

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

OPEN MEETING IN RE:

INTEGRATION OF CARE AND FINANCING FOR MEDICAID-ONLY
and MEDICARE AND MEDICAID ELIGIBLE (MME)

Integrated Care Initiative
Oversight, Monitoring and Continuous Improvement
Stakeholder Workgroup Meeting: Session 1

Date: Tuesday, July 24, 2012
Time: 3:00-5:00 p.m.
Place: Warwick Public Library
Room 101
600 Sandy Lane
Warwick, Rhode Island

APPEARANCES:

Diane Taft, MPA
Senior Medical Care Specialist
RI Executive Office of Health & Human Services

Sharon Kernan, RN, MPH
Assistant Administrator - Family & Children Services
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1 (HEARING COMMENCED AT 3:10 P.M.)
2 MS. KERNAN: Good afternoon. I'd like to
3 welcome you all here. I'm Sharon Kernan, and I
4 work for DHS Medicare program. And I am one of
5 the co-presenters this afternoon to present to you
6 on this topic, Integration of Care and Financing
7 for Medicaid-Only and Medicare and Medicaid
8 Eligible, which we call the duels.
9 So we're meeting today. This is the first
10 meeting of the workgroup. And this is the
11 workgroup on Oversight, Monitoring and Continuous
12 Improvement. And it is the first of three that
13 we'll be having. And we're very pleased that you
14 could join us today. So before I start, I would

15 like to ask everyone who is here to just briefly
16 introduce themselves and say where they are from.

17 We can start with Rosa.

18 MS. BAIER: I'm Rosa Baier, B-A-I-E-R,
19 Senior Scientist and Healthcentric Advisors.

20 MS. KERNAN: Everyone else please do try
21 to speak up because we do have a stenographer
22 here, so she can accurately --

23 DR. BORLASE: I am Bradley Borlase,
24 Director of Compensation and Pension, Providence
25 V.A. Medical Center.

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1 MR. BUECHNER: I am Jay Buechner,
2 B-U-E-C-H-N-E-R, and I am with the evaluation
3 improvement of the Neighborhood Health Center of
4 Rhode Island.

5 MS. DEXTER: I am Cheryl Dexter, the Vice
6 President of Quality and Compliance. We are with
7 the PACE Organization of Rhode Island.

8 MS. GORMAN: I'm Kathy Gorman, former DHS

9 person and social worker, and I am affiliated with
10 the Older Women's Policy Group.

11 MS. ABBOTT: I am Greta Abbott. I am
12 also from the Older Women's Policy Group. I have
13 had experience in the health field lobbying
14 government issues in my prior life.

15 MS. HEREN: Kathleen Heren, H-E-R-E-N.
16 I'm with Alliance For Better Long-Term Care State
17 LTC Ombudsman.

18 MR. PANEL: I'm Jim Panel. I'm from the
19 Providence Center. I am the Director of Child,
20 Family and Adult Services.

21 MS. BAKER: I am Fay Baker from the
22 Providence Center and Director of Acute Care.

23 MS. SHEEHAN: Rena, R-E-N-A, Sheehan. I
24 am from The Kent Center. I am the Vice President
25 of the Clinical Services.

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1 MS. DWYER: Mary Dwyer, D-W-Y-E-R, NRI

2 Community Services. I am the Assistant Executive
3 Director.

4 MS. GILL: Janice Gill, G-I-L-L, from
5 E.R. Card. It is a patient's center for
6 electronic personal health records.

7 MS. THIBEAULT: My name is Madeleine
8 Thibeault. I am from the V.A. in Providence. And
9 I work in the Quality Department. Glad to be part
10 of the group today because this is new for us
11 because we are usually a closed shell.

12 MS. TAFT: Diane Taft, Senior Medical Care
13 Specialist for the Executive Office of Health and
14 Human Services.

15 MS. KERNAN: Okay. We have one more who
16 is signing in. Can you introduce yourself.

17 MS. GOLDSTEIN: Elaina Goldstein,
18 G-O-L-D-S-T-E-I-N. I am from URI.

19 MS. KERNAN: Before we start, I want to
20 you let you know that I do have myself and Diane
21 Taft that will start us off today to give you some
22 background and what the purpose of these meetings
23 are, etc. And we do have three meeting
24 facilitators who are Madeleine Thibeault, who is

25 back there. And you can come up here whenever you

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1 are ready. And Bradley Borlase and Rosa Baier.

2 So thank you for the introductions. And why don't

3 we go to the purpose of why we are here and what

4 we are meeting on.

5 Our overall goal is to solicit

6 recommendations for the development of State

7 contract procurement documents, and we'll be

8 explaining a little bit more about what it is that

9 we want to procure. But we are very interested in

10 getting all of your comments and recommendations.

11 And this specific goal for this particular

12 workgroup is to provide recommendations for

13 determining the appropriate quality performance

14 measures for individuals enrolled in the program

15 to monitor outcomes and develop a process for

16 oversight, evaluation, and continuous quality

17 improvement. So that's why we're here today.

18 So, in a nutshell, the problem that

19 we're trying to address here is the fragmentation
20 of the delivery systems for the population of
21 folks who have Medicare and Medicaid eligibility,
22 also known as the duals. We've been working on
23 this for a little while, and we've determined
24 already that there are several problems, many of
25 them and some of them are listed here:

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- 1 o inadequate person-centered care
- 2 coordination.
- 3 o lack of focus on primary and
- 4 preventative care.
- 5 o long-term services and
- 6 supports/behavioral health
- 7 coordinated separately.
- 8 o fragmentation of benefits coverage
- 9 leads to confusion and inefficiencies.
- 10 o cost shifting (hospital and nursing
- 11 facility)

12 MS. GOLDSTEIN: I guess I'm confused about
13 how do they get their long-term care system.

14 MS. KERNAN: So whenever we get to
15 Phase 2.

16 MS. GOLDSTEIN: But NHB goes into Rhody
17 Health Partners. They manage just the primary
18 health specialty of human and health services.

