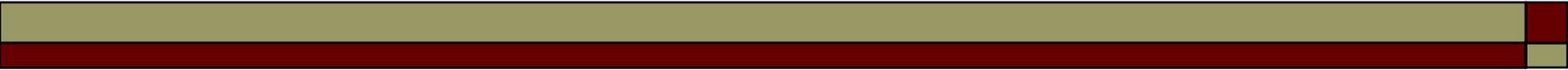


**CON Redesign Special PHHPC Planning Committee,
PHHPC Health Planning Committee Meetings:
June – December 2012**

- | | |
|---------------------------|--|
| 6/21/12 – Albany | Driving Health System Improvement in New York State: Policy Priorities and Tools |
| 7/25/12 – Albany | Innovations in Financing and Organizing Health Care: Implications for CON and Health Care Regulation |
| 9/5/12 - Rochester | Regional Health Planning |
| 9/19/12 – NYC | Establishment and Governance |
| 10/3/12 – NYC | Active/Passive Parent Structures and Financial Review |
| 10/12/12 – NYC | Public Need |
| 10/30/12 – NYC | Review Draft Recommendations
(Cancelled due to Super Storm Sandy) |
| 11/15/12 – Albany | Review Draft Recommendations |
| 11/19/12 – NYC | Discuss and Adopt Recommendations |
| 11/30/12 – Albany | Discuss Recommendations |
| 12/6/12 - Albany | Adoption of Report by Health Planning Committee
Adoption of Report by Full Council |

Driving Health System Improvement in NYS: Policy Priorities and Tools

Presentation to the Public Health and Health Planning Council Health Planning Committee
New York State Department of Health
June 21, 2012
(revised)



Charge to PHHPC

- The PHHPC will conduct a fundamental re-thinking of CON and health planning in the context of health care reform and trends in health care organization, delivery and payment.
- The goal of Phase 2 is to develop and implement a regulatory and health planning framework that, together with payment incentives and other policy tools, drives health system improvement and population health.

Calendar of Meetings

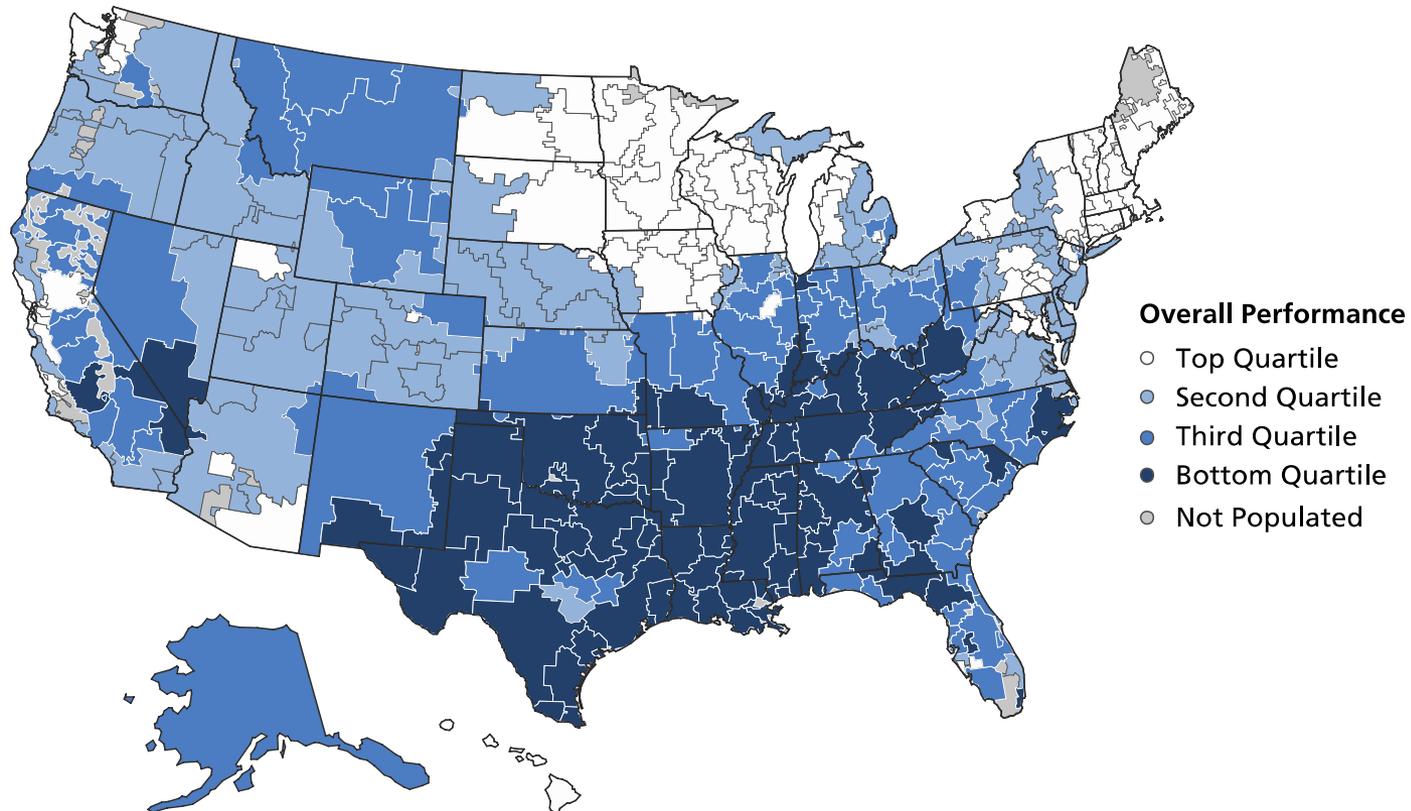
- **6/21/12 – Albany** Driving Health System Improvement in New York State: Policy Priorities and Tools
- **7/25/12 - Albany** Innovations in Financing and Organizing Health Care: Implications for CON and Health Care Regulation
- **TBD** Regional Health Planning
- **9/19/12 – NYC** Establishment, Governance and Financial Feasibility
- **10/12/12 – NYC** Access and Public Need
- **10/30/12 – NYC** Review Draft Report
- **11/14/12 – Albany** Discuss Revised Report
- **11/15/12 – Albany** Adoption of Report by Committee
- **12/6/12 - Albany** Adoption of Report by PHHPC



Health System Performance in NYS

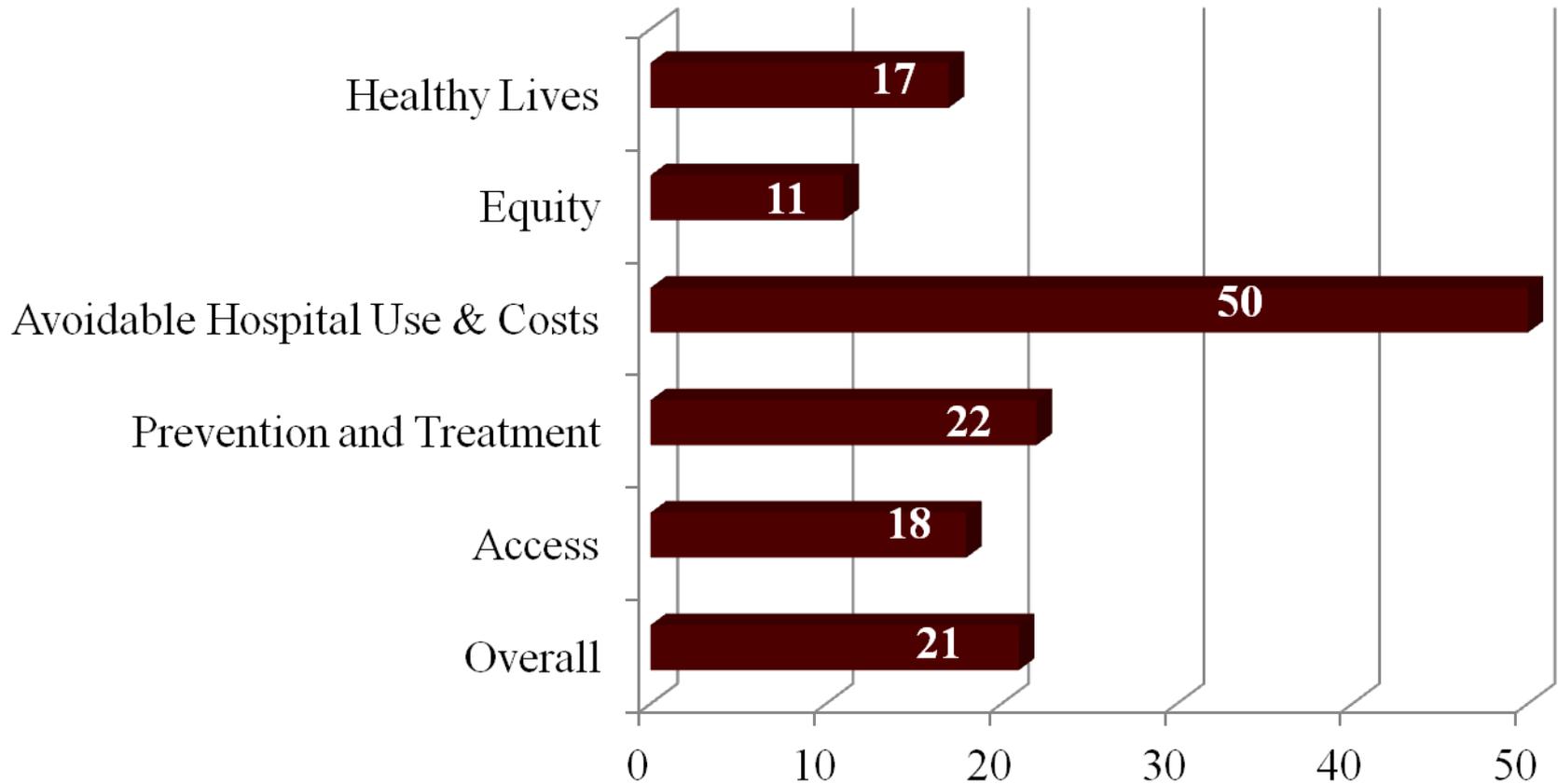
Delivery System Performance

Overall Health System Performance



Source: Commonwealth Fund Scorecard on Local Health System Performance, 2012.

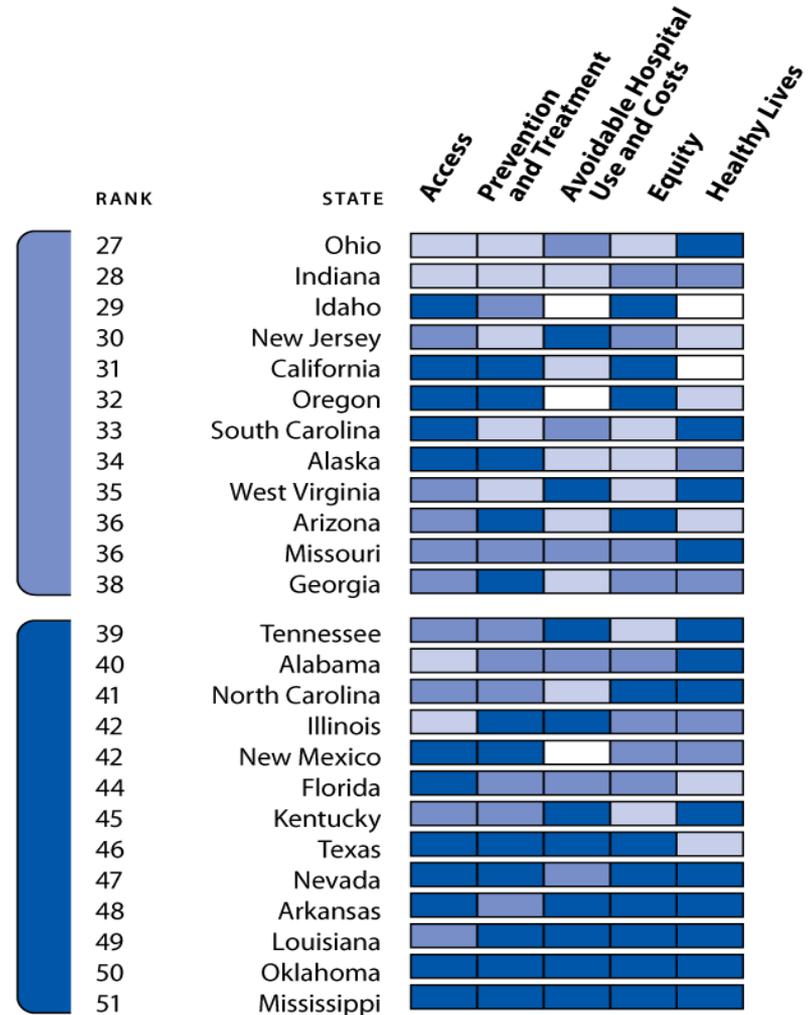
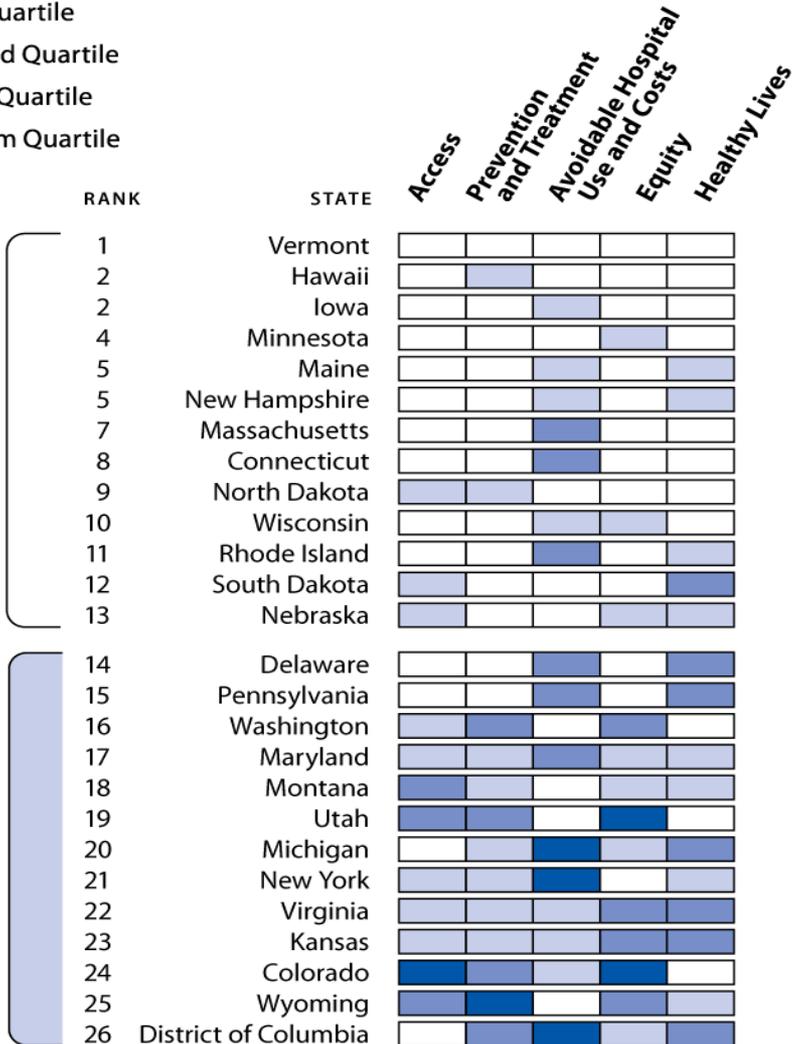
How Does NYS Rank?



2009 State Scorecard Summary of Health System Performance

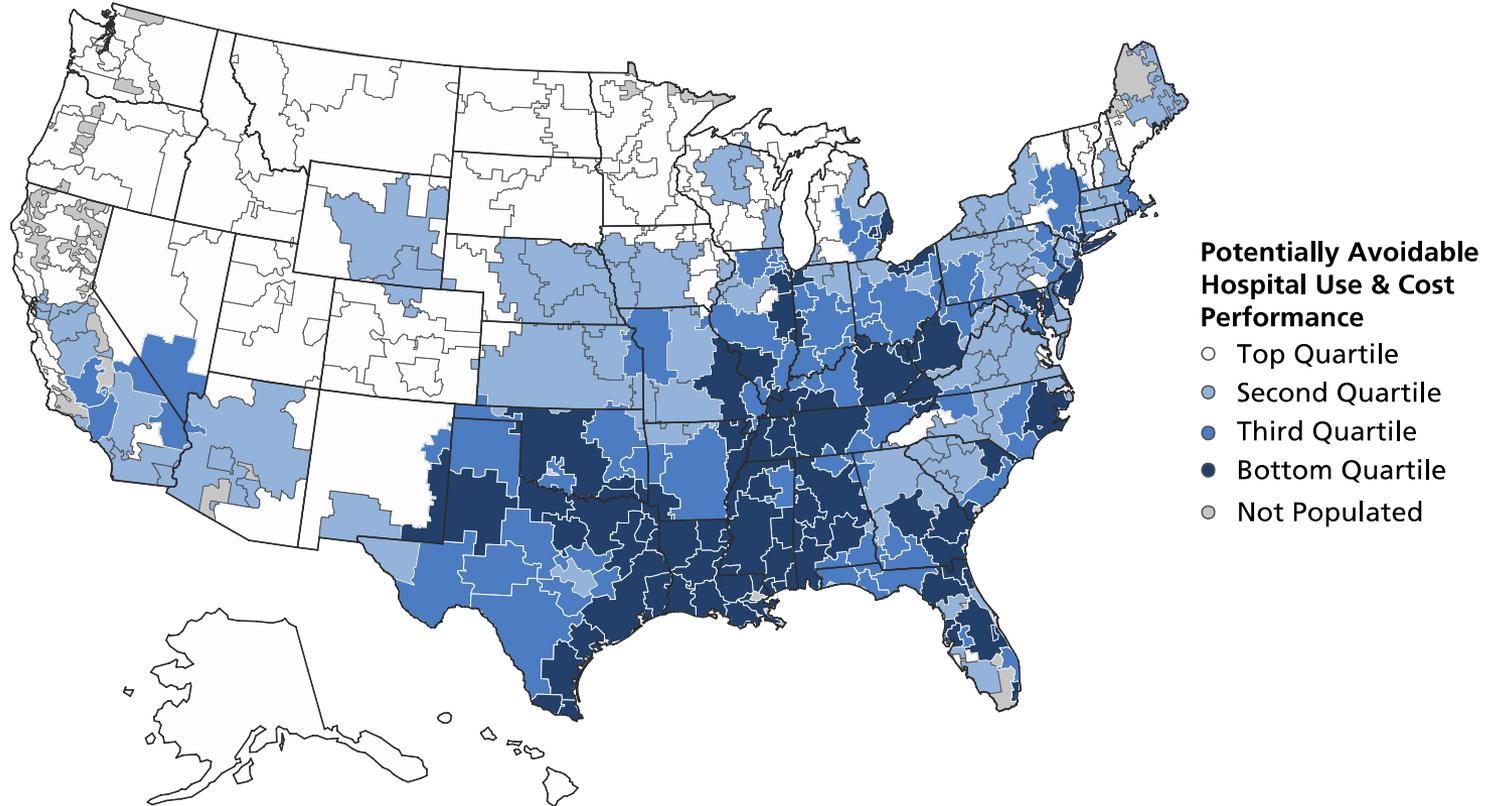
State Rank

- Top Quartile
- Second Quartile
- Third Quartile
- Bottom Quartile



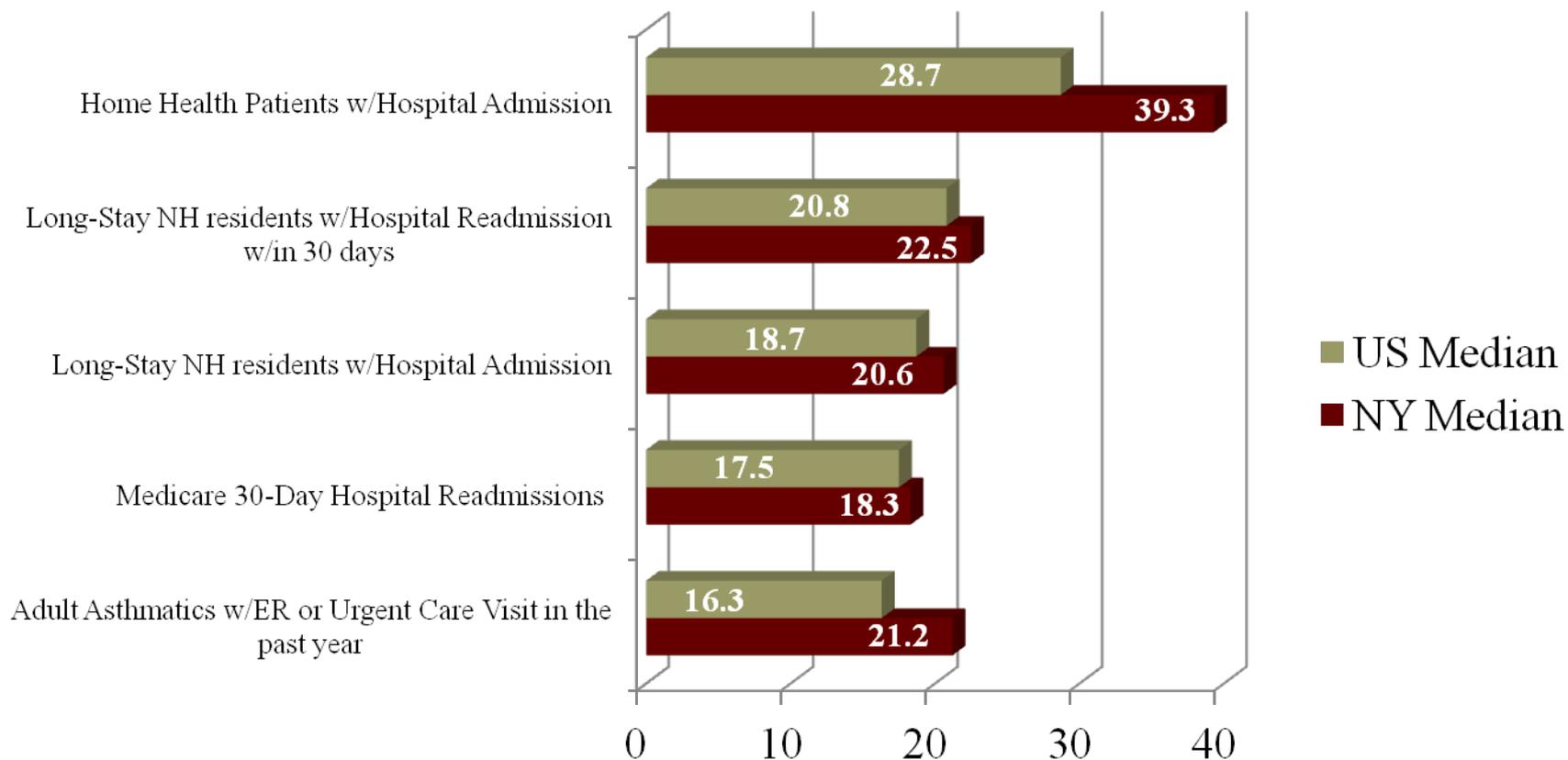
SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2009

Overall Performance on Potentially Avoidable Hospital Use & Cost Dimension



Source: Commonwealth Fund Scorecard on Local Health System Performance, 2012.

Avoidable Hospital Use & Costs



Avoidable Hospital Use & Costs

- Hospital Admissions for Pediatric Asthma per 100,000 Children
 - **New York: 253.5 US Median: 125.5**
- Medicare Hospital Admissions for Ambulatory Care Sensitive Conditions per 100,000 Beneficiaries
 - **New York: 7,269 US Median: 6,291**
- Hospital Care Intensity Index, Based on Inpatient Days and Inpatient Physician Visits Among Chronically Ill Medicare Beneficiaries in the last two years of life
 - **New York: 1.322 US Median: 0.958**

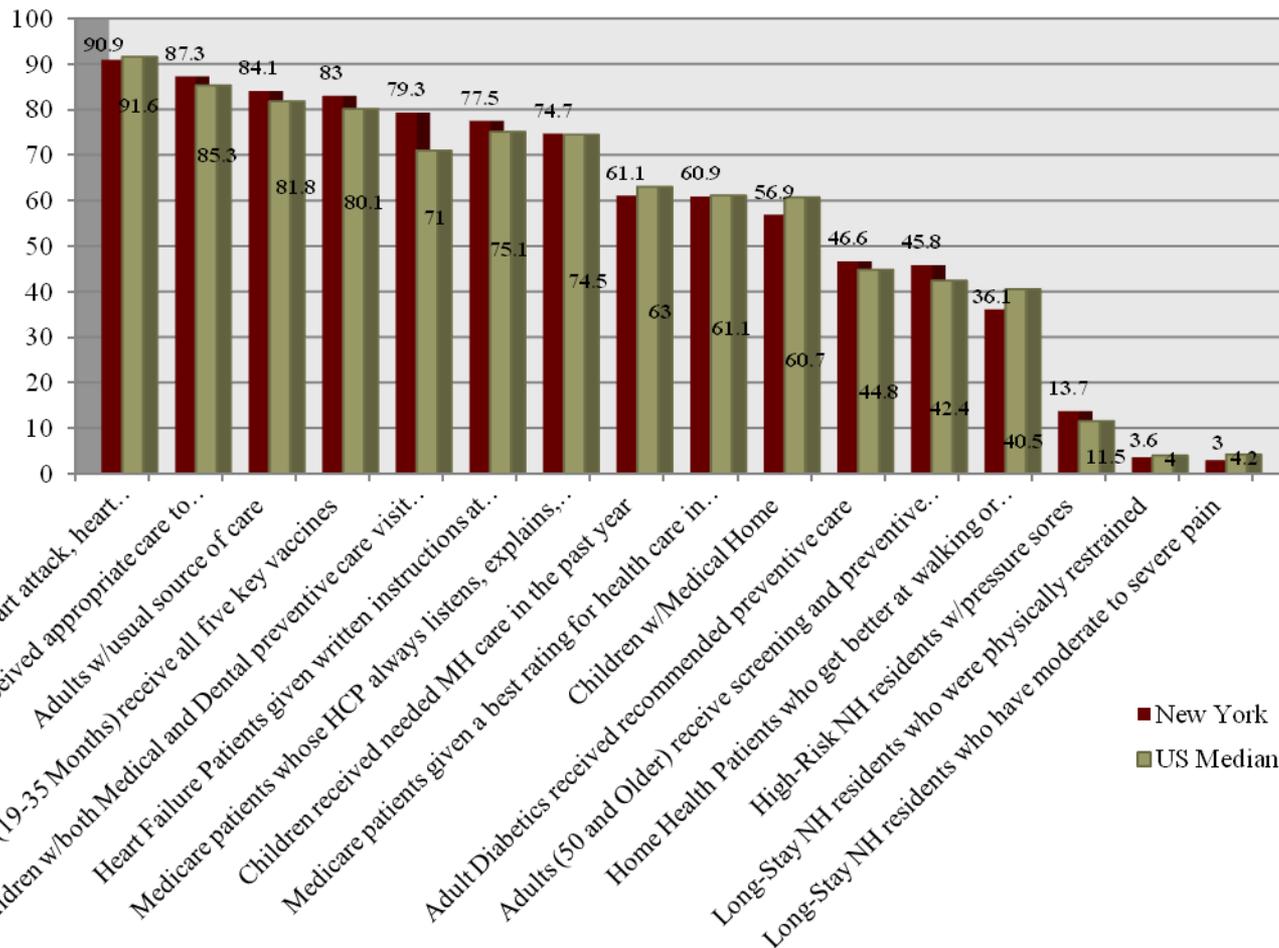
Source: Commonwealth Fund State Scorecard on Health System Performance, 2009

Data: Healthcare Cost and Utilization Project (HCUP) State Inpatient Databases; not all states participate in HCUP. Estimates for the total U.S. are from the Nationwide Inpatient Sample (AHRQ, HCUP-SID 2005). Reported in the National Healthcare Quality Report (AHRQ 2008); Analysis of Medicare Standard Analytical Files 5% Data from the Chronic Condition Data Warehouse (CCW) by G. Anderson and R. Herbert, Johns Hopkins Bloomberg School of Public Health (CMS, SAF 2006, 2007); and Dartmouth Atlas of Health Care (Dartmouth Atlas Project 2005).

