payers, but the HSCRC-approved reimbursement rates may be adjusted up or down based on changes in volume over the performance year to ensure that the hospital meets its budget. Allowable adjustments may occur without prior approval of the HSCRC within a corridor of plus or minus 5%. Rate adjustments beyond the corridor require prior approval of the HSCRC. In fiscal year 2020, the HSCRC had 48 full-time equivalents to oversee these programs.²²

An evaluation of the Maryland All-Payer Model was commissioned by CMS and published in 2019. The evaluation is valuable for answering empirical questions about the effects of the global budget program on expenditures, utilization, and quality, and for its qualitative dimension as well. The evaluation describes hospital operational and programmatic responses to the global budget model, as well as the impressions and experience of hospital leadership and clinicians working within the model. Figure 3 below represents content excerpted from the CMS evaluation and summarizes the estimated effects of the global budget program on utilization and expenditures.

20. More information on the Maryland Total Cost of Care Model is available at: <https://innovation.cms.gov/innovation-models/md-tccm>.

21. Please see <https://hscrc.maryland.gov/Pages/budgets.aspx> for more information.

22. View <https://dbm.maryland.gov/budget/Documents/operbudget/2022/agency/MarylandDepartmentofHealth.pdf> for further information.

Figure 3: Maryland All-Payer Model Effects on Utilization and Expenditures

Source: Reproduced from RTI International, *Evaluation of the Maryland All-Payer Model Volume 1: Final Report* (Waltham, MA: RTI International, 2019), 63, <https://downloads.cms.gov/files/md-allpayer-finalevalrpt.pdf>.

Program effects on utilization and expenditures varied across the outcome measures. While total Medicare expenditures and commercial hospital expenditures grew more slowly than the control groups, total commercial expenditures did not significantly slow due to increased expenditures on professional services. The evaluation also found that the hospital global budget program did not adversely impact hospital financial performance. “Maryland hospitals successfully operated within global budgets without adverse effects on their financial status. Despite constraints on hospital revenues imposed by global budgets, operating margins increased over the course of the All-Payer Model, although there was not a consistent upward trend in all years.”²³

23. RTI International, *Evaluation of the Maryland All-Payer Model*, 47.

The Maryland model proves that hospital global budgets can be deployed on a statewide scale. Lessons from the five-year All-Payer Model demonstration and the current Total Cost of Care demonstration can be garnered for application to program design in other states.

New York: The Hospital Experimental Payment Program. In the late 1970s a coalition of hospitals in the Rochester, New York region convened to develop a regional global budget for hospital services to address hospital expenditures and financial stability. Known as the Hospital Experimental Payment (HEP) program, it was developed in the late-1970s and implemented between 1980 and 1987. Under the terms of the HEP, nine Rochester hospitals agreed to abide by a community-wide revenue cap on hospital inpatient and outpatient expenditures. The HEP was overseen by the Rochester Area Hospitals' Corporation (RAHC), a non-profit corporation comprised of the nine hospitals participating in the HEP. This corporation provided data and technical assistance to the participating hospitals.

The HEP experiment represented an alternative to regulation and yielded several outcomes of interest. First, hospital expenditures per Medicare beneficiary grew more slowly than the national average and select comparison metropolitan areas, such as Boston. Second, aggregate hospital expenses grew more slowly among the nine HEP hospitals for the first five years of the experiment (46% cumulative growth over five years) compared to other New York State hospitals (52%) and hospitals nationally (68%). Finally, concurrent with these outcomes, the Rochester hospitals also experienced strong financial performance for period 1980 through 1984, generating an operating profit, in contrast the other hospital regions in New York.²⁴

Rhode Island: The MAXICAP. A review of select hospital global budgeting approaches would not be complete without mention of an approach taken by Rhode Island in the 1970s. In the early 1970s, Rhode Island's hospitals and dominant insurer, Blue Cross & Blue Shield of Rhode Island (BCBSRI), developed a program to moderate hospital cost increases by subjecting hospital operating expenses to an aggregate community-wide budget called the MAXICAP. An important feature of the program consisted of tripartite review and negotiation of hospital operating budgets by BCBSRI, the State of Rhode Island Budget Office, and the hospitals. Descriptions of the genesis and mechanics of the program were quarried from documents submitted as congressional testimony by former State of Rhode Island Governor J. Joseph Garrahy in May 1977.²⁵

