A Regional Perspective on the Certificate of Need Process

October 20, 2011

Submitted to the Public Health and Health Planning Council by the members of the Adirondack Rural Health Network Community Health Planning Committee

Adirondack Medical Center
Adirondack Rural Health Network
Elizabethtown Community Hospital
Essex County Public Health
Franklin County Public Health Services
Fulton County Public Health
Glens Falls Hospital
Greater Adirondack Perinatal Network
Hamilton County Public Health Nursing Service
Hudson Mohawk Area Health Education Center
Moses-Ludington Hospital
Nathan Littauer Hospital and Nursing Home
Saratoga Hospital
Saratoga County Public Health Nursing Service
Warren County Health Services
Washington County Public Health

This response was developed by the Adirondack Rural Health Network with guidance from the Community Health Planning Committee

Adirondack Rural Health NETWORK

Introduction

On September 28, 2011, the New York State Public Health and Health Planning Council released a statement asking stakeholders to provide comments and recommendations on the scope and content of the Certificate of Need (CON) process. The Adirondack Rural Health Network Community Health Planning Committee is a regional collaboration that conducts community health assessment and planning activities by providing the forum for local public health services, community health centers, hospitals, community mental health programs, emergency medical services, and other health-related service agencies to assess regional needs and the effectiveness of the rural health care delivery system. Since 2002, the ARHN has been recognized as the facilitator of formal health assessment activities for Essex, Fulton, Hamilton, Saratoga, Warren and Washington counties. In 2011, Franklin County joined the regional planning efforts.

The members of the Adirondack Rural Health Network Community Health Planning Committee present the following responses to the five questions provided by the New York State Public Health and Health Planning Council.

1. **How can the CON process be refined to respond appropriately to new models of care, new ways of structuring relationships among health care providers, new technologies and migration of services to outpatient settings?**

   As health care spending continues to grow more rapidly than the nation's economy, there is renewed interest in CON regulation as a way to improve health and help control spending. The CON process needs to ensure there is a coordinated system that meets the needs of consumers as well as providers. As New York State begins their deliberation on the current CON process, the following remarks should be considered:

   - Intent and Structure of CON: Conduct a thorough analysis of the original intent of Article 28 of the Public Health Law to determine if the current CON process is providing a structure that meets the needs of the people of New York State:
     - Protection & Promotion of Health: the current system exempts some health care providers from CON review while holding other providers to a strict standard of quality.
     - Efficiency: The CON is inefficient and hinders health care providers' ability to provide care in an efficient and timely manner.
     - Proper Utilization: The CON system has no impact on, and does not address, proper utilization of care.

- Access to Care: The complex, drawn-out and expensive CON process significantly limits providers' ability to develop local healthcare infrastructure that meets community need in a timely manner and at a reasonable cost.
- Quality of Care: The often lengthy CON process can negatively impact quality by delaying acquisition of new technology and keeping facilities from having the most-advanced and potentially higher-quality equipment.
- CON and Health Reform: The 2010 Patient Protection and Affordable Care Act includes a key provision that might impact the CON Process:
  - An increase in the insured population that will demand more services, which may call for increased provider capacity. Communities with a high proportion of currently uninsured people, and truly inadequate capacity in key areas, will need an approval process that is efficient and allows for timely response to increased demand.
  - Reducing CON regulations will benefit other goals of health care reform, such as the creation of integrated health systems, medical homes and accountable care organizations.

2. **How can the CON process incorporate consideration of public health priorities to ensure that our health care delivery system has the capacity to prevent disease, and, with local partners, improve the health of the community it serves, not just react when prevention efforts fail?**

   We fundamentally agree that to change the ways in which we deliver care will require focused and combined efforts by patients, health care organizations, healthcare professionals, community members, payers, government organizations, and other stakeholders. We agree that there needs to be a more direct connection between public health and other segments of the healthcare system in order to improve population health and prevent disease. However, we do not agree that this can or should be addressed through the CON process. The health care system would most benefit from increased incentives for initiation of evidence-based interventions and program/service evaluation. Instead of a State administered process, move toward a process driven by local and regional data and collaborative planning.

3. What is the role of regional planning?

Regional health planning can provide valuable information by identifying gaps in service, assess accessibility of critical services and conduct data collection, research and analysis. For regional health planning to be effective, the following resources need to be available:

- A better system of data collection so the procurement of the majority of planning data is at zip code level.
- Zip code level data will allow for targeted area analysis that will more appropriately create services that address pockets of need.

4. What projects should no longer be subject to CON and/or what projects should be reviewed but currently are not?

We recommend that CON requirements be applicable to the following only:

- Projects with total cost exceeding $10,000,000.
- Any project proposing to add new inpatient beds to the operating certificate.
- Any project proposing to add new services to an organization’s main operating certificate or adding services to the operating certificate of an extension clinic whose cost exceeds $250,000.
- Changes in ownership, mergers and consolidations.

Additional Remarks

- We endorse that the CON requirements be fair and equitable across the health care system with all providers required to follow the same process regardless of designation.
- We also recommend that an equitable reporting process be required for all providers of care irrespective of their designation.
- We recommend a less restrictive process when removing services from an operating certificate.

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October 26, 2011

Dr. John Rugge, Chair
Health Planning Committee
Public Health and Health Planning Council
433 River Street, 6th Floor
Troy, NY 12180

Dear Dr. Rugge,

The Community Health Center Association of New York State (CHCANYS) appreciates the opportunity to comment on the scope and content of the Certificate of Need process and share its recommendations for reform.

CHCANYS' purpose is to ensure that all New Yorkers, including those who are medically underserved, have continuous access to high quality community-based health care services including a primary care home. To do this, CHCANYS serves as the voice of community health centers as leading providers of primary health care in New York State. As New York State's Primary Care Association, CHCANYS works closely with the more than 60 Federally Qualified Health Centers (FQHCs) and FQHC Look-Alikes that operate approximately 490 sites across the state. Serving 1.4 million New Yorkers, these FQHCs are central to New York's health care safety net. Twenty-seven of New York State's 62 counties are home to at least one FQHC; FQHCs are located in most of the state's major cities, throughout New York City's five boroughs, and in upstate New York rural communities.

As an association that represents the statewide network of FQHC's, our providers play a critical role in the health care delivery system, a role that is taking on dramatically greater importance as we move deeper into federal and state health reform initiatives aimed at expanding preventative services.

In order to be able to respond to these challenges, our providers need to operate within a regulatory process that strikes a more equal balance among bureaucracy, responsiveness and flexibility. As an association, we have reviewed existing CON regulations, policies and protocols, and offer the following ideas for reform.

- Timing of reviews – Many times, our providers propose to fully or partially fund projects with grant proceeds, the majority of which emanate from the federal government (HRSA). These grants are highly competitive and usually require the applicant to be "shovel ready" and complete construction within 120 days and two years, respectively. New York state providers are challenged to meet these deadlines under CON processing timeframes and risk losing federal funding opportunities. A potential solution to this problem would be the initiation of an expedited review process for projects proposing grant funding. If HRSA approves a site, initial contingent approval should be granted. Administrative processing for an otherwise full review should be allowed, and all administrative reviews of CONs in this category should be completed within no more than 60 days.

- Timelines for each level of review should be established by the DOH and adhered to. The uncertainty and delays posed by the current elongated process pose a myriad of problems for an industry that will require substantial expansion. Full reviews should be completed no later than 120 days from submission, administrative 90 days (except for grant funded projects).
- The current procedure of "30 day letter" generation by each of the review units (as many as six different) should be replaced by one common, thorough, non duplicative electronic letter.
- A single point of contact should be established within the CON program. That individual would be responsible for processing from submission right through to project implementation. This level of familiarity and continuity would bring long needed efficiency to the process, and should shorten review times.
- DOH should encourage an initial meeting with all applicants, wherein all reviewing units are gathered to provide their initial review comments. This meeting should immediately be followed up with one single, written electronic communication outlining the outstanding issues, with an agreed-upon schedule of deadlines leading up to the expected approval date.
- It is our understanding that the process for "emergency approvals" no longer exists. We believe that this is a serious setback to the goal of maintaining access to needed services. There are many situations in which continuity of care cannot afford the delays associated with the CON process. We urge you to reinstate the emergency approval process, accompanied by a clear explanation of the rules.
- Although we recognize that this is a difficult one, CON approvals should move toward a basis in relative quality of care. The current process links approval to the absence of infractions, not on the comparability of quality to standards and the results of other providers. We believe that a well thought out and implemented process that rewards documented good quality, and penalizes those with inferior and stagnant quality outcomes, should be devised.
- The current policy of the DOH is to require a CON approval as a prerequisite to processing a rate appeal for recognition of the attendant capital costs. With the increasing CON cost thresholds, many projects do not require CON approval. As providers are entitled to capital cost reimbursement, this disconnect must be remedied. Its continuation will cause increasing revenue shortfalls and reconsideration of needed projects.
- The pre-opening survey process needs to be overhauled to assure timeliness and consistency from the beginning of the CON process through to occupancy or implementation. All too many times, surveyors at the pre-opening stage interpret the same regulations used at the front end of the process differently. This poses many problems at a time when the applicant believes it has complied with all requirements and is ready to open. The consequences of this disjointed process range from unexpected increased expenditures to delays in providing needed preventative services.
- The issue of the "unlevel playing field," i.e. a strict, time-consuming and sometimes expensive process for regulated providers under Article 28 vs. the virtual freedom enjoyed by the private health delivery sector, i.e. private physicians. This policy places the regulated providers at a distinct disadvantage when seeking to grow and expand services. Either both segments should be regulated equally, or Article 28s should be given much broader freedom to implement projects.
- The recent move toward free standing Emergency Rooms deserves careful review. As an organization, CHCANYS supports the development of these hybrid providers where needed. However, the types of visits it provides should be defined and distinguished, and the need review should be required to

consider all existing outpatient clinics in the service area and the nature of services provided. To do otherwise may have the effect of creating excess primary care capacity and thus expenditures.

- Existing regulations that prohibit the sharing of revenues between private physicians and other types of non–Article 28 providers should be re–examined. These type of restrictions may inhibit the very types of collaborations needed to achieve true health reform and/or require the creation of complex and expensive legal structures and documents.
- Policies and regulations governing the " co–location" of Article 28 services with other provider types (other Article 28s, private practices, A16, A31, etc.) must be reformed. Health reform demands greater collaboration among these types of providers; the existence of such strong impediments will only serve to delay needed partnering.
- The partial "Upgraded Diagnostic and Treatment Center" regulations should be completed by adding programmatic and reimbursement elements. This type of provider may serve to meet the needs of rural areas more effectively, and has some interest, but cannot be implemented as presently constituted.
- The concept of "self certification" should be utilized more broadly, particularly in the area of architectural and engineering reviews. This stage of the CON process is the cause of many time delays, some rather lengthy. A process that holds providers accountable and provides for look backs with appropriate penalties should be initiated.
- Consideration should be given to imposing requirements for Medicaid access by providers. The uneven distribution of Medicaid patients via business and referral practices in and of itself creates an un-level playing field, and places a disproportionate and unfair burden on those providers who are mission based to accept all patients.
- A clear and concise definition of a "non–clinical" project should be published and adhered to throughout the review process.
- A coordinated and consistent process should be established for anyone wishing to formally oppose a project, and made available to the public.
- The DOH should make available any data sets that are not otherwise restricted to providers for their use in more effectively planning projects.
- Consideration should be given to expanded use of "limited life " approvals, or a variation thereof, to hold applicants accountable for delivering commitments made in CON applications.

Thank you for the opportunity to share our thoughts on CON Reform. CHCANYS appreciates your attention to this important issue and looks forward to continued dialogue on CON and health planning for New York State.

Sincerely,

Elizabeth H. Swain
Chief Executive Officer

Upstate Health Planning Coalition
Improving Health Care through Regional Health Planning
November 2011

Regional Health Planning Recommendations

The regional health planning organizations or Regional Planning Groups (RPGs) for the four major Upstate Metropolitan areas are developing the Upstate Health Planning Coalition (UHPC) to maximize our effectiveness in addressing healthcare planning and program development needs and improving population health in the 30 counties we serve. This white paper presents UPHC's consensus position on the value of regional health planning and on recommendations for a sustainable health planning infrastructure in New York State.

VALUE OF HEALTH PLANNING AND REGIONAL PLANNING GROUPS

The coalition has identified several means by which **regional health planning** and its inherent commitment to local involvement adds value to healthcare delivery and community health:

- **Health planning brings together community** stakeholders to analyze health needs, address challenges, assess results, and design interventions for change. They work to improve the performance of their health systems, supporting the "Triple Aim" of the Institute for Healthcare Improvement – better care for individuals, better health for populations and lower per-capita costs.

- **Local processes provide the best understanding of unique factors and are attuned to relationships among sectors of care.** They are also better positioned to evaluate the impact that decisions in one sector can have on the other and to negotiate and consider tradeoffs that may be necessary.

- **Local processes can effectively deal with system change and restructuring** evidenced by hospital closures, mergers and conversions, development of shared services, new practice networks, reductions in length of stay, and diversion of surgery and other procedures to outpatient settings over the last twenty years.

- **Regional Planning Groups are unique** in their ability to bring a regional perspective to carrying out health planning functions that:

    - identify community health care needs and develop recommendations and strategies to promote and improve the health of individuals and communities
    - facilitate access to affordable, high quality health care
    - identify health care and health care delivery system resources to meet community needs
    - consider relationships that exist between tertiary and local county providers of care.
    - examine demographic, health status, health service, and resource variations within regions and across urban, suburban, and rural areas

- **Regional Planning Groups can serve as independent, community-based vehicles** for:

  - understanding the range of health related issues in their respective communities
  - networking and sharing ideas in building healthier communities
  - designing and implementing local and regional healthier community projects
  - advising DOH and others on local program and funding priorities
  - advocating for health issues that are important to the community
  - identifying health disparities in the region and strategies for pooling resources of providers, payers, and others to address unattended health needs.
  - providing a forum to balance or distinguish community needs from those driven by institutional imperatives to expand services based solely on competitive pressures

- **Regional Planning Group operations foster credibility and legitimacy at the local level**. They can promote public acceptance of change and serve to enhance the ability of local boards of trustees to act in the public interest as they carry out their fiduciary responsibilities.

RECOMMENDATIONS

- **Regional health planning** in New York State **should be maintained and utilized** as a vehicle in shaping the future of health care in the 21st Century. New York State should continue to **invest and assist in efforts to help sustain a viable regional health planning core infrastructure**.

- The New York State **Commissioner of Health should formally recognize RPGs** to advise the community, local providers, DOH and others on high priority community health needs. This recognition would legitimize RPG responsibilities for collaboratively identifying local and regional health priorities, designing or promoting community-based prevention strategies, recommending health system changes to address needs, and tracking success in achieving healthier communities.

- Currently, two of the RPGs are health systems agencies with designated functions under Section 82-1.6 of the NYS Health Code. **These same functions should be utilized as an overall framework for all RPGs** to serve as the basis for analyzing and articulating regional community health needs in advising both governmental and private sector decision-making. Local priorities and resource limits necessitate that certain functions (e.g. those relating to CON review) be optional for each RPG.

- **RPGs should supplement state data bases and information sources** by collecting and analyzing local data, structuring focus groups and performing needs assessments. Topical policy papers should be developed and widely distributed for use in policy development and advising both public and private sector decision making.

UPSTATE HEALTH PLANNING COALITION

- **The Upstate Health Planning Coalition will** provide a means for RPGs to **speak with a unified voice** in serving as a resource for state policy makers - including the Department of Health, the Governor's Medicaid Redesign Team and the Public Health and Health Planning Council. It can do this through:

    1. *Consistent data reporting* - working to develop common benchmarks, definitions and data measures based on research and evidence-based standards
    2. *Collaboration* - Upstate Health Planning Coalition members collaborate in a variety of ways, providing a convenient forum for state leaders who want to understand how state policies or proposals will affect Upstate communities
    3. *Shared vision* - Development of consensus opinion with regard to State policy and Upstate priorities and goals

- **The Upstate Health Planning Coalition will provide a two-way link** between the community agencies and the state in sharing information on data, best practices, and other issues, as illustrated in the examples below

State Policy Makers

- Affordable Care Act implementation
- Medicaid redesign and reform
- Health care 3.0
- Population health and usage data sharing
    - All payer database
    - SPARCS, Cost Report, Vital Stats
    - Integrated public access database
    - RHIO data

Regional Connections

- Common definitions and data reporting (PQI, HEDIS, claims data)
- Policy impact assessments and recommendations
- Benchmarks and best practices

Community Health Initiatives

- ⬇ Hospital readmission rates
- ⬇ Avoidable hospital admissions (Prevention Quality Indicators)
- ⬇ ED crowding and overuse
- ⬇ Health disparities
- ⬆ Improved Service/Resource Distribution
- ⬆ Alignment of Aging and Long Term Care Services
- ⬆ Data and Program synergies with RHIOs

November 15, 2011

John Rugge, M.D., Chair
Health Planning Committee
Public Health and Health Planning Council
433 River Street, 6th Floor
Troy, New York 12180

Dear Dr. Rugge:

We appreciate the opportunity to share our views on the importance of regional health planning and to participate in the PHHPC Health Planning Committee's review of the CON process. The Upstate Health Planning Coalition (UHPC) is in strong support of the Committee re-visiting and updating the CON process consistent with the rapid changes in today's heath care environment.

While two of the Regional Planning Groups (RPGs) represented by UHPC have CON review roles as HSAs and two do not, we all believe that the CON process can play an important role in advancing population health outcomes, particularly when linked to regional planning analysis and priority setting. RPGs provide the best resource for clarifying important contextual factors in a region. To that end, UHPC has developed 1) a "white paper" with recommendations based on the key functions and assets of RPGs and 2) a set of consensus recommendations on the use of regional planning in the CON process. Both documents are attached.

Sincerely,

Upstate Health Planning Coalition

Central NY Health Systems Agency and Health Advancement Collaborative of Central NY
Timothy Bobo, Executive Director, CNYHSA
Rob Hack, Executive Director, HAC-CNY

Finger Lakes Health Systems Agency
Fran Weisberg, Executive Director

Healthy Capital District Initiative
Kevin Jobin-Davis, Executive Director

P2 Collaborative of Western New York
Shelley Hirshberg, Executive Director

Certificate of Need Recommendations

The regional health planning organizations or Regional Planning Groups (RPGs) for the four major Upstate Metropolitan areas are developing the Upstate Health Planning Coalition (UHPC) to maximize our effectiveness in addressing healthcare planning and program development needs and improving population health in the 30 counties we serve. This paper presents UPHC's consensus position on Certificate of Need Reform. UHPC supports the Public Health and Health Planning Council effort to review the intent and benefits of the CON process to clarify how the process can best improve population health outcomes within the dynamic changes currently occurring in the healthcare industry.

- Streamlining the CON process for applicants is an essential part of CON reform. Often there are multiple levels of state approval required for an applicant. This imposes a tremendous burden on the applicant at substantial cost. Just as the state has approached administrative streamlining with the Sage Commission, a similar endeavor needs to be part of the CON reform to eliminate redundancy and conflict for those seeking CONs.

- DOH should be encouraged to utilize RPG needs assessments, policy papers and recommendations as guidance in its review of CON applications, program development and funding decisions. Local, voluntary options can also be exercised by RPGs to encourage applicants' to address planning and prevention priorities. These options include:

  - Developing planning and program opportunities for potential applicants participation prior to, or independent of, a CON submission
  - Providing public comment to DOH on CON applications as allowed for in the state's CON process
  - Recommending conditions to DOH for approval of certain CON proposals, particularly those with a high impact on the community

- The New York State Department of Health's Certificate of Need applicant questions on Community and Public Need review should be modified to take account of regional and community planning priorities identified by recognized RPGs such as health system agencies, local health improvement initiatives, and rural health networks. Specifically, CON schedules (16B, 17B, 18A, 19B, 20A and 21A) should be revised to require an applicant to address regional planning priorities or related needs and research findings identified by RPGs.

- Schedules 16B and 17B should also include a question on Hospital and D &T Center applicants' partnerships and commitment to preventive health care programming in their service area.

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President

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February 1, 2012

1) ROT
2) CON Redesign file

Dr. John Rugge
Chair, Health Planning Committee
New York State Public Health and Health Planning Committee (PHHPC)
c/o Hudson Headwaters Health Network
9 Carey Road
Queensbury, New York 12804

Dear Dr. Rugge,

On behalf of the Board of Directors and members of the New York State Association of Health Care Providers, Inc. (HCP), thank you for conducting a thorough review of the current Certificate of Need (CON) system.

HCP represents approximately 500 offices of Licensed Home Care Services Agencies (LHCSAs), Certified Home Health Agencies (CHHAs), Long Term Home Health Care Programs (LTHHCPs), Hospices and related health organizations throughout New York State.

HCP provided testimony to the Planning Committee of the State Hospital Review and Planning Committee in 2008. Since that time, the Council and the Department have advanced a number of HCP's recommendations, including:

- Consolidation of the State Hospital Review and Planning Council (SHRPC) and the Public Health Council (PHC) into a single body;
- The creation of a reliable, accessible, and centralized source of information on pending CON applications through the Department of Health Web site;
- Draft regulations to revise the Certified Home Health Agency (CHHA) charity care requirement, allowing the creation of Community Service Plans, as is currently permitted for hospitals.

The latest round of CON process analysis and reform will further refine the system, better aligning it with the State's policy goals and the rapidly evolving health care system. As you consider streamlining and comprehensive reform of the CON process, HCP offers the following recommendations.

Elimination of Public Need Determinations for Certified Home Health Agencies

While the decades-long moratorium on Certified Home Health Agencies (CHHAs) remains in place, the Department of Health and the PHHPC recently approved the use of a Request for Application (RFA) process to solicit new applications for CHHAs and/or CHHA expansion. The justification for doing so on a short-term emergency basis was that there was insufficient time to revise the need methodology and determine if there was, in fact, public need for new and expanded CHHAs.

Rather than proceeding in a limited, RFA approach, HCP recommends the elimination of the CHHA public need methodology to help establish a "level playing field" for home health care delivery, permitting competition, with the prospect of enhancing efficiency, quality and access.

Dramatic changes in health care, and specifically in home health care delivery, have occurred over the years that are not accounted for in the current CHHA public need methodology:

- Public policy shifts have increased the need for home care, as patients are discharged from hospitals sooner and require post-acute care;
- Technological advances have made it ever more possible during the last decade to administer treatment in a home environment that previously had been confined to a hospital setting. Telehealth and Infusion therapy are major examples;
- The delivery systems for home care have become more efficient and effective, as home care begins to focus on patient outcomes;
- Unlike hospitals or nursing home beds, the number of CHHAs has no impact with respect to controlling the utilization of home health services. Further, because the need for capital in the establishment of a CHHA is not as significant an issue, there is no need to demonstrate that there is adequate demand for home health services in order to secure financing;
- The closure of county-operated CHHAs has left many consumers with limited access to care and choice. While the Department has issued a limited Request for Applications (RFA) to help fill this gap, a wiser approach would be to eliminate the existing need methodology.

The needs test is an arbitrary restriction to the market that is antiquated and flawed. Eliminating the public need criteria that is currently used in connection with the establishment of CHHAs is necessary to appropriately respond to these dramatic changes in the evolving health care delivery system.

HCP supports increased access to both public and private markets for home care services for providers who are able to demonstrate character, competence and financial feasibility in the delivery of services. There are entities, including Licensed Home Care Services Agencies (LHCSAs), that have the expertise, interest and the capacity to become CHHAs, but are unable to do so because of the existing public need methodology.

The artificial restriction of the marketplace effectuated by the CHHA public need methodology, akin to a taxicab medallion, only serves to stifle the efficiency and quality born of competition. The CHHA public need methodology has been criticized for artificially restricting the home health market. Elimination of the CHHA public need methodology would help to establish a "level playing field" for home health care delivery, permitting competition, with the prospect of enhancing efficiency, quality and access.

The elimination of the public need methodology as a criterion for the establishment and expansion of a CHHA would require the enactment of statutory change by the Legislature and the Governor, and the recommendation by this distinguished body would go a long way in helping to secure such enactment.

Streamline, Standardize CON Process

HCP recommends that the State simplify the CON process that providers must navigate to respond to changes in the health care market and by working to make home and community based services more accessible. HCP also recommends that all DOH regulations, including those related to certificate of need, be applied in a uniform, consistent and fair manner for all providers who provide similar care.

The current CON process takes a very, very long time to complete, as applicants often face multiple delays at several stages of the review. In order to respond in a meaningful way to the growing demand for home and community-based services in New York, the process must be streamlined to reduce the burdens on applicants associated with the CON process. The establishment of NYSE-CON, the State's

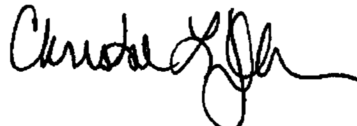
electronic Certificate of Need (CON) system is an important component of the effort to streamline the process, however NYSE-CON is not yet applicable to Licensed Home Care Services Agencies (LHCSAs).

Local Health Planning

HCP recommends that any local health planning initiatives be funded and implemented in a fair and equitable manner, and not according to politics at the state or local levels. It is also critical that such local planning process provide opportunity and processes that involve local home and community-based providers in a meaningful way to facilitate any consensus among stakeholders on community health care needs and priorities and appropriate strategies to address them. However, HCP cautions that local health planning will add another layer to an already complex process. Without reform of the current system, local health planning could slow down the process even further.

Again, thank you for the opportunity to provide comments on CON reform. Please do not hesitate to contact me if you have any questions or need any additional information.

Sincerely,



Christine L. Johnston
President

October 24, 2011

John Rugge, M.D., MPP
Chair, Health Planning Committee
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Dear Dr. Rugge:

I am writing on behalf of LeadingAge New York to provide input on the state's Certificate of Need (CON) process, per your recent request. LeadingAge NY represents over 500 not-for-profit and public providers of long term care and senior services throughout the state. We are pleased that the Health Planning Committee of the Public Health and Health Planning Council (PHHPC) is undertaking a review of the CON process in order to achieve new efficiencies while also addressing the reconfiguration of services that is already underway throughout the state.

Our response to each of the questions posed follows:

1. **How can the CON process be refined to respond appropriately to new models of care, new ways of structuring relationships among health care providers, new technologies, and migration of services to outpatient settings?**

   Flexibility, relevance and timeliness will be critically important considerations in refining the CON process in an environment characterized by rapid changes in service delivery, the role of care coordination, provider models, payment policies, technologies and locus of service.

   An overall framework for revisiting CON would include an effort to streamline the process generally, and to ensure an appropriate level and type of review depending on the proposal. Full review should be reserved for the most significant actions that would benefit from the added due diligence and public discourse that PHHPC review brings with it.

   There could be specialized administrative pathways based on the type of provider/action, local planning needs and recommendations, and innovative new models. For example, specialized pathways could be based on provider type. This concept would recognize that the capital needs of a home care agency, for instance, are far different from those of an institutional provider. Specialized applications for different providers or types of proposals could be appropriate and help streamline the process. For instance, should the review for a straightforward service expansion differ from a project requiring a capital investment and, if so, could different processes be

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employed to enhance the efficiency and effectiveness of the review process? Again, using the home care example, a simplified approval process could be used for an existing provider, in good standing with DOH, to expand service in the face of a clearly defined need in the established service area. The premise being that this would make the system more responsive to consumer needs.

Special consideration should be given to expediting the processing of technology projects, given their growing importance in service delivery. Along these same lines, the CON process needs to be more responsive to changing models of care. Consumer demand in long term care is clearly changing and the future CON process needs to be flexible enough to evolve as well.

LeadingAge NY urges the PHHPC to closely examine the efficacy of the transitional care unit (TCU) demonstration program. TCUs largely duplicate services that nursing homes offer; are certified as nursing home beds; and are paid under Medicare's nursing home benefit. Nursing homes are authorized to offer the very same services as TCUs; many are providing "subacute" care; and they are often a more appropriate care environment. The Department of Health's (DOH's) initial report on TCUs (2009) indicated that TCU patient satisfaction surveys revealed concerns about the care environment and discharge processes. Unfortunately, the report did not address nursing care hours per patient or overall staffing levels, nor did it conclusively demonstrate that TCU patients could not be served in nursing homes. Reported TCU occupancy rates ranged from 54 to 72%, well below nursing home occupancy levels. With more TCUs being authorized, the PHHPC should ask DOH to provide the follow-up TCU demonstration report that was never completed.

Historically, DOH and the Council have carefully reviewed CON applications involving nursing home construction or renovation, since Medicaid's capital reimbursement methodology recognizes these costs and Medicaid is the predominant payer of services. However, the state's Medicaid redesign contemplates a move away from fee-for-service to managed care for Medicaid recipients, meaning that Medicaid would not directly pay nursing homes for most care. This change in payment policy could have major negative implications for repayment of existing nursing home debt, needed upgrades to physical plants and future capital formation. LeadingAge NY will be educating state policymakers on these potential implications and the need to carefully consider how capital costs are reimbursed in the future by Medicaid. If in fact capital becomes part of the rates negotiated between Medicaid managed care plans and nursing homes and is no longer reimbursed on a fee-for-service basis, the PHHPC and DOH will need to reassess the level of review accorded such projects.

Finally, LeadingAge NY continues to recommend repeal of the Medicaid access requirements [10 NYCRR § 709.3(m)]. For years now, the percentage of Medicaid recipients in New York's nursing homes has exceeded that of most other states, dispelling the notion that Medicaid access is an issue. At a time of growing concerns about Medicaid expenditures and excessive reliance on Medicaid as the *de facto* financier for long term care, it is counterproductive to have a regulation in place which effectively discourages maximization of alternative payment sources.

2. **How can the CON process incorporate consideration of public health priorities to ensure that our health care delivery system has the capacity to prevent disease, and, with local partners, improve the health of the community it serves, not just react when prevention efforts fail?**

   As implied by the question, public health and health care delivery are not just functions of medical care. They occur in a broader societal context and are dependent on an infrastructure that includes transportation, other non-medical services, social supports, affordable housing, workforce and other elements. The PHHPC's planning function – which will hopefully continue to inform the CON process – needs to consider the full infrastructure needed to deliver health care services and promote public health in New York's communities. Health care providers can and should be partners in the public health and prevention agenda, and this involvement can be encouraged through state policy and local planning efforts.

3. **How can the CON process incorporate health care quality considerations?**

   The PHHPC should consider convening a task force to examine models of value based purchasing and quality enhancements to payment, with the understanding that the objective science around measuring quality is still evolving and imperfect at best. We see more and more initiatives to incorporate value based purchasing and quality improvement, but almost all of these models share the same fundamental flaws and biases. Oftentimes, these initiatives seem to be afterthoughts that are tacked onto Medicaid reimbursement systems to meet public expectations, with little thought as to how appropriate or effective they will be at measuring and encouraging true quality. Based on its health planning charge, the PHHPC should assess the role of value based purchasing and quality enhancement initiatives in New York's health care delivery system.

   The underlying intent of the CON character and competence review is important in the context of assessing quality, but the current application of the process is rather limited in its effectiveness. The fact that existing established operators can add, subtract or change board members without triggering a character and competence review arguably limits the benefit of this process. We are concerned about the effect of character and competence reviews on volunteerism in not-for-profit organizations. It is already difficult to find qualified, willing, capable and engaged individuals to serve on volunteer boards for these organizations. However, current policy dictates that if such an individual has been on the board of a nursing home that, within the last ten years, had a repeat survey deficiency at the G level or higher and/or a finding of immediate jeopardy or substandard quality of care, he or she is categorically disqualified from serving on the board of a facility undergoing character and competence review. This policy should be examined.

   LeadingAge NY remains very wary of "representative governance" models that have the practical effect of allowing the principals of a publicly-traded corporation to establish a New York affiliate and offer Article 28 and Article 36 certified services. We remain strongly opposed to allowing publicly-traded corporations to operate nursing homes and home care agencies in the state. In other states that allow this to occur, these entities are much less accountable to the state and local

communities and more accountable to shareholders. As a result, serious quality of care lapses have more often been associated with these "chain" operated providers than with community-based providers such as those that characterize New York's health care system. Without a clear authorization from the Legislature, the CON process should not be used as a vehicle to circumvent the current statutory proscriptions on publicly-traded corporate ownership and operation of health care facilities and agencies in New York.

4. **What should be the role of local and/or regional planning in support of the CON process**?

LeadingAge NY believes that local and regional planning are important, and will become even more important as new systems of care delivery emerge in response to federal health reform and state Medicaid redesign. However, we do not support re-creating the local Health Systems Agencies or the regional structure used by the Commission on Health Care Facilities in the 21st Century. While these approaches had some positive aspects, they alternately introduced processes and outcomes that were often cumbersome, costly, time-consuming and politically charged.

There is no universal model that can or should work in every region or community of the state. Some communities have initiated planning processes that work in their particular areas. Perhaps DOH and the PHHPC could collect information on the various planning approaches currently in use, and systematically evaluate these approaches to determine critical success factors, limitations, and ability to replicate and sustain the applicable approach in one or more other communities.

A CON process that is sensitive to local concerns should facilitate public input into decision-making. We recommend a combination of more timely notice of pending actions, greater access to meetings, more Internet-based information and directed outreach to alert interested stakeholders to pending CON applications.

PHHPC meeting agendas are finalized and published a short time before the meetings are held, giving applicants and other interested parties very little if any advance notice or ability to provide timely input. While there may be last minute adjustments to agendas, a greater effort should be made to publish these agendas earlier. PHHPC meetings are typically held in New York City and Albany, with teleconferencing available to DOH staff and Webcasts available to the public. In order to increase the public's access to these meetings, consideration should be given to: (1) opening the Albany teleconferencing facilities to outside stakeholders, with opportunities to provide input where appropriate; and (2) developing a means by which Webcast participants can electronically submit questions and input for consideration by DOH and Council members.

The DOH Web site should include a designated area that enhances and consolidates the available information. This area of the Web site should include all relevant CON information posted in one place including: (1) an easy-to-understand summary of the CON process; (2) CON applications and instructions; (3) upcoming meeting agendas; (4) more detailed project summaries; (5) the current status of each application; (6) public need information; (7) information on how to provide input on

applications; and (8) summaries of DOH staff reviews and Council actions. While we support making more detailed summaries of pending applications available, we do not recommend providing access to full CON applications via the Internet. CON applications can contain sensitive information which may affect negotiations among the applicant, DOH and other third parties.

In terms of directed outreach, efforts could be made to seek input from service providers and other stakeholders that might be affected by the proposal within an established timeframe. This could be accomplished by sending letters to affected parties; posting information on the Health Commerce System; and/or hosting regional "forums" in the CON area of the DOH Web site.

5. Are there types of projects that should no longer be subject to CON review or projects that are not subject to review, but should be?

The 2010 revisions to the CON threshold levels for review were helpful in focusing Council and DOH resources on those proposals most requiring review. Having said that, CON review timeframes can still amount to several months. With declining DOH staffing resources, the only way to address this issue is to further limit the number of actions requiring CON approval and revisit levels of review. This could be undertaken by: (1) raising the thresholds for initial reviews and amendments; (2) further limiting the need for full reviews; (3) excluding other types of clinical and non-clinical projects from review; (4) utilizing architectural self-certification; and (5) deeming approval.

