

Spending Cap Subgroup
Department of Administration, Conference Room A
November 10, 2015
7:30am

Attendees: Al Charbonneau, Mark Montella, Mark Adelman, Lou Giancola, Hugh Hall, Linda McDonald, Wendi DiClerq, Paco Trilla, Al Kurose, Mike Souza, Rele Abiade-Ritter, Sam Salganik, Sam Marullo, Secretary Roberts, Lauren Lapolla

I. Welcome

Secretary Roberts welcomed the groups. Advised that today's presentation slides will be put up on the website, and sent around. This will be posted for public comment for two weeks, at which time those the comments will be folded in to a draft of the report for additional review.

II. Questions

Mark Montella: Does that [Office of Health Policy] infer that this is another policy planning group within the Executive Office of Health and Human Services (EOHHS) that then replicates Department of Health (DOH), etc. ? We have always taken issue with Senator Miller's bill as there doesn't seem to be clarity.

Secretary Roberts: Our goal is a coordination. We may eliminate some, we may not eliminate all groups, but there would be a coordination. There are many who would not recommend abolishing other entities – as you need groups to get work done. We need something that aligns where we are going, simplifies the process and gets the work done in a coordinated way. Yet that is one of the areas we want input on.

Mark Montella: The Health Services Council for example is advisory – they don't make policy. The DOH makes policy. There is an example of what policy we are following. There is a concern that simply setting up a new enterprise without there being clearly established rules of how it works inter-governmentally will create enormous frustration from a provider point of view.

Secretary Roberts: Let's be clear, our goal here is not to make everyone more frustrated with state government. The goal is rather to think about how we coordinate.

Al Charbonneau: I may be misinformed, wasn't that what EOHHS was formed to do?

Secretary Roberts: EOHHS has a responsibility to coordinate program and policy inside government across agencies – DCYF, DHS, BHDDH, and DOH. OHIC has regulatory authority over commercial market, but legally they are not within the EOHHS umbrella. My job as Secretary under the law is internally focused; the work of the OHIC is externally focused. The governor has underscored the key to working together.

Al Charbonneau: I thought it was refreshing in one of the earlier meetings when you or someone else said we do not have the infrastructure Massachusetts has – but are we doing that now as we look to this?

Secretary Roberts: Other states like Oregon have a Health Authority, Vermont has a similar entity; create something that loops together financing, policy, and ways that we can influence the system. The goal here is how you create a coordinated way to do that. Creating a state health plan is something we have been talking about, for example. The capacity and needs assessment, workforce planning, how we create something like a Center for Health Information and Analysis (CHIA) in Massachusetts to drive system change.

Mark Adelman: Do you view this as more expansive than the SIM state health plan?

Lou Giancola: SIM isn't charged with coming up with a state health plan, it is charged with reform. In our conversations around the SIM table, we ask what the broader policy context that we are coordinating here may be. Look at this full slide (3).

Secretary Roberts: I would define SIM as narrower than a comprehensive state health plan. We are saying because we now have some levers that we once didn't, i.e. OHIC, we have more pieces to link together, more stakeholder engagement processes to link together, what we do to coordinate. The SIM is also a time limited piece of our work, a four year life with a goal of looking at how we use resources to drive change in our system. It will not be a home for health planning on its own.

Sam Salganik: I think any of the things we discuss here you would need more capacity in state government so I think it's great to see this. We encourage ACOs, but I have a hard time conceptualizing who is responsible for overseeing that type of conduct. There are many aspects of it that are like a health care provider. One goal I am hoping for there to be a line of authority- are you expecting that that type of authority would be lodged in this health policy office?

Secretary Roberts: I do not see this as a regulatory entity. I do not think we want to remove the regulatory authority of other groups and move it here. But if people say that want to strip that authority away, and move it to the public body that is a conversation to share.

Lou Giancola: I think that is an important policy decision. Do you have policy lodged one place, and regulatory authority elsewhere? Some have thought it may be good to set policy in this body, and continue to keep regulatory work elsewhere.

Al Kurose: I feel that may have been a separate conversation that was left unfinished, though definitely important. I would love to hear more of the pros and cons for unifying those functions vs. keeping them separate.

Secretary Roberts: The other question is that this is a policy group that works with a structure that oversees all of these components. The Secretariat oversees many components, but not HealthSourceRI, not the Office of the Health Insurance Commissioner (OHIC), etc. How do we carve them in in a coordinated way?

Sam Salganik: I am thinking of something separate, a regulatory authority that does not exist over ACOs. OHICs has authority over licensed insurance companies, not provider groups.. Not sure what the rules

should be.

