



Health Care Planning and Accountability Advisory Council

Wednesday, February 27, 2013 10:00 a.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; Marie Ganim, Ph.D.; Herbert Gray; Jane Hayward; Dennis Keefe; Eve Keenan, Ed.D, RN; Dale Klaztker, Ph.D.

Regrets: Douglas Bennett; Nicki Cicogna; Beth Cotter; Patricia Flanagan, MD; Robert Hartman; Gloria Hincapie George Nee; Donna Policastro, RNP; Sandra Powell; Louis Rice, MD; Ed Quinlan; and Fox Wetle, Ph.D.

Staff in Attendance: Edward D'Arezzo, Associate Director, Health Services Regulation, Department of Health; 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 10:00 a.m. by Health Insurance Commissioner, Christopher Koller. Mr. Koller explained all of the documents contained in Council members' packets.

Jodi Bourque suggested that the Council vote on the CON and HCA sub-committee findings first. Fox Wetle has identified proposed changes that have been distributed for review. Herb Gray also sent in some suggestions and recommendations.

Proposed changes will be display on the overhead so Council member can review language for voting purposes. Those recommendations for which there are no proposed changes will be voted "en bloc" at the end.

The March 11th meeting will consider and approve the final report to be sent to the General Assembly by March 15, 2013.

The minutes from the February 12, 2013 Council meeting were approved as written, with no additions or corrections.

CON and Hospital Conversions: Background and Recommendations

CON: (See language related to proposed findings below).

Background/ Recommendation: No changes suggested to 1-A, 2-A, 4-A, 5-A (to be voted "en bloc"). Items #1-B; 2-B; 3-B; 4-B; 5-B to be discussed separately. (Reverse #4 and #3 for purposes of discussion).

1-B: After discussion, the Council voted as follows: See attached spreadsheet for abstentions and “no” votes. All other Council members present voted in the affirmative.

2-B: After discussion, the Council voted as follows: See attached spreadsheet for abstentions and “no” votes. All other Council members present voted in the affirmative.

3 is the recommendation formerly labeled # 4: All Council members present voted in the affirmative.

4 is the recommendation formerly labeled #3: See attached spreadsheet for abstentions and “no” votes. All other Council members present voted in the affirmative.

5-B: After discussion, the Council voted as follows: All Council members present voted in the affirmative.

The CON findings “en bloc” noted above along with the five background statements: All Council members present voted in the affirmative.

HCA Findings and Recommendations

HCA: (See language related to proposed findings below). No changes suggested to 1-A, 2-A, 3-A, and 4-A (to be voted “en bloc”). Discussed separately: 1-B; 2-B; 4-B; and 4-C.

1-B: After discussion, the Council voted as follows: All Council members present voted in the affirmative.

2-B: After discussion, the Council voted as follows: All Council members present voted in the affirmative.

4-B: After discussion, the Council voted as follows: See attached spreadsheet for abstentions and “no” votes. All other Council members present voted in the affirmative.

4-C: After discussion, the Council voted as follows: See attached spreadsheet for abstentions and “no” votes. All other Council members present voted in the affirmative.

The HCA findings and recommendations “en bloc” noted above: All Council members present voted in the affirmative.

Secretary Costantino thanked the Council for the time spent on this process and reminded the group that these findings are recommended to the General Assembly for their consideration.

Public Comments: None.

Next meeting: The next meeting of the Health Care Planning & Accountability Advisory Council is scheduled for: **Monday, March 11, 2013 at 2:00 pm in Department of Administration, Conference Room “A”, One Capitol Hill, Providence, Rhode Island 02908.** The March 11th meeting will be spent discussing the remainder of the findings and recommendations.

With no further discussion, the meeting adjourned at 12:05 pm.