1. *Thresholds for review.* The dollar and percentage thresholds should be periodically re-examined for each level of CON review, with the goal of maintaining realistic standards that could further streamline the process. The rules governing review of amendments to previously approved CON projects should be further liberalized to limit the number of such projects subjected to full review. For example, the 10% thresholds on changes in financing costs or basic costs of construction should be increased to 15%.
2. *Limiting full reviews.* Certain projects should not be subjected to full CON review, such as: (1) initiating Article 28 facility-sponsored outpatient clinic services and adding dialysis services in a nursing home setting. These services have evolved in ways that make administrative or limited review more appropriate; (2) name changes or other nominal changes to providers' corporate structures, which should require only written notices to DOH; and (3) reasonable changes to an approved construction or equipment acquisition project that do not materially alter the approved concept, which would instead require prior notice to DOH.
3. *Exclusions from review.* DOH should provide an analysis of categories of clinical and non-clinical projects that are not subject to full review and are always or nearly always approved without material modifications. Based on this analysis, further categories of actions could be excluded from review. Providers could still be required to provide advance notice to DOH of such projects.
4. *Self-certification.* A significant cause for delays and added expenses is the lack of architectural reviewers within the Department. Providers routinely use certified architects

to design projects in conformity with established DOH regulations and building codes. These architects should be able to certify to the provider (and thus to the state) that their plans were developed in conformity with the requirements.

5. *Deemed approval.* Projects that do not require full review which are not reviewed by DOH within established timeframes should be deemed approved. This would include pre-opening surveys and other area office reviews, provided that the projects have been issued certificates of occupancy (where relevant) or other approvals precedent to DOH approval.

There are opportunities to streamline the application preparation process as well by: (1) re-examining the CON applications and schedules to determine if all of them are needed; (2) considering the use of exception reporting for some elements of the CON application rather than exhaustive full reporting; (3) providing on the DOH Web site, or by request, samples of completed CON applications so that potential applicants have a better idea of what is expected of them; and (4) otherwise better documenting CON requirements upfront so that 30-day letters and other follow up information is not as often needed.

The review process within DOH is divided up among silos, with each step in the approval process often separate and distinct from the others. Breaking down these silos may help streamline the process. In this regard, the concept of a CON "concierge" may be worth exploring. The CON concierge would coordinate an application through the various review stages and fast track certain projects based on levels of priority.

Efforts to reform the CON process must take into account a series of complex trade-offs including promoting transparency versus encouraging negotiations; weighing greater timeliness against broadening stakeholder input; and encouraging a market-based approach versus exercising greater regulatory control. From our perspective, the CON process can only be reformed in a meaningful way by looking beyond simplistic comparisons and statistics, understanding system dynamics, empowering providers and consumers to adapt to needed change, using state and local resources effectively and efficiently, and above all, ensuring that frail and disabled New Yorkers of all ages receive the long term care services and supports they expect and deserve.

Thank you for the opportunity to provide input. LeadingAge NY remains available to work with the Health Planning Committee and full Council on CON reform efforts. If you have any questions on our comments, please contact me at (518) 867-8383 or dheim@leadingageny.org.

Sincerely,

Daniel J. Heim
Executive Vice President

HEALTHY CAPITAL DISTRICT INITIATIVE

"Working Together to Improve Access to Health Care"

315 Sheridan Avenue ♦♦ Albany, NY 12206
(518) 462-1459 ♦♦ FAX: (518) 462-7021
www.hcdiny.org

MEMBER ORGANIZATIONS

Albany County Department of Health

Albany Medical Center

Catholic Charities of the Roman Catholic Diocese

Capital District Physicians' Health Plan

Ellis Hospital

Fidelis Care New York

Hometown Health Centers

Northeast Health/ Samaritan Hospital/ Albany Memorial Hospital

Rensselaer County Department of Health

Schenectady County Public Health Services

Senior Whole Health

Seton Health/ St. Mary's Hospital

St. Peter's Health Care Services

Whitney M. Young, Jr. Health Services

In collaboration with the **School of Public Health University at Albany** with support from the **New York State Department of Health; Kellogg, W.T. Grant & Robert Wood Johnson Foundations**

October 26, 2011

Public Health and Health Planning Council
433 River Street, 6th Floor
Troy, New York 12180

To Whom It May Concern:

The members of the Healthy Capital District Initiative have been working toward a consensus document on the role of regional planning groups and the certificates of need process. Our discussions have been robust, but unfortunately have not reached their conclusion. We would like to submit the recommendations below as to the specific role of RPGs in the CON process and will submit additional recommendations on the role of RPGs in the coming weeks.

Since 1997, the HCDI has brought the public health departments, hospitals, insurers, catholic charities, community organizations; and to a greater extent as the topics of inquiry require, employers, consumers, public officials, and schools. Every 5 years we produce a community health profile and facilitate a process to solicit broad community input and identify regional health priorities. We take on focused health planning projects, such as emergency department utilization, and provide direct services. We are facilitated enrollers for public health insurance, community health advocates, school-based preventive dental service providers.

After much discussion, our coalition agreed that regional planning activities should not add another layer of local approval to the CON process, but rather be a resource for the applicant and the department by providing detailed analysis in high priority areas to illuminate population health needs and access to care issues. Specifically, we recommend:

Certificate of Needs (CONs)

1. DOH and applicants should utilize existing needs assessments, policy papers and recommendations as guidance in CON applications, program development and funding decisions. Relevant information would include prevention health indicators and population health priorities identified for the service area.

2. Continuing to streamline the CON process for applicants is an essential part of CON reform. Many Limited and Administrative Reviews could be eliminated. Often there are multiple levels of state approval required for an applicant, which imposes a tremendous burden on the applicant at substantial cost.

Sincerely,

Kevin Jobin-Davis, Ph.D.
Executive Director

Healthcare Association
of New York State

Proud to serve New York State's
Not-For-Profit Hospitals, Health Systems,
and Continuing Care Providers

Daniel Sisto, President

October 21, 2011

John Rugge, M.D., M.P.P.
Chief Executive Officer
Hudson Headwaters Health Network
9 Carey Road
Queensbury, NY 12804

Dear Dr. Rugge:

Thank you for inviting the Healthcare Association of New York State (HANYS) to provide comments regarding the scope and content of the Certificate of Need (CON) process and to share the views of our membership on the questions posed in your letter to stakeholders.

We strongly believe that the existing CON process needs to change significantly to better facilitate the move to a more patient-centered health care system and to enable providers to reconfigure their services to meet state and federal health reform goals. A streamlined CON process would allow providers and their communities to quickly adapt and adjust their services to participate in new care coordination models, to forge new partnerships, and best use the limited resources available.

As a first step to improving the timeliness of the CON process, legislation (enclosed) signed by Governor Cuomo in July (Chapter 174 of the Laws of 2011) exempts large categories of projects from CON. The exemptions will remove routine projects from the CON process and allow state regulators and health care planners within facilities to focus their resources on more complex issues and projects. HANYS encourages a broad interpretation of the law—for example, we believe energy efficiency upgrades should be exempted based both on the new law and on the state's energy policy.

As the new law is implemented, DOH should solicit provider input to ensure the resulting policies are workable and consistent with the law's intent. We believe the CON program needs to be reconfigured to be commensurate with Department of Health (DOH) staff resources available to carry out the program.

New models of care will require new collaboration and relationships among a range of providers, some licensed and subject to CON, and others not. These relationships must be viewed from the perspective of achieving the most efficient and effective manner to meet the needs of patients. The silos driven by various categories of licensure must disappear to achieve a coordinated approach to meeting community health needs.

MAIN HEADQUARTERS: One Empire Drive / Rensselaer, New York 12144 / (518) 431-7600 / fax (518) 431-7915 / www.hanys.org
WASHINGTON, D.C. OFFICE: 499 South Capitol Street SW, Suite 405 / Washington, D.C. 20003 / (202) 488-1272 / fax (202) 488-1274

The CON process should be seamless and the playing field must be made more level between licensed facilities and providers not subject to facility licensure requirements. This can be accomplished by eliminating CON requirements for licensed facilities for services that can be provided by private physician practices that have no CON obligations. For example, a hospital seeking to expand primary care in under-served communities should not be delayed by a CON process that would not apply to a private practitioner seeking to establish the same service.

The architectural certification process developed by DOH earlier this year and piloted by a number of hospitals is one example of a potential solution that could alleviate the workload on the limited number of state reviewers, while still requiring a professional attestation that the project meets all applicable regulations and codes. This process should be made available for use as an option by all facilities for limited review and administrative applications. Using this process in the CON application phase demonstrated a significant improvement in timeliness—and DOH always has the option of conducting its own inspections when staff are available. The architectural certification option should be extended to the pre-opening inspection stage of the process in cases where DOH resource constraints do not allow these inspections to be conducted quickly.

To avoid facility delays in meeting federal mandates—such as the requirement for sprinkler systems in nursing homes and meeting health information technology system "meaningful use" requirements—an alternative to CON should be developed, perhaps a form of notification and certification process.

Local and regional planning capacities and vehicles vary from community to community. That variation may be appropriate, since communities have different characteristics across the state. While local and regional planning are clearly important steps in determining the best use of resources, HANYS does not support the creation of another regulatory layer in the CON process that could cause further delays and add paperwork to the process. Rather, HANYS recommends that applicants be allowed to describe the local planning efforts they have undertaken as part of their CON submission, as many already do. As appropriate, elements of required community service plans can be incorporated into these efforts to ensure public health priorities are addressed.

To meet community needs, a consistent, centralized system, outside of CON, is needed to allow for a rapid response to emergency situations, such as the recent flooding. The relocation of services to assure continuity of care is particularly important during times of disaster.

In rural and under-served communities, retention of physician practitioners is critical. Many Article 28-licensed facilities must hire physicians in order to retain them. However, the current CON process delays the conversion of private practices to primary care clinics. This delay is contrary to stated DOH goals of improving access to primary care. Again, meeting the needs of patients should be the motivating factor, not process fulfillment.

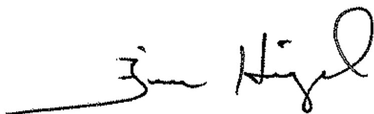
Another area of concern is need methodologies that have not been updated and do not reflect current standards. For example, limited need methodologies are not relevant for academic medical centers whose service areas extend worldwide. For projects involving existing licensed service areas, the need review should be eliminated.

During this period of rapid change within the health care delivery system, flexibility is needed both to meet state goals and for facilities to be able to operate as efficiently as possible. Areas where the CON process hinders the ability to change rapidly and operate efficiently need to be re-assessed, modified, or eliminated.

This letter represents some initial thoughts and recommendations. Many details have yet to be addressed. As such, we greatly appreciate your acknowledgement that this is just the beginning of an extended discussion. The continued involvement by health care providers in this discussion is critical to ensure a speedy transition to a CON process that reflects today's real-world circumstances.

Thank you again for the opportunity to participate in your deliberations.

Sincerely,



Frederick Heigel
Vice President
Health System Redesign and Regulatory Affairs

FH:sm
Enclosure

LAWS OF NEW YORK, 2011

CHAPTER 174

AN ACT to amend the public health law, in relation to hospital construction

Became a law July 20, 2011, with the approval of the Governor.
Passed by a majority vote, three-fifths being present.

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Subdivision 1-a of section 2802 of the public health law, as added by section 58 of part A of chapter 58 of the laws of 2010, is amended and a new subdivision 1-b is added to read as follows:

1-a. The following types of construction projects by a hospital possessing a valid operating certificate shall not require prior approval pursuant to this section*, provided that a written notice has been submitted to the department together with, where appropriate, a written architect and/or engineering certification that the project meets the applicable statutes, codes and regulations specified in the certification statement and, where required by the department, the hospital shall implement a plan to protect patient safety during construction*:

(a) correction of cited deficiencies, provided that[~~:~~

~~(i)~~] the construction is limited to the correction of the deficiencies and is authorized by a plan of correction approved by the department;

[~~(ii) a written notice has been submitted to the department together with, where appropriate, a written architect and/or engineering certification that the project meets the applicable statutes, codes and regulations specified in the certification statement; and~~

~~(iii) the hospital shall implement a plan to protect patient safety during construction; and~~]

(b) *repair or maintenance, regardless of cost, including routine purchases and the acquisition of minor equipment undertaken in the course of a hospital's inventory control functions;*

(c) non-clinical infrastructure projects regardless of cost including, but not limited to, replacement of heating, ventilating and air conditioning systems, roofs, fire alarm and call bell systems, parking lots and elevators;

(d) one for one equipment replacements regardless of cost, including replacement of equipment with another piece of equipment used for similar purposes but employing current technology; and

(e) other projects as specified in regulations adopted by the council and approved by the commissioner.

1-b. The commissioner is authorized to waive any requirement for pre-opening certifications and/or surveys for construction projects approved in accordance with this section.

§ 2. This act shall take effect on the one hundred eightieth day after it shall have become a law.

EXPLANATION--Matter in *italics* is new; matter in brackets [~~-~~] is old law to be omitted.

The Legislature of the STATE OF NEW YORK **ss:**

Pursuant to the authority vested in us by section 70-b of the Public Officers Law, we hereby jointly certify that this slip copy of this session law was printed under our direction and, in accordance with such section, is entitled to be read into evidence.

DEAN G. SKELOS	SHELDON SILVER
Temporary President of the Senate	**Speaker of the Assembly**

Greater New York Hospital Association
555 West 57th Street / New York, N.Y. 10019 / (212) 246-7100 / FAX (212) 262-6350
Kenneth E. Raske, President

Transforming New York State's Certificate of Need Program

Greater New York Hospital Association (GNYHA) firmly believes that New York State's certificate of need (CON) program requires substantial reform to ensure that the State can best meet its overarching goal of improving health and health care while also controlling costs. Given the extraordinary evolution of the health care system since the State's CON program was created in 1964, its value and role in promoting cost control, quality, and access have diminished significantly. Many aspects of the program are unnecessarily complicated, expensive, and lengthy; it is both over- and under-inclusive; and it is dated in terms of the categories of projects it reviews and its methodologies. In fact, the program often undermines its intended goals by adding significant costs to the health care system and interfering with the efficient operation of health care facilities without clearly improving either quality or access. For similar reasons, many states have eliminated their CON programs entirely, while others have substantially limited the number of services, providers, and projects subject to review.

GNYHA therefore urges New York to transform its program to:

- End the program's review of construction, renovations, and the acquisition or movement of equipment and services in general, almost all of which the State approves at unnecessary expense to the State and the providers involved.
- Focus primarily on the establishment of new providers; the introduction of new services that may require review to promote quality and access; the discontinuation of services that may create access problems; and certain identified services, such as proton beam therapy, that are exceptionally expensive or that may cause an unnecessary proliferation of expensive services.
- Streamline its approach to ensuring facility compliance with construction, life safety, and other codes by relying upon a combination of facility, architect, and engineering certifications, use of outside experts, and other approaches that will help expedite reviews for all involved.

Recent Reforms and Need for More Fundamental Change: GNYHA recognizes that the State recently implemented changes to its CON program to reduce the level of review required for certain projects. GNYHA also recognizes that New York is in the process of implementing a new State law that exempts from review repair and maintenance projects, non-clinical infrastructure projects, and one-for-one replacements of equipment, provided that notice and architect and/or engineering certifications are submitted. GNYHA and its members are grateful for these changes, as well as for the State's implementation of an electronic system for submitting CON applications.

GNYHA believes, however, that more fundamental reforms are required, given the increasing financial pressures facing providers and the State, the fact that many aspects of the program are unnecessary in today's environment, and the unreasonable burdens often imposed by the program. When New York put forward its recent threshold changes, it characterized them as an "initial phase" of reform and stated that they were designed to focus the State's resources on "projects that involve the delivery of highly complex services, the investment of substantial resources, and/or the creation of new facilities or beds." It is time to move fully in that direction, for the benefit of the State, its providers, and most important of all, the residents of New York.

I. CON Programs Are Ill-Suited for Controlling Costs in Today's Environment

As currently structured, New York's CON program no longer effectively serves its intended purpose of promoting cost control, quality, and access given the tremendous changes that have taken place since the program began in 1964. Historically, the primary reason for CON programs was to control costs, particularly capital costs, during a time of cost-based reimbursement. Thus, in 1975, Congress passed the National Health Planning and Resources Development Act of 1974 (the Act), which required states to create CON programs to receive funding under a number of Federal programs. However, in 1986, with the advent of prospective payment systems and other factors, the Federal government repealed this mandate, as well as its funding for planning purposes. In the decade following the Act's repeal, many states in turn repealed their CON programs, and many more have since reduced the number of projects they review.

Myriad Environmental Factors Limit Provider Capital Expenditures: Today, many factors significantly limit the ability of hospitals and other health care providers to embark on capital projects, thereby eliminating the need for many aspects of CON programs. Those factors include limited capital reimbursement, ever-increasing limitations on operating revenues, and increases in both operating and capital costs. In addition, changes in the capital markets have made it increasingly difficult for providers to finance capital projects.

At the Federal level, the Medicare program has not, in general, paid hospitals for their hospital-specific operating costs since 1983, paying them instead under a prospective payment system. It has also not paid hospitals for their hospital-specific capital costs for years. In 2009, hospitals agreed to accept a significant cut in Medicare payments for the next ten years in connection with the passage of the Affordable Care Act. Hospitals are now bracing for additional Medicare cuts given the current Federal debt ceiling and related economic problems, with the 2% reduction in payments recently triggered by Federal sequestration perhaps being only the starting point.

In New York, Medicaid payments to hospitals have been cut 10 times over the last five years for a cumulative loss to hospitals of $1.4 billion a year. In addition, during State fiscal years 2012 and 2013, Medicaid payments are subject to a "global cap" under which provider payments can be cut if the cap is exceeded. The global cap, an important achievement of the State's Medicaid Redesign Team, has been the most effective cost control tool that the State has put in place for many years, and is more effective than the project-by-project approach inherent in CON programs. At the same time, all payers are creating incentives and mechanisms to constrain

health care costs, including bundled payments, health homes, medical homes, managed care focused on specific types of populations, and accountable care organizations.

Provider Difficulty Accessing Capital: Many hospitals in New York have considerable trouble accessing capital in any event due in part to their poor credit quality, their heavy dependence on shrinking Medicare and Medicaid payments, and the lengthy State process for approving construction and financings. As a result, they have had to rely on credit enhancement, such as the Federal Housing Administration's mortgage insurance program or State-supported debt, which increases the time needed to gain approval of projects. These factors are reflected by the fact that the average age of hospital plant in New York is 12.1 years, compared to 9.8 years nationally.

Questionable Success in Controlling Costs: Not only is using CON programs to control spending unnecessary today, some studies have indicated that CON programs may never have been particularly successful in controlling costs. For example, in 2004, the U.S. Department of Justice (DOJ) and the Federal Trade Commission (FTC) released a report discussing many aspects of health care. On the issue of CONs, the report stated: "Empirical studies indicate that CON programs generally fail to control costs and can actually lead to increased prices." The report quoted one commentator as stating "[t]he regulation of supply through mechanisms such as CON may have made sense when most reimbursement was cost-based and thus there was incentive to expand regardless of demand but they make much less sense today when hospitals are paid a fixed amount for services and managed care forces them to compete both to participate in managed-care networks and then for the plans' patients." The agencies thus urged CON states "to reconsider whether they are best serving their citizens' health care needs by allowing these programs to continue."[1]

GNYHA notes that the American Health Planning Association took significant issue with the report, calling its conclusions "unsupported."[2]

No Surge in Spending Following CON Program Elimination: At least one still often-quoted study from 1998 published in the *Journal of Health Politics, Policy, and Law* looked at what happens to health care spending when CON programs are eliminated, given that a number of states had discontinued their CON programs in the decade after the Federal government repealed its mandate for CON programs in 1986. The study concluded that states that had "lifted CON did not experience a rise in spending on hospital and physicians' services relative to those that retained it." Given that there was no evidence of a surge in costs following a state's elimination of its CON program, the authors stated that there was "no reason to fear an expenditure surge" after CON laws are repealed.[3]

New York no longer needs a comprehensive CON program to control capital expenditures because numerous external factors attempt to control those expenditures every day. In addition, studies indicate that CON programs are not particularly successful at controlling costs and that capital expenditures do not necessarily increase following the repeal of CON programs.

II. CON Programs Have Limited Value in Promoting Quality

Turning to CON programs' other goal, ensuring quality and access to care, GNYHA believes strongly that today's health care environment provides more effective, ongoing approaches to overseeing or incentivizing accessible, quality health care than that afforded by many aspects of the State's comprehensive CON program. In New York, the State Department of Health (DOH) exercises significant oversight of the quality of care provided by health care providers, most of which are subject to extensive State regulations and requirements. DOH is joined by a number of other State agencies in fulfilling its oversight role, depending upon the provider type and the services delivered. The Centers for Medicare & Medicaid Services and The Joint Commission also impose significant regulatory and accreditation requirements and standards. For example:

- Numerous agencies survey and require plans of correction for health care providers.
- Medicare collects and makes public many quality indicators for each hospital.
- New York State collects, analyzes, and makes public information about cardiac procedures, infection rates, and a number of other quality indicators.
- New York State also makes public volume data for most major procedures by hospital.
- New York State requires hospitals to track and make public upon request data related to nursing-sensitive indicators.
- Many other organizations also publish report cards on hospitals and other providers, including Leapfrog, Health Grades, and The Joint Commission.
- Medicare and Medicaid refuse to pay for certain adverse events and hospital-acquired conditions.
- In Federal fiscal year 2013, Medicare will begin its value-based purchasing (VBP) program, under which Medicare will adjust hospital reimbursement based on how well a hospital performs under a number of process-of-care measures.
- In Federal fiscal year 2014, Medicare will expand its VBP program to base Medicare payments on outcomes of care and efficiency measures.

High Quality in Non-CON States: While there are many rankings of hospitals, perhaps the most well-known is *U.S. News & World Report's* annual "America's Best Hospitals," which ranks hospital services across the country. The ranking includes an "Honor Roll of Hospitals," which this year includes 17 hospitals across the country, including NewYork-Presbyterian Hospital and Mount Sinai Hospital Center. GNYHA mentions the Honor Roll to point out that a number of the top-ranked hospitals are located in states that do *not* have CON programs, including the Mayo Clinic, Ronald Reagan UCLA Medical Center, UCSF Medical Center, Hospital of the University of Pennsylvania, University of Pittsburgh Medical Center, and Stanford Hospital and Clinics. Although many factors affect the quality of care in the Honor Roll hospitals, the number of hospitals in states without CON programs indicates it is certainly not necessary to have such a program to offer high-quality, nationally ranked care.

Negative Impact of Stringent CON Programs: An early study by Stephen M. Shortell, Ph.D. and Edward F.X. Hughes, M.D., Ph.D., found an association between *higher mortality rates* among inpatients and the stringency of state CON programs, suggesting that CON programs may actually have a *negative* impact on quality. The authors examined mortality rates among

Medicare patients for 16 clinical conditions at 981 hospitals and concluded that the stringency of CON programs was positively and significantly associated with higher mortality rates.[4]

The authors found this association of interest because one might expect that stricter CON programs would be associated with *lower mortality rates* given that the process often examines whether patient volume is sufficient to produce positive outcomes. The contrary argument posited was that CON programs might act as a "barrier to the development of innovative programs and the possible upgrading of hospitals' physical plants and equipment. Thus, patients at hospitals whose applications for certificates of need have been rejected and those who may not have applied because of the stringent review criteria may have poorer outcomes because the hospitals continue to provide care with outdated facilities and technology." To test this, the authors examined the mortality rates related to the five conditions considered the most susceptible to CON program impacts, as opposed to the 11 less susceptible conditions. According to the authors, "The association of higher mortality rates with more stringent certificate-of-need programs was indeed stronger and had a higher level of significance for the 5 conditions defined as the most susceptible…than for the remaining 11 conditions…These findings indicate that regulation of capital expenditures appears to have particularly adverse effects on outcomes for patients with the conditions most directly affected by the regulation."

Unclear Benefits of CON Regulation of Even Coronary Artery Bypass Graft Surgery: Later studies bring into question the benefits of CON programs with respect to regulating even coronary artery bypass graft (CABG) surgery specifically, a service where higher volumes are linked to better outcomes. Thus, it is often assumed that CON programs should be beneficial in that they typically regulate how many and which providers may offer open-heart surgery. In one 2002 study published in the *Journal of the American Medical Association* that looked at this issue, the authors concluded, as expected, that CABG mortality rates in states that *do not* regulate open-heart surgery through CON programs were statistically higher than in states that do regulate this service. Also as expected, a higher proportion of patients in states without CON regulation of open-heart surgery underwent CABG surgery in low-volume hospitals.[5]

However, in another study, published in *HSR: Health Services Research* in 2009, the authors concluded that states that discontinued their reviews of cardiac CONs experienced lower CABG mortality rates relative to states that kept their CON programs in this regard, although this difference was not found to be permanent.[6]

In still another study, published in 2006 in *Circulation: Journal of the American Heart Association,* the authors found that while average annual hospital CABG surgery volume was higher in states with CON regulation compared to states without CON regulation, there was no significant difference in CABG surgery mortality rates between the two categories of states. According to the authors, "The present data suggest that state CON laws are not a sufficient mechanism to ensure quality of care for CABG surgery."[7]

GNYHA recognizes that there are many factors that affect quality and outcomes as suggested by the study published in *Circulation* referenced above and that states can—and do—administer their CON programs differently. However, the seemingly disparate results of the studies cited above should be considered in reviewing the value, scope, and application of CON programs.

CON Programs as Potential Barriers to Higher-Quality Services: On the issue of quality, the DOJ and FTC report referenced earlier commented that CON programs can impede the entry of providers or services that can provide higher-quality care. The agencies therefore concluded that there are more effective means of achieving the goal of enhancing quality and access that do not pose some of the anticompetitive risks of CON programs.[8]

The foregoing discussion reinforces that CON programs are not, in general, necessary in today's environment to ensure that quality care is provided, except perhaps in certain limited circumstances where the volume of procedures performed helps to improve the quality of care. Even on that subject, though, opinions differ as to whether and how much CON programs are helpful in that regard. Conversely, there are arguments that CON programs can negatively affect health care quality because they can slow or discourage the entry of new services or needed improvements.

III. New York's Recognition of Its CON Program's Limitations

Over the years, New York has recognized the eroding value of its CON program in meeting its intended purposes. For example, in 1996, the Public Health Council adopted a report, *Recommendations for Reform of the Establishment and CON Functions.* The report reviewed the history of CON in New York and concluded that, because the program was developed for an earlier era, it was "ill-suited" for an environment that paid hospitals on the basis of a prospective payment system, encouraged the growth of managed care, and demanded that providers deliver services more efficiently. As a result, the report recommended that need determinations be eliminated in most cases and that, for the great majority of activities, including construction projects, expansions of services, and changes in services, "the role of government should be limited to assuring that services are provided according to standards set by the state with, as much as is possible, standards tied to measures of outcomes."[9]

Similarly, in 1998, DOH commented in the *New York State Register* that the CON program had been designed to promote "judicious use of publicly funded capital" and to help ensure access to quality health care services. "However, the changing health care system, the growth of managed care, and the passage of the Health Care Reform Act have made it possible to achieve these goals with a CON program that is less stringent and more supportive of today's more market-oriented health care environment."[10] At that time, DOH increased the thresholds for CON review, citing the fact that the changes would help reduce the cost of filing CON applications, lost revenues, and limits on competitive capacity associated with the program. As noted earlier, in proposing additional reforms of the program in 2010, DOH stated that the reforms were being put forward as an initial phase and were aimed at focusing the resources of the State more appropriately and at reducing costs to providers.

IV. The Unnecessarily High Cost of New York's CON Program

The prior sections demonstrate how the need for CON programs has diminished over time. Using CON programs to control capital expenditures has become much less important in an era of

prospective payment systems, limited capital reimbursement, relentless payment cuts, and movements to new reimbursement systems and approaches.

At the same time, the delays associated with filing and gaining approval of CON applications in New York, particularly for construction, renovations, acquisition/installation of equipment or movement of services, have become unreasonable, notwithstanding the streamlining initiatives the State has undertaken over the last several years.

There seem to be at least two points of considerable delay in the State's approval of construction, renovations, movement of services or acquisition/installation of equipment: 1) at the point that DOH's architectural bureau undertakes an initial review of a project's schematic design; and 2) at the point that DOH's regional offices undertake surveys of completed construction before providers occupy the renovated or new space.

Significant Delays in Processing Times: GNYHA recently asked a number of its members about the average time it takes to obtain CON approval of their projects. The following represents the range of waiting periods generally reported, not including the time it takes to gain approval of final construction drawings required with respect to administrative and full review projects:

- Limited Review Projects: 3–6 months
- Administrative Review Projects: 6–11 months
- Full Review Projects: 6–12 months

GNYHA notes that many hospitals reported that approvals of some of their applications are taking much longer than the above time frames, even though the affected projects might have "priority" status because, for example, they are funded in part by HEAL funds. On the other hand, one member reported an average waiting period of only two to four months for its limited review approvals, although the same hospital also reported the longest waiting periods for approval of its administrative and full review projects. Finally, several hospitals also reported waiting significant periods of time for approval of their final construction drawings before they can begin construction.

By way of comparison, when DOH increased its review thresholds in 1998, it commented that the changes would help save costs associated with processing projects at higher levels of review. In support of those changes, DOH reported in the August 19, 1998, *State Register* the following processing times for CON projects in 1996:

- Administrative Review Projects: 41 days
- Full Review Projects: 163 days

As can be seen, the CON processing times experienced by many hospitals today are materially *longer* than they were in 1996, notwithstanding two sets of much-appreciated threshold increases and good faith attempts by DOH at streamlining the process since then. GNYHA recognizes that the waiting times include time frames when DOH is waiting for hospitals to reply to questions

posed by DOH. Nevertheless, the total time currently required to approve a CON application of any kind is unnecessarily long and must be reduced for the benefit of all involved.

Significant Delays in Scheduling Pre-Opening Surveys: At the other end of the process, hospitals are finding that it can take months to schedule pre-opening surveys of their renovated or new space so they can occupy it. Hospitals have reported that it can take up to four months to schedule a survey, even when they begin the scheduling process well before the project's completion. In addition, hospitals find there are often inconsistencies in positions taken among surveyors, as well as between regional office surveyors and personnel in Albany that can take significant time to untangle.

The Resulting Cost of the CON Program: GNYHA recognizes that the foregoing delays are caused, in part, by limited staffing due to State budget and other constraints. However, the delays and problems have in turn caused providers and the health care system at large to incur considerable and unnecessary costs in the form of:

- Increased construction and equipment acquisition costs, which, according to DOH, have increased anywhere from 4% to 12% *annually* over the last ten years;
- Increased costs for outside architects, engineers, consultants, and attorneys;
- Increased personnel costs related to responding to questions, submitting additional information, and gaining approval of applications;
- Delays and interruptions in patient care; and
- Delays and interruptions in receiving revenues related to affected services.

To illustrate the associated increased cost of construction, a six-month delay in a $100 million construction project at a time when construction costs might rise at an annual rate of 6% adds as much as $3 million to the project's cost. This incremental cost means that projects needed to upgrade New York's outdated physical plants are either deferred or decreased in the service levels they provide, or alternatively, the unnecessary additional costs are assumed by providers and/or shifted in part to payers. Viewed across the entire State, such delays increase total health care spending significantly, with, in many cases, no discernable benefit in terms of quality, access, and cost control.

The foregoing delays, costs, and consumption of health care resources are unfortunate at any time and for any reason. However, the diminished value of CON programs makes the costs all the more unfortunate, thereby dictating that New York must significantly revise its program.

V. Recommendations for Transforming the CON Program

As outlined above, CON programs no longer effectively serve their initial purposes of controlling costs and promoting quality and access, given the evolution of the health care system. At the same time, they are often unreasonably costly, burdensome, and complicated. A cost/benefit analysis of New York's program leads to the clear conclusion that the program must be transformed so that both the State and providers can better focus their efforts on improving

quality, patient safety, and access in more productive and meaningful ways. To this end, GNYHA makes the following recommendations.

Eliminate Construction Reviews: GNYHA strongly recommends that the State eliminate all CON reviews of construction, including all renovations, additions, and acquisitions or movement of equipment or services, regardless of cost. To the extent that such activities might involve adding services that the State wishes to regulate in some fashion, the State should review only the addition of that service and not the related construction. GNYHA recognizes the importance of ensuring that construction complies with the requisite building, life safety, and other codes for the protection of all who enter health care facilities. GNYHA discusses how this should be accomplished in Section VI.

The foregoing is consistent with the route that many states have taken with respect to their CON programs. Fourteen states do not have CON programs at all, including Pennsylvania, California, Wisconsin, Minnesota, and Texas. In addition, many states with some form of CON programs do not require review of hospital construction except perhaps in connection with the establishment of entirely new facilities. Among those states that do not review construction as part of their CON programs are Connecticut, New Jersey, Ohio, and Florida.

Assess the Need to Review Certain Providers and Services: GNYHA also strongly recommends that the State undertake a thoughtful, but expeditious review of what services or providers it should subject to continuing CON review. As part of this deliberation, GNYHA suggests that there are several main categories in which the State's CON program may still play a meaningful role of protecting and promoting quality and access, as well as reducing unnecessary expenditures.

- **New Entrants:** GNYHA believes the CON program can serve a valuable purpose through its establishment process by ensuring, to the extent possible, that new providers are qualified and capable of delivering quality care and that they are willing to ensure meaningful access to their services. GNYHA understands that the State is already planning to look at ways to do this more effectively.
- **Protecting Key Providers:** As part of the process for reviewing the establishment of new providers, the State should also ensure that a new provider's entry does not materially undermine the services being provided by existing key or essential providers or add unnecessary costs to the health care system. While GNYHA recognizes that this issue is sensitive and arguably raises anti-competitive concerns, we firmly believe that the State must be cognizant of the negative impact on quality and access that might occur should a new provider enter an area and undermine the services provided by an existing needed health care provider. The classic example is the entry of a free-standing, non-hospital-owned ambulatory surgery center that will deliberately or otherwise divert a significant number of certain services from area hospitals, leaving hospitals with the overhead of providing emergency services, trauma care, critical care, and other needed community services without the revenues to cover the cost of that care.
- **Addition of Services Where Volume and Quality Are Linked:** The program should oversee the introduction of services where there is a clear relationship between volume and quality, such as has been the case with certain cardiac procedures.

- **Exceptional Services:** The program should oversee the expansion of services or modalities that are determined to be exceptional either because of their high costs (e.g., proton beam therapy) and/or their tendency to generate unnecessary volumes of procedures.
- **Discontinuance of Certain Services:** The program, or at least the State in some form, should review the discontinuance of services that will lead to access problems in certain communities.

Necessity of Updated Need Methodologies or Criteria: Many of the foregoing areas that GNYHA recommends should be considered for continuing CON review require updated need methodologies or criteria. GNYHA offers to assist the State's efforts by participating in that process directly, and/or identifying experts among its members who can provide valuable input into the process.

Need for a Level Playing Field, Fixed Time Frames for Review, and Streamlined Processes: Finally, to the extent that services, providers, or equipment remain subject to review, the State should:

- Ensure a level playing field among different types of providers in terms of review and oversight.
- Be required to undertake its reviews within reasonable time frames at all stages of the approval process.
- Streamline its review and survey processes for the benefit of providers and the State. See Section VI below for recommendations for streamlining the review and survey processes.

VI. Streamlining the State's Review and Survey Processes

GNYHA is hopeful that the State will eliminate from CON review all construction projects and certain equipment acquisitions for existing providers. GNYHA recognizes, however, that the State will still retain its role of licensing authority and therefore have the responsibility of ensuring that construction, services, and equipment comply with relevant building, design, and life safety codes, as well as other requirements specific to health care providers.