19 MS. KERNAN: Yes.

20 MS. GOLDSTEIN: And they plan the model.

21 MS. KERNAN: Yes. Yes.

22 MS. GOLDSTEIN: And then how do they get
23 services if they had to wait? They're eligible to
24 get the long-term care services. Who do they
25 get --

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1 MS. KERNAN: They get it through assistant
2 waivers.

3 MS. TAFT: So that's what happens now.

4 MS. KERNAN: Correct.

5 MS. GOLDSTEIN: So now we're merging into

6 Medicare in the integrated Medicaid project?

7 MS. KERNAN: It's not integrated now until

8 Phase 1.

9 MS. GOLDSTEIN: So it is integrated in

10 Phase 2?

11 MS. KERNAN: I'm going to get to that

12 next. Let's get to that slide and see if you have

13 questions. So that will make it easier for, I

14 think, the audience as a whole.

15 MS. GOLDSTEIN: Let's start with PACE and

16 Medicare. Medicare gives a capitated menu. They

17 cover all Medicare/Medicaid Services. I assume

18 they have money left out of services and one of

19 their key components. And the fact that they have

20 an interdisciplinary team of procedures that we

21 work together for a plan, so I know what that is.

22 What's the difference between a plan integrated

23 Medicare and Medicaid?

24 MS. KERNAN: You mean between the enhanced

25 connect care choice and the MCO?

1 MS. GOLDSTEIN: Right.

2 MS. KERNAN: Well, the enhanced connect
3 care choice is still an MME model. It is not a
4 managed care delivery system.

5 MS. GOLDSTEIN: So that the middle one is
6 considered a provider under Medicare. And
7 Medicare/PACE is considered a provider. It is not
8 a health plan. It is considered a provider. It
9 operates differently than HMO.

10 MR. KERNAN: I understand that. You know,
11 Elaina, I think you're bringing up some pretty
12 complicated issues. So we do have a website that
13 you can post questions to. So I think if you have
14 detailed questions, you should post your questions
15 on that, and then they will be able to answer it.

16 MS. GOLDSTEIN: It's hard to follow this
17 if you don't know what the distinction was. Do
18 you know what I'm saying? And I think I know --

19 MS. KERNAN: Well, I think the main point
20 is we're trying to integrate Medicaid/Medicare
21 into three delivery systems. It is already

22 integrated into the model one PACE. We want to
23 continue with that model because it is a very good
24 option. It is very well represented. We want the
25 other two models that we want to make available,

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1 starting with Phase 2, that includes
2 Medicare/Medicaid funding and it includes
3 long-term services. That was the major
4 difference.
5 Now, the funding for long-term services
6 and supports, which includes nursing homes, will
7 all be in an integrated funding service. And it
8 will all be aligned. A lot of the details have
9 not yet been finalized on how this is yet going to
10 work. We are in the beginning stages here today,
11 and we are asking this group on their help on how
12 to implement. So that is my explanation. Why
13 don't we go to the next slide. So now Diane is
14 going to come up and talk about the quality
15 assurance, performance, and improvement.

16 MS. TAFT: I am just going to go over what
17 our current quality assurance performance measures
18 are and that way we'll have a base on which to
19 start. Currently, on our goals and principles --

20 MS. THIBEAULT: I would just like to say a
21 couple of things. I am from the V.A., but when I
22 first heard this and Dr. Borlase first heard this,
23 we are intrigued by this because we are a
24 capitulated medical agency, and we know about them.
25 So when we look at all of these elements, they are

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1 pieces that we are doing. Well, nothing wrong
2 with it. But some pieces that I will be able to
3 offer and say, "This is what we've done in the
4 last two years to address this aspect. And this
5 is how we're measuring the effectiveness of the
6 changes that we've put in."

7 MS. BAIER: I'm just going to start.
8 Madeleine and I are here to facilitate. I just

9 want to draw everyone back to one of the opening
10 slides, which is the goal of this committee. I
11 think to analyze points earlier, there are
12 probably going to be some questions that arise
13 today. But I think asking those questions will
14 help the team dig out what we need to research and
15 do with the next meeting because this is a
16 three-step process that we're going to go
17 through.

18 The goal is specifically to provide
19 recommendations for the appropriate party for
20 individuals and goals to find new outcomes and
21 develop a process for outcome evaluations and
22 improve quality. I think that the first two
23 meetings probably will focus on the first part of
24 that. We're just figuring out what measures we
25 should be targeting.

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1 So we are going to rely on you as the
2 providers that stakeholders who work with the

3 patients in these populations and have facts and
4 ideas about the things that -- but, really, we
5 want to hear from you.

6 So, like I said, Madeleine -- I think she
7 described her experience with quality and
8 improvement with the V.A., and I just want to tell
9 you a little bit about my background. I am with
10 the State's public recording program from the
11 Department of Health. So my background is in
12 quality measurement, but my expertise is not in
13 the dual eligible population.

14 So we can generate a list and some
15 priority that the team from Medicaid can use to
16 this about which measures you might want to
17 propose and prioritize at the next meeting in
18 addition to that work. So the care coordination
19 is something that is close to my heart as well.

20 So with that, I want to just pause to
21 facilitate a discussion among the group. And
22 everyone has some ideas. That's why you are here
23 today. We will just ask that if -- we are going
24 to be sort of monitoring the time, and we want to
25 make sure everyone that wants to speak that they

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1 will have an opportunity. So, again, feel free
2 to raise questions about the advice and the
3 discussion today that will help the team
4 prioritize the measures. Remember, they are
5 researching so we can come to the second meeting
6 and figure out a little bit more about where we
7 should be.

8 MS. GOLDSTEIN: I am specifically
9 addressing the disability population and the
10 duals. And many times somebody becomes eligible
11 for Medicaid first, because of the long process to
12 become eligible under Medicare on the disability
13 process. So when that happens, they are not a
14 dual yet, obviously. And I guess this question
15 goes to health reform and as you apply to the --
16 to be part Medicaid and you are also applying to
17 be on Medicare.