Avoidable Hospital Use & Costs

- Total Single Premium per Enrolled Employee at Private Sector Establishments that Offer Health Insurance
 - **New York: 4,638 US Median: 4,360**
- Total Medicare (Part A & Part B) Reimbursements per Enrollee
 - **New York: 9,564 US Median: 7,698**

Prevention & Treatment



Source: Commonwealth Fund State Scorecard on Health System Performance, 2009

Data used to create graph retrieved from: <http://www.commonwealthfund.org/Maps-and-Data/State-Data-Center/State-Scorecard/DataByState/State.aspx?state=NY>



Health Care Spending in New York State

Commercially Insured and Medicare Spending per Enrollee, Relative to U.S. Median Spending for Each Population

Commercial Spending

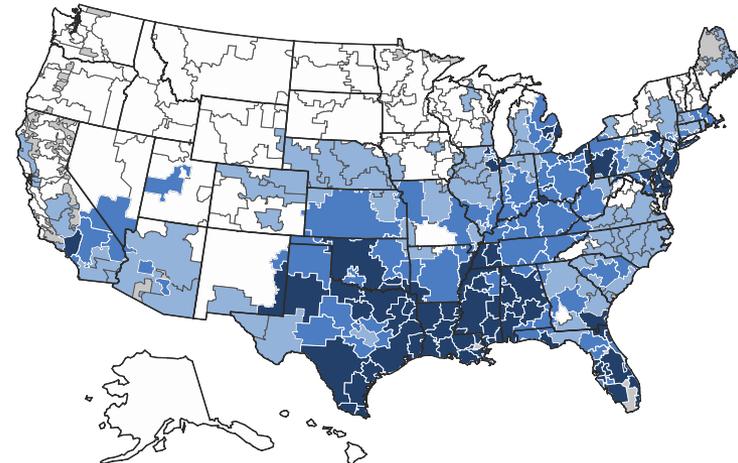
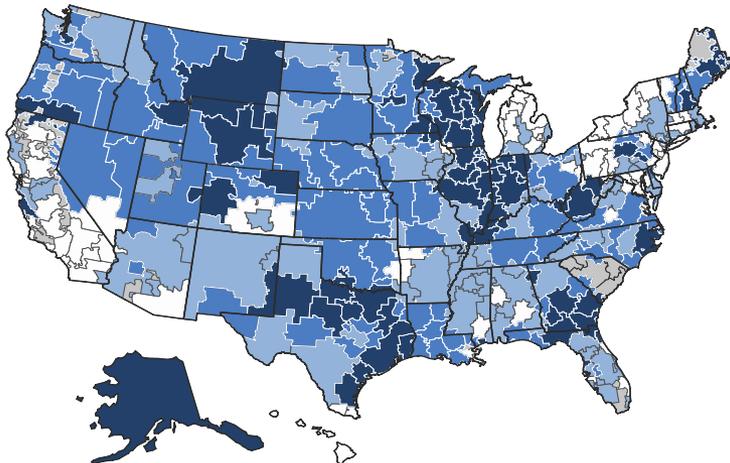
Expressed as ratio to median commercial spending

- 0.61–0.89 (71 HRRs)
- 0.90–0.99 (79)
- 1.00–1.09 (80)
- 1.10–1.53 (71)
- Not Populated or Missing Data (5)

Medicare Spending

Expressed as ratio to median Medicare spending

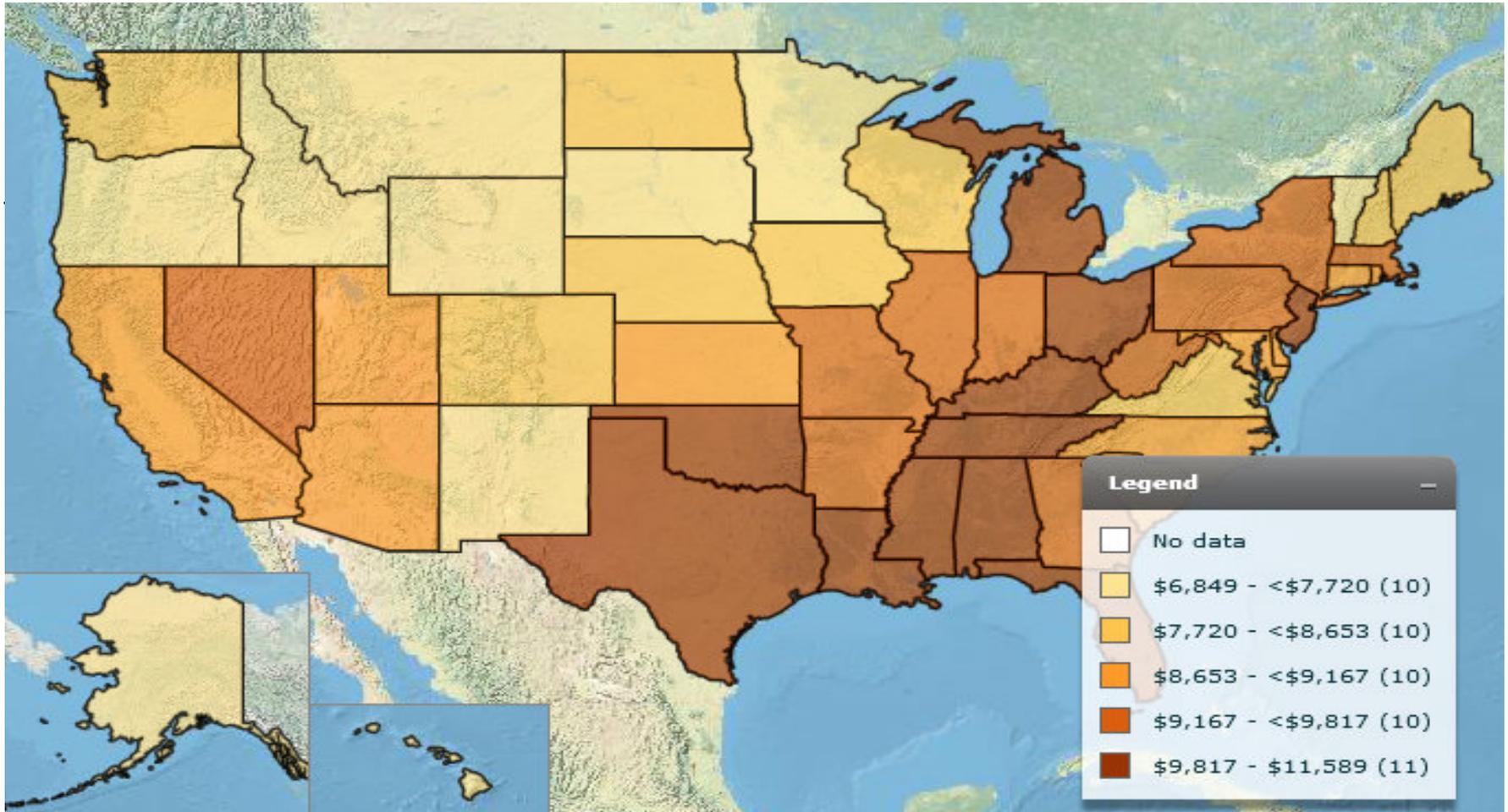
- 0.63–0.89 (81 HRRs)
- 0.90–0.99 (72)
- 1.00–1.09 (75)
- 1.10–2.00 (78)
- Not Populated



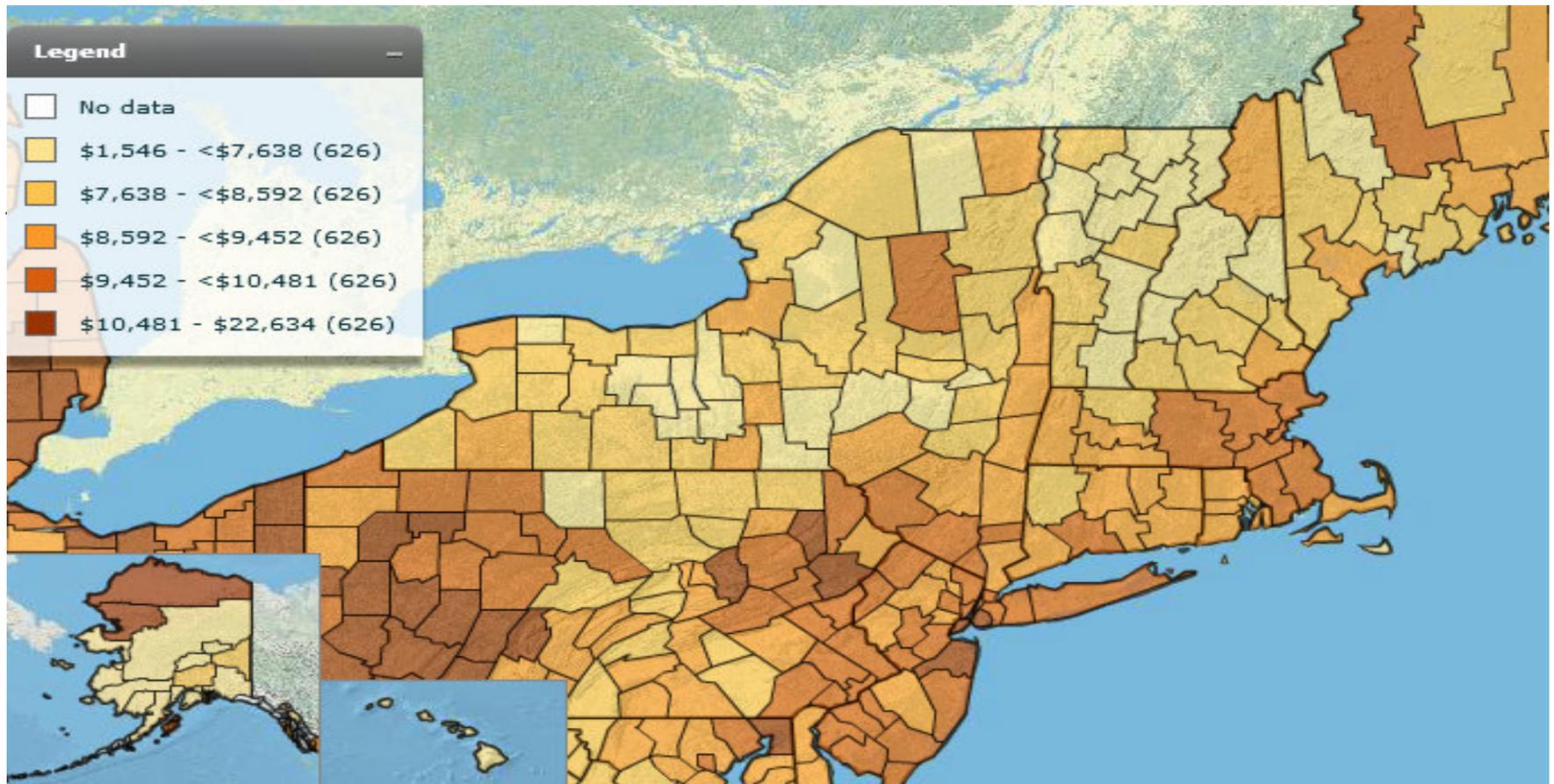
HRR = hospital referral region.

Data: Commercial – 2009 Thomson Reuters MarketScan Database, analysis by M.Chernew, Harvard Medical School. Medicare – 2008 Medicare claims as reported by IOM.

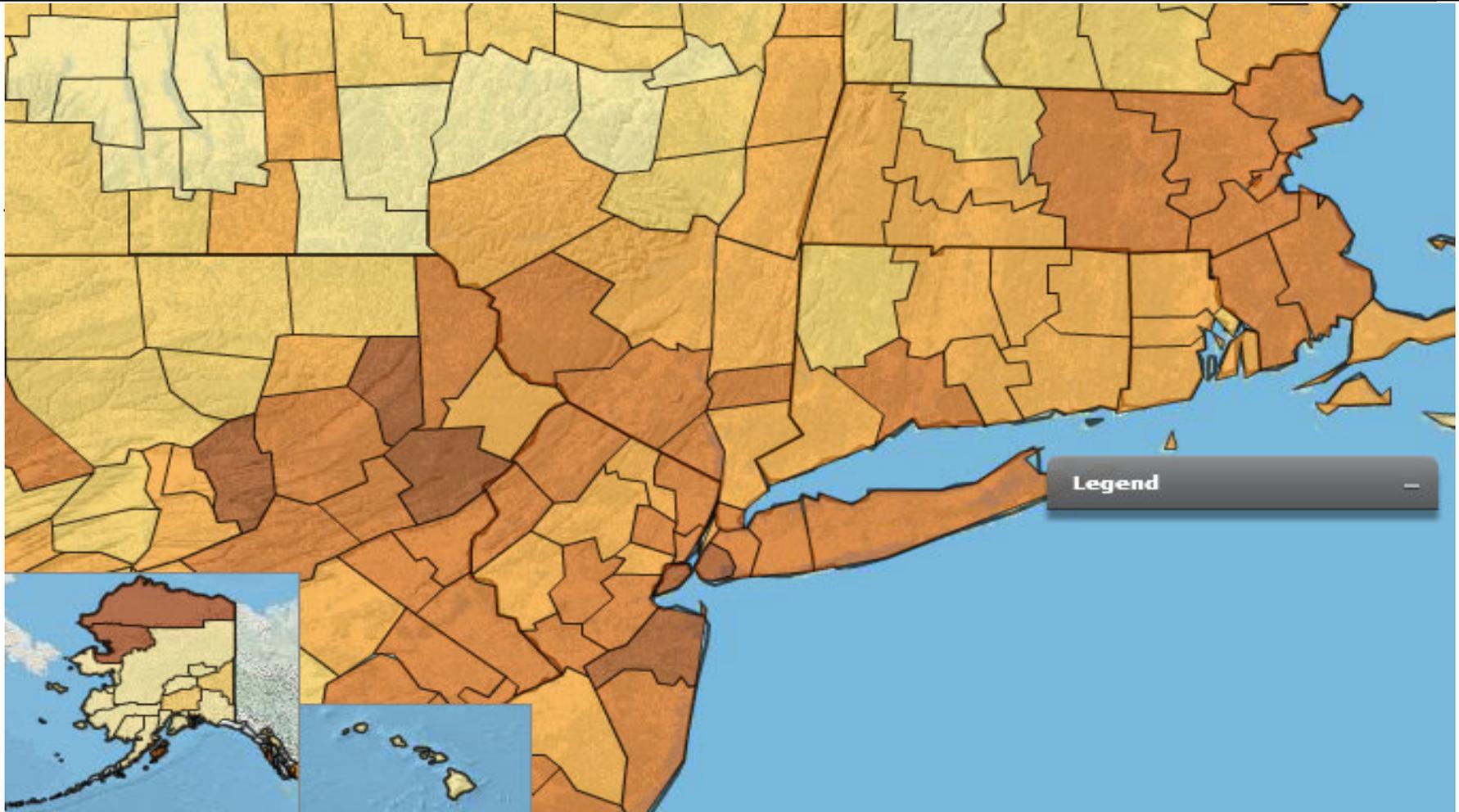
Note: Ratio values lower than 1.0 indicate lower than median spending, ratio values higher than 1.0 indicate higher than median spending. Median spending is determined separately for the commercially insured (ages 18–64) and Medicare populations (age 65 and older).



Price-Adjusted Medicare Payments per Enrollee, by Adjustment Type and Program Component
 (Program Component: Overall; Adjustment Type: Price, Age, Sex & Race; Year: 2009; Region Level: State)

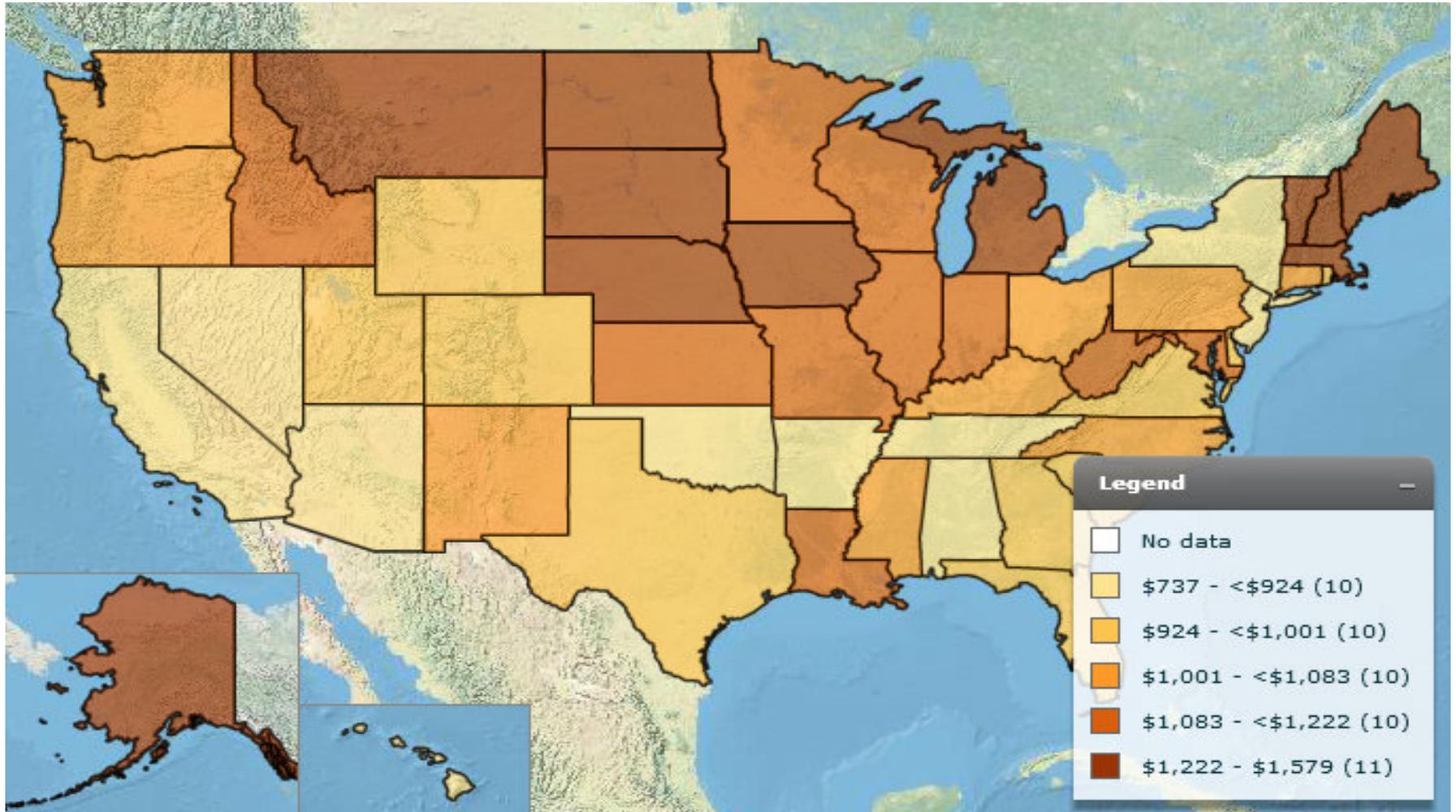


Price-Adjusted Medicare Payments per Enrollee, by Adjustment Type and Program Component
 (Program Component: Overall; Adjustment Type: Price, Age, Sex & Race; Year: 2009; Region Level: County)

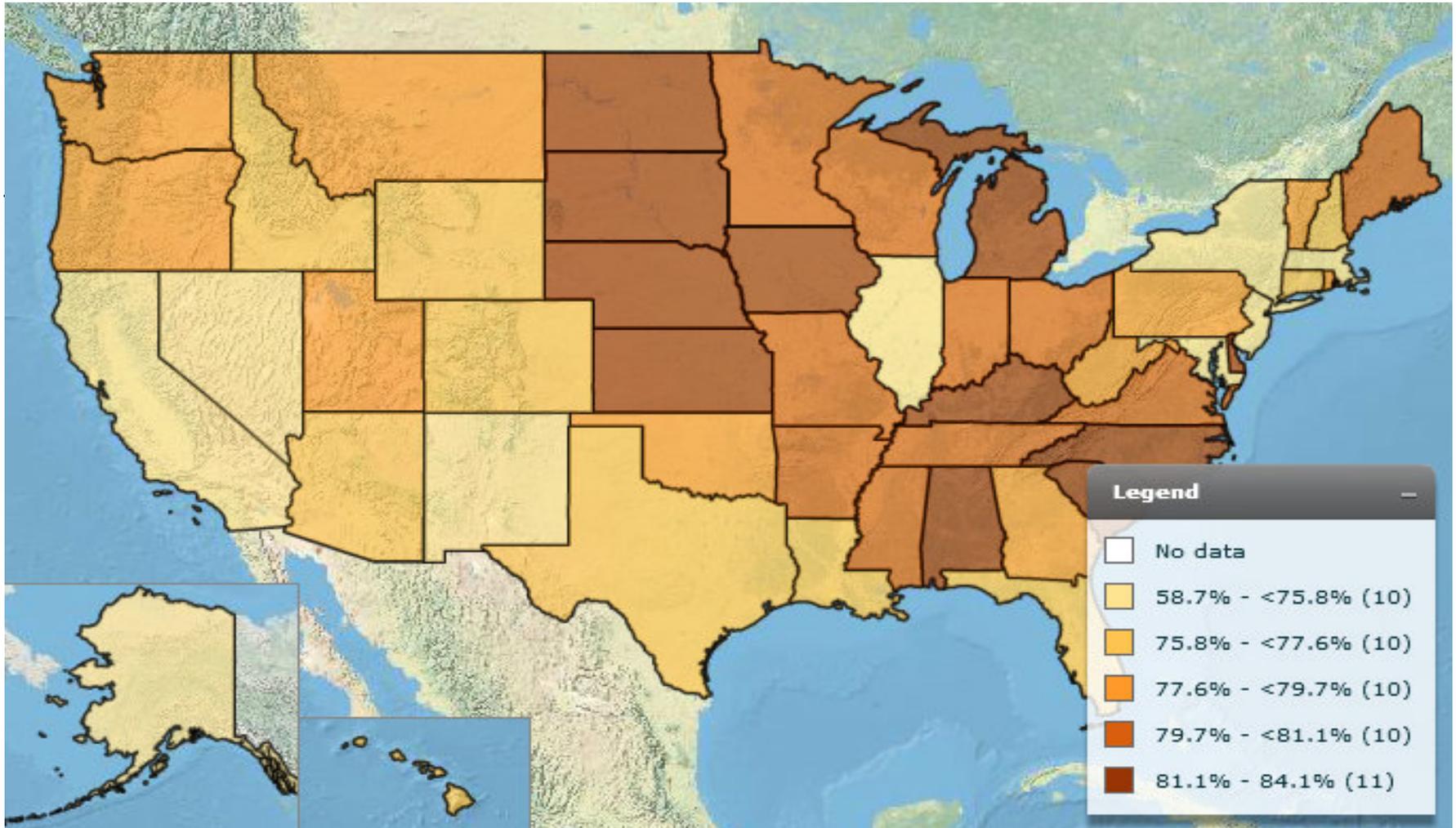


Price-Adjusted Medicare Payments per Enrollee, by Adjustment Type and Program Component

(Program Component: Overall; Adjustment Type: Price, Age, Sex & Race; Year: 2009; Region Level: County)



Medicare Reimbursements for Outpatient Services per Enrollee, by Gender (Gender: Overall; Year: 2007; Region Level: State)



Percent of Medicare Enrollees Having Annual Ambulatory Visit to a Primary Care Clinician, by Race
 (Race: Overall; Year: 2003-2007; Region Level: State)





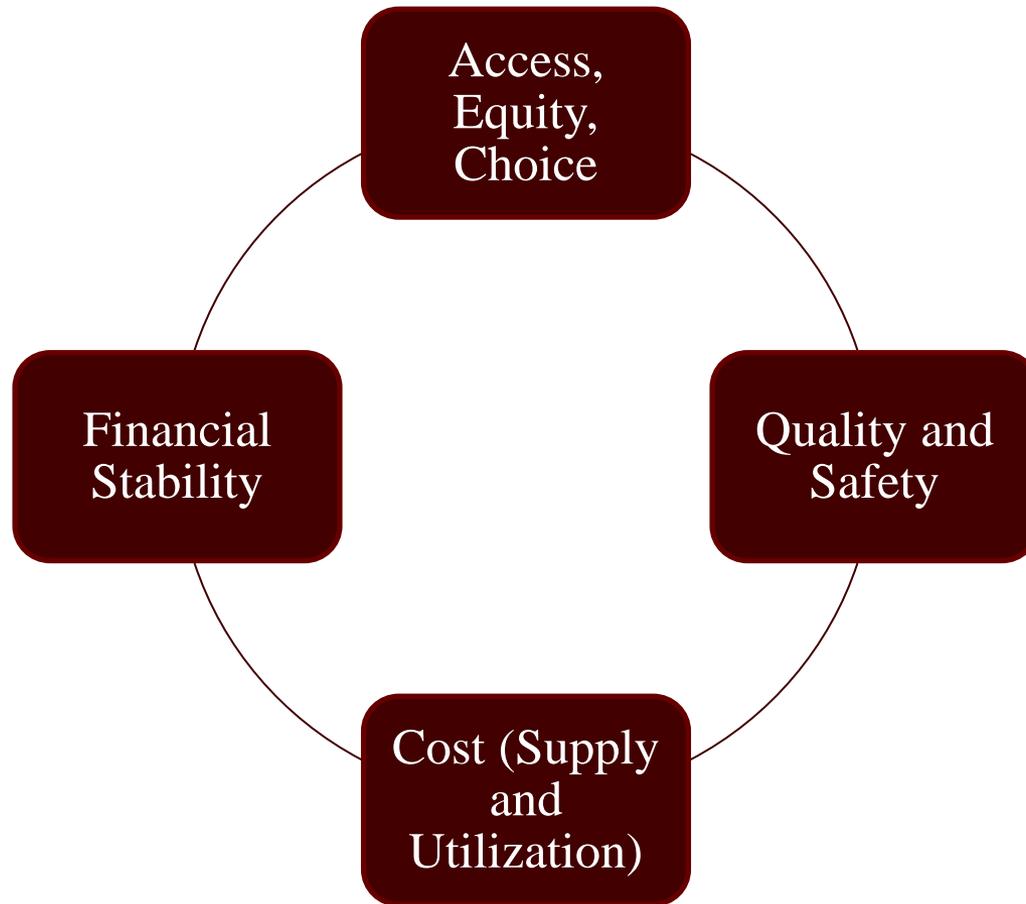
Policy Priorities and Tools



Goals of Health Care Regulation: The Triple Aim

- ❑ Improve the patient experience of care (including quality and satisfaction);
- ❑ Improve the health of the populations; and
- ❑ Reduce the per capita cost of health care.

Targets of Regulation to Achieve the Triple Aim

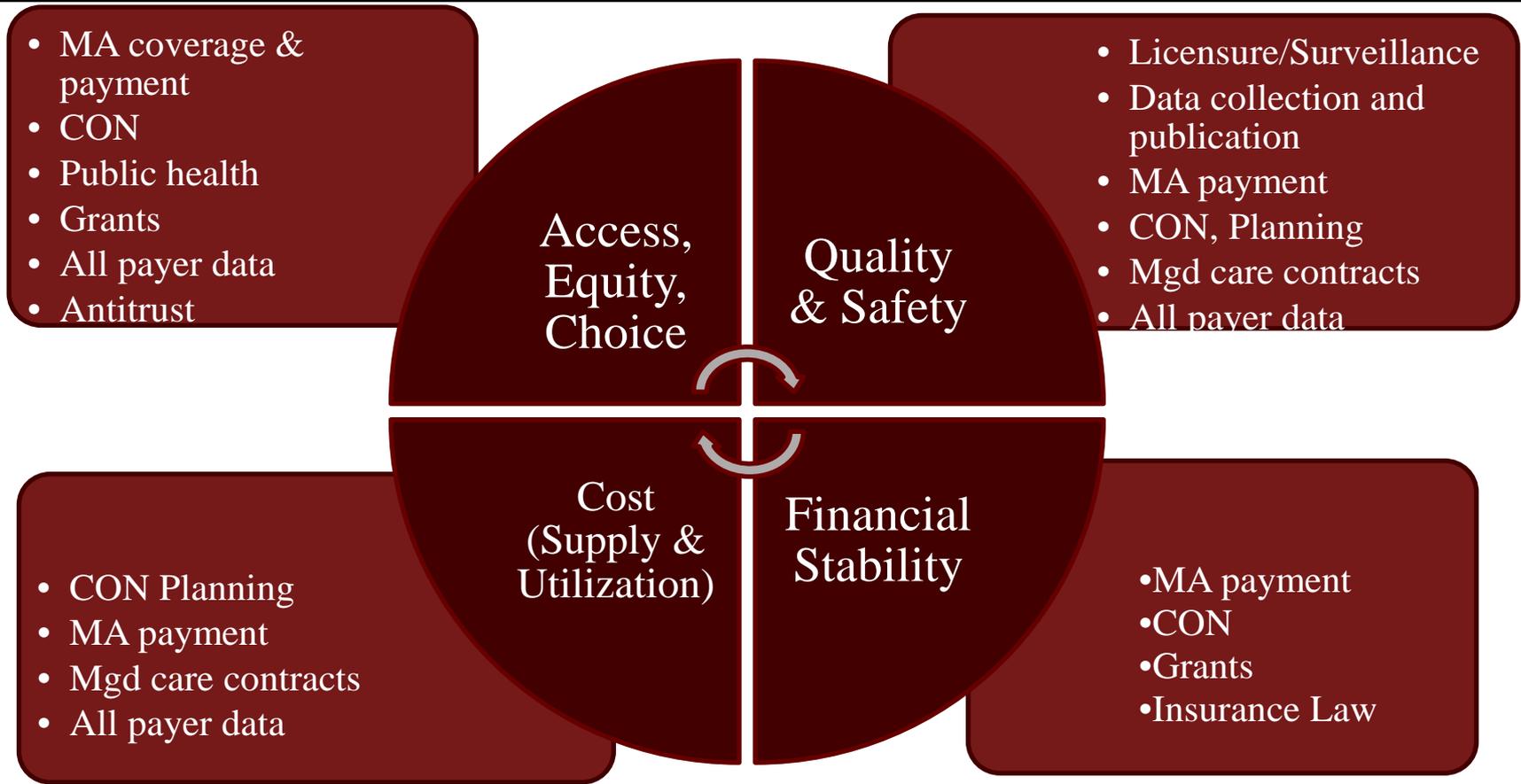




Policy and Regulatory Tools

- ❑ Certificate of Need
- ❑ Licensing and surveillance
- ❑ Medicaid payments
- ❑ Medicaid managed care plan contracts
- ❑ Health plan regulation
- ❑ Public health initiatives
- ❑ Health planning, Community Service Plans, CHAs
- ❑ All-Payer Database; data collection and publication
- ❑ Antitrust, Certificate of Public Advantage
- ❑ Grants

Targets and Tools



Lessons

- NYS Health System Performance:
 - Scores well on access and equity and poorly on avoidable hospital use and costs.
 - Scores at the median on prevention and treatment.
 - Significant regional variation in health care spending. Medicare spending is concentrated on inpatient care and highest downstate.
- Variety of regulatory tools to address access, quality, cost, and financial stability.