As the State carries out this responsibility, either in conjunction with remaining CON reviews or separately, GNYHA strongly urges DOH to undertake this role as efficiently and effectively as reasonably possible. GNYHA emphasizes this because the regulatory functions of approving design and occupancy, even in the absence of CON review, are among the functions causing the delays in the State's CON program today. Therefore, as DOH continues to exercise oversight of these areas, GNYHA strongly urges that DOH do so in a streamlined and efficient manner so that it fulfills its responsibilities without triggering unnecessary costs to the health care system.

Minimize the Number of Projects Subject to DOH Design/Pre-Opening Review: In furtherance of this request, GNYHA strongly urges the State to eliminate as many projects as possible from direct DOH design review and/or pre-opening surveys. Health care providers are already subject to extensive and detailed national building, design, and life safety requirements

that are incorporated by reference in State and Federal regulations and The Joint Commission standards, all of which are designed to protect and promote the safety of patients. Providers are also subject to local building, fire, and other codes, as well as various types of local agency inspections before, during, and after construction that are aimed at protecting all who enter the buildings. In addition, many hospitals have extensive facilities, architectural, engineering, and other departments that are regularly involved in planning and overseeing construction. Separate from in-house capabilities, health care construction projects almost always involve outside licensed architects, engineers, consultants, and in some cases, construction managers. Finally, providers are subject to on-going, regular inspections and surveys that are meant to identify any life safety code concerns and to promote patient safety.

Alternatives to DOH Reviews and Surveys: To the extent that the State believes it must exercise oversight given the particular project involved, GNYHA believes that the following approaches and alternatives to direct DOH review and survey should be acceptable, many of which are exercised by other states in fulfilling their regulatory roles.

- Meeting with providers to review their plans early in the construction planning stages.
- Accepting provider notification regarding a project and certification with respect to compliance with relevant codes.
- Accepting certification as to code compliance by the provider's architects and/or engineers, all of whom are presumably licensed by the State.
- When necessary, scheduling appointments with the provider's team of facility personnel and outside architects and engineers to review plans for the project with the aim of completing the review in one sitting to the extent possible and appropriate.
- Developing a panel of experts who can be called upon to assist with planning, reviews, and surveys.
- Contracting with other state agencies to undertake reviews and/or inspections. In some states, central design personnel review plans. In New York, GNYHA endorses use of architects and engineers at the Dormitory Authority of the State of New York for this purpose.
- Permitting providers to occupy finished space without requiring a pre-opening survey and allowing any necessary surveys for certain projects and space to take place at a later point in time.

Improved Review and Survey Processes: To the extent that the State assumes direct responsibility for certain reviews or surveys, it should develop improved processes for undertaking those functions. For this purpose, GNYHA suggests that the State consider engaging an expert in process engineering to review its procedures for undertaking reviews and surveys to streamline the processes as much as possible. In addition, the State should establish specified time frames for completing its reviews. GNYHA has spoken with personnel in a number of states that review plans and undertake pre-opening surveys. Almost to a state, they seem to be able to undertake their activities within 30, 45, 60 or maybe 90 days. New York must address its lengthy review and survey processes, which are unnecessarily expensive for all involved.

Need for Increased Staffing at DOH: As noted, GNYHA appreciates that the delays in processing applications and undertaking surveys are attributable, in part, to State cutbacks in

personnel and inadequate numbers of staff for these purposes. GNYHA therefore urges the State to dedicate sufficient personnel to the functions it retains to minimize unnecessary costs to the health care system and ultimately to the State itself.

GNYHA's and Members' Commitment to Improving Quality and Patient Safety: In making the foregoing recommendations, GNYHA emphasizes that it and its members are committed to improving quality and access and protecting patient safety at all times. Indeed, great efforts are taken to protect patients and employees in the planning, building, renovating, and opening of health care facilities. But these very efforts, together with the extensive efforts, certifications, and oversight by licensed architects and engineers, consultants, construction managers, and local authorities, should form the foundation of the State's review, thereby minimizing the amount of additional oversight that the State needs to provide.

VII. Conclusion/Summary

As outlined above, the value of and need for CON programs have diminished considerably over the years, and they no longer effectively serve their intended purposes of controlling costs and improving quality and access. In New York in particular, the CON program is unnecessarily complicated and expensive, it is dated, and it is over- and under-inclusive. As a result, GNYHA recommends that the State should, at the very least, exempt from review all construction, renovations, and acquisitions or movement of services and equipment. It should also assess which new providers, services, and equipment it believes still require CON review, developing revised need methodologies and criteria for those that remain subject to review.

Finally, New York must reduce the amount of time and unnecessary effort currently involved in reviewing those projects that remain subject to review, whether as to need, design, or occupancy. This should be done through the most efficient processes reasonably possible, including wide use of provider certifications, architect/engineer certificates, or other mechanisms designed to speed the efficient and safe delivery of health care. In the end, the goal should be for the State and providers to concentrate their efforts on improving quality, safety, and access through the most effective and productive means.

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[1] U.S. Department of Justice, Federal Trade Commission. "Improving Health Care: A Dose of Competition" (2004). Chapter 8, 1–4.
[2] American Health Planning Association. "The Federal Trade Commission & Certificate of Need Regulation: An AHPA Critique" (January 2005): 3.
[3] Conover, Christopher and Frank A. Sloan. "Does Removing Certificate of Need Regulations Lead to a Surge in Health Care Spending?" *Journal of Health Politics, Policy and Law* 23, no. 3 (June 1998): 455–481.
[4] Shortell, Stephen M. and Edward F.X. Hughes. "The Effects of Regulation, Competition, and Ownership on Mortality Rates Among Hospital Inpatients" *The New England Journal of Medicine*. 318, no.17 (April 28, 1988): 1100–1107.
[5] Vaughn-Sarrazin, M.S., E.L. Hannan, C.J. Gormley, et al. "Mortality in Medicare Beneficiaries Following Coronary Artery Bypass Graft Surgery in States With and Without Certificate of Need Regulation" *Journal of the American Medical Association.* 288, no. 15 (October 2002): 1859–1866.
[6] Ho, V., M. Ku-Goto, and J.G. Jollis. "Certificate of Need for Cardiac Care: Controversy over Contributions of CON." *HSR: Health Services Research.* 44, no. 2, Part I (April 2009): 483–500.

[7] DiSesa, V.J., S.M. O'Brien, et al. "Contemporary Impact of State Certificate-of-Need Regulations for Cardiac Surgery." *Circulation: Journal of the American Heart Association* 114 (October 30, 2006): 2122–2129.
[8] See note 1.
[9] Public Health Council. *Recommendations for Reform of the Establishment and CON Functions*. 1996.
[10] *New York State Register* August 19, 1998.

October 21, 2011

John Rugge, M.D.
Chair, Health Planning Committee
State Public Health and Health Planning Council
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Dear Dr. Rugge,

Finger Lakes Health Systems Agency is pleased to have the opportunity to provide input to the Health Planning Committee's review of the Certificate of Need process. FLHSA has participated for over 35 years in New York's CON process, and, in fact, the state's program was initially modeled after a review process in the Rochester area. In addition to advising NYSDOH on CON reviews, FLHSA also administers a local review process, the Community Technology Assessment Advisory Committee, which provides input to local insurers on need for new technology and capital service expansions. Our comments are derived from this experience.

Before seeking to respond to the Committee's study questions, we would like to provide some principles on which we believe CON reform should be based:

- CON review should be based on public health needs, and on community rather than institutional needs.
- Priority consideration should be given to needs identified in plans developed by community health planning processes.
- The CON process should not be "first in–first out;" rather, it should seek to ensure needed services exist in the way that is best for the community.

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- Dollar thresholds should be set for both capital costs and incremental operating costs, as each affects community cost of care.
- Present dollar thresholds may be appropriate for construction projects, but are too high to generate a review requirement for many services that have substantial impact on community health and community cost.
- The existence of private-auspice services should be considered in review, while assuring that capacity meets the needs of inpatients and ED patients are met.
- There should be only one reviewing body for every service in order to streamline the review process.
- In any organizational arrangement in which a defined population is to be cared for by a fiscally responsible entity, services/capacities of that entity necessary to care for the defined population should be exempt from review or subject to a reduced level of scrutiny.

In our comments to the Committee questions, we will seek to provide examples of how the principles might be applied.

→ **How can the CON process be refined to respond appropriately to new models of care, new ways of structuring relationships among health care providers, new technologies, and migration of services to outpatient settings.**

- Annually, or even every six months, request all providers to indicate the services they believe they will be filing applications for in the next period. When the review authorities observe a trend in interest or a new service to an area, issue an RFP so that any provider interested in that service can apply. Then conduct a competitive review to assure that the best proposal(s) is approved.
- As a *quid pro quo* to the above, the topics on the list of upcoming applications should have a three-month review target and a six-month review deadline. For topics not on the list, have a six-month review target and a twelve-month review deadline. This will help to ensure reviews occur on a more timely basis.
- There should be only one reviewing body for every service in order to streamline the review process. For example, inpatient psychiatry units are presently reviewed by DOH, but that review

must await a review by OMH, substantially increasing the review time. Either DOH or OMH should review the proposal. Then, for instance, OMH can still have oversight of the unit's operation, but not have to review for community need.

- Review should focus on community rather than institutional need. For instance, FLHSA's *2020 Commission* review of local hospital expansion/renovation projects, it was found that community-wide need for inpatient beds was lower than the sum of individual facilities proposals. The FLHSA's *Sage Commission* found there was excess capacity for SNF beds, and community need for additional assisted living and home and community based services. Even though an institution with a license may apply for major renovation/replacement, if there is not community need, there is need to show how the excess capacity will be reduced before additional capital is expended for unneeded capacity. Another example is a hospital adding a freestanding ambulatory surgery center when there is underutilized ambulatory surgery capacity in the community.
- The existence of services provided by private medical practices should be considered in review, while assuring that capacity needed to service inpatients and ED patients exists. The Committee's review of the CON process may be an appropriate time to re-consider the long-standing legislative and judicial barrier to review of private auspice services. It is still nonsensical to ignore that private capacity exists as presently occurs. For example, if a hospital needs an MRI to perform guided interventions, it should be reviewed irrespective of community-wide MRI capacity. However, if the hospital is requesting an additional unit to perform ambulatory scans, the existing capacity of all (public and private) units should be considered in review of need for the proposed unit. Otherwise, excess capacity is developed and must be paid for by the community.
- ACOs, if they occur, should be accorded the same review consideration as HMOs in their time: In exchange for assuming financial and health responsibility for a defined population, they get exempted from review of service capacity for that population. Under existing language in NYCRR a project by or on behalf of an HMO that is for the benefit of the members of the HMO undergoes a limited review. An example of existing regulatory language, in this case related to ambulatory surgery: "Notwithstanding anything to the contrary in this section, the addition of ambulatory surgery services to be provided directly to an HMO-enrolled population shall be

approved when the HMO can demonstrate to the satisfaction of the commissioner that the provision of services shall be cost-effective and accessible to plan enrollees" (NYCRR10 Section 709.5).

- CONs should be required to detail the anticipated cost impact of a project. The state could then apply that cost impact to publicly funded insurance and hold the institution at risk to not impact cost more than their projection.

→ **How can the CON process incorporate consideration of public health priorities to ensure that our health care delivery system has the capacity to prevent disease, and, with local partners, improve the health of the community it serves, not just react when prevention efforts fail?**

- Local and statewide public health priorities have been established, and should be incorporated into review of applications. Similar to the criteria established by the Cardiac Advisory Committee, reviews should consider actions by the applicant to incorporate prevention services into the proposal. Examples include investment in prenatal care in addition to investment in a NICU expansion, or development of a diabetes control extension clinic in a region with above-average diabetes PQIs and mortality. The review consideration should be "how does the applicant work to ameliorate the root problem;" preference can then be given to applicants with greater commitment to prevention. Also, review should consider the "upstream" effect on need for the project. For instance, programs can be put in place to reduce PQI admissions or re-admissions, reducing the need for additional inpatient beds. Or to repeat an earlier example, consider the effect of prenatal/perinatal care in reducing need for NICU beds. To assure performance by applicants in this area, consideration should be given to providing a time-limited approval that requires participation in community projects to decrease demand.
- In contrast to past DOH policy, projects supporting primary care should be encouraged.
- All proposals need to detail how a service will interact with community-based services.
- In areas supporting Patient Centered Medical Home programs, review should consider needs as identified by PCMHs. Applicants with a track record of working closely with PCMHs should also be given preference.
- Access to services should take into account access, disparities in treatment outcome, and capacity of addressing the needs of hard to serve populations.

→ **How can the CON process incorporate health care quality considerations?**

- While meeting the statutory requirements, the existing "character & competence" review is inadequate to incorporate the many existing public sources of quality data. For instance, a recent review of a proposed new operator of a nursing home had a track record in Medicare Compare data of sharply decreasing the quality of care provided at nursing homes it acquired, yet DOH staff indicated such data could not be considered in its review. Usage of quality data that is vetted and nationally endorsed needs to become a routine part of CON reviews.
- Requests for expansion of services needs to document how much current capacity is being absorbed by inappropriate or potentially avoidable use. An example is recent requests for PCI capacity in an environment where national studies suggest that 40% of procedures are inappropriate.

→ **What should be the role of local and/or regional planning in support of the CON process?**

- If a pro-active plan exists from an HSA or other recognized local planning entity, that plan must be considered in any CON review/decision.
- Local community need evaluation is necessary to account for the unique nature and sub-populations of each region.
- Local health planning organizations should have review authority over assisted living services parallel to their authority over skilled nursing services.

→ **Are there types of projects that should no longer be subject to CON review or projects that are not subject to review but should be?**

- Not every hospital needs all services. DOH can determine, however, that some services are essential and reduce the level of review of such services. For example, CT scanners initially were only placed at some hospitals, but over time they became a standard of care that should be at every hospital, regardless of size of the institution and volume of use.
- Existing dollar thresholds are too high to capture some services that have a substantial impact on community health and community cost. A number of services, for example hyperbaric oxygen chambers, have a low capital cost but generate a large operating cost due to cost per service and volume of services per course of treatment. A service such as HBOT should be reviewed despite its relatively low capital cost, especially as HBOT has substantial latitude in utilization and can be subject to capacity-induced demand. Thus, incremental operating cost

should be a consideration triggering review. Approaches to this problem could be separate cost thresholds for capital and operating costs, or, retention of the existing capital cost thresholds but an increase the list of "always reviewed" services to incorporate those of interest.

In conclusion, FLHSA appreciates the opportunity to add to the Health Planning Committee's deliberations. Please do not hesitate to contact us if you need amplification of these comments and/or information on the differences between the existing CON program and processes of the local CTAAB process.

Sincerely,

Fran Weisberg
Executive Director

Thomas Mahoney, MD
Director, Research and Planning

Arthur Streeter
Project Manager/Health Planner

CNYHSA Planning and Consulting Services for Community Health Improvement

October 27, 2011

John Rugge, M.D., Chair
Health Planning Committee
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Dear John:

Thank you for the opportunity to participate in the PHHPC review of the state's CON process. CNYHSA has been involved in CON review for 35 years with a strong conviction to maintain and enrich the CON process at the local level. There is also a real advantage in linking CON reviews to local planning to take advantage of the potential for collaboration and development of projects that grow out of the planning and consensus-building process.

Our comments and thoughts on the questions put forth for the current review are as follows:

- *How can the CON process be refined to respond appropriately to new models of care, new ways of structuring relationships among health care providers, new technologies, and migration of services to outpatient settings?*

  - Update need methodologies so that they reflect the impact of innovation, new models of care and programmatic relationships among providers, and changes in practice patterns and treatment modalities. The underlying framework for most current methodologies (as opposed to their calculation) has not been updated for more than 20 years. Examples include the nursing home bed need methodology which does not fully reflect what has been happening in assisted living and, delivery of community based care and the hospice methodology which ignores that role that hospice truly plays in death and dying especially with non-cancer patients who constitute more than half the hospice caseload. The hospice movement has grown dramatically over the last 20 years and nationwide, hospice care is now involved in approximately 40% of all deaths.

  - Build more flexibility into the CON process, particularly to make need methodologies more sensitive to innovations and new models of care.

  - Methodologies should also factor in privately-owned or operated resources as legitimate inventory when considering resource needs of Article 28 facilities (e.g. MRI, Radiation Oncology)

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- Establish ad hoc task forces under PHHPC and/or Health Planning Committee auspices to address specific issues or a standing committee on Innovations and New Models of Care (perhaps recasting the former SHRPC Emerging Issues Committee concept). Topics which might be addressed include: the current trend toward hospital integration and acquisition of physician practices; the extent to which traditional licensure categories (hospital, D&TC, etc.) apply to different models of care and provider relationships.

- Employ the "limited life" approval concept in selective cases to better gauge the impact of new models, new ways, new technologies, etc. Alternatively, consideration should be given to demonstration or pilot projects that involve a monitoring or evaluation component to provide guidance and conclusions on future approvals or expansions. The current provisions for Demonstration Projects under Part 705.8 should be fully employed and maximized in this regard.

- Utilize the CON tool of conditions and/or contingencies in those new model or structural proposals that are not fully tested or have less than certain outcomes.

- *How can the CON process incorporate consideration of public health priorities to ensure that our health care delivery system has the capacity to prevent disease, and, with local partners, improve the health of the community it serves, not just react when prevention efforts fail?*

  - Expand on the Community Need–Public Need Summary schedules of CON applications to address the public health/prevention question. A new question might be added or existing question #4 revised in Schedules 16 and 17. Give extra weight to those proposals that can clearly demonstrate a public health/prevention commitment, e.g. contribute to or share staff with local Health Department. (It should be cautioned that many CON applications are for facility improvements, renovations, or equipment and as such should be judged on their own merits.)

- *How can the CON process incorporate health care quality considerations?*

  - Questions should be added to the Community Need–Public Need Summary CON schedules of applications for the applicant to address if and how the proposal takes account of quality improvement, its measurement, and the project's impact on overall patient quality.

- *What should be the role of local and/or regional planning in support of the CON process?*

We believe that there is considerable value in local input in the CON process – local participation fosters credibility and legitimacy. Local participation should be broad-based and reflect the interests of different parties (e.g. consumers, providers, government, payors, business). It brings with it a better understanding of local needs and factors that may be unique to the area, as confirmed by our experience with reviews over the past several years.

Examples where this has happened in Central New York include a "community forum" review component on Upstate Medical Center's acquisition of Community General Hospital; a dialysis review where local process resulted in a partnership approach replacing a duplicative private practice vs. hospital application scenario; a "community dialogue" on Upstate Medical Children's Hospital proposal which dealt with outlying hospitals' concerns for more active participation in a collaborative regional approach to pediatric services; a radiation oncology review which dealt with the dynamics of hospital and private practice approaches and the need for an integrated solution focusing on continuum of cancer treatment services; and a cardiac catheterization review documenting hospital size and utilization as a major factor for approval.

- HSAs should continue to carry out their statutory review responsibilities. Other regionnal planning entities should be encouraged to participate in review or be given the opportunity to provide local input on proposals with a major impact on the community.

- Develop a menu of options for local planning groups' engagement in CON to accomodate the wide variation in the structure, focus, and resources of local planning groups. Menu choices could be based on a screening process which would likely concentrate on proposals with high community need or regional impact. The menu of options could include:

  - ➢ Standing Committee Reviews with provider presentation, staff analysis, board action
  - ➢ Hearing Process with formal solicitation of facts and options and minimal analysis
  - ➢ Hearing Process involving formal presentation by a neutral topical expert
  - ➢ Use of Special Ad Hoc Task Force – collect data, ask questions, develop recommendations
  - ➢ Local Community Hearing involving a site visit
  - ➢ Charge to local planning body to make recommendations
  - ➢ Simple solicitation of comment (on-line or through other media) from entities in the planning region, which then is submitted to DOH

- Increase opportunities for collaboration and data-sharing between the Department and local planning groups on CON and health systems change. A strong partnership would concentrate resources on high-potential collaborations and use of CON as a tool to promote co-ordination.

  - ➢ Involve local planning agency staff and or volunteers in the development of need methodologies

  - ➢ Invite planning agencies to make presentations/testify on issues related to CON actions. These might involve application batching, need for capital investment, need for program development, restructuring, etc. (A good example is the Finger Lakes HSA presentation on its 2020 Commission and related hospital CON recommendations).

  - ➢ Provide access to data and promote discussions on use and formats involving local stakeholders and provider entities

- *Are there types of projects that should no longer be subject to CON review or projects that are not subject to review, but should be?*

  - While we have no immediate suggestions on projects that are not subject to review, but should be, we do recognize the challenge involved in considering non-Article 28 projects. Those projects that are currently subject to CON review could follow a priority-setting process, which concentrates CON review on projects which:

    - have high community or regional impact
    - relate to technology diffusion or specialty care
    - involve tradeoffs with regard to local and regional capacity, access, and cost effectiveness
    - involve issues about the relative capacity of licensed and non-licensed services
    - are politically sensitive or controversial
    - represent obvious duplication
    - are based on poor or inflated documentation of need
    - may be inappropriate for the type of facility making the proposal

  - Since the adoption of major revisions to the CON process took place just over one year ago, it may be worthwhile for the Department to first evaluate the impact of those changes (particularly with regard to raising cost thresholds) before additional changes are made to exempt more types of projects from review (or add new ones). Such an evaluation could solicit feedback from stakeholders and also take into account the experience in transitioning the CON role from the SHRPC to the PHHPC.

  - Project amendments may be one area which lends itself to further streamlining. The 2010 changes reduced the number of projects required to come back to the PHHPC for full review by allowing administrative review for amendments meeting certain thresholds and conditions. If experience with these amendment reviews indicates routine approval with few exceptions, then consideration should be given to replacing the administrative review amendment submission with a simple notification requirement of sponsors unless there are substantial changes in the project.

I congratulate you and members of the PHHPC for undertaking this review of the CON process during this challenging period of rapid change in health care. We're firmly convinced that well-structured local and regional planning can continue to play a major role in the system change and restructuring that you reference. We look forward to working with you as the PHHPC Health Planning Committee pursues its task.

Sincerely,

Timothy J. Bobo
Executive Director

Submission of CON Comments via PHHPCPlanning Email re: SEPTEMBER 2011 LETTER FROM DR. RUGGE

Commission on the Public's Health System – *Submitted by Judy Wessler on October 10, 2011*

Dear Dr. Rugge:

Thank you for your request to participate in this important effort to review the CON process. I think that it was about 3 years ago that Karen Lipson of the department asked that I participate in a similar review - although this description seems broader. I submitted testimony on behalf of the Commission on the Public's Health System and also participated in a follow-up "planning" exercise in Albany.

The concern of CPHS, as noted in our testimony, is to make the CON process more people focused and to collect data and review the data with an eye to health care disparities. It appears that our concerns were largely ignored as the changes were made at that time in the CON process.

We still remained concerned about the impact of expansion, contraction, and the spending of capital dollars in the health care system when there is no place for reviewing the impact particularly on low-income, medically underserved, immigrant and communities of color. New York State has a very poor record in this regard and it is our greatest belief that this should change. CPHS, along with other community organizations, mounted a campaign to raise the issue of health care disparities, along with cultural competence and language access within the Medicaid Redesign Team's work. Because of this organizing effort, there is a Health Disparities committee that is looking at many of the relevant issues and should have some impact. This effort should spill-over into CON reviews.

If there is an interest in exploring these issues further, I would be happy to meet with state people along with you to have that discussion. Please let me know if that is possible or of interest. If so, I would be happy to share my testimony and ideas, as well as bring other people to the table with expertise in this issue.

Thank you for the invitation.

Excellus – *Submitted by Christopher Booth on October 31, 2011*

This is in response to Dr. Rugge's email to David Klein soliciting views on the CON process. I know it is beyond the specified timeline for response but I will provide comments in the hope it may not be too late.

I have four comments to offer:

1. We need to review the types of situations we have seen in Western NY relating to urgent care clinics. It appears that, in multiple cases, doctors establish the clinic as a private practice, get it up and running and then convert it to an Article 28 in order to get enhanced reimbursement. These facilities have been approved as Article 28 facilities, presumably on the basis they already exist and it appears the Health Dept. would prefer to regulate it (jurisdiction). However, this method effectively evades the CON need process when it is established in the first place. We should review these cases, determine if there is evasion and whether there is a way to address.
2. I also think we need a strategy for dealing with "me too" applications which appear to be more frequent, especially Upstate. Essentially, one system decides to add a service or capacity of some sort, the competing systems learn of it and they all begin to apply. Should those

applications be considered separately or combined? What if there is need for only one? Should collaborative or community solutions be sought?

3. I think CON application needs to change with technology changes and site of service changes. If very expensive equipment can go in private practices, shouldn't it be governed by the same process?
4. Local input (where local broad-based interest exists) should be encouraged, given serious consideration and even be leveraged to help establish the solutions (for example, in the "me too" situations).

Thank you for the opportunity to comment.

Submission of CON Comments via PHHPCPlanning Email re: JUNE 2012 LETTER FROM DR. RUGGE

Fort Drum Regional Health Planning Organization – *Submitted via MRTWaiver email by Corey Zeigler on August 5, 2012*

We appreciate the opportunity to provide feedback on the MRT plan. Due to the character restrictions on the form, we are emailing our response as well as two "fact sheets" (links and attachments) about the Fort Drum Regional Health Planning Organization (FDRHPO) and the North-Country Health Information Partnership (N-CHIP). We would welcome the opportunity to discuss further; please feel free to contact me via the info below.

MRT Letter –
https://sharepoint.fdrhpo.org/public/FDRHPO%20Public%20Documents/Primary%20Care%20Recommendations%20for%20the%20MRT%20Waiver.pdf

FDRHPO Factsheet –
https://sharepoint.fdrhpo.org/public/Shared%20Documents/FDRHPO%20Overview%20Fact%20Sheet%202012.pdf

N-CHIP Factsheet - https://sharepoint.fdrhpo.org/public/Shared%20Documents/N-CHIP%20Fact%20Sheet%202012.pdf

August 1, 2012

John Rugge, M.D.
Chair, Health Planning Committee
Public Health and Health Planning Council
Empire State Plaza, Corning Tower, Room 1805
Albany, NY 12237

Re: Redesign of New York State's Certificate of Need Program

Dear Dr. Rugge:

I write to provide the Health Planning Committee of the Public Health and Health Planning Council (PHHPC) with stakeholder comments regarding Phase II of the efforts to redesign New York's Certificate of Need (CON) program. Any reform to the state's CON process must maintain its commitment to thorough public oversight of proposed health facility transactions, transparency in the approval process and ample opportunity for affected communities to provide comments.

The MergerWatch Project has 15 years of experience working with communities across the nation, including several here in New York State, to protect patients' rights and access to care when secular hospitals form business partnerships with religiously-sponsored hospitals. We bring to this discussion our hands-on experience assisting local residents in communities such as Kingston, Rhinebeck, Troy, Batavia, Niagara Falls, Smithtown and Schenectady to understand how to effectively participate in New York State's CON process.

From our experience working with community health care advocates in 36 other states, we have seen the negative outcomes that can occur when CON processes are abandoned or relaxed to the point where consumer interests can easily be ignored. We urge that New York carefully consider how to improve, not diminish, the opportunities for local residents to provide valuable information and perspectives that can help guide wise state decision-making about proposed health facility transactions in our state.

Changes in the role and purpose of the CON process

New York was the first state in the United States to establish a CON program, enacting its statute in 1964.[1] The program was originally designed to prevent costly duplication of health care services. Today, however, the CON process is more likely to be triggered by proposed mergers, acquisitions and closings, as health care facilities cope with a shifting health care landscape.[2] Because of that shift in focus, it is especially important to ensure adequate opportunity for comments from consumers, who may be at risk of losing one of their local hospitals or seeing consolidation of two or more area facilities.

Ten years after New York's CON law was enacted, a federal process for promoting community health planning was established when the federal government in 1974 passed the National Health Planning and Resource Development Act, which required all states to create local Health Systems Agencies (HSAs) for each of their regions.[3] The major functions of HSAs included collecting and

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[1] "Certificate of Need: State Health Laws and Programs," Nat'l Conf. of State Legislatures (Jan. 2011*)*, *available at*, http://www.ncsl.org/issues-research/health/con-certificate-of-need-state-laws.aspx.
[2] Id.
[3] 42 U.S.C.A. 281t.

analyzing data related to health planning, establishing health systems plans, and making recommendations to the appropriate state agency on the need for new institutional health services proposed to be offered in their region and on the "appropriateness" of all existing health services in their regions. By 1987, New York State had established eight HSAs.

However, the Act was repealed and a few years later the funding for HSAs was discontinued.[4] Today, only two HSAs remain in New York State: the Central New York Health Systems Agency (CNYHS) and the Finger Lakes Health Systems Agency (FLHSA). While many health facilities executives and some state officials believed the HSA system had become too cumbersome and burdensome, its demise left a gap in the CON process. Consumers no longer had reliable local notice of proposed health facilities transactions, nor opportunities to provide comments in their own communities.

In recent years, a number of states have taken further steps to eliminate or sharply reduce the opportunity for consumers to influence decisions about the future of the health facilities on which they rely. To date, 14 states have abolished their CON processes and 33 other states have deregulated it considerably, giving health care facilities a green light to merge, expand, downsize or even close with minimal government oversight and no public comment.[5] We have seen in our hospital merger work in a number of these states how deregulation has deprived local residents of the opportunity to point out potential negative consequences of proposed transactions, and has led to poor health outcomes that could have been avoided with better public oversight.

New York reformed its own CON program in 2010, raising the cost threshold for construction projects requiring CON application approval and combining the two health councils into what is now known as the PHHPC. These changes limited the number of applications that qualify for review and reduced the timeline of the review process by several months. Nonetheless, New York State still has one of the most robust health facility review processes in the nation and should take care not to weaken it.

Protection of Consumer Interests

Without the HSAs, consumers have managed to voice their concerns about hospital proposals by learning about and seeking to influence New York's now-centralized CON process. Often, local residents have required the assistance of a group such as MergerWatch, which has facilitated meetings with NYS DOH officials and helped consumers to prepare testimony to be given at meetings of PPHPC's predecessor organizations. These consumers have had to travel to Albany or New York City to provide their testimony. Below are two examples of how consumers have effectively utilized the CON process to protect community access to vital health care services:

- In 1997, two nonsectarian hospitals in the Mid-Hudson Valley (Kingston and Northern Dutchess hospitals) attempted to merge with Benedictine Hospital, a Catholic entity. There was vehement community opposition to the planned discontinuation of reproductive health services at the nonsectarian facilities because of the introduction of Catholic health restrictions. Community members were able to use the CON review process to voice their concerns about losing local access to key health care services, and eventually the transaction fell apart. Ten years later, in 2007, Kingston and Benedictine

[4] "Certificate of Need: State Health Laws and Programs."
[5] "State Certificate of Need Laws," American Health Planning Association, *available at*, http://www.ncsl.org/issues-research/health/con-certificate-of-need-state-laws.aspx#Program; See also, Mike Hornbut, *Cutting Through the Confusion: Movement to Relax the Limits*, American Medical News (Feb. 2005).

Hospitals were mandated to merge by the Berger Commission. The community's history of activism, which was reactivated by this new merger plan, helped bring about a requirement from the Berger Commission that access to comprehensive reproductive health care be maintained in Kingston after the two hospitals merged. This commitment was honored through a CON review process that considered consumer comments and eventually approved the creation of the Foxhall Ambulatory Surgery Center to continue provision of abortions and interval tubal ligations. Now that merged entity, Health Alliance, is seeking approval from the DOH to close one of the two hospitals, Kingston area health consumers will once again be relying on the CON process to safeguard their access to vital health care services.

- In Troy, NY, Northeast Health agreed to ban abortions, tubal ligations, contraceptive counseling and other services at its Samaritan Hospital ahead of its affiliation with (Catholic) St. Peter's and St. Mary's Hospital. The Burdett Care Center, a 20-bed separately-incorporated maternity facility on the second floor of Samaritan Hospital, was created to insulate the Center from the Catholic restrictions that now prevail in the rest of the hospital. The Center consolidates all maternity services from both Troy hospitals (Samaritan and St. Mary's) and allows women delivering babies to have post-partum tubal ligations.

  As the Center's application proceeded through the CON process, community members became fearful that the establishment of the Burdett Care Center would eliminate access to the midwifery model of care that was popular at St. Mary's Hospital. The CON process provided an avenue for community members to state their concerns in January 2009. Eager to receive the needed approval from the DOH, the leadership of Samaritan Hospital appropriately addressed these community concerns by incorporating key suggestions made the public into the plans for the new facility.

At its best, the CON process in New York State provides a vital avenue for consumer and health care advocates to learn about and comment on major proposed health care transactions, making hospital administrators accountable to the communities they serve. However, effective and informed consumer participation in the process can only occur if there is adequate public notification of CON applications that have been filed, and an effort is made to explain how consumers can provide comments to inform the decision-making.

Recommendation
In phase II of its CON reform process, New York State should seek to enhance, not diminish, public participation in the process. These enhancements should include methods of better notifying affected community members about proposed health care transactions and explaining the process by which public comments can be submitted. Consideration should also be given to providing opportunities for people to give comments in person in their own regions, rather than having to travel to Albany or New York City.

Monitoring Transactions After Approval
Transactions that were previously approved need to be adequately monitored in order to ensure that conditions issued during the CON application review process are actually met. Without rigorous monitoring system, applicants may neglect to follow the assigned conditions of approval and change their policies without repercussions from the state, thereby allowing them to diminish consumer access to comprehensive health care. The following example illustrates the need for state oversight of completed transactions:

- After two attempts to merge in the past were stymied by community opposition, Kingston Hospital and Benedictine hospitals formed an affiliation as recommended by a state-mandated hospital right-sizing commission. State health officials specified that the Kingston-Benedictine partnership be contingent upon Kingston Hospital continuing to provide reproductive health services in a location proximate to the hospital. With the support of a $4 million state grant, abortion services and elective sterilizations were moved to the separately-incorporated Foxhall Ambulatory Surgery Center built in the parking lot of Kingston Hospital. The center opened in February 2008.

  Last fall, the Foxhall Center's only abortion provider retired and was not replaced. For 10 months, the Center's board has failed to provide abortion services, which were the primary purpose for creation of the center. MergerWatch staff was made aware of the gap in service in March 2012 and subsequently denounced the situation in interviews with local press and attempted to secure a meeting with Foxhall management. We put in a request for Foxhall's required annual report to the DOH and discovered that Foxhall's operators had yet to submit such a report. Meanwhile, MergerWatch staff immediately helped to identify a family practice doctor as a replacement abortion provider, but as of July 2012, she has not officially received clearance to begin practicing at the center.

Recommendation
The CON process must have a monitoring system in place to protect consumers' interests after applications are approved. The DOH must be given the authority to intervene on behalf of local communities if commitments that hospitals have made during a CON process are violated. Hospital partnerships that receive CON application approval contingent upon providing comprehensive access to reproductive health care must face regulatory sanctions against hospitals that fail to fulfill the conditions attached to their CON approvals.

<u>Maintain Restrictions on Publicly-Traded, For-Profit Investors</u>
In 1970, New York passed a law prohibiting publicly traded, for-profit companies from owning hospitals in the state.[6] Investor-owned facilities are less accountable to the community they serve and the state officials with an interest in public health. This law prevents out-of-state shareholders who have the potential to prioritize profits over quality of health care and consumer interest from holding a stake in New York's hospitals. Efforts to repeal the law failed in the mid-1990s.