Notes prepared and respectfully submitted by:

Elizabeth Shelov

Elizabeth Shelov, MPH/MSSW

Chief, Family Health Systems

Executive Office of Health & Human Services

March 5, 2013

**Health Care Planning & Accountability Advisory Council
Report to the General Assembly**

Draft Findings & Recommendations

RI Inpatient Capacity: Findings

1. In Rhode Island, falling inpatient utilization combined with steady-to-rising bed supply has led to declining occupancy rates, weak hospital financial performance and potentially excess beds supply
2. When forecasting the demand for inpatient beds in the state, the following factors are considered most important: population changes, utilization demand changes, primary care infrastructure, and target occupancy rate
3. Using a model that takes the factors from Finding 2 into consideration, the projected number of inpatient staffed hospital beds needed in 2017 ranges from a shortage of 64 over current levels to a surplus of 338, depending on the combination of assumptions. The most likely set of assumptions yields an excess of 202 staffed beds, as depicted in Figure XX above (Finding 2).
4. The estimates of bed need assume current inpatient export and import patterns.
 - a. Exports: The number of discharges from Massachusetts and Connecticut hospitals of RI residents is 5.7% of all RI hospital admissions and grew by 248 discharges between 2010 and 2011. Since 1997, exports have increased by 26%.
 - b. Imports: The number of discharges from RI hospitals for out of state residents is about 8% of all RI hospital discharges and fell by 646 discharges between 2008 and 2011, or 5% annually.
5. The savings associated with eliminating excess inpatient capacity are projected to be \$12.6m for the most reasonable estimate of surplus beds, based on the marginal fixed cost of each bed. The savings would be much larger if fixed costs could be eliminated as well.
6. This report makes no formal findings on ways to identify the types of excess inpatient capacity but does discuss potential options
7. For certain procedures, there are generally-accepted volume thresholds below which quality can be compromised. For some procedures, Rhode Island hospitals do not meet these thresholds.
8. There are seven hospital service areas in Rhode Island. The percentage of residents seeking inpatient care outside of their local hospital service area ranges from a low of 9 (Providence) to a high of 63 (Pawtucket).
9. Inpatient services are only half of a hospital's operating revenue; the rest comes from outpatient services. Additional study is needed to understand the array of outpatient services that various hospitals provide, how hospital-based outpatient services relate to other outpatient services available in the communities they serve, and past and future trends in these areas.

Formatted: Bullets and Numbering

RI Primary Care Infrastructure: Findings

1. Primary care physician (PCP) supply per resident is higher in Rhode Island than in many other states, though it is not clear whether this rate is optimal.
2. Research indicates that the supply and organization of primary care physicians can greatly influence the demand for other medical services, including inpatient hospital services.
3. In Rhode Island, the potential reduction in hospitalizations (and thus on bed need) from a more integrated primary care delivery system ranges from 6.15% and 43.9%.

CON: Background & Recommendations

1. Background & Recommendations 1:

a. **Background:** The establishment of a multi-practice physician /podiatry ambulatory surgery center requires a CON pursuant to RIGL 23-15. Multi-practice physician /podiatry ambulatory surgery centers are defined in RIGL 23-17. The definition as it relates to CON requirements is not clear.

b. **Recommendation:** CON thresholds for physician /podiatry ambulatory surgery centers shall be a facility in excess of two (2) operating rooms.

Deleted: Finding
Formatted: Bullets and Numbering

2. Background & Recommendations 2:

a. **Background:** The definition of “affordability” in RIGL 23-15 is very broad and does not specifically reference increases in per person per year cost of health care.

b. **Recommendation:** “Affordability” for a CON shall consider the impact on the per person per year cost of health care in Rhode Island and shall include a comprehensive cost impact analysis as defined in R.I. G.L. 23-15-2(2).

Deleted: be defined
Deleted: as
Formatted: Bullets and Numbering
Deleted:
Deleted: 4

3. Background & Recommendations 3:

a. **Background:** Conditions of approval should relate directly to the CON application in addition to the Health Services Council’s review criteria {See RIGL 23-15-4 (e)}.

b. **Recommendation:** Conditions of approval shall be relevant to the specific CON.

