

**Coordinated Health Services Planning
Advisory Committee
January 4, 2007
RI Department of Administration, Conference Room A
3:00 – 4:30 p.m.**

Meeting minutes (not yet approved)

Attendees (Committee members): Fox Wetle, Chair; Kerri Jones-Clark; Kathleen Connell; Lauren Conway (for Stephen Farrell); Kathleen Fitzgerald, MD; Louis Giancola; Robert Guneyi, MD; Katherine Heren (for Roberta Hawkins); Donna Huntley-Newby, PhD; Joan Kwiatkowski; Toni Roderick (for Dennis Langley); Yvette Mendez; Peter Oppenheimer; James Purcell; Robert Quigley, DC; Jackie Dowdy (for Mark Reynolds); Frank Spinelli; Margaret Sun, MD; Alan Tavares; Nick Tsiongas, MD

Attendees (Dept. of Health Staff): Stephanie Kissam

Attendees (Interested parties): Mary Brinson; Steve DeToy; Rick Farias; Liz Gemski; Meghan Purvis; Craig O'Connor; Josie Santilli; Craig Syata.

I. Introductions

II. Dec. 7th meeting minutes approved

III. Review comparison of options for the “organizational home” for the Coordinated Health Planning process

Lou Giancola, Chair of Hospital Association of RI, President of South County Hospital, and member of the Coordinated Health Planning Executive Committee, presented a document that summarized the benefits and concerns of each option for the “organizational home” of coordinated health planning:

General principles -

- One aim of a health planning process is to develop a “single-payer system” without a single payer – essentially, want the health planning process to inform all payers of the priorities and principles for purchasing health care.
- The coordinated health planning process should be accountable for delivering results.
- Wherever the organizational home is, there should be a mechanism to insulate the health planning process from day-to-day politics. Participants in the health planning process should serve terms.

Considerations for the “organizational home”:

1. Existing non-profit, e.g., RI Foundation or SHAPE Foundation-like entity. Executive Committee could not identify an existing non-profit organization appropriate for this purpose.

2. Department of Health

Benefits: having existing regulatory authority over some aspects of the health care delivery system and has public accountability

Concerns: questionable credibility to do health planning, potential conflict of interest when Director of Health is the final arbiter of recommendations from a health planning process and of implementation of those recommendations in CON or regulatory process.

3. Executive Office of Health and Human Services

Benefits: Purpose of office is to coordinate across health and human service agencies, has public accountability, and has some authority over Medicaid purchasing decisions

Concerns: questionable credibility to do health planning because of short track record and limited numbers of staff

4. Quasi-public entity

Benefits: Model lends itself to public-private collaboration

Concerns: Needs start-up time; concern over whether it would be feasible or desirable to cede some existing state agency authority (e.g. for purchasing or regulation) to a new agency, concerns regarding resources needed to create and implement such an entity.

All options have similar need for a significant amount of additional resources to implement.

IV. Discussion of Executive Committee recommendations

Comment: Every individual or organization that participates in a health planning process will have a conflict. In fact, an entity that has a conflict in balancing cost vs. quality vs. access is more preferable than anointing an entity with a single responsibility to prioritize only one of those features of the health care system.

Comment: The fact that Certificate of Need is administered by the Dept. of Health (DOH) is a reason to have the planning process at DOH.

Comment from Dr. Quigley, chair of Health Services Council: The current statewide health plan is out of date, and this hinders the Health Services Council's ability to do its job. The Health Services Council would like a health plan with which to justify its recommendation to the Director of DOH on the applications it gets for Certificate of Need.

Comment: If there is a planning commission created within DOH, there would be no conflict with the Director's responsibilities now.

Comment: There must be some authority resting with a commission or organization to do health planning, especially since it touches so many areas of health care, such as emergency planning. Can we amplify the planning that DOH does now?

Comment: The value of the Executive Office of Health and Human Services is its purchasing power and direct communication with other health and human service departments. Could it create a commission (or some other body) that would allow for a public-private partnership?

Comment: There is concern that decisions about health planning would rest with a political appointee.

Comment: The Statewide Health Coordinating Council (20-30 years ago) was comprised of participants appointed by the Governor, with a mandate to have a majority of consumers.

Comment: Health planning is not enforcement – enforcement comes from those that buy health care. We should have less concern that a Director of DOH would micromanage the enforcement of a health plan.

Comment on resources: We need to assess what new functions we want, and be serious about how much a health planning process will cost, even if it is a large amount of money.

Comment: The health planning function is not going to be effectively implemented unless there's more comprehensive reform of the health care system, including the cost of health care.

Response: Need to consider the General Assembly's acceptance of a proposal for initiating a health planning process – if setting rates is part of health planning, that means that the General Assembly will have to cede some of its authority to set rates for payments (e.g., Medicaid payment rates).

Comment: Planning in health care is not about creating one document, but is rather an ongoing dialogue. A health planning entity has to be sensitive enough to capture data, analyze it, adapt the plans, and make decisions in a consensus-based model.

Comment: A plan that does not address payment rates will not be meaningful.

Comment: If there's a plan and agreement across the community as to how to spend money on health care, then you relieve pressure on any one payer.

Comment: The Dept. of Health has the most existing authority and responsibility for the quality of care. It makes sense to make DOH the organizational home of health planning, so long as procedural safeguards are in place to ensure that the Director of DOH is not the final arbiter of decisions, and that the planning takes place in public-private collaboration.

Comment: Need to consider how health planning will interface with other state agencies.

Comment: As a practical matter of hiring and doing the work of health planning – state agencies are restricted in their purchasing, hiring, etc. We may want a health planning entity with flexibility in its operations.

Comment: Concern that the envisioned health planning process is getting too broad. It may be premature to do rate-setting and health planning.

Response: Health planning should give payers, providers, and DOH's regulation direction. It should broaden and deepen the responsibility of DOH.

Comment: Traditionally, payers pay providers for procedures, not the cognitive part of medicine. The model of payment needs to be changed, which includes some planning for payment rates.

Comment: Guidance on payment rates would be a good thing. A planning process should balance the needs of primary care against hospitals.

Comment: This group should take the opportunity to be bold. We could make a recommendation as to what happens first and what next steps to take. We might not have enough information at this moment to determine the entire scope of the health planning process.

Question to the group: Is there broad agreement that the organizational entity should be DOH?

Responses:

- No, should instead be a hybrid of EOHHS and a quasi-public entity.
- Yes, because it could use an existing office and bring in a public-private commission.
- Yes, it has to have the authority to implement. Don't want more regulation, but it's better that we do something rather than nothing.

Other responses:

- Can't slow down process with consensus – need to take action.
- It would be a mistake to set up a new entity just to do health planning.
- EOHHS has the mandate to coordinate planning across health and human service agencies, has staff, and has the authority to submit a consolidated budget (e.g., for Medicaid.)
- The General Assembly would not accept direction (or mandates) from a new agency as to how they should spend health care dollars – it may result in unintended consequences.
- Guidelines are fine, but process needs to secure agreement on the same types of incentives for the same types of providers for doing the same types of things.
- Can't be scared away from articulating to the General Assembly some of the essential problems with the current health care system.

Next steps

- Suggestion to reconvene to discuss authority over who can best enforce health planning process.
- Suggestion to provide materials to Committee members ahead of time.
- Next meeting February 8th, 3 – 4:30.
- Community Forum: February 12th, 3 – 4:30.
- Staff will send out draft materials to group before next meeting.

Meeting adjourned at 4:30 p.m.

Respectfully submitted by:

Stephanie Kissam
RI Department of Health