Recommendation:
The DOH has wisely prevented investors from owning health care facilities in the state and must actively resist any attempt to amend or repeal the current law in the interest of protecting consumer interests and health care access.

<u>Conclusion</u>
Hospitals are consolidating at a rapid rate in response to tight economic times and shifting community needs. New York's CON process may have changed since its enactment, but it still plays a vital role in promoting access to care and protecting community choices of health care services. We have experienced first-hand how public participation can help shape proposed transactions. Any redesigning of the CON program must build upon this foundation of community involvement.

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[6] 28 N.Y. Pub. Health Law § 2801-a(d)(e).

I respectfully urge the Health Planning Committee of the Public Health and Health Planning Council to ensure that the concerns we have raised be addressed during Phase II of the CON Redesign efforts. Should you have any questions concerning these comments, you can reach me at 212-870-2010. Thank you for your consideration.

Sincerely,

Lois Uttley
Director, The MergerWatch Project
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Christopher C. Booth
President and Chief Operating Officer

July 31, 2012

John Rugge, M.D.
Health Planning Committee
Public Health and Health Planning Council
Empire State Plaza
Corning Tower, Room 1805
Albany, NY 12237

Dear Dr. Rugge:

This is a response to your request for input on the CON process. Set forth below are my comments and suggestions.

General Comments

I am supportive of the discussion of the Committee to think broadly about the future and the evolution of the CON and health planning. I hope these discussions are fruitful and a long-term plan can be developed.

I am supportive of approaches to make the CON process more proactive in helping the State meet it's public health improvement plan and to proactively address health care needs (as opposed to being purely reactive to applications submitted by proponents of additional capacity).

However, any long-term evolution is, by definition, off in the future. In the meantime, we need to address existing processes and make needed shorter term changes. Committee time should be split with adequate time for both long-term strategic changes and short-term needed improvements.

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Revise the CON Criteria/Factors

I am impressed with the criteria utilized by the State of Maine in their CON process. I think New York should modify their criteria as necessary. Some of the relevant criteria/factors in Maine are:

- Financial feasibility
- Public need
- Promotes high quality outcomes
- Does not result in inappropriate increases in utilization
- Promotes reduction of avoidable and inappropriate services such as admissions or emergency room use
- Promotes efficiency or lower costs
- Improves access to necessary services
- Reduces unwarranted variation in care

High Cost Technology and a Level Playing Field

I urge the Committee to include required reviews of any additions of expensive technologies, including new technologies that are introduced in the future. I think that should include:

- Imaging equipment
- Hyperbaric chambers
- Surgical robots

We have seen significant installation of these technologies in Upstate, in numbers in excess of what I think is legitimate need.

Although likely controversial, my view is that CON requirement should be applied in all settings for such technologies (inpatient, outpatient, clinics, medical offices). We need a true level playing field for capacity management to be successful.

Consideration of Operating Cost

As part of financial feasibility analysis, understanding both capital costs and impact on operating costs on an ongoing basis is important. Some investments

lead to significant operating cost increases which are relevant to financial feasibility as well as efficiency. To be an effective oversight process, even smaller capital projects (below thresholds) with significant ongoing operating costs should be included in the projects requiring review.

Financially Distressed Providers

As part of the Council's streamlining recommendations, there was a recommendation that the Dept. take steps to ensure the financial feasibility of capital projects undertaken by financially fragile providers.

My view is that it is important to follow through on this recommendation as part of the CON reform process.

Address Article 28 "End-Arounds"

There appears to be situations where certain providers have conducted a scheme to avoid a substantive CON review. As an example, these situations have occurred in the urgent care center area. A physician or physicians will open a clinic as a medical practice in a new building often with imaging equipment, often as an urgent care clinic. Since it is legally set up as a medical practice, CON does not apply and there is no review. Once built and established, the practice will then apply for an Article 28 certification. The Article 28 certification is desired in order to obtain reimbursement at a higher Article 28 level.

Since the clinic is already operating and since the Department generally would prefer to have these facilities regulated, these applications are approved without a real need review (after all the capacity is already in place).

It is suggested that this scheme to avoid substantive need review needs to be addressed.

One suggestion would be to adopt a rule that no such applications can be submitted or considered within the five (5) years after the original opening of a facility.

Address "Me Too" Applications

We have seen circumstances where one facility in an area may propose a new service or expensive piece of equipment, soon to be followed by the other competitors in that region. It appears these additional applications are often triggered by wanting to have everything the other facility has, rather than compelling need.

If I understand it correctly, the CON process has typically reviewed and decided each application separately.

I would urge that the process explicitly address such scenarios and how they will be handled. The applications should be considered together and decided based upon overall community need. Only truly needed applications should be approved and where competitive applications apply, the application best meeting community need should be given preference. Collaborative approaches should also be given preference.

Wherever there is a local health planning body comprised of community stakeholders, their views of community need and community preferences should be given considerable weight.

Charter and Competency Reviews

One of the consistent areas of complaint of the CON process is the burdens and delays involved in the character and competence reviews. Very long delays can result from compliance requests of regulators in other states, some of which are not responsive.

While the need for detailed reviews of new, first-time applicants, not well known to the Department. is important, full reviews (with delays) of well known, longstanding operators with good compliance records is unnecessary.

I would propose streamlining the process for well known, longstanding operators with good compliance records. One suggested option is to provide a timeline for other states to respond and a policy to move forward without responses after a specified timeframe (but only for these longstanding, well known and compliant operators).

Importance of Local Health Planning

The process should both support and provide credence (listen to) local health planning.

All healthcare is local. Local problems almost always require local solutions. Local community stakeholders who are engaged can develop local innovations and solutions and develop community support for these solutions.

The Rochester health planning and community collaboration experience demonstrates how local planning can help develop a high quality, lower cost health delivery system.

Local health planning efforts should be supported, their input into CONs in their regions should be sought and given significant weight in Council decisions.

Ideally, these local bodies should also provide the Council with outstanding community needs which can lead to RFAs and other proactive activities on the part of the Council in cooperation with the local planning bodies.

Promotion of Local Technology Assessment Advisory Boards

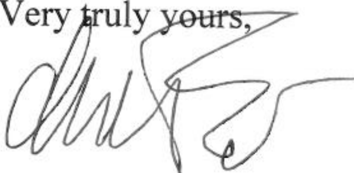
The Community Technology Assessment Advisory Board in Rochester has been a great tool in assessing new technologies and managing capacity in Rochester. It is comprised of a board of community stakeholders that reviews and makes recommendations to health plans about the community need for new technological equipment.

Expansion of this to other communities should be a priority. Given legal concerns voiced by some stakeholders in other communities, State action to support and promote such local bodies will be important.

The Committee should examine the CTAAB experience and discuss whether similar bodies in other communities should be encouraged.

I appreciate the opportunity to provide input to this important initiative.

Very truly yours,



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Health Planning Committee of the PHHPC
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Albany, New York 12237

VIA ELECTRONIC SUBMISSION

August 1, 2012

To members of the Health Planning Committee of the PHHPC;

In response to the request for stakeholder input, Family Planning Advocates of New York State (FPA) is pleased to offer the following general principles that must be kept in mind as you move into Phase II of CON Redesign. FPA represents the state's family planning provider network in New York. Our provider members include eleven Planned Parenthood affiliates, hospital-based and freestanding family planning centers, and a wide range of health, community and social service organizations that collectively represent an integral part of New York's health care safety net for uninsured and underinsured women and men. Family planning providers offer critical preventive health care services at more than 200 sites across the state. Services offered include family planning care and counseling, contraception, pregnancy testing, prenatal and postpartum care, health education, abortion, treatment and counseling for sexually transmitted infections, HIV testing and prevention counseling as well as breast and cervical cancer screenings. All of FPA's member health centers are licensed under Article 28 of the Public Health Law and are therefore subject to and familiar with the Certificate of Need ("CON") process.

Reform needs to reflect new models of care.

As health care calls for increased integration of providers, the CON process will need to change to reflect new ways of delivering health care services that better meet patient needs, including changes that will allow for the co-location of health care services. The existing regulatory structure is based on the traditional model of health care delivery where one entity provides a set of services at one established location used exclusively by that provider. The co-location of separately incorporated health care providers at the same location is one model of integration that family planning providers are interested in pursuing. This has been raised as a model to better meet the needs of many patient populations, particularly those with mental illness. The 2012-

2013 budget contains provisions that authorize the commissioners of various agencies to waive some regulatory requirements in order to allow for the co-location of health providers, so it is a direction that providers are beginning to consider. However, co-location is not currently contemplated in existing law and regulations governing the construction and operation of health facilities or in the CON process. Although existing rules do seemingly allow for flexibility through DOH's ability to either waive some rules or create a demonstration program, providers would benefit from guidance that would provide a framework for the standards that will apply to co-located services.

Rules governing the operator of a licensed health facility could be changed to recognize that more than one provider may provide services at a location and allow shared operators to enter into contractual agreements that line out responsibilities of each shared operator.

Ensuring access and protecting the safety net.
FPA is pleased to see that one of the guiding principles for reform will be the "preservation and expansion of access to needed health care services." Ensuring access and protecting the safety net are inextricably linked concepts and the CON process needs to be able to look at impacts on safety net providers when new projects are considered for approval.

New York has recently seen an infusion of federal funds into the state for the construction or expansion of FQHCs. We are concerned that some of this expansion is occurring without any consideration of the availability of existing primary care providers and services and whether there is a need for increased access to specific services. Although the expansion of more primary care services will be important in meeting the needs of increased numbers of insured patients, approval of these centers should not create an oversaturation of duplicate services within the same market area.

For example, in one region of the state an FQHC was given approval to open new family planning services at the same time the existing family planning provider was seeing a decline in the number of patients. The CON process, when evaluating applications to expand access should be able to consider the extent to which community needs are currently being met and when needs are met, should be able to direct the use of resources to more pressing needs or should encourage providers to work collaboratively to make better use of limited health care dollars resources.

The CON process could be used to encourage providers to co-locate as an aspect of regional health planning. This could be particularly beneficial in rural areas where the costs of a health facility could be shared in order to create efficiencies that will result in increased access to care while ensuring the sustainability of providers struggling to provide care.

Reproductive health services are unique in many ways and need enhanced oversight to ensure access.
The CON process has been instrumental in preserving access to a comprehensive range of reproductive health services and the process should not be streamlined to the degree that the state

loses its ability to ensure the public has continued access to these services. Because of religious and ideological objections, reproductive health services, including abortion are often targeted for elimination or banned from being provided for reasons that are not related to financial considerations or community need. The State, through the CON process has made approval of some hospital affiliations contingent on the continued availability of reproductive services, including in Kingston and Troy where sectarian and non-sectarian hospitals entered into affiliations that, without the strong state oversight, could have resulted in the elimination of hospital-based reproductive services for entire communities.

Like other primary care services, reproductive health services play a vital role in reducing health disparities and decreasing the costs of care. Unlike other primary care services, reproductive health services have special protections that reflect the reality that many women seek such services from either a family planning health center or an OB/GYN practice, preferring not to seek these services in conjunction with other primary health care. Many patients seek services this way because of family planning providers' commitment to providing confidential care, their expertise in providing counseling and education on reproductive and sexuality-related topics, and the ability to schedule patients on a timely basis.

Existing law offers enhanced protections to ensure women can exercise this preference. The free access policy allows women in the Medicaid program to access reproductive health services from any provider that accepts Medicaid and New York insurance law allows women insured through private, commercial plans to obtain reproductive health services without a referral from their primary care provider. Six in ten women who receive care at a family planning health center consider it their primary care provider. For these patients, family planning is the entry point to health care and it is essential that access to these safety net providers is preserved.

In order to ensure that access to family planning health centers and the services they offer are preserved as health care delivery is transformed, the CON system must maintain the ability to ensure community need for reproductive health services is met.

****

FPA appreciates the opportunity to provide input to members of the PHHPC as it begins the second phase of CON redesign. We look forward to providing more input to ensure our concerns are addressed as the process moves forward.

Sincerely,

Ronnie Pawelko
General Counsel

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July 23, 2012

John Rugge, MD, Chair
Health Planning Committee
Public Health and Health Planning Council
Empire State Plaza
Corning Tower, Room 1805
Albany, NY 12237

Dear Dr. Rugge:

Thank you for the opportunity to provide input as the Council moves forward with streamlining New York's Certificate of Need (CON) Program. Comments and suggestions in response to the questions posed in your recent "Dear Colleague" letter are attached.

The Hospice and Palliative Care Association of New York State (HPCANYS) represents the state's certified hospice providers and palliative care providers, as well as individuals and organizations concerned with care for patients and their families at the end of life.

Hospice serves patients at the end of life and uses a unique interdisciplinary team approach to provide pain and symptom management (palliative care), address social, emotional and spiritual needs and provide care and support to the bereaved. Hospice services are provided in the home, nursing home, inpatient facilities, and hospice residences.

Palliative Care, as defined by the World Health Organization, seeks to address not only physical pain, but also emotional, social and spiritual pain to achieve the best possible quality of life for patients and their families. Palliative care extends the principles of hospice care to a broader population that could benefit from receiving this type of care earlier in their illness or disease process.

The Hospice and palliative care models are based on case management patient-centered care. Hospice and palliative care provide the quality, compassionate care that patients want and need, while being cost effective. Hospice is one of Medicare's most cost-effective programs:

- According to an independent study conducted at Duke University, hospice saves Medicare an average of $2,300 per patient, or nearly $2 billion a year.
- A recently published study by Aetna found that "Liberalization of hospice benefits that permits continued curative treatment and removes limits on hospice benefits is a

strategy that is financially feasible for health plan sponsors, insurers, and Medicare." (*A Comprehensive Case Management Program to Improve Palliative Care,* C.M. Spettell, PhD et al, Journal of Palliative Medicine, Vol. 12, Number 9, 2009)

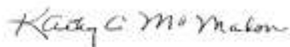
- Data from the Dartmouth-Atlas of Health Care 2008, "*Tracking the Care of Patients with Severe Chronic Illness*" demonstrates "…more resources and more care (and more spending) are not necessarily better."
- A 2008 study by Dr. Sean Morrison validates costs savings associated with hospital-based palliative care consultation programs (Morrison, R.S., et al, 2008; Cost Savings Associated with US Hospital Palliative Care Consultation Programs. *Archives of Internal Medicine*, 163(16), 1783-1790)
- Palliative care alongside usual care has maintained or improved the quality of care while generating substantial cost savings. (Smith, T., Cassel, J.B.; 2009. Cost and Non-Clinical Outcomes of Palliative Care; *Journal of Pain and Symptom Management,* 38(1), 32-34)
- According to the National Hospice and Palliative Care Association's 2010 Family Evaluation of Hospice Care Survey, 94.4% of families reported that hospice care provided was consistent with the patient's end of life care wishes; and 98.3% would recommend hospice to others.

The Medicaid Hospice Benefit enhances patient quality while also controlling costs. In addition to being cost effective, patient satisfaction is high. One study, conducted by Brown University, supported the role of hospice in nursing homes, concluding that hospice patients:

- Are less likely to be hospitalized in the last 30 days of life; and
- Received superior pain assessments.

Again, thank you for the opportunity to be part of the New York State CON redesign process. We are confident that the Public Health and Health Planning Council will recognize the importance of hospice and palliative care as they redesign the CON process. We urge you to assure that hospice and palliative care will continue to be accessible to all New Yorkers.

Sincerely,



Kathy A. McMahon
President & CEO

Attachment

Hospice and Palliative Care Association of New York State

Comments on

Certificate of Need (CON) Redesign

The Hospice and Palliative Care Association (HPCANYS) believes that New York's CON process has been successful in providing the necessary oversight to ensure that the state has an appropriate number of hospice providers in the state and agrees that any new Hospice Article 40 provider should be subject to the CON review. New York's CON process has prevented the unbridled growth in hospice services that has been seen in states such as Texas, Louisiana, and Oklahoma, all of which have come under scrutiny by MedPAC.

1. ***Structuring CON to work together with other regulatory and policy tools…to encourage health care delivery system improvement and population health*** – As recommendations from the Medicaid Redesign Team are implemented it is important that within the CON review process there is a cross-check system in place to assure that the intent of the various MRT approved recommendations (e.g. MRT #109, MRT # 209) are carried out and not compromised in any way.

2. ***Refining the CON process to respond appropriately to new models of care, new ways of structuring relationships among health care providers*** – As the state transitions to new Care Coordination Models (CCM), hospice and palliative care should be part of these new models. Patients receive hospice and palliative care services in the various health care settings -- in the home, nursing home, and inpatient facilities – and as such can be an effective approach to addressing appropriate patient care in these settings.
    - Managed Care: Recent research has shown that hospice and palliative care services are cost-effective and provide high patient satisfaction. Hospice and palliative care should not be marginalized as managed care is implemented, but rather should be considered an important part of health care for patients in need of these services. Referral to hospice within managed care must be seamless, and access to the hospice benefit and palliative care must not be impeded. Unfortunately, the current system does not adequately address the time-sensitive nature of patients in need of hospice services which results in patients either not receiving these services at all or receiving them too late in the process for them to achieve any significant benefit. The process to integrate hospice and palliative care into managed care must be scrutinized to identify any "unintended consequences" that could have a negative impact on access to those services and should be revised to in fact encourage referral to hospice.
    - Medicaid Redesign: hospice and palliative care should be integrated into the following proposals that were developed through the Medicaid Redesign effort:

- Dual Eligible Patients (MRT #101) – Integrate Hospice and palliative care into the demonstration projects currently under development.
- Patient Centered Medical Homes (MRT # 209): Integrate Hospice and palliative care into Patient Centered Medical Home pilot projects.
- Accountable Care Organizations (MRT # 209): Integrate Hospice and palliative care into Accountable Care Organizations.

➢ Managed Long Term Care: Allow patients in the Long Term Home Health Program (or future program that would serve these patients) to access hospice care. States such as Arizona, Florida, Ohio, Georgia, Massachusetts, Michigan and Texas are allowing long term care waiver beneficiaries who also qualify for the Medicare hospice benefit to receive both when the care is coordinated.

3. ***The role of CON in promoting access to care and protecting the health care safety net*** –New York State recognizes the important role of hospice and palliative care in effectuating comprehensive redesign of the Medicaid system and enthusiastically supports the implementation of these proposals. However, the median length of stay in hospice continues to remain low at 17-19 days which means that patients are not receiving the full benefit of the services offered by hospice. The CON should promote the following efforts that would encourage access to hospice:
   - Address the low use of hospice care in nursing homes by providing incentives for nursing homes to make hospice care available through contracts with their local hospices. In 2009, only 27% of Medicare beneficiaries who died in a nursing home in New York had been admitted to hospice, compared to 54% nationally (Hospice Analytics Market Report). This is a lost opportunity to reduce Medicaid expenditures since Medicaid saves 5% of the nursing home rate if the resident is on the Hospice Medicare benefit. Similar results are likely to be found in other long term care settings.
   - Encourage health care providers to provide hospice by implementing a reimbursement process that, consistent with Federal law, authorizes Medicaid payment for physician services separate from the daily hospice rate when hospice physicians and nurse practitioners serve as a patient's attending physician.
   - Support increasing the cap on hospice residence beds from 8 to16. Twelve hospice residences are currently operating in New York State, and all are at capacity, many with waiting lists. Sixteen beds would better meet community needs and would be much more cost efficient.

4. ***Types of projects that should no longer be subject to CON review –*** A change in ownership resulting from the death of a partner of a non-profit hospice should come under administrative review rather than full CON review.

5. ***Modifications to the current CON process –*** To expedite the approval process of construction CONs, we recommend that the Council consider modifying the architectural review process to allow the project's licensed professionals (engineers, architects, etc.) to attest that construction requirements set forth by the State have been met.

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07-23-12

Primary Care Development Corporation Recommendations to the Public Health and Health Planning Council on Regional Planning and Certificate of Need Reform

Thank you for the opportunity to comment on Certificate of Need reform and how it relates to regional planning. We are reserving comment on what role CON can and should play, and using this as an opportunity to address New York State's approach to health planning. We note that these are very preliminary ideas but we hope they are valuable to the evolution of a health planning infrastructure.

One of the shortcomings of the CON process is that it is reactive. Decisions are made in response to provider proposals for site facilities in a given area, as opposed to proactively addressing the needs of a region. Regional Health Planning Organizations (RHPOs) could bring back a health planning infrastructure that has long been missing from New York State. This would help us make more informed decisions about health care resources and give New York State residents greater control over the health of their communities. It would aid the NYS Department of Health in implementation of State health policy related to public health and facilities planning; build capacity through knowledge and data sharing; and form significant partnerships with community stakeholders. This could be particularly important to helping us understand the regional impact of new payment and delivery models like health homes and accountable care organizations.

There is an imperative to reform CON, streamline other regulatory processes, and develop a regional health planning process as quickly as possible. New York may soon have the opportunity (and requirement) to deploy hundreds of millions of dollars each year over five years for health system redesign under the MRT waiver. It will be vitally important that we have a regulatory framework that will help us deploy these funds as rapidly as possible, yet ensure that their impact can be well documented.

New payment and delivery models may correct for some of the market distortions brought about by traditional fee-for-service, but traditional market dynamics alone will still not be sufficient for health planning, particularly in underserved communities with large health care service gaps. And while the health care providers in these communities are essential to the planning process, and that process is essential to their own organizational planning, we cannot rely on providers alone to define the needs of their catchment areas. The health planning must be larger, more inclusive and more comprehensive. It should include all available planning and data resources, including community health assessments, hospital community service plans, and health center and hospital

A hospital may, for instance, se an overcrowded emergency department as a need for more ED capacity. But it may also mean that more primary care and preventive services are needed to reduce ED visits and hospital admissions. Or there may be a need to employ new service models that may not fit the traditional hospital or D&TC model. The answer can only be derived through an objective look at all available health and resource data.

Authority and accountability: A key question will be what level of authority New York State is willing to grant RHPOs, and what resources will be made available. What role will RHPOs play in ensuring the "triple aim" goals on a regional level?

Depending on how they are structured and resourced, RHPOs could be a vital element in helping the NYS Department of Health meet Medicaid spending and health outcomes targets. Bringing all necessary data to the table, the NYS Department of Health might collaborate with RHPOs to get community input and build consensus.

Some RHPO roles worth exploring include advising and technical assistance for providers; analyzing regional health outcome, public health and cost data; coordinating resource; soliciting input and building stakeholder consensus; and facilitating public health and healthy community initiatives (which involve not just health providers, but others entities that impact the social determinants of health).

PHHPC may want to explore "revenue sharing," where RHPOs that meet or exceed these goals could receive financial rewards or a share of savings that could be reinvested back into the health care system.

One challenge will be what kinds of entities would fall under the "jurisdiction" of RHPOs. Currently, article 28 facilities are regulated by the CON process. As different payment and delivery models emerge (i.e. health homes, accountable care organizations), what will the RHPO be responsible for overseeing, and what will fall outside its purview?

Governance and representation: The planning entities that are created need to be stable and enduring. One of the key questions that needs to be answered before a governance structure can be discussed is how much and what kind of authority RHPOs should have, and what should the relationship be with the NYS Department of Health? The RHPO should act in partnership with local health and service providers and other stakeholders (e.g. consumers, businesses, community health centers, behavioral health providers, local health departments, hospitals, health plans, research organizations). The actual governance structure needs to be carefully thought through with respect to conflicts. Having stakeholders as part of the governance may bring about broad-based consensus, but could put members in positions where their organization's interests and those of the organization are not aligned. Each RHPO should have a representative or representatives appointed to the Public Health and Health Planning Council or whatever organization is granted statewide authority over health planning and health systems.

Regional Health areas might follow the Department of Labor regional boundaries, and there is a case to be made that RHPOs should be coordinated with the NYS Regional Economic Development Councils. While the missions are quite different, there are data and planning that would inform the work of both entities.

Conclusion

The health care landscape is changing in significant and meaningful ways. As we move forward on many of the changes brought on by the Affordable Care Act and the possibility of the MRT Waiver, we must also develop a robust framework that drives decisions closer to the patient, yet ensures accountability "up the chain." RHPOs could play a significant role in addressing this need. We look forward to working with the PHHPC to advance these goals.

Submitted by Ronda Kotelchuck, CEO (rkotelchuck@pcdc.org, 212-437-3916; and Dan Lowenstein, Director of Public Affairs, (dlowenstein@pcdc.org, 212-437-3942), Primary Care Development Corporation.

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August 1, 2012

John Rugge, M.D., M.P.P.
Chair
Planning Committee of the Public Health and Health Planning Council
New York State Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Dr. Rugge:

I write in response to your recent invitation to provide commentary on a series of questions related to efforts by the Planning Committee of the Public Health and Health Planning Council (PHHPC) to redesign the state's Certificate of Need (CON) program. HANYS is pleased to have the opportunity to have input and applauds the work of the Planning Committee. HANYS also wishes to be clear that each of our previous recommendations for CON system streamlining and modification, contained in our October 2011 and May 2012 correspondence, remains relevant. Virtually all of our recommendations have been reflected in committee member input, but most have not yet been included in proposed reform.

To inform our comments, we shared your letter with our entire statewide membership for review and input. In addition, we convened our statewide workgroup on CON and health planning. That group has guided our previous recommendations. At the request of the Department of Health (DOH), we also included a review of certain past recommendations in that discussion, as well as the tool recently developed by DOH to standardize pre-opening survey expectations.

Although we convened our workgroup in mid-July, we had very good attendance—this topic is of critical importance to our membership. The current CON system creates barriers to desired delivery system change and we are hopeful that a system that incentivizes and supports needed change will result from the Committee's activities. The presentations at the Committee meeting last week and the active dialogue that followed made it clear that significant modification of the current CON process is warranted.
I will begin by addressing the seven questions posed in your letter. Our member reaction as expressed in this letter focuses on the practical application of the process.

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We would welcome the opportunity to meet with you to discuss the policy implications.

1. How can CON be structured to work together with other regulatory and policy tools, such as licensure, payment, and public health initiatives, to support and encourage health care delivery system improvement and population health?

The CON process should be modified so as not to be a barrier to achieving policy goals; it should support the achievement of those goals. The desired expansion of primary care services is a good example where CON creates an impediment to expansion. This is particularly the case when a hospital employs a physician and purchases an existing private practice, or wishes to open a new primary care extension site. Actions of this nature should be incentivized by being exempt from CON and should fall solely into the realm of licensure. In fact, HANYS recommends a reimbursement incentive be offered to facilities that are willing to expand primary care services, especially to under-served areas.

Multi-institutional planning needs to be encouraged. While initial efforts to implement Article 29-F through development of a Certificate of Public Advantage program have not been successful, there is a real need to remove state anti-trust related barriers.

It is unclear how CON intersects with the other stated policy tools. Regardless of how the modified CON system is structured, the resources and linkages necessary to support it must be in place. In fact, the availability of adequate resources must be a consideration in how a modified CON system is structured.

2. How can the CON process be refined to respond appropriately to new models of care, new ways of structuring relationships among health care providers, new technologies, and migration of services to outpatient settings?

Another policy priority is integrating the delivery system. The current CON system works against integration and perpetuates silos.

One avenue to greater integration is to encourage joint ventures between existing Article 28-licensed providers. However, the interpretation of the requirements of Section 600.9(c) has been that both existing entities would need to become established as a new operator to participate in the net revenues of the new facility. Existing Article 28 entities should be encouraged to partner rather than duplicate. Thus, we recommend that Section 600.9(c) be reinterpreted or modified to encourage joint venture integration.

Similarly, DOH's position and any applicable rules regarding co-location of Article 28 facilities need to be reassessed to encourage providers to work more closely together.

Integration between state agencies themselves could also be improved and would further facilitate service integration. An example involves integration of physical health and behavioral health services. Currently, DOH, Office of Mental Health, and Office of Alcoholism and Substance Abuse Services have individual, and not always consistent, roles in that process. To better facilitate integration of these services, there should be a lead state agency designated to work with the provider(s) rather than providers being required to work with multiple agencies that may not always agree on requirements.

In addition, a truly integrated delivery system would involve all providers of care, including those not subject to licensure under Article 28. New models of care being explored include the involvement of private practitioners as a critical component. CON and regulatory barriers to joint ventures between Article 28 licensed entities and private practitioners also need to be eliminated for a truly integrated delivery system to evolve.

3. What should be the role of CON in promoting access to care and protecting the health care safety net?

Our response to this question is essentially the same as our response to question #1. CON barriers to expanding access must be eliminated, especially with respect to acquisitions of private physician practices and additional extension sites. Financial incentives to expand into under-served areas need to be developed.

The current CON process does not promote access, and in some cases, may even impede it. The other policy tools referenced are more pertinent. CON should be modified to support those other efforts, not present barriers to their success.

4. What should be the role of local and/or regional planning in support of the CON process, health system improvement, and population health?

HANYS supports valid local and regional health planning efforts. However, we also recognize that community needs, resources, and capacities vary substantially across the state. A standard level of baseline tools already exists, including Community Service Plans, Community Health Needs Assessments, and federal community benefit (990 Schedule H)-related activities. Local health departments, notably New York City's, provide significant and valuable information to providers to assist in their planning efforts. Various other planning related entities exist across the state, tailored to the areas they serve.
Broad access to data is a critical underpinning of successful health planning. Development of an all payer database and access to the information it contains will prove to be a very useful addition.

At the request of the Cuomo Administration, HANYS is exploring proven approaches to local health planning and will provide further recommendations on this important topic.

5. How can the state's oversight of the character, competence, and governance of providers be improved?

HANYS strongly supports the premise that to be an established provider under the Public Health Law, individuals must be of sound character and must demonstrate competence to operate quality health care facilities. We also recognize the challenges associated with making this threshold determination. As currently applied, the test for character and competence provides advantage to new inexperienced operators, essentially because they have little or no track record in operating a health care facility. While the character of these individuals can be assessed from a range of perspectives, ensuring their competence is far more difficult.

Licensed health care facilities in New York State are very complicated organizations to operate successfully. Providers face many variables and challenges. DOH should have more flexibility to assess the competence of existing providers in an effort to level the playing field with operators with little or no track record. This needed flexibility may necessitate changes to Section 600.2 of the regulations. However, HANYS believes that an assessment of character and competence needs to be applied to all potential owners and operators of health care facilities established in New York State.

Governance of an existing licensed facility should be addressed through the surveillance process.

HANYS is aware of DOH's interest in looking further at the passive vs. active parent relationships and the implication for change in policy. To address this topic in the most informed manner possible, we recommend a group of stakeholders be convened and consulted for input and recommendations before any decisions are made.

6. How can the state's oversight of the financial stability of providers and the costs associated with new facilities and services be improved?

With the access to capital financing limited for health care providers in New York State, both government and private lenders provide a very significant level of scrutiny before making funds available and, in the case of financing through the Dormitory Authority of the State of New York, surveillance of outstanding bonds. In most cases, the DOH review focuses on essentially the same elements of performance. Duplicative reviews are costly, time consuming, and unnecessary. Where possible, DOH should rely on the due diligence of lenders. With capital cost reimbursement essentially a thing of the past, this review component now has less relevance in general application and should be targeted in a very careful and limited fashion.

Provider financial stability is a matter of great concern to HANYS. As such, we are convening a group of hospital representatives and others to address this topic. We will report back to DOH as this effort proceeds and will make specific recommendations.

7. Are there types of projects that should no longer be subject to CON review or projects that are not subject to review that should be?

A clear category of projects that should not be subject to CON review is any project the state approves and/or is willing to fund through offerings such as Health Care Efficiency and Affordability Law for New Yorkers (HEAL-NY) or those that potentially may be funded through a successful Medicaid 1115 waiver. CON review just delays the implementation of these state desired projects and adds unnecessary costs.

In addition, HANYS continues to recommend that any service that can be offered in a private practice setting should not require a CON from a licensed provider. Examples of services falling into this category are:

- imaging services;
- certain therapeutic modalities;
- opening additional primary care sites; and
- opening additional specialty care sites.

In response to a DOH inquiry on this particular recommendation, HANYS wishes to clearly state that the addition of an ambulatory surgery service is not included. Private practitioners must become established and licensed to operate an ambulatory surgery center and licensed providers must obtain CON approval to do so.

A third major category of CON projects that should be eliminated includes projects to address defined community health needs. A notable example is the operation of a primary care clinic in an area of defined community need.

The most problematic areas of concern with the CON process involve delays and their associated costs. These delays impede the ability of the delivery system to evolve rapidly to meet the goals of federal and state health reform, and add unnecessary cost to the system.

HANYS fully agrees that the CON system can benefit from further, significant streamlining and reconfiguration. The system should incentivize desired delivery system change not create a barrier to that change. One real incentive would be to eliminate the need for a CON for projects implemented to achieve population health goals and for certain types of system integration. Expanded use of the notification process should be enacted, which can readily be accomplished through regulations. The state should consider conversion of CON to a request for applications-

like process, but not one limited by state procurement rules, to address defined areas of community need. DOH should provide technical assistance to applicants and eliminate the 30-day letter process and its inherent delays.

CON should focus on the establishment of new providers. It should facilitate service delivery integration. It should provide incentives to meet community health needs. A system with these attributes has a much greater chance of supporting federal and state health reform.

HANYS very much appreciates the opportunity to provide commentary and recommendations to the Planning Committee, as well as the efforts of the Committee to achieve needed system reform. I do wish to reiterate our interest in meeting with you in person to discuss the broader policy implications of this effort.

Sincerely,

Daniel Sisto
President

DS:sm

cc: Nirav Shah, M.D., M.P.H.
James Introne

July 31, 2012

John Rugge, MD, MPP
Chair, Health Planning Committee
Public Health and Health Planning Council
New York State Department of Health
Corning Tower, Empire State Plaza
Albany, NY 12237

Dear Dr. Rugge:

The Central New York Health Systems Agency is now affiliated with the Health Advancement Collaborative of Central New York doing business as HealtheConnections. As you may be aware, Timothy Bobo has retired and I am the new Executive Director for Health Planning.

The Joint Health Planning Committee of our Boards of Directors met May 9th and formed a **Certificate of Need Sub-Committee** to review the proposed Administrative Streamlining recommendations and to make further recommendations for CON improvements based on our regional experiences.

Principles

1. All health care is local. The CON regulations should prioritize and support regional health planning.
2. NYS Department of Health (DOH) should focus their resources (people/talent/money) on those proposals which have truly significant implications for access, expense or systems change.
3. Health care delivery is moving toward population-based services including prevention and wellness. NYS needs to revamp its entire regulatory framework to accept the premise that many consumers of health care are not sick and many providers of health care are not physicians.
4. NYS regulations in general and CON regulations in particular need to be modified to reflect the change in health care delivery models away from large facility-based centers to portable, community, home-based and electronic service delivery systems.
5. The transition to "attestation" of regulatory compliance using third party licensed professionals establishes accountability of operators and reduces the strain on NYSDOH staff resources.
6. The revised CON regulations should be compatible with the §1115 Waiver as approved by the federal government.