18 You're starting out on Medicaid. Would

19 you even be eligible for Medicaid because you can
20 go through the exchange now, and I guess the
21 bottom line is how do you ever become a dual in
22 that scenario because you would be -- a lot of the
23 eligible requirements for a disabled person are at
24 a higher income. So you could be getting
25 long-term care services as well as the basic

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1 Medicaid services. And then you are applying for
2 Medicare. So your Medicare will then pick up
3 the -- do you understand? Do you get that? So
4 then the issue with health reform, how does
5 somebody -- you know, where does somebody go and
6 how are you going to make sure that they're
7 getting the right services that they need in both
8 the Medicaid program or the private health
9 insurance program that they're being subsidized
10 under?

11 MS. BAIER: If I could paraphrase. I know
12 your question has a little bit to do with

13 logistics. But once you are eligible --

14 MS. KERNAN: I can answer her questions.

15 I just went to a meeting this morning on the
16 exchange, and they actually came up with health
17 and reform. No one who is currently eligible for
18 Medicaid is going to lose it. It is only more
19 people are going to be eligible.

20 So the folks that are eligible will
21 continue to be eligible and most folks that are
22 not eligible now, 36 percent of the population
23 will be eligible without Medicare, which can
24 happen. They will receive all the services they
25 received.

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1 And assuming that they don't have any
2 commercial conveyance, Medicaid will be their
3 primary provider that will pay for everything
4 through the Medicare/Medicaid integrated system.
5 That will be the goal. The details I can't answer

6 now. But I don't think there's a problem here.

7 MS. GOLDSTEIN: Well, the problem is that
8 right now all that is available for somebody with
9 a disability waiting for Medicare is to go on to
10 Medicaid. But now with the exchange and with the
11 subsidies that are available, they haven't been
12 determined disabled yet. So --

13 MS. KERNAN: So they can apply then for
14 subsidies. It looks like there are other folks
15 who want to say something about this issue. Let's
16 see what they have to say.

17 MR. VARADIAN: Hi, I'm Michael Varadian
18 from BHDDH, which is one of the health center
19 organizations that are participating in the
20 Medicaid/Medicare managed care program.

21 I want to start by saying that I think
22 this is an opportunity for Medicaid to build on
23 a model that I think is working very well,
24 really, for the current population. And that
25 model, as you outlined, has a lot of the elements

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1 in it that there is some very good information on
2 how Rhode Island compares with other parts of the
3 country without managed care programs.

4 And this just benchmarks to let us know
5 how we are doing. It is relative to a large
6 variety of some plans in other parts of the
7 country. And I think that's relevant. I would
8 hate to see us lose that.

9 And in the past the Medicare program has
10 redacted that as they have brought on different
11 populations. For example, Rhody Health, there is
12 an increase in chronic care and chronic disease
13 management. So I think that model is a very good
14 place to start. And as we move into duels, there
15 will, obviously, be issues on long-term care and
16 parent care and behavioral health. And I think
17 all of those can be addressed in much the same
18 way.

19 And I encourage Medicaid to look at this
20 as an opportunity to have an integrated
21 performance measurement system for all of the
22 Medicaid populations. So that's sort of a

23 general, I think, approach that has been taken
24 so far. It is nationally recognized as an
25 excellent approach.

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1 MAN FROM AUDIENCE: Thanks. My question
2 might be kind of basic when I am kind of curious
3 about we are talking about what is the intent. It
4 seems to me like a balanced approach makes sense.
5 Is it the intent to deal with an MCO?

6 You're looking at performance measures
7 that it might provide. Are you talking about
8 performance measures that might shape the policy
9 around particular benefits that a particular
10 population might get, and to point out specific
11 outcomes at an early decline? Or is there some
12 type of mechanism on State and local government
13 of reimbursement? It seems to me that there is a
14 large variety of the data itself, and I just want
15 to know what do you share on in terms of the

16 intended basis.

17 MS. BAIER: That's a great question that

18 maybe somebody --

19 MS. THIBEAULT: When I saw this article,

20 the V.A. system has a 120 performance schedule of

21 measures that covers the support system, both the

22 business side as well as the clinical and

23 everything in between. Everything that you said,

24 sir, is what we use it for that drives either

25 Washington to make changes because our patient

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1 population may be changing and needing something

2 different or it drives evidence based practice in

3 a different way from the clinical side. And it

4 also drives efficiencies, getting efficiencies out

5 of all of our processes, and it is across the V.A.

6 I always refer to D.C. as the mother ship.

7 The mother ship directs and we use those measures.

8 Those performance measures drive what we do

9 clinically as well as from a business perspective,

10 and there is a competitive edge to it as well.

11 MS. KERNAN: And I would just like to add
12 the performance measures that we're asking you to
13 help us with, we're really building on a model
14 that we have now that we use to evaluate and
15 monitor our ongoing Medicaid/Medicare system.
16 These are measures that are used in a number of
17 ways for oversight and monitoring.

18 Are the plans doing what they are
19 supposed to do? Are they meeting their access
20 standards? Are they meeting the standards that
21 Diane mentioned about all kinds of things;
22 business operations, clinical care, access
23 to care network, etc. It is all part of a very
24 elaborate and I think it has been a quite
25 successful system to oversee, monitor, and seek

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1 for improvement. That is one of our goals; is to
2 continuously improve, and we hope that Medicaid

3 will be a part. But we intend to do as good of a
4 job as we're doing now.

5 MS. BAIER: So I think we're hearing from
6 a couple of different perspectives on building on
7 what we are already doing now. I think one of the
8 underlying -- I hear a few questions in the
9 agenda. I think one of those basic questions ask
10 what is successful for continuous coverage or
11 thinking about patients' feelings, making sure
12 that patients have coverage. I mean, a whole host
13 of reasons. And that is so we will even figure
14 out what those managements are so we can recommend
15 what we will do next.

