



Health Care Planning and Accountability Advisory Council

Monday, January 14, 2013 2:00 p.m.

Department of Administration, Conference Room "A"

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

Attendees: Alyn Adrain, MD; Peter Andruszkiewicz; Timothy Babineau, MD; Kenneth Belcher; Jodi Bourque, Esq.; Al Charbonneau; Michael Fine, MD; Patricia Flanagan, MD; Neal Galinko; Marie Ganim, Ph.D.; Herbert Gray; Dennis Keefe; Eve Keenan, Ed.D, RN; Dale Klaztker, Ph.D.; Edward Quinlan; and Fox Wetle, Ph.D.

Regrets: Douglas Bennett; Nicki Cicogna; Beth Cotter; Robert Hartman; Jane Hayward; Gloria Hincapie; George Nee; Donna Policastro, RNP; Sandra Powell; 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

Introduction

The Council meeting was convened promptly at 2:00 pm by Health Insurance Commissioner, Christopher Koller. Mr. Koller explained all of the documents contained in Council members' packets. These materials included findings and recommendations related to the Certificate of Need and Hospital Conversions Act statutes. A vote of the Council will be taken on these recommendations when the Council considers the entire General Assembly report (February 27, 2013). The policy goals of the Council will be sought as the creation of the report to the General Assembly comes due.

Dr. Keenan indicated that there was not universal consensus on these recommendations among members of the HCA sub-group. Attorney Bourque pointed out that Bullet #4 is not reflected in the draft legislation that was distributed in the packet.

Dr. Fine presented the findings of the CON sub-group. He thanked the staff for keeping the process on track. The CON sub-group developed five (5) recommendations. There was considerable discussion in the sub-group about whether recommendations should go forward in the absence of a statewide health plan. *Dr. Fine* described the statutory recommendations as "tune ups" rather than major policy changes. A statewide health plan would incorporate such CON recommendations. *Dr. Fine* asked for questions.

Dr. Wetle: Why would the CON thresholds for physician /podiatry ambulatory surgery centers be in excess of two (2) operating rooms? Where did this come from? *Dr. Fine:* We need to create a definition. The language as it stands today is vague. This number is based upon a survey of such facilities that was done in the last few years.

Dr. Babineau: Regarding "affordability", what is the data source? *Dr. Fine:* We do not have an agreed upon source yet. A single standard has not been developed yet. *Dr. Wetle* had the same question about bullet #5. *Dr. Fine* would like to see applicants submit data from the same source/ denominator. A

standardized data set might be authorized by statute and defined in regulations.

Commissioner Koller indicated that no collective ground rules for proceeding to vote on final recommendations and the final report have been established¹.

Commissioner Koller distributed a revised Council meeting schedule. New meetings have been added. Please post on your calendars². The final report due to the General Assembly on March 1, 2013 will be constructed in accordance with the outline distributed to the group³. *Commissioner Koller* reviewed this outline with the group.

Mr. Quinlan: How will the group vote on the report?

Attorney Bourque suggested that each recommendation be voted on separately by a majority of the members. Consensus would be acceptable for the entire report, if a vote is taken on each of the recommendations.

Mr. Andruszkiewicz: An “up or down” vote on the entire document is not enough. He wants a sense of unanimity about the report.

Dr. Wetle: A consensus list could be developed; any member can pull an item off the list for discussion.

Dr. Ganim: Members can then comment on those items upon which they disagree.

Dr. Keenan: In the end, all concerns should be noted.

Commissioner Koller introduced Mr. Randy Haught from The Lewin Group in Washington, D.C. who came to present “Rhode Island Coordinated Health Planning Project Final Presentation on the Bed Need Model.” Lewin has spent the last several months on this project. Lewin had previously presented a summary of their preliminary findings at the Council’s November 5, 2012 meeting.

Mr. Haught stated that Lewin conducted an analysis of Rhode Island inpatient hospital bed capacity and demand through: 1/ data analysis; 2/ literature review; and 3/ key stakeholder interviews.

Key Findings

- ☒ There has been a decrease in utilization compounded by an increase in bed supply which results in rapid decline in occupancy rates.
- ☒ Utilization of inpatient services has decreased in both discharges and days.
- ☒ Rhode Island hospitals’ inpatient bed capacity has increased while bed capacity has declined nationally.
- ☒ Rhode Island has higher occupancy rates relative to national benchmarks.

¹ See Appendix 1 for a suggested process for developing final recommendations and report submitted by Dr. Wetle.