Priorities

1. Although the process is called Certificate of Need, there is very little priority given to external analysis of unmet need, estimated utilization, alternative options or competing providers. Each region should be supported to have a multi-stakeholder planning process to forecast population health care needs in a pro-active, future oriented manner. Local planning should include consumer input and prioritization. Where are the gaps in service? Where is excess capacity? The current CON process is usually re-active and primarily addresses projects already well underway.
2. Streamlining the CON process is imperative. There should be timelines for steps within the review process, and a required response time (perhaps Limited 60 days; Administrative 90 days; Full 120 days).
3. Hospitals and Health Centers should be permitted to acquire the practices of existing physicians (for example, at time of retirement or restructuring) in order to continue service to their existing patients, using an expedited CON process that provides for the option of "limited life" approval (three months to five years) that allows the practice to function under the new operator while making plans for major renovation or relocation, and permanent "waivers" of Article 28 regulations for minor deviations from regulations (such as 2" ceiling height or hallway width). The current CON process in these circumstances tends to be lengthy and expensive, jeopardizing patient access to care.

Points

- The requirement of CON for services that unregulated private physician practices can develop without going through CON creates an uneven process with the regulated providers at a disadvantage.
- The merger of the Public Health Council with the State Hospital Review and Planning Council into the Public Health and Health Planning Council reflects an understanding that healthcare is moving in the direction of care management for 'covered lives' rather than a series of disconnected facility-based encounters.
- The boundaries between health care delivery 'units' are blurring. Business models include collaboration, co-location, co-ownership, insurance company involvement, contracts and employment relationships that support care coordination and quality health outcomes, but may trigger questions of anti-trust, character and competence and/or change in ownership under the current regulations.
- When CON review is required, do the people reading the application have the expertise to evaluate whether a particular device, technique or strategy is appropriate? There are new innovations in healthcare all the time. What once was rare may now be routine. What was once routine may now be discredited. Will there be sufficient volume of use to support the innovation? How is the PHHPC addressing these concerns?

- The revised process puts more accountability on architecture/planning/design professionals. This should be limited to building codes, fire safety and AIA guidelines and should not be confused with medical need justification. Medical need justification should be within the purview of regional health planning organizations such as HealtheConnections. Also, not all architecture/planning/design professionals are familiar with NYSDOH regulations – the intensity of oversight could be weighted based on the experience and skills of the firms involved.
- One way to facilitate pre-opening approval could be to utilize external engineering firms for building 'commissioning', which is generally being done by health care facilities in order for construction and renovation projects to be LEED™ certified. This may result in additional costs for the operator, but will verify issues such as envelop integrity and air quality. Building code compliance could be accepted from local and municipal inspections. NYSDOH could save scarce resources by accepting these reports in lieu of doing its own analyses.
- For those projects that continue to require CON authorization, there should be recognition of work provided to other governmental/regulatory entities to reduce duplication of effort. For example, application materials to provide services as an Accountable Care Organization or a Federally Qualified Health Center or under the Health care Efficiency and Affordability Law could be accepted in lieu of duplicative paperwork.
- The NYSDOH and the PHHPC may look to the Regional Economic Development Councils and the Medicaid Redesign Team for models for engaging in regional prioritization and system restructuring.
- The NYSDOH should engage with the Department of Financial Services - Insurance. Insurance companies are increasingly involved in the design and structure of health care delivery systems.

If I may provide additional information please do not hesitate to contact me at 315.472.8099 or swbollinger@healtheconnections.org.

Sincerely,

Sara Wall Bollinger
Executive Director for Health Planning

Comments submitted via PHHPCPlanning Email re: DRAFT RECOMMENDATIONS

St. Elizabeth Medical Center – *Submitted by Robert C. Scholefield, Vice President /COO on November 30, 2012*

Thank you for providing the CON/Governance Reform draft recommendation related to suggested CON revisions. My comments are based on my experience utilizing the current system, as well as St. Elizabeth Medical Center's overall experiences.

I. A Health Care Delivery System in Transition:

In the opening portion of the document, the "*Viability of Essential Providers and Disparities"* is an excellent point. As a safety net provider we rely our other lines of business to fund these essential services. As competition for those lucrative services increases, we find that our payor mix moves toward a point where we may no longer be able to be continue to expand or even maintain these essential safety net services. Many facilities have already experienced the loss of private/commercial payor patients to outside services, and leaving the hospitals as the only option for safety net patients.

II. Advancing The Triple AIM Through Regional Planning:

This recommendation appears to be an updating of the previous HSA model. While regional coordination may be of value, what will this added step add in terms to time for the approval of projects. Should it be limited to particular types of projects? What role would regional planning play on mission related services, competitive posturing, physician practices, and the perception of collusion?

II. Driving Healthcare System Performance Through Certificate of Need and Licensure:

A. Recommendation #6: Strongly agree with the elimination of CON for primary care facilities. As more and more physicians make the decision to leave private practice and join an established hospital system, the CON process and timing can be a detriment. In the case of a retiring practitioner, it leaves the potential of lack of access for a period of time.

B. Recommendation #7: Projects approved through an RFA process should be streamlined through the CON process. The time spent developing simultaneous applications is significant, and often delays these time specific projects.

C. Recommendation #7: Hospitals are often challenged to buy the latest technologies. Sometimes technology emerges as the next wave of healthcare advances and sometimes they don't have the benefits that initially were expected. In either case significant investments are made. Having research that is accepted across the industry may help, but getting consensus is often a difficult, and may be a long process. Once approved, adding it to the CON process may not be an advantage unless an applicant is requesting an waiver or exception to the accepted use. It would also be valuable that the payor system be in concert with this research as well. Technologies become available long before the reimbursement system addresses the additional cost for providing the care.

III Update CON and Licensure to Reflect the Complexity of Physician Practices.

A. Recommendation #13: This essentially levels the playing field between hospitals and physician

practices. It should insure the inclusion of the needs of the safety net patients, insure that the same standard for construction and physical plant safety. How would this recommendation tie into the regional planning process?

V. Incorporate Quality and Population Health into CON Reviews:...

A. Recommendation #20: *Meeting or exceeding the quality benchmarks established by the State;* Is this to assume that additional quality benchmarks will be developed, or utilize what is currently being reported? Hospitals are currently required to collect, report and improve upon a wide variety of quality indicators from a number of sources. It would be beneficial that these could be coordinated in a way that the benchmark data is consistent or based off some currently required data.

C. Recommendation #21: *CON applications submitted by financially stable hospitals should be subject to less scrutiny...;* How would financial stability be measured? As compared other New York State hospitals, or nationally, or some other criteria. Those hospitals that provide safety net services often sacrifice bottom line performance to address mission and community need, would that be factored into the equation?

The CON process would certainly benefit from many of the recommendations outlined in the draft. There needs to be balanced between the process and the benefits to the community and those we serve. I appreciate the opportunity to comment and I would be willing to provide and additional assistance that you may find valuable coming from a direct user of the system.

St. James Mercy Health System – *Submitted by Mary LaRowe, President and CEO on December 1, 2012*

Dear Public Health and Health Planning Council members:

I am writing to provide comment on the proposed establishment of a health planning process for the state. I applaud the Department of Health's goal to establish a regional health planning process; however, I fear that the unique characteristics of rural providers will not be adequately addressed. A "one-size-fits-all" approach has the potential to jeopardize years of complex planning and the development of collaborative relationships between rural hospitals, providers, and networks. Often challenged by the lack of resources, primary care providers, and specialists, rural providers have found creative ways to address economically challenged environments, geographic impediments, and the limited access to community health services. A regional planning process must not undo the foundational work of rural providers, but rather, support their work through a collaborative approach with their urban and suburban counterparts.

From a governance perspective, I am equally concerned about the potential for changes to the "passive parent" model. As an organization with a passive parent (Catholic Health East), St. James Mercy Hospital has benefited from a number of system-benchmarking initiatives focused around the areas of quality of care, operational efficiencies, risk management, and revenue cycle management (to name only a few). To conduct such initiatives in a small rural facility with limited human and financial resources, yet, gain the results we have in a short timeframe would be impossible without a partner with the depth of experience and commitment of our sole corporate member. Additionally, the board education provided to our trustees is invaluable and assists in the recruitment and retention of highly skilled community members to our board. The changes proposed to the "passive parent" model will only serve to make small rural providers less attractive to larger organizations and may even place existing relationships at risk.

Lastly, I applaud all efforts that will make the CON process more efficient, effective, and fair. The lack of a “level playing field” concerns me the most. St. James Mercy Hospital is proud and committed to serve a frail and vulnerable population, the un-insured, under-insured, and disadvantaged. However, we cannot continue to do so when unlicensed providers are allowed to provide the same services, yet, “cherry pick” their patient population, taking only the well-insured or private pay population.

Despite our challenges, St. James Mercy remains true to its Mission, “……….committed to being a transforming, healing presence within the rural communities we serve, particularly addressing the needs of the poor, underserved, and disadvantaged.” I hope the discussions you conduct and resulting actions allow us to continue to do so.

CPHS – *Submitted by Judy Wessler on December 8, 2012*

These will be minimal comments to just raise concerns about parts of these proposals. Also because I want to support and endorse the very substantive comments that were submitted by the New York State Nurses Association, which I hope that you have all seen.

Despite the recognized need to adopt actions that address and ameliorate health care disparities, (and by the way, you left out immigrants and the disabled from the list of populations affected by disparities) this proposal just mentions the words but recommends nothing that would target disparities as a major reason for action. You can not target populations that need action unless you collect information about these populations and that is nowhere evident in the draft that would happen. I was asked early in the process, by Dr. Rugge, to provide comments and I did. I talked about a Civil Rights Complaint that I had been involved with many years ago against the State and the NYC Health Systems Agency. One of the outcomes of this action, was a negotiated Access schedule that was added to the CON application. Unfortunately, this did not last long. That was the essence of my testimony. It remains a very serious concern after reading the draft proposal.

There is mention of using the CON as a tool to promote access to care - but the evidence in nowhere found within the recommendations. As a matter of fact, the weakening of requirements for review of CON applications, appears to take the system in the other direction - namely no review of access to care.

The first five recommendations address setting up regional planning mechanisms - which is a laudable goal. The way that these structures are developed, and the powers they are given would be determinative of their effectiveness. The language that would accomplish a true planning body that represents the interests of communities is missing from these recommendations. Descriptions of representation are sparse. Without the ability to influence or direct resources to where they are needed, the same political football that currently prevails, will surely continue. The divide between the haves and have nots could actually increase. Health planning is critically important particularly for medically underserved communities. But, the health planning has to have a community focus and a recognition that not all communities are equal in gaining resources. The details of membership, powers, and community involvement must be spelled out so that there is clarity that this is not just another big hospital dominated body.

Although we welcome the focus on expansion of primary care evidence in recommendation #6, there is an assumption that primary care built anywhere is sufficient. But we know from too many reports now that there are huge neighborhoods lacking in access to primary care and this recommendation would not stop this from happening, nor enhance the focus on need. Recently, one hospital preliminarily proposed using state funds to set up three new primary care centers in the most well-endowed part of their catchment area. Loosening the review and criteria could lead to more of this being proposed, and actually happening.

Recommendation #7 also raises concerns. The Department of Health does wonderful work, but is also susceptible to the same politics as the health care system. Pretending that winning a DOH grant is the equivalent of being reviewed as in a CON, is somewhat dangerous. This method of operation also reduces the little amount of transparency that currently exists in the CON program.

Recommendation #9 addresses CON's for hospital beds. The market place is not a good measure of where services are needed, as witness all of the hospitals and hospital beds closing in the most medically underserved communities. As networks become larger and stronger, the removal of services and beds from underserved communities become more of a threat. We have seen recent examples in the St. Vincent Catholic Medical Center, in Continuum, and other networks. We also believe that there must be a mechanism for review when hospitals or hospital beds are being closed, for the same reasons as cited above. Although the great hope is seen as the new ACO's, these same bodies could mean the demise of many community-based services needed in their neighborhoods. (#10).

There is much more that could be said, but I will stop here. I hope that I have raised some flags that need to be addressed. I would highly recommend that the PHHPCP, a primarily hospital-dominated body, should not be the last word on these regulations.

I hope that there is still an opportunity for consideration to be given to these comments, and in particular, the much more detailed comments submitted by NYSNA.

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Maria Roche
Board Member – Carthage Area Hospital

Denise Young
Executive Director FDRHPO

To: NYS DOH Public Health and Health Plannning Council
From: Fort Drum Regional Health Planning Organization
Subject: CON Redesign and Regional Planning Draft Proposal
Date: November 27, 2012

The Fort Drum Regional Health Planning Organization recognizes the significant amount of effort undertaken by the New York State Public Health and Health Planning Council to redevelop the CON and regional planning process and appreciates the opportunity to provide the following comments on the draft recommendations.

I. The FDRHPO has found that regional planning is an effective and critical tool to advance the CMS Triple Aim and agrees with the PHHPC that it must be carried out by multi-stakeholder collaboratives. Support for regional planning through policy levers, such as grant awards and the development of common data sets will be valuable to promote effective and accountable planning.

II. The PHHPC's recognition that successful regional health planning must have capable executive leadership with the experience and expertise to carry out the responsibilities is sound.

III. The FDRHPO strongly supports the identification of the Tug Hill Seaway Region, encompassing Jefferson, Lewis and St. Lawrence Counties as a separate planning region in the best interest of the health and well-being of the region's population.

IV. The draft is well thought out and attempts to tackle very complex issues in relation to the CON process in NYS. At this time it does not clearly lay out what role the RHICs will play in the CON process but this likely has not yet been fully determined as further development by NYS Department of Health is noted within the draft.

Overall, the draft is very well done and clearly results from significant work on the part of the Planning Council. This work is greatly appreciated by the board, committees and staff of the Fort Drum Regional Health Planning Organization.

Respectfully submitted,

Denise K. Young
Executive Director

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Kenneth E. Raske, President

October
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John Rugge, M.D.
Chair, Health Planning Committee
NYS Public Health and Health Planning Council
Empire State Plaza
Corning Tower Building, Room 1805
Albany, New York 12237

RE: GNYHA Comments Regarding CON Redesign, Health Planning, and Governance

Dear Dr. Rugge,

I am writing on behalf of the Greater New York Hospital Association (GNYHA) to provide comments on certificate of need (CON) redesign phase two, health planning, and governance in the context of health care reform and health care delivery trends. Although GNYHA has commented extensively on these topics at recent Health Planning Committee meetings, we appreciate having had the opportunity to listen to the exceptionally informative presentations and discussions of these issues at those meetings before submitting comprehensive written comments.

GNYHA begins by thanking the Health Planning Committee, the full Public Health and Health Planning Council (PHHPC), and the Department of Health (DOH) for embarking on their CON redesign discussions, and we thank you in particular for your administrative streamlining recommendations as part of CON redesign phase one. We recognize that great thought and care went into developing the recommendations to ensure efficiencies and cost savings while simultaneously protecting patient care and safety. GNYHA's members have begun to experience shorter CON processing times as a result of those recommendations, and we look forward to their full implementation.

To assist you in reviewing GNYHA's comments regarding CON redesign phase two proposals, GNYHA has both indented and italicized its recommendations and conclusions. GNYHA has also tried to respond to the initial set of questions put forward by the Committee and therefore has inserted those questions in the relevant sections of its comments. GNYHA assumes that it will be permitted to submit additional comments, depending on the specifics of the report that will be drafted by the Committee over the next several weeks, and we thank you in advance for that opportunity.

I. SETTING THE SCENE: HEALTH REFORM AND TRENDS

A. The Health Care System's Pursuit of the Triple Aim and GNYHA's Views in Brief

GNYHA believes that at no prior time in history have there been so many new health care initiatives under development, all in pursuit of the Triple Aim of enhancing the patient experience of care, improving population health, and controlling the cost of care. And, at no prior time has there been so much emphasis on care coordination, quality, access, and the social determinants of health.

> *Given health reform's singular focus on the same goals that CON programs and other regulatory tools have historically served, GNYHA believes that reform is making many aspects of CON programs and other state regulations even less necessary than they had become due to the myriad cost pressures and programs to improve quality, safety, and access already in place. As a result, GNYHA recommends additional streamlining of the State's CON program and related regulatory requirements. When the CON program is used, it should be only when it can be demonstrated to have considerable value.*

With respect to regional health planning, GNYHA notes that health reform requires providers to collaborate with not only other health care providers but with providers of services of all types, and of course with the purchasers of care, in order to improve population health.

> *Therefore, GNYHA urges that planning be aimed at improving the health of communities through a process that includes not just providers, insurers, and consumers, but schools, social services, and other representatives of the determinants of health; that it be treated as a process, and not a regulatory apparatus; and that it build upon existing local relationships and systems. What it should not be is the planning of old, which focused more on limitations and allocations than health needs, nor should it be tied to the CON program.*

Finally, on the issue of health care governance, GNYHA supports the importance of improving every aspect of health care operations on an ongoing basis.

> *GNYHA appreciates the importance of responsible governance and accountability, and welcomes the opportunity to work with the State to identify mechanisms for improving health care operations in general, including governance. GNYHA notes, however, that there are already many requirements pertaining to, and mechanisms for overseeing health care facility governance. GNYHA supports rationalizing the State's approach to determining the character and competence of board members and operators. Finally, it urges the State to permit the continuation of sponsorship arrangements that rely upon the State's "passive parent" regulations in recognition of the significant value such arrangements bring to health care providers and the system.*

B. Health Reform's Focus: Improving Quality and Population Health and Reducing Costs

The Federal Affordable Care Act (ACA) and the State's Medicaid Redesign Team (MRT) recommendations contain significant tools, incentives, and mechanisms for redesigning our health care system in a way that requires providers, particularly hospitals, to restructure the way they deliver care. In essence, both the ACA and the MRT require providers to focus intensively on improving the quality of care, enhancing population health, and controlling costs, collectively referred to as the Triple Aim. Taken together, the ACA and the MRT establish a framework for innumerable programs designed to improve quality, care coordination and management, access to care, health care coverage, and overall population health.

In particular, the ACA:

- Requires the establishment of health insurance exchanges that will provide affordable insurance coverage to provide better access to quality care and pave the way to better health.
- Provides 90% Federal matching funds to states that establish a Medicaid Health Home program to improve the care management of patients with chronic conditions.
- Encourages creation of accountable care organizations (ACOs) that will be responsible for the quality, coordination, and cost of care for Medicare beneficiaries. ACOs that meet quality benchmarks and reduce costs are eligible for shared savings. To reach these goals, the ACA attempts to remove Federal legal and regulatory barriers that would inhibit ACO formation.
- Calls for state Medicaid agencies to reimburse primary care physician services at the Medicare rate, with the Federal government providing 100% funding for any rate increases to promote access to primary care.
- Strives to improve care coordination overall and reduce avoidable hospital admissions by linking the possibility of sharing savings to meeting relevant benchmarks.
- Establishes programs aimed at addressing the health needs and costs of dually eligible Medicare and Medicaid beneficiaries. The programs focus on care coordination and integration of benefits to deliver seamless, efficient, quality care.

Similarly, initiatives emanating from the State's MRT focus on care management, population health management, and reducing Medicaid expenditures. In particular, the MRT called for:

- Developing health homes to provide care management for Medicaid enrollees with multiple chronic illnesses or serious mental illness, making the homes responsible for coordinating the needs of their assigned population. Services are to include comprehensive care management, health promotion, transitional care, and referrals to community and social services.
- Creating behavioral health organizations to manage the behavioral health benefits for Medicaid enrollees, with a focus on connecting patients to appropriate post-discharge care and eventually moving toward broader care management for covered individuals.
- Developing initiatives to coordinate care for dually eligible individuals to improve care as well as to control related costs.

C. The State's Medicaid Waiver Application: Also Supporting the Triple Aim

The State has filed a Medicaid waiver application that requests $10 billion in Federal funding over five years to support 13 different reform initiatives whose overriding goal is to achieve the Triple Aim. The request is premised on the projection that the MRT reforms will save the Federal government $17.3 billion. Among the 13 initiatives are those that expand primary care capacity and access; support health homes; develop care delivery models focusing on care coordination, improving quality, and reducing disparities and costs; expand funding for vital access and safety net providers; expand supportive housing; transform long term care; support integrated delivery systems; and support public health and quality.

D. Additional State Initiatives to Improve Health, Quality, and Efficiency

As discussed at several recent Health Planning Committee meetings, there are also a number of additional regulatory and other initiatives designed to improve quality and population health and control costs. These initiatives range from financial incentives to reduce readmissions and adverse outcomes to the availability of data to identify health needs and support health care decision-making. The types of providers affected by such initiatives run the gamut and include managed care organizations, institutional providers, and physicians.

II. DIMINISHED ROLE OF CON PROGRAMS

Given the significant impact of health reform at both the Federal and State levels and the many initiatives aimed at improving care and health and controlling costs, GNYHA believes that the need for many aspects of CON programs is even more diminished than it was when the Health Planning Committee undertook its administrative streamlining review earlier this year.

A. CON Redesign Phase One: Administrative Streamlining

As part of phase one of the Committee's review, GNYHA presented a paper, *Transforming New York State's Certificate of Need Program,* which described the extraordinary evolution of the health care system since the State's program was created in 1964. GNYHA pointed to the many factors that limit capital expenditures today, including limited capital reimbursement, limits on operating revenues, and changes in capital markets. Similarly, GNYHA enumerated the many initiatives, agencies, and incentives that are more effective at promoting quality and access on an ongoing basis than today's CON programs. Only in certain situations might CON programs have a beneficial impact on quality and access, such as where quality is linked to volume and/or where access to care may be undermined by the entry or exit of a provider or service. As a result, GNYHA argued that CON programs' value in promoting cost control, quality, and access had diminished significantly. GNYHA attaches a copy of its paper to this comment letter.

As stated at the beginning of this letter, GNYHA and its members are very appreciative of the Committee's efforts to streamline the State's CON program as part of CON redesign phase one, as well as its continued willingness to discuss the redesign of the program.

B. CON Redesign Phase Two: Repurposing CON

As part of CON redesign phase two, the Committee reviewed a number of studies that evaluated how well CON programs contribute toward their goals of quality, access, and cost-control. Taken as a whole, the results of those studies were equivocal, with some studies indicating value in these areas and others not. The observation was that the value of CON programs is contextual and depends on the existence of other factors present in a particular region.

The Committee also heard a lengthy and impressive presentation on health care trends, which concluded that while there are questions about the relevance of CON in the long term, the program might be needed in the intermediate term to protect against unintended consequences. While in use, however, it should be focused on where it can make a difference.

C. Responding to the Committee's Questions Regarding CON Redesign

In light of the Committee's recent discussions and health reform's strong focus on population health, care improvement, and cost control, New York's CON program arguably has a more diminished role today than when the Committee began its initial streamlining review less than a year ago.

> *Given that the goals of health reform overlap with the goals traditionally served by CON programs, GNYHA urges the State to give broad interpretation to the CON reforms already adopted and requests the Committee to continue its efforts to streamline the program.*

GNYHA discusses this position in more detail by responding to the four specific questions raised by the Committee with respect to CON redesign.

Question 1: The Committee first inquires how CON can work with other regulatory tools:

> How CON can be structured to work together with other regulatory and policy tools, such as licensure, payment and public health initiatives, to support and encourage health care delivery system improvement and population health?

As discussed in detail above, health reform has focused the entire health care system (and beyond) on improving care, enhancing population health, and controlling costs. At the same time, myriad other initiatives, incentives, and forces have already diminished the value of CON programs to the point that their costs may outweigh their benefits. Presentations made to the Health Planning Committee in June and July underscored the equivocal value of CON programs, as well as the vast number of other regulatory approaches to improving quality, controlling costs, and enhancing population health, particularly in New York.

> *The simple answer is that CON programs have a greatly diminished role in today's environment, given the myriad regulatory and policy tools that already exist or are planned as part of health reform, all of which are designed to serve the same goals as*

CON programs on a continuous basis. Thus, the State's CON program should continue to be streamlined in recognition of these circumstances.

Question 2: The Committee next inquires whether CON can be refined to respond to health care trends:

> How can the CON process be refined to respond appropriately to new models of care, new ways of structuring relationships among health care providers, new technologies, and migration of services to outpatient settings?

Most, if not all, of the new models of care and new relationships come hand-in-hand with their own regulations, regulatory oversight, and many sets of cautious eyes on their development. In addition, as stated, presentations to the Health Planning Committee in July outlined the many regulatory agencies overseeing quality, health, and costs from many different angles. The value of CON programs was already diminished due to new payment and other incentives, and their value is being diminished even more in this era of new models of care being dictated by Federal and State reform, all of which focus on improving quality and access and reducing costs.

> *Given the health care system's intensive focus on quality, health, and costs, it is unclear what role CON programs might serve in this context, other than to add a layer of regulatory requirements to programs and initiatives that are already the subject of Federal and State regulation and oversight.*

Question 3: The Committee goes on to ask a broader, more general question:

> Are there types of projects that should no longer be subject to CON review or projects that are not subject to review, but should be?

GNYHA's answer to this question is detailed and set forth in the discussion below.

CON Should Not be a Barrier to Reform Efforts: First, it is essential that CON not be a barrier to the development of the new models of care and relationships expected by Federal and State health reform.

> *Health care projects, models of care, and relationships encouraged by reform, grant programs, and new payment mechanisms should be exempt from CON review. For example, providers sometimes complain that they must wait long periods of time for CON approval of a project that has been awarded HEAL funding and, as a result, they fear loss of that funding. This type of circumstance is one that should be avoided, particularly because the HEAL process has its own approval process in place as is the case with many health reform initiatives.*

The State Should Level the Playing Field: Second, hospitals and others have often stated that it makes little sense that hospitals must seek approval for certain services and equipment when other providers can add the same services and equipment without CON review. This

phenomenon does little to improve population health or reduce health care costs, particularly as the focus of the health care system moves increasingly to outpatient care and care in the community.

At the October 12 Health Planning Committee meeting, DOH introduced proposals that address this concern by either extending CON review to all providers or eliminating CON review for everyone, with respect to certain enumerated services. The services discussed included radiation therapy equipment, diagnostic imaging, ambulatory surgery centers (ASCs), hospital beds, primary care, and hospice services. In each case, DOH outlined the pros and cons of the alternatives. DOH also cautioned that if CON review were extended to everyone, DOH would not have the resources required to process the resulting applications.

GNYHA and its members greatly appreciate DOH's recognition of the importance of leveling the playing field. Although GNYHA continues to collect input from its members on the issues raised by DOH at the October 12 meeting, those members with whom GNYHA has spoken generally support eliminating CON review for the entire list of services except for free-standing, non-hospital-based ambulatory surgery centers. Members support the importance of leveling the playing field, believe that extending CON to all providers will probably never carry the day politically, and recognize that DOH does not have the resources to extend CON to everyone. Furthermore, members also fundamentally believe that filing a CON application with respect to many of the services should not be necessary in today's world, with some members focusing more particularly on primary care, hospice, and hospital beds, and others focusing on radiology equipment. However, with respect to ASCs, GNYHA and its members have long expressed significant concerns that certain free-standing, non-hospital-based ASCs will undermine the ability of hospitals to serve their communities.

At the same time, members recognize the possibility of increased costs as well as other unintended consequences resulting from eliminating CON review for certain services, particularly if all services were eliminated from review at one time. As a result, some members prioritized services that should be removed from review, again with some putting primary care, beds, and hospice at the top of the list, and others putting radiology equipment at the forefront.

> *Based on the discussions GNYHA has had to date, GNYHA recommends strong consideration of eliminating from CON review all of the services put forward by DOH except free-standing, non-hospital-based ASCs. Given concerns about unintended consequences, however, GNYHA recommends that DOH consider putting in place a system for reviewing surges in unnecessary costs or procedures, quality concerns, or system-integrity concerns that could perhaps result from eliminating CON review for all such services.*

GNYHA will continue to discuss these proposals with its members and provide additional recommendations as the Committee discusses the proposals and its eventual report.

The State Should Implement Existing Reforms as Broadly as Possible: The streamlining recommendations approved by PHHPC earlier this year, as well as other recent reforms, should be implemented as fully as possible to ensure the efficiencies and reforms intended. In particular,

GNYHA strongly urges that the statutory language required to effectuate the elimination of construction from review regardless of cost be drafted broadly to give full meaning to that recommendation. GNYHA had put forward the recommendation due to the numerous regulatory and other factors that discourage capital spending today, thus making CON review unnecessary in most cases.

To guard against projects that might unnecessarily drive up health care costs, the recommendation approved by PHHPC listed types of projects, which, if they accompany construction projects, might warrant some level of review. GNYHA strongly urges that the list of "carve-outs" be drafted narrowly so as to give the reform a broad interpretation.

> *Therefore, GNYHA requests that the description of the list of potential cost drivers in the proposed bill language make it clear that the State is required to review 1) only those enumerated cost drivers themselves as opposed to the entire project, unless of course the "cost driver" itself is the purpose of the construction.*

Thus, for example, if a hospital proposes to renovate a wing to convert beds from double to single occupancy and one aspect of the project is to repurpose certain beds, the statutory language should be clear that the State should review only the repurposing of the beds, if required, and not the construction aspect of the project (and only if the repurposed beds would be considered a significant cost driver).

> *In this same vein, GNYHA urges that the State ensure that the definition of a facility replacement be limited to only those situations where the nature of a facility and its services are to be changed, as opposed to the replacement of the structure itself.*

GNYHA believes that the foregoing is consistent with the language in the text of the recommendations that would permit renovation of a building to convert from double rooms to single rooms without CON review. However, GNYHA wants to ensure that the proposed statutory language reflects this intent.

Similarly, members have recommended that the definition of projects subject to the notice process implemented pursuant to legislation passed in 2011 be given a broad interpretation.

> *Thus, while the notice provision lists repair and maintenance projects, one-for-one equipment replacements, and non-clinical infrastructure projects as qualifying for the State's new notice process, members request that construction related to a one-for-one equipment replacement also qualify for the notice process and a provider not be required to file either a limited review or administrative review application.*

> *Members also request that basic cosmetic work performed at the hospital not be subject to any requirement, notice or otherwise. These were projects that were not reviewed previously, and have somehow became subject to the notice process when it was implemented.*

The State Should Revise Need Methodologies for Remaining Projects and Services: GNYHA members have also requested that the State revise its need methodologies for those projects or services that remain.

> *GNYHA recommends that the State revise its need methodologies for projects and services that remain subject to CON review, something that GNYHA knows is important to the State as well.*

Question 4: The Committee's final question regarding CON redesign focuses on access:

> What should be the role of CON in promoting access to care and protecting the health care safety net?

As discussed above, a significant focus of health reform is on promoting the experience of care, population health, and cost-control. In turn, a major part of that effort involves improving access and care coordination and focusing on those populations and providers that need the most support and funding. The list of reform initiatives that appears at the beginning of this letter is intended to draw attention to these efforts.

> *While access has been a traditional goal of CON programs, it is hard to see how the State's CON can provide significant assistance to the goal of promoting access beyond what health reform is already encouraging. CON programs may be of some assistance in preserving the health care safety net as it goes through the transition required by health reform. But CON programs should not be expanded in the name of access.*

III. HEALTH PLANNING: PROMOTING POPULATION HEALTH

Question 5: The Committee also inquires regarding the potential role of health planning:

> What should be the role of local and/or regional planning in support of the CON process, health system improvement and population health? How should local/regional health planning be organized and funded?

The State's MRT waiver application calls for regional health planning to promote the Triple Aim, ACA goals, and MRT recommendations. GNYHA and its members are supportive of health planning for these purposes and indeed believe that planning is already occurring as providers undertake community health needs assessments, develop community service plans, and join with other providers and agencies to coordinate care, share data, improve quality, and reduce costs, all overseen by existing Federal and State mandates and rules.

GNYHA appreciates however that more planning is required. In providing input to GNYHA on how planning should be organized, GNYHA members first made it clear what they don't want.

> *As GNYHA stated at the September 5 Health Planning Committee meeting, GNYHA members do not want the reprise of health systems agencies (HSAs) as they existed previously. Instead, they believe it is important to view planning as a process or function,*

rather than as a fixed body or organization. It should also build upon the organizations and relationships that already exist in a community, rather than feeling the need to create something entirely new or prescriptive.

In essence, members do not want what they perceive might be another regulatory body that creates additional burdens or costs to the process of moving in the direction already spelled out by reform. The Committee's September 5 meeting helped demonstrate that planning bodies, even when still called HSAs, do not necessarily have to engage in bureaucratic, directive activities.

GNYHA members also do not want the planning function tied to CONs.

Again, the Committee's September 5 meeting was helpful in that regard given that another planning organization (the P2 Collaborative) stated that one of its first decisions was to not get involved in CONs.

Focus on Health Improvement: So what do GNYHA members support? They most definitely support a planning function that focuses on population health or health improvement, or that would help improve primary care or the coordination of care. Several members indicated they would welcome the opportunity to use the planning process to decide which providers should offer which services; however, that view was not universally held by GNYHA members. This latter function could of course be raised and/or be the focus of the process in a particular region.

Therefore, while a particular locale might choose to undertake different functions, GNYHA strongly recommends that planning activities should focus on population health and health improvement, areas that everyone agrees should be addressed through a planning process and that are a high priority for the State and the nation.

For this purpose, GNYHA draws specific attention to the State's Health Improvement Plan, on which considerable time has already been spent identifying community needs as well as evidence-based guidelines for tackling those needs. It would seem that the State's plan is a perfect candidate for health planning and implementation. As stated, regions that wish to tackle other matters could of course undertake the planning that the region requires and needs.

Broad Participation in the Process: GNYHA members also support a process that brings together providers, consumers, insurers, businesses, and unions. But they also support including the broader community of entities that represent the social determinants of health, such as schools, transportation, and social service agencies. This is necessary in that population health is influenced by far more factors than the health care system.

Thus, GNYHA recommends that the planning process include providers, consumers, insurers, businesses, unions, as well as representatives of the array of social determinants of health to ensure the greatest impact on population health.

Definition of Regions: With respect to defining regions, GNYHA appreciates that the State feels the need to have specific defined regions and thus the State began its discussion in this regard by looking at the State's Economic Development Council (EDC) regions. Again, GNYHA recommends that the State should build upon organizations, relationships, and "regions" that already exist rather than prescribe specific regions. GNYHA is also concerned about designating a region that would be the size of New York City, which is one of the current EDC regions. On the other hand, GNYHA recognizes that dividing New York City by, say boroughs, artificially carves up areas where populations seek care and services of many sorts.

Thus, for the New York City area, one solution might be to have a high-level panel of individuals who might act as an executive committee for the process. In turn, local panels could tackle specific subjects and would be empaneled on an ad-hoc basis depending on the issues and goals to be achieved. None of this is meant to be exclusive, but rather to ensure that the right people are involved in the right discussions and issues. In addition, it is meant to ensure that the process evolves as issues and circumstances evolve.

Designing and Operationalizing Health Planning: GNYHA also recommends specific criteria for the operation of health planning.

- *GNYHA supports the MRT waiver application's recommendation that there be a neutral and trusted convener at the core of each planning process.*
- *GNYHA supports the recommendation that there should be common, reliable data used for such purposes and that neutral experts are required to interpret the data.*
- *GNYHA believes that the primary goals and vision of such planning should be established and supported by DOH. It is essential that the State take this central anchor role. That is not to say that a locale could not choose to address a particular concern faced by the area. But the State Commissioner of Health should play a significant role in identifying the goals of such planning and supporting it throughout the State.*

GNYHA members also consistently stated that the planning function should be time-limited. GNYHA appreciates that to have a meaningful planning process, it is necessary to devote sufficient resources to data development and analysis, leadership, and staff support for a reasonable period of time. However, the underlying concern of wanting a time-limited process is related to the initial concern stated above, namely, that the planning process not result in the creation of another bureaucratic, regulatory process that adds to the inefficiencies and costs of care. If that concern can be addressed, then presumably the time-limited criterion may become less important.