Certificate of Need – Functions and National Comparison

CON and Policy Targets

- Cost
 - Restrain capital spending
 - Limit excess supply → Reduce overtreatment
- Access
 - Geographic
 - Financial
 - Preserve safety net
- Quality
 - Consolidate volume and expertise
- Financial Stability
 - Promote rational borrowing and investment decisions

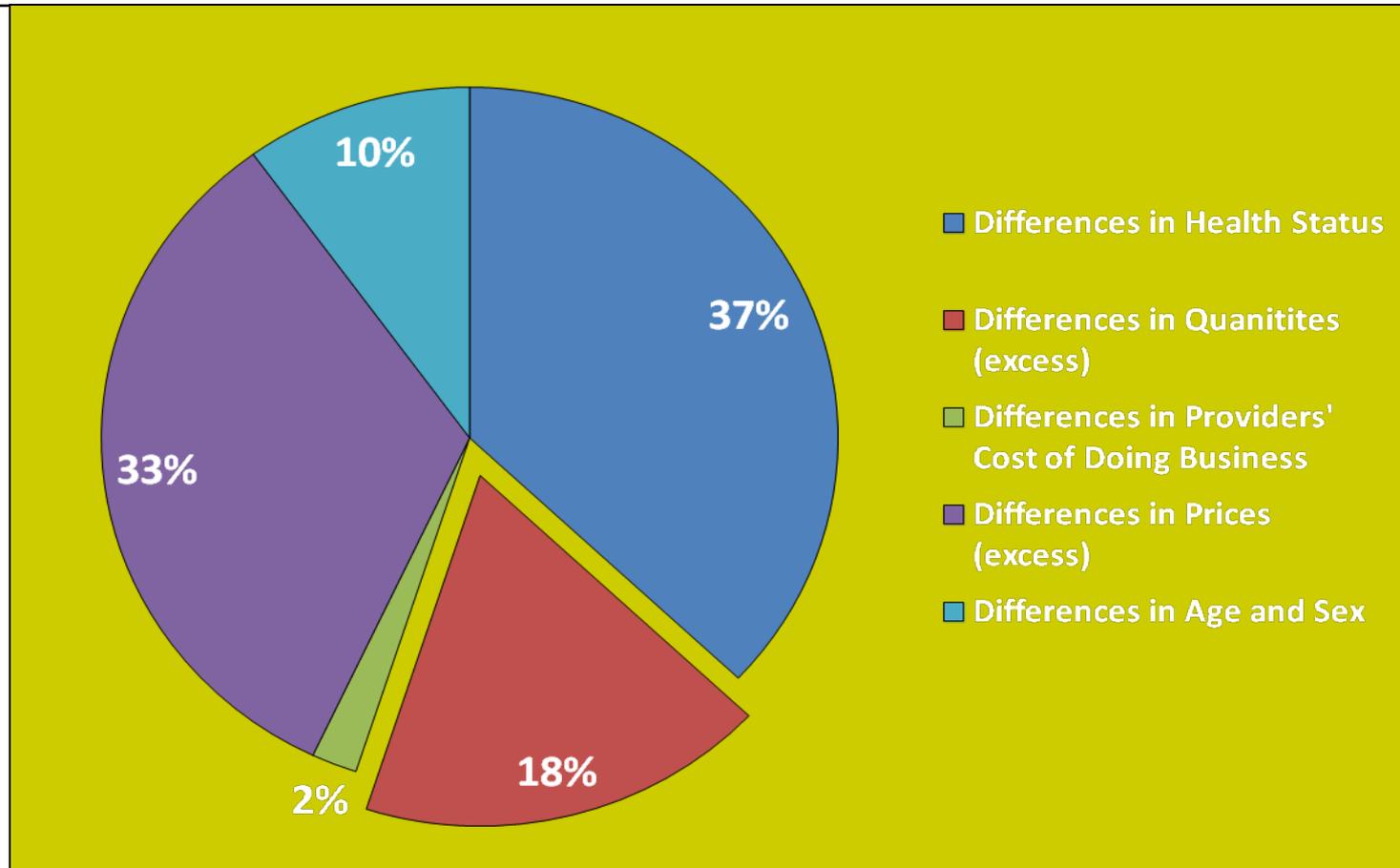
Economic Rationale for CON

- Health care market forces do not operate to optimize supply and costs:
 - Consumers lack sufficient expertise to make informed choices.
 - Services are not price-sensitive:
 - Third parties pay for them;
 - Consumers view them as essential.
 - Physicians order services and often receive payment for them.

Association between Supply, Utilization, and Spending

- “The single most powerful explanation for the variation in how patients are treated is the fact that much of the care they receive is “supply-sensitive”; that is, the frequency with which certain kinds of care are delivered depends in large measure on the supply of medical resources available.”
- “Nationally, supply-sensitive care accounts for well over 50% of Medicare spending.”
- Hospitalizations for most medical admissions, ICU stays, physician visits, specialist referrals, diagnostic tests, home health care, and long-term care facilities belong to the “supply-sensitive” category of care. (Wennberg, et al., 2008)

Association between Utilization and Spending



GM, Ford and Daimler Chrysler Studies Found Correlation between CON and Lower Health Care Costs

Certificate of Need: Endorsement by DaimlerChrysler Corporation (July 2002)

<u>Location</u>	<u>Adjusted 2000 Cost*</u>
Kenosha, WI	\$3,519
Indiana	\$2,741
→ Newark, DE	\$2,100
→ Michigan	\$1,839
→ Syracuse	\$1,331

***Age, Gender, and Geographically Adjusted.**

See also, Ford Motor Co., CON Study (CY 2000); Statement of General Motors Co. on CON Program in Michigan (2002).

Effectiveness of CON in Relation to Costs

- Evidence is equivocal.
 - Difficult to control for market conditions, stringency of program, and other variables that drive costs.
- Studies have reached conflicting conclusions. CON:*
- Reduces or has no effect on beds;
- Makes hospitals more efficient;
- Reduces acute care spending, but not overall spending; reduces charges for elective surgery; reduces per capita health care expenditures.
- Decreases LOS or has no effect; and
- Increases, decreases or has no effect on cost/admission.

* E.g., Yee, et al, NIHCR, 2012; Ferrier, 2008; Hellinger, 2009; Fric-Shamji, 2008; Conover, Sloan, 2003; Conover, Sloan, 1998; Lewin-ICF, 1992; Begley, et al. , 1982.

CON and Access

- Few studies on impact of CON on access. There is some evidence that CON:
 - Protects access in urban and rural areas by shielding community and safety net hospitals from competition and preventing exodus to suburbs.
 - Provides opportunity to condition license on services to Medicaid beneficiaries and uninsured.
 - Provides opportunity to prevent decertification of services and beds.

Effects of Repealing CON

- Varies based on stringency of CON program, existing capacity, relative spending, type of facility or service, demographic trends.
- Some states experienced surges in beds, construction of new hospitals, ASCs, cardiac services, dialysis; some surged and retrenched.
- Some experienced above average growth in hospital spending post CON repeal; others did not.
- Ohio: 15 hospitals closed, 11 in urban areas, some migrated to suburbs. Substantial growth in ASCs.

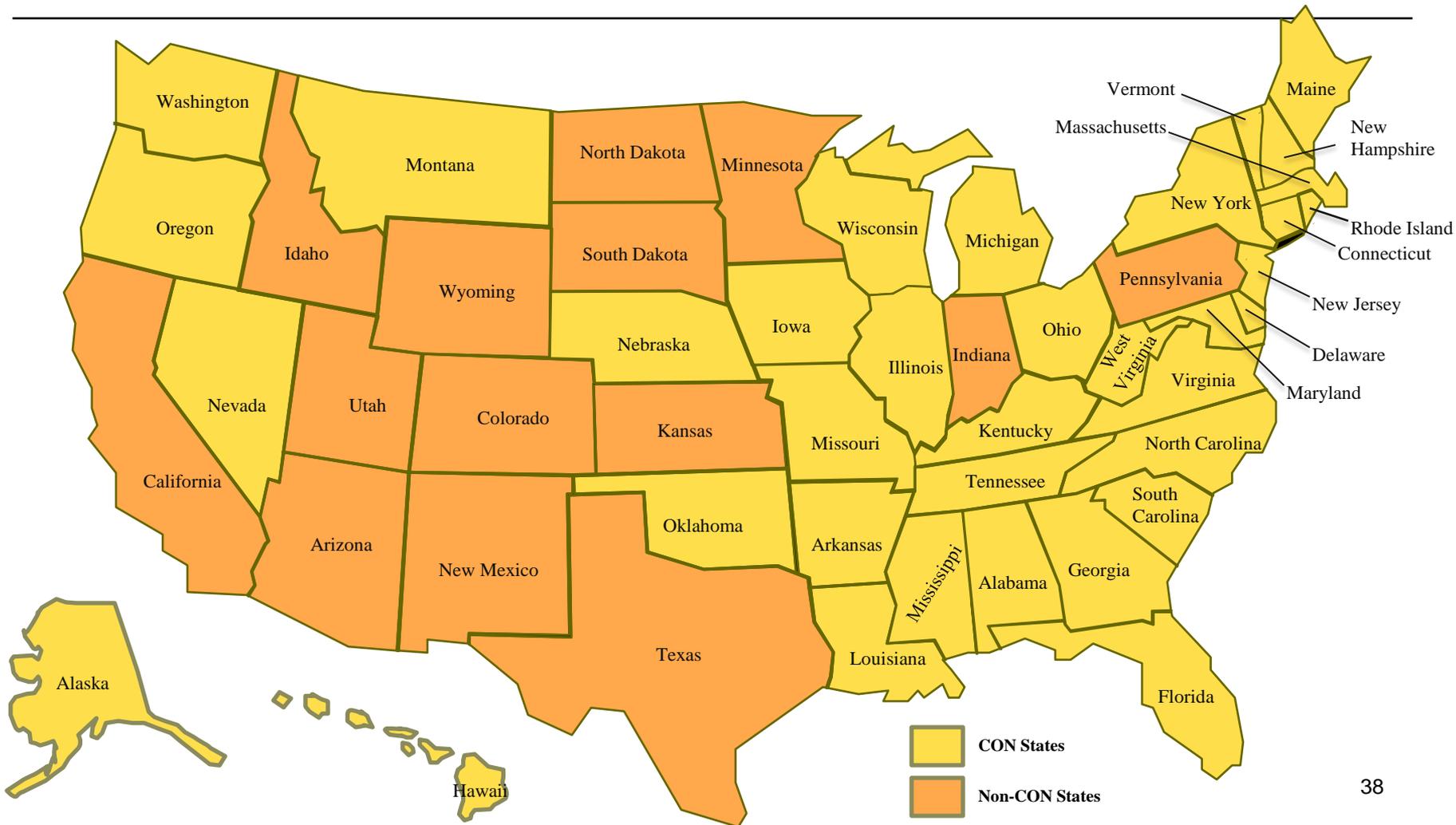
CON and Quality

- ❑ Higher volume is associated with lower mortality for a variety of conditions and procedures; magnitude of the association is greater for certain high-risk procedures and conditions. (Halm, et al. 2002)
- ❑ Majority of studies show positive association between volume and outcome for CABG, coronary angioplasty. (Ibid.)
- ❑ Open heart surgery mortality was 22% greater in states without CON regulations as compared to states with continuous CON regulations. (Vaughn-Sarrazin, et al. 2002)
- ❑ Marginally significant reduction in operative mortality for CABG in CON states; but accounting for state variation as random effects reduced significance of difference in mortality. (DiSesa, 2006).
- ❑ Lower NICU bed numbers and lower all infant mortality rates were found in states with CON compared with states without CON (Lorch, P, 2012)

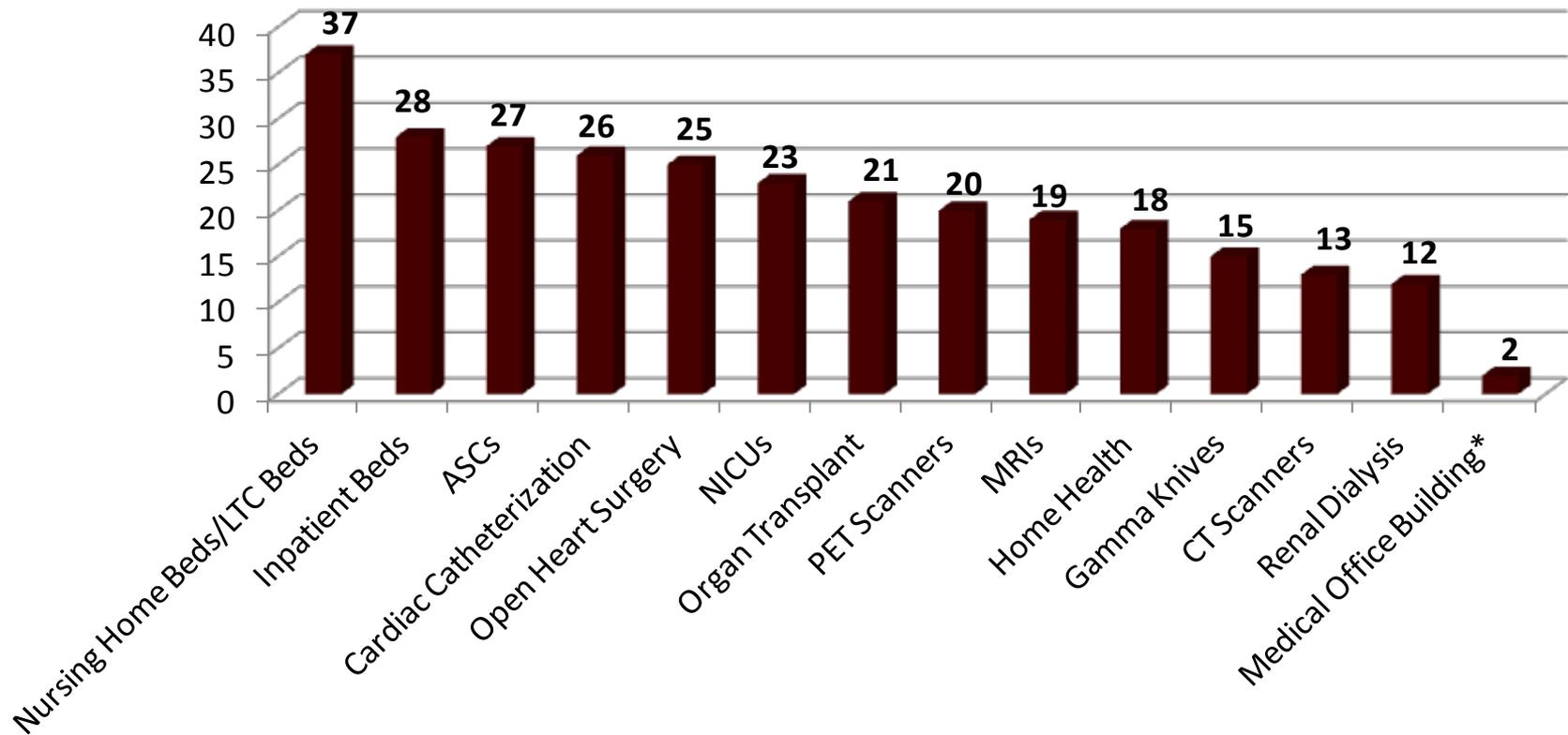


CON: National Scan

State CON Health Laws, 2012



CON Scope: National Scan



Data compiled from AHPA, 2011.

*New York requires CONs for clinics and their services, but no CONs are required for "Medical Office Buildings."

Cost Thresholds

- Range from \$0 (Connecticut) to \$16M (Virginia)
- Some have separate thresholds for medical equipment and services, ranging from \$400,000 (NH) to \$5.8M (DE)
- NY: \$6M for Admin.; \$15M for Full;
 - Recent streamlining recommendation would eliminate CON for certain construction projects regardless of cost.



Approaches to Public Need Determinations

- NY uses administrative rule-making to establish public need methodologies.
- Some states establish public need through the development and publication of a State Health Plan.



North Carolina Medical Facilities Plan

- Projections of need for acute care, long-term care, and major medical equipment
- By county, or multi-county planning areas, depending on bed or service category
- Updated annually to reflect increases or decreases in capacity in preceding year

North Carolina Medical Facilities Plan

Services Covered

- Acute Care Facilities and Services
 - Hospital beds, ORs, open heart surgery, burns care, transplants, inpatient rehabilitation.

- Long-term Care Facilities and Services
 - Nursing homes, adult care homes, home health care, hospice, ESRD facilities, psychiatric inpatient, chemical dependency treatment, ICF/DD facilities.

- Technology and Equipment
 - Lithotripsy, Gamma knife, linear accelerator, PET, MRI, cardiac catheterization.



North Carolina Medical Facilities Plan

- Relatively narrow in scope
- Focus is on facilities, beds, equipment and specialty services
- Not a planning document for other elements of the health care system (e.g., prevention, health care reform, payment/reimbursement).



Maine State Health Plan

- Issued Biennially
 - Current Planning Period 2010-2012

- Broad Scope
 - Addresses five major areas
 - Sets forth goals for each area and strategies and tasks for achieving



Maine State Health Plan

- Reduce Waste and Inefficiency
 - Reduce Inappropriate ED Use
 - Strengthen Primary Care
 - Eliminate Duplicative Testing
- Strengthen Public Health and Prevention
- Payment Reform
- Align Policies and Systems
 - Workforce Development
 - Data Infrastructure
 - Health Information Technology
 - Certificate of Need
- Implement Federal Health Reform



Maine:

CON Linked to State Health Plan

- The Commissioner shall approve an application for a CON if the project:
 - Meets financial feasibility and public need;
 - **Is consistent with the State Health Plan;**
 - Ensures high-quality outcomes and does not negatively affect the quality of care delivered by existing service providers; and
 - Does not result in inappropriate increases in service utilization.

Maine: Criteria for CON Project

Consistency with SHP

Projects that meet more will receive higher priority if they:

- ❑ Focus on population-based health
- ❑ Reduction of avoidable and inappropriate ER use
- ❑ Consolidation, collaboration or right-sizing to improve efficiency and lower cost of care
- ❑ Improve access to necessary services
- ❑ Favorable impact on regional and statewide insurance premiums

Maine: Criteria for CON Project Consistency with SHP (cont'd)

- ❑ Reduce unwarranted use of high-cost, high-variation outpatient services in the service area
- ❑ Applicant demonstrates a culture of patient safety
- ❑ Applicant employs or has concrete plans to employ HIT to enhance quality of care and patient safety
- ❑ Applicant has regularly met voluntary cost control targets set forth in statute.



CON and Batching Applications

- Proactive
 - Florida - for certain types of beds, based on need.
- Periodic
 - Virginia - based on a published schedule
- Reactive
 - Michigan and New York - based on applications for the same services in the same service area.

CON and Physician Practices: NYS

- Education Law
 - Bans corporate practice of medicine, except through established health care facilities.
 - Limits DOH regulation of physician practices.
- Public Health Law – Requires establishment and licensure of health care facilities.
 - Regulations identify characteristics that define an outpatient facility requiring establishment and licensure.

Physician Practices: NYS

- ❑ DOH oversight limited to issues such as: professional misconduct, medical records, OBS accreditation, radiation equipment, and public health threats.
- ❑ Generally, no “facility fee” reimbursement.
- ❑ No CON requirement.
- ❑ No HCRA surcharges.
- ❑ No indigent care reimbursement.

Physician Practices: Other States

- Many CON states require CON approval and/or licensure of physician practices that operate:
 - Ambulatory surgery services (e.g., GA, MA, MD, MI, NJ, VA);*
 - Linear accelerators or radiation therapy (e.g., CT, RI, MI, VA);*
 - Imaging equipment (e.g., CT, MI, VA, GA)*; or
 - New technology (e.g., ME, MA)*



HEALTH CARE FACILITY LICENSURE

CON and Licensure

CON	Licensure
Cost (supply, capital spending)	Quality
Access (financial, geographic)	Physical Plant Safety
Financial Stability	
Quality	



Health Care Facility Licensure in NYS

- ❑ Character & Competence
- ❑ Physical Plant Safety
- ❑ Staffing and Program
- ❑ Pre-Opening Survey
- ❑ Accreditation and Deeming

Possible Accreditation by Facility Type

Facility Type	Accreditation Required?	Can be Deemed?
Hospital	No	Yes. Must undergo Triennial Survey by AO to ensure compliance with Federal COPs <u>and</u> AO Standards. Must pay additional annual fee to AO.
Ambulatory Surgery Center	Yes	Yes. Must undergo Triennial Survey by AO to ensure compliance with Federal COPs <u>and</u> AO Standards. Must pay additional annual fee to AO.
Other Diagnostic and Treatment Center	No	No
Rehab Agency (OPT/SP) or RHC	No	Yes. Must undergo Triennial Survey by AO to ensure compliance with Federal COPs.
ESRD, CORF	No	No

Surveys by Accreditation Type

	Unaccredited Facility	Accredited Facility	Deemed Facility
Federal Periodic Survey	Conducted by NYSDOH based on CMS scheduling rules	Conducted by NYSDOH based on CMS scheduling rules.	Conducted by AO every three years to ensure compliance with COPs.
Federal Validation Survey	N/A	N/A	Conducted by NYSDOH based on random sample selected by Federal Government
Federal Complaint Investigation (for alleged non-compliance with Federal Conditions of Participation)	Conducted by NYSDOH. No authorization required.	Conducted by NYSDOH. No authorization required.	CMS must authorize NYSDOH to conduct investigation
Re-Accreditation Survey	N/A	Conducted by AO every three years to ensure compliance with AO Standards.	Conducted by AO every three years to ensure compliance with AO Standards. (Simultaneous with AO Federal Periodic Survey)
State Periodic Survey	Conducted by NYSDOH on appropriate cycle. Simultaneous with Federal Survey when possible.	Permitted under the Collaborative Agreement, however NYSDOH usually accepts the AO Triennial in lieu of conducting a survey.	Permitted under the Collaborative Agreement, however NYSDOH usually accepts the AO Triennial in lieu of conducting a survey.
State Complaint Investigation (for alleged non-compliance with NYS regulation or statute)	Conducted by NYSDOH.	Conducted by NYSDOH.	

Certification and Surveillance Process for NYS Nursing Homes

- Skilled nursing facilities (SNFs) and nursing facilities (NFs) must:
 - Be licensed under PHL Article 28;
 - Comply with Article 28 and 10 NYCRR Part 415, etc.;
 - Comply with 42 CFR Part 483, Subpart B to receive payment under the Medicare and Medicaid Programs.

Certification and Surveillance of Nursing Homes in NYS

- To certify a SNF or NF, the state survey agency (NYS DOH) must complete:
 - Life Safety Code (LSC) Survey
 - Standard/Recertification Survey
- Federal surveys are:
 - Unannounced and occur every 9-15 months (penalties involved if breached).
 - Can be conducted on weekends, or at any time 24 hours a day.
- Accreditation is voluntary; no deeming.

Nursing Home Complaint and Incident Investigations in NYS

- Determine compliance with all applicable **Federal and State** program requirements.
- Process involves medical record review, document review, observation, interview with residents, staff and key personnel, policy & procedure review.
- Concerns that are investigated and identify findings of non-compliance with state or federal requirements will result in the provider receiving a statement of deficiencies, which may require the provider to respond with an acceptable plan of correction.



Licensing in Massachusetts

- Licensed providers:
 - Hospitals
 - Nursing homes and rest homes
 - Hospice programs
 - Clinics
 - ASCs
 - Dialysis
- Not home care agencies
- Licenses issued for 2-year terms

Massachusetts Process

- Determination of need
- Architectural plan review
- Determination of suitability
 - Compliance record of operator
 - Criminal history
 - Financial capacity
 - Compliance with governance, public hearing, and community benefit requirements (acute care hospitals only)



Licensing in Pennsylvania

- No CON
- Licensed providers:
 - Hospitals
 - Nursing homes
 - Birthing Centers
 - Home health/hospice agencies
 - Ambulatory surgery centers
 - Cancer treatment centers



Pennsylvania Process

- Applicant background information
 - Business structure and controlling person
 - Managers
 - Compliance record in operating health care facilities
 - Charity care intentions

Pennsylvania Process (cont'd)

- Architectural plan reviews conducted prior to construction for all construction projects;
- Review of policies and procedures, staffing
- On-site, occupancy survey for any new facility, new service or construction. Some projects are inspected during construction too.
- Licenses issued for a 2-year period.
 - Provisional licenses may be issued for up to 6 months.

Observations

- CON's impact is contextual
- Depends on:
 - Implementation
 - Payment incentives
 - Other market forces
 - Regulatory/policy environment
- We need mutually reinforcing policies to drive health system improvement.

HMO Oversight and Its Relationship to Delivery System Performance

Presentation to the Planning Committee of the
Public Health and Health Planning Council
July 25, 2012

Nina M. Daratsos, JD, MSN
Director, Bureau of Managed Care Certification and
Surveillance
New York State Department of Health



Who Regulates Health Insurance Products?

DOH

Limited to HMOs,
(including PHSPs)

DFS

Fee-for Service
(indemnity plans),
POS, PPO, EPO,
HDHP

HMO – commercial
benefits and financial
health

Delineation of Responsibilities for HMOs

DOH

- ❑ Fiscal Solvency/Reserves: MMC
- ❑ Capitalization Requirements: MMC
- ❑ Provider contract approval: Prior approval - all HMOs
- ❑ Monitoring and Oversight: Annual surveys, focused review, ongoing reviews of key areas: all HMOs
- ❑ Fraud and Abuse: Limited to MMC with between 10,000 and 60,000 members

DFS

- ❑ Fiscal Solvency/Reserves: Commercial MCOs
- ❑ Capitalization Requirements: Commercial MCOs
- ❑ Provider contract approval: None
- ❑ Monitoring and Oversight: Fiscal audit once every three years: Commercial only
- ❑ Fraud and Abuse: MCOs with 60,000 or more members enrolled

Laws and Policies Affecting Insurance Coverage and Payment

Medicaid Managed Care Model Contract

- Enrollment and disenrollment inpatient coverage
- Benefit coverage
- Authorization and appeal process

HMO Only (PHL, SSL)

- Out-of-network access, transitional care
- Provider rights, credentialing
- 15-month claim filing (MA, FHP, CHP) for non-par providers

HMO and Indemnity Contracts

- Prompt pay law
- Pre-existing conditions
- Overpayment recovery
- Utilization Review
- External Appeal
- Adverse reimbursement change
- Benefit coverage Commercial
- Credentialing limited to Art 48 products



Self-Funded Plans and ERISA Pre-emption

- As more companies become self-funded, impact of State oversight becomes more limited.
 - Provider protections diluted
 - Member protections less defined
 - Article 49 Appeals and External Appeal

Enrollment in Self-Funded vs. Insured Employer Sponsored Health Insurance

Based on the Urban Institute's HIPSM modeling for 2010:

- 9,671,000 New Yorkers have employer-sponsored coverage.
- Approximately 4,293,924 NY employees are covered by self-funded plans (approximately 44%).

Health Insurance Coverage for the Nonelderly in New York (2011)

□ Employer	9,603,000	57%
□ Employer (HNY)	65,000	0%
□ Non-Group	32,000	0%
□ Non-Group (HNY)	113,000	1%
□ Medicaid/CHP	4,067,000	24%
□ Uninsured	2,724,000	16%

Adapted from “Coverage and Cost Effects of Implementation of the Affordable Care Act in New York State,” Urban Institute Health Policy Center (March 2012).



Who Bears the Most Risk?

- Risk is assumed largely by:
 - Self-funded business
 - State/Federal Government
 - Insurance carriers for large group commercial market

Financial Stability

- HMO market
 - 10NYCRR 98-1.11 – Operational and Financial requirements for HMO's
 - Contingent Reserve requirements
 - % of net premium income for the calendar year
 - Increasing amount until 12.5% with some special rules for HMOs forming after 2011

Transfer of Risk by MCO to Provider

- HMO agreements are reviewed for transfer of risk from HMO to provider
 - **Level 1:** Contracts with providers or IPAs based on FFS arrangements, including with-holds and bonuses up to 25% of the payment to the provider
 - **Level 2:** Contracts transferring risk to providers or groups of providers for a specific service they directly provide with the provider accepting all *medical risk* for that service

Transfer of Risk by MCO to Provider (cont'd)

- **Level 3:** Contracts that transfer broader risk to providers (multiple services provided directly, inpatient hospitalization, or FFS with withholds or bonuses greater than 25%)
- **Level 4:** Contracts that transfer risk to IPAs for a single or multiple services.
- **Level 5:** Contracts falling under risk level 3 or 4 that include services not provided directly (out-of-network services).

11 NYCRR 101 – Regulation No. 164

- Standards for Financial Risk Transfers Between Insurers and Health Care Providers
 - Permits transfer of risk in prepaid, “capitation” arrangements
 - Applies to HMO/Provider (IPA) arrangements

ACOs and Risk

- Different ACO scenarios:
 - ACO contracts with insurer/HMO and provides clinically integrated services for capitated payment: No insurance license required.
 - ACO contracts directly with health care purchaser and receives FFS payment with shared savings: No insurance license required.
 - ACO contracts directly with health care purchaser and receives capitated payment: Insurance license may be required.

Considerations for Delivery System Performance: Financial Stability

- Whether applicant plans to accept risk now or in the future
 - In what context?
 - Insurance model (IPA, Medical Group)
 - ACO
 - Other
 - What financial resources are available?
 - Will parent or affiliated organization bear risk for providers?
 - What markets does the provider “play” in?
 - Medicare, Medicaid, Commercial
 - Percentage of the market in each of the above categories

Considerations for System Performance: Access to Care

- HMOs required to submit network through HCS
 - Reviewed for accessibility using time/distance standards, choice
 - Lack of access to network provider requires out-of-network access.
- Other Managed Models PPO, EPO
 - Networks are not reviewed for adequacy
 - OON access, but risk lies with member for payment
- Exchanges will require network submissions, but may not include an analysis for adequacy



Considerations for Delivery System Performance: Cost and Quality

- ❑ Integrated systems have great potential to improve quality.
- ❑ May yield systems that can deliver care more efficiently and improve quality more cost effectively.

