Health Care Planning and Accountability Advisory Council

Wednesday, July 17, 2013 2:00 p.m.

Conference Room "A", Department of Administration

One Capitol Hill, Providence, Rhode Island

Co-Chairmen: Steven Costantino, Secretary, Executive Office of Health & Human Services; Michael Fine, MD, Guest Co-chair

Attendees: Peter Andruszkiewicz; Alyn Adrain, MD; Timothy Babineau, MD; Ken Belcher; Jodi Bourque, Esq.; Al Charbonneau; Patricia Flanagan, MD; Marie Ganim, Ph.D; Herbert Gray; Jane Hayward; Gail Costa for Dennis Keefe; Eve Keenan, Ed.D, RN; Dale Klaztker, Ph.D.; Ed Quinlan; Lynne Urbani-Craddock (representing House Policy Office); Fox Wetle, Ph.D.

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

Staff in Attendance: 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 at 2:05 p.m. by Steven Costantino, Secretary of the Executive Office of Health & Human Services.

Public comments were requested; there were none.

The minutes from the May 13, 2013 Council meeting were amended to include comments from Dr. Gus Manocchia contained in a July 9, 2013 e-mail message to Elizabeth Shelov from Shawn Donahue at Blue Cross/Blue Shield of Rhode Island that read as follows: "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. "

Minutes were approved as amended by a unanimous vote of the group.

Kim Paull presented a brief update on "HealthyRI", a planning process related to statewide healthcare payment transformation. The federal Centers for Medicare/Medicaid Innovation {CMMI} grant awarded to Rhode Island requires a six month planning process that results in a payment innovation plan. The payment transformation process will result in a shift from a "cost-based" to a "value-based" system. Another grant application will be made for CMMI funding to implement the plan. The federal government will allocate $30-50 million over three years to implement the state transformation plan. To have a positive grant application, there has to be a positive return on investment. For example, if the grant allocation is $30 million dollars, there has to be a $30 million dollar demonstration of savings.

Gail Costa: What are the implications for the work here? Is there work that should be done here?

***Kim Paull*:** There is an important distinction between payment reform and health care planning. How are we paying for care versus where is care provided? This group is very data-oriented and may identify potential savings that could come with some of these innovations.

Dr. Fine: Let's watch and learn together. Health care is an $8.8 billion dollar business. The challenge is to create changes in the delivery system. Even with $30 million dollars, what we do will be a model for other changes to come. So let's watch and learn together. This is an opportunity for all to participate.

***Kim Paull*:** There are opportunities to feed data into the CMMI plan. We have outsized mental health utilization rates and payment rates. A technical advisory group can share these data. There will be a timeline for submission of public comments related to the CMMI work.

Dr. Ganim presented a highlight of 2013 relevant legislation. Dr. Ganim suggested that as part of the Council's November agenda, potential new legislation should be discussed in order to submit a bill next year. The Council's recommendations came too late in the legislative cycle, with the exception of the Hospital Conversions Act bill.

The "future of health care planning in Rhode Island" bill did not pass. Alternate language was proposed in S832A. There was a recognition that resources do not exist to do a comprehensive statewide health plan. Two major areas of the discussion included: should the membership of this Council be dominated by the public sector or by the health industry; and what is the relationship of health planning to CON and HCA.

Legislative Commission on the Integration of Primary Care and Behavioral Health (S834): The Director of Health and the Director of Behavioral Healthcare, Developmental Disabilities and Hospitals are members of the Commission. The Medicaid Director is not on the Commission.

Comprehensive health care cost containment initiative (S540) passed. There was tremendous push-back on this bill. The final result was a bill that is not as aggressive as Massachusetts. The Department of Health will have a more aggressive role, related to hospital costs, a checklist of care, a study of total cost drivers, pediatric trends, behavioral health care, and workforce recommendations, including cultural competency and scope of practice issues.

Mandated benefits: What is the impact of mandated benefits? Some mandates are very worthwhile, but there are cost issues. Mandates can drive business costs up and people become frustrated. New mandates have to have measurable goals. OHIC will prepare a report on mandated benefits. OHIC will also review behavioral health parity laws to make sure insurers are complying. This work is related to CMMI, the design of accountable care organizations, health care delivery, and payment structure.

Jodi Bourque, Esq: The Council's CON and HCA recommendations were already recommended last year. Why would it be discussed again this November?

Dr. Fine: The co-chairs could carry recommendations forward in October and November.

Dr. Keenan: The Council worked hard and its recommendations were ignored. Why isn't there a process for our body of work to move forward? Was this a process issue?

Dr. Fine: Our work didn't come at the right place in the legislative cycle.

Secretary Costantino: The Council handed over its work. Hopefully, it will guide the CON process. The General Assembly was looking for advice and we gave it.