16 MS. GOLDSTEIN: The dual population is a
17 different population than the government in the
18 past. And I think when you're looking at quality
19 measures, you have to go back, back to why they
20 are a problem with people at duels. You have to
21 set quality measures because you have to look at
22 the problems, and this is a whole -- that it comes
23 from basically the consumers' experience. And we
24 really think that that has to do with your top
25 measures.

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1 Are you eliminating the problems for the
2 duel population that you have already identified
3 as making sure that your system is developing and
4 addresses those? And, of course, the other
5 measures that are out there health wise. These
6 are really critical.

7 MS. THIBEAULT: So what you're saying is
8 that in the model, when I hear you say that, yeah,
9 there are probably issues and challenges that you
10 all face. But those are the problems that
11 processes need to be identified from the
12 performance. We would measure what -- how
13 successful was the problem solving putting in
14 place to address just what you're speaking to.

15 MS. GOLDSTEIN: Right. And when you do
16 that, the problems are issues for people with
17 disabilities, when they are trying to figure out
18 what is the health care. But you wouldn't
19 experience it at the V.A. because that's -- their

20 health plan is the V.A.

21 MS. THIBEAULT: V.A. all inclusive. I
22 think that is a must. We have to partner with
23 many services within the private sector that we
24 don't provide when it is some facet of outpatient
25 care.

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1 MS. GOLDSTEIN: But you have your V.A.
2 system.

3 MS. THIBEAULT: Yeah.

4 MS. GOLDSTEIN: You don't have another
5 system.

6 MS. THIBEAULT: We have to partner with
7 the Medicare/Medicaid and all the other providers
8 of plans that are out there. And we do have
9 practices in place to manage that pool of money.

10 MS. BAIER: So one of the things that you
11 should do is go back to that report.

12 MS. GOLDSTEIN: And identify from you

13 people what is the problem and how could we fix
14 this, you know what I'm saying? Which is a
15 process in and of itself.

16 MS. THIBEAULT: Absolutely. Absolutely.

17 MR. PINELE: Hi. Jim Pinele from the
18 Providence Center. For putting the shift in gear,
19 have we determined and will we be moving into one
20 of those three?

21 MS. KERNAN: There is a discussion with
22 BHDDH. It needs to determine what the disabled
23 populations will be moved into. There has been
24 some discussion but there is more discussion
25 needed. So it isn't yet determined at this point

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1 in time.

2 DR. BORLASE: Just a comment that there
3 are SPNAI members who are Medicaid eligible who
4 are not duly eligible who are already in the
5 system, including managed care. So there will be
6 the SPCI dual eligible that we are talking about.

7 MS. KERNAN: Right.
8 DR. BORLASE: There are a number of places
9 that we can look for measures that might be added
10 or might be the basis for the performance
11 measurement system. Just in January in the
12 Federal Register there was a final report on
13 nationally recommended adult measures. The
14 Affordable Care Act directed the Feds to produce
15 them and they spent a lot of time.

16 I think there are 35 measures that could
17 have a broad area of adult health, and a national
18 quality is for measures relative to all kinds of
19 health issues. And I think some of the
20 disabilities as to my populations should be
21 desperate measures issues.

22 MS. BAIER: I think that, Mike, back to
23 something you said earlier to meeting some of
24 these members, that will also give us an
25 opportunity to benchmark.

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1 MS. THIBEAULT: There is something Jay
2 mentioned that I wanted to share this for
3 discussion is that there is a grant opportunity at
4 least from CMS in which Jay represented and in
5 which the State of Rhode Island is very interested
6 in pursuing regarding Medicaid eligible adults.
7 So we believe that this is a great opportunity for
8 the State of Rhode Island, and it aligns with this
9 discussion. So we'll keep you posted as that's
10 part of our process.

11 We want to continue to get stakeholders to
12 be back involved. I would pursue that opportunity.
13 And, perhaps, at the next workgroup session, we
14 can bring those measures and take it a little
15 further. In addition to the other national
16 quality forum also identified is a host of
17 potential measures at looking at this population
18 of folks and how that measures to access to care
19 and services to care.

20 And I will say that in terms for me it
21 is -- one critical domain is how you measure the
22 integration of Medicaid/Medicare services and how

23 well that is occurring, which is a critical
24 domain. And I am not sure how many measures are
25 out there.

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1 CMS is still looking at the question of
2 quality in relation to this initiative. I have
3 heard that within the year there will be a set of
4 core measures that will come out, CMS will bring
5 out. You want to take the opportunity to speak.
6 I think you just used a couple of important words
7 as well. I think the words will help us with
8 other discussions at the next meeting as well. So
9 prioritizing measures as well.

10 WOMAN FROM AUDIENCE: This is a follow-up
11 question to Jim's question. Specific to the SPMI
12 population, which is not in managed care, but it
13 is contained out of the managed care called the
14 consumer support population in the community
15 health centers, and this is an initiative with
16 BHDDH. It helps the home initiative that is

17 currently happening. And I'm wondering where in
18 the vision this helps home phenomenon and goes
19 along with the health duels. So have you thought
20 about this? Or has there been discussion around
21 that?

22 MS. KERNAN: I can answer that. We would
23 want to discuss that closely with BHDDH, and I
24 haven't been at the table with the discussions
25 that have already occurred on the integration of

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1 the SPMI population. And that would certainly be
2 a consideration we wouldn't want to lose. I think
3 it could logically fit into an integrated model,
4 and we would have to think it through. And,
5 hopefully, that will happen. But it is going to
6 require more discussions. We don't have an answer
7 for you on that right now.

8 MR. TREAT: My name is Mark Treat, and I
9 am with the Nalari Health Center. So this

10 particular point is a little bit self-serving.
11 We are kind of interested in the thought process
12 around measures that are new in the technology
13 enabled neighborhood. For example, when you talk
14 about the 36, we also have an eligibility to
15 measure.