Considerations for Delivery System Performance Cost and Quality

- Risk that the delivery system may wield market power to:
 - Increase costs resulting in increased insurance premiums (affecting employers, government or individual purchasers of health insurance)
 - Decrease access by reducing competitors
- Lack of competition and shifting of risk could adversely affect quality.



Questions ?



Redesigning
THE MEDICAID PROGRAM



Public Health and Health Planning Council Meeting - Planning Committee Session

Long Term Care Policy Questions and Implications

Mark Kissinger

Director, Division of Long Term Care

July 25, 2012



Long Term Care (LTC)

- Long Term Care is costly and unwieldy
- State is a dominant player in paid care – national policy elusive
- Family or informal care is really the system



LTC in New York State

- New York is moving away from fee-for-service approach toward care management for all
- Managed Long Term Care platform is the initial approach
- Duals demonstration – important milestone for change
- Full integration of care/benefits is goal



LTC Policy Implications/Questions

- State oversight of providers/plans will evolve
- Managed care contracts become the vehicle to monitor access/quality
- Reliance on institutions will be reduced
- What is the role of residential providers (not just nursing homes)?



LTC Policy Implications/Questions (cont.)

- What is the role of the family/informal supports?
- Level of disability – can public health interventions really help?
- New York State role versus local roles
- Wide Geographic variation



Roll-Out of Mandatory Managed Long Term Care (MLTC)

- **Mandatory Population:** Dual eligible, aged 21 and over, receiving community based long term care services for over 120 days, *excluding* the following for now:
 - *Nursing Home Transition and Diversion waiver participants;*
 - *Traumatic Brain Injury waiver participants;*
 - *Nursing home residents;*
 - *Assisted Living Program participants;*
 - *Dual eligible that do not require community based long term care services.*



Roll-Out of MLTC

Phase I: New York City

- Beginning July 2012 - Any dual eligible case new to service, fitting the mandatory definition in any New York City county will be identified for enrollment and referred to the Enrollment Broker for action.
- Enrollment will be phased-in by service type by borough. People will be given 60 days to choose a plan according to the following schedule:
 - A) July 2012 – December 2012:** *Begin personal care cases in New York Boroughs, starting in New York County*
 - B) January 2013:** *Initiate enrollments citywide of long term home health care program, home health over 120 days, adult day health care program and private duty nursing cases not enrolled under personal care case activity*
 - C) February 2013 and until all people in service are enrolled:** *Personal care, consumer directed personal assistance program, long term home health care program, home health over 120 days, adult day health care program and private duty nursing cases in New York, Bronx, Kings, Queens and Richmond Counties*



Roll-Out of MLTC Final Phase

- As plan capacity is established, dually eligible community based long term care service recipients will be enrolled as follows:
 - **Phase II - V:** *Nassau, Suffolk and Westchester Counties, Long Island, Metro New York and Upstate Counties – Anticipated January 2013 – June 2014*
 - **Phase VI:** *Previously excluded dual eligible groups contingent upon development of appropriate program*



Context of Proposed Demonstration

- The capitated programs build off the mandatory Medicaid Advantage Plus (MAP) that is being implemented, includes broader benefit package while improving access and enhancing consumer protections.
- The MFFS program will build off of the Health Home program that is being implemented.
- Provides opportunity to test and evaluate fully-integrated care model.



Highlights of the Duals Demonstration

- Capitated Model (FIDA): duals requiring 120 days or more of community-based LTSS
- OPWDD pilot program for OPWDD duals (10k)
- Added Managed FFS (MFFS) approach – using Health Home for dual eligibles
- Full Demonstration proposal can be found here:
http://www.health.ny.gov/facilities/long_term_care/docs/2012-05-25_final_proposal.pdf



Redesigning
THE MEDICAID PROGRAM



New York Medicaid Redesign

Public Health and Health Planning Council Payment Reform

July 25, 2012

A blue-tinted photograph of the New York City skyline across a body of water, with the title 'Historical Payment Reform' overlaid in the center. The skyline features several prominent skyscrapers, including the Empire State Building, which is the tallest and most central structure. The water in the foreground is calm, and the sky is filled with soft, white clouds. The overall tone is professional and serene.

Historical Payment Reform



Pre-MRT Payment Reforms

- In the past 3 years, New York has shifted the operating component of the Medicaid rate from cost-based reimbursement to pricing methodologies in various sectors.
- Health Sector changes:
 - Inpatient – Rebasing/APR-DRGs (2009)
 - Outpatient/Clinic – APGs (2009)
 - Managed Care/MLTC – Regional Payment Model (2011)
 - Nursing Homes – Pricing (2012)
 - CHHAs – Episodic Payment (2012)



**Medicaid Redesign Team:
Payment Reform &
Quality Measurement
Work Group**



“It is of compelling public importance that the State conduct a fundamental restructuring of its Medicaid program to achieve measurable improvement in health outcomes, sustainable cost control and a more efficient administrative structure.” – Governor Andrew M. Cuomo, January 5, 2011

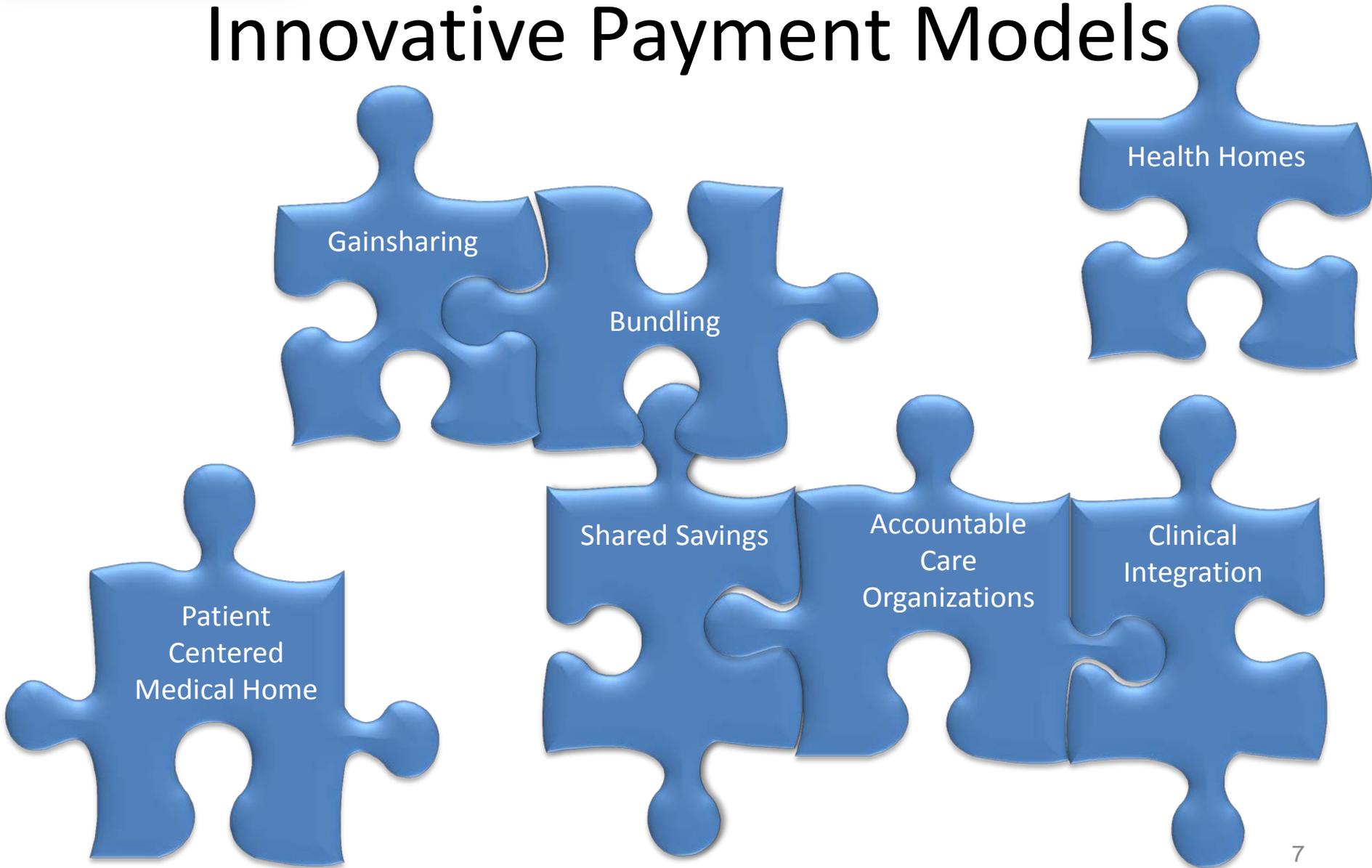


Payment Reform & Quality Measurement Goals

- On January 5, 2011, Governor Cuomo issues an Executive Order creating the Medicaid Redesign Team (MRT).
 - The MRT subdivided into 10 work groups to deal with more complex issues.
- The Payment Reform and Quality Measurement Work Group was created to develop a series of recommendations to :
 - 1) Facilitate the transformation of New York's health care system;
 - 2) Encourage the development of innovative payment and delivery models;
 - 3) Explore and identify evidence-based quality indicators to benchmark New York's Medicaid program and the provider delivery system;
 - 4) Incorporate Federal Health Care Reform's focus on the development of shared savings models, pioneer accountable care organizations, risk-sharing assumption demonstrations, clinical integration, and bundling of services and payment across traditional silos of delivery; and
 - 5) Maintain a patient-centric focus on quality improvement, care coordination and patient safety.

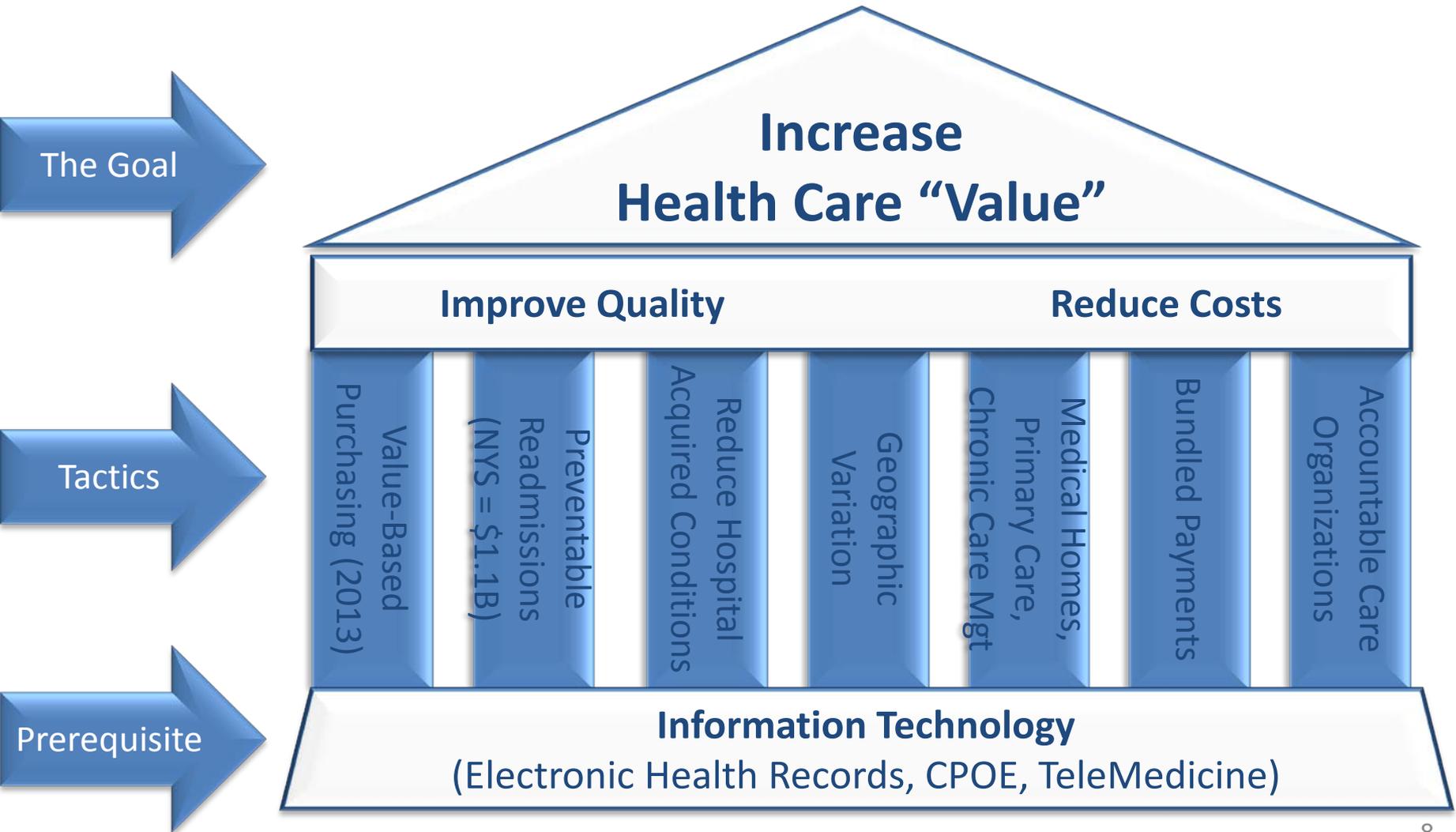


Innovative Payment Models





Builds Health Care Delivery System Reform



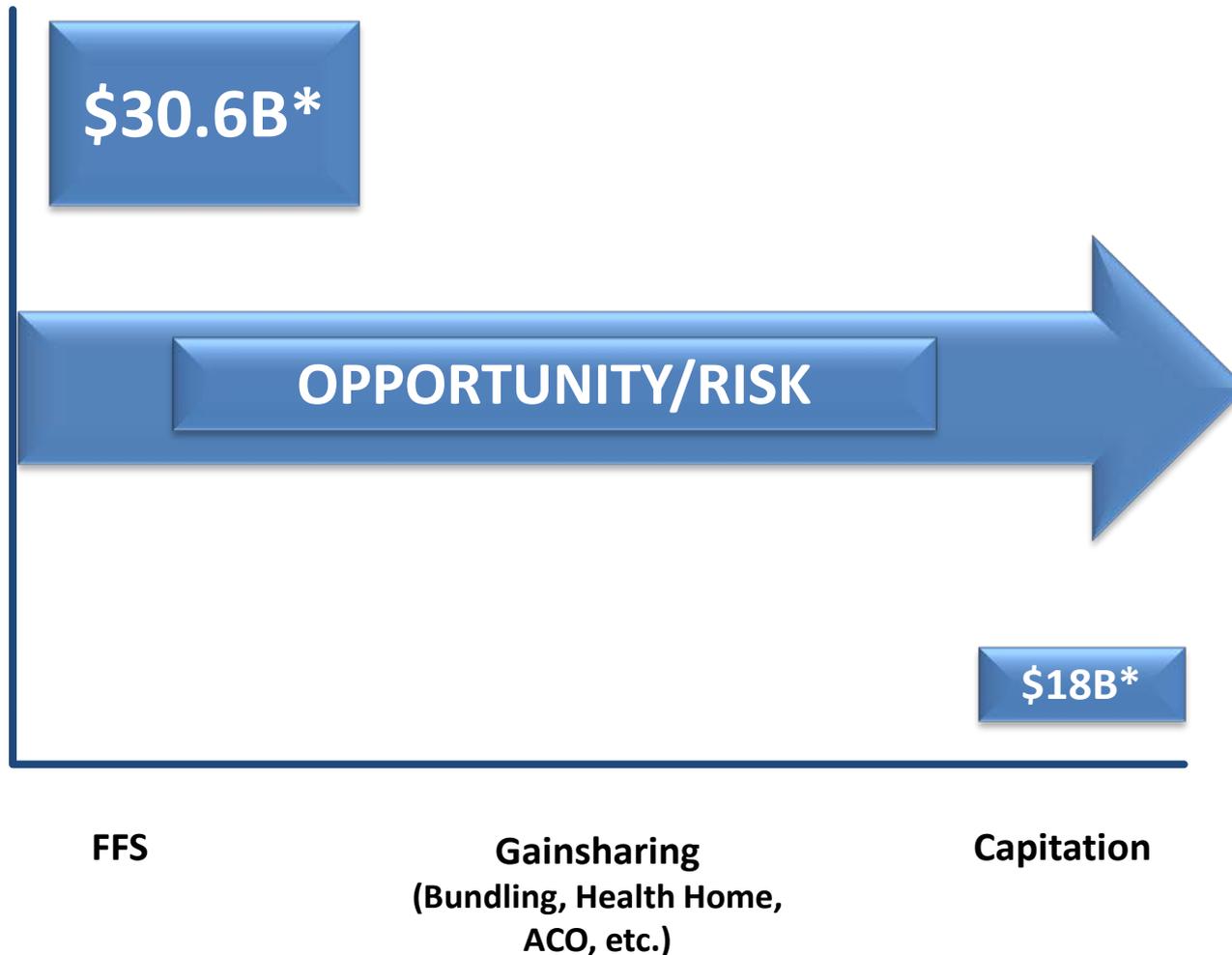


MRT Multi-Year Action Plan

- The MRT action plan, which will take five years to fully implement, is the most sweeping Medicaid reform plan in State history.
- Key elements of Plan Involving Payment Reform:
 - Global Spending Cap
 - Care Management for All
 - Health Homes, Patient Centered Medical Homes & Behavioral Health Organizations
 - Strengthening/Transforming the Health Care Safety Net
 - Supportive Housing
 - System-wide Pay-for-Performance and Quality Measures



MRT Will Provide Opportunities for Shared Savings & to Shift Risks to Plans/Providers Over the Next 3 Years



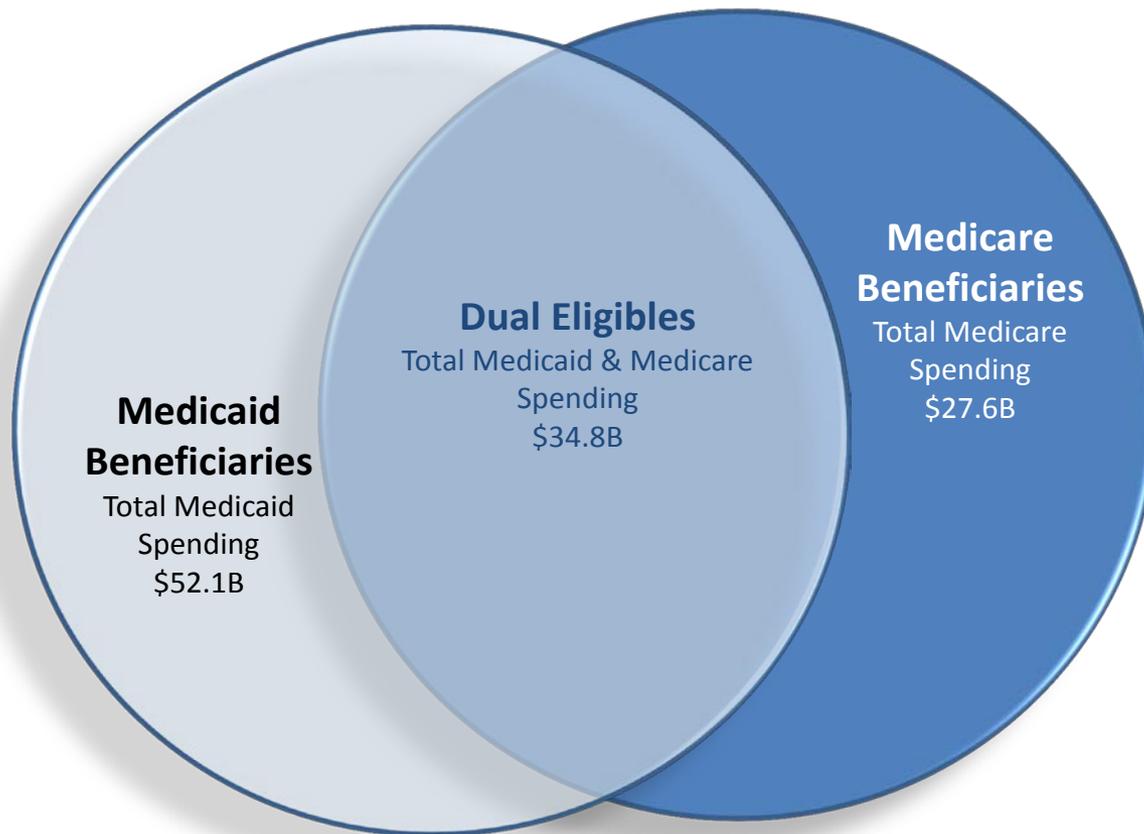
**Source: Medicaid claims data from the Salient Tool (SFY 2010-11): Managed Care: \$18 billion & FFS: \$30.6 billion. MMC (including Family Health Plus) includes drug spending that currently occurs in the FFS system. Excludes off-line payments such as DSH.*



**Long Term
Reimbursement Reforms:
High Cost Populations and
Paying for Quality**



Dual Eligible Recipients (700,000 approx.)
Comprises 45% of Medicaid Spending (\$23.4B)
Comprises 41% of Medicare Spending (\$11.4B)



Sources: Medicare – National health expenditure data (2004) trended by Medicare market basket to 2010; Medicaid – United Hospital Fund (2010) data net administration costs; Duals – Kaiser (2005) data trended by market basket to 2010 & Kaiser (2007) dual eligibles share percentage (45%) applied to 2010 Medicaid spending estimate. Note: DOH is in the process of working with CMS to update data.



Multiyear Strategy to Integrate Care for Dual Eligible Individuals

- In March 2011, NYSDOH received a planning grant from CMS to develop a demonstration proposal around integrated care for individuals eligible for Medicaid and Medicare (Dual Eligibles)
- Individuals in need of LTSS (less than 120 days) will begin to mandatorily enroll with a health plan for Medicaid starting September 2012; Medicare capitation starts January 2014 under the Fully-Integrated Duals Advantage (FIDA) program
- Managed Fee-For-Service within a health home for dual eligibles in need of behavioral health and chronic care services
- An additional, small-scale FIDA OPWDD dual eligibles demo will provide managed care to 10,000 OPWDD dual eligibles

An aerial, blue-tinted photograph of New York City. The image shows the dense Manhattan skyline on the left and right, with Central Park's greenery in the center. The Hudson River and the George Washington Bridge are visible in the background. The text "Looking Ahead: Payment Reform/Innovation" is overlaid in a bold, dark blue font across the middle of the image.

**Looking Ahead:
Payment
Reform/Innovation**



Areas of Payment Reform/Innovation Department of Health is Exploring

- Refining Risk Adjustments for Dual Eligibles Enrolled in Managed Care (3M/MEDPAC)
- Developing Health Systems Performance Incentives to Align and Reward Health Plans and Providers (3M/Mercer/DOH)
 - Possible Alliance with Commercial Payors
- Defining Both Medicaid and Medicare Gain Sharing Rules with CMS
 - New Analytic Tool That Will Allow DOH and Health Homes to Measure Patient-Centric Performance Against Benchmarks
- Explore Capital Pricing to Further Expand CON Reform



Future Role of DOH Rate Setting

- Eliminate Fee-For-Service Rate setting
- DOH Will Set “Benchmark” Rates for Managed Care Premium Setting and to Monitor Price Competition Within Markets:
 - APR-DRG Input
 - Nursing Home
 - Home Care
- Continue Working on New Payment Methods (e.g. Bundling)
- Measuring and Paying for Quality/Gain-Sharing



Quality



Measuring Quality of Care in Medicaid Managed Care

- Began in the 1994 measurement year, evolving ever since
- Quality Measures based on the national HEDIS data set, called QARR (Quality Assurance Reporting Requirements)
- Measures collected for Medicaid, commercial (HMO and PPO), and Child Health Plus
- Annual Data submission
- Audited data



Integrating Quality into Program: Progress over Time

- 1996: QARR was publically reported.
- 1997: The Quality Matrix began, which is a tool used to target measures/areas for improvement for managed care plans. Plans required to do a root cause analysis and action plan.
- 1997: Regional Medicaid Consumer Guides were developed. The Consumer Guides have been included as part of the managed care enrollment packet since 1997.



Integrating Quality into Program: Progress over Time

- 1999: Quality is incorporated into the annual surveillance of managed care plans, and quality staff participate in select onsite reviews.
- 2000: Quality measures were used to change the auto-assignment algorithm for Medicaid managed care enrollees.
- 2001: NYSDOH established a Quality Incentive, a pay for performance program for Medicaid managed care.



Integrating Quality into Program: Progress over Time

- 2001: Quality performance as measured in QARR becomes part of the expansion review policy for managed care plans.
- 2007: Managed care contracts now include a clause that NYSDOH can terminate a plan's contract if performance over a three-year period is substandard.



Improving Quality for Medicaid

- Selective Contracting
 - Bariatric Surgery
 - Breast Cancer Surgery
- Managed Long Term Care Measurement
- Measure development



New Measurements in Development

Efficiency Measurements

Preventable Hospitalizations

Potentially Preventable Readmissions

Potentially Preventable Complication

Quality Measurements

Mental Health/Substance Abuse

- Early stages of measurement development with OMH

Long Term Care

- In 2012, public release of a Managed LTC Quality Report
- Intend to align measures across LTC settings
- UAS will be the future basis for most LTC measures



Quality and MRT

- MRT Payment Reform and Quality Subgroup
- Recommendation: Adopt a series of accepted performance measures across all sectors of health, aligning measures already being collected in New York in Medicaid managed care, including managed long term care with federal requirements.



Quality and MRT

- Developed MRT Quality Measure set across all of Medicaid
 - Aligned with:
 - NYS QARR
 - Federal Meaningful use
 - CHIPRA
 - Medicaid Adult Core Set of Measures
 - Federal Health Home Measures
 - NYS Medicaid unique population
- http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrtfinalreport.pdf

A blue-tinted photograph of a city skyline. The central focus is a tall, slender skyscraper with a distinctive top section. To its right, there are several shorter, cylindrical skyscrapers. In the foreground, a large, modern, bowl-shaped structure is visible. The background shows a dense urban area with various buildings and a clear sky.