Formatted: Bullets and Numbering
Deleted: uniform and

4. Background & Recommendations 4:

a. **Background:** There is no statutory authority in RIGL 23-15 to fine or penalize applicants for non-compliance with CON conditions of approval.

b. **Recommendation:** Provide statutory authority for the Director of Health to fine applicants for non-compliance with CON conditions of approval.

Formatted: Indent: Left: 1", No bullets or numbering
Deleted: 3

5.

Formatted: Bullets and Numbering
Deleted:
Deleted: <#>[[
Background & Recommendations 4:
Formatted: Font: Bold
Formatted: Font: Bold

6. Background & Recommendations 5:

a. **Background:** There are no evidence-based uniform standards and databases to guide the CON process.

b. **Recommendation:** Evaluative standards shall be developed by the Department by regulation.

Formatted: Normal, Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Tab after: 0" + Indent at: 0.5"
Deleted: Background: Conditions of approval should relate directly to the CON application in addition to the Health Services Council’s review criteria (See RIGL 23-15-4 (e)).
Deleted: Recommendation: Conditions of approval shall be uniform and relevant to the specific CON.
Formatted: Bullets and Numbering
Deleted: Applicants shall use standardized data in their public need analyses.

HCA: Findings and Recommendations

1. Findings & Recommendation 1:

- a. **Finding:** The Hospital Conversions Act requires the Department of Health to consider whether the conversion demonstrates, among other things, a “balanced health care delivery to the residents of the state”.
- b. **Recommendation:** Add to § 23-17.14-8(9), § 23-17.14-11(8): Whether the conversion is consistent with a state health plan or community health needs assessment officially adopted by the Department of Health.

Formatted: Bullets and Numbering

Deleted: other officially-adopted

2. Findings & Recommendation 2:

- a. **Finding:** The judicial review provision is inconsistent with the Administrative Procedures Act (APA) process for appealing agency decisions. The current provision allows for review of preliminary decisions that would not automatically be reviewable if they were decisions by other agencies. It also contains a standard of review that is lower than those used for all other agency decisions. In addition, it contains a balancing test that inappropriately balances the rights of the transacting parties against the interests of the citizens of the state in a safe, accessible and affordable healthcare system
- b. **Recommendation:** Apply the Administrative Procedures Act Standard to both the Dept. of Health and Attorney General’s Office.

Deleted: Revert the statute to its original language with respect to the judicial review provision, except ensure the review standard applies equally to both

The resulting language for this section would then read: *Any transacting party aggrieved by a final order of the department of health or the attorney general under this chapter may seek judicial review in the superior court in accordance with section 42-35-15.*

3. Findings & Recommendation 3:

- a. **Finding:** The Hospital Conversion Act’s criteria for the Department of Health should balance the need for both community health improvement and workforce development, with an emphasis on population health improvement
- b. **Recommendation:** In § 23-17.14-3 of the Hospital Conversions Act, add: Assure the viability of a safe, accessible and affordable healthcare system that is available to all of the citizens of the state with an emphasis on population health improvement as the overriding objective

Formatted: Bullets and Numbering

4. Findings & Recommendation 4:

- a. **Finding:** The legislature recently created an expedited review process in the Hospital Conversion statute in the instance of a non-profit acquiring a financially distressed non-profit
- b. **Recommendation:** Expedited review should be limited to in-state non-profit hospitals as the acquiring transacting parties.
- c. **Recommendation:** Eliminate the requirement that in-state non-profit hospital or hospital systems be financially distressed to qualify for expedited review. However, if the transacting parties do not qualify as financially distressed, the review timeframe contained in R.I. G.L. 23-17.14-12.1(e) shall be 120 days

Deleted:

Deleted: .

Formatted: Font: Cambria, 12 pt

Formatted: Bullets and Numbering