16 We actually collected information
17 symmetrically on a day to day basis. We are
18 instructed to do things like measuring time
19 prevention, particularly in the long-term care
20 center where you've got geriatric patients and
21 co-relations and hospitalizations.

22 And I'm just wondering what your thought
23 process is, for lack of a better word, assuming
24 this is a long-term contract that you are about to
25 go into.

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1 The new measures that you're going to be
2 implementing, how do you get those new measures,
3 is one question. And the second question, the

4 world isn't perfect. So you collect data in some
5 populations and other data.

6 At what point do you make judgment
7 calls that quality members who are collecting
8 are adequate or supercede other members because
9 there are certain appropriate national
10 judgments that you have to apply for the
11 determination of the result. I just want to
12 hear from you all on your thought process on
13 how that happens.

14 MS. BAIER: For me, it would probably be a
15 question for this group as well. Or is this an
16 opportunity as new technology and services -- I
17 imagine that that would be a question for others
18 as we service the basics. I think that is
19 something that we want to advise Medicaid on
20 that process where we could move it.

21 MR. TREAT: I don't really expect an
22 answer. But what I'm trying to do is I'm trying
23 to see if there is an opportunity to change in
24 terms of timeliness. And the way you do that
25 maybe involves --

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1 MS. BAIER: You also mentioned data, which
2 is a topic here. And I don't know much about it.

3 MS. TAFT: If you have a specific
4 question, you can send it to my e-mail address.

5 MS. GOLDSTEIN: I want to add that we are
6 working with the dual eligible population, and it
7 is an innovation system change. So it wasn't
8 sort of -- as a matter of fact, the systems
9 that we are budgeted to provide are not in the
10 Medicare/Medicaid services today. So we are to
11 create a new system. So that is what we got a
12 grant to do.

13 So what I'm trying to figure out is where
14 I am with -- what that opportunity is all about is
15 how to develop a new system that will work better,
16 to choose one. But even though you've got a
17 Medicaid proposal and a Medicare proposal, there
18 were these other problems, and how do you resolve
19 them?

20 I mean, you really can't unless you add --
21 you change the system. And by doing that, you
22 need to modify a system. It just seems like what
23 we're trying to do here is integrate financing and
24 integrate the services that currently exist and
25 attempt to make them -- make it work.

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1 So I guess I'm having some problems. And
2 I'm asking some of these questions because we
3 started out with the people who are receiving
4 benefits to ask them what's wrong with the system,
5 how could we make it better.

6 So I'm sitting here, you know, I'm
7 thinking, "Okay, how is it beneficial for me to
8 come to these meetings here?" And maybe it is not
9 where you're thinking, you know what I'm saying?
10 CMS was pretty clear.

11 So I don't know how I could be of help in
12 this process. I would like to, but I have
13 problems of my own. But they seem to want me to

14 be involved in this process. Maybe we could sort
15 of, again, figure out how, how -- if I'm not going
16 to be helpful, it is going to make you frustrated
17 and me frustrated. Then I'm not going to do it.
18 So if this is something that could be helpful, I
19 want to be helpful.

20 MS. BAIER: It sounds like some
21 operational issues that you're considering and you
22 have questions about. This may not be the right
23 venue.

24 MS. KERNAN: You might be serviced better
25 with the Services Support Group.

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1 MS. BAIER: But I think at least today we
2 should be thinking about some of the operations.
3 We should also try to define and from that
4 perspective, your comments about talking to CMS
5 about what is important in improving the system,
6 you could think about this discussion in defining

7 those methods. I think that maybe will help you
8 to --

9 WOMAN FROM AUDIENCE: I'm just curious as
10 to how the folks go off Medicare and are no longer
11 dual eligible, how do they factor in the equation
12 when you do a measurement because they are in and
13 out of the population? If you're looking at
14 long-term outcomes, how will it affect how they
15 are doing?

16 MS. KERNAN: We would have definitions to
17 determine who we would be measuring. Usually,
18 there is some interval of enrollment. I don't
19 know if that's been determined for this specific
20 population. But they are enrolled in a delivery
21 system because, otherwise, you can't hold the
22 delivery system responsible if they are in and out
23 too much.

24 WOMAN FROM AUDIENCE: So it will be an in
25 and out manner?

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1 MS. KERNAN: Well, I would hope there
2 wouldn't be too much of this in this term. I
3 think there's less turning with this population
4 than with the RITECARE population because their
5 incomes are more set, and they're disabled. They
6 have a disability. Unfortunately, they are not
7 going anywhere. That's what I've been told.

8 MS. BAIER: I think that is a request that
9 we would need for the next meeting, that for those
10 definitions, you should probably go to the
11 population.

12 MS. GOLDSTEIN: I'm sorry. Here's an
13 another one. The movement from CMS for the last
14 11 years is to get people with disabilities into
15 competitive employment, and that is a big, big
16 function of how -- from what I think. So to say
17 that somebody with disabilities is stable with
18 income is completely not where the country is
19 going and people with disabilities are going.

20 So, you know, we have the Medicaid by-in,
21 The Sherlock Plan, which has not been really,
22 really effective, but it has been incredibly
23 effective across the country. And that is,

24 actually, getting people off of Social Security,
25 and you're on Medicaid in a much higher income

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1 level because you are making money. So that is
2 one of the issues that does drive me, how do you
3 work with this population, which is more turnable
4 than a senior population?

5 There are so many questions that come up
6 that -- including employer health benefits. And
7 that is why the issues of how does the exchange
8 and how does the private health benefits work with
9 Medicaid, because if your goal is to try to get
10 people off of Social Security and off of SSDI
11 because they are now making a living wage? So
12 that's a big, big --

13 MS. TAFT: And that could be a measure in
14 the health plan. They could ask that question as
15 people are coming off a present income and have a
16 disability. That would be a question that they

17 could ask to make sure that they are enrolled in
18 The Sherlock Plan and must be in the plan. So
19 that will be something to think about.

