



Health Care Planning and Accountability Advisory Council

Thursday, September 20, 2012 2:30 p.m.

Lower Level Conference Room Department Operations Center

Department of Health, 3 Capitol Hill, Providence, Rhode Island

Co-chairmen: Steven Costantino, Secretary, Executive Office of Health & Human Services; Christopher Koller, Commissioner, Office of the Health Insurance Commissioner

Attendees: Kenneth Belcher; Douglas Bennett; Jodi Bourque, Esq.; Albert Charbonneau; Nicki Cicogna; Stephen Farrell; Michael Fine, MD; Patricia Flanagan, MD; Marie Ganim, Ph.D.; Gloria Hincapie; Dennis Keefe; Eve Keenan, Ed.D, RN; Kate Kennedy (for Herbert Gray); Rebecca Kislak (for Jane Hayward); Dale K. Klatzker, PhD; Edward Quinlan; Mark Reynolds; and Fox Wetle, Ph.D.

Members absent: Alyn Adrain, MD, Peter Andruszkiewicz; Dr. Timothy Babineau; Beth Cotter; Robert Hartman; George Nee; Donna Policastro, RNP; Sandra Powell; and Louis Rice, MD

Staff in attendance: Melinda Thomas, Senior Policy Advisor, Executive Office of Health & Human Services; Michael Dexter, Chief, Office of Health Systems Development, Department of Health; Kim Paull, Director of Analytics, Office of the Health Insurance Commissioner; Elizabeth Shelov, Chief, Family Health Systems, Executive Office of Health & Human Services; and Cara Sammartino, Health Policy Intern, Executive Office of Health & Human Services and Brown University PhD candidate

The meeting was convened at 2:30 pm by *Christopher Koller*, Commissioner, Office of the Health Insurance Commissioner (OHIC). Commissioner Koller apologized for the re-scheduling of this meeting from September 20, 2012 due to a meeting called by Governor Chafee. As a result of the time change, the Commissioner acknowledged that a number of members could not be here today. The bulk of today's meeting content consists of presentations related to the Hospital Conversions Act and the state's Certificate of Need Program. *Jodi Bourque, Esq.*, Health Care Advocate and Assistant Attorney General in the Department of Attorney General (AG) and *Dr. Michael Fine*, Director of Health, will present PowerPoints on these topics.

Meeting Minutes

The meeting minutes from the May 11, 2012 and July 19, 2012 meeting were discussed. *Commissioner Koller* indicated that the May 11th meeting minutes were expanded, as Council members had previously requested. The July minutes are consistent with the Council's direction. *Drs. Wetle and Keenan* made a motion to accept both sets of minutes.

At the July 19th meeting, a suggestion was made that the May 11th meeting minutes reflect the 2007 health advisory committee's principles. A rather brief set of principles was contained in the 2007 report and it was suggested that these be inserted into the May 11th minutes. *Dr. Wetle* pointed out that a recognition of these principles would be a good starting point for this group. *Dr. Keenan*

requested that the principles also reflect a statement about transparency of costs and the need to define the term “access.” The Council unanimously voted to adopt both the May 11, 2012 and the July 19, 2012 minutes with the changes noted above.

Work Plan, Time Line, and Update on Procurements

The HCA/CON discussion was moved to this meeting, in part to accommodate the work of the vendors. It is also planned that the January Council meeting agenda will include a discussion of the HCA and CON.

Contracts have been executed with both The Lewin Group and The Robert Graham Center (policy division of the American Academy of Family Physicians). The Robert Graham Center will perform a gap analysis of the delivery of primary care services and health care workforce development in Rhode Island. The Lewin Group is studying acute care inpatient providers and inpatient utilization.

Both vendors are willing to consider the Council’s research questions as part of their scopes of work. The Graham Center will investigate how different ways of organizing primary care infrastructure drive Rhode Island’s need for hospital services. The second question related to the ideal number, location, and type of hospital beds that yields the best outcomes at the lowest cost will be contained in Lewin’s scope of work. Kick-off conference calls have recently been conducted with both vendors. In addition to any vendor presentations, there will be periodic reports to the Council to discuss specific work being done. Any materials from the vendors will go to the Council at least a week before the meetings.