Paying for Quality



Paying For Quality: Incentives

- Medicaid Managed Care Quality Incentive
 - Reward high performing plans with up to 3% of premium
- Nursing Home Quality Pool (2012)
 - \$50M pool to begin next year
- Proposed Quality Incentive for Managed Long Term Care



Paying for Quality: Payment System Changes

- Risk-based payment systems
 - Medicaid Managed Care
 - Managed Long Term Care
 - Home Care
 - Health Home
- Payment for systems change, that will improve quality
 - Medical home enhancement
 - Meaningful use (CMS) payment



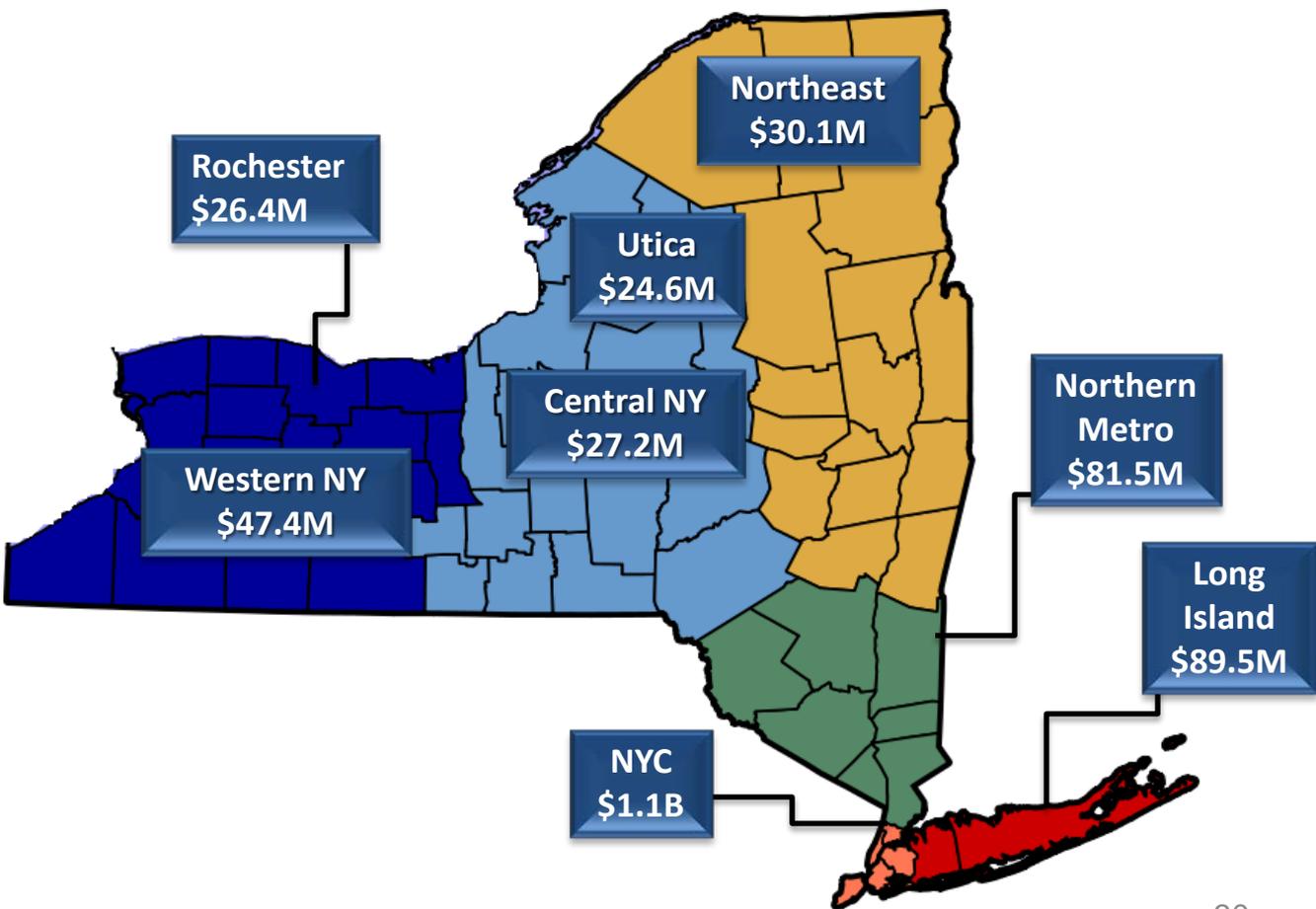
Paying For Quality: Disincentives

- Reduction of capitation payments for poor quality, efficiencies gained on reducing:
 - Avoidable Hospitalizations
 - Potentially preventable readmissions (PPRs)
 - Potentially preventable complications (PPCs)
- FFS hospital payments reduced for high rates of :
 - PPRs
 - PPCs



Total Inpatient Medicaid Spending Related to PPAs and PPRs (Statewide Total = \$1.4B)

	PPAs	PPRs
NYPHRM-R:	(per 100 admissions)	
Long Island	15.3	6.7
NYC	18.5	7.7
Northern Metro	13.6	6.4
Northeast	13.9	7.5
Utica	13.8	6.3
Central	13	5.9
Rochester	12.3	6.2
Western	13.2	6.4
Statewide	16.8	7.3



*Data Source: 2008 SPARCS; FFS and MMC; Includes Behavioral Health admissions



United Hospital Fund

***Trends and Changes in New York's
Health Care Delivery System
and Payment Systems:
Implications for CON and Health Planning***

Gregory C. Burke

Director, Innovation Strategies

Presentation to the Planning Committee of the

Public Health and Health Planning Council

July 25, 2012

Goals of Presentation:

- *Describe trends in*
 - *Health system organization and performance*
 - *Payment systems*
- *Discuss implications of those trends*
 - *For the delivery system*
 - *For NYS' regulatory priorities and tools.*

Organization of the Discussion

- ***Some Game-Changers***
- ***The Vision:***
 - *What we're trying to achieve*
 - *Levers of Change*
- ***Trends and Changes:***
 - *Payment System*
 - *Acute Care Delivery System*
 - *ACO's*
 - *Long-Term Care*
- ***Implications***
 - *Some Scenarios and Issues for the State*
 - *Role and Purpose of CON – Now and in Future*
- ***If Not (Only) CON, What Else?***
 - *Other State Imperatives and Tools*
 - *Role of Regional Planning*

Some Game-Changers

Cost

Population Health

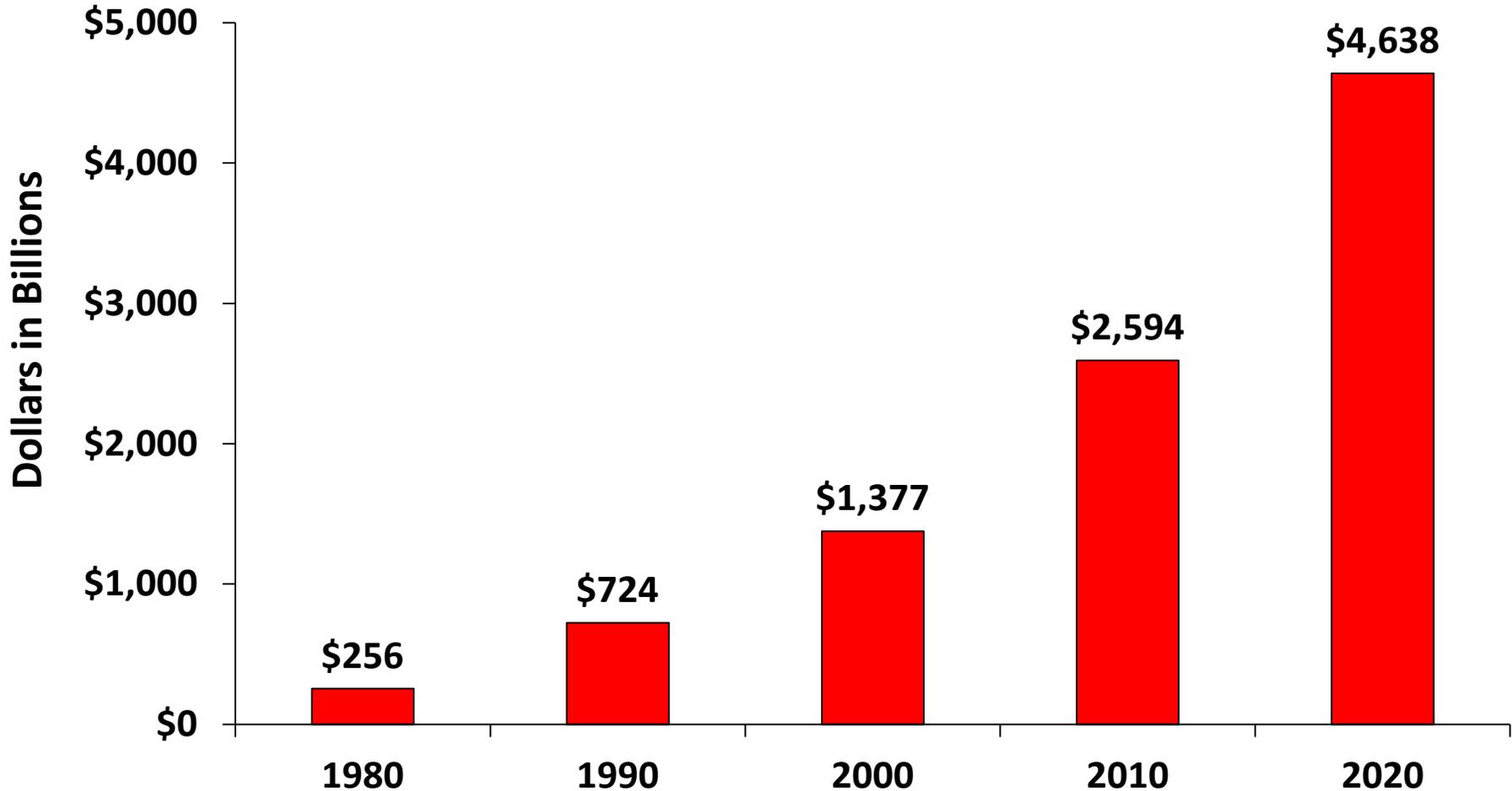
HIT

Evidence-Based Medicine

Patient Engagement

Cost: The compelling priority

U.S. National Health Expenditures: 1980–2020

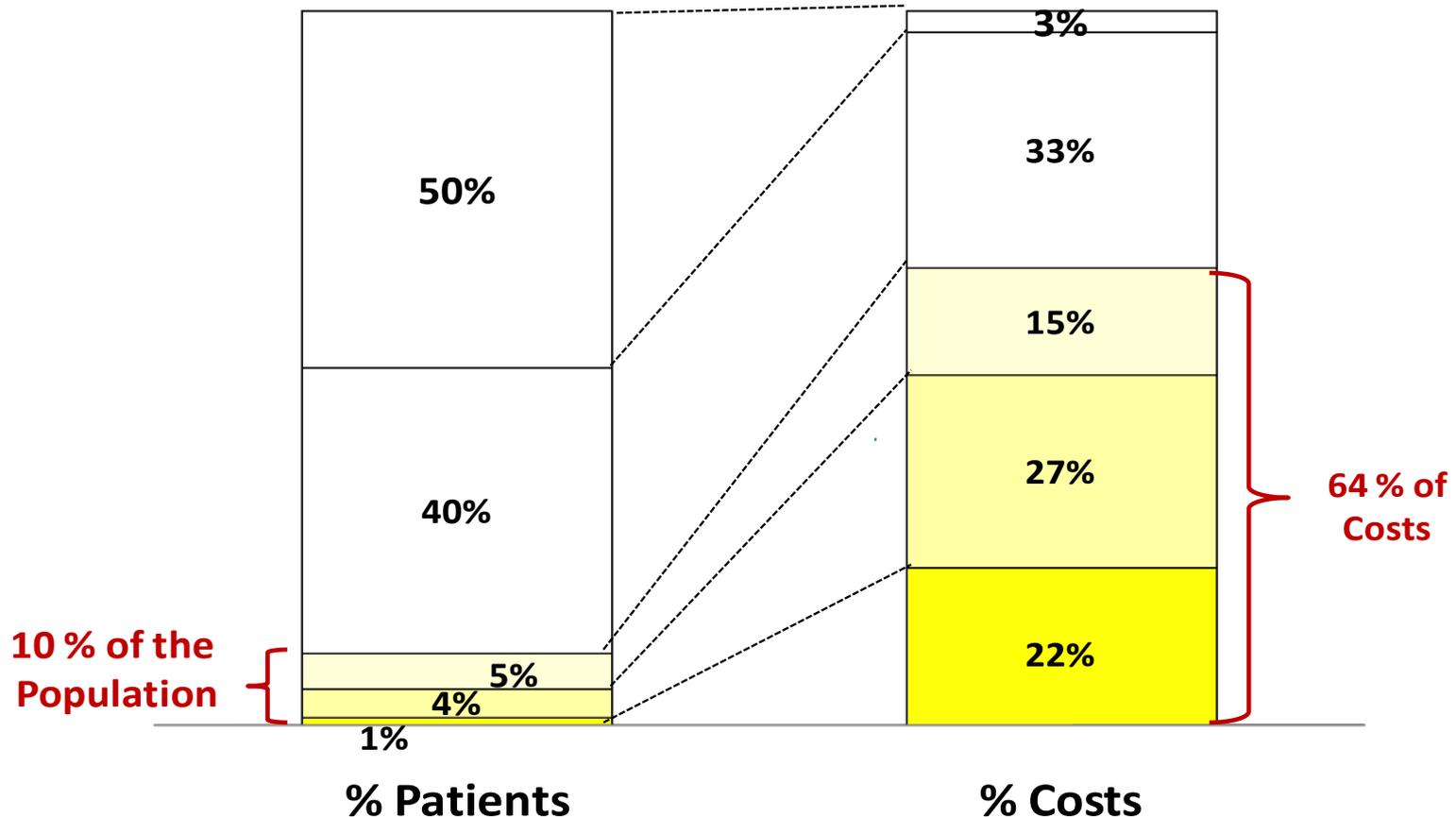


Source: United Hospital Fund analysis of CMS National Health Expenditure data.

Note: Expenditures in 2020 are projected.

The Data Suggest Where We Might Focus

Small Populations Account for a Disproportionate Share of Health Care Costs



Cohen, S. and Yu, W. *The Concentration and Persistence in the Level of Health Expenditures over Time: Estimates for the U.S. Population, 2008–2009. Statistical Brief #354. January 2012. Agency for Healthcare Research and Quality, Rockville, MD.*

http://www.meps.ahrq.gov/mepsweb/data_files/publications/st354/stat354.shtml

What do you mean, “Population Health”?

- ***Geographic***
- ***Utilization Segments***
- ***Purchasers and Payers***

Population Health – Utilization Segments

Different Health Status

*Population Segments Differ, in Term of
What Services They Use, and How Much*



The “Well”



The Acutely-Ill



The Chronically-Ill



Population Health – Insurance Segments

Medicare, Medicaid, Commercial

- **Cover Different Populations:**

- *Medicare: The young-old, the old-old, the disabled*
- *Medicaid: The poor, those w behavioral health problems and those requiring long-term care (LTC)*
- *Dual-eligible: Disabled, old and poor, also LTC*
- *Commercial: The employed-insured, and their families (some retirees)*
- *Uninsured*

- **They have some of the same, and some different issues**

- **Similar:**

- *Chronic disease, prevention/wellness, “preventable” admissions*
- *Need for primary care, care management for complex patients*

- **Different:**

- *Impact of demographics, and social determinants on health and disease*
- *“Pain-points” – who are their “high-cost patients”, cost-drivers*
- *Parts of the health system they need, and use*
- *Points of leverage, and interventions*

Impact of Advances in Health Information Technology

- ***“On-line”: Operations improvement***

- *EMR’s and e-prescribing → improved quality and safety*
- *Registries → targeted care management*
- *RHIOs → communication, care coordination among providers*
- *Telemedicine and remote monitoring → access, care management*
- *Patient “connectivity” → patient engagement*

- ***“Off-line”: Increased Accountability, Transparency***

- *Data-mining of claims and EMR data*
- *Can “attribute” patients, populations to providers, networks*
 - *Measure their care quality, outcomes, use and cost*
 - *And “attribute” it to specific providers and systems*
- *Can measure, analyze, report and compare performance among providers/networks*

Impact of HIT

- **HIT Meets Evidence-based Medicine**
 - “Best practices” and Guidelines → “benchmarks”
 - “On-line”: EMR’s, can prompt/ influence provider behavior
 - “Off-line”: can assess performance vs. standards
- **Enables**
 - Providers/systems to focus QI
 - Purchasers, payers to identify/reward performance
 - Public reporting, transparency to consumers/patients
- **Connecting patients with their own care**
 - Patient portals, and e-communications improve access
 - Smart-phones and web

“Patient Engagement”

- ***Patient Experience***
 - *Measured, reported, a factor in Value-Based Purchasing*
 - *The Q: What do people want?*
 - *A relationship; help with care coordination; to be heard, involved*
- ***Patients as Partners in their own care***
 - *Education, involvement, empowerment*
 - *Critical to chronic disease management*
- ***Patients as informed consumers of health care***
 - *Selecting providers on basis of quality and cost*
 - *Increased cost-sharing and “Consumer Choice” plans*
 - *Changing expectations and demands*
 - *“Choosing wisely”*

The Vision

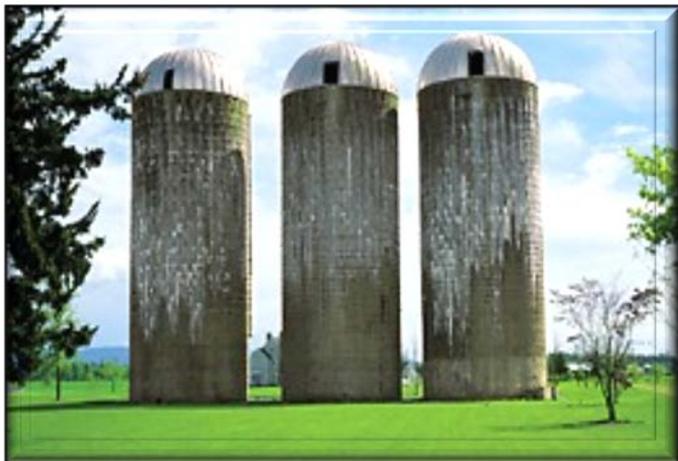
Where we are

Where we think we want to go

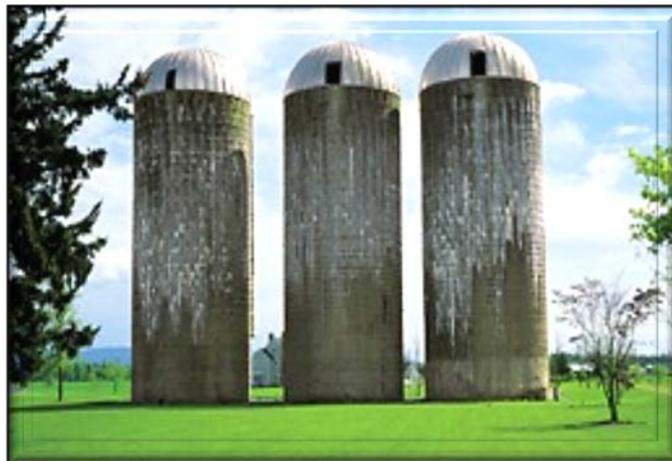
The levers of change

The Delivery System: Where We're Starting

Acute Care Delivery System



Long Term Care System



Behavioral Health System



The Vision

A High-Performing Delivery System

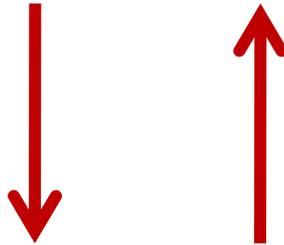
- **Integrated Delivery System:**
 - “An organized network of health care providers that provides or arranges to provide a coordinated continuum of services to a defined population and is willing to be held clinically and fiscally accountable for the outcomes and health status of the population served.” (Shortell, 1996)
- **Pursuing the Triple Aim**
 - Better Care, Better Population Health, Lower Costs
- **Across the Delivery System**
 - Primary Care
 - Specialty Care
 - Behavioral Health Care
 - Urgent and Emergent Care
 - Inpatient Acute Care
 - Home Care and Nursing Home Sub-Acute and
 - Long-Term Care

Improving Performance:

Improving Care and Population Health, Reducing Costs

Regional Populations / Segments

Characteristics, Risk, Burden of Disease



Health Care Delivery System

The Goal:

- To improve the Performance of Regional Delivery Systems, and***
- How they respond to the needs of the communities they serve***

The Importance of the Payment System

Incentives, Disincentives Drive Behavior

Regional Populations / Segments

Characteristics, Burden of Chronic Disease

***Payment
Systems
and Incentives***



Health Care Delivery System

Trends

Purchasers/Payers

Acute Care System

ACO's

Long-Term Care

Purchaser/Payer Trends

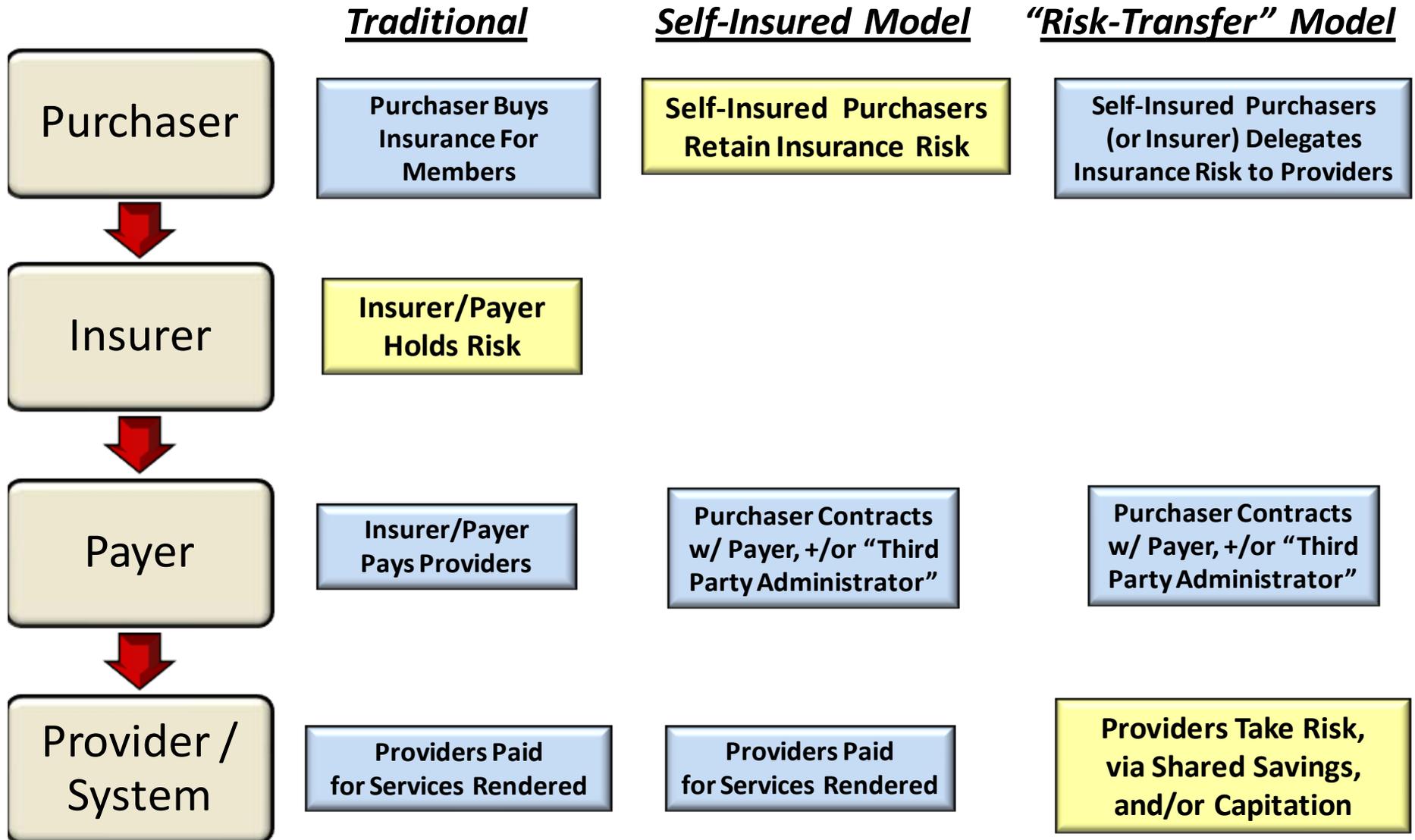
- **The Performance Imperative:**
 - *Manage premium costs / Total health care spend*
- **How:**
 - *Prevention/Wellness*
 - *Reducing “Potentially Preventable Events”*
 - *A New Emphasis on Primary Care*
 - *Chronic Care Management*
 - *Care Management for high-risk, high-cost patients*
 - *Patient Engagement*
- **Measuring, analyzing provider behavior**
 - *Attribution of patients/populations to providers/groups*
 - *Analyzing process, outcome measures*
 - *Identifying “high-performing” providers/systems*
- **Driving business to high-quality, low-cost providers**
 - *Identifying providers with those characteristics*
 - *Offering members different products: “Tiered networks”, w premium differential*
- **Sharing/shifting risk to members – incent cost-conscious behavior**
 - *Point of sale – co-pays and deductibles*
 - *High-deductible plans, w HSAs*

Purchaser/Payer Trends

- **Changing Incentives: FFS → Buying Quality, and Value**
 - Increasing payments for primary care, additional PCMH payments
 - P4P
 - Medicare VBP system
 - Readmissions penalties
- **Buying care management**
 - PCMH
 - Health Homes
 - MLTC
- **Changing business model**
 - Offering self-insured employers “ASO” services
 - Offering providers data/analytics “back-room”
- **Partnering with Providers**
 - Tiered networks – channeling volume to high-performers
 - Accountable care arrangements
 - Co-branding
- **Risk-sharing/transfer to providers**
 - Bundling
 - Shared savings
 - Shared/delegated risk

Insurance/Payment System Changes

Who Holds the Insurance Risk?



Provider System Trends

- ***The Performance Imperative: (the Triple Aim)***
 - *Improve quality and safety*
 - *Reduce unit costs*
 - *Improve patient experience*
- ***Accountability - Performance can be***
 - *Attributed to specific providers, networks*
 - *Measured, analyzed, compared to benchmarks*
 - *Rewarded, and punished*
- ***“Where the puck is going to be”***

An “ambulatory care-centric” delivery system, managing quality, cost and patient experience for patients and populations, across the continuum

Provider System Trends

The Performance Imperative

- **What:**
 - *Access*
 - *Coordination*
 - *Quality/Safety*
 - *Patient Experience*
 - *Utilization and Costs*
- **How:**
 - *Process and practice redesign → evidence-based approaches*
 - *A Focus on Population Health*
 - *Using HIT to support performance improvement*
- **Where**
 - **Within** *a given provider's sites and services*
 - *Cost management initiatives*
 - *Quality improvement collaboratives*
 - *A focus on the patient experience*
 - **Between and among** *parts of the delivery system*
 - *Managing utilization and costs, across providers/levels of care*
 - *Coordinating and managing referrals*
 - *Transitions of care*

Provider System Trends

- ***New competencies***
 - *Understanding, managing “total costs of care”*
 - *Population health management*
 - *Chronic disease management*
 - *Care management, across the continuum*
 - *Patient engagement*
- ***New program models***
 - *Patient-Centered Medical Homes*
 - *Health Homes*
 - *Integrated delivery systems*
- ***The importance of scale***
 - *Required to support new infrastructure*
 - *HIT – EMRs, registries, RHIOs*
 - *Care management*
 - *Patient education and engagement*
 - *Ability to track and manage utilization, and costs*
 - *Ability to measure, report performance*
 - *Needed to participate in new models, payment schemes*

Provider System Trends

New Organizational Models

- ***Consolidation/Integration***

- ***Horizontal: Among providers of the same service***
 - ***Purpose: to achieve scale, gain economies***
 - ***Examples:***
 - ***Primary care, Specialty care groups***
 - ***Hospitals***
 - ***Home care***
- ***Vertical: Across different parts of the delivery system***
 - ***Purpose: Manage, improve care, across delivery system***
 - ***Examples:***
 - ***Multi-Specialty Groups and IPAs***
 - ***Physicians partnering with/employed by hospitals***

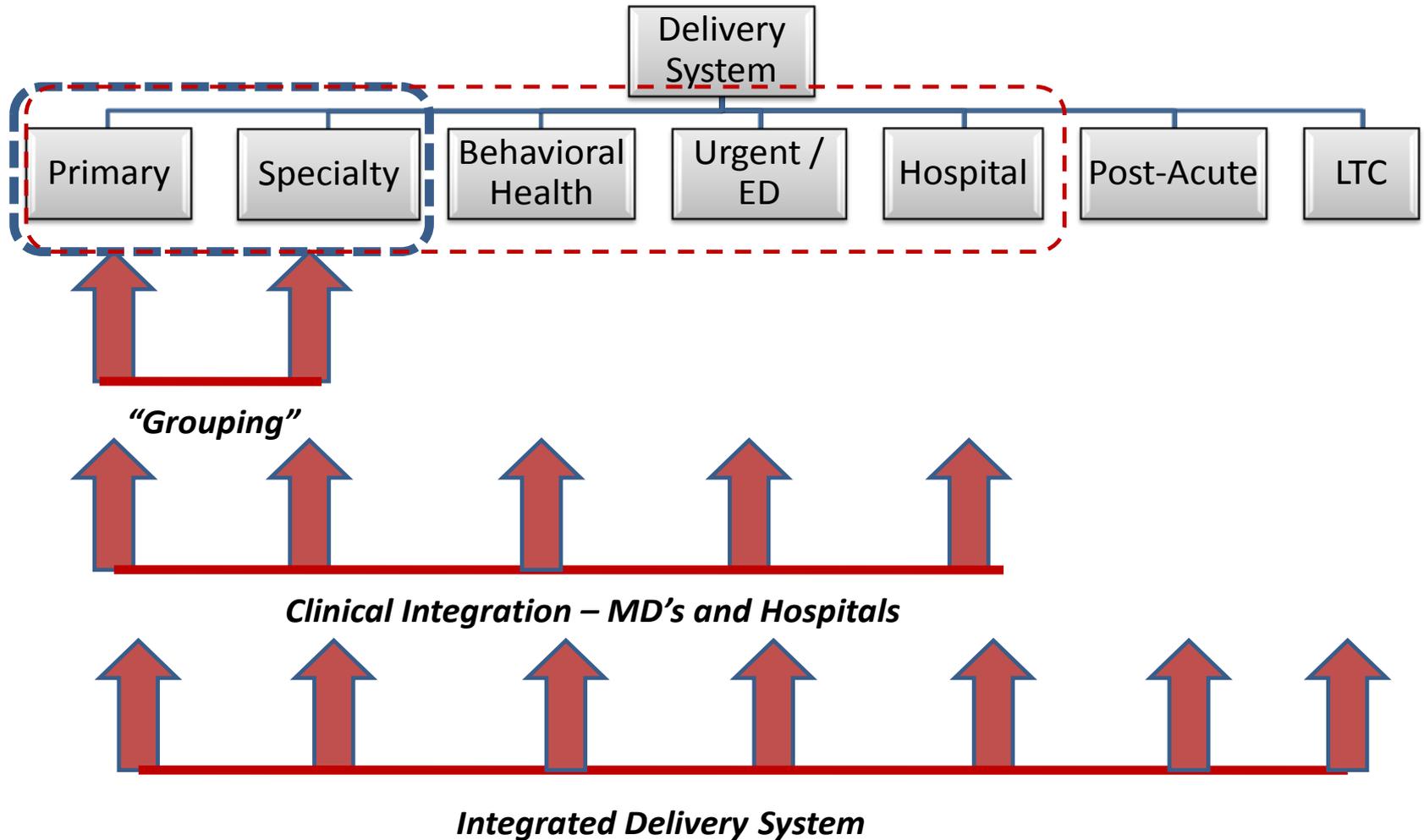
- ***New Organizational Forms and Relationships***

- ***Physicians “grouping” into MSGPs and IPA’s***
- ***Physicians employed by / partnering with hospitals***
- ***“Health Systems”***

- ***Growth of Regional Integrated Delivery Systems***

- ***Purpose: Gain scale, Manage Population Health***

Integrating the Delivery System



Accountable Care

- **Defined:**
 - *Partnership between organized group of providers and a purchaser or payer to accept responsibility for care and costs of a defined population*
 - *By definition, a contract between a (single) payer and a provider group*
- **Approaches**
 - *Basic idea: Health Care “on a budget”*
 - *If “total health care spend” < Target, providers get to retain some or all savings*
 - *Focus:*
 - *Managing a population’s total per-capita costs of care (Insurance POV)*
 - *Target: The “preventable’s” – particularly hospital admits*
 - *Risk-sharing Models*
 - *Shared savings only*
 - *Shared risk*
- **Organizational Models for Contracting**
 - *With organized physician groups (MSGP or IPA)*
 - *With Integrated Delivery Systems*
- **Implications of Risk-Sharing Varies by Model**
 - *Shared savings has little/no down-side risk*
 - *Risk-transfer has downside risk*
 - *Implications different for provider contracting w payer, vs. w an employer/purchaser*

Medicare ACO's in New York

Medicare Pioneer ACOs (N=32)	Location
<i>Bronx Accountable Healthcare Network (BAHN)</i>	<i>Bronx, Westchester</i>
Shared savings ACOs, round 1 (N=27)	
<i>Accountable Care Coalition of Mount Kisco, LLC</i>	<i>Westchester</i>
<i>Crystal Run Healthcare ACO, LLC</i>	<i>Middletown, NY</i>
<i>Accountable Care Coalition of the North Country, LLC</i>	<i>Canton, NY</i>
<i>Chinese Community Accountable Care Organization</i>	<i>New York, NY</i>
<i>Catholic Medical Partners</i>	<i>Buffalo</i>
Shared savings ACOs, round 2 (N=89)	
<i>Accountable Care Coalition of Syracuse, LLC,</i>	<i>Syracuse</i>
<i>WESTMED Medical Group, PC,</i>	<i>Westchester</i>
<i>ProHEALTH Accountable Care Medical Group, PLLC,</i>	<i>Nassau</i>
<i>Mount Sinai Care, LLC,</i>	<i>NYC</i>
<i>Balance Accountable Care Network/Independent Physicians ACO</i>	<i>NYC</i>
<i>Beacon Health Partners, LLP,</i>	<i>Lake Success</i>
<i>Healthcare Provider ACO, Inc.,</i>	<i>Garden City</i>
<i>Asian American Accountable Care Organization,</i>	<i>NYC</i>
<i>Chautauqua Region Associated Medical Partners, LLC,</i>	<i>Jamestown</i>

Examples of ACO Relationships with Commercial Insurers

- ***Westmed Medical Group:***
 - *Accountable care contracts with both Cigna and United Healthcare/Optum.*
- ***Weill Cornell Physician Organization:***
 - *Partnering with Cigna on a Collaborative Accountable Care initiative*
- ***Kaleida Health:***
 - *Accountable care initiative with BlueCross BlueShield of Western New York.*
- ***Montefiore :***
 - *Managing care of Emblem Health members under full-risk capitation contract*
- ***Participating in Premier's ACO Implementation Collaborative:***
 - ***Rochester General Health System / GRIPA***
 - ***North Shore - Long Island Jewish Health System***

LTC Providers

A Foot in Two Worlds

A Mixed Model, Different Populations, Products, and Payers:

	Sub-Acute Care (All Payers)	Long-Term Care (Mostly Medicaid)
Home Health	Post-acute Homecare	Long-Term Community- Based Care
Nursing Homes	Post-Acute Institutional Care	Long-Term Nursing Home Care

Long Term Care

- **The Performance Imperatives:**
 - *Improve quality, patient experience, cost*
 - *In sub-acute care: reduce readmissions*
 - *In LTC: Improve quality, safety, maintain function, and quality of life*
- **The Focus:**
 - *Improve Quality, Reduce hospital use by Medicaid, Duals in LTC*
 - *But, for dual-eligibles, that only benefits Medicare*
 - *Expand use of community based care alternatives*
 - *Build Community Care Systems*
 - *Close connection with other social/supportive services*
 - *Limited by availability (affordability) of supportive housing*
- **Consolidation/Integration?**
 - *Horizontal*: *Historically, more in Home Health*
 - *Vertical*: *Providers of LTC partnering → LTC Systems*
 - *With each other, integrating levels of care*
 - *With managed care plans - MLTC*
 - *With housing initiatives – Assisted Living*
 - *With community-based services*

The Long Term Care System

- **The Challenges:**

- LTC system includes very high-cost patients
- It is essentially “owned” by Medicaid
- Institutional LTC system under financial stress
 - Substantial pent-up capital needs, and Medicaid still pays for capital
- Both LTC sectors serve many dual-eligibles
 - But Medicare pays only for acute care and limited post-acute services
 - FIDA would combine Medicare w Medicaid in unified managed care program
- Both LTC sectors generate “preventable” admits

- **The Initiatives**

- MLTC
 - MLTC consolidates variety of programs into unified managed care program
- FIDA
 - Initial focus on Medicaid and dual-eligibles living in community
 - Future option to extend FIDA, for duals, to nursing homes
- CMS initiatives focusing on LTC and Community Care
 - Increasing payment for community-based care
 - Reducing hospital admits by nursing home residents

Summary : Trends and Changes Under Way

- **Some of the drivers**
 - **Costs**
 - **HIT**
 - **“Population Health”**
 - **“Evidence-Based” Care**
 - **Patient engagement**
- **Delivery and payment systems are clearly changing**
 - **Providers:**
 - **The “Performance Imperative”**
 - **“Grouping” into systems, new models for organizing and delivering care**
 - **Managing populations’ health, accepting performance-based risk**
 - **Payers**
 - **Buying value, incenting quality and cost-effectiveness**
 - **Partnering with providers, to improve performance, for their “covered lives”**
- **Not an “on-off” switch, a rheostat**
 - **Different communities moving at different speeds**
 - **Some will get “there” sooner than others**
 - **Meanwhile, the “old” ways and behaviors will remain**
 - **FFS payments**
 - **Specialty-driven**

Implications

Scenarios

Issues

CON: Then, Now, and Future

Where to, from here?