Mark Montella: We do not even have clarity now about how the process works. Will ACOs be required to acquire an MCO license? There are statutes on the books now that we do not even understand, and now we speak about layering on another entity. I think we need clarity. As we keep thinking about a paradigm based on efficiency, cost effectiveness and value, there is disparity about how we implement.

Secretary Roberts: Okay, so from your perspective tell me how you feel the system could be better; what would you see as best practice?

Mark Montella: Candidly, I hear that everyone looks at efficiency in state government. Predictability is a hallmark of wanting to set up a business in a state. Right now there is a disparate, fragmented system that is not coded by one place; if there are, the codes are not consistently applied. You have lawyers battling lawyers; state government. Perhaps do an audit about what all of those functions are. State government has shrunk over the past 20 years, nevertheless the codification of the mandates hasn't shrunk, rather there are fewer people to do the same work. I think someone should go in, do an audit of how all these interactions take place. The lack of resource leads to an imbalance. With an audit you could outline the rules of the roads, and not leave people stranded. I don't believe right now with the fragmentation that exists in statute, we can do this, layer on another group of processes on top of a broken system.

Lou Giancola: I struggle with the layering as the General Assembly has endorsed health planning. The problem that we have with a health system is that there is no overarching plan or principles. I think what you are trying to do here is to lodge that responsibility in one place; I thought it was to take some of the resources out of departments that are conducting this work now. Mark, I'm sure has a good understanding of all these laws and may be right, but I do not think that should impede these efforts.

Secretary Roberts: Existing groups would not lose the statutory regulatory authority. Pieces of the roles in existing groups would be consolidated – that is one of our next conversations, what would you coordinate across. You have in the Secretariat a structure that coordinates a number of levers inside government, and as with any large organization you do have allocated responsibilities. You want to be on a path of consistent effort. Let's move forward now with the presentation and we can accept written comments, and hear from you all more later on this topic.

Mark Montella: I understand the conceptual linkages and practical between connecting with the economy and what we spend on health care. There would be a worry that we need a safety valve. Historically, our declines have been steeper than in other parts of the country and our climb out would be steeper. If we do not have a safety valve, if we go into a deeper decline than others, our concern would be if we were in a long and sustainable downturn while our neighbors experience growth, then we would lose exponentially. We would be locked into a paradigm that says sorry nothing we can do. Massachusetts' economy can grow at 6% or 7 % a year and they could spend less of a percentage of their economic activity on healthcare, but because they are growing fast they do not lose.

Secretary Roberts: As a point of clarification we are considering a spending target, not a cap – gives transparency, but at the moment we do not have a means of assessing. We have a governor who has

said we will not accept an underperforming economy, and other areas are losing out as a result of the high cost of healthcare. She looks to see how to improve economic activity without increasing healthcare dollars. Understood there are potential downside implications, the Governor is trying to figure out how to drum up resources to invest in other parts of the economy to free up health care spend. I will also say, as someone on the edge who wonders how we change the system, one of the components may be tightening the spigot. Hospitals right now are looking at that with their rate cut. We have to put added pressure in the system.

Mark Montella: I wasn't suggesting that there needs to be discipline in the system; unless it is titrated very carefully. I've been here long enough to know that we set targets but then we move to stringent guidelines.

Secretary Roberts: I will disagree there – I think that the General Assembly would be very reticent to place a stringent cap on healthcare. But what are the processes that help to push change in the system? We did it from the other side with Reinventing Medicaid.

Al Charbonneau: Everyone accepts the idea that healthcare spending is high. I am troubled by the extra layer of bureaucracy, but it strikes me that we are not looking back to see what is crowding out other things. Has it been overhead costs, or has it been the expansion of clinics, the expansion of an entity of service? I understand your concern about not having a broad based policy, but on the other hand we are all sophisticated enough that given the right data we can make good decisions.

Sam Marullo: I would also just refer you to our next slide (5) as well.

Al Charbonneau: I understand that, but I am also talking about looking back.

Paco Trilla: If we accept, and we do, that healthcare costs have a negative impact on economic growth, then the concern we have is timeline. Look at the legislative structure, premium study.

Sam Salganik: I want to voice some support, let's set a target and try to manage it. I like the flexible nature of it, that the target can move, even to Mark's point if we regionally see changes we can be pliable. I am supportive of that.

Lou Giancola: How does the Center for Health Data and Analysis link to the Office of Health Policy noted on slide 1?

Secretary Roberts: This currently lives in DOH but my vision is that we may centralize a lot of that capacity. How do we make sure that OHIC work is tightly linked with work in Medicaid, is linked with what is in the health department, how can we pull that together. Here we look at the CHIA in Massachusetts that ties many together.