Dr. Keenan: Whatever we do, we have to make sure it has the right energy and direction.

Mr. Belcher: Supports Eve's point. The rules of the game have to be clear. As legislative changes are recommended, we need to know the time line.

Dr. Fine: We can charge ourselves in the Fall with the transmittal or re-transmittal of bills.

Mr. Gray: There was no reaction in the General Assembly to the Council's report. There were no comments or feedback.

Dr. Ganim: Timing was a huge factor. There was no vehicle at that moment to make the changes.

***Secretary Costantino*:** For the next round of work, studies related to the total medical costs for health care in Rhode Island and behavioral health care issues will be prepared for the General Assembly. (The Council previously discussed these priorities. See page 3 of the May 13, 2013 meeting minutes).

OHIC will fund the report on total medical expenditures and EOHHS will fund the behavioral health care /substance abuse study with its $150,000 base allocation. A Medicaid match for some of this EOHHS funding is likely, contingent upon review of the scope of work by the Medicaid Director.

Kim Paull reviewed the Council's new research questions as below:

1.) ***Total Medical Expenses/Cost Drivers***

a.) **Total Spending:** How much does Rhode Island spend on health care for its residents – both insured and uninsured?

b.) **Comparison:** On a per-capita basis, how does the spending compare to national benchmarks and RI historical trends? *Risk-adjusted basis*

c.) **Spending breakdown:** How is that spending allocated by geography, primary care physician and service type? *Risk-adjusted basis*

d.) **Locus of control:** What is the appropriate accountable entity for measuring health care spending? *Risk-adjusted basis*

e.) **Drivers:** What are the relative magnitudes of the primary drivers of medical spending in Rhode Island? [price, utilization, service mix, site mix, etc.]

2.) ***Mental and Behavioral Health***

a.) **Spending:** How much does Rhode Island spend on mental and behavioral health care for its residents – both insured and uninsured? On a per-capita basis, how does the spending compare to national benchmarks and RI historical trends? *Risk-adjusted basis*

b.) **Demand:** What is the incidence rate of mental illness and demand for behavioral health services in Rhode Island? How do these measures compare to national and state benchmarks? *Risk-adjusted basis*

c.) **Supply:** What is the best way to measure supply (units and organizational structure) and how

does RI compare to national and state benchmarks? *Risk-adjusted basis*

d.) **Outcomes:** How do Rhode Island mental and behavioral health outcomes compare to national and state benchmarks? *Risk-adjusted basis*

e.) **Recommendations:** How can Rhode Island better meet the triple aim in this field? (Better health and better care at lower cost)?

The proposed Council work plan time line is as follows:

HCPAAC | **Proposed Work plan through Q1 2014** | July 17, 2013

Date	Main Topic
July 17, 2013	Confirm research questions and work plan
September 18, 2013	Confirm scopes of work, procurement update
November 13, 2013	Total Cost of Care/Cost Drivers background meeting
January TBD	MH/BH background meeting
March TBD	Procurement update and initial analysis work

Mr. Charbonneau: What are we tackling? This is a small amount of money. Preventable hospitalization data are very powerful. This is an opportunity to do cost containment and supply data to the provider community.

Dr. Babineau: This is enormously complicated. Should two smaller studies or one big study be completed?

Ms. Lynne Urbani-Craddock: Pharmaceutical expenses should be included in both the medical expense/cost driver and mental/behavioral health studies.

Dr. Adrain: The work of this group should compliment CMMI. Mental health issues are equally important and equally complicated.

Secretary Costantino: We could do a request for information {RFI} first. This would craft the RFP, but it would also delay the process.

Mr. Andruszkiewicz: Will preventive care be included in the medical expenditures? We have to separate wellness from prevention. The data have to be granular enough so we learn from it. We are spending all of this money, do we know if it makes a difference?

Kim Paull suggested that a draft outline of scope and definitions be prepared for the next meeting.

Dr. Klatzker: What behavioral health care outcomes should be measured? There are no national measures.

***Secretary Costantino*:** Let's find out what is out there. And then we can look at it. There is a necessity for children's behavioral health to be included in the array of services. Pharmacy expenses should be included in the study, along with its relationship to outcomes that improve behavioral health.

Dr. Wetle: It would be helpful to have a meeting schedule of regular monthly meetings, starting in March 2014.

With no further discussion, the meeting adjourned at 3:20 pm.

The next meeting of the Council will be convened on **Wednesday, September 18, 2013 at 2:00 p.m.** in the **Department of Administration, Conference Room "A",** One Capitol Hill, Providence, Rhode Island.

Notes prepared and respectfully submitted by:

Elizabeth Shelov, MPH/MSSW
Chief, Family Health Systems
Executive Office of Health & Human Services
July 23, 2013