GNYHA recommends that the planning process be time-limited which can probably be addressed by establishing a series of time-limited planning projects. This recommendation is put forward to avoid developing an unnecessarily bureaucratic or regulatory process. For example, the MRT process was a time-limited, goal-oriented process. A similar series of time-limited, goal-oriented processes could be identified and carried out seriatim within a broader planning framework.

IV. IMPROVING GOVERNANCE: A CONTINUOUS RESPONSIBILTY

Question 6: The Committee also poses a question regarding the governance of providers:

> How can the state's oversight of the character and competence and governance of providers be improved?

A. Recognizing the Importance of Governance: Extensive Requirements and Oversight

GNYHA believes in the importance of strong governance and accountability. In recognition of the importance of governance, many Federal and State laws, agencies, and accrediting organizations impose a broad array of requirements regarding governance and wield a broad array of oversight and other tools for enforcing those requirements including:

- The State's Not-for-Profit Corporation Law's standards for the governance and operation of not-for-profit organizations, which the State Attorney General can enforce.
- Federal laws and regulations regarding the conduct of tax-exempt organizations that focus heavily on governance and that are enforceable by the Internal Revenue Service, as well as the annual, mandatory filing of the Form 990, which includes governance questions and is publicly available.
- The Centers for Medicare & Medicaid Services' Conditions of Participation that apply to many types of providers and that focus on governance.
- The Joint Commission's accreditation standards that place great emphasis on governing body responsibilities.
- Oversight by DOH and PHHPC through the initial establishment process of health care facilities and the selection of governing body members.
- State regulations regarding the roles and responsibilities of governing bodies in health care facilities.
- The State's authority to survey against these standards and to respond to complaints in this regard.
- The State's authority to issue statements of deficiencies when DOH believes a governing body has not fulfilled its responsibilities.
- The State's ability to pursue enforcement actions and assess fines against a facility for serious, recurrent violations of such responsibilities.
- Ultimately, the State's authority to limit the activities of the facility under the State's license.

Given the foregoing authorities that exist at many levels, GNYHA recommends against adding more standards or authorities. However, GNYHA would welcome the opportunity to work with DOH to develop ways in which health care providers can improve their operations in general and their governance in particular.

B. Rationalizing Character and Competence Reviews

In order to improve the State's oversight of health care providers, however, GNYHA recommends that the State "rationalize" its character and competence review process. As noted above, the State's authority over health care governance begins with approving the establishment

of a facility and reviewing those individuals proposed as board members or operators of the facility. At that time, the State is required to determine whether the individuals have the character and competence to operate a facility given its complexity and the nature of its services. To accomplish this, the State requires each proposed board member and operator to fill out a detailed form regarding his or her background that includes extensive information regarding the individual and his/her businesses, assets, finances, and other matters.

The State's 10-Year Look-Back Period: The State also looks at the past record of other facilities on whose board an individual may have served, or with respect to which the individual was an operator during the prior 10-year period, commonly referred to as the "look-back" period. (In its June 2012 report, PHHPC recommended that this period be reduced to seven years, a change that will require a statutory amendment and that GNYHA supports.) Under current State law, DOH is required to affirmatively find by substantial evidence that "a substantially consistent high level of care is being or was being rendered in each such hospital…or institution" with which each proposed incorporator, board member, or operator was affiliated over the prior 10 years.

The Public Health Law provides that the State shall *not* find that a facility has provided a substantially consistent high level of care where there have been violations of the State Hospital Code or other applicable rules and regulations that 1) threatened to directly affect the health, safety, or welfare of any patient or resident and 2) were recurrent or were not promptly corrected. As a matter of practice, the State determines that a substantially consistent high level of care was not delivered during the proposed operator's service at another facility if the facility experienced two enforcement actions during the prior 10-year period related to what the State determines is the same issue.

Problems Raised by the Look-Back Period: In general, GNYHA believes the State's statutory standard and approach end up being both unreasonably broad and unreasonably narrow, the effect of which is that individuals whom the State should welcome on new boards are not permitted to serve, and individuals who may not be the most experienced are permitted to serve instead. This phenomenon is the product of the length of the look-back period as well as DOH's view of how it must interpret the term violations that "were recurrent or were not promptly corrected."

With respect to the time period, a 10-year period is unreasonably long, particularly when a facility may have made material strides in improving care over that period. In addition, DOH's view that two enforcement actions for what it may call the same event must lead to a finding that the requisite standard cannot be met leads to over-restrictive adverse determinations regarding character and competence. For example, if two separate hospitals in the same Article 28 established network have two enforcement actions that implicate the same provisions of the Hospital Code, DOH believes it must determine that a "substantially consistent high level of care" was not provided in those facilities. This could occur even though the circumstances of the two cases may be different, the two hospitals were separate, the board members had no specific involvement in the events in either facility, and DOH believes that the facilities have delivered high quality care in the intervening years.

As a result, GNYHA recommends that the State's approach to reviewing character and competence be "rationalized," as DOH says, both to avoid arbitrary outcomes and to enable the State to look more broadly at quality issues that may affect a determination. GNYHA specifically recommends the following:

1) *The State should continue to consider whether other facilities for which the proposed board member or operator served provided a substantially consistent high level of care, but should focus on the care provided in recent years and the efforts made to address concerns that may have been raised.*
2) *Related to this recommendation, GNYHA recommends that the State eliminate any reference to a specific time period.*
3) *The State should look at the specific involvement of the individual being reviewed in the events that raise questions, looking of course at actions taken and not taken.*
4) *The State should revise its approach to determining whether events are recurrent. GNYHA has seen situations in which events in different facilities are truly different, but because DOH has cited the facilities for some of the same provisions of the State Hospital Code, (e.g., medical staff or medical record provisions), DOH has concluded that the events underlying the enforcement actions were recurrent. GNYHA believes that citations that involve the same Code provisions should not necessarily make events sufficiently similar to be considered recurrent, and there should be a closer look at what occurred in each circumstance. GNYHA urges that this can and should be done even in the absence of any statutory change to the Public Health Law since this circumstance is a function of DOH's interpretation of its enforcement actions.*
5) *Related to the foregoing recommendation, GNYHA also believes that DOH should consider whether a particular deficiency caused the adverse event in question. Often DOH will issue a number of statements of deficiency (SOD) when it undertakes a survey of a facility, as it should do. However, not all of the SODs may have caused the adverse event. GNYHA thus requests that when DOH considers the issue of "recurrence," it take into account only those deficiencies that caused the event in question.*

C. Recognizing the Value of Passive Parent Arrangements

At the September 19 and October 3 Health Planning Committee meetings, DOH discussed what are referred to as "passive parent" arrangements with respect to Article 28 facilities, indicating that concerns about accountability have been raised with respect to such arrangements.

While GNYHA appreciates the importance of responsible governance and accountability, GNYHA believes that passive parent arrangements reflect sound not-for-profit law principles, serve a valuable function in the health care system, and should not be disrupted merely because of their corporate configuration.

New York's Not-for-Profit Corporation Law and Basic Corporate Principles: In these arrangements, a not-for-profit corporation (the parent) is a corporate member of another not-for-profit, established Article 28 facility, or, in some cases, has the right to appoint the individual members of the licensed facility. Under New York State's Not-For Profit Corporation Law (NPCL), the members of a not-for-profit corporation have a number of powers or authorities vis-

à-vis the licensed not-for-profit facility, including the election of the board. Although the members or parents may hold a number of important authorities, they are not typically involved in the direct operation of the not-for-profit licensed facility. As a result, the members are appropriately insulated from direct financial liability for the operations of the licensed facility under basic corporate law principles, unless of course there are reasons to pierce the corporate veil based on particular facts and circumstances or if specific laws so require. This analysis tracks not-for-profit laws that exist in other states, as well as what occurs with respect to for-profit corporations, namely, that shareholders are not typically directly responsible for the operations of the for-profit entity as such.

New York's Passive Parent Regulations: Separately, New York State regulations found in 10 NYCRR Section 405.1 outline authorities that a member (parent) of a not-for-profit licensed facility may *not* exercise without being considered by DOH to be "active" in the operations of the facility and thus be required to be established and licensed by the State. Those authorities that would make the corporate parent "active" are the following:

1) Appointment or dismissal of hospital management-level employees and staff, except the election or removal of corporate officers;
2) Approval of hospital operating and capital budgets;
3) Adoption or approval of hospital operating policies and procedures;
4) Approval of CON applications filed by or on behalf of the provider;
5) Approval of hospital debt necessary to finance the cost of compliance with operational or physical plant standards required by law;
6) Approval of hospital contracts for management or for clinical services; and
7) Approval of settlements of administrative proceedings or litigation, except approval of settlements that exceed insurance coverage or applicable self-insurance fund.

What it Can Mean to be an "Active" Parent: If the not-for-profit parent undertakes any of the foregoing activities, the parent will be considered "active" for DOH's purposes and must go through the process of being established and licensed. However, not only must the parent become licensed, such action can potentially expand the parent's responsibility for the actions of, and circumstances facing its sponsored organizations. For example, DOH's approach to reviewing the character and competence of board members of an active parent treats adverse events as "recurrent" if the same type of event occurs in two different facilities in a network having an active parent arrangement. Not-for-profit parents that wish to provide support to the licensed facilities that they sponsor, but do not wish to risk the potential for expanded liability, thus observe the provisions of Section 405.1 to remain passive parents under State regulations. This course is consistent with basic corporate law principles. GNYHA also notes that many sponsored facilities do not want the control that comes with having an active parent, wanting to rely instead on local control and authority.

The Value of Passive Parent Arrangements: GNYHA believes that the State should encourage such arrangements because of the value they bring to both network participants and the health care system at large, particularly at a time that providers are encouraged to affiliate, coordinate, and align interests. Often such passive parents are able to offer their affiliates shared services at a cost and of a quality that they cannot replicate directly. For example, one such network with a

"passive" parent provides quality improvement, HIT, group purchasing, and other services for network participants, charging them for participation but at a price that takes into account the efficiencies gained from shared services. Other passive parents in New York represent religious organizations or educational facilities that are sponsors of the licensed facilities, but that do not act as active participants of the facilities.

Based on GNYHA's conversations with its members, some of them might decide to discontinue their membership in certain organizations and thus withdraw their sponsorship or support if they were required to move to an "active" parent arrangement, an outcome that GNYHA believes DOH should not want to encourage.

> *Thus, GNYHA strongly urges that DOH permit such passive arrangements to continue in light of the strong benefits and rationale associated with them. To the extent that the State believes there may be abuses of such arrangements or governance at large, DOH should address those specific circumstances rather than do away with such arrangements or restrict their configurations.*

Notification to State: GNYHA appreciates DOH's desire to be aware of such arrangements, and as noted by one hospital system at a recent Committee meeting, many such arrangements are already noted on the State's Web site in its Hospital Profile section.

> *To that end, requiring facilities to provide some form of notification to DOH regarding their corporate structures would seem to address the State's interest.*

Mirror Image Boards: DOH has also suggested that perhaps mirror boards between a parent and an entity of which it is the member should be limited. GNYHA disagrees, noting that mirror boards should be viewed as addressing DOH's concerns about its potential lack of authority.

> *In other words, if DOH has concerns that it doesn't have authority over a passive parent, the use of mirror boards between the parent and the not-for-profit licensed facility should provide comfort to DOH since it will have authority over the very individuals who have responsibility for both the parent and the licensed entity.*

Clinical Integration: DOH has also suggested that entities in a passive parent network should be clinically integrated. GNYHA is not certain how that suggested requirement arises in terms of passive versus active parent discussions. GNYHA appreciates that clinical integration may be of assistance to organizations that undertake certain activities, such as certain negotiations. But separate Federal and State laws govern those activities, and thus GNYHA is not certain what DOH's suggestion in that regard may connote.

> *In summary, GNYHA believes that passive parent arrangements serve a valuable function in New York State's health care system. They also reflect sound corporate principles of limiting liability among separate corporations, except to the extent that the parent organization undertakes certain activities with respect to its related licensed entities. Requiring networks to assume configurations that potentially increase liabilities may remove valuable supports and care coordination that the State should want to encourage,*

particularly in an era where population health management and cost reductions are so vitally important.

In the end, DOH has authority and control over those portions of the network that are delivering care through the establishment and licensure of those entities, which affords DOH significant control and authority. As a result, there appears to be no compelling reason to require a different corporate configuration for DOH to exercise the control it needs and already has.

V. FINANCIAL REVIEWS OF NEW PROJECTS

Question 7: Finally, the Committee asks a question about the financial review of providers and projects:

> How can the state's oversight of the financial stability of providers and the costs associated with new facilities and services be improved?

At the October 3 meeting of the Health Planning Committee, DOH suggested undertaking a tailored approach to conducting financial reviews of providers proposing new facilities and services. For that purpose, DOH described how it currently reviews projects from a financial feasibility standpoint and proposed undertaking differing degrees of reviews depending on the financial circumstances of each provider. Thus, providers considered financially fragile or distressed and thus score low on various financial benchmarks may need a rigorous financial review. On the other hand, providers that have robust bottom lines or score well on key financial indicators may require no review at all. Those in between, again depending on their financial performance or where they stand with regard to specified financial benchmarks, may require some degree of financial review, but something less than those who are struggling financially.

GNYHA strongly supports DOH's recommended more tailored approach to undertaking financial reviews and appreciates DOH's efforts to continue to streamline its regulatory oversight. In this vein, GNYHA requests that DOH be willing to look at reasonably recent financial information that may already be on file with DOH in connection with a previous project or otherwise in lieu of requesting providers to submit new financial data, depending, of course, on the circumstances.

In supporting this recommendation, GNYHA points out that many facilities that borrow funds to undertake a project must prepare financial feasibility analyses of the project in question upon the request of the lender or organization providing credit enhancement. In many such cases, the feasibility studies are performed by outside consultants after significant due diligence and review. Even if a provider is not required by a lender or issuer to undertake such a study, most providers prepare feasibility studies in any event as part of their own due diligence.

GNYHA recommends that the availability of internal or external feasibility studies be taken into account in determining the level of review required by DOH so that neither DOH nor the provider must duplicate what has already been done. Efficiency and

economy are important on both sides, and DOH should receive comfort from the availability of such studies.

Finally, DOH has demonstrated willingness to entertain—and approve—innovative financing mechanisms designed to save providers interest and other borrowing costs. Often the viability of such mechanisms may turn on the financial strength of the organization or other distinguishing factors. GNYHA members are appreciative of the efforts that DOH has devoted to understanding and approving such mechanisms.

GNYHA recommends that DOH continue to be receptive to innovative financing arrangements to reduce health care costs overall.

VI. CONCLUSION

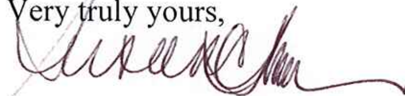
GNYHA is appreciative of the opportunity to participate in the Committee's meetings and to provide input on CON redesign, health planning and governance. In summary, GNYHA believes CON programs have a greatly diminished role today, particularly in the context of health reform, whose goals overlap with those of CON programs. We therefore request that the State implement its phase one reform recommendations broadly and continue to streamline the program as much as possible.

On the issue of planning, GNYHA supports the value of health planning, but calls for it to build upon existing local structures and relationships; concentrate on being a process, and not a regulatory apparatus; focus on population health and health improvement; include stakeholders representative of the social determinants of health; and be overseen, supported, and reflect the goals established by the State.

Finally, on governance, GNYHA supports the importance and value of strong governance; urges the State to rationalize the character and competence review process to permit DOH discretion in reviewing quality matters; and supports the importance and value of sponsorship models that include passive parent arrangements.

GNYHA concludes by thanking the Committee and DOH for the immense amount of time, deliberation, and resources they are devoting to this process, and we share your goal of developing a high-performing health care system for everyone.

Very truly yours,



Susan C. Waltman
Executive Vice President and General Counsel

Attachment

cc: Nirav Shah, M.D., M.P.H
James Introne

Transforming New York State's Certificate of Need Program

Greater New York Hospital Association

Transforming New York State's Certificate of Need Program

Greater New York Hospital Association (GNYHA) firmly believes that New York State's Certificate of Need (CON) program requires substantial reform to ensure that the State can best meet its overarching goal of improving health and health care while also controlling costs. Given the extraordinary evolution of the health care system since the State's CON program was created in 1964, its value and role in promoting cost control, quality, and access have diminished significantly. Many aspects of the program are unnecessarily complicated, expensive, and lengthy; it is both over- and under-inclusive; and it is dated in terms of the categories of projects it reviews and its methodologies. In fact, the program often undermines its intended goals by adding significant costs to the health care system and interfering with the efficient operation of health care facilities without clearly improving either quality or access. For similar reasons, many states have eliminated their CON programs entirely, while others have substantially limited the number of services, providers, and projects subject to review.

GNYHA therefore urges New York to:

- End the program's review of construction, renovations, and the acquisition or movement of equipment and services in general, almost all of which the State approves at unnecessary expense to the State and the providers involved.
- Focus primarily on the establishment of new providers; the introduction of new services that may require review to promote quality and access; the discontinuation of services that may create access problems; and certain identified services, such as proton beam therapy, that are exceptionally expensive or may cause an unnecessary proliferation of expensive services.
- Streamline its approach to ensuring facility compliance with construction, life safety, and other codes by relying on a combination of facility, architect, and engineering certifications, use of outside experts, and other approaches that will help expedite reviews for all involved.

Recent Reforms and Need for More Fundamental Change: GNYHA recognizes that the State recently implemented changes to its CON program to reduce the level of review required for certain projects. GNYHA also recognizes that New York is in the process of implementing a new State law that exempts from review repair and maintenance projects, non-clinical infrastructure projects, and one-for-one replacements of equipment, provided that notice and architect and/or engineering certifications are submitted. GNYHA and its members are grateful for these changes and for the State's implementation of an electronic system for submitting CON applications.

GNYHA believes, however, that more fundamental reforms are required, given the increasing financial pressures facing providers and the State, the fact that many aspects of the program are unnecessary in today's environment, and the unreasonable burdens often imposed by the program. When New York put forward its recent threshold changes, it characterized them as an "initial phase" of reform and stated that they were designed to focus the State's resources on "projects that involve the delivery of highly complex services, the investment of substantial resources, and/or the creation of new facilities or beds." It is time to move fully in that direction, for the benefit of the State, its providers, and most important, the residents of New York.

I. CON Programs Are Ill-Suited for Controlling Costs in Today's Environment

As currently structured, New York's CON program no longer effectively serves its intended purpose of promoting cost control, quality, and access given the tremendous changes that have taken place since the program began in 1964. Historically, the primary rea-

son for CON programs was to control costs, particularly capital costs, during a time of cost-based reimbursement. Thus, in 1975, Congress passed the National Health Planning and Resources Development Act of 1974 (the Act), which required states to create CON programs to receive funding under a number of Federal programs. But in 1986, with the advent of prospective payment systems and other factors, the Federal government repealed this mandate and its funding for planning purposes. In the decade following the Act's repeal, many states in turn repealed their CON programs, and many more have since reduced the number of projects they review.

Myriad Environmental Factors Limit Provider Capital Expenditures: Today, many factors significantly limit the ability of hospitals and other health care providers to embark on capital projects, thereby eliminating the need for many aspects of CON programs. Those factors include limited capital reimbursement, ever-increasing limitations on operating revenues, and increases in both operating and capital costs. In addition, changes in the capital markets have made it increasingly difficult for providers to finance capital projects.

At the Federal level, the Medicare program has not, in general, paid hospitals for their hospital-specific operating costs since 1983, paying them instead under a prospective payment system. It has also not paid hospitals for their hospital-specific capital costs for years. In 2009, hospitals agreed to a significant cut in Medicare payments for the next 10 years in connection with the passage of the Affordable Care Act. Hospitals are now bracing for additional Medicare cuts given the current Federal debt ceiling and related economic problems, with the 2% reduction in payments triggered by Federal sequestration perhaps being only the starting point.

In New York, Medicaid payments to hospitals have been cut 10 times over the last five years for a cumulative loss to hospitals of $1.4 billion a year. In addition, during State fiscal years 2011–12 and 2012–13, State-share Medicaid payments are subject to a "global cap" under which provider payments can be cut if the cap is exceeded. The global cap, an important achievement of the State's Medicaid Redesign Team, has been one of the most effective cost control tools the State has put in place for many years, and is more effective than the project-by-project approach inherent in CON programs. At the same time, all payers are creating incentives and mechanisms to constrain health care costs, including bundled payments, health homes, medical homes, managed care focused on specific types of populations, and accountable care organizations.

Provider Difficulty Accessing Capital: Many hospitals in New York have considerable trouble accessing capital due in part to their poor credit quality, their heavy dependence on

shrinking Medicare and Medicaid payments, and the lengthy State process for approving construction and financings. As a result, they have had to rely on credit enhancement, such as the much-appreciated Federal Housing Administration's mortgage insurance program or State-supported debt, which increases the time needed to gain approval of projects. These factors are reflected by the fact that the average age of hospital plant in New York is 12.1 years, compared to 9.8 years nationally.

Questionable Success in Controlling Costs: Not only is using CON programs to control spending unnecessary today, some studies have indicated that CON programs may never have been particularly successful in controlling costs. For example, in 2004, the U.S. Department of Justice (DOJ) and the Federal Trade Commission (FTC) released a report discussing many aspects of health care. On the issue of CONs, the report stated: "Empirical studies indicate that CON programs generally fail to control costs and can actually lead to increased prices." The report quoted one commentator as stating "[t]he regulation of supply through mechanisms such as CON may have made sense when most reimbursement was cost-based and thus there was incentive to expand regardless of demand but they make much less sense today when hospitals are paid a fixed amount for services and managed care forces them to compete both to participate in managed-care networks and then for the plans' patients." The agencies thus urged CON states "to reconsider whether they are best serving their citizens' health care needs by allowing these programs to continue."[1]

GNYHA notes that the American Health Planning Association took significant issue with the report, calling its conclusions "unsupported."[2]

No Surge in Spending Following CON Program Elimination: At least one still often-quoted study from 1998 published in the *Journal of Health Politics, Policy and Law* looked at what happens to health care spending when CON programs are eliminated, given that a number of states had discontinued their CON programs in the decade after the Federal government repealed its mandate for CON programs in 1986. The study concluded that states that had "lifted CON did not experience a rise in spending on hospital and physicians' services relative to those that retained it." The authors thus stated that there was "no reason to fear an expenditure surge" after CON laws are repealed.[3]

As outlined above, New York no longer needs a comprehensive CON program to control capital expenditures because numerous external factors attempt to control those expenditures every day. In addition, studies indicate that CON programs are not particularly successful at controlling costs and that capital expenditures do not necessarily increase following the repeal of CON programs.

II. CON Programs Have Limited Value in Promoting Quality

Turning to CON programs' other goal, ensuring quality and access to care, GNYHA believes strongly that today's health care environment provides more effective, ongoing approaches to overseeing or incentivizing accessible, quality health care than that afforded by many aspects of the State's comprehensive CON program. In New York, the State Department of Health (DOH) exercises significant oversight of the quality of care provided by health care providers, most of which are subject to extensive State regulations and requirements. DOH is joined by a number of other State agencies in fulfilling its oversight role, depending on the provider type and the services delivered. The Centers for Medicare & Medicaid Services and The Joint Commission also impose significant regulatory and accreditation requirements and standards. For example:

- Numerous agencies survey and require plans of correction for health care providers.
- Medicare collects and makes public many quality indicators for each hospital.
- New York State collects, analyzes, and makes public information about cardiac procedures, infection rates, and a number of other quality indicators.
- New York State also makes public volume data for most major procedures by hospital.
- New York State requires hospitals to track and make public upon request data related to nursing-sensitive indicators.
- Many other organizations also publish "report cards" on hospitals and other providers, including Leapfrog, HealthGrades, and The Joint Commission.
- Medicare and Medicaid refuse to pay for certain adverse events and hospital-acquired conditions.
- In Federal fiscal year 2013, Medicare will begin its value-based purchasing (VBP) program, under which Medicare will adjust hospital payments based on how well a hospital performs under a number of process-of-care measures.
- In Federal fiscal year 2014, Medicare will expand its VBP program to base Medicare payments on outcomes of care and efficiency measures.

High Quality in Non-CON States: While there are many rankings of hospitals, perhaps the most well-known is *U.S. News & World Report*'s annual "America's Best Hospitals," which ranks hospital services across the country. The ranking includes an "Honor Roll of Hospitals," and the most recent edition includes 17 hospitals across the country, including NewYork-Presbyterian Hospital and Mount Sinai Hospital Center. GNYHA mentions the Honor Roll to point out that a number of the top-ranked hospitals are located in states that do *not* have CON programs, including the Mayo Clinic, Ronald Reagan UCLA Medical Center, UCSF Medical Center, Hospital of the University of Pennsylvania, University

of Pittsburgh Medical Center, and Stanford Hospital and Clinics. Although many factors affect the quality of care in the Honor Roll hospitals, the number of hospitals in states without CON programs indicates it is certainly not necessary to have such a program to offer high-quality, nationally ranked care.

Negative Impact of Stringent CON Programs: An early study by Stephen M. Shortell, Ph.D., and Edward F.X. Hughes, M.D., Ph.D., found an association between *higher mortality rates* among inpatients and the stringency of state CON programs, suggesting that CON programs may actually have a *negative* impact on quality. The authors examined mortality rates among Medicare patients for 16 clinical conditions at 981 hospitals and concluded that the stringency of CON programs was positively and significantly associated with higher mortality rates.[4]

The authors found this association of interest because one might expect that stricter CON programs would be associated with *lower mortality rates* given that the process often examines whether patient volume is sufficient to produce positive outcomes. The contrary argument posited was that CON programs might act as a "barrier to the development of innovative programs and the possible upgrading of hospitals' physical plants and equipment. Thus, patients at hospitals whose applications for certificates of need have been rejected and those who may not have applied because of the stringent review criteria may have poorer outcomes because the hospitals continue to provide care with outdated facilities and technology." To test this, the authors examined the mortality rates related to the five conditions considered the most susceptible to CON program impacts, as opposed to the 11 less susceptible conditions. According to the authors, "The association of higher mortality rates with more stringent certificate-of-need programs was indeed stronger and had a higher level of significance for the 5 conditions defined as the most susceptible… than for the remaining 11 conditions…These findings indicate that regulation of capital expenditures appears to have particularly adverse effects on outcomes for patients with the conditions most directly affected by the regulation."

Unclear Benefits of CON Regulation of Coronary Artery Bypass Graft Surgery: Later studies bring into question the benefits of CON programs with respect to regulating even coronary artery bypass graft (CABG) surgery specifically, a service where higher volumes are linked to better outcomes. Thus, it is often assumed that CON programs should be beneficial in that they typically regulate how many and which providers may offer open-heart surgery. In one 2002 study published in the *Journal of the American Medical Association* that looked at this issue, the authors concluded, as expected, that CABG mortality rates in states that do not regulate open-heart surgery through CON programs were statistically higher than in states

that do regulate this service. Also as expected, a higher proportion of patients in states without CON regulation of open-heart surgery underwent CABG surgery in low-volume hospitals. [5]

However, in another study, published in *HSR: Health Services Research* in 2009, the authors concluded that states that discontinued their reviews of cardiac CONs experienced lower CABG mortality rates relative to states that kept their CON programs in this regard, although this difference was not found to be permanent.[6]

In still another study, published in 2006 in *Circulation: Journal of the American Heart Association*, the authors found that while average annual hospital CABG surgery volume was higher in states with CON regulation compared to states without CON regulation, there was no significant difference in CABG surgery mortality rates between the two. According to the authors, "The present data suggest that state CON laws are not a sufficient mechanism to ensure quality of care for CABG surgery."[7]

GNYHA recognizes that there are many factors that affect quality and outcomes as suggested by the study published in *Circulation* referenced above and that states can—and do—administer their CON programs differently. However, the seemingly disparate results of the studies cited above should be considered in reviewing the value, scope, and application of CON programs.

CON Programs as Potential Barriers to Higher-Quality Services: On the issue of quality, the DOJ and FTC report referenced earlier commented that CON programs can impede the entry of providers or services that can provide higher-quality care. The agencies therefore concluded that there are more effective means of enhancing quality and access that do not pose some of the anticompetitive risks of CON programs.[8]

The foregoing discussion reinforces that CON programs are not, in general, necessary in today's environment to ensure that quality care is provided, except perhaps in certain limited circumstances where the volume of procedures performed helps to improve the quality of care. Even on that subject, though, opinions differ as to whether and how much CON programs are helpful in this respect. Conversely, there are arguments that CON programs can negatively affect health care quality because they can slow or discourage the entry of new services or needed improvements.

III. New York's Recognition of Its CON Program's Limitations

Over the years, New York has recognized the eroding value of its CON program in meeting its intended purposes. For example, in 1996, the Public Health Council adopted a re-

port, *Recommendations for Reform of the Establishment and CON Functions*. The report reviewed the history of CON in New York and concluded that, because the program was developed for an earlier era, it was "ill-suited" for an environment that paid hospitals on the basis of a prospective payment system, encouraged the growth of managed care, and demanded that providers deliver services more efficiently. As a result, the report recommended that need determinations be eliminated in most cases and that, for the great majority of activities, including construction projects, expansions of services, and changes in services, "the role of government should be limited to assuring that services are provided according to standards set by the state with, as much as is possible, standards tied to measures of outcomes."[9]

Similarly, in 1998, DOH commented in the *New York State Register* that the CON program had been designed to promote "judicious use of publicly funded capital" and to help ensure access to quality health care services. "However, the changing health care system, the growth of managed care, and the passage of the Health Care Reform Act have made it possible to achieve these goals with a CON program that is less stringent and more supportive of today's more market-oriented health care environment."[10] At that time, DOH increased the thresholds for CON review, citing the fact that the changes would help reduce the cost of filing CON applications, lost revenues, and limits on competitive capacity associated with the program. As noted earlier, in proposing additional reforms of the program in 2010, DOH stated that the reforms were being put forward as an initial phase and were aimed at focusing the resources of the State more appropriately and at reducing costs to providers.

IV. The Unnecessarily High Cost of New York's CON Program

The prior sections demonstrate how the need for CON programs has diminished over time. Using CON programs to control capital expenditures has become much less important in an era of prospective payment systems, limited capital reimbursement, relentless payment cuts, and movements to new reimbursement systems and approaches.

At the same time, the delays associated with filing and gaining approval of CON applications in New York, particularly for construction, renovations, acquisition and/or installation of equipment or movement of services, have become unreasonable, notwithstanding the streamlining initiatives the State has undertaken over the last several years.

There seem to be at least two points of considerable delay in the State's approval of construction, renovations, movement of services or acquisition and/or installation of equipment: 1) at the point that DOH's architectural bureau undertakes an initial review of

a project's schematic design, and 2) at the point that DOH's regional offices undertake surveys of completed construction before providers occupy the renovated or new space.

Significant Delays in Processing Times: GNYHA recently asked a number of its members about the average time it takes to obtain CON approval of their projects. The following represents the range of waiting periods generally reported, not including the time it takes to gain approval of final construction drawings required for administrative and full review projects:

- **Limited Review Projects:** 3–6 months
- **Administrative Review Projects:** 6–11 months
- **Full Review Projects:** 6–12 months

GNYHA notes that many hospitals reported that approvals of some of their applications are taking much longer than the above time frames, even though the affected projects might have "priority" status because, for example, they are funded in part by Health Efficiency and Accountability Law for all New Yorkers (HEAL NY) funds. On the other hand, one member reported an average waiting period of only two to four months for its limited review approvals, although the same member also reported the longest waiting periods for approval of its administrative and full review projects. Finally, several hospitals reported waiting significant periods of time for approval of their final construction drawings before they can begin construction.

By way of comparison, when DOH increased its review thresholds in 1998, it commented that the changes would help save costs associated with processing projects at higher levels of review. In support of those changes, DOH reported in the August 19, 1998, *State Register* the following processing times for CON projects in 1996:

- **Administrative Review Projects:** 41 days
- **Full Review Projects:** 163 days

As can be seen, the CON processing times experienced by many hospitals today are materially *longer* than they were in 1996, notwithstanding two sets of much-appreciated threshold increases and good faith attempts by DOH at streamlining the process since then. While GNYHA recognizes that the waiting times include time frames when DOH is waiting for hospitals to reply to questions posed by DOH, the total time currently required to approve a CON application of any kind is unnecessarily long and must be reduced for the benefit of all involved.

Significant Delays in Scheduling Pre-Opening Surveys: At the other end of the process, hospitals are finding that it can take months to schedule pre-opening surveys of their renovated or new space so they can occupy it. Hospitals have reported that it can take up to four months to schedule a survey, even when they begin the scheduling process well before the project's completion. In addition, hospitals find there are often inconsistencies in positions taken among surveyors, as well as between regional office surveyors and personnel in Albany that can take significant time to untangle.

The Resulting Cost of the CON Program: GNYHA recognizes that the foregoing delays are caused, in part, by limited staffing due to State budget and other constraints. However, the delays and problems have in turn caused providers and the health care system at large to incur considerable and unnecessary costs in the form of:

- Increased construction and equipment acquisition costs, which, according to DOH, have increased anywhere from 4% to 12% *annually* over the last 10 years;
- Increased costs for outside architects, engineers, consultants, and attorneys;
- Increased personnel costs related to responding to questions, submitting additional information, and gaining approval of applications;
- Delays and interruptions in patient care; and
- Delays and interruptions in receiving revenues related to affected services.

To illustrate the associated increased cost of construction, a six-month delay in a $100 million construction project at a time when construction costs might rise at an annual rate of 6% adds as much as $3 million to the project's cost. This incremental cost means that projects needed to upgrade New York's outdated physical plants are either deferred or decreased in the service levels they provide, or alternatively, the unnecessary additional costs are assumed by providers and/or shifted in part to payers. Viewed across the entire State, such delays increase total health care spending significantly, often with no discernable benefit in terms of quality, access, and cost control.

The foregoing delays, costs, and consumption of health care resources are unfortunate at any time and for any reason. However, the diminished value of CON programs makes the costs all the more unfortunate, thereby dictating that New York must significantly revise its program.

V. Recommendations for Transforming the CON Program

As outlined above, CON programs no longer effectively serve their initial purposes of controlling costs and promoting quality and access, given the evolution of the health care sys-

tem. At the same time, they are often unreasonably costly, burdensome, and complicated. A cost/benefit analysis of New York's program leads to the clear conclusion that the program must be transformed so that both the State and providers can better focus their efforts on improving quality, patient safety, and access in the most productive and meaningful ways. GNYHA therefore makes the following recommendations:

Eliminate Construction Reviews: GNYHA strongly recommends that the State eliminate all CON reviews of construction, including all renovations, additions, and acquisitions or movement of equipment or services, regardless of cost. To the extent that such activities might involve adding services that the State wishes to regulate in some fashion, the State should review only the addition of that service and not the related construction. GNYHA recognizes the importance of ensuring that construction complies with the requisite building, life safety, and other codes for the protection of all who enter health care facilities, and discusses how this should be accomplished in Section VI.

The foregoing is consistent with the route many states have taken with respect to their CON programs. Fourteen states do not have CON programs at all, including Pennsylvania, California, Wisconsin, Minnesota, and Texas. In addition, many states with some form of CON programs do not require review of hospital construction except perhaps in connection with the establishment of entirely new facilities. States that do not review construction as part of their CON programs include Connecticut, New Jersey, Ohio, and Florida.