20 WOMAN FROM AUDIENCE: Madeleine can
21 correct me if I'm wrong, but the State does look
22 at disenrollment and fully tracks that to answer
23 your question. And, again, correct me if I'm
24 wrong because I'm new, but right now at least on
25 the MCO side, and this will continue, Rhode Island

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1 broke up the maps on a top 20 in terms of
2 accredited Medicaid plans and MCOs that will
3 potentially be available to this population will
4 have to be no doubt accredited and meet those
5 requirements currently and a lot of the measures
6 that have specifications.

7 So in terms of the turnable, my
8 understanding -- again, correct me if I'm
9 wrong -- is they are using Administrative claims
10 and that's who's enrolled at that time would be

11 part of that calculation, if you will. But I'm
12 happy to make what I called the Bible of measures
13 so that if people at some point have a specific
14 question on a specific measure, we could also have
15 that to look at.

16 We have two models with that; primary care
17 and the MCO model. And I think that one thing
18 that the State will like to look at is a goal
19 using the same set. Maybe it is just three
20 measures or five to start, that each program, each
21 model is implemented to be able to track and
22 monitor for post programs, the same exact thing.
23 So that's just something I thought I'd mention.

24 MS. MORALES: I'm Debbie Correia Morales,
25 Xerox State Health Care Rhode Island, and Rhode

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1 Island Medicaid. This is a personal question,
2 Madeleine. So you are asking how we know success.
3 And I think, Madeleine, you mentioned something

4 about the quality measures. Going back to this
5 blueprint concept, if you have that many measures,
6 would it be difficult to discern what they really
7 are?

8 MS. THIBEAULT: Initially for the year.
9 So we look at what are the performances for these
10 measures over time. And certain ones I've chosen
11 because it is a higher area. We can focus on this
12 area so we can make a difference. The system has
13 a 120 measures at a given time. So right now up
14 in Providence we have all of the usual measures,
15 but we're focussing on probably 20 where we have
16 invested a lot, a lot of energy in it with
17 everything that is associated with it.

18 MAN FROM AUDIENCE: And I think this is
19 just a stab in the dark. I'll just throw it out
20 there. I'm thinking about balancing the budget.
21 The other four that I came out with, the first is
22 outcomes. So that would be things like health
23 vitality functioning. The second -- I don't know
24 what I would call it -- it has to do with getting
25 the right service at the right time.

1 And that has to do with access to care,
2 the right benefit structure, provider performance,
3 enrollment, those kind of things might roll up in
4 that one.

5 MS. THIBEAULT: We call it a category
6 access.

7 MAN FROM AUDIENCE: So maybe we can do the
8 outcomes and do access. The next one I came up
9 with is just patient satisfaction. Are customers
10 happy? We can always measure that. And the
11 fourth is financial. You have to look at the cost
12 and base line out there. I'm just throwing it out
13 there for consideration. I'm assuming that there
14 will be some kind of dashboard. But if there is a
15 way that you have that score card up there and you
16 can, you could measure the performance over time
17 and your emphasis on any particular individual
18 but it all gets filtered in somehow. That's how I
19 would -- how do you measure --

20 MS. BAIER: And I would just add with the

21 patient experience and so I know Debbie mentioned
22 that these are initiative measures and 120,
23 depending on how you want --

24 MS. THIBEAULT: People are going to walk
25 away when you start talking about a 120 measures.

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1 It is a 100 total measures. The focus is on maybe
2 20, 25. That doesn't mean that we are expecting
3 new data and establishing metrics for everything.
4 But we do focus.

5 MS. BAIER: I think the concept that you
6 talked about earlier, the integration, that is a
7 form of that access at the right place at the
8 right time. Those are the categories -- are other
9 things that people -- but there might be some
10 others that should be included.

11 MS. MORALES: I just want to clarify those
12 35 core measures will be built upon what is
13 currently in existence now in both models. The

14 MCO side, the over 40 measures that are collected
15 etc., and now a PW. I am just thinking in terms
16 of this particular population of individuals,
17 specific course and measures to that.

18 DR. BORLASE: When I had, like, Medicare
19 first to think about is measuring some measures of
20 functionality, a member functionality. And Martha
21 has mentioned the SF36, which is definitely the
22 one that goes. Basically, you could do that kind
23 of measurement at daily living, especially for
24 people who are disabled or have substantial
25 chronic disease.

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1 And employability, that's another level of
2 functionality that is, I think, important for a
3 population to have also, so we can live our lives.
4 And that socialization is a part of that to the
5 extent of which this program will help people
6 improve in all those areas, which would be good to
7 measure. And it is a difficult process. But it

8 would be good to measure that, if you could.

9 WOMAN FROM AUDIENCE: This is more of a
10 process measure. But as we come to realize that
11 more and more health behaviors and health issues,
12 if it's not already there, should center around is
13 this a really good screening and accessible for
14 follow-up for people to identify other health
15 issues developing; behavioral, addictions. And
16 somebody is looking at that. And proactively that
17 would be great.

18 MS. BAIER: So one of the questions on the
19 agenda is potential challenges and concerns. We
20 have touched on some of this, especially that there
21 are some logistics that we need to think about;
22 that there are some services that may change over
23 time that we need to think about. Is there
24 anything else that people want to throw out there
25 that we should be thinking about in addition to

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1 those?

2 MS. GOLDSTEIN: I think it is important to
3 get the right people looking at different
4 measures. You were mentioning APBL and
5 functionality but to make sure that you would
6 bring in people from DLT or voc rehab. And when
7 you're looking at the issues of employment and
8 employment supports and what is necessary and how
9 you can measure that somebody is employment first
10 is certainly a goal in all of this for people with
11 disabilities. So how do we get this? And I think
12 it's bringing in people who are generally at the
13 Medicaid table to help with those measurements.

14 MS. BAIER: It's the first question on
15 there. I think we have touched on some of these
16 concepts as well as delivery community based on
17 long-term support services and integrational. We
18 talked about integration. Are there other
19 opportunities in the work environment or things
20 that we should be considering that maybe you
21 haven't measured? What else is there ongoing
22 among the circle that you have just mentioned?
23 Who else should be at that table?

