Health Care Planning and Accountability Advisory Council

Monday, May 13, 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; Jodi Bourque, Esq.; Al Charbonneau; Michael Fine, MD; Patricia Flanagan, MD; Marie Ganim, Ph.D.; Herbert Gray; Jane Hayward; Dennis Keefe; Eve Keenan, Ed.D, RN; Dale Klaztker, Ph.D.; Edward Quinlan; and Fox Wetle, Ph.D.

Regrets: Kenneth Belcher; Douglas Bennett; Nicki Cicogna; Robert Hartman; Gloria Hincapie; George Nee; Donna Policastro, RNP; Sandra Powell; Louis Rice, MD

Staff in attendance: Kim Paull, Director of Analytics, Office of the Health Insurance Commissioner; Elizabeth Shelov, Chief, Family Health Systems, Executive Office of Health & Human Services

Introduction

Executive Office of Health & Human Services Secretary Steven Costantino convened the meeting at 2:10 p.m.

Commissioner Koller noted one change in the Council's meeting minutes of April 15, 2013 (page 2). The minutes should note that Mark Montella, of Lifespan, wanted to abstain on the vote regarding the Health Care Planning & Accountability Advisory Council's final report to the General Assembly. {Mr. Montella was not permitted to vote, as he is not an appointed member of the Council and Dr. Babineau, the voting member, was absent at the April 15th meeting}.

Dr. Ganim indicated that language similar to that found in a Massachusetts bill related to a cap on medical spending was included in Senate bill #540. Such a cap would prohibit medical spending that exceeds the state's consumer price index.

Secretary Costantino indicated that this Council has limited resources for its work. Given the financial resources available, what issues should be addressed in the next year? Primary care and hospital services were both studied in the first round of the Council's research.

Some options identified by the group included:

- Methods to assess medical spending (look at what Massachusetts is doing);
    - Examine the costs of Rhode Island's health care system and all of its fragmentation;
- What is driving health insurance premiums? Factors include: technology and labor as the major drivers of costs;
- Primary care work force;
    - Primary care scope of work issues;
- Develop a foundation of data;

- Mental health and substance abuse issues;
- Pediatrics inpatient and outpatient issues (e.g., preparing children for learning).

Mr. Gray: What is our process? If there is excess hospital bed capacity in Rhode Island, what is going to happen as a result? Do we just leave this issue and move on to something else?

Commissioner Koller: The statute guides the work. Dr. Ganim indicated that while the Council's report arrived late to the General Assembly, the proposed Hospital Conversions Act amendments were integrated into a Sub-A bill.

Secretary Costantino: We are on an incremental path that represents some progress.

The State Innovation Models Initiative (SIMS) process is underway. With this grant funding, the Centers for Medicare & Medicaid Services (CMS) is looking at different ways to purchase health care services. SIMS is an innovation, pilot grant seeking Medicaid-driven proposals. A Rhode Island innovation plan is supposed to be completed within the next six months. The SIMS process might result in all-payer reforms that would be useful to monitor. If this process does not inform what Rhode Island does regarding service provision, it could be a distraction for this group.

Dr. Fine: Primary care workforce: Rhode Island leads the nation in patient centered medical homes. Massachusetts has a public primary care-oriented medical school. Our spin on the workforce has to be fundamentally different. Policy solutions have to be on the table. Data collection can be improved through the licensing process. We have to register our primary care practices.

***Mr. Andruszkiewicz*:** Subspecialty and ancillary service data are missing. Having these data would provide an inventory and connect with SIMS for a broader picture of the health care system, as opposed to a narrower approach.

Dr. Flanagan: We have started studying primary care in Rhode Island, but it is with a broad brush.

Ms. Hayward: If the General Assembly is dictating what the group is doing, this conversation is moot. The SIM process is happening quickly and does that inform this work? Ms. Hayward does not want this group to be scattered.

Dr. Wetle: A view of medical spending would serve as a contextural framework. It could be a good tool.

Atty. Bourque: What does the statute tell us to do? If we are doing a health plan, let's do it on a timeline that makes sense.

Chapters of a health plan might currently include information related to: the Hospital Conversions Act, the certificate of need program, primary care, and hospitals.

Dr. Flanagan: What are the biggest health needs for the people of Rhode Island? Is there a way health care for children could be addressed (children with special needs, low birth weight)?

Mr. Charbonneau indicated that $8.8 billion is spent on health care in Rhode Island, and $90 million of the total is public money (does not include the prison health care system expenses).

Mr. Keefe: There will be recommended changes to the payment system as a result of SIMS. Mr. Keefe is very concerned about doing work that is not related to expenditures and the growth of medical expenses, which are

unsustainable. He wants time and energy dedicated to getting at core incentives and the right payment incentives. The inventory approach is not so useful.

Do we need a statewide health plan? The determination of need program in Massachusetts has the foundational data.

***Mr. Andruszkiewicz*:** Do we address delivery system reform vs. statewide health plan? Having a fact set is always a good thing.

Secretary Costantino: Payment reform is not the work of this group. This group's work can inform payment reform. The certificate of need program needs data to inform it.

Who's keeping score if payment reform is working? How do we know that it is working?

Dr. Flanagan advocates for behavioral health needs and pediatric issues. The Council's original mission was related to services: where are the services and what are the needs? We cannot lose this focus.

Dr. Keenan: Services and costs: we have to focus on a little bit of both in this round.

Dr. Klatzker: Agree on expenditures: it is time to examine costs. But we rank poorly in the area of mental health /substance abuse.

Secretary Costantino wants to do a behavioral health study. A cost study could also be done.

Atty. Bourque supports a mental health/behavioral health study.

If matching funds become available, the pediatrics issues could be placed in the mix. Primary care would be last in the queue.

Dr. Fine: Persons with behavioral health care issues have co-morbidities and shorter life spans. It might be helpful to have a presentation on health care disparities as they relate to behavioral health care.

No vote was taken but the final list of Council priorities included the following:

- Methods to assess medical spending;
- Mental health and substance abuse issues;
- Pediatrics inpatient and outpatient issues (if matching funds are obtained); and
- Primary care scope of work and work force issues.

Any further research should be correlated with the SIMS grant.

Public comment: Gus Manocchia from Blue Cross/ Blue Shield of Rhode Island: A stronger primary care infrastructure, greater healthcare transparency, and payment reform will lead to significant delivery system change , but it will take a long time. In the short term however, Rhode Island is plagued by serious capacity [and cost] issues associated with a very non-robust "certificate of need" [CON] program. The Health Services Council would benefit greatly from a much stronger CON rule, as well as access to a complete database/inventory of existing healthcare services and providers in the state.

Betsy Laske from Health RITE: The General Assembly is proposing giving this Council more resources and more authority. If you could support the bill, it would be helpful.

No other matters were discussed and meeting adjourned at 3:25 pm.

Notes prepared and respectfully submitted by:

Elizabeth Shelov, MPH/MSSW
Chief, Family Health Systems
Executive Office of Health & Human Services
July 18, 2013