Assess the Need to Review Certain Providers and Services: GNYHA strongly recommends that the State undertake a thoughtful but expeditious review of what services or providers it should subject to continuing CON review. As part of this deliberation, GNYHA suggests that there are several main categories in which the State's CON program may still play a meaningful role of protecting and promoting quality and access, as well as reducing unnecessary expenditures.

- **New Entrants:** GNYHA believes the CON program can serve a valuable purpose through its establishment process by ensuring, to the extent possible, that new providers are qualified and capable of delivering quality care and that they are willing to ensure meaningful access to their services. GNYHA understands that the State is already planning to look at ways to do this more effectively.

- **Protecting Key Providers:** As part of the process for reviewing the establishment of new providers, the State should also ensure that a new provider's entry does not materially undermine the services being provided by existing key or essential providers or add

unnecessary costs to the health care system. While GNYHA recognizes that this issue is sensitive and arguably raises anti-competitive concerns, we firmly believe that the State must be cognizant of the negative impact on quality and access that might occur should a new provider enter an area and undermine the services provided by an existing needed health care provider. The classic example is the entry of a freestanding, non-hospital-owned ambulatory surgery center that will deliberately or otherwise divert a significant number of certain services from area hospitals, leaving hospitals with the overhead of providing emergency services, trauma care, critical care, and other needed community services without the revenues to cover the cost of that care.

- **Addition of Services Where Volume and Quality Are Linked:** The program should oversee the introduction of services where there is a clear relationship between volume and quality, such as certain cardiac procedures.

- **Exceptional Services:** The program should oversee the expansion of services or modalities determined to be exceptional either because of their high costs (e.g., proton beam therapy) and/or their tendency to generate unnecessary volumes of procedures.

- **Discontinuance of Certain Services:** The program, or at least the State in some form, should review the discontinuance of services that will lead to access problems in certain communities.

Necessity of Updated Need Methodologies or Criteria: Many of the foregoing areas that GNYHA recommends should be considered for continuing CON review require updated need methodologies or criteria. GNYHA offers to assist the State's efforts by participating in that process directly, and/or identifying experts among its members who can provide valuable input into the process.

Need for a Level Playing Field, Fixed Time Frames for Review, and Streamlined Processes: Finally, to the extent that services, providers, or equipment remain subject to review, the State should:

- Ensure a level playing field among different types of providers in terms of review and oversight.
- Be required to undertake its reviews within reasonable time frames at all stages of the approval process.
- Streamline its review and survey processes for the benefit of providers and the State. *See Section VI for recommendations for streamlining the review and survey processes.*

VI. Streamlining the State's Review and Survey Processes

GNYHA is hopeful that the State will eliminate from CON review all construction projects and certain equipment acquisitions for existing providers. GNYHA recognizes, however, that the State will still retain its role of licensing authority and therefore have the responsibility of ensuring that construction, services, and equipment comply with relevant building, design, and life safety codes, as well as other requirements specific to health care providers.

As the State carries out this responsibility, either in conjunction with remaining CON reviews or separately, GNYHA strongly urges DOH to undertake this role as efficiently and effectively as reasonably possible. GNYHA emphasizes this because the regulatory functions of overseeing design and occupancy, which have been built into the State's CON program, are among the functions causing delays in processing CON applications today. Therefore, as DOH continues to exercise oversight of these areas, GNYHA strongly urges that DOH do so in a streamlined and efficient manner so that it fulfills its responsibilities without triggering unnecessary costs to the health care system.

Minimize the Number of Projects Subject to DOH Design and/or Pre-Opening Review: GNYHA strongly urges the State to eliminate as many projects as possible from direct DOH design review and/or pre-opening surveys. Health care providers are already subject to extensive and detailed national building, design, and life safety requirements that are incorporated by reference in State and Federal regulations and The Joint Commission standards, all of which are designed to protect and promote patient safety. Providers are also subject to local building, fire, and other codes, as well as various types of local agency inspections before, during, and after construction that are aimed at protecting all who enter the buildings. In addition, many hospitals have extensive facilities, architectural, engineering, and other departments that are regularly involved in planning and overseeing construction. Separate from in-house capabilities, health care construction projects almost always involve outside licensed architects, engineers, consultants, and, in some cases, construction managers. Finally, providers are subject to ongoing, regular inspections and surveys meant to identify any life safety code concerns and promote patient safety.

Alternatives to DOH Reviews and Surveys: To the extent that the State believes it must exercise oversight given the particular project involved, GNYHA believes that the following approaches and alternatives to direct DOH review and survey should be acceptable, many of which are exercised by other states in fulfilling their regulatory roles.

- Meeting with providers to review their plans early in the project planning stages.

- Accepting provider notification of a planned project and certification of compliance with relevant codes.
- Accepting certification as to code compliance by the provider's architects and/or engineers, all of whom are presumably licensed by the State.
- When necessary, scheduling appointments with the provider's team of facility personnel and outside architects and engineers to review plans for the project with the aim of completing the review in one sitting to the extent possible and appropriate.
- Developing a panel of experts who can be called upon to assist with planning, reviews, and surveys.
- Contracting with other state agencies to undertake reviews and/or inspections. In some states, central design personnel review plans. In New York, GNYHA endorses use of architects and engineers at the Dormitory Authority of the State of New York for this purpose.
- Permitting providers to occupy finished space without requiring a pre-opening survey and allowing any necessary surveys for certain projects and space to take place at a later point in time.

Improved Review and Survey Processes: To the extent that the State assumes direct responsibility for certain reviews or surveys, it should develop improved processes for undertaking those functions. GNYHA suggests that the State consider engaging an expert in process engineering to review its procedures for undertaking reviews and surveys to streamline the processes as much as possible. In addition, the State should establish specified time frames for completing its reviews. GNYHA has spoken with personnel in a number of states that review plans and undertake pre-opening surveys. Almost to a state, they seem to be able to undertake their activities within 30, 45, 60, or maybe 90 days. New York must address its lengthy review and survey processes, which are unnecessarily expensive for all involved.

Need for Increased Staffing at DOH: As noted, GNYHA appreciates that the delays in processing applications and undertaking surveys are attributable, in part, to State cutbacks in personnel and inadequate numbers of staff for these purposes. GNYHA therefore urges the State to dedicate sufficient personnel to the functions it retains to minimize unnecessary costs to the health care system and ultimately to the State itself.

GNYHA's and Members' Commitment to Improving Quality and Patient Safety: In making the foregoing recommendations, GNYHA emphasizes that it and its members are committed to improving quality and access and protecting patient safety at all times. Indeed, great efforts are taken to protect patients and employees in the planning, building, renovating, and opening of health care facilities. But these very efforts, together with the exten-

sive efforts, certifications, and oversight by licensed architects and engineers, consultants, construction managers, and local authorities, should form the foundation of the State's review, thereby minimizing the amount of additional oversight the State needs to provide.

VII. Conclusion/Summary

The value of and need for CON programs have diminished considerably over the years, and they no longer effectively serve their intended purposes of controlling costs and improving quality and access. In New York in particular, the CON program is unnecessarily complicated and expensive, dated, and over- and under-inclusive. As a result, GNYHA recommends that the State should, at the very least, exempt from review all construction, renovations, and acquisitions or movement of services and equipment. It should also assess which new providers, services, and equipment it believes still require CON review, developing revised need methodologies and criteria for those that remain subject to review.

Finally, New York must reduce the amount of time and effort currently involved in reviewing those projects that remain subject to review, whether as to need, design, or occupancy. This should be done through the most efficient processes reasonably possible, including wide use of provider certifications, architect/engineer certifications, or other mechanisms designed to speed the efficient and safe delivery of health care. In the end, the goal should be for the State and providers to concentrate their efforts on improving quality, safety, and access through the most effective and productive means.

Citations

1. U.S. Department of Justice, Federal Trade Commission. “Improving Health Care: A Dose of Competition” (2004). Chapter 8, 1–4.
2. American Health Planning Association. “The Federal Trade Commission & Certificate of Need Regulation: An AHPA Critique” (January 2005): 3.
3. Conover, Christopher and Frank A. Sloan. “Does Removing Certificate of Need Regulations Lead to a Surge in Health Care Spending?” *Journal of Health Politics, Policy and Law* 23, no. 3 (June 1998): 455–481.
4. Shortell, Stephen M. and Edward F.X. Hughes. “The Effects of Regulation, Competition, and Ownership on Mortality Rates Among Hospital Inpatients.” *The New England Journal of Medicine*, 318, no.17 (April 28, 1988): 1100–1107.
5. Vaughn-Sarrazin, M.S., E.L. Hannan, C.J. Gormley, et al. “Mortality in Medicare Beneficiaries Following Coronary Artery Bypass Graft Surgery in States With and Without Certificate of Need Regulation.” *Journal of the American Medical Association*, 288, no. 15 (October 2002): 1859–1866.
6. Ho, V., M. Ku-Goto, and J.G. Jollis. “Certificate of Need for Cardiac Care: Controversy over Contributions of CON.” *HSR: Health Services Research*, 44, no. 2, Part I (April 2009): 483–500.
7. DiSesa, V.J., S.M. O’Brien, et al. “Contemporary Impact of State Certificate-of-Need Regulations for Cardiac Surgery.” *Circulation: Journal of the American Heart Association*, 114 (October 30, 2006): 2122–2129.
8. See note 1.
9. New York State Public Health Council. *Recommendations for Reform of the Establishment and CON Functions* (1996): 10.
10. *New York State Register* August 19, 1998: 8–10.

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Hospice and Palliative Care Association of New York State

Comments on
Public Health and Health Planning Council's
Certificate of Need Draft

November 26, 2012

Thank you for the opportunity to comment on the Public Health and Health Planning Council's draft document on New York's dynamic health care system and Certificate of Need (CON). The Hospice and Palliative Care Association of New York State (HPCANYS) strongly supports the Council's Triple Aim approach and we offer the following comments and recommendations:

A Health Care Delivery System in Transition - In describing New York's health care delivery system as a system in transition, the Council recognizes the emergence of accountable care organizations (ACOs) and patient-centered medical homes (PCMHs). We want to underscore that the Medicaid Redesign Team (MRT recommendation #209) supported the expansion of hospice, including integrating hospice into medical home and ACO projects. As the New York State Department of Health (DOH) moves forward with these new delivery systems, we urge the Council to assure that hospice is truly integrated to allow transparent access to the hospice benefit.

Advancing the Triple Aim Through Regional Planning – We support the concept of regional planning and urge that the eleven Regional Health Improvement Collaboratives (RHICs) include representation from hospice and palliative care providers serving those communities. It is imperative that the full continuum of care be represented as the collaboratives work toward improving quality health care while reducing the per capita cost of care. Hospice and palliative care have demonstrated that they provide quality, cost effective care.

Driving Health System Performance Through Certificate of Need and Licensure – Recommendation #11 calls for updating the hospice need methodology. HPCANYS concurs with the Council's recognition that "the data suggests the need for interventions to expand access to hospice," which aligns with HPCANYS' mission to promote the availability and accessibility of quality hospice and palliative care for all persons in New York State confronted with life-limiting illness. HPCANYS continues to place a high priority on community outreach and the development of tools that will help members achieve higher utilization rates in the communities they serve.

HPCANYS agrees with the Council's recognition that "the CON process likely plays a minimal role in the underutilization of hospice." The draft also states "Updating our CON process is one place to start." The Hospice and Palliative Care Association of New York State welcomes the opportunity to serve as a resource to the PHHPC as they examine and develop recommendations to update hospice need methodology. HPCANYS has recently established a CON Task Force and we are working with a consultant to analyze Medicare data and develop modeling options that should foster higher utilization of hospice services.

It is imperative that any changes in the hospice need methodology not only encourage greater utilization of hospice, but also support the viability of essential hospice providers. As with any major policy change, it is crucial that any "unintended consequences" be avoided, and we urge the Council to carefully evaluate and weigh the pros and cons of any draft hospice need methodology proposals.

In Conclusion - HPCANYS urges the Council and DOH to foster access to hospice and palliative care by:

- Using the resources and expertise of HPCANYS as they update the hospice need methodology;
- Implementation of the Hospice Modernization Act, including applying the 12 month terminal prognosis to Medicaid (pending CMS approval of the State Plan Amendment);
- Implementation of the Palliative Care Access Act (MRT #109);
- Pursuing the recommendations in MRT #209 regarding concurrent care and integrating hospice in ACOs and PCMHs to expand hospice; and

- Allowing MLTCP clients to elect the hospice benefit without disenrolling from MLTCP.

As the Council proceeds with their deliberations relative to streamlining CON, it is important that some type of cross-checking system be in place to assure consistency among the various health care redesign and reform plans under consideration or in the process of being implemented.

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November 28, 2012

John Rugge, M.D., M.P.H.
Chair
Planning Committee of the Public Health and Health Planning Council
New York State Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Dr. Rugge:

HANYS again appreciates the opportunity to provide input on behalf of our members to the Public Health and Health Planning Council's Planning Committee regarding the Committee's draft reform recommendations. In addition to the input we provided in our November 12 letter, I urge you to consider the following additional comments.

What began as an effort to streamline the Certificate of Need (CON) process has expanded into a discussion regarding development and implementation of regional health planning, and more recently, to extending state oversight authority over facility governing bodies, potentially adding new statutes and regulations. The complexities of this expanded discussion are significant, and these important issues should not be acted upon with haste. Further deliberations are warranted.

While the scope of the discussion topics has expanded significantly, the time for public digestion and input has not. As more complex topics have been added to the roster, the process has been accelerated to a pace where transparency has all but disappeared. This creates the potential for grave unanticipated consequences.

Many of the 22 recommendations included in the Committee's draft report are appropriate and will assist the state in achieving the "triple aim" and improve population health. While HANYS supports achieving those goals and appreciates the incorporation of many of our recommendations into the report, there are recommendation topics that truly warrant further analysis and dialogue.

Clearly, recent public testimony has revealed conflict over some very consequential recommendations—most notably, extending state oversight over passive parent governance arrangements, the expectation that passive parent systems be clinically integrated, and a proposed increase in state oversight authority over hospital governing bodies to the extent that the Department of Health (DOH) would be able to appoint or dismiss individual board members or name a facility receiver.

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If the shared goal of system integration is to be met, the passive parent option must be maintained. The passive parent approach was debated and addressed through regulation more than two decades ago, and it has stood the test of time. Facilities with passive parent religious sponsorship provide substantial positive contribution to improving population health. Other passive relationships have demonstrated consistent high performance. The expectations around clinical integration of passive parent systems should be no different from other system models.

To more readily achieve the goal of greater system integration, the state should focus efforts on facilitating discussions about provision of definitive anti-trust protections.

Regarding DOH authority over governing bodies, as the issuer of operating licenses, DOH is well recognized and respected, and historically has exercised existing authority to bring about needed corrections and even to close the doors of facilities.

Further streamlining of the CON process is needed to make it more timely and responsive, and to facilitate desired and needed health system change. Relatively simple facility improvements and service enhancements continue to be delayed by the need for CON approval. Those delays serve no one well, especially patients. We all pay for those costly delays. Leveling the playing field between Article 28 licensed providers and those not subject to such licensure is a prime example of needed streamlining. This was a topic of substantial discussion throughout Committee deliberations, with no definitive relief included in the recommendations.

HANYS strongly recommends the Committee put forth the recommendations for which controversy has been alleviated, and defer those that are the subject of debate, to allow proper time for discussion with impacted stakeholders so that a satisfactory resolution can be achieved. Recommendations #17, 18, and 19 clearly fall into that category. We look forward to continuing the dialogue on those items.

Sincerely,

Daniel Sisto
President

DS:sm

cc: Nirav Shah, M.D., M.P.H.
James Introne
Members of the Public Health and Health Planning Council

Bradford C. Berk, MD, PhD
CEO, University of Rochester Medical Center
Senior Vice President for Health Sciences

UNIVERSITY of ROCHESTER MEDICAL CENTER

MEDICINE of THE HIGHEST ORDER

November 27, 2012

Dr. John Rugge
Chair, Health Planning Committee
NYS Public Health and Health Planning Council
Empire State Plaza
Corning Tower Building, Room 1805
Albany, NY 12237

Dear Dr. Rugge:

On behalf of the University of Rochester Medical Center (URMC), I commend the Department of Health (DOH) and the NYS Public Health and Health Planning Council (PHHPC) for taking the necessary steps to review and streamline the Certificate of Need (CON) process to reduce regulatory barriers that hinder efficiency with no impact on quality of care. The reforms being implemented through both the Affordable Care Act and the Medicaid Redesign Team are transforming the way health care is provided through new incentives focused on coordinated, patient-centered care and payment mechanisms focused on quality and outcomes. As fiscal incentives change, we move away from assumptions where the supply of health services directly impacts the demand for those services, creating an ideal time to reform the CON process.

We applaud many of the CON reform recommendations before the Council. In particular, we support the recommendation to eliminate the CON for primary care facilities for both D&TCs and hospital extension clinics. Despite the positive steps towards greater streamlining, we do have several concerns as some of the proposals are discussed. Specifically, we do not believe a grant approval should eliminate the need for CON approval. The CON process still has considerable value in these instances as the CON process addresses capacity issues holistically. As we work to level the playing field between private practice and Article 28 facilities in these proposed reforms, eliminating the need for a CON for projects receiving a state grant approval could give some institutions a competitive advantage in particular circumstances, such as bed-type conversations and other changes. We urge the Council to continue the CON process even for those projects receiving state grant approval in order to ensure that capacity issues both statewide and regionally are fully vetted. A timeline could be implemented for CON approvals on approved grants in order to prevent additional project delays.

Given the great experience in regional planning in the Finger Lakes Region, we also have a few considerations for the Council as they review the recommendations on Regional Health Planning. Regional Health Planning has been very successful in the Finger Lakes Region as providers, payers, patients, and the business community regularly collaborate

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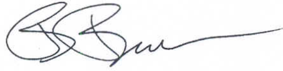
to meet the public health concerns of our region. Rochester is a community able to develop innovative, cooperative approaches to health care financing and delivery. Our history of community planning and capacity management has led to great efficiency and cost-effectiveness that keep Rochester's monthly premiums 25% below the national average. However, while regional planning plays an important role in determining community needs, it should not serve as an added layer of bureaucratic approval. Instead, regional planning organizations are important conveners and facilitators, bringing all regional stakeholders together to assess the true needs of the community. Rather than add to the procedural process of a CON review, regional planning organizations should be included in the process by providing regional input on a case by case basis to DOH.

We would also recommend that as the Regional Health Planning recommendations are further developed, the regional boundaries need to be carefully planned. Regional health planning should build upon the crucial partnerships that exist in a community, and existing health care affiliations and relationships should be considered when establishing regional boundaries. Further, it is critical that those regions being developed are broad enough to meet minimum population sizes for healthcare services for designated facilities, such as centers of excellence. Broader population bases are required in many of the upstate regions for specific services, such as solid organ transplantation or pediatric neurosurgery, for example. Upstate cities alone do not have the population needed to support a national class center of excellence for these complex services. The regions should also be large enough to address issues of workforce development and in particular, medical education. Centers of excellence and academic medical centers attract the highest quality medical professionals and trainees. It is therefore critical that regions upstate with smaller population bases are not disadvantaged in the planning process due to any regional boundaries that are developed and continue to be competitive for specialty designations like centers of excellence. Further, workforce training efforts need to be considered beyond regional boundaries to ensure the highest quality health workers are available in all areas of the state.

Finally, as you are well aware, hospitals face tremendous challenges in accessing the capital they need to develop the innovative patient-centered care delivery models that will improve the health of our communities. There are many ways to address these access-to-capital issues and the fundamental non-profit nature of many of the hospital systems in our state needs to be maintained. An active parent governance model is most effective when developing affiliations and alliances. These relationships can be most easily regulated by the state and in many cases are critical to the continued system integration of many facilities, including those facilities with financial challenges. Further, the Council should avoid greater state control over the governing bodies of hospitals, including the authority to appoint or dismiss individual board members. The Department of Health already has substantial authority over governing bodies and can take a range of actions in response to a failure in governance. These current avenues are adequate to address governance failures.

Thank you for the opportunity to provide input for your ongoing efforts to further improve the CON process.

Sincerely,



Bradford C. Berk, M.D., Ph.D.

cc: Dr. Nirav Shah
James Introne

Via Email: PHHPCplanning@health.state.ny.us

November 27, 2012

Public Health and Health Planning Committee

To Whom It May Concern:

NYSNA has reviewed the draft PHHPC CON Redesign Recommendations (hereafter "Draft Plan") distributed on November 19, 2012 and wishes to raise the following concerns/criticisms:

1. Lack of Meaningful Opportunity for Review and Comment

The Draft Plan was distributed for review and comment on November 20th and the public and other interested stakeholders were given a one week deadline (to November 27th) for submission of responses. This short period of time deadline for submission of responses is in and of itself inadequate under ordinary circumstances, given the extent and scope of the proposed changes to the CON process. The timing of the release of the Draft Plan, however, just two days before the Thanksgiving holiday, further exacerbates the shortness of the time period for analysis of and responses to the Draft Plan and raises questions as to whether the timing of the release was intended to preclude or limit input and criticism. The time period for submission of comments on the Draft Plan should be extended.

2. Contradictions Between the Stated Goals and Purposes of Changes in Health Care Delivery and the Proposed Redesign of the CON Process

Section I of the Draft Plan outlines in broad strokes the goals and purposes of current moves to transform the health care delivery system nationally and in New York, and highlights the guiding role of the "Triple Aim" imperatives of 1) bending the cost curve, 2) improving the quality of care and 3) improving health outcomes through new models of care and payment.

In this introductory analysis, the Draft Plan focuses heavily on the cost element and the development of new organizational models of health care delivery. The issues of quality of care and health outcomes, however, are either unaddressed in any specific manner or are generally assumed to be a given result of the very process of reducing costs and promoting new and innovative health care provider "alignments" and "payment arrangements." There is no real discussion of how these new payment paradigms and changes in provider organizational structural will actually work to produce better quality of care and improved health outcomes. These improved outcomes are tacitly assumed to result as a matter of logic, as if prior tendencies to abuse or "game" the system can be eliminated through the magic of market forces, economic incentives and the relaxing of oversight and control.

Also lacking is an attempt to come to grips with the question of how patient care and the public health will be affected by the potential conflicts and contradictions between cost cutting, improved efficiency, increased market concentration in the hand of larger provider networks, relaxed regulation and oversight of new or expanded provider facilities and organizations, regional planning, state control, and input and power for "stakeholders."

The introductory section and the specific proposals set forth in the Draft Plan are permeated by recurring contradictions that raise questions about both the intent of the proposals and the implementation of the proposals. These contradictions include the following:

- Strengthening the CON process as a means of driving improved health care delivery while reducing its scope and applicability and allowing applicants to "self-certify";

- Creating Regional Health Improvement Collaboratives to democratize the planning and decision making process while delegating more control and decision making authority to the State or directly to health care provider organizations;
- Seeking to prevent the opportunity for fraud or waste while relaxing the restrictions on CON approval of persons or entities with a history of such practices;
- Recognizing the need for CON oversight and monitoring while encouraging the expansion of areas of practice or health care delivery that are not subject to regulation or oversight;
- Emphasizing the need for planning in the delivery of care and health outcomes while encouraging deregulation and market forces to take on a growing role;
- Promoting a diversity of competitive organizational forms/structures while allowing or encouraging the creation and growth of large monopolistic health enterprises.

Even more notable than these contradictory aspects of the Draft Plan is what it does not address at all or merely mentions in passing. The Draft Plan makes reference to the need to improve access to care for underserved segments of the population, to protect safety-net providers and other financially marginal facilities from being weakened or otherwise damaged by “cherry-picking” or “creaming” competitors who strip away more lucrative patients or services, but its actual recommendations and proposals make no concrete proposals to ensure that these critical issues are addressed and steps taken in the CON process and the RHICs to prevent or redress inadequacies. Completely unmentioned are the issues of using the CON process and the RHIC structure to enforce minimal standards of care, to guarantee access to care regardless of ability to pay and commensurate to community needs, and to require providers to maintain minimum safe staffing levels (medical personnel, registered nurses, ancillary staff, etc.) at the bedside and in the treatment rooms where patients are actually provided with care.

The CON process has traditionally been largely bureaucratic in nature and has been applied without effective democratic control/participation and in a less than transparent manner, with information and decision making processes that are not open to effective public input and participation. It is our position that the CON process should play a critical role in monitoring and analyzing the effectiveness of the coming changes in the health care system, and that the promotion of quality care, democratic access to and control of health care systems, and improvement of health care outcomes for all segments of the population will require a strengthening of the CON process. We also welcome the introduction of a strong network of RHICs with clearly defined powers and authority to implement rational regional planning guidelines and guarantee that the needs of patients and the public are effectively protected.

The Draft Plan creates the appearance of a more open, democratic process for controlling and improving access to health care and enhancing public health outcomes, but uses this appearance to mask concrete proposals that effectively will have the opposite effect.

3. Advancing the Triple Aim Through Regional Planning (Recommendations 1-5)

We support the concept of creating Regional Health Improvement Collaboratives (RHICs) and believe that they can serve an important role in democratizing the CON and health planning process, guaranteeing the rights of the public, patients, stakeholders, and ensuring that the transformation of the health care system proceeds in a manner that meets all aspects of the Triple Aim, including particularly the goals of improved access to care and better health outcomes for underserved populations.

We would like to note however the following concerns regarding the RHICs:

- There is a lack of clarity of the specific powers and role of the RHICs, with the implication being that they would serve mostly as window dressing and would not have much ability to actually drive regional health care planning and exercise effective decision-making power;
- The role and function of the RHICs within the broader state regulatory apparatus is completely unaddressed;
- The proposals emphasize “neutrality” over “objectivity”, implying that the role of the RHICs should be to provide “balanced” recommendations rather than to advocate for the needs of the public and the patients in the healthcare system;
- There is no discussion of the nature of the “capable executive leadership”, who will select that leadership, and how that leadership will interact with the “stakeholders” who will make up the “governance” of the RHICs;
- The RHICs are charged with developing a consensus around strategies to promote aspects of the delivery and organization of healthcare, but there is no mechanism for making decisions where consensus cannot be reached;
- The list of concrete areas to be reviewed by the RHICs does not include any reference to improved access to care and dealing with underserved communities;
- The proposal does not address the issues of ability to pay and maintaining or creating networks of care available to all within the region regardless of ability to pay;

- The proposal does not address the issue of staffing standards at the point of direct provision of care; the RHICs should specifically be empowered to collect data on and review staffing levels in all health care facilities/organizations in the region, and should establish and enforce applicable minimum staffing ratios or guidelines in all health care settings in their respective regions;
- The RHICs are should be directly integrated in the CON process for applications that will impact their region; this integration should be meaningful and should include all phases of the CON process, from initial filing to ultimate determination; the RHICs should have a direct role in the approval or denial of CONs.

4. Driving Health System Performance Through Certificate of Need and Licensure (Recommendations 6-12)

The Draft Plan correctly highlights the importance of the CON system in directing and overseeing health system performance, and also notes some of the shortcomings of the current system, especially with respect to accessibility to low income patients, provision of high quality care and the development of institutions of care in under-served areas. It is correctly noted, for example, that the current CON process does not have the ability to address delivery system failures or mismanagement, does not prevent physicians or other unregulated players from destabilizing or undermining providers of essential safety net services through predatory or opportunistic competitive practices.

On the other hand, the Draft Plan seems to either exaggerate or over-emphasize problems related to the opening of licensed primary care sites and the regulation of “complex” or “integrated” health care organizations. The inability of health care providers to rapidly expand services, facilities, and acquire ever more extensive arsenals of expensive equipment and machinery to provide duplicative or unnecessary services does not seem to have been a problem plaguing our health care system in recent decades. Indeed, the very premise of the Triple Aim is to crack down on providers who are quick to act in pursuit of perceived opportunities to milk quick profits out of the system.

The Draft Plan’s specific proposals for addressing these “problems” are notable for their logical inconsistency. The CON process is identified as a lever for driving solutions, but the proposals set forth in the plan instead aim to dismantle that lever and gut the CON process in the name of making it more effective.

Specific examples of this approach in the Draft Plan include the following:

- The removal of CON controls on primary care facilities will allow free reign to larger or stronger hospital networks to actively seek to poach patients, and particularly more desirable patients with better insurance coverage, from their more financially fragile safety-net competitors; instead of allowing this practice by eliminating CON review, primary care facilities seeking to expand or to open new operations should be subject to stringent controls to prevent such poaching or to require them to provide care to all comers, regardless of ability to pay;
- The Draft Plan allows primary care facilities to avoid CON review if they employ a physician in at least one of a specified list of practice areas, which would allow manipulation of the rule to create surgical or other more lucrative facilities and avoid oversight by employing a token primary care practitioner;
- Projects funded with DOH grants that have gone through an RFA review would be allowed to avoid CON public need review, thus allowing the DOH authority to make decisions without public scrutiny or input; this would undermine any sense of democratic control and would open possibilities for powerful providers to abuse the system and create more possibilities for fraud and public corruption;
- Though the CON process for hospital beds is to be retained, the door is opened to removing it entirely 3 to 5 years; the assumption that NY has too many beds is debatable, especially in the context of the need for a surge capacity in the event of serious health emergencies (witness the recent disruptions caused by Hurricane Sandy in Manhattan and other parts of New York City); the further assumption made here is that CON review of beds will not be necessary due to changes in reimbursement rates; this market incentive assumption is flawed, in that it fails to take into account the behavior of organizations that are seeking to increase their market share or penetrate new markets and who will be willing to assume short term losses in the form of unoccupied beds to attain those goals; this problem may be exacerbated by the recommendation of relaxed CON review of “complex” and “grand-parent” ownership structures that would allow out-of-state hospital networks or corporations to begin acquiring interests in NY State (as occurred in the dialysis field, for example); these corporate players would be willing to create unnecessary beds in order to obtain such a toe hold in the NY market;
- The use of an the ACO certification process is put forward as an alternative to the CON process for promoting appropriate distribution of facilities and services; again, the underlying assumption that financial incentives will regulate the expansion of facilities by ACOs suffers from the same problems noted in the previous paragraph; instead of eliminating CON applicability to such providers, it should be incorporated into the ACO approval process to ensure that there are no manipulations of the new reimbursement systems to take unfair advantage or otherwise game the system;
- The Draft Plan proposes to monitor and institute a time limit to prevent “banking” of CONs; this is a good first step, but should be further developed to actually require ongoing rescission of CONs where an applicant is not moving forward or where the CON is failing to meet any of its conditions.

In addition to these problem areas with the proposal put forth in the Draft Plan, we feel that there are numerous aspects of the current CON process that were not addressed with specific proposals, including the following:

- All CON approvals should be subject to minimum staffing requirements on an ongoing basis that make licensure or approval contingent upon presenting detailed staffing plans the set forth minimum staffing requirements consistent with quality care and enhanced patient health outcomes; such staffing plans should include minimum medical care requirements, nurse to patient ratios or guidelines, and minimum ancillary care staffing;
- All CON approvals should be subject to a thorough analysis of the patterns of service to under-served demographic groups and generally accessibility to care and conditional upon specific commitments to address such short-falls in care/access;
- All CON approvals should analyze the existence of populations without the ability to pay or with limited ability to pay or obtain insurance coverage and commitments to specific free care should be included in the CON process.

5. Update CON and Licensure to Reflect the Complexity of Physician Practices (Recommendation 13)

The Draft Plan raises the concern that physician practices can be used to manipulative the gray area between licensed facilities that require CON review and small doctor's offices that do not. The potential for abuse is correctly noted, with particular concern for their ability to manipulate this status to skim profitable patients from hospitals and otherwise disrupt local health care markets.

The Draft Plan, however, reflecting opposing viewpoints and a lack of consensus, asks the State to decide whether this disparity should be addressed by allowing facilities currently under CON restrictions that want to offer similar services to also be exempt from the CON process or by bringing physician groups to come into the CON process.

Given the ability of physician groups to disrupt health care delivery service and provider markets, it makes no sense to expand the possible scope for such disruptions by also allowing licensed facilities to engage in the same activity without CON oversight. The Draft Plan should recommend that all such behaviors should be subject to CON controls to prevent abuses and disruptions in care.

6. Promoting Improvements in Quality and Efficiency through Governance (Recommendations 14-19)

The Draft Plan proposes to streamline the CON process for "establishment" of new providers by loosening the current procedures for excluding participation in such providers of persons with prior histories or incidents of illegal or immoral behavior in their capacity as health care providers. It is alleged that these restrictions hamper the creation of large integrated provider systems and the recruitment of "experienced governing body members." It is further alleged that the screening process is cumbersome and may be irrelevant to judging large, complex organizations.

The Draft Plan accordingly proposes to change the emphasis from judging individual members to reviewing the entire organization. The Plan thus proposes to analyze whether the corporation as an entity is subject to questions about its standards and practices rather than on the individuals who govern it. This standard is also proposed for large, "established" non-profit entities, and "complex proprietary organizations (e.g., publicly-traded, private-equity-owned)."

In addition to shifting the focus of review from individuals to the total corporate entity, the Draft Plan also recommends that corporate applicants be allowed to "self-certify" by conducting their own review of their ethical and legal standards and to receive approval on the basis of this self-certification.

The perils of self-certification of one's integrity, veracity and moral standing are obvious – people routinely lie about themselves and this tendency is even more apparent where large amounts of wealth and money are involved. Given that one of the drivers of the Triple Aim and the reform of the health care delivery system is that the system is manipulated by a small segment of unscrupulous providers engaged in abusive practices or outright fraud, it would not seem unreasonable to expect such people to lie about their past and present levels of integrity and commitment to honest dealings with patients and payers.

Also troubling is the apparent willingness of the authors of the Draft Plan to open the door to a massive and unrestricted influx of for-profit, corporate entities to rush into New York and start grabbing market share. We have already discussed our concerns about this phenomenon and note that some of these players have been associated with massive frauds, a drive to acquire control of the most lucrative patients and patient care services, leaving the unprofitable sectors to the safety-net providers to handle.

Accordingly, we feel that the proposals to eliminate any meaningful CON review of complex-corporate providers (both for-profit, private-equity-owned, and non-profit) is a recipe for disaster and the brunt of any abuses that result will be felt most keenly by the under-served segments of the populations.

If there are short-comings in the current review process, the answer is not to eliminate CON oversight, but to make changes in the CON process that allow better monitoring of the principals behind applications for new operational licenses.

The Draft Plan recommendations regarding changes in the composition of boards of directors and giving greater power to step in and take control of failing providers are positive steps. We believe that the proposals, however, do not go far enough, and would recommend the following additional provisions:

- Loss of licensure for failure to comply with minimal staffing plans set forth as a condition to the granting of the CON;
- Failure to provide access to care for any persons based on inability to pay;
- Failure to provide services to underserved communities in the manner indicated in the CON approval'
- Engaging in disruptive practices, or otherwise acting to undermine the stability of facilities or organizations that are safety-net providers.

7. Incorporate Quality and Population Health into CON Review; Streamline Financial Feasibility Reviews; and Relax the Revenue Sharing Prohibition (Recommendations 20-22)

We support the recommendation to consider quality and population health concerns in the CON process, and further recommend that this approach be expanded to include specifically issues of minimum staffing plans as noted above.

We repeat our concerns, however, that consideration of these concerns in the CON process is undermined by the broad reductions in the scope and applicability of the CON review process that are proposed in the Draft Plan. As we have previously noted, the consideration of quality of care, staffing and local health care needs should be the primary focus throughout the CON process, from submission to approval, and should be subject to ongoing monitoring to ensure compliance after operations have commenced.