The program originated as a response to escalating health insurance premiums that were driven by increasing hospital costs. In the late 1960s, BCBSRI filed "for sizable rate increases three years in a row." Documents describe the role of the State of Rhode Island Department of Businesses Regulation which, prior to OHIC's creation in 2004, reviewed insurer rate filings, as follows:

The state director of business regulation, required by Rhode Island state law to pass on the "reasonableness" of Blue Cross rates, reacted with increasing alarm to each subsequent rate increase filing. Blue Cross took the position that rising premium rates were merely symptoms of the real problem, that is, rising hospital costs, and that hospitals, therefore, should be parties to Blue Cross filings and should testify at rate hearings. After extended hearings in 1969 (for 1970 rates) during which hospitals were asked to testify, the department took the position that a major culprit in the cost spiral was the "open-ended cost reimbursement contract." The director

24. James A. Block, Donna I. Regenstreif, Paul F. Griner, "A Community Hospital Payment Experiment Outperforms National Experience: The Hospital Experimental Payment Program in Rochester, NY," *Journal of the American Medical Association*, 257, no. 2 (1987): 193-197. <https://doi.org/10.1001/jama.1987.03390020059027>.

25. United States House of Representatives, *President's Hospital Cost Containment Proposal: Hearings Before the Subcommittee on Health of the Committee on Ways and Means, House of Representatives, Ninety Fifth Congress, First Session* (Washington, DC: United States Government Printing Office, 1977), 169-237, https://books.google.com/books/about/President_s_Hospital_Cost_Containment_Pr.html?id=wb4WAAAAIAAJ.

essentially “ordered” hospitals and the Plan to overhaul the reimbursement system so as to build in cost ceilings and incentives for savings, if not to discard the present system altogether.²⁶

The MAXICAP was a statewide limit on allowable annual hospital operating expense increases. It was negotiated among BCBSRI, the Hospital Association of Rhode Island, and the state. Within the MAXICAP construct, hospital budgets were negotiated after each party reviewed the individual hospital budget submissions. In aggregate hospital operating expenses were required to fall within the MAXICAP, though individual hospital budgets could vary from the consensus MAXICAP percentage increase. Once hospital budgets were determined, payers set reimbursement rates with reference to these established operating budgets. The program included adjustments due to changes in volume, patient mix, and unexpected major contingencies.

Application of Advanced VBP Adoption to the Merged Entity if Approved. The Rhode Island Foundation report recommended that the merged system “target 80% of its patient population to be in value-based payment models within five years of the merger.”²⁷ OHIC recommends that the focus for the merged entity should be on adopting advanced value-based payments that include an explicit predetermined budget. There are a number of ways that the merged entity could adopt advanced VBPs. Short of full global capitation, which is most feasible within an integrated delivery system and payer structure, the merged entity could build off of existing TCOC contracts with payers and shift the preponderance of hospital and employed physician services to hospital global budgets and physician sub-capitation.

Related Regulatory Considerations

It is OHIC’s position that a permanent regulatory oversight structure must be empowered to oversee the merged entity. Alternative structures have been tentatively proposed by others, including ideas set forth in the Rhode Island Foundation report and the Milbank Memorial Fund commissioned report, [Rhode Island: Legal and Regulatory Options for Addressing Health System Consolidation](#). OHIC does not take a position on the form and location of the necessary oversight powers within state government. It may be that the present course of regulatory review and approval of the proposed merger by the Federal Trade Commission (FTC), State of Rhode Island Department of Health, and State of Rhode Island Office of the Attorney General will find that conditional approval and oversight by those agencies is sufficient. If the merger is ultimately approved on its present track, beyond any conditions of approval, it is also possible that the legislature may choose to provide additional administrative powers and resources to the executive branch to oversee the merged entity.

Should the merger be challenged on antitrust grounds, the parties may seek an alternative pathway to complete the transaction, such as a certificate of public advantage (COPA). A COPA is a means of immunizing the merger from antitrust review. Under the judicial doctrine of state action, anticompetitive conduct may be shielded from antitrust enforcement if the conduct satisfies two conditions: (1) the conduct is “in furtherance of a clearly articulated state policy” and (2) the conduct is “actively supervised by the state.”²⁸ The General Assembly would need to pass legislation allowing the parties to the merger to enter cooperative agreements and apply for a COPA from the state. Such legislation would need to meet the aforementioned two conditions to satisfy state action. This includes a clear articulation of state

26. United States House of Representatives, *President's Hospital Cost Containment Proposal*, 181-182.

27. Rhode Island Foundation, *Ensuring the Integrated Academic Health System*, 10.

28. Federal Trade Commission Office of Policy Planning, *Report of the State Action Task Force* (Washington, DC: September 2003), 1, https://www.ftc.gov/sites/default/files/documents/reports/report-state-action-task-force-recommendations-clarify-and-reaffirm-original-purposes-state-action/stateactionreport_0.pdf.

policy, including the standards for review of the COPA application, and an articulation of the administrative framework for active supervision by the state.

COPAs involve difficult tradeoffs and demand long-term state commitments. The COPA mechanism grants that anticompetitive conduct may yield public benefits that outweigh the potential harms from the loss of competition. Furthermore, this calculus can be improved when the application of strict regulatory standards and active supervision effectively mitigates the potential harms. As an example, states have used COPAs to allow presumptively anticompetitive consolidation of providers in rural areas to preserve access to care and support rural hospital financial stability in the face of potential facility closures.²⁹ This was the case in Tennessee and Virginia in 2017, which has been ably described by Erin C. Fuse Brown in [*Hospital Mergers and Public Accountability: Tennessee and Virginia Employ a Certificate of Public Advantage*](#). In this example, consolidation was viewed by state policymakers as a means to support the health of rural populations and to preserve access to care and jobs in rural areas. These perceived benefits were weighed against the potential harms from loss of competition.

The FTC has viewed COPAs with some skepticism in the past.³⁰ This is not surprising. COPAs authorize the creation of business concerns that permanently displace market competition. Mitigation of the potential harms from the loss of competition raises the stakes for effective regulation and there lies the heart of the issue. In the context of a COPA, will the agency charged with active supervision of the entity be vested with sufficient powers and resources? Can such an entity be effectively regulated within its local political economy? Will the COPA be subject to repeal at a future date, leaving consumers to confront an unregulated monopoly? Ultimately, if market competition is displaced by a COPA to bring the merger to fruition, then the state must be prepared to concentrate faith, resources, and steadfast commitment into meaningful public oversight of the merged entity.

Absent specific legislation to create a COPA process in Rhode Island, remarks must be general in nature related to one. If a COPA comes into play, care should be taken to ensure that the COPA creates a robust regulatory oversight structure to maintain active supervision of the merged entity in perpetuity. In addition, institutional safeguards should be put into place to ensure that a COPA cannot be terminated without significant public engagement and activation of an enforceable plan of separation of the merged entity.

Discussion

Some of the public discourse around the proposed merger of CNE and Lifespan has consisted of statements of conditional support. These statements recognize the necessity of sufficient “guardrails” to address concerns centered on access, cost, quality, and the general public interest as critically important factors. It was in this spirit that the Rhode Island Foundation sought community input and issued its report referenced earlier. As stated in OHIC’s previous working paper, there are substantive questions of law and policy that regulators currently reviewing the merger application must weigh and answer, such as the permissibility of the merger under antitrust law and the Hospital Conversions Act. OHIC is not qualified to address those questions and reiterates that it takes no position on the disposition of the merger. However, it is necessary that OHIC consider all contingencies, including the possibility that the merger is approved by the relevant regulatory bodies with or without conditions or that the merger is facilitated by an act of

29. Erin C. Fuse Brown, *Hospital Mergers and Public Accountability: Tennessee and Virginia Employ a Certificate of Public Advantage* (New York, NY: Milbank Memorial Fund, September 2018), 8, <https://www.milbank.org/publications/hospital-mergers-and-public-accountability-tennessee-and-virginia-employ-a-certificate-of-public-advantage>.

30. Erin C. Fuse Brown, *Hospital Mergers and Public Accountability*, 18-20.

the General Assembly under the auspices of a COPA. If such approvals occur, policy and regulation must adjust to address new market conditions.

The literature on provider consolidation reviewed in the previous paper discloses potential risks based on evidence derived from data on market comparisons and successful mergers and acquisitions. In order to inform the vital public dialogue around the merger, in this paper OHIC has sought to outline the potential payment model structures that would be necessary to mitigate risks that we perceive to have profound consequences for the health insurance market. If the merger is approved, it is important that the merged entity face a system of thoughtfully constructed economic incentives for cost containment, continued access, and quality improvement. Thus, the regulatory oversight model for the merged entity must address how the entity is paid and these objectives should be built into the commitments and regulatory expectations on which any potential approval is grounded. Above, OHIC has reviewed three sets of policies that could be applied to the merged entity: comprehensive price caps, quality incentive requirements, and advanced VBP adoption.