² Revised Council meeting schedule attached at Appendix 2.

³ Report outline attached at Appendix 3.

- ☒ Rhode Island hospitals' financial performance is weak.

Three Key Assumptions Driving the Model: population growth (demographic changes); inpatient utilization; and target occupancy rates.

Six scenarios were run (see slide #8): Status quo model with compounding set of factors, such as population growth (demographic changes), impact of the Affordable Care Act (ACA), trends in technology, reimbursement reform, and very broad high/low estimates.

Feedback from Stakeholder Interviews (slide #9)

- ☒ Observation stays should be included in the model, as the same resources are required to care for these patients.
- ☒ Geographical issues: Rhode Island patients do not like to travel too far for care.
- ☒ Not all beds are the same: Med /surg should be separated from OB, psych, and ICU. Major teaching hospital costs should be separated, due to higher cost of maintaining standby capacity.
- ☒ Delivery system reforms: new reimbursement models and delivery system reforms have an impact upon utilization.
- ☒ Changing demographics and health care reform have an impact upon utilization.

Components of the Model (slide #11): include population trends, inpatient utilization data, geographic service areas, forecasting future demand, determining ideal capacity, identifying current capacity, determining bed shortage, and estimating cost of excess capacity (if any).

Current Capacity: The Hospital Association of Rhode Island (HARI) "jumped through hoops" to get current bed capacity to Lewin in the last week. *Thanks to HARI!*

Factors Influencing Future Inpatient Demand (slide #12): include population and demographic changes (1.5% - 4.2%); health care reform (3%); health status (obesity) (1.4% - 3.1%); reimbursement models (targeting reducing re-admissions (2.4% - 4.8%); technology (transition to outpatient care (5.35% - 8.0%); impact of the economy (uncertain); and enhanced primary care (import Graham Center analysis).

Population Growth and Rhode Island: Data from six years ago show predicted population growth in Rhode Island. Current estimates are that population will be declining in the future. Lewin performed two data runs, based upon both scenarios. The U.S. Census Bureau stopped making statewide projections as of 2000.

Geographic Areas: Lewin deliberated over which hospital service areas to use. Dartmouth Atlas units were selected. There are seven geographic areas in the state. Providence has the largest population area. The referral region is the entire state (entire state is considered to be the service area).

Dr. Babineau pointed out that Providence includes Bradley and Butler specialty hospitals.

Looking back in time, across all services, many patients are willing to travel to Providence for inpatient care. (See slide #15). About 50% of Rhode Islanders travel to Providence for care.

Mr. Charbonneau: Were they referred to Providence for care? Lewin: Good question!

New Reimbursement Models Will Target Inpatient Utilization (see slide #16)

- ☒ All payer Patient-Centered Medical Home (PCMH) Program began in 2008.
- ☒ Medicare's Accountable Care Organization (ACO) program began in 2012.
- ☒ Planning to move persons eligible for both Medicare and Medicaid ("duals") to managed care arrangements in 2013.
- ☒ Commercial insurers considering shared savings arrangements and other new payment models.
- ☒ Medicare readmission reduction program, value-based purchasing, and bundled payments.

Health care utilization continues to decline for 3-4 years following the beginning of economic improvement. It could take a few more years in Rhode Island, given the economic pressure here.

Slide #18: There are 2,508 staffed beds at 11 acute and three (3) specialty hospitals in Rhode Island. (This is HARI data). These data included Peds and NICU.

Low Range Assumption: There will be a reduction in utilization by 6.6% by 2017. This analysis is based upon the impact of population changes, health care reform, and includes all of the assumptions noted above. Current trend in observation days: days are climbing. There will be a surplus of 158 beds by 2017, assuming a target occupancy rate of 78% (70% for OB).

High Range Assumption: There is an increase in demand (2.8% demand increase) by 2017.

Dr. Wetle: Did you include observation days in assumptions related to total number of beds?

Mr. Haught: YES, they were included.

Population Rising Assumption: There will be a shortage of 79 beds by 2017. At this target, there would be OB and psych beds shortages.

Historical Utilization Assumption: Inpatient demand could decline by 5.0% - 7.1% between 2010 and 2017. Under both scenarios (high and low range), there will be a slight decrease in days needed in 2017.

What is the optimal occupancy rate that should be used? (See slide #25)

- ☒ The literature indicates that there is no standard for determining the optimal occupancy rate.
- ☒ About 25 years ago, the Centers for Medicare & Medicaid Services (CMS) favored an 85% occupancy rate.
- ☒ Standard occupancy rates used by various state CON programs for medium-sized hospitals range from 65% -- 85%.