Dr. Keenan indicated that observation patients take up an inordinate amount of resources in each community hospital and this issue should be considered.

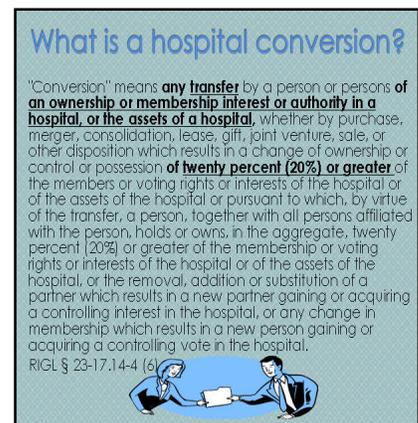
Hospital Conversions Act Presentation

With no other comments or questions about the vendors, *Attorney Bourque* was called upon to do her presentation. *Attorney Bourque* started with a disclaimer that any opinions stated in the presentation are hers alone and do not represent official positions of the Department of Attorney General.

The HCA was amended in 2000 to include several additional criteria. By contrast, in 2012, the Act was streamlined. The purpose of the HCA is to assure the viability of a safe, accessible and affordable health care system that is available to all of the citizens of the state (see slide #3).

What is a hospital conversion? (see slide #4). Slide #5 clarifies the jurisdiction and authority for the HCA. The initial application (there is only one application) is described in slide #6. The concurrent review with the Department of Health has been very successful.

During the last HCA review, there were not many requests to review documents. Some documents are held to be confidential. Many documents are reviewed. Seventy-three questions are contained on the present application; 42 of which are set forth in the statute. Every single review is tailored to a particular set of facts.



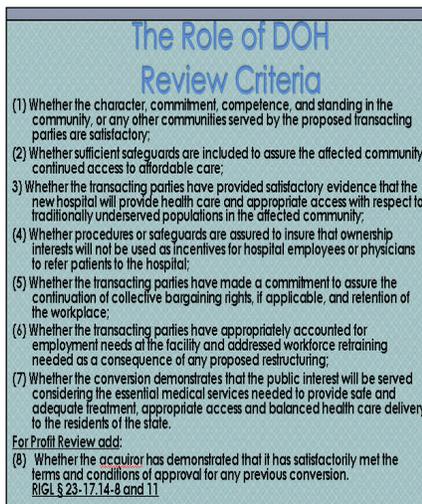
Numerous binders are submitted by the applicant and there are 30 days allotted for the AG and HEALTH to determine if the application is complete. This is a completeness review that poses the question: For the purposes of the application, does it contain all of the required information?

The AG publishes a notice of public hearing in a paper of general circulation in the state. This public informational meeting is an important part of the process. This is a part of the review that is really helpful; the microphone is open to anyone who wishes to speak. This part of the process is very important, as people do not generally send written letters. Currently, there are 120 days from date of acceptance to the date of making a decision (it used to be 180 days).

Slide #10 describes the criteria the AG uses for its reviews. Only one criteria is shared with DOH. There are 30 criteria required for review in a for-profit conversion and 21 criteria reviewed in a not-for-profit conversion.

Slide #11 describes the HCA and charitable foundations. Subsections 23-17.14-22 through 23-17.14-27 RIGL discuss charitable foundations. These subsections contain specific detailed requirements related to a foundation. A 7-member board and the role of The Rhode Island Foundation are contemplated in the statute. The Superior Court has jurisdiction over this matter. When asked, Ms. Bourque indicated that she can provide the citation for the process by which funds are transferred to such a foundation.

Common law authority (slide #13): This slide relates to the common law powers of the AG related to charitable asset distribution.



DOH review criteria (slide #14): There are 7 DOH criteria, with the top criteria related to patient safety and quality. One additional criteria is related to for-profits.

Charity care (slide #15): requirements are contained in the HCA.