Price controls are a relatively simple guardrail that can be accomplished through conditional approval or legislative action. Of course, existing OHIC regulations cap hospital inpatient and outpatient price growth through the mechanism of insurance regulation, but as was noted in the previous paper, OHIC's price controls could be overridden by a future legislature. It is important that any attempt to impose price controls on the merged entity be made directly binding on the merged entity and be no less stringent than existing insurance regulations.

The ability of the merged entity to ensure access to care and the provision of high-quality care that addresses the important principle of health equity, is likewise amenable to the thoughtful application of economic incentives. Above OHIC has described a simple way to leverage existing regulatory constructs that embed quality performance incentives within the pricing structure. Beyond this, OHIC recommends thoughtful consideration of health equity gaps in the context of quality measurement and public reporting of quality performance by the merged entity and its constituent hospitals and professional provider groups.

The merged entity must also be set on a course to tie a significant proportion of its annual revenues to budget-based advanced value-based payment models. In addition to building off of existing TCOC models, the merged entity should adopt hospital global budgets and professional provider sub-capitation, where feasible. These payment models should not only support aligned financial incentives between hospitals and professional providers to control health care expenditures, they should also emphasize revenue predictability and financial stability for the merged entity. The latter considerations are important because the merged entity would control critical acute and specialty care resources in the state and serve as a major employer.

This paper has reviewed payment model structures that could be applied to the merged entity, but it does not offer a blueprint for how to do so from a regulatory perspective. The specific policy features of the regulatory oversight model and the associated human resources and legal resources necessary to carry out oversight of the merged entity will be conditioned by the form of approval by the relevant state agencies or the legislature. At minimum, it is OHIC's position that the merged entity should be required to fund the costs of state oversight in perpetuity.

Conclusion

One of the priorities put forward in the Rhode Island Foundation report is governance and included among the recommendations related to this topic is a recommendation to "commence a national search as soon

as possible to hire a new CEO for the merged system” if the merged entity is approved.³¹ This speaks to the importance of leadership for the merged entity if it is approved and most important in the area of leadership—from OHIC’s perspective—is that the new CEO and all those responsible for the governance of the merged entity face a set of thoughtfully structured economic incentives that maximally incentivize affordability and quality. Given this, the reason that this paper is focused on the payment model structures for the merged entity is because OHIC views the payment model as potentially the most efficacious mechanism (though—to be sure—not the only mechanism) to ensure that economic incentives are arranged in a way that will compel a focus on conducting the merged entity’s delivery of health care in a manner that sustainably furthers affordability and quality for all Rhode Islanders over the long-term, should it be approved.

OHIC’s view here concerning the central importance of the payment model for the merged entity to further affordability and quality is also directionally aligned with what the Rhode Island Foundation report puts forward related to both cost and quality. Regarding cost, the report states that:

While limiting cost growth and implementing broader payment reform is an issue larger than just the proposed [merged entity], given [the merged entity’s] market power, and given the track record of other health system consolidations, it is imperative that all stakeholders come together to explore tools and models that can help address rising [health care] costs in Rhode Island. Such an approach would have Rhode Island leading the way nationally, at the forefront of the shift to value-based care models, for example global budget payments, which can help reduce the per capita cost of health care.³²

And related to quality, the report argues that the merged entity should “commit to ensuring patient experience scores are in the top 10% of hospitals in New England within five years of the merger, as well as meeting nationally recognized quality benchmarks that focus on both outcomes and achievement.”³³ The payment model structures outlined by OHIC in this paper aligns with these recommendations and holds the potential to be a strong mechanism to make them a reality if the merger is approved.

In conclusion, it bears mentioning as well that the proposed merger—despite the significant risks it presents for Rhode Islanders and the Rhode Island health care system, also “has the potential to be a transformational step for Rhode Island’s health care system, that can positively impact public health.”³⁴ If approved, the fundamental task of policymakers, regulators, and all stakeholders will be to make extraordinary efforts to ensure that this potential becomes a reality, despite the preponderance of evidence suggesting that this is unlikely to occur. OHIC will continue to track developments around the proposed merger and may update this paper in light of additional information. The office will continually seek to educate the public about the risks and opportunities connected to the proposed merger.

31. Rhode Island Foundation, *Ensuring the Integrated Academic Health System*, 37.

32. Rhode Island Foundation, *Ensuring the Integrated Academic Health System*, 26-27.

33. Rhode Island Foundation, *Ensuring the Integrated Academic Health System*, 29.

34. Rhode Island Foundation, *Ensuring the Integrated Academic Health System*, 4.