24 MS. GOLDSTEIN: I don't know. You know
25 more about this. I'm not sure which -- if

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1 somebody is on a Medicaid health plan, are they
2 also going to be in the exchange health plan? And
3 how can you make sure, like, if it's they have to
4 move because of income based issues, how can they
5 do that? And making sure that it's a similar
6 benefits package as possible so it is less
7 confusing for the consumer. What happens to them
8 because now they have increased their income?
9 That would -- looking at it from a consumer point,
10 where the consumers are, "I just want my health
11 care."

12 MR. BUECHNER: I'm from the Neighborhood
13 Health Center of Rhode Island. So I can't, I
14 can't say much about what you are thinking. But
15 from my point of view, I think the Voc Care Act is
16 a great opportunity for us to become candidates
17 for duels. There will be a Medicaid exchange in

18 2014. That's a new population for us to make
19 challenges. So exchange is pretty far down the
20 list.

21 There are some of them that we would have
22 to think to be listed as a Medicaid only plan.
23 So it is a big step for us to go in the exchange.
24 I think the commercial health plan. So that's a
25 ways down the road. You look at our current

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1 membership is about 90,000 current members.
2 And we looked at how long it's been since they
3 first became a member in one of our homes, like
4 Rhody Health Partners. Over half of them joined
5 the Neighborhood at some point five or more years
6 ago, and a good proportion of them ten or more
7 years ago. So even though these people go off and
8 on our health plan, we consider them our
9 population because they often leave and come back.
10 So the health investments that you make

11 today are going to come back in three or
12 four years. We deal with our members not just
13 while they are on the health plan. It is a little
14 bit of a long-term retirement investment. But it
15 is a long-term proposition. But we know that that
16 is where the long-term goal is really.

17 DR. BORLASE: We want to look at the whole
18 population of folks that are either currently
19 or --

20 WOMAN FROM AUDIENCE: So I'll try to
21 comment on the big picture. I am responsible for
22 the medication part of the business. So in that
23 case that is the ability to move to a lot of
24 different products but they will look at different
25 benefits where we are going to drive the package.

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1 So the ones that are sold on the exchange which is
2 going to look different from what you currently
3 offer it. So there's always going to be movement
4 based on income. And it is, it's not going to be,

5 "I got Package A and it is going to look exactly
6 like Package B," and then there is this whole
7 middle component, which is subsidized adult.

8 And I am just saying that there are a
9 great many of adults between 110 to 200 percent
10 above poverty level that might have the option for
11 a health plan if the State of Rhode Island decides
12 that this is an option that will be into the
13 exchange and purchase health care a lot better.
14 So those are things that we don't know yet. We
15 are the Director and we are looking for direction
16 and then how to manage that. I don't think -- but
17 it will at least be aligned so people will move
18 back and forth between those scenarios. I think
19 that's what you are trying --

20 MS. GOLDSTEIN: I think it is good that
21 everyone is certainly thinking about it because
22 this is the next thing is how do you make this
23 simple and understanding enough because the
24 consumer, even though they are United, it is a
25 different United when you are in Medicaid.

1 WOMAN FROM AUDIENCE: It is the same
2 company but the products are different.

3 MS. GOLDSTEIN: I used to work with
4 insured verses self-insured and people thought
5 they are insured by Aetna. And it seems simple
6 when you're in the business. But this is just
7 incredibly complicated.

8 WOMAN FROM AUDIENCE: And one of the
9 reasons for exchange is really about education and
10 consumer education, how to make it understandable.
11 So there's a big task of understanding. And one
12 that we are all close to, Massachusetts, about
13 half of it was that Massachusetts was a big
14 enrollment.

15 MS. GOLDSTEIN: One of the things I was
16 interested in is in what Jay said, and I think you
17 can comment on it. But I think that people turn
18 on and off Medicaid and then they come back to
19 you. But you are looking at them as a membership
20 for United. It is a different kind of issue

21 because they actually may have stayed on United
22 but just in different products with different
23 benefits. So we are looking at outcomes, the fact
24 that there are going to be a different benefits
25 package and a means of getting to those benefits

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1 needs to be so addressed because that will impact
2 the person's -- whatever the document is that they
3 are selecting and depending on different benefits
4 and their access to that.

5 MS. THIBEAULT: And so we're trying to
6 make sure that the terminology as we change our
7 health care or benefits or our availability and we
8 are able to change that component and move it to
9 that health care. But from a national perspective
10 they talk mainly 20 and up percent of people who
11 are turning their channels where you had changes
12 around Medicaid eligibility. It is a big issue
13 and we are going to help them understand with the
14 exchange of what they are looking at and what

15 their choices are.

16 MS. BAIER: So the words used that I
17 haven't mentioned in, like, discussions, I haven't
18 heard a discussion about care coordination once
19 you are in the system, and the utilization. But
20 more importantly, too, about communication between
21 providers.

22 MS. GORMAN: Hi, I'm Kathy Gorman. I just
23 wanted to make some comments based on my
24 experience working as a social worker in the
25 field. And this can go back a number of years

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1 now. So how much could I comment on? But I know
2 that I have observed a lot and sometimes there is
3 increasing difficulty over a period of time
4 between health care providers and community based
5 providers. So I was wondering if it is, if it
6 would be useful in building measures as a way of
7 encouraging communication long-standing between

8 community service providers and health care
9 providers.

10 There were two other issues that I
11 noticed, was that one, sometimes the health care
12 people received was not the best for someone at an
13 age facility. So that when you're dealing with
14 community care providers, one of the things that I
15 think would be useful is seeing what gerontologist
16 would be useful in the elderly population.