Closing or reduction of medical services “reverse CON” (slide #16): Primary care and emergency department services cannot be eliminated without a plan approved by the Director of Health.

HCA tools include experts, investigations, and penalties (slide #17)

Experts: The scope of the experts is pretty broad. It might include persons with expertise in national trends in hospitals, financial experts, persons with experience in hospital transactions. It might also include attorneys and accountants. Experts may be used a bit more in the future, as the time line has been shortened for reviews. Investigations can consume a great deal of time. Some of the best information obtained during the last conversion was obtained by interviewing the transacting parties. There is no requirement that such interviews be done under oath. During the last conversion, interviews were not conducted under oath.

HCA amendments 2012 (slide #18): The 3-year ban on a for-profit acquiring another hospital has been eliminated. The review time line went from 180 to 120 days.

Mandatory conditions for approval of for-profit applications (slide #22): DOH has eight conditions to consider such as the governing board, contributions to coordinated health planning, and restrictions on incentives for out-of-state hospital services. The AG has one condition: minimum investment to protect the assets, financial health and well-being of the new hospital and for community benefits.

Mandatory reporting and monitoring (slide #24): Three years of reports must be filed by the acquirer, detailing compliance with the conditions and any other conditions on the conversion approval or license of the new hospital. Failure to meet this requirement is cause for penalties.

Judicial review section changed substantially (slide #25): The standard of review for appeals is now different from any other agency in the state and there is a balancing test in effect. *Ms. Bourque* noted that she had testified on the bill that a balancing test was not an appropriate test.

The new expedited review process is a 90-day review (slide #26): Both parties must have owned a hospital for at least three years and have to be considered a distressed hospital in a finding by the Director. There is an application form available now for distressed hospital status. There are 13 categories in the statute for expedited initial application. There are 90 days available to do the review with the same review criteria. There are no timeframes for a completeness review. Within 20 days of an application being deemed to be complete, DOH will notify the public of an opportunity to comment.

Yearly reporting (slide #30): On or before March 1st of each year, a report with all updated financial information is required to be provided to the Department of Health.

AG Review (slide #31): If there is an expedited review at the Department of Health, the AG still performs whatever kind of review deemed appropriate. The reviews are performed concurrently, with the AG determining the nature of the review.

Expert Costs (slide #32): Costs for experts are limited by caps: \$25,000 per \$100,000,000 of total net patient service revenue of the acquiree and acquirer in the most recent fiscal year.

The Department of Health and the Department of the Attorney General are now working with the 2012 HCA amendments.

Certificate of Need Presentation

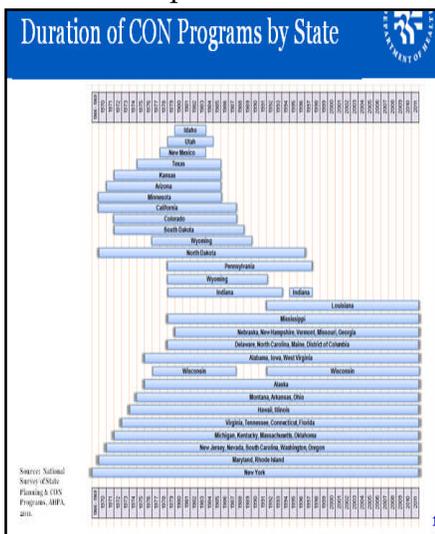
CON exists to ensure that health care services meet the needs of the population, but does not identify service delivery gaps, or channel applications from existing providers.

CON is required for new specialty services regardless of cost. The list of reviewable categories appears at the bottom of slide #4. CON has been around since 1968 and was expanded pursuant to federal action. Federal funds were eliminated in 1986 but CON has continued to this day. In 2011, the expenditure thresholds increased (see slide #5).

The District of Columbia plus 36 other jurisdictions still have CON programs. Twenty-five states have CON and state health plans; while 12 states have CON but no state health plans.

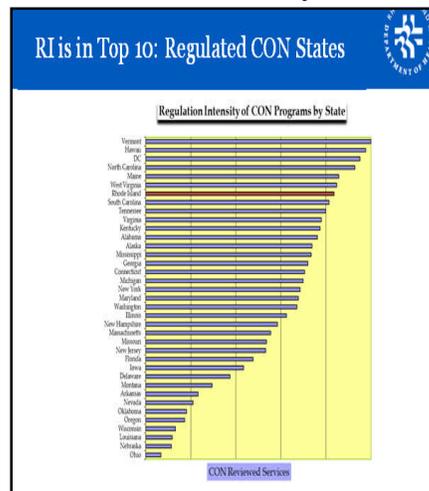
The description of the Health Services Council’s functions appears on [slide #7](#). The Council makes recommendations to the Director of Health, who can accept or reject the recommendations based upon the information provided. No CONS have been denied since 2008 ([see slide #9](#)).

[Slide #10](#) presents a list of number of CON programs nationally by year. [Slide #11](#) visually presents the duration of CON program by state.



[Slide #12](#) presents a metric of regulation intensity developed by Mike Dexter, Chief of the Office of Health Systems Development. In this schematic, RI is in the top 10 regulated states for CON.

A review of recent CON literature indicates that CON may be an effective tool for regulating cost and quality. Among cardiac surgery programs established between 1993–2004, the most rapid rise in such programs was in states that repealed their CON programs. Increasing the supply when demand is declining results



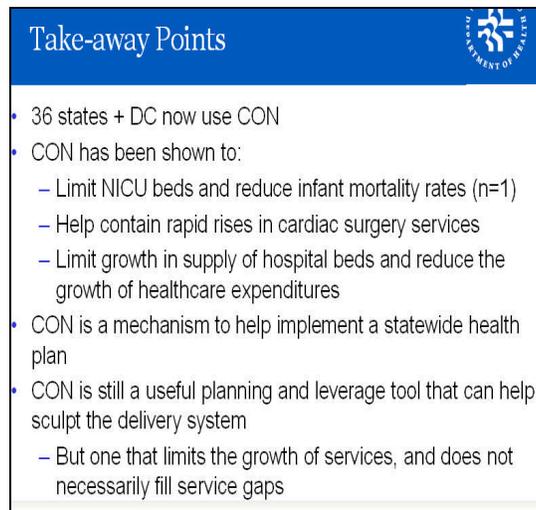
in a growing proportion of procedures performed in hospitals where volumes are low.

Benefits of CON appear on [slide #16](#) and risks of CON appear on [slide #17](#). CON is a complex and time consuming process.

Options for reform begin on [slide #18](#):

- Focus on cost/outcome and utilization, with a focus on technology
- Create a statewide health plan
- Administrative simplification: drops RI from 7th to 22nd most intensely regulated using the home-grown scale
- Suitability reviews focus on ability to provide the services
- High volume specialty services where there is evidence of good outcomes
- Data collection: use standard evaluation approach in collecting data; there is no standard information or data context to which a proposal can be compared; we do not have data on system wide cost impacts; we do not have a place to ask: “what is the cost impact of such a service?”
- Cost outcome/ utilization outliers: review outlier services that may contribute to problematic system performance, such as new but untested imaging or surgical technologies, new training programs, expanded emergency departments focused on increased volume, pharmacy based clinics; titrate the educational training programs with the needs that we have.
- System leverage comes up in conditions of approval that tie profitable services to needed unprofitable services, such as new training programs, multidisciplinary chronic pain centers, case management, alternative urgent treatment for intoxicated patients, and referral for Hepatitis-C.

Take away points: [see slide #24](#)



Take-away Points

- 36 states + DC now use CON
- CON has been shown to:
 - Limit NICU beds and reduce infant mortality rates (n=1)
 - Help contain rapid rises in cardiac surgery services
 - Limit growth in supply of hospital beds and reduce the growth of healthcare expenditures
- CON is a mechanism to help implement a statewide health plan
- CON is still a useful planning and leverage tool that can help sculpt the delivery system
 - But one that limits the growth of services, and does not necessarily fill service gaps

Discussion

Questions / discussion among the group included:

Ed Quinlan to Mike Dexter: Can you do a look back at non-hospital based services? What is an appropriate definition of “community need”? We do not have a standard definition. It is important that partners look at health status of the population, talk to each political entity and ask about the definitions and come up with common goals and objectives. Health planning is difficult without a community health assessment.

Dr. Fine: In the current state of CON, the onus is on the applicant to demonstrate need and affordability. But is there any consistency across applicants? The Health Services Council is being pushed to determine that a service will have a positive impact on population health and not increase costs. For physician-owed entities, how do they relate to a health plan? We do not have a requirement to establish population-based health outcomes.

Mike Dexter: To respond to Ed’s question, [slide #9](#) is not limited to hospitals, but also includes two PET CT applications that were rejected.

Mr. Reynolds: Are the definitions of need statutory or regulatory? How do you determine need? Where is it? *Mike Dexter:* It is explicated in statute, with further opportunity to create standards in the regulations.

Dr. Klatzker: A statewide health plan and hospital mergers/acquisitions should be driven by a more logical process. Do states that have CON and health plans fare better? There has to be consistency.

Mike Dexter: All states run their CON programs differently. Fourteen states do not have health plans and CON together. Texas is a good state to do business, if the absence of CON is the goal. California is a bit different, perhaps because the market is driven by Kaiser-Permanente.

Mr. Belcher: When it comes to utilization, there may be perceived community need, but there are 15 CT scanners being used only a small percentage of the time.

Mike Dexter: Experts have been used (e.g., Harvey Zimmerman) and surveys done with the applicants. The data are good and go back at least five years.

Dr. Klatzker: Behavioral health care access is important: Rhode Island has highest inpatient and outpatient utilization in the US. *Dr. Fine:* There is a missing link between costs, utilization, and outcomes. Utilization and service data are very variable; we have good data for Medicare services. Data for the “commercial population” is not so good.

Attorney Bourque: Standard of judicial review for HCA should be changed in this upcoming General Assembly session. This is a legal issue that should be fixed. Two things have happened: 1. standard of review that gives deference to agency fact-finding is not the same as the standard applied by a judge who may not have access to the same information. 2. The appeal standard should be the same as in every other state agency. In this context, a balancing test is not used for any other agency. In this instance, the transactions come together, with the purpose to bring parties together for the good of the people of the state. A balancing test is not required. Would the Council members like to look at proposed language for consideration?

Dennis Keefe: A positive, nimble process is needed. If efficiency-type changes are made in the Act, it will be very helpful.

Dr. Keenan:: If we raise the dollar amount higher for big ticket items, we could be selective where we expend energy. We do not manage the expansion of the marketplace. We do not manage the contraction or rightsizing either. All of our “health planning eggs are in the CON basket.” Do we have the services we need? CON without a statewide health plan does not manage anything.

Mr. Belcher: It would be worthwhile to see Attorney Bourque’s proposed changes.

Dr. Ganim: We have struggled to revise CON for 20 years. The HCA was just overhauled, but we have to be more broad in our thinking. We have to envision “what can be.”

Dr. Flanagan: What is the timeline for the completion of the community health assessments? *Dr. Fine:* “The 990s will come fairly soon.”

Mr. Reynolds: The legislature directed us to provide recommendations on HCA and CON. It would be nice to have baseline work done by contractors before these recommendations are submitted.

Secretary Costantino: The vendors will be completing their studies related to hospital services first. Their work will inform the recommendations.

Attorney Bourque: We are supposed to discuss recommendation again in January 2013. Timing is an issue with the work plan.

Commissioner Koller thanked *Attorney Bourque* and *Dr. Fine* for their work. With no further discussion, the meeting adjourned at 4:00 p.m.

Notes prepared and respectfully submitted by:



Elizabeth Shelov, MPH/MSSW

Chief, Family Health Systems

Executive Office of Health & Human Services

September 26, 2012