Lou Giancola: One comment on the cap: one of the criticism I have heard is if you set a cap that is what the costs will go up to. Secondly, businesses say it is too expensive now – so if you let it go up, then you haven't improved the business climate. It seems we have a lot of data about efficient systems and total medical expense per capita and I am curious why that isn't the target? That suggests that you want to move the system to a place where it can function at the same level of other efficient systems, as

opposed to if the economy grows 3% that is what health care can grow; to me that doesn't make a lot of sense. Not sure we should model around Massachusetts.

Secretary Roberts: One of the intellectual challenges I have seen is 'do you approach the cap from the broader economic climate of what it should be', or do you use the approach of 'here is a cost should it go up or down and manage around that.' We are spending the dollars, are we spending them disproportionately in the wrong place. That, to me, drives system change. You're right to think about it – do we go one way or another or marry those approaches?

Al Kurose: I want to advocate for what Lou is talking about. Part of what we are doing here is advocating for state. If we concentrate on cost performance we may miss a lot of information. As we break down that spend we can start looking at what it is on a sector level. You will not fix the inefficiencies across sectors if you just focus on trend. I think this is a mistake that Medicare shared savings made; I think in Massachusetts it is an error. Introducing more examination of absolute cost performance globally and then start chunking down that is how we can understand where we need to go.

Secretary Roberts: Interesting; I would want to think about if people would want the state regulating that?

Al Kurose: Flip it and say put this trend restriction on everyone, you have efficient and inefficient providers and if you put them both under the same trend constraints I do not think that it improved performance and others will object to that. That is a problem when you enable the poor performance and dis-incent the strong performers.

Sam Salganik: A potential middle ground would be for the data and analysis center to have a statutory charge to compare systems in the state vs systems outside. RI is a small state with not many providers who have a ton of people; once you try to do cost of care contracting or quality contracting you need a lot of people. An idea may be to have a centralized database on type of quality measures, outcomes measures, and cost performance measures that carriers can speak to.

Al Kurose: Having the ability to aggregate the data is diff than having the ability to aggregate the providers. I think yes, potentially goes to how to use the APCD, but have to keep in mind that if thinking in those terms, aggregating the data.

Al Charbonneau: I am a tad disappointed in that I took the comment that we do not have the infrastructure ; I thought the lack of infrastructure would put us in a position to challenge provides in a substantial way. Perhaps the middle ground is plan on building your infrastructure, policy group all the things that happen there, recognizing that the business community is wondering what to do now, we have been involved in this process now for 5-6 years, and there is still nothing coming down the cable that promises impact now.

Secretary Roberts: To me there is no way you meet these targets without the providers driving this change. The system will change because of the way providers are structured, the outcomes we are driving toward.

Mark Montella: If you look at some of the experience behind ACOs some got out because they performed really well and the feds didn't recognize it. A high cost provider may perform better in an ATG than a low cost provider there are no utilization controls. Has to look at the episode treatment group, the treatment modality of a patient. When you look over them longitudinally, they are more effective; look at the data in a more sophisticated way, what are we spending, what is the value. How do we define how cost. We are high utilizers in RI, we could posit because we churn highly. It is a complicated dynamic but simply looking at costs won't do it. Most insurance companies do ATG work and look to see this may be expensive on the front end but on the back end its better mileage.

Al Kurose: Right, but conceptually then identifying more cost efficient entities in the system we need to do.

Al Charbonneau: I am not saying your approach doesn't involve providers, but it is a longer term process. I was hoping that the lack of infrastructure in RI would help engage providers and move it along more quickly. What are the factors that will prevent us with respect to cost? Can you say here is what is driving your and what can you do about it?

Lou Giancola: Right now, there is a bit of a policy fork in the road. Medicaid moving to Accountable Entities, commercial insurers contracting through ACOs, etc.. You are saying that you are concerned it may take too long, may not be successful if you don't get the providers involved and conform the non-system into a system. In a way I think this is both. Apply pressure downward on cost, but also lay the system in place.

Al Charbonneau: What is missing, in my view, is the global budgeting is based on hospital systems not based on the community population. I always worry that if one performs well and another but then add all up something has gone wrong. Putting all in the same room to discuss how to hit the goal that will benefit all. I also get skeptical over the long term about relationships between regulators and providers; sociological literature seems to imply issues. Begin to talk about the hospitals.

Secretary Roberts: There is an interesting dynamic currently, in that there are two payers right now that control the majority of the market.

Lou Giancola: What we agreed to in the [Whitehouse-Steinberg] compact is key.

Secretary Roberts: Right, interesting to think about how we drive that; how we drive the change rather than just creating structures is a valuable one to take back.

III. Public Comment

No additional comment offered by the public at this time.

IV. Adjourn – Final slide and proposal will be circulated to the group for written comment and to tee up the discussion for next week's meeting.