Some Scenarios for the future?

It Depends...

- **On how strong financial / performance improvement incentives prove to be**
 - *Near-term, a mixed model, FFS + VBP*
 - *Old revenue-seeking, volume-seeking behaviors are burned-in, will be hard to change*
 - *“Managing in the middle” is tough, providers taking steps to reduce their own revenues*
 - *Is a multi-payer alignment of incentives needed, achievable?*
- **On how well physicians (and hospitals) can work together, as systems**
 - *Will they be able to overcome old behaviors, to increase FFS revenues?*
 - *Will they collaborate, or - in a constrained fiscal environment - compete?*
 - *Will they be able to create effective systems of care?*
 - *Who leads, who follows: Hospitals, physician groups*
- **On where you are, in the state (resources, needs, issues differ)**
 - *Rural*
 - *Suburban*
 - *Urban, multi-hospital/multi-system*
 - *NYC*
- **On what time frame you’re looking at**
 - *Near-term – 1-2 years*
 - *Intermediate term – 3-5 years*
 - *Longer-term*

Some Risks to be Considered in This New World

- ***As the new systems get stronger → the only game in town***
 - *Market power => price increases*
 - *How well will they include the uninsured, underserved*
 - *What to do about providers that are “left out”?*
- ***The weak increase in number and fragility***
 - *If and as hospitals close, how deal w jobs, and “stranded capital”*
- ***Systems are not just NY-based providers***
 - *Border counties already dealing w out-of-state partners*
- ***If and as systems take on risk,***
 - *Who’s watching the impact*
 - *How and by whom is that regulated?*
 - *What to do when systems “too large to fail”, do?*
- ***In a competitive market (2+ systems competing)***
 - *On what basis are they competing?*
 - *Who manages the conflict?*
 - *Who watches the public goods?*
- ***As physician groups move into accountable care...***
 - *Who watches, analyzes, reports on, regulates their activities?*

CON - A “supply-side” intervention

- **CON’s Foundations:**
 - **Protect the public’s health**
 - *Assure character and competence*
 - *Limit diffusion of services where strong volume-quality relationship*
 - *Distribute services, based on Need*
 - *Protect “safety net” providers and vulnerable populations*
 - **Protect the public’s purse**
 - *Constrain, manage capital spending (Capital Reimbursement)*
 - *Manage supply of beds, high-tech equipment against “need” (FFS system)*
- **Focus: Capital Projects and Service Changes**
 - *Reactive process: First, providers must apply for CON approval*
 - *Focus: capital projects and service changes, in state-licensed facilities and services*
 - *For each project, review of four key elements*
 - *Need, Character/Competence, Financial Feasibility, Code Compliance*
- **Perceptions of the effectiveness/impact of the CON vary**
 - *Impact on quality and cost control debatable*
 - *But, CON is “the cop on the beat”*
 - *Limits “destructive competition”*
 - *We still have “market failures”*
 - *Needed providers at risk, and failing*
 - *Populations at risk, and disparities*

A Changing System

Demand-side Interventions

- **Delivery system changes**
 - From hospital-centric to ambulatory care-centric systems
 - New organizational forms, including physician groups accepting risk
 - Managing care and reducing preventable use of hospitals, specialty care
- **Payment system changes**
 - No cost-based capital reimbursement (except Medicaid, for now...)
 - FFS being replaced by “value-based” payment systems
 - Incentives to provide quality care, cost-effectively
 - Dis-incentives to over-use, with a sharp focus on “preventables”
- **HIT and public reporting: increased transparency**
 - Quality, cost reporting of providers’ and systems’ performance
- **Purchasers, payers provide incentives to patients / “members”**
 - To select and use high-quality, cost-effective providers/systems
 - To participate in wellness programs, and avoid unnecessary utilization
- **The net effect (in theory):**
 - Increased demand for organized ambulatory care (mostly non-Article 28)
 - Reduced use of / spend on hospitals, ED’s, specialty care
 - Increasing concerns about financial viability of hospitals

What do we need CON for, Going Forward?

- 1. To assure projects, services, facilities are “needed?”*
- 2. To manage distribution of services, control unbridled competition?*
- 3. To assure adequate character and competence?*
- 4. To control capital costs?*

What do we need CON for, Going Forward?

- 1. *To assure projects, services, facilities are “needed?”***
 - In future, facilities/services will drive costs more than revenues*
 - In interim (as FFS-skewed payment systems wind-down) may be an issue*
 - Competition for volume may drive unnecessary development*

- 2. *To manage distribution of services, control unbridled competition?***

- 3. *To assure adequate character and competence?***

- 4. *To control capital costs?***

What do we need CON for, Going Forward?

- 1. To assure projects, services, facilities are “needed?”***
- 2. To manage distribution of services, control unbridled competition?***
 - Legitimate issue, as strong systems get stronger***
 - Future issues may be more about***
 - Reduction/closure of inpatient services and facilities***
 - Location and access to ambulatory care facilities***
 - An issue for regional planning?***
- 3. To assure adequate character and competence?***
- 4. To control capital costs?***

What do we need CON for, Going Forward?

- 1. To assure projects, services, facilities are “needed?”*
- 2. To manage distribution of services, control unbridled competition?*
- 3. To assure adequate character and competence?*
 - Clearly important, but an establishment/ licensure function*
 - Issues:*
 - New organizational models, beyond current scope of Article 28*
 - Out-of state providers/systems partnering w NYS physicians, facilities*
 - Physician organizations accepting risk*
- 4. To control capital costs?*

What do we need CON for, Going Forward?

- 1. To assure projects, services, facilities are “needed?”*
- 2. To manage distribution of services, control unbridled competition?*
- 3. To assure adequate character and competence?*
- 4. To control capital costs?*
 - Less of an issue, going forward, since capital is increasingly tight*
 - Less incentive to over-do projects, w/out capital reimbursement*
 - Less incentive to over-build, as FFS-driven utilization declines*
 - But, competition for volume may drive unnecessary development*
 - In LTC, nursing home renovations are a real issue*

What do we need CON for, Going Forward?

- 5. To manage utilization and costs?*
- 6. To assure that institutions don't take on non-feasible projects, that could destabilize institutions?*
- 7. To improve quality?*
- 8. To assure that capital projects meet code requirements?*
- 9. To improve access, and reduce disparities?*

What do we need CON for, Going Forward?

5. To manage utilization and costs?

- CON's role is based on Roemer's Law*
- But payment system changes likely to be better at that*

6. To assure that institutions don't take on non-feasible projects, that could destabilize institutions?

7. To improve quality?

8. To assure that capital projects meet code requirements?

9. To improve access, and reduce disparities?

What do we need CON for, Going Forward?

5. To manage utilization and costs?

6. To assure that institutions don't take on non-feasible projects, that could destabilize institutions?

- Mgmt, boards and lenders are likely to be more conservative***
- Future issue will likely be more focused on institutional financial viability***

7. To improve quality?

8. To assure that capital projects meet code requirements?

9. To improve access, and reduce disparities?

What do we need CON for, Going Forward?

5. To manage utilization and costs?

6. To assure that institutions don't take on non-feasible projects, that could destabilize institutions?

7. To improve quality?

- CON's impact on quality is unclear*
 - Strongest case has been in volume-quality-sensitive services*
- Changes in quality reporting, analysis, coupled with regional planning, and payment system incentives may be more effective approach*

8. To assure that capital projects meet code requirements?

9. To improve access, and reduce disparities?

What do we need CON for, Going Forward?

- 5. To manage utilization and costs?*
- 6. To assure that institutions don't take on non-feasible projects, that could destabilize institutions?*
- 7. To improve quality?*
- 8. To assure that capital projects meet code requirements?*
 - May be other/better ways to do that, via architectural review , “licensure”*
- 9. To improve access, and reduce disparities?*

What do we need CON for, Going Forward?

5. To manage utilization and costs?

6. To assure that institutions don't take on non-feasible projects, that could destabilize institutions?

7. To improve quality?

8. To assure that capital projects meet code requirements?

9. To improve access, and reduce disparities?

- CON's effectiveness is unclear*
- Insurance, access and attention to social determinants better*
- Regional Planning may have a role, here*

Where To, From Here?

- *There are risks inherent in all this change*
- *The State's role:*
 - *To protect its citizens, and*
 - *To help shape the systems that serve them*
- *Need to focus where “the market” traditionally fails*
 - *Fragile providers, systems and populations*
 - *Safety net providers and rural hospitals*
 - *At-risk populations*
 - *The State has a number of tools available*
- *The Role of CON*
 - *Long-term, questions about its relevance as currently constructed*
 - *Intermediate-term, may need it, to protect against unintended consequences*
 - *Need to focus CON where it matters, where it can make a difference*

If Not (Only) CON, What Else?

Other Tools
Regional Planning

Some Other Tools Available to the State

- *Health information technologies*
 - *Collect, analyze, benchmark, report performance*
 - *All-Payer Database*
- *Finances, payment systems and targeted grants*
 - *Stimulate , incent, reward positive delivery system change*
 - *Tracking financial status of providers, and systems*
- *Licensure, surveillance, reporting*
 - *Character, competence, performance*
- *Insurance coverage, and the regulation of plans, and risk*
- *State-level and regional planning*

Future of Regional Health Planning

The State Health Improvement Plan

- Well-grounded and focused Public Health Plan***
- Focused on key determinants of health and disease***

Proposed Priority Areas

Prevent Chronic Diseases

Advance a Healthy Environment

Promote Healthy Mothers, Healthy Babies,
Healthy Children

Prevent Substance Abuse, Depression, and
other Mental Illness

Prevent HIV, STIs and Vaccine Preventable
Diseases

Future of Regional Health Planning

- ***NYS is articulating priorities for the delivery system***
 - *What issues, imbalances, goals, priorities, statewide?*
 - *What expectations of the delivery system?*
 - *What expectations of payers?*
- ***Regional Planning***
 - *All health care is, in fact, local*
 - *Needs, resources, communities vary greatly, across regions*
 - *Local and regional constituencies for delivery system change*
 - *Providers, purchasers, payers, communities*
 - *Core functions of regional planning*
 - *Data, analytics, reporting, benchmarking*
 - *Identifying local/regional issues – quality, access, cost*
 - *Convening, focusing attention, setting agenda, building momentum*
 - *Crafting local responses to local issues, including community resources*
 - *State support for regional planning*
 - *Framework and overall priorities*
 - *Data and analytics support*



United Hospital Fund

***Community Health Planning
Perspectives and Opportunities***

James R. Tallon

President, United Hospital Fund

***Presentation to The Planning Committee of the
Public Health and Health Planning Council
September 5, 2012***

Community Health Planning Defined

- *“The deliberate pursuit of improvements in health status of a community, or in the efficiency of the health care system, through a public process that allows all members of the community to have significant input.” (UHF Report, 2008)*
- **Key elements:**
 - **Purposeful:**
 - *Understanding where we are,*
 - *Deciding where we should be going*
 - **Focused on improving:**
 - *The health status of populations and communities*
 - *The performance, efficiency of the health care system*
 - **Public process, with community input**

Additional Regional Actors

- ***Regional Quality Improvement Collaboratives***
- ***MRT, ACA programs and demonstrations***
- ***SHIN-NY, RHIOs***

A Brief History

- *Ancient times (1940's – 1990's)*
- *Recent times*
 - *Berger Commission*
 - *Affordable Care Act*
 - *Medicaid Redesign Team*
- *An unknown and predictable future*
 - *Ideological Division*
 - *Constrained Resources*
 - *A System in Motion*

Changing Concepts

Historical

- **Increase Access**
 - Insurance expansion
- **Maintain Quality**
 - “Best in the world”
- **Contain Costs**
 - New investments
- **“Two Out of Three Ain’t Bad”**

Triple Aim

- **Better Health**
 - Population and public health
- **Better Care**
 - Consensus standards
 - Continuous improvement
- **Lower Costs**
 - Total costs of care
- **“High Performance Health Care”**

Changing Relationships

- ***The Role of Doctors***
- ***The Shifting of Risk***
- ***The Emergence of Care Management***
- ***The Power of the Patient***

Challenges for the State

- *Create vision to transform MRT/ACA initiatives into an all-payer high performance system*
- *Set improvement goals*
- *Highlight persistent problems*
- *Define regions*
 - *Sufficient scale for population health improvement*
 - *Alignment with other sectors*
 - *Scale, complexity of NYC*
- *Support tiered regional planning implementation*
 - *Tier I: Information*
 - *Tier II: Collaboration*
 - *Tier III: Planning*

Information – The New Age

- *The availability of information is qualitatively and quantitatively different than in the past.*
- *Information has both internal and external users. Their needs differ.*
- *Standardization is essential.*
- *Our challenge is to transform all-payer database into useful regional planning systems.*
- *Planning must establish:*
 - *Key Triple Aim performance indicators and*
 - *Specific improvement goals*



Finger Lakes Health Systems Agency

The Value of Regional Health Planning

Fran Weisberg, Executive Director

Public Health and Health Planning Council
Health Planning Committee
September 5, 2012

Welcome to Rochester!



FLHSA: Vision, Mission & Strategy

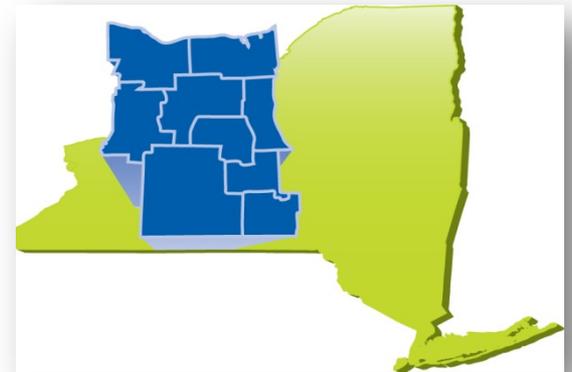
Vision: We envision being America's healthiest community with health equity for all people in our region, while serving as a national model for continuous improvement in community health and healthcare cost and quality.

Mission: We bring focus to community health issues via data analysis, community engagement, and solution implementation through community collaboration and partnership..

System Performance	Capacity Management	Community Health
<i>Quality and efficiency—</i> Making the best use of health-system resources	<i>Infrastructure optimization—</i> Achieving the right number and type of facilities	<i>Patient responsibility—</i> Educating and engaging consumers to improve their own health and require less care
The right care.	In the right place.	At the right time.

FLHSA's Roles

- Host *“the community table”* in the nine-county Finger Lakes region
 - Convene and staff task forces and commissions
- A catalyst to drive change
- Provide local input to state regulators
- Maintain extensive and objective community health data
- Help secure funding
- Staff with 150+ years of experience in health-system analysis



Rochester's Collaborative Model

- 1,115 people in our community involved in local health planning efforts
 - Representing 390 organizations
 - Actively involved in 20+ major committees, coalitions
 - Informing and supporting FLHSA analytics through:
 - Community education
 - Community mobilization
 - Grassroots advocacy for change



Health Planning in Action: 2020 Commission

Batched CON review of hospital expansion projects

- Balanced hospitals' modernization plans against community needs and resources

Process: Why successful

- Included active participation of all stakeholders: hospitals, providers, minority communities, payers, business leaders, and the public
- Reached a community consensus: Broad stakeholder support and a unanimous Commission vote
- NYS DOH was an integral part of the process and embraced the recommendations

Results

- Monroe County's three major hospitals will add 126 fewer hospital beds than requested (saving \$20 million in annual operating costs)
- Hailed by DOH as "exciting and innovative"

2020 Performance Commission

PQI

ED

Rural

Reduce readmissions and avoidable ED visits

Reduce preventable hospitalizations by 25% by 2014

Earlier return to treating physician, more engaged patient/family, improved access to practitioners, adherence to evidence-based guideline-directed care

**PQI / ED
Work Group**

Transitions
Coaching

Embedded
Care Mgrs.

Discharge
Planning

Reduce readmissions
and
avoidable ED visits

**Reduce preventable hospitalizations by 25%
by 2014**

Earlier return to treating physician, more engaged patient/family, improved access to practitioners, adherence to evidence-based guideline-directed care

2020 PC: Results

- Hospitals agreed to common discharge standards
- Insurers paying for coaching
- Placed care managers in PCP offices
- 25-30% reductions in hospital readmission rates among coached patients.
- *Goal: Save more than \$150M in local health-care costs by 2014*



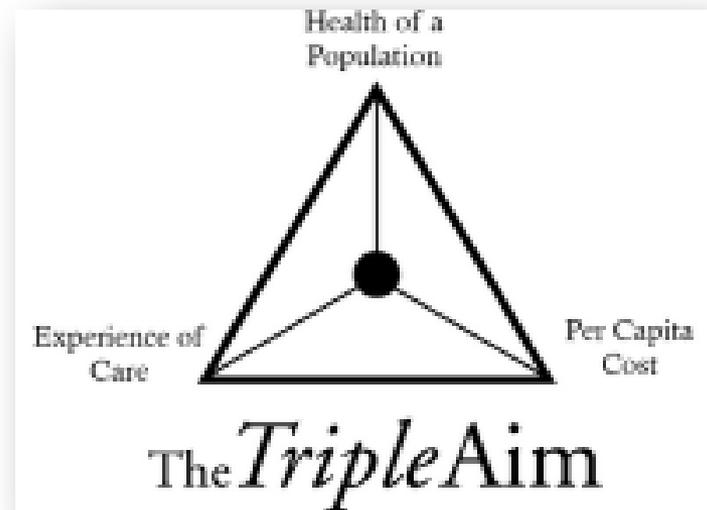
Sage Commission

- Developed a comprehensive, long-range plan to address the health service needs of the 65 and older population
- Created a vision for a local system that makes health care more accessible for older adults, minimizes disparities, and that is financially viable
- Plan completed, sent to NYS in spring 2011



Pursuing the Triple Aim: Addressing the Demand Side

- Healthi Kids – childhood obesity/overweight
- African American and Latino Health Coalitions
- Coalition to Prevent Lead Poisoning
- Partnership on the Uninsured



High Blood Pressure Collaborative

- FLHSA-Rochester Business Alliance partnership to improve hypertension care
- Working to decrease HBP's devastating impact on adults and families in Monroe County
- Multi-stakeholder coalition of 50 community organizations and 100 individuals



Benefits of Regional Health Planning

- Stakeholders have an open forum to discuss and resolve health issues
- Consumers obtain better information about their own health and health care
- Local health departments can make sure underserved populations aren't left behind.
- NYS policymakers can establish policies solidly based on local information and local needs



Recognized as a National Leader: A Success Story

CMS CTI \$3M Grant

- Leveraged by NYSDOH
HEAL grant



CMMI \$26.6M Grant

- The largest Health Care Innovation grant
in the nation

Three-Pronged Approach

- Support primary care
- Address the social and behavioral effects
on health
- Create a primary-care payment model
that rewards better outcomes

The Value of Regional Health Planning to CON Reform

- Focus more on reducing demand for care than controlling the supply of care facilities;
- Provide essential data that help hospitals and other stakeholders to define local needs;
- Facilitate community agreement on effective strategies among providers, consumers and payers to coordinate care, reduce unnecessary utilization, and promote population health;
- Conduct proactive studies of community health needs;
- Provide a recognized forum for community and consumer engagement; and
- Secure federal and state resources to support hospitals as they transform to new models of care

**“If you build it with them –
They will already be there!”**

- Debra L. Ness, President
National Partnership for Women & Families



Finger Lakes Health Systems Agency

The triangle represents our agency's role as a fulcrum—the point on which a lever pivots—boosting the community's health by leveraging the strengths of all stakeholders. The fulcrum is also a point of equilibrium, reflecting our ability to balance the needs of consumers, providers and payers on complex health matters. The inner triangle also evokes the Greek letter delta—used in medical and mathematical contexts to represent change—with a forward lean as we work with our community to achieve positive changes in health care.

Give me a lever long enough and a fulcrum on which to place it,
and I shall move the world. —Archimedes

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Observations and the Impact of the Public Health Law and Current Health Department Regulations on Healthcare Organization Governance Structures

Presentation to the Health Planning Committee of the Public
Health and Health Planning Council

September 19, 2012

Peter J. Millock

Health Care Organizations in New York Have Evolved in Response to Many Factors

- increased costs
- low profit margins
- shortage of capital
- value based competition
- government health planning through the Berger Commission and the Medicaid Redesign Team
- national health reform
- higher government and public expectations for responsible corporate behavior

The Changes are Dramatic

- Hospitals have consolidated; many have ceased being independent institutions or have closed entirely;
- Hospital systems are functioning as operating companies with centralized control and not as mere holding companies;
- Hospital systems have extended across New York State borders;
- Some private medical practices have grown into megapractices with multiple offices and hundreds of physicians covering a broad geographic area;

The Changes are Dramatic

- Private medical practices have staffed and equipped facilities that look remarkably like Article 28 clinics or small hospitals;
- Hospitals have explored new and old methods to combine with the megapractices and other private practices, including accountable care organizations, IPA's, PHO's and medical practice acquisitions;
- Hospitals, surgery centers, assisted living residences and other providers have attracted private investment without direct private ownership; and
- Hospitals and other providers have outsourced clinical and support services.

Health Care Organizations Outside of New York Have Changed More

- Hospital and nursing home chains continue to be bought, sold and re-shuffled.
- Convenience care clinics have multiplied.
- Substantial private equity has poured into assisted living and dialysis centers.
- Payers are consolidating with providers.
- Taxable/non-taxable hybrid partnerships have proliferated.

The CON Process

Over the years, what has happened to New York laws and regulations concerning the CON process and provider governance and operations?

- The answer is: Very Little.
 - CON thresholds have been raised.
 - Publicly traded dialysis providers have been permitted.
 - Your Committee has made several very welcome administrative streamlining recommendations.

The fundamental law and policies have remained unchanged.

Several New York Laws and Policies Have Shaped How New York Health Care Organizations are Governed.

I will focus on four:

- **The active/passive hospital parent distinction;**
- **Corporate fee splitting;**
- **The laws affecting hospital system operations;**
and
- **Accountable care organizations.**

The Active/ Passive Hospital Parent Distinction

- DOH regulations require corporate members/parents with one or more specified powers to have establishment approval.
See: 10 NYCRR §§405.1(c).
- Corporate members/parents with other powers need not be approved

The Active/ Passive Hospital Parent Distinction

The purpose of the distinction is to assure that entities exercising key decisionmaking powers judged necessary for provision of health care services will be reviewed, approved and held accountable for those services. Key powers include:

- control of operating and capital budgets and the incurrence of debt;
- choice of management employees and medical staff;
- approval of CON applications; and
- control of operating policies and procedures.

The Active/ Passive Hospital Parent Distinction

The active/passive distinction is problematic:

- First - the distinction may not reflect reality.
 - Passive parents may have a lot of power
 - Subsidiary boards may enjoy only a superficial autonomy
 - Many systems today rest on centralized control
- Second - the criteria for distinguishing active from passive are imprecise.
 - The only widely acknowledged trigger for a CON establishment application is budget approval.

The Active/ Passive Hospital Parent Distinction

- Third, the distinction between active and passive parents has an all-or-nothing impact.
 - Either a parent with some but not enough explicit and significant powers is treated as “passive” and is not evaluated, approved or held accountable in any way at all, OR
 - A parent is considered “active” and must get CON approval and be fully accountable for actions by its subsidiary even if the parent’s power does not extend to all aspects of the subsidiary’s behavior.
 - There is no adjustment of accountability to fit the scope or intensity of the active parent’s power.

The Active/ Passive Hospital Parent Distinction

- Fourth, the burdens of being considered active often cause hospitals to arrange governance just to avoid active parent treatment. For example, a parent will not be considered active if it exercises control only through the designation of subsidiary board members.
- Fifth, and most importantly, the distinction between active and passive may not advance any legitimate public health goal. For example, the free pass given to passive parents may allow them to escape responsibility for the hospitals in their system. The distinction may actually retard the development of financially sound, cohesive and efficient healthcare systems.

The Active/ Passive Hospital Parent Distinction

If the State wishes to evaluate the continued utility of the active/passive distinction, it must contend with many questions:

- Does passive parenthood afford a useful engagement period before an eventual marriage?
- Does passive parenthood convey more benefits than even looser connections between providers?
- Is there only an all or nothing resolution?

The Active/ Passive Hospital Parent Distinction

- Can parent accountability be achieved another way?
- What ownership/control changes will the elimination of the distinction cause and are these desirable changes?
- Will elimination of the distinction require expanded character and competence reviews and can these reviews be conducted efficiently?

Corporate Fee Splitting

DOH regulations prohibit an unestablished entity from receiving all or part of the gross or net revenue of a clinic, ambulatory surgery center or hospital. See: 10 NYCRR § 600.9(c). This is the corporate parallel to the limits on fee splitting by physicians in Education Law § 6530(18) and (19).

The purpose of the prohibition is to:

- limit control by an unregulated and unaccountable entity over a licensed provider, and
- to protect the financial viability of the licensed provider

Corporate Fee Splitting

The prohibition:

- forces providers to estimate and adjust a fixed fee that approximates the percentage they anticipate receiving and to allocate fixed fees across different services.
 - The financial result of this gyrating remains the same, but the gyrating is required to comply with the regulation.
- makes it more difficult to reward good work measured by one universal criteria: contribution to profit.
 - The result may be reliance on other vacuous performance standards.

Corporate Fee Splitting

- pushes revenue sharing from agreements where the fee splitting prohibition applies explicitly (e.g., management agreements) to other agreements between the same parties.
- This can create a multiplicity of agreements each of which is innocuous and legal but, together, allow an unlicensed entity to withdraw substantial funds from the operations of a hospital, ambulatory surgery center or DTC and exercise substantial control over its operations.

Hospital System Operations

- The major provisions of Article 28 of the Public Health Law, including the CON process, were enacted when hospitals were individual units.
- Health systems in New York today include:
 - Multiple hospitals
 - Providers of other levels of care
- Each provider must have
 - Its own board of directors, however weak
 - Its own operating certificate

Hospital System Operations

Multi-hospital systems that have not merged their constituent entities into one single corporate entity, but seek the efficiencies and other improvements related to size, face many operational hazards because of the outdated focus of the current law.

Hospitals within a system face several questions:

- May one hospital share QA information with another hospital?
- May one hospital share a medical record system and medical records with another hospital?

Hospital System Operations

- May hospitals share credentialing information with another hospital after initial privileges are granted?
- May the hospitals share peer review information?
- If a hospital shares this information, does it lose whatever privileged protection it has against further mandated disclosure?
- May the hospitals have one unified medical staff?
- May the hospitals have one unified board of directors?

Hospital System Operations

Hospital systems have answered these questions in different ways.

I interpret the current state and federal law as follows:

- There is no barrier to centralized credentialing information gathering provided that each physician consents to it.
- There is no barrier to centralized monitoring of credentialing, overall quality assurance functions, and the sharing of non-identifying information.

Hospital System Operations

- Identifying information may be shared across a system provided an “organized health care arrangement” is formed under HIPAA, there is proper notice to patients and physicians, and the system’s and the constituent hospitals’ certificates of incorporation and bylaws are amended.
- Physician identifying peer review information may be shared, with Department approval.
- The system parent may share in credentialing, peer review and quality assurance decisionmaking if there is an overlap in board composition.

Hospital System Operations

- Each hospital must have its own medical staff but medical staff bylaws may provide that a loss of privileges in one hospital is cause for disciplinary action in another.
- Each hospital must have its own board but “mirror” boards are permitted.

Hospital System Operations

These ad hoc solutions are not ideal.

Explicit and clear legal authority to share such information across all entities within a health care system will allow systems to enhance patient protection and realize the quality assurance benefits that size may offer.

Unified medical staffs may be appropriate and efficient in some situations.

Accountable Care Organizations

The formation and operation of accountable care organizations (“ACO”) have been facilitated by State and federal laws that address some of the questions noted above for hospital systems.

- By authorizing ACOs under the Public Health Law, the State hopes to:
 - reduce health care costs
 - promote effective allocation of health care resources, and
 - enhance the quality and accessibility of health care.

Accountable Care Organizations

Under New York State law an ACO is an organization of clinically integrated health care providers that work together to provide, manage, and coordinate health care (including primary care) for a defined population. PHL §§ 2999-o(1), 2999-p(1).

Under existing law, DOH is authorized to establish the standards for governance, leadership, management structure of the ACO including the manner in which clinical and administrative systems or clinical participation will be managed.

PHL § 2999-q(2)(a)

Accountable Care Organizations

If the Governor signs legislation now before him, the PHL will offer certain legal protections to State certified ACO's. The PHL will:

- create a state action exemption from anti-trust prosecution for ACO's;
- protect ACO's from prosecution under the corporate practice of medicine prohibition;
- seek to protect ACO's from prosecution under the State's Mini-Stark law; and
- by treating an ACO as one "hospital," seek to avoid the application of the non-disclosure limitations noted above for hospital systems.

Accountable Care Organizations

Why will the same consideration not be shown to hospital systems?

Most systems seek the same outcomes as ACO's

- reduction of costs
- effective allocation of resources, and
- enhanced quality and accessibility of health care.

Other Current Regulations and Policies Have a Major Impact on Governance

The two most distinctive New York laws are:

- the prohibition against publicly traded corporations owning hospitals and other Article 28 facilities (see, e.g.: PHL § 2801-a (4)(e)); and
- the prohibition against the corporate practice of medicine and other licensed professions (see, e.g.: Education Law § 6522, PHL Article 28, and Business Corporation Law § 1503).

Other Current Regulations and Policies Have a Major Impact on Governance

The prohibition against publicly traded corporations is actually stated as a prohibition against the stock of a corporate operator being held by another corporation;

- with a publicly traded corporation, corporate stock ownership is always possible.
- business corporations without corporate shareholders may own a hospital.

The prohibition against the corporate practice of medicine is not articulated in any one statute or regulation.

- permits (with limited exceptions) only professional corporations and licensed hospitals and other licensed providers to employ physicians and other professionals.

Other Current Regulations and Policies Have a Major Impact on Governance

- These two prohibitions, more than any others, shape facility governance arrangements in New York.
 - The two prohibitions are linked to the fee splitting.
 - The prohibition on publicly traded hospitals and corporate practice pushes investors to other forms of engagement with New York providers and other means to secure profits on their investment in these providers.

Other Current Regulations and Policies Have a Major Impact on Governance

Also worth the Committee's attention are:

- the out-of-date distinctions between private practices and Article 28 clinics;
- the imprecise distinction between management agreements and administrative services/consulting agreements;
- the unresolved state policies on co-location and convenience care clinics; and
- the burdensome and somewhat arbitrary standards for both character and competence.

Conclusion

What, if anything, should be done with current statutes, regulations, policies and procedures?

The evaluation should be guided by the following principles beyond the obvious primary goal of doing what is best for the public's health:

- No law or regulation, no matter how old and cherished in New York, should be immune from review and change.
- Laws should be adjusted to achieve the accepted goals for the health care system and not to advance abstract principles or New York exceptionalism.

Conclusion

- Laws should not ignore economic realities.
- All laws should be enforceable and enforced. If the state does not have the resources, will or desire to enforce a law, it should repeal the law.
- The interrelationship between all of these laws and policies (e.g.: between fee splitting and corporate practice and between active/passive and character and competence) must be taken into account in the evaluation.

Establishment and Governance

Presentation to the Health Planning Committee of the Public Health and Health Planning Council
New York State Department of Health
September 19, 2012



Goals for Meeting

- Consider update of C&C reviews of:
 - Complex corporate structures;
 - Not-for-profit boards
- Rationalize the criteria that trigger disqualification from establishment and the parties that are disqualified;
- Consider mechanisms to strengthen governance, especially in light of new systems of care.



CHARACTER & COMPETENCE



Character & Competence: Process

- Two steps:
 - Review of qualifications and compliance record of individuals in governing body;
 - Determine whether violations of regulations by affiliated facilities/home care agencies trigger disqualification (“taint”).

Step 1: Review of Individual Qualifications

- Goal: Authorize persons with “the character, experience, competence and standing in the community” to operate health care facilities, home care agencies and hospices.
- Current process for assessment:
 - Character: Applicant provides actions against professional licenses or certificates, criminal proceedings.
 - Competence: Applicant provides employment history, surveillance record, civil and administrative actions, other compliance-related actions.

Character and Competence Reviews

Type	Check Type	Source	Notes
Establishment	Schedule 2A Check	Schedule 2A	Personal History of the natural persons
Establishment	Out of State Compliance Check	Schedule 2D	Other states submit compliance information about facilities operated in their state by the applicant corporation
All	Pending Enforcements	Enforcements Databases	Puts project “on hold” until enforcement is resolved.
Establishment	Taint	Enforcements Databases	Two enforcements for the same transgression taints any individuals serving at the time of both transgressions.
Establishment	Medicaid Exclusion	www.omig.ny.gov	
Establishment	Medicare Exclusion	www.oig.hhs.gov	
Establishment	OPMC Completed Disciplinary Actions	http://www.nyhealth.gov	
Establishment	NYS Education Department Licensure Database	http://www.op.nysed.gov/opsearches.htm	To check status of professional licensure
Establishment	Other License Verification Databases	Varied	To verify licenses granted by other states, and other professions licensed by New York State.
Establishment	Intra-/Inter-Agency Check	OHIP, OPH, OMH, OASAS, OPWDD	

Step 2: “Taint” or Disqualification (PHL 2801-a(3))

- With respect to an individual;
- Within the past ten years;
- Who has been an . . . operator of any hospital or other residential facility;
- “[N]o approval shall be granted unless the [PHHPC] . . . shall affirmatively find by substantial evidence a substantially consistent high level of care is being or was being rendered;”
- No finding of a substantially consistent high level of care where there have been violations that:
 - threatened to directly affect the health, safety or welfare, and
 - were recurrent or were not promptly corrected.

C&C and “Taint:” Hospitals Compared to Home Care

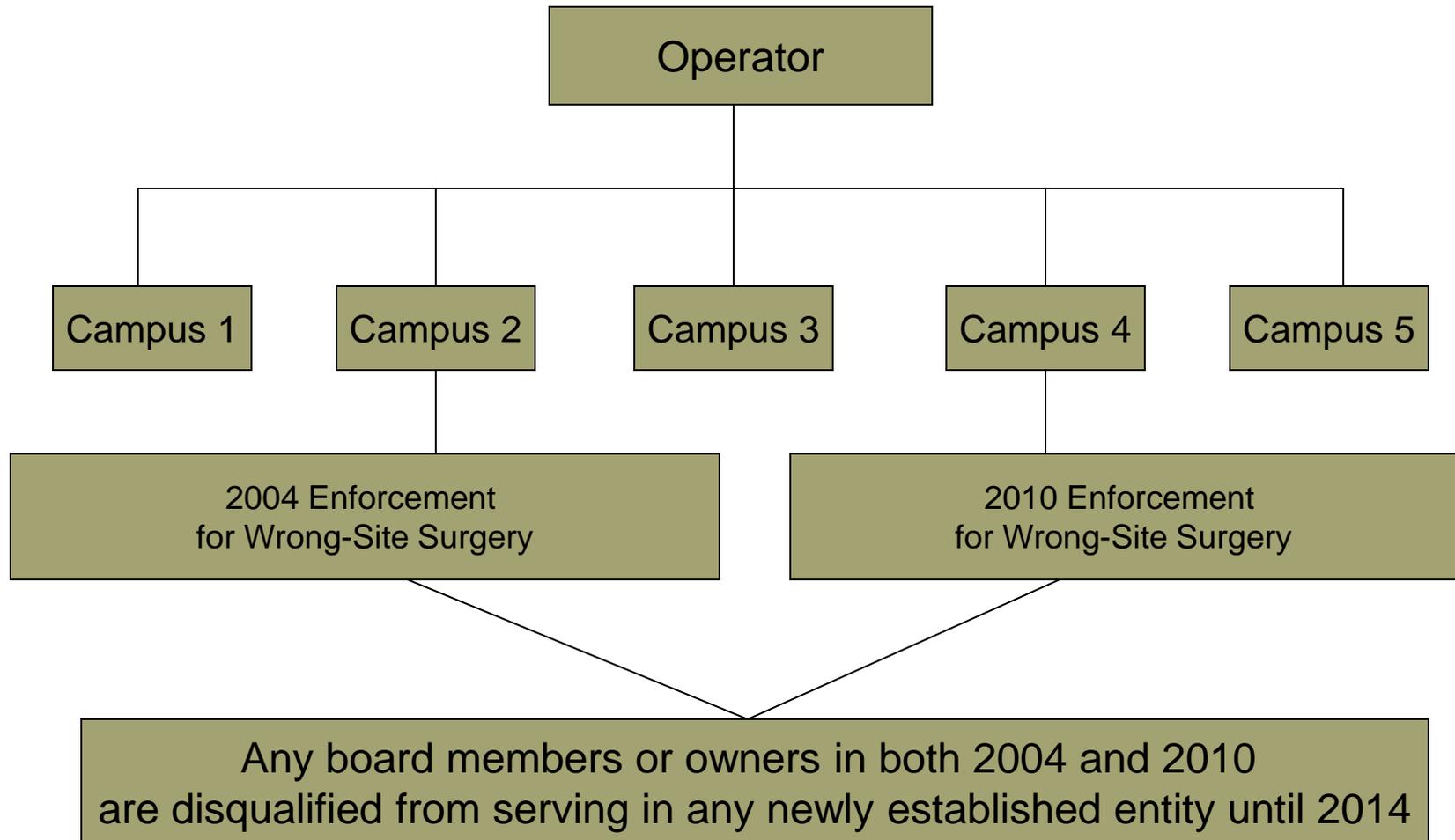
Article 28 (Hospitals, DTCs, RHCs)	Art. 36 (CHHAs, LHCSAs)
Review all shareholders in corps., all members of LLCs.	Review all shareholders with interests > 10%, all members of LLCs.
No review of passive parents in not-for-profits.	Review passive parents, investors, “controlling persons,” etc.
Statutory 10-year look-back with mandatory bar.	No statutory 10 year look-back.

Disqualification or “Taint”

- Taint: Two enforcements for the same health/safety transgression taints any board member or owner serving at the time of both violations.

- Enforcement: An action taken by DOH against a health care facility as a result of a survey or investigation resulting in a final determination.
Examples include:
 - Identified patient harm or the potential for patient harm due lack of systems to prevent.
 - Repeat instances of non-compliance related to the same issue.

Case Study Applying Current “Taint” Policy



C&C Reviews: Limitations

- Difficult to assess character and competence in context of an application.
- Ill-defined affirmative requirements, e.g., types of experience required.
- Disqualification rules:
 - Disadvantage applicants with health care facility/agency experience;
 - Inflexible – may disqualify high-performing operators because of 2 isolated events.
 - Under-protective:
 - Encourage negotiations to avoid “repeat” or recurrent violations;
 - Encourage replacement of tainted individuals with inexperienced ones;
 - Encourage passive parent relationships;
 - Prevent establishment actions, but not expansions of services or capacity.



C&C Reviews: Shortcomings

- Growth of integrated systems will likely lead to more disqualifications based on repeat enforcements.
- Reviews and disqualification rules focus on individuals, without examining the role of the individual in the organization or the organization as a whole.
- No discretion - disqualification is mandatory when there are 2 health/safety enforcements within 10 years.

C&C Reviews: Shortcomings

- Significant investment of DOH staff and applicant resources:
 - High volume of applications;
 - Many with complex organizational structures and dozens of individuals in governing body.
- Benefits are difficult to measure:
 - Sentinel effect
 - Excludes individuals from facility/agency governing bodies due to:
 - Non-compliance - taint
 - Professional licensure actions
 - Failure to disclose
 - Promotes creation of capable, trustworthy governing bodies.

Updating C&C Reviews: Not-for-Profit Corporation Option

- Require established operators to conduct C&C review of new board members consistent with DOH regulations.
- Require updated C&C by established operators in the event of any establishment action (e.g., merger, acquisition, joint venture).
- Require attestation by operator regarding review.
- Coordinate with OMIG Compliance Plan submissions.

Updating C&C Reviews: Complex Organizations Option

- E.g., publicly-traded, private equity-owned, multi-state enterprises:
- Review individual board members, LLC members, owners, officers of proposed operator (regulated entity) and direct parent; and
- Attestation from ultimate parent and any shareholders/members with authority to influence its governance or operations concerning:
 - Organizational compliance history and operational track record of parent, controlling shareholders/members, and related entities;
 - C&C of controlling owners, directors and officers;
- Independent review of C&C and compliance of ultimate parent and related entities; or DOH review.

Rationalize Taint Rules

- Eliminate mandatory disqualification for 2 enforcements in 10 years.
- Create discretionary disqualification of individuals based on:
 - Pattern or multiple instances of non-compliance that threatens health/safety/welfare;
 - Consider role of individual in organization (presumption of disqualification for non-compliance, but individual can rebut);
 - Consider compliance record of organizations in which individual has served as CEO/CFO.



Rationalize Taint Rules (cont'd.)

- Discretionary disqualification of organizations
 - Operators with pattern or multiple instances of non-compliance.
 - Apply disqualification to major new services, new sites, expansions of capacity, in addition to establishment actions.

Updating C&C Reviews – Role of Quality Measures

- Growing use of standardized measures of quality
- Greater availability of data necessary to apply measures
- Challenges:
 - Which measures?
 - Which applications?
 - Process?



GOVERNANCE

Governance: Passive Parents

- Typically, appoint board of directors of not-for-profit health care facility.
- May not exercise any of the following powers:
 - appointment or dismissal of hospital management level employees and medical staff, except the election or removal of corporate officers by the members of a not-for-profit corporation;
 - approval of hospital operating and capital budgets;
 - adoption or approval of hospital operating policies and procedures;
 - approval of certificate of need applications filed by or on behalf of the hospital;
 - approval of hospital debt necessary to finance the cost of compliance with operational or physical plant standards required by law;
 - approval of hospital contracts for management or for clinical services; and
 - approval of settlements of administrative proceedings or litigation to which the hospital is party, except approval by the members of a not-for-profit corporation of settlements of litigation that exceed insurance coverage or any applicable self-insurance fund.



Problems with Passive Parents

- ❑ Effective control through board appointments

- ❑ Lack of accountability

Strengthen Governance: Passive Parent Options

- Clarify that appointment of top management is active parent or facility governing body responsibility.
 - Same person may not serve as passive parent CEO and facility CEO.
- No mirror boards.
- Require clinical integration among passive parents and facilities.
- Require DOH approval if 1/3 or more of board is replaced within specified period.
- Require DOH approval of passive parents.



Other Proposals to Strengthen Governance

- Mandate board, owner training
- Permit removal and appointment of board members or appointment of temporary operators by DOH in the event of consistent non-compliance, financial instability

Surveillance is the Key

- ❑ Monitoring quality of care and financial stability after approval is more effective than pre-approval screening of C&C.
- ❑ Increase penalties for non-compliance.
- ❑ Strengthen and expand the ability to revoke, suspend, limit operating certificates for governance, quality of care issues.
- ❑ Revocation, limitation of operating certificates if attestations are found to be false (10 NYCRR 600.5).
- ❑ Consider expanded use of time-limited operating certificates.



Additional Governance Issues

- ❑ System Integration Barriers
- ❑ Corporate Practice of Medicine vs. Corporate Ownership of Health Care Facilities
- ❑ De Facto D&TCs



System Integration Barriers

- Laws and regulations inhibit sharing of information among separate facilities in a single system:
 - QA info
 - Credentialing and privileging info

Corporate Practice of Medicine

- Professional misconduct under Education Law
 - Exception for practice through licensed health care facilities, HMOs, or home care agencies.
- Rationale: Licensed professionals retain control over care; not business enterprises
 - But, non-established entities participate in practice of medicine through lease of medical equipment, administrative services agreements, etc.
 - Some medical practices operate like large corporations.
- Disadvantages: Impedes certain joint ventures, capital access, delivery models.

Corporate Ownership of Health Care Facilities

- PHL 2801-a bars for-profit ownership of health care facility operators by non-natural persons.
 - Prohibition on corporate ownership of stock in corporate health care facility operators effectively bars publicly-traded corporate ownership, private equity/venture capital ownership.
 - Exception for dialysis facilities.
- Rationale: Ban promotes accountability, local control, retention of revenue in community.
- Disadvantage: Limits access to capital

De Facto D&TCs

- PHL Art. 28 requires licensure of facility engaged principally in providing services by or under supervision of a physician, including a “diagnostic center” or “treatment center.”
- 10 NYCRR 600.8 sets forth criteria defining the operation of a D&TC that would require licensure, including:
 - Relationship between patients and facility
 - Administration
 - Scope of services
 - Physical Plant

Prohibition on Revenue Sharing with Non-Established Entity

- ❑ Limits administrative services and similar arrangements with enterprises that might provide capital.
- ❑ Rationale: Prevents effective control over facility by non-established entity.
- ❑ But impedes certain joint ventures, obligated groups, access to capital.



Active/Passive Models

October 3, 2012

Presentation to the Public Health and Health
Planning Council Health Planning Committee

Active/Passive Models

July 28, 1993 – from General Counsel Peter Millock to Establishment Committee: “Review of Passive Control of Not-for-Profit Hospitals.”

... a single not-for-profit hospital corporation could acquire, through membership status and/or the ability to install common directors, indirect control over every other voluntary hospital in the state. The possibilities are even greater. NFPCL 601 (a) does not limit potential members to individuals or voluntary corporations. A proprietary corporation could become the sole corporate member of a voluntary operating corporation.

Passive Parent Models

- NY Presbyterian Hospital (8)
- North Shore / Long Island Jewish (10)
- United Health Services (4/2)
- Bassett Health System (5)
- Continuum Health Network (3)
- NYU/NYU Hospital (1)
- Medisys (2)
- Rochester Strong Memorial and FF Thompson
- St. Peter's Health Partners / Catholic Health East (4)
- Long Term Care Models

Active Parent/Governance

- Kaleida
- Catholic Health Services
- Kingston and Benedictine
- Guthrie Health System
- Arnot Ogden
- Olean and Bradford
- Fletcher Allen and CVPH/Elizabethtown
(Proposed)
- NSLIJ

Passive Parent Characteristics

- Multiple models and purpose
- Each unique/Driven by vision
- Sole corporate member – maintain distinctive features and autonomy
- Network/Corporate model
 - Sits over system
 - May utilize mirror boards/CEO
- Sponsorship (Catholic Health East/Ascension)

Strengths of Passive Parent

- Preserve local influence and/or identity
- Avoid assumption of financial liabilities
- Establish working relationship – foundation of merger or Active Model
- Significant benefits for affiliate to stabilize system

Benefits to Affiliate

(Building a Relationship or Dependence?)

- Management or Administrative Service Agreement
 - Billing and IT Services
 - Management and Finance expertise
 - Senior Staff (CEO, CFO, etc)
 - Greater purchasing power for supplies
- Medical Services Agreement
 - Access to Specialists (maintain a program or new revenue)
 - Recruitment of physicians
 - On-call support

Benefits to Affiliate

(Building a Relationship or Dependence?)

- Assistance with Managed Care negotiations
- New Insurance products for employees (self-insurance)
- Improved access to credit lines and financial loans
- Improved market position/Image
- Improved quality and patient safety (expertise, access to analytics, etc.)

Benefits to Parent

- Expanded geographical and clinical network
 - New referrals
 - Market strength with Insurers
 - Preparation for direct contracting
- Expand purchasing power for supplies and technologies
- Foundation for population management and new models of care

Market Reforms/Community Improvements

- Potential preservation of failing facilities
- Rightsizing and re-aligning services
- Improved access to specialty services for rural areas and the underserved
- Recruitment of Specialists in Upstate/Rural Areas (need patient population to support)
- New services /areas (Bassett, Southside, and UHS Trauma)
- Coordination of Care across areas/systems
- Improved quality

Problems with Passive Models

- Partial integration/limited savings to system.
- Competition for patients between parent and affiliate.
- Financial alignment is not complete: Dependence without long term sustainability can occur.
- Transparency of governance confusing to community and employees.
- Separation is difficult for affiliate; bankruptcy may still reach parent.
- Regulatory Accountability

Mission/Philosophy Exception

405.1(d)

“Nothing ... of this section shall require the establishment of any member of a not-for-profit corporation, which operates a hospital, based upon such member’s reservation and exercise of the power to require that the hospital operate in conformance with the mission and philosophy of the hospital corporation.”

Catholic Health East (CHE) (1997)

- Multi-institutional health system – cosponsored by 8 religious congregations
- 35 Acute Care Hospitals – 4 Long Term Care Hospitals – 26 Long Term Care Facilities – Largest home care in nation
- Serves 11 states – Alabama, Connecticut, Florida, Georgia, etc.

Ascension Health (1999)

- Serves 21 states
- Ascension Health Care Network (Ascension Health and Oak Hill Capitol Partner – for profit entity)

Passive Parent – Policy Questions

- Accountability and Transparency – Is the licensed entity and Board in charge?
- Do Mirror Boards assure:
 - Duty of Care – act in good faith and informed judgment; in best interest of system
 - Duty of Loyalty – display undivided allegiance when making decisions
 - Duty of Obedience – Faithful to the mission
- Would separate boards undermine collective strength and promote internal disagreements?
- Would regulation of Passive Parent Model discourage affiliations?
- Once aligned through Passive Parent – How does the state and/or community determine accountability for strategic and/or operational actions?
 - (The licensed entity and Board are accountable under Public Health Law but Board is accountable to non-established entity)
- Nothing prevents a not-for-profit hospital board (established) from turning Board over to a distinct individual(s) or investor without review.

Strengthen Governance: Passive Parent Options

- Clarify that appointment of top management is active parent or facility governing body responsibility.
 - Same person may not serve as passive parent CEO and facility CEO.
- No mirror boards.
- Require clinical integration among passive parents and facilities.
- Require DOH approval if 1/3 or more of board is replaced within specified period.
- Require DOH approval of passive parents.



October 3, 2012

NEW YORK
state department of
HEALTH

Certificate of Need Financial Feasibility and Cost Assessment

Charles Abel, Acting Director
Division of Health Facility Planning
NYS Department of Health





The Goal of Feasibility Assessment



To perform an objective financial Assessment
is completed on proposed projects to ensure
that:

- The project can be initiated; and
- The facility/enterprise can sustain itself based
on the submitted business plan.



Rationale for Feasibility Assessment



- Financial feasibility review process is used to assess the viability of the enterprise and proposed projects, which centers on the ability to offset expenses with revenues.
- Analysis is designed to shed light on the uncertainty and risk surrounding a capital project and/or business decision to an acceptable level through a thoughtful and structured process.



Why Department of Health Review?



Financial reviews are made up of targeted elements to ensure governance and financial structures are in compliance with the NYS Department of Health policies and regulations, which also consider the applicant's business plan and the market dynamics.

What Projects Are Reviewed

- CONSTRUCTION PROJECTS
- NEW STARTS UPS
- WORKING CAPITAL ASSESSMENTS
- CHANGE OF OWNERSHIP
- FINANCING STRUCTURES



Project Review Measures



- **FINANCIAL CABABILITY:** The reviewer ensures that the applicant has the proper resources and documents to enable a project, including the down payment, working capital, needed borrowing and the other necessary requirements to initiate or take over the operations.
- **FINANCIAL FEASIBILITY:** Review budgets for reasonableness and to ensure revenues meet or exceed expenses in order to maintain a sustainable entity. The goal is to review all the relevant information and test the applicant's assumptions.



Project Measures Expenses



- **REVENUES:** Revenues are tested using accepted benchmarks, utilization, and valid reimbursement methodologies to ensure reasonableness.
- **EXPENSES:** Expenses are assessed using various techniques:
 - Rent - Rent reasonableness letter from third parties.
 - Property - Review certified appraisals or apply lower of cost or market.
 - FTEs - Largest expense typically seen. Review proposed staffing levels, compensation, benefit rates against benchmarks.
 - Supplies and Contractual Agreements - Review for reasonableness against established benchmarks.



Project Measures Debt Instruments



- DEBT INSTRUMENTS - Review term, rate, and amortization to ensure accuracy and market conditions.
 - Bond Offerings - Bond Rating, Issuer/Credit Enhancement, Eligibility.
 - Loan Agreements - Fixed Rate Analysis, Swap Rates, Variable Rates, Amortization Tables
 - Preference - Fixed Rate, Level Debt Service, Self - Amortizing



Items Reviewed by the Bureau of Financial Analysis



(Financial Review)

- Certified Financial Statements
- Projected Operating and Capital Budgets
- Net-Worth Statements
- Pro-Forma Balance Sheet
- Equity Contributions
- Ratio Analysis
- Organizational/Enterprise Relationships
- Utilization
- Debt Structures
- Letter of Interest
- Payor Mix

(Document Review)

- Leases
- Contracts/Agreement
- Administrative Service Agreements
- Asset Purchase Agreements
- Maintenance/Service Agreements
- TELP/DASNY Agreements
- Medicaid Affidavits
- Dept. of State Filing
- Board Resolutions
- Judgments/Legal Agreements
- Governance Structures/Agreements
- Bankruptcy Documents
- Business plans
- Demand Analysis



Project Measures Debt instruments



- DEBT INSTRUMENTS - Review term, rate, and amortization to ensure accuracy and market conditions.
 - Bond Offerings - Bond Rating, Issuer/Credit Enhancement, Eligibility.
 - Loan Agreements - Fixed Rate Analysis, Swap Rates, Variable Rates, Amortization Tables
 - Preference - Fixed Rate, Level Debt Service, Self - Amortizing



Capital Cost Review Process



- Submitted project square foot costs are compared to a DOH database of approved historic project costs by functional group to determine approvability. This database is continuously updated as new projects are approved.
- Construction industry cost trends are used in determining allowable costs. The Department uses multiple independent sources to project future construction cost trends.



Construction Cost & Square Foot Analysis

(Hospitals, D & T Centers, Amb. Surg, Etc.)



- Total Project Costs (TPCs) include “hard cost” items such as construction, site prep, equipment, A/E Fees, and Design/Construction contingencies). TPCs are compared to previously established parameters and guidelines.
- Detailed breakouts of TPCs are provided by the applicant in CON Schedule 10 - Space & Construction Cost Distribution.
- Square foot totals are checked against project narratives, plans and other schedules for consistency.
- Submitted costs outside of established parameters are subject to increased review, analysis and justification.



Examples of Standards / Norms



Square Foot costs

Standards based upon:

- Location - Region of State (Rural, Urban)
- Construction Type - New, Renovations (major gut / minor alteration)
- Functional Space Type - Linac, Emergency Dept., ORs, Medical/Surgical, Administrative, Storage, etc.

Additional Consideration Given To:

- Non-Typical Construction - Restricted site access, high rise additions, sloped sites, high water table, projects within operational facilities.
- Operational Efficiencies - Geothermal, dual fuel, green construction, etc.
- Demonstration Projects - New technologies, treatment therapies
- Special Features - Ventilator beds, bariatric room features, etc.





Nursing Home Cost Review



- Reimbursable nursing home project costs are assessed based on region, project scope and number of beds proposed.
- A maximum allowable regional cost per bed (bed cap) has been established which determines the approvable reimbursable project cost.
- New Construction: A new or replacement nursing facility can be eligible for up to 100% of the bed cap allowance
- Renovation: Capital Reimbursement for renovation projects are substantially lower depending upon the extent of the construction and changes to the facility.