- ☒ Economic literature: 74% is the rate CMS used before their prospective payment system (PPS) started.
- ☒ Queuing theory: “ideal” occupancy rate increase with lower desired probabilities of having to turn away emergency patients. (78% for 150-bed hospital for probability of turning away 1 in 1,000 emergency cases).

Dr. Wetle: How does a surge affect occupancy? Working with averages gives a very different picture.

Dr. Babineau: It is hard to predict a surge; influenza has had a tremendous impact on occupancy this year. Census in psych inpatient has been around 90%. On med/surg units, census can swing by 100+ beds.

Surplus calculations are highly sensitive to target occupancy rates (see slide #26).

Slide #28: Using the population declining assumption, there is a shortage of beds everywhere except Providence. This is the low-range estimate. There would be a shortage in ICU beds. Local discrepancies might go away if people are willing to travel for care. The assumption for this slide is that people only seek care in their regional areas.

Dr. Wetle indicated that the assumption noted above is faulty and does not reflect reality.

Dr. Babineau: What’s on this slide is interesting but irrelevant.

Dr. Fine: The slide is relevant as there are hospitals in many localities and Rhode Islanders who do not want to travel for their care.

Dr. Flanagan: There is not an excess of beds in Providence.

Mr. Charbonneau: It is odd that we would have this slide. Patient choice factors into this community issue. Do we know why patients move for care? Are they choosing or are they referred?

Mr. Quinlan: Why was this slide included? This slide assumes that Providence hospitals only treat Providence residents and that every hospital provides identical services. This is not true.

Mr. Belcher: This is a “dangerous slide.” Not every hospital offers every service to every patient.

Mr. Keefe: Please explain the ICU column. NICUs are included with med/surg. The 22 ICU beds in Providence represent the excess number of beds.

Attorney Bourque: Are we taking out the last slide #28? Is there a finding associated with this slide?

Commissioner Koller: Slides included as findings will also have related recommendations.

Mr. Quinlan: Does the research reflect that Rhode Island has the densest population in the U.S.?

Calculating Cost of Excess Capacity (see slide #32)

Lower occupancy rates require hospitals to spread fixed costs across a smaller number of patients

which generates higher costs per patient. In other words, there is a higher cost per patient when the number of patients shrinks. Lewin's model was designed to provide "what if's."

Stakeholders indicated that they have to staff to the census. If a bed is anticipated to be unoccupied, then the variable costs associated with the output is avoided.

Gary Anderson and Gaynor (1991) estimated that the marginal fixed costs associated with an empty bed are equal to 18% of the average total cost per bed (or \$50,000/excess bed) if 78% is optimal capacity.

Secretary Costantino: Is it possible to apply migration rates (see slide #15 that demonstrates how patients will move across service areas) to slide #28? Slide #28 is a Providence-only slide. Is there a way to incorporate service provision data to the migration rate and factor in to the Providence slide?

Commissioner Koller: We are discussing marginal reductions in costs. If you just drop beds across the board, you would not get anywhere.

Dr. Klatzker: What alternative actions could be taken in the community to impact bed availability?

Graham Center is doing some of these analyses. *Dr. Klatzker:* No patient migration is not necessarily what we can afford. It is not impossible to drive 30 minutes.

Mr. Keefe: Regarding psych and OB beds in Providence, we need another cut of the data. Why are people migrating to different locations?

Mr. Andruszkiewicz: There is a fair amount of in- and out-migration here.

Mr. Haught: We have "imports" included in these data.

Mr. Keefe: We need a sort of the import data.

Commissioner Koller: In terms of future demand, the greater issue is "exports."

Mr. Haught: We assume that exports are constant. If you change this assumption, it will affect the model.

Mr. Haught: Imports are declining into Rhode Island.

Commissioner Koller: Will there be additional changes to your final report based upon the feedback received here today?

Mr. Haught: There are five or six additional items that have to be addressed. The final Lewin report should be out in a week or two.

The Lewin Group's presentation concluded at 3:25pm.

Commissioner Koller asked for public comments. There were none.

Dr. Fine: We are working with the Graham Center on another presentation using three or four primary care scenarios. For example, what would hospital bed need look like if the patient model used was the

best performing ACO in the state? What would the impact be? Projections will be brought to the Council on Feb. 12th as part of the Graham Center's next presentation.