17 The other issues that I encountered had
18 to do with poverty, understanding poverty issues
19 and, you know, giving someone a prescription who
20 doesn't have transportation available to get the
21 prescription filled. And I'm sure that people --
22 the providers with the RITECARE population have
23 developed some expertise. But that is where we
24 dealt with long-term care crisis that had to do
25 with people whose house is unsafe or whose water

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1 had been shut off. RITECARE providers were

2 completely overwhelmed by some of the issues that
3 their patients presented. So I'm thinking about
4 the value of home safety evaluations. And I know
5 that we're talking about wanting to keep people at
6 home for as long as possible. But there are times
7 when people really need placement in order to be
8 safe. So how do you determine what their outcome
9 is? I think it is really -- there is real
10 difficulty with this population, as it is
11 absolutely known to be something that would be
12 necessary and not necessarily measuring a failure.
13 So I guess in looking at car insurance measures,
14 it would be useful to take some of these issues
15 into consideration than without measures that
16 would have provided a strength in your ability to
17 respond appropriately to them.

18 MS. BAIER: We have identified the best
19 practices for communication for providers in
20 multiple settings including home and community
21 services. I have been working with the providers
22 to incorporate those barriers into their contract
23 and the health insurance. For example, those
24 metrics can be incorporated into the hospital

25 contracts as well.

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1 WOMAN FROM AUDIENCE: I just wanted to add
2 that I think there is also an occasion for looking
3 at the end of somebody's life and advance the
4 records and making sure that -- I mean, it kind of
5 falls on utilization. This is well-known data and
6 that the utilization and cost of care in the last
7 six months of life is astronomical, but I think
8 you need to be considering that as well.

9 MS. GOLDSTEIN: Maybe this is important
10 for the group in our model. It is very, very much
11 a huge part that has been interdisciplinary teams
12 and how we are going to get all the providers who
13 work with the individual consumer talking to each
14 other and creating a plan together, instead of
15 moving from one specialty list to another
16 specialty list. And people, obviously, with
17 chronic disease are a multiple specialty list.

18 And that is what our model is about is
19 how are we going to go about doing that, to
20 change the way providers work with each other
21 and with the patient. It is a different plan
22 base because it is a core team and then an
23 individual team, it is on the providers
24 individual scene now and their specialty list
25 now to get at that question.

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1 And so I'm hoping -- we have to get our
2 new project up and running in six months, and
3 within a year hopefully know whether or not this
4 model is going to be successful.

5 So my hope is that if this model is
6 successful and HP and United and Blue Cross and
7 even PACE would want to include this type of
8 language, for lack of a better word, provider
9 care into their systems because they need a
10 successful way of doing business. So that is
11 how I see on how we are trying to do to

12 integrate the State to get involved with each
13 other. So if that helps.

14 MS. BAIER: Absolutely. And I think that
15 Mark said something different with the evolution
16 of the services and about the different services
17 that are available. So we have about 20 minutes
18 left, and I want to make sure that everyone has
19 had a chance to comment.

20 I think what we are going to do for the
21 next meeting is to take the ideas and have these
22 folks go back and give those measures to the next
23 meeting for discussion and to look at them in
24 more detail, and maybe to prioritize them on how
25 it is best what to do next.

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1 MAN FROM AUDIENCE: I have a question.
2 This is about collecting the metrics. I think
3 about this State as a contractor. Now, with the
4 audio contractor in the neighborhood and people

5 for the record getting benefits in some other
6 format, is the State envisioning, for example, to
7 hire a vendor who would then do quality across
8 all of the different contract vehicles? Or are
9 each contractor or vendor expected to perform
10 that function? And is the cost of that
11 anticipated in the whole package?

12 MS. BAIER: I don't know if that's
13 something that you guys have definitively
14 decided. But you have the second charge on this
15 as well as on the logistics. So that will be
16 something that we could think about.

17 DR. BORLASE: I just wanted to add
18 something that some of Mark's comments and some
19 other comments have turned in my head. There
20 is a second place for looking at the capacity of
21 providers as well as the outcomes of members of
22 Medicaid. And some of the things is that EQR is
23 available and how well it is to address the health
24 patients, the health information, whether it is
25 accredited for a patient medical home.

1 There's a whole lot of provider members
2 we could be thinking about, who are not members
3 who respect the quality of care available to them.

4 MS. BAIER: Are there any other thoughts
5 or comments that you want to make sure are on the
6 record here? Okay. Any closing facts?

7 MS. KERNAN: No. I think we should just
8 let folks know when the next work group meeting
9 is.

10 MS. BAIER: When is the next working
11 group?

12 MS. MORALES: The next meeting is on
13 August 7th. We will be meeting at the same time
14 and same place.

15 MS. BAIER: And we will prioritize those
16 measures that we are going to research. So we
17 hope to see all of you back here on August 7th.
18 And certainly if you have other colleagues that
19 have facts and ideas, this is an open meeting and
20 we will --

21 MS. MORALES: If anyone after getting home

22 either tomorrow or a few days from now you have a
23 thought as far as quality, please feel free to
24 e-mail me at that address to answer a question and
25 it will get to us, and I can include that in for

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1 the next work group meeting. We would really
2 appreciate it. And thank you so much for taking
3 your time and interpreting it with us and sharing
4 your thoughts and feedback.

5 (MEETING ADJOURNED 4:45 P.M.)

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CERTIFICATION

I, Cynthia M. Spagnole, do hereby certify
the foregoing pages to be a true, accurate, and
complete transcript, according to my stenographic
notes, of the RHODE ISLAND EXECUTIVE OFFICE OF HEALTH
AND HUMAN SERVICES WORK GROUP SESSION 1 OPEN HEARING

ON OVERSIGHT, MONITORING, AND CONTINUOUS IMPROVEMENT,
held on TUESDAY, JULY 24, 2012, at the Warwick Public
Library, Room 101, Warwick, Rhode Island.

IN WITNESS WHEREOF, I have hereunto set my
hand this 14th day of ____August____, 2012.

CYNTHIA M. SPAGNOLE
CERTIFIED SHORTHAND REPORTER AND
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