Capital Reimbursement Methodologies



Provider Type	Capital Rate Setting Methodology	
Hospitals	Inpatient	Outpatient
	Actual rate year capital after a 44% reduction in Major Moveable Equipment (MME)	Two year lag of historical capital after 44% reduction in MME
Nursing Home	Cost based reimbursement methodology with two year lag (e.g., 2012 rates reflect 2010 allowable costs for real property, moveable equipment) <ul style="list-style-type: none"> •Proprietary Homes: Mortgage interest /amortization /return on/of equity •Voluntary/Public Homes: Mortgage interest and depreciation 	
Diagnostic and Treatment Centers	Two year lag of historical capital no adjustment for MME FQHCs: Average 1999 and 2000 capital per Federal statute (appeals allowed for capital increases)	





Capital Cost Trends for Hospitals and Nursing Homes



- Hospitals: Medicaid allowable capital costs have increased from \$780 million (2006) to \$930 million (2010) or by an annual average of 4.4 %
- Nursing Homes: Medicaid allowable capital costs have remained relatively stable from \$609 million (2008) to \$601 million (2011)

Note: Total allowable costs for the same periods above for Hospitals are approximately \$2.6 billion and \$3.1 billion respectively, and for Nursing Homes approximately \$812 million and \$801 million respectively



45% of NHs and Hospitals have Negative Three Year Average Operating Margins that are Below the National Average



Three Year (2008-2010) Average Operating Margins	Hospitals	Nursing Homes	Total
# Facilities with Average Negative Operating Margins below the National Average (Financially Challenged)	73	291	364
# Facilities with Average Positive Operating Margins below the National Average	106	173	279
# Facilities with a Positive Operating Margin above the National Average	15	154	169
Total	194	618	812

National Average 6.4% 3.6%





Financially Challenged Hospitals are more highly leveraged and Nursing Homes are more dependent on Medicaid resources



	Facilities with Negative Three Year Average Operating Margins Below the National Average (Financially challenged)	
	Hospitals (73)	Nursing Homes (291)*
Debt to Capitalization Ratio (Total Long Term Liabilities/(Total Assets + Total Long Term Liabilities))	44%	27%
Age of Physical Plant	13 years	15 years
Medicaid Utilization	30%	76%

*65% of such NHs have 2012 capital per diems that are below the statewide average capital per diem of \$20.00
 160 of the 291 NH's will benefit from the new pricing methodology





Medicaid Capital Reimbursement in a Managed Care Environment

- Managed care plans and facilities negotiate payment rates.
- DOH creates FFS rates as benchmarks.
- DOH has asked CMS for authorization to carve out capital from managed care payments to nursing homes. If authority is granted, capital reimbursement will continue to be paid as a cost-based pass-through on a FFS basis.



Financial Monitoring Tools



- DOH is creating a tool to assess hospital and Nursing Home financial status and importance to community access.
- Methodology ranks facilities based on deviation from the Regional and Statewide means.
- Uses:
 - Waiver funding
 - Alert system for financially troubled facilities
 - CON reviews



Financial Monitoring Tools: Financial Metrics



- Profit Margin Metric
- Cash on Hand Metric
- Capital Structure Metrics (Long Term Debt to Assets, etc.)



Financial Review Options



- Focus financial review resources on weaker hospitals; maintain current processes for nursing homes.
- Assessment of enterprise/system performance and impact; not just project.
- Flexibility with debt structures for high performing hospitals.

Thank You



Public Need Options

Health Planning Committee

Public Health & Health Planning Council

October 12, 2012



Context

- Health System Transformation
 - New value-based, risk-based payment mechanisms
 - Integration and affiliation of providers
 - New models of care that require
 - Capital investment
 - Strong governance
 - Data and analytics
 - Rising power of physician groups
 - New emphasis on population health



New Opportunities and Risks

□ Opportunities

- Reduce preventable utilization and spending
- Improve patient safety and quality
- Focus on prevention and chronic disease management
- Improve health

□ Risks

- Systems too big to fail
- Anticompetitive behavior that drives up costs
- Instability of essential providers
- Underserved and rural areas abandoned

Administrative Streamlining

- Major change in approach to public need review of construction projects:
 - PHHPC recommended elimination of public need and many financial reviews for construction projects that do not involve changes in services, major equipment, location or capacity.



Public Need Options: Phase 2

- 3 categories:
 - Facilities in State-Certified ACOs
 - High Impact Facilities/Services
 - Low Cost/Low Utilization Facilities and Services



Options for Facilities in State-Certified ACOs

Promote Integrated Systems of Care through State-Certified ACOs

- Modify CON for facilities participating in state-certified ACOs that:
 - Receive significant portion of revenue through risk-based (e.g., capitated) payment mechanisms; and
 - Participate in regional planning and SHIP efforts; and
 - Report outcomes in relation to identified quality and population health benchmarks.

Modify CON for Certain Facilities in State-Certified ACOs

- Rationale:
 - Promotes clinical and financial integration
 - Risk-based reimbursement discourages unnecessary development
 - Can advance population health objectives
- Concerns:
 - Uncertain effectiveness of financial incentives, especially given consolidation and market power
 - Inability to mediate competitive issues between systems
 - Protection of safety net/essential providers
 - Ensure capacity in rural, under-served areas
 - Difficult to operationalize



Options for High Impact Facilities/Services

Options for High Impact Facilities/Services

- High Impact Facilities/Services =
 - Supply-sensitive (i.e., greater supply drives greater utilization and spending);
 - Volume-sensitive (i.e. concentration of volume drives higher quality);
 - Significant drivers of Medicaid spending;
 - Capital-intensive;
 - Emerging technologies of uncertain efficacy.

High Impact Facilities/Services: Radiation Therapy

- Apply CON to radiation therapy equipment (e.g., linear accelerators) regardless of setting.
- Rationale: Would help to level playing field; mediate competitive issues with hospitals.
- Concerns: Lack of government resources to regulate. May drive up reimbursement.

High Impact Facilities/Services: Radiation Therapy Alternative

- Eliminate CON for radiation therapy equipment regardless of setting
- Rationale: Given expansion of physician practice sites, CON's utility is reduced. Would level playing field.
- Concerns: Weakens ability to mediate competitive issues. Weakens ability to control entry of unproven technologies. Permits unfettered investment in expensive equipment.

High Impact Facilities/Services: Diagnostic Imaging

- Apply CON to diagnostic imaging regardless of setting.
- Rationale: Supply sensitive, cost driver.
Over-use of radiation emitting imaging raises public health concerns.
- Concerns: Lack of regulatory resources.

High Impact Facilities/Services: Diagnostic Imaging Alternative

- Eliminate CON for diagnostic imaging regardless of setting.
- Rationale: Given physician practice penetration, CON's utility is limited. Would level playing field.
- Concerns: Public health and cost issues associated with over-use. Weakens ability to control entry of unproven, expensive technologies. Permits unfettered investment in expensive equipment.

Options for High Impact

Facilities/Services: Ambulatory Surgery

- Develop a numerical need methodology for ASCs
- Rationale: Some are supply-sensitive. Facility-based reimbursement drives higher spending. Numerical methodology would promote consistency and predictability. Would control unnecessary development.
- Concerns: How effective is CON, in the absence of CON for OBS practices?

Office-Based Surgery

- Require CON for OBS practices of specified size (e.g., >1 OR)
- Rationale: Would level the playing field and help to mediate competitive issues. Would promote licensure and payments to HCRA pools.
- Concerns: Lack of regulatory resources. Greater penetration of licensed facilities would drive up spending.

Ambulatory Surgery: Alternative Option

- Eliminate CON for ASCs. Retain licensure, physical plant oversight.
- Rationale: Given development of OBS practices, CON has limited utility. Would encourage conversion of OBS sites to regulated facilities that would pay into HCRA pools.
- Concerns: Greater penetration of ASCs would drive higher spending. Loss of ability to mediate competitive issues between ASCs and hospitals.

Hospital Beds: High Impact or Low Impact?

- ❑ Eliminate CON for hospital beds over next 5 to 10 years. Retain prior approval for elimination relocation or conversion of beds.
- ❑ Rationale: Financial incentives will discourage unnecessary development of beds. CON will become unnecessary.
- ❑ Concerns: Incentives are not yet effective. Sentinel effect of CON may control development.



Options for Low Cost/Low Utilization Services and Facilities

Options for Low Cost/Low Utilization Services and Facilities

- Low Cost/Low Utilization Services and Facilities are:
 - *Not* supply-sensitive (greater supply does not drive higher utilization);
 - *Not* volume-sensitive (concentration of volume does not drive higher quality);
 - *Not* capital intensive;
 - *Not* drivers of significant Medicaid spending;
 - *Not* emerging technologies of unproven efficacy.



Options for Low Cost/Utilization Services and Facilities: Primary Care & Medical Specialty Consultations

- Eliminate CON review of primary care and medical specialty consultation services (i.e., *not* amb. surg., imaging, or radiation therapy). Retain licensure, physical plant oversight.

Low Cost/Low Utilization Services and Facilities: Primary Care and Medical Specialty Consultation Services

□ Rationale:

- Not capital intensive.
- Promote development of integrated systems.
- Promote primary care access.

□ Concerns:

- Development can destabilize essential providers.
- Proliferation of clinics may drive up costs.
- Proliferation of clinics may strain surveillance resources.

Low Cost/Low Utilization Facilities and Services: Hospice

- Update Hospice Need Methodology
- Rationale:
 - Current methodology is based heavily on cancer incidence;
 - Promote choice.
- Concerns:
 - Influx of competition could destabilize existing providers;
 - Proliferation of programs could strain surveillance resources.

CON Redesign: Draft Recommendations

Health Planning Committee
Public Health and Health Planning Council
November 14, 2012



Outline

- Context underlying redesign recommendations
- Description of problems/risks posed by context
- CON role and shortcomings
- Regional planning
- Update CON/licensure to promote appropriate supply
- Update CON/licensure to reflect complexity and scope of physician practices
- Promote improvements in quality and efficiency through governance
- Update CON in relation to population health, quality, and financial oversight



Context: Triple Aim Imperative

- ❑ Improve the patient experience of care (including satisfaction and quality);
- ❑ Improve the health of populations;
- ❑ Reduce the per capita cost of care.



Context: Federal and State Actions

- MRT and 1115 waiver amendment
- Affordable Care Act
 - Community Health Needs Assessment requirement
 - Access to affordable insurance
- New State Health Improvement Plan



Context: Delivery System Transformation

- ❑ Performance and cost-containment imperatives fuel new models of care and organization.
- ❑ Driven by value-based payment mechanisms.
- ❑ Prioritizing primary care.
- ❑ Enabled by health IT.



Context: New Models of Care and Organization

- Characterized by:
 - Focus on population health;
 - Patient engagement
 - Chronic disease management
 - Consumerism;
 - Vertical and horizontal integration;
 - Transfer of risk;
 - Importance of scale;
 - Growing influence of organized physician groups.



Risks

- ❑ Unsound risk arrangements and systems too big to fail.
- ❑ Penetration of “unregulated” providers.
- ❑ Destabilization of essential providers.
- ❑ Diminished access, especially for low-income and rural populations.
- ❑ Continuation of unsustainable cost curve and sub-optimal quality of care.



Role of CON in Addressing Risks

- Promote alignment of health care services with community needs:
 - Protect essential providers from destabilizing competition;
 - Encourage development in under-served areas;
 - Discourage closure of essential services.
- Reduce unnecessary capital development and supply-driven utilization and spending.

Shortcomings of CON in New Context

- Impacts supply, not demand; need multi-stakeholder, regional/local strategies to advance Triple Aim.
 - Does not provide funding to protect and promote needed services.
- Mismatch between providers covered by CON and development of services in marketplace.
- May delay development of licensed primary care and other needed services.



CON Shortcomings (cont'd)

- C&C reviews are misaligned with the complexity of health care organizations, the need to develop integrated systems, and the authority exerted by non-established entities.



ADVANCING THE TRIPLE AIM THROUGH REGIONAL PLANNING



Regional Planning: Principles

- Region-wide, collaborative planning;
- Focusing on health and health care, including coordination with behavioral health local planning;
- Representative of all affected stakeholders;
- Diverse governance structures based on regional circumstances and stakeholder interests;



Regional Planning: Principles

- ❑ State must be engaged in overseeing and encouraging through policy levers;
- ❑ State should develop a common data set;
- ❑ Regions must collect, analyze and display regional data in a neutral manner.
- ❑ Planning should address financial stability of delivery system.



Health Planning Entities

- Regional Health Improvement Collaboratives (RHICs)
- Convened by a neutral entity
- Governance structure representing key stakeholders: e.g., consumers, local public health officials, providers, payers, business, unions, community organizations.



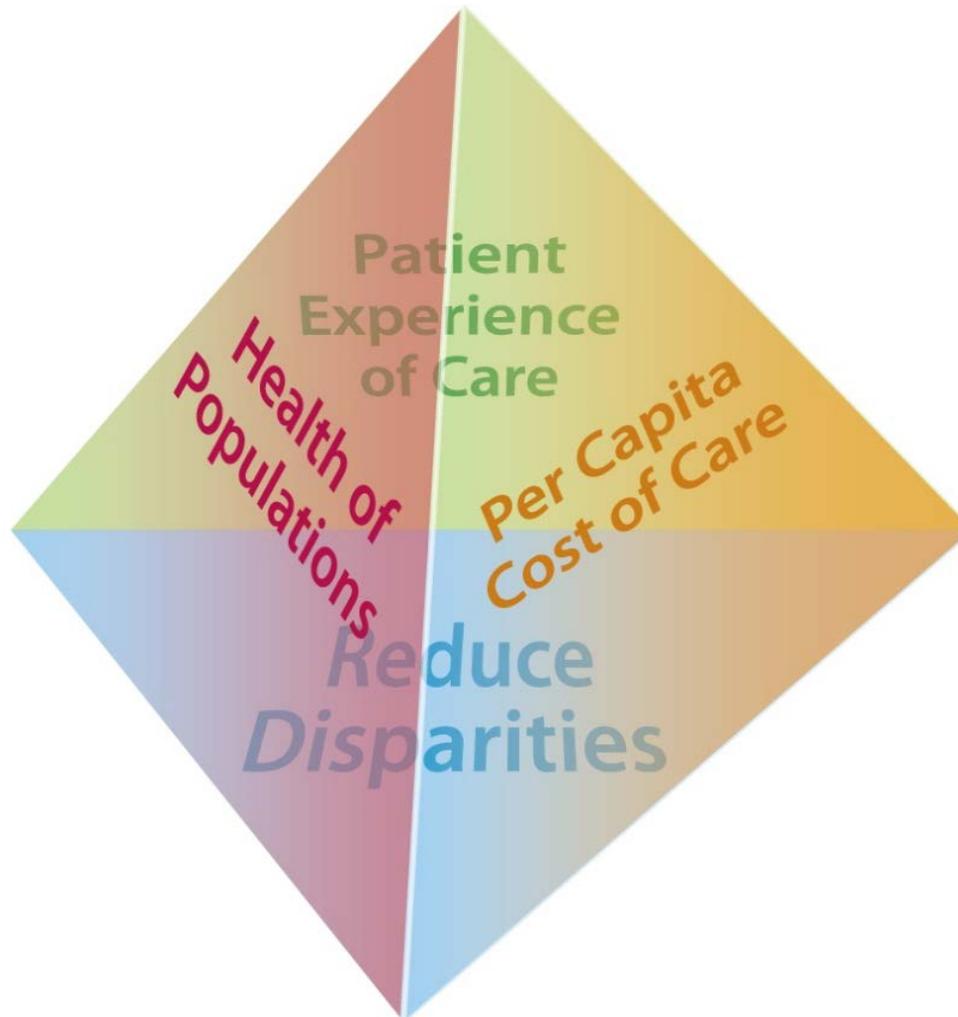
Regions

- Impossible to create perfect regional boundaries for health planning purposes.
 - Boundaries do not limit health care consumers, disease, or public health emergencies.
 - Cross-border and sub-regional activities will be important.

Regions (cont'd)

- New map based on stakeholder feedback
 - Recognizes existing health planning infrastructure and relationships.
 - 11 Regions
 - 4 regions will relate to 2 Economic Development Councils

RHIC Responsibilities: Advance the Triple Aim





RHIC Responsibilities: Health of Populations

- Advance at least 2 SHIP Priorities:
 - To be selected by stakeholders based on regional needs.
 - Address health disparities in connection with those priorities.

RHIC Responsibilities: Patient Experience of Care

- Examples include convening, analytics and technical support for:
 - Measurement of health system performance
 - Quality collaboratives
 - PCMH development
 - Evidence-based patient engagement strategies

RHIC Responsibilities: Per Capita Cost of Care

- Examples include convening, analytics and technical support for:
 - Strategies to reduce preventable utilization;
 - Health care needs assessments;
 - Multi-payer, value-based payment and benefit design initiatives;
 - Publication of quality, cost, spending data;
 - Collaborations that improve efficiency and financial stability of essential providers.



Regional Planning: Cross-Cutting Issues

- Health Disparities
- Workforce

Advancing the Triple Aim through CON



NYS Health System Performance

- Comparatively weak in:
 - Avoidable hospitalizations
 - Cost
 - Treatment/quality

Driving Health System Performance through CON

- CON is one of many tools
- CON, in transition, plays a role:
 - Curbing development of supply-sensitive services;
 - Channeling development in under-resourced areas;
 - Concentrating volume of highly-complex services.
- CON should:
 - Not impede development of new primary care
 - Facilitate development of integrated systems
 - Adapt to new models of care and payment

CON and Licensing: Distinct Disciplines

CON	Licensing
C&C of operator	C&C of operator
Public need	
Quality (volume-sensitive services)	Quality - program, staffing, policies/procedures
Reasonable cost	Physical plant safety
Financial feasibility	Financial resources

Updating CON to Promote Appropriate Supply

Streamlined Process for Projects that Do Not Affect Supply

- Administrative streamlining recommendation:
 - Narrowed scope of CON by exempting construction projects that don't affect supply and distribution.
 - Will not apply to nursing homes in short term.
- Retained licensing
 - Character and competence/compliance
 - Program review
 - Compliance with construction/design standards

Promoting Appropriate Supply: Supporting Primary Care

- Exempt primary care clinics from CON
 - Facilities that provide high-end imaging, radiation therapy, dialysis, or surgery would not be eligible for exemption.
- Licensure requirements would apply, including prior approval of:
 - Establishment, C&C, compliance, quality
 - Physical plant compliance

Promoting Appropriate Supply: Supporting Primary Care

- Hospital and FQHC acquisition of primary care physician practices:
 - Licensing reviews should be expedited where primary care access is threatened.
 - Renovations to satisfy physical plant standards may create delays.
 - DOH should work with stakeholders to create a process that preserves access while facilities are undertaking steps to comply with physical plant requirements.

Promoting Appropriate Supply: Grant-Funded Projects

- Projects funded with HEAL and other time-sensitive capital grants:
 - If entire project was approved through RFA process, it should be exempt from public need and subject to limited financial review.
- Licensing review, including physical plant oversight, should be required.

Promoting Appropriate Supply and Quality: Technology

- NYS should be at the forefront of innovation in medical care; but:
- Capital-intensive, emerging technologies should not be widely disseminated before they have demonstrated their value.
- Volume-sensitive, complex services should be concentrated in specialized centers.
- DOH should contract with a research institute to evaluate technologies and services that should be subject to CON.

Promoting Appropriate Supply: Hospital Beds

- ❑ New payment incentives are expected to discourage development of hospital beds.
- ❑ In the future, inpatient care may not be supply-sensitive.
- ❑ During transition, CON should be retained.
- ❑ Reexamine applicability of CON to hospital beds within 3 to 5 years.

Promoting Appropriate, Supply and Quality: ACOs

- Delivery system is shifting to integrated systems of care that:
 - Implement evidence-based practices
 - Accept risk-based payments.
- Diminished incentives to develop unnecessary capacity, services.
- State certification process could promote preservation of essential services, population health, and quality.
- Re-visit CON for ACO participants once certification process is adopted.

Promoting Appropriate Supply: Updating CON

- Hospice need methodology should be updated.
- Pipeline projects should not be permitted to “bank” their CON approvals indefinitely.
 - Prevents accurate evaluation of unmet need.
 - CONs should expire, if construction is not commenced or establishment is not finalized within a specified period (e.g., 5 years).



UPDATING CON TO REFLECT COMPLEXITY OF PHYSICIAN PRACTICES

Promoting Appropriate Supply and Quality: Leveling the Playing Field

- Disparate requirements and payment for facility-based services versus physician practice-based services.
- Certain services raise issues regardless of setting:
 - Supply-sensitive and/or capital-intensive
 - Competitive concerns for hospitals
 - Unnecessary radiation exposure
 - Volume-quality associations

Promoting Appropriate Supply and Quality: Leveling the Playing Field (cont'd.)

- DOH should consider equalizing treatment based on studies regarding:
 - Relative quality and cost of OBS and ASC services.
 - Impact of ASC and OBS services on hospital viability, access and public health.
 - Impact of physician practice-based operation of high-cost equipment on costs, quality, access, and public health.

Leveling the Playing Field: Corporate Practice and De Facto Clinics

- DOH should consider updating or adding regulatory oversight of:
 - D&TC look-alikes by clarifying the criteria that define a facility subject to licensure requirements; and
 - Corporate control of physician practices.



**PROMOTING IMPROVEMENTS
IN QUALITY AND EFFICIENCY
THROUGH GOVERNANCE**

GOALS

- ❑ Rationalize “taint” rule to eliminate barriers to integration and recruitment of experienced leadership;
- ❑ Focus on track records of organizations, where appropriate;
- ❑ Streamline review processes to accommodate complex organizations and facilitate integration;
- ❑ Promote system integration and align oversight/accountability with effective control;
- ❑ Strengthen DOH authority to respond when governing body fails.

Support System Development and Recruitment of Experienced Leadership

- “Taint” Rule: Eliminate mandate based on 2 enforcements; instead disqualify individuals or organizations based on:
 - Pattern of, or multiple, enforcements; and/or
 - Poor performance on quality metrics developed by Office of Patient Safety and Quality.
- Presumption of disqualification can be rebutted based on role, experience, recent performance.



Streamline Review Processes to Accommodate Complex Organizations

- Character & Competence Reviews of Established NFP Operators:
 - Require established NFP operators to conduct C&C reviews of new board members at appointment;
 - Require operators to update C&C review prior to any establishment action.
 - Instead of DOH verification, require attestation and disclosure by operator.

Streamline Process to Accommodate Complex Organizations (cont'd)

- Character and Competence Review of Proprietary Organizations with Corporate Ownership (e.g., dialysis, home care):
 - Review individuals in the regulated entity and direct parent (or grandparent if parent is holding company);
 - Secure attestation from ultimate parent(s) concerning organizational compliance history, including controlling shareholders and related entities, and C&C of directors and officers and any individual controlling shareholders.

Character and Competence Review of Proprietary Organizations with Corporate Ownership (cont'd.)

- Verify attestation through:
 - Independent review by auditor, accrediting body, or other appropriate entity; or
 - DOH review.



Strengthen Governance: Passive Parent Models

- ❑ Encourage governance models that support integration of services, quality, and efficiencies.
- ❑ Some oversight of passive parents is warranted.

Strengthen Governance: Passive Parent Models

- Require established health care facilities to submit a notice to DOH 90 days prior to commencing a passive parent relationship.
- Include entities involved, board members and affiliation agreement.

Strengthen Governance: Passive Parent Models

- DOH would have 90 days to recommend disapproval. If no action were taken, transaction would be deemed approved.
- Approval would be time-limited (i.e., 3 years), with opportunity for extension.

Strengthen Governance: Passive Parent Models

- Grounds for disapproval would be:
 - Poor compliance or quality record;
 - Financial instability.
- If disapproval were recommended, application would be submitted and advanced to PHHPC.

Strengthen Governance: Existing Passive Parents

- Grandfather approved passive parents of existing affiliates.
- Conduct periodic review (i.e. every 3 years), including satisfactory quality, financial and compliance record among affiliates.
- Poor track record could result in revocation of approved status, temporary operator, or appointment of new board members.
- Existing passive parents affiliating with new entities would be subject to 90-day review.



Strengthen Governance: Passive Parent Models and Clinical Integration

- Require passive parents that negotiate health plan contracts on behalf of their affiliates to be clinically integrated.
 - May require change in passive parent powers.
 - Would require standards for clinical integration.



Strengthen Governance: Monitor Major Changes in Boards

- Create more structured process for annual board membership filings.
- Require operators to report any change of 25 percent or more in board membership within a 12-month period.



Strengthen DOH Authority to Respond to Failures in Governance

- Ongoing monitoring and authority to intervene are more effective tools in promoting quality, integrity, and financial stability than character & competence reviews.



Strengthen DOH Authority to Respond to Failures in Governance

- Enact legislation that would permit DOH to appoint a temporary operator or replace board members of a hospital or D&TC under limited circumstances, when:
 - Health and safety of patients is at risk;
 - Financial instability threatens patient care.



Strengthen DOH Authority to Respond to Failures in Governance

- Expand use of limited-duration operating certificates:
 - Establishment of new operators;
 - New models of care; or
 - Compliance or quality concerns are identified.



**UPDATE CON IN RELATION
TO POPULATION HEALTH,
QUALITY, AND FINANCIAL
OVERSIGHT**



Incorporate Quality and Population Health into CON and Licensure

- Incorporate quality and population health considerations into CON and licensure using measures appropriate to the project.

Incorporate Quality and Population Health into CON and Licensure

- Require satisfaction of quality benchmarks prior to approval of new capacity or services;
- Expand “public need” schedule to include relationship to SHIP priorities;
- Require implementation of certified EHR and connection to SHIN-NY;



Incorporate Quality and Population Health into CON and Licensure

- Require SPARCS submission as condition of CON or licensure of new services or sites;
- Require prior approval of clinical construction to assure physical plant safety.

Promote Financial Stability

- ❑ Monitor financial status of hospitals and nursing homes, using standard metrics.
- ❑ Conduct more calibrated approach to financial feasibility reviews, focusing on financially-weak providers.
- ❑ Consider impact of risk-based payments.
- ❑ Provide greater flexibility in review of debt structures for financially strong hospitals.

Promote Financial Stability and Cost-Effective Collaborations

- Relax prohibition on revenue sharing with non-established entities.
 - Permit collaborations among providers in connection with care coordination and value-based reimbursement;
 - Permit commercially-reasonable arrangements with vendors.
- Require review of terms or limits on revenue sharing, but not necessarily establishment.

CON Redesign: Proposed Recommendations of the Health Planning Committee

Health Planning Committee
Public Health and Health Planning Council
November 19, 2012



Regional Health Planning

- **Recommendation #1:**
- **In this time of rapid change, health planning should be reinvigorated on a regional basis through multi-stakeholder collaboratives to promote improvements in the patient experience of care (including quality) and the health of populations and reductions in the per capital cost of care.**

Regional Health Planning

- **Recommendation #2:**
- **PHHPC recommends the creation of multi-stakeholder Regional Health Improvement Collaboratives (RHICs) to conduct regional planning activities.**
- **Recommendation #3:**
- **PHHPC recommends the creation of 11 geographic planning regions.**
- **Recommendation #4:**
- **Each RHIC should be responsible for advancing each dimension of the Triple Aim in its region.**
- **Recommendation #5:**
- **The PHHPC should consult with the RHICs concerning the regional health and health care environments, unmet needs, and effective planning strategies and interventions that could be disseminated statewide.**

Driving Performance through CON and Licensure

- **Recommendation #6:**
- **PHHPC recommends eliminating CON for primary care facilities, whether D&TCs or hospital extension clinics. Retain licensure.**
- **Recommendation #7:**
- **Projects approved and funded through time-sensitive State Department of Health grants should be exempt from public need review and subject to limited financial review.**

Driving Performance through CON and Licensure

- **Recommendation #8:**
- **DOH should enter into a contract with a research institute to evaluate emerging medical technologies and services that might be appropriate for CON.**
- **Recommendation #9:**
- **Retain CON for hospital beds at least in the short run and reconsider in the next three to five years.**

Driving Performance through CON and Licensure

- **Recommendation #10:**
- **Use Certification of ACOs to Promote Appropriate Distribution of Facilities and Services and SHIP Goals**
- **Recommendation #11:**
- **Update the CON Process for Hospice**
- **Recommendation #12:**
- **Update the CON Process for Pipeline Projects**

Update CON and Licensure to Reflect Complexity of Physician Practices

- **Recommendation # 13:**
- **Update the Criteria that Trigger the Facility Licensure Requirement and Equalize Treatment of Physician Practices and Facilities Under CON, Based on Recommendations to be Provided to PHHPC within 6 Months.**

Promoting Improvements in Quality and Efficiency through Governance

- **Recommendation #14**
- **Rationalize “Taint” to Eliminate Barriers to Integration and Recruitment of Experienced Governing Body Members.**
- **Recommendation #15:**
- **Streamline Character and Competence Reviews of Established Not-for-Profit Corporations.**
- **Recommendation #16:**
- **Streamline Character and Competence Reviews of Complex Proprietary Organizations (e.g., publicly-traded, private-equity-owned) and New, Complex Not-for-Profit Systems.**

Promoting Improvements in Quality and Efficiency through Governance

- **Recommendation #17:**
- **Align “Passive Parent” Oversight with Powers Exerted by Parents and Promote Integrated Models of Care**
- **Recommendation #18:**
- **Improve Transparency of Major Changes in Board Membership**
- **Recommendation #19:**
- **Strengthen DOH Authority to Respond to Failures in Governance**

Incorporate Quality and Population Health into CON Reviews, Streamline Financial Feasibility Reviews, Promote Innovative Payment Arrangements

- **Recommendation #20:**
- **Consider performance on quality benchmarks and relationship to the SHIP, when reviewing applications to expand services or sites.**
- **Recommendation #21:**
- **Pursue a more calibrated approach to financial feasibility reviews.**
- **Recommendation #22:**
- **Relax the prohibition on revenue sharing among providers that are not established as co-operators to facilitate collaborations and innovative payment arrangements.**