Mr. Andruszkiewicz: This work is important in order to have a base upon which to build. It can be frustrating work, but it is really important.

Dr. Fine: The work of the Council has been helpful in obtaining meaningful data.

Secretary Costantino: Even with the "growing pains," it is useful work.

Mr. Keefe: We have had good response from staff and a willingness to look at the issues.

Graham Center data will be shared in advance of the February 12th meeting.

Next Meeting

The next meeting of the Health Care Planning & Accountability Advisory Council is scheduled for: **Tuesday, February 12, 2013 at 1:00 p.m.** in the **Department of Health's Operations Center** (lower level of the Cannon Building), Three Capitol Hill, Providence, Rhode Island 02908.

With no further discussion, the meeting adjourned at 3:30 pm.

Notes prepared and respectfully submitted by:

Elizabeth Shelov

Elizabeth Shelov, MPH/MSSW

Chief, Family Health Systems

Executive Office of Health & Human Services

January 23, 2013

Appendix 1

Coordinated Health Planning Advisory Council

January 2013

Suggested Process for Developing Recommendations and Final Report

1. Staff and Co-Chairs will draft findings and Recommendations based on evidence presented at meetings and work of Council to date.
2. Those findings and recommendations will be considered by the Council *en bloc* (collectively)
3. Any Council member may pull any finding or recommendation for consideration and redrafting.
4. If a finding or recommendation is pulled for consideration
 - a. The concerned Council member(s) are encouraged to offer alternative language for the Council's consideration.
 - b. A majority vote of Council Members in attendance is required to adopt the alternative language.
 - c. If adopted, the votes will be recorded.
5. If a Council member has an additional finding or recommendation for Council consideration.
 - a. The member must propose the language.
 - b. A majority vote of Council Members in attendance is required to adopt the language.
 - c. If adopted, the votes will be recorded.
6. Once all special requests have been considered, the Council will vote on the revised list of findings and recommendations *en bloc*.
 - a. A majority vote of Council Members in attendance will be required to adopt the findings and recommendations.
 - b. The votes will be recorded.
7. Based on the approved findings and recommendations, Council staff will write and circulate a draft report.
8. Editorial comment from Council Members will be solicited via e-mail. Staff will use best efforts to address these comments, producing clean and redlined drafts.
9. A majority vote will be required to adopt the final report.
 - a. Votes will be recorded.
 - b. Minority reports, if submitted, will be included with the report as appendices.

Appendix 2

Rhode Island Health Planning & Accountability Advisory Council

Newly added Meeting

Meeting Schedule 2012-2013

Date	Day	Time	Location	Comments
January 14, 2013	Monday	2:00-3:30	DoA Conf rm A 1 Capitol Hill, Providence	
February 12, 2013	Tuesday	1:00-2:30	DOC Lower Level Dept of Health 3 Capitol Hill Providence	Confirmed with HEALTH 010913
February 18, 2013 CANCELLED	Monday	2:00-3:30	DoA Conf rm A	Added on 7/31/12
February 27, 2013	Wednesday	10:00-12:00	DoA Conf rm A 1 Capitol Hill, Providence	Confirmed with DoA 222-6200 010913
March 11, 2013	Monday	2:00-3:30	DoA Conf rm A 1 Capitol Hill, Providence	
May 13, 2013	Monday	2:00-3:30	DoA Conf rm A 1 Capitol Hill, Providence	
July 17, 2013	Wednesday	2:00-3:30	DoA Conf rm A 1 Capitol Hill, Providence	Confirmed with Sandy 222-6200 010813
September 18, 2013	Wednesday	2:00-3:30	DoA Conf rm A 1 Capitol Hill, Providence	Confirmed with Sandy 222-6200 010813
November 13, 2013	Wednesday	2:00-3:30	DoA Conf rm B 1 Capitol Hill,	Confirmed with Sandy 222-6200 010813

			Providence	
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Appendix 3

Proposed Council Report Outline

I. Introduction and legislative charge

- a. Summary of findings, recommendations and connection among the topics

II. Inpatient hospital service needs assessment (LEWIN)

- a. Issue Background, research question, methodology
- b. Findings
- c. Recommendations

III. Primary care needs assessment (GRAHAM)

- a. Issue Background, research question, methodology
- b. Findings
- c. Recommendations

IV. Recommendation Certificate of Need

- a. Issue Background, Description of issue review process
- b. Findings
- c. Recommendations

V. Hospital Conversion Act

- a. Issue Background, Description of issue review process
- b. Findings
- c. Recommendations