With respect to the proposals to ease the level of financial feasibility review for "financially stable" hospitals, we would note that ongoing review of financial feasibility of expansion projects is an important way of making sure that such hospitals stay financially stable. There have been numerous examples of hospitals that expanded to quickly or too much, incurred large amounts of debt on false financial assumptions and subsequently went into bankruptcy, closed or had to be bailed out by the state. As we move to ever large systems and networks, the threat of such catastrophic financial melt-downs will only increase. Accordingly, it is critical that the CON process continue to pay close attention to financial issues in CON applications. The recent history of our banking sector could easily be repeated in New York, with the prospect of "too big to fail" hospitals abruptly collapsing or saddling the state with huge bills.

Finally, we believe that the Draft Plan proposal to allow "established" operators to share revenue with non-established entities is an open invitation to fraud, market manipulation, and undue outside influence in our health care system and should be rejected.

Thank you.

Anne Bove, RN

Anne Bove, RN

Cc: Nancy Kaleda, Deputy Director, NYSNA
Leon Bell, Associate Director, NYSNA

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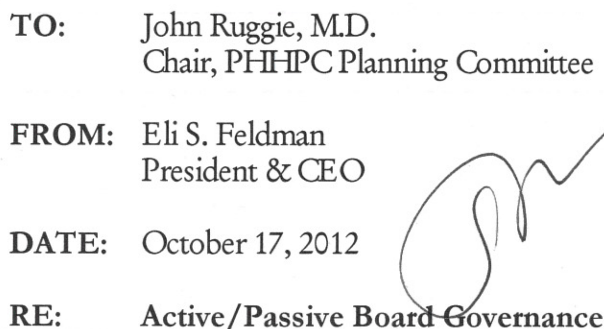
MJHS

MEMORANDUM



TO: John Ruggie, M.D.
Chair, PHHPC Planning Committee

FROM: Eli S. Feldman
President & CEO

DATE: October 17, 2012

RE: **Active/Passive Board Governance**

MJHS has concerns regarding the governance recommendations the Department of Health has made to the Public Health and Health Planning Council's Planning Committee, believing they are, at best, unnecessary and, at worst, counter-productive to integrating care across the continuum and ensuring care management for all.

The five recommendations appear intended to essentially eviscerate a governance model that has worked well in New York and that has produced far more benefits than drawbacks. In general, those benefits include:

- Ensuring that provider organizations are rooted in their communities.
- Enabling organizations to achieve economies of scale – which ultimately benefit state, federal and commercial payers – notably in hiring top-notch management, in administrative services such as billing and IT), and purchasing supplies.
- Enabling organizations to access capital and other financing in the private marketplace, thereby limiting government exposure.
- Sharing best practices and clinical pathways across multiple entities, thereby enhancing quality at reduced cost.
- Integrating care across the continuum, thereby easing transitions of care for consumers and reducing unnecessary re-hospitalizations.
- Allowing flexibility in governance structure.

More specifically, point-by-point:

- ***DOH does not want the same person to serve as the passive parent CEO and a facility CEO.*** This is a decision best left to the organization. Some organizations may want CEO-level overlap to inculcate a single vision and mission across parent and one or more "children" or to ensure that the best talent and expertise is shared. Others may use the passive parent as a vehicle to link several independent organizations and the parent may have little or no staff. To require separate CEOs in all situations will add administrative costs and potentially thwart good mission and management.

- ***DOH does not want mirror boards.*** This is truly short-sighted since having mirror boards is far more efficient and effective -- both for board members and management -- than having multiple separate boards. For example, MJHS has 14 affiliated organizations. If we had to have 14 separate boards meeting four times a year, the burden to identify qualified voluntary trustees, educate them and staff all of those meetings would be a full-time job for multiple administrative staff. That is neither efficient nor cost-effective. And DOH should not under-estimate the difficulty of recruiting voluntary trustees. Even in a city as large as New York, finding volunteers with expertise in and a passion for health care, long-term care, medicine, corporate compliance, philanthropy, information technology, etc. is difficult. Mirror boards are also used to address regulatory requirements. For example, an organization may have several related activities operated on the same campus, such as a senior housing complex with independent living and a nursing facility. For regulatory purposes or financing requirements, these two activities might be operated as separate corporations. The most efficient governance structure for this facility would be a mirror board.

- ***DOH has proposed requiring clinical integration among passive parents and facilities.*** Since passive parents are used to address non-clinical activities as well as clinical ones, requiring integration may be inappropriate. However, integration is one of the benefits that can flow from a passive parent structure. For example, MJHS' structure has enabled the development and sharing of nationally recognized clinical pathways by and among our CHHAs and LTHHCP and, we expect, with our MLTCP and MAP. Our structure has also enriched our Medicare Advantage Institutional Special Needs Plan for dual eligible nursing home residents, which has achieved reductions in hospitalizations among I-SNP members.

- ***DOH wants authority to approve if 1/3 or more of a board is replaced within specified period.*** This is not only impractical, but irrational. Setting an arbitrary threshold overlooks the extensive body of literature and attention paid to non-profit governance, especially in health care, that has led to most boards having term limits and staggered terms that can result in healthy, routine board turnover. Furthermore, additional vacancies routinely occur as a voluntary trustee with a salaried job is transferred or retires out of his/her area of service. Lastly, it is unclear what DOH would do with its authority - if the intent is to approve individuals who are nominated to fill vacancies, that would constitute excessive State interference with a single non-profit sector and would be a huge burden on DOH itself.

- ***DOH also wants authority to approve of passive parents.*** This is a major power shift without a clear purpose. The whole idea of non-profit governance is that community members, not State government, run the organization. And with limited staff, how is DOH going to play this expansive role? The State already has many enforcement mechanisms they can use to go after bad actors. For example, the Charities Bureau of the State Attorney General's office has broad authority to police non-profits and the Office of Medicaid Inspector General has oversight of health care corporate compliance. Self-dealing or unlawfully delegating decision-making authority to a non-regulated entity are such a clear violation of State Not-for-Profit Corporation Law and Public Health Laws, the removal of a board and appointment of a receiver would be warranted. There also are federal rules that allow for suspension of Medicare and Medicaid payments where a "credible allegation of fraud" exists.

I hope a slow thoughtful approach will be given to this matter, as any significant shift can cause unintended consequences in a changing complex health care environment.

I would be happy to share further thoughts should you wish a fuller discussion. I can be reached at (office) 718-921-8066; or cell phone: 917-952-1800.

Cc: William Streck, M.D.
Chair of PHHPC

Nirav R. Shah, M. D., M. P. H.
Commissioner of Health

Comments submitted via PHHPCPlanning or MRTWaiver Email re:
PROPOSED REGIONAL BOUNDARIES MAP

P^2 Collaborative of WNY – *Submitted by Kate Ebersole on September 18, 2012*

Please find listed below the comments on the proposed regional boundaries planning map:

1. The map aligns with the current catchment area for the P^2 Collaborative of WNY; the eight counties of WNY. The activities that we engage in as an organization include consumer engagement, education, and empowerment in all eight counties of WNY including Consumer Advisory Teams in most of those counties, quality improvement activities in primary care practices in all eight counties of WNY, quality improvement activities in the hospital systems in all eight counties of WNY, regional community health improvement activities in all eight counties of WNY and performance reporting on key quality indicators in the eight counties of WNY.

2. The eight county area of WNY is also the catchment area of our WNY RHIO; HEALTHeLINK

3. The eight county area of WNY is also the catchment area of our WNY Public Health Alliance

4. The CMS 3026 contract for care transitions is for the seven rural counties of WNY

5. The WNY Beacon contract from the Office of National Commissioner (ONC) of the Department of Health and Human Services (through HEALTHeLINK) is for the eight counties of WNY

6. P^2 is the grant holder for the Regional Extension Center grant from the ONC through the New York eHealth Collaborative and our catchment area for that grant is the eight counties of WNY

7. P^2 is the grant holder for the New York State Health Foundation Meeting the Mark grant and our catchment area for that grant is the eight counties of WNY

8. There is ongoing quality improvement work being done in primary care practices throughout the eight counties of WNY that is sponsored by P^2. Through our Aligning Forces for Quality grant from the Robert Wood Johnson Foundation, which covers the eight counties of WNY, we have been able to bring in national speakers, evidence based practices, and quality improvement training through collaborative learning groups and meetings involving the providers in the eight counties of WNY.

9. The Safety Net providers of WNY (SNAPCAP – Safety Net Association of Primary Care Affiliated Practices) is an ongoing active collective of safety net practices located in the eight counties of WNY who are using needs assessment data and collective group activities to improve safety net care in the eight counties of WNY.

10. In support of all of our QI activities in the eight counties of WNY, we have a network of Community Based Extenders who hire the QI personnel who work in the primary care practices and consumer engagement associates for patient and consumer outreach activities which includes the Chronic Disease Self-Management program and the Diabetes Prevention Program. Part of our network is Lake Plains Community Care Network, a rural health network covering the three eastern counties of our eight county region; Orleans, Genesee and Wyoming counties.

Ellis Medicine – *Submitted by David Smingler on behalf of James Connolly, President and CEO*

Thank you for the opportunity to comment on the proposal to establish a regional health planning framework based on "modified economic development regions."

While the proposed regions are generally consistent with the boundaries used by many other agencies and programs, they do reflect a significant departure from the current Health Department arrangement, particularly by splitting up the existing Northern Region into three separate areas. In the case of Ellis Medicine, this places our service area in two separate planning regions, and is likely to have a similar impact on other providers located near the edge of the new boundaries.

In order to minimize potential conflicts and inconsistencies when planning activities in one region may impact patients and providers in another region, we suggest three potential options:

1) Review the service areas of major providers (hospitals and perhaps large FQHCs and/or CHHAs) and reconfigure the counties within each region to avoid splitting combined primary and secondary service areas.

2) Split counties into two or more regions when provider service areas or other traditional community distinctions show clear affinities for part of a county with a different region.

3) Require regional planning entities to formally consult and cooperate with their equivalent entities in an adjacent region whenever any proposed activity would impact providers and/or patients in the adjacent region, ensuring that all regional activities are consistent and non-duplicative.

Ontario County – *Submitted by Mary Beer on September 24, 2012*

This email is regarding the proposed "Option #2: Modified Economic Development Regions" for regional health planning. There are several reasons why I do <u>not</u> believe that the proposed region for my county, Ontario, will serve to strengthen regional health planning.

First and foremost, the Finger Lakes/Southern Tier region that we have worked with for the last 30 years is comprised of nine counties: Monroe, Livingston, Steuben, Schuyler, Chemung , Seneca, Ontario, Wayne and Yates. Numerous coalitions and affiliations serve all or part of these nine counties, including: the regional NYSDOH office (Rochester), Finger Lakes Public Health Alliance (FLPHA), S2AY Rural Health Network and the Finger Lakes Health Systems Agency (FLHSA). Strong working relationships have been established with all of the entities, supporting Public Health Planning. Mutual aid agreements have been established in this region for public health emergencies as well as weekly communicable disease surveys throughout most of this region. From the public health side of things, these nine counties are the historical and logical region to use for health planning.

Looking at hospital-related health planning, while the choice is not quite as clear, these nine counties represent the most logical choice as a region. While Guthrie is a growing presence in Steuben and Chemung Counties in recent years, with some folks traveling to Sayre, Pennsylvania for tertiary care, the historical pattern has been travel to Rochester to receive care rather than out of state to Pennsylvania.

Lastly, there is no established relationship for health planning, or for any other relationship, for the counties proposed to be "the Southern Tier region." While we have some working relationships with Tioga County and Tompkins Counties, we have almost no relationship with Broome, Chenango, and Delaware Counties. Public health departments from these counties do not generally interact except as

part of broader state or upstate initiatives. In addition, no one from our county travels to Broome, Chenango, or Delaware County for any kind of medical care.

I strongly believe that population-based health outcomes will best be supported in our region by the nine county area currently served by the FLHSA.

Tompkins County – *Submitted by Lisa Holmes and Betty Falcao on October 1, 2012*

Dear Planning Committee members,

Thank you for this opportunity to comment on the September 13, 2012 revised map of the proposed boundaries for the regional health planning framework. This positions Tompkins County in the Southern Tier, in alignment with the Regional Economic Development Council regions.

After due consideration, the Boards of both the Tompkins Health Network (our Rural Health Network) and the Health Planning Council of Tompkins County concur with this placement of Tompkins County in the Southern Tier region. This best fits with our current health care service patterns, our various regional affiliations, regional identity and other connections. Increasingly Tompkins County's planning in transportation, workforce development, housing and environmental concerns have been oriented to the south.

Because of our geographic location, Tompkins County has always been part of regions that extend in different directions. Sometimes we are grouped with counties surrounding Binghamton, sometimes with Syracuse, or Rochester or Elmira. In the previous Health Systems Agency planning structure Tompkins County had been grouped with Central New York; we remain in the RHIO based in Syracuse. Even while our primary health planning region will be with the Southern Tier, we will still actively maintain collaborative partnerships with organizations in other areas as desirable to best meet the health care needs of our residents.

We also encourage you to provide some flexibility in funding community-based local health planning. Tompkins County has very favorable health rankings, low hospital readmission rates and Medicare costs in the lowest quartile. In our 40+ years, we have a track record of working together in coalitions and task forces to strengthen coordination of care, identify and reduce gaps in services, develop patient-centered care models and promote effective prevention strategies. Having locally-based planning has helped create these many community benefits and will continue to be part of NYS achieving the goals of the triple aim.

We appreciate your soliciting our comments and look forward to future developments.

Cayuga Medical Center – *Submitted by Rob Mackenzie, President and CEO on October 1, 2012*

Planning Committee
Public Health and Health Planning council
Department of Health
Albany, NY

Dear Planning Committee members:

Thank you for allowing us to comment on the newly proposed boundaries for regional health planning, which position Tompkins County in the Southern Tier—as in the Regional Economic Development Council regions.

At its meeting on September 15, 2012 the Board of Directors of Cayuga Medical Center endorsed the placement of Tompkins County in the Southern Tier region. We agree with our local health Planning council that this geography best fits with our regional identity and other connections. Increasingly Tompkins County's planning in transportation, workforce development, housing and environmental concerns have been oriented to the south. However, even should our primary health planning region be with the Southern Tier, we still plan to actively maintain collaborative partnerships with organizations in other areas to best meet the health care needs of our residents.

We hope you will also maintain some degree of flexibility in funding community-based local health planning. As you know, Tompkins County is now rated by the Department of Health as the second-healthiest county in the state. Cayuga Medical Center's rates for preventable admissions are half the age and sex-adjusted expected levels. Our medical center rate for all-cause 30-day readmissions is in the top five among 190 New York State hospitals. And our Medicare costs remain in the lowest quartile, nationally. These favorable ranking would not have been possible without vigorous multi-stakeholder local health planning.

Thank you very much for your attention to these important matters. Please do not hesitate to call or write if we can be of further assistance.
Sincerely,

Rob Mackenzie, MD
President /CEO

Cc: Frank Kruppa, Public Health Director, Tompkins County Health Department
Betty Falcao, Executive Director, Health Planning Council of Tompkins County

Western New York Public Health Alliance – *Submitted by Barbara Hastings on October 1, 2012*

Good afternoon.

Thank you for the opportunity to offer comments regarding the regional health planning framework for New York State.

On behalf of the Western New York Public Health Alliance, we would like to advocate for the 8 counties of Western New York to remain a region (as depicted in the current NYS map).

Our current Board membership consists of the Public Health Directors from each county in the region as well as the Erie County Health Commissioner. In addition, the Board has members from: a Rural Health Care network, an HMO and a representative from the University of Buffalo's School of Public Health. I have attached a listing of the Board of Directors.

Our Vision

Improve the health, safety and wellness of our eight county Western New York Region.

Our Mission

Lead the development of public and private sector partnerships and collaborations to efficiently coordinate resources for improving the health status and safety of populations in our Western New York region through public health surveillance, education, prevention and intervention.

Our History

Originally established in 1992 as the Western New York Public Health Coalition, the partnership has grown over the years, leading to the eventual incorporation of the WNYPHA as a 501(c)(3) organization.

This eight (8) county, western New York region has a long history of successful collaborations in the health arena. As the previous Co-Chair of the Western New York Medicaid Managed Care Coalition I have personal experience in many successes related to the implementation of the 1115 waiver. This success could not have happened without the WNY regional effort.
Some of the other eight (8) county collaborative efforts are:

- The Western New York Department of Social Services Homecare Association
- The P2 Collaborative
- The Facilitated Enrollment Implementation group
- The Court Ordered Services/Medicaid Managed Care group
- The Behavioral Health/Medicaid Managed Care group

The WNYPHA believes it is in the best public health interest of New York's citizens, and the greatest economy of tax dollars, to continue this eight (8) county western regional approach for future health needs and collaborative opportunities. This region needs to continue regional partnerships. In addition we need to promote and encourage new regional partnerships as needed in order to work together in improving the public health of our region and the public health of New York State.

I thank you in advance for your time and consideration of this position. The WNYPHA looks forward to working with you, as needed, to advance this important New York State initiative.

Very best regards,

Barbara J Hastings, RN, MSN
Executive Director

Glens Falls Hospital – *Submitted by David Kruczlnicki on October 1, 2012*

Dear Health Planning Council Members,

Please consider this note as a strong vote for inclusion of Warren County in the Capital Region District rather than the East North Country District.

It seems that a predicating factor in the designation of health planning districts should be where patients move to/from for their health care services. After all, it is the patients for whom we are planning health care services in the first instance. As a practical matter, the movement of patients from Warren County for health services not provided/not available in Warren County is almost entirely to our south….to the Capital Region. Almost no patients travel north from Warren County for health care services.

Glens Falls Hospital, its ER (53,000 visits per year) and its twenty physician practices and health centers relate to Albany and Schenectady area providers for tertiary care, collaborative partnerships, and clinical coordination. As an example, this week GFH and Saratoga Hospital are jointly announcing a study to investigate how our facility's two cancer programs might formally collaborate and potentially affiliate in the interest of improving care, coordination, and access. We would like to see this initiative as a potential building-block toward further collaboration as our communities are only 20 minutes apart and our medical staffs are increasingly overlapping. To separate these medical staffs and community hospitals for health planning purposes would be counter-productive.

In addition and as we all know, the world is becoming smaller all the time. Increasingly, Glens falls and much of Warren County (the vast majority of the County's population is in the extremes southern end of the County – Glens Falls and Queensbury – the weighted votes of the County Board of Supervisors bear this out) is becoming a bedroom community for the Albany region. We see more and more commuters who work to the south of us (especially Global Foundries), which again makes the case that the natural relating of services, people, and commerce in Warren County is to the south….not the north.

Finally, the State's economic Development Councils have designated Warren County in the Greater Capital district geography designation. This has worked well, and has encouraged a more formal connection of warren County business, government, and community leaders with our neighbors next door to the south. Business planning is alive and well via this geographic designation and process. Why would we not want to acknowledge that success, as well as the geographic designation and build on it for health planning purposes as well?

I would be pleased to comment further or respond to any questions. Thank you for the opportunity to provide input.

Catholic Health System – *Submitted by Maria Foti on October 1, 2012*

Catholic Health System in Buffalo, New York would like to comment on the State's position on Regional Health Planning. As one of the more innovative health systems in New York State, we totally support the concept of promoting the Triple Aim. However, we are in agreement with the submitted HANYS white paper that regional planning needs to be flexible in its creation and not a one size fits all concept. We don't believe the State should be creating permanent organizations that need ongoing financial support to drive a regional planning agenda. Instead we believe stakeholders in the region will come together to seek funding to effectuate evidence-based interventions as funding sources are made available. We believe the State should continue to do everything in its power to continue to push and provide for access to complete, accurate, impartial data to assist stakeholders in their regional planning efforts. We do <u>not</u> agree that CON approvals should flow through any regional planning group. It is impossible for any group to be totally impartial. And in this day of new collaborations between payors and providers and physicians, there will never be a body that could be unbiased. As we view the possible core functions that the State is proposing for regional planning, we agree that having access and support for Community Health Assessments, Advancing the State Health Improvement Plan, assisting in evaluation of health disparities, and sharing national best practice interventions would be helpful and beneficial. We do <u>not</u> agree that a regional planning entity could develop and effectuate strategies to reduce preventable utilization, strengthen essential providers, align payment and benefit design with quality outcomes, or address gaps in service delivery. The only ones who could do these things are the providers themselves. In response to the question of geographic boundaries, we believe these boundaries are irrelevant as the "region" within regional planning will change based on the planning effort at hand. Quaternary services would have a much greater region for planning (much larger than the boundaries proposed) than primary care planning.

As stated above, we support the white paper submitted by HANYS and have added our additional comments and clarifications to HANYS white paper above. If you have any questions based on our feedback above, please do not hesitate to contact us directly. We thank the State for the opportunity to comment as we all seek to promote the Triple Aim and improve the health of our communities.

Sincerely,

Maria A. Foti
Senior Vice President, Planning

Wyoming County Community Health System – *Submitted by Donald Eichenauer on October 2, 2012*

Re: Proposed Regional Planning Map

We would like to offer the following comments.

Although we are not opposed to the Planning Map proposed by the New York State Department of health we do offer the following for consideration.

We call to your attention the fact that

a) Wyoming County Government is part of the Finger Lakes Regional Economic Planning Council and the Chairman of the Board of Supervisors serves on that Council through an appointment by

the governor. As a result the County does significant economic planning in conjunction with the Finger Lakes area.

b) Wyoming County Community Health System recently announced it had entered into a collaboration agreement with URMC Strong Memorial Hospital in Rochester which is in the Finger Lakes Region.

We ask that the regional committee consider whether the above should impact our assigned region. We do understand that WCCHS is virtually half way between the Buffalo and Rochester area and is also involved in various planning efforts with the Western New York Region. Depending on the overall objective of the assigned region the above items may impact the appropriate assignment for WCCHS. If you need additional information please feel free to give me a call.

Saratoga Hospital – *Submitted by Angelo Calbone, President/CEO on October 17, 2012*

While a little late I wanted to share a possible concern that we have with the proposed planning geographic designations being considered to accomplish regional planning. It appears as though Saratoga County and Warren County are not proposed to be in the same district. I would suggest that the two counties both be within the Capital District. There can be several points to support this position but for me the one that is the most important is that the two hospitals in their respective counties are exploring opportunities for collaboration. Presently we are sharing a much needed medical specialty between us and have also recently announced that we are undertaking a study to determine the possible value of a collaborative relationship around our cancer programs. There may very well be other areas of interest between us.

Separating our two hospitals across two separate planning entities may present an obstacle at a time when regional collaboration is much needed.

Glens Falls Hospital – *Submitted by Michael Massiano, member of the Board of Governors on October 24, 2012*

James Introne
Deputy Secretary for Health/Director of Healthcare Redesign
Executive Chambers
New York State Capitol Building
Room 242
Albany, New York 12224

Dear Mr. Introne:

My name is Michael F. Massiano. I am a member of the Board of Governors of Glens Falls Hospital.

In addition, I am the retired Chairman and CEO of Arrow Financial Corporation and Glens Falls National Bank & Trust Co.

I am writing to urge your support to the inclusion of Warren and Washington Counties to the Capital District Health Planning Region currently being considered by the New York State Public Health and Health Planning Council.

My understanding is that two options are under consideration for the health planning regions: one mirroring Governor Cuomo's Regional Economic Development Council regions; and a second option that modifies this map. I strongly believe that Warren and Washington Counties, currently included in the Capital District Region of Governor Cuomo's Regional Economic Development Councils, should likewise be included in the Capital Region Health Planning District. There are several reasons for this:

•As a practical matter, the movement of patients from Warren and Washington County for health services not provided/not available in Warren and Washington County is almost always to the Capital region. Rarely do any patients travel north from Warren and Washington County for healthcare services.

• Glens Falls Hospital and its busy Emergency Care Center (53,000+ visits/year) and its 20 physician practices and health centers relate to Capital Region providers for tertiary care, collaborative partnerships, and clinical coordination. As an example, Albany Medical Center serves as this Hospital's DOH-designated partner for oversight of its cardiac intervention program. Beyond that, we work very closely with Albany Medical Center on issues of patient transfers; indeed over 90% of all patient ransfers from this regional community hospital last year were to Albany Medical Center or other Capital Region providers.

•Glens Falls Hospital serves a large number of patients from Saratoga County, particularly in the northern portion of that county. Saratoga Country is just a few blocks from the front door of Glens Falls Hospital. The Towns of South Glens Falls, Moreau, Gansevoort, and Wilton—all northern Saratoga County towns are all within the primary service area of Glens Falls Hospital. In addition, Glens Falls Hospital owns and operates a primary care center in Saratoga County at Exit 16 of the Northway—Wilton and has received approval from the DOH to establish (groundbreaking expected before year-end) of a joint-venture eye surgery center at the Exit 16 campus. In short, the northern part of Saratoga County is very much a part of the Glens Falls/Warren County medical marketplace.

•In Washington County, Glens Falls is the predominate provider of primary and specialty care, owning and operating seven primary care health centers or physician practices throughout the county.

•Programmatic and joint hospital collaboration is evolving rapidly, and we see increased coordination of our institution with Capital Region healthcare providers. For example, Glens Falls Hospital and Saratoga Hospital are jointly supporting a study, currently underway, to investigate how our institution's two cancer programs might formally collaborate and potentially affiliate in the interest of improving quality, reducing cost, and enhancing access—the "triple aim" goals of Federal and State reform. Saratoga Hospital and its medical community are just minutes down the Northway from the Warren and Washington county medical communities and Glens Falls Hospital, and we are optimistic about increased collaboration between these two organizations in the future. To establish both in separate Regional Health Planning Councils would be counterproductive.

•Governor Cuomo's Regional Economic Development Councils have been successful in spurring regional coordination for economic growth. Warren and Washington Counties are part of the Capital Region Economic Development Council under Governor Cuomo's design, and we believe that has functioned very well. It makes most sense to build on that success and replicate Governor Cuomo's Capital Region designation to include Warren and Washington Counties with the Capital District for health planning as well.

These are times never before seen in New York State health planning. Major changes are underway with heightened collaboration among providers. We urge you and the Public Health and Health Planning Council to support and encourage the linkages historically established by maintaining Warren and Washington County in the Capital Region District for health planning purposes.

Thank you for your attention to this matter.

Sincerely,
Michael F. Massiano

cc: Nirav Shah, MD, MPH, NYS Commissioner of Health
William Streck, MD, Chairman/Public Health and Health Planning Council
John Rugge, MD, Chairman/Planning Committee of Public Health and Health Planning Council

Fort Drum Regional Health Planning Organization – *Submitted by Denise Young on November 13, 2012*

Director Lipson and Members of the NYS Public Health and Health Planning Council,

Please note the attached resolution: "A Resolution by the Fort Drum Regional Health Planning Organization to the New York State Public Health and Health Planning Council on the delineation of Health Planning Regions for Northern New York State" which was adopted by Executive Action of our Board of Directors on November 7, 2012.

The Fort Drum Regional Health Planning Organization (FDRHPO) provides a platform to analyze the existing healthcare delivery options and to seek opportunities for coordinating and leveraging healthcare resources to carry out a regional healthcare approach that meets the needs of the military and civilian residents in Jefferson, Lewis and St. Lawrence Counties.

The FDRHPO and our seven member hospitals encompassing Jefferson, Lewis and St. Lawrence Counties are currently undertaking an extensive process to develop a plan for shared governance to improve the delivery and to reduce the cost of care through a NYS Department of Health HEAL 21 award. Moving regional planning away from Western Northern New York would jeopardize the current regional planning being undertaken in Jefferson, Lewis and St. Lawrence Counties

Our organization urges the New York State Public Health and Health Planning Council to act to ensure that Jefferson, Lewis and St. Lawrence Counties be designated a separate planning region in the best interest of the health and well-being of the population of Western Northern New York.

Thank you for your attention to this matter.

Denise K. Young

Wayne County
Public Health Service
1519 Nye Road, Suite 200, Lyons, New York 14489
Phone: 315-946-5749 Fax: 315-946-5767

Diane Devlin
Director of Public Health

I am writing regarding the proposed "Option #2: Modified Economic Development Regions" for regional health planning. The proposed region for our county (Wayne) will not serve to strengthen regional health planning for several reasons.

First and foremost, the Finger Lakes/Southern Tier region that we have worked with for the last 30 years is comprised of 9 counties: Monroe, Livingston, Steuben, Schuyler, Chemung, Seneca, Ontario, Wayne and Yates. Numerous coalitions and affiliations serve all or part of these nine counties, including: the regional NYSDOH office (Rochester), Finger Lakes Public Health Alliance (FLPHA), S2AY Rural Health Network and the Finger Lakes Health Systems Agency (FLHSA). We have established strong working relationships with all of the entities, and rely on them to assist with Public Health Planning. We have a mutual aid agreement established in this region for public health emergencies, and also do a weekly communicable disease survey throughout most of this region. From the public health side of things, these nine counties are the historical and logical region to use for health planning.

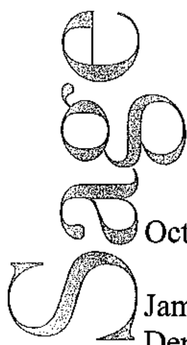
Looking at the hospital-related health planning, while the choice is not quite as clear, but these nine counties represent the most logical choice as a region. While Guthrie is a growing presence in Steuben and Chemung Counties in recent years, with some folks traveling to Sayre, Pennsylvania for tertiary care, the historical pattern has been travel to Rochester, rather than out of state Pennsylvania, to receive this care.

Lastly, there is no established relationship, for health planning, or for any other relationship, for the counties proposed to be "the Southern Tier region." While we have some working relationships with Tioga County and Tompkins Counties, we have almost no relationships at all with Broome, Chenango and Delaware Counties. Public health departments from these counties do not generally relate except as part of broader state or upstate initiatives and no one from our county travels to Broome, Chenango or Delaware County for any kind of medical care.

We strongly believe that population-based health outcomes will best be furthered by not changing our region of the nine county area currently served by the FLHSA.

Sincerely,

Diane Devlin, RN, BSN, MS
Director, Wayne County Public Health



Sage Graduate Schools EDUCATION HEALTH SCIENCES MANAGEMENT

School of Nursing and Health Sciences

65 1st Street
Troy, NY 12180
www.sage.edu

October 24, 2012

James Introne
Deputy Secretary for Health/Director of Healthcare Redesign
Executive Chambers
New York State Capitol Building
Room 242
Albany, New York 12224

Dear Mr. Introne:

My name is Glenda Kelman. I am a member of the Board of Governors of Glens Falls Hospital.

In addition, I am the Chair of Nursing & Associate Professor in the Department of Nursing at The Sage Colleges.

I am writing to urge your support to the inclusion of Warren and Washington Counties to the Capital District Health Planning Region currently being considered by the New York State Public Health and Health Planning Council.

My understanding is that two options are under consideration for the health planning regions: one mirroring Governor Cuomo's Regional Economic Development Council regions; and a second option that modifies this map. I strongly believe that Warren and Washington Counties, currently included in the Capital District Region of Governor Cuomo's Regional Economic Development Councils, should likewise be included in the Capital Region Health Planning District. There are several reasons for this:

- As a practical matter, the movement of patients from Warren and Washington County for health services not provided/not available in Warren and Washington County is almost always to the Capital region. Rarely do any patients travel north from Warren and Washington County for healthcare services.
- Glens Falls Hospital and its busy Emergency Care Center (53,000+ visits/year) and its 20 physician practices and health centers relate to Capital Region providers for tertiary care, collaborative partnerships, and clinical coordination. As an example, Albany Medical Center serves as this Hospital's DOH-designated partner for oversight of its cardiac intervention program. Beyond that, we work very closely with Albany Medical Center on issues of patient transfers; indeed over 90% of all patient transfers from this regional community hospital last year were to Albany Medical Center or other Capital Region providers.
- Glens Falls Hospital serves a large number of patients from Saratoga County, particularly in the northern portion of that county. Saratoga Country is just a few blocks from the front door of Glens Falls Hospital. The Towns of South Glens Falls, Moreau, Gansevoort, and Wilton—all northern Saratoga County towns are all within the primary service area of Glens Falls Hospital. In addition, Glens Falls Hospital owns and operates

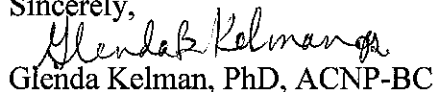
a primary care center in Saratoga County at Exit 16 of the Northway—Wilton and has received approval from the DOH to establish (groundbreaking expected before year-end) of a joint-venture eye surgery center at the Exit 16 campus. In short, the northern part of Saratoga County is very much a part of the Glens Falls/Warren County medical marketplace.

- In Washington County, Glens Falls is the predominate provider of primary and specialty care, owning and operating seven primary care health centers or physician practices throughout the county.
- Programmatic and joint hospital collaboration is evolving rapidly, and we see increased coordination of our institution with Capital Region healthcare providers. For example, Glens Falls Hospital and Saratoga Hospital are jointly supporting a study, currently underway, to investigate how our institution's two cancer programs might formally collaborate and potentially affiliate in the interest of improving quality, reducing cost, and enhancing access—the "triple aim" goals of Federal and State reform. Saratoga Hospital and its medical community are just minutes down the Northway from the Warren and Washington county medical communities and Glens Falls Hospital, and we are optimistic about increased collaboration between these two organizations in the future. To establish both in separate Regional Health Planning Councils would be counterproductive.
- Governor Cuomo's Regional Economic Development Councils have been successful in spurring regional coordination for economic growth. Warren and Washington Counties are part of the Capital Region Economic Development Council under Governor Cuomo's design, and we believe that has functioned very well. It makes most sense to build on that success and replicate Governor Cuomo's Capital Region designation to include Warren and Washington Counties with the Capital District for health planning as well.

These are times never before seen in New York State health planning. Major changes are underway with heightened collaboration among providers. We urge you and the Public Health and Health Planning Council to support and encourage the linkages historically established by maintaining Warren and Washington County in the Capital Region District for health planning purposes.

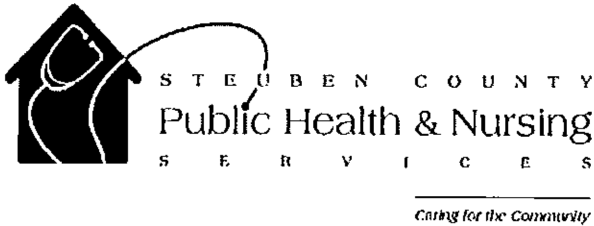
Thank you for your attention to this matter.

Sincerely,



Glenda Kelman, PhD, ACNP-BC

cc: Nirav Shah, MD, MPH, NYS Commissioner of Health
William Streck, MD, Chairman/
Public Health and Health Planning Council
John Rugge, MD, Chairman/
Planning Committee of Public Health and Health Planning Council



September 27, 2012

Dear Health Planning Council Members,

I am writing regarding the proposed "Option #2: Modified Economic Development Regions" for regional health planning. The proposed region for our county, Steuben, will not serve to strengthen regional health planning for several reasons.

First and foremost, the Finger Lakes/Southern Tier region that we have worked with for the last 30 years is comprised of 9 counties: Monroe, Livingston, Steuben, Schuyler, Chemung , Seneca, Ontario, Wayne and Yates. Numerous coalitions and affiliations serve all or part of these nine counties, including: the regional NYSDOH office (Rochester), Finger Lakes Public Health Alliance (FLPHA), S2AY Rural Health Network and the Finger Lakes Health Systems Agency (FLHSA). We have established strong working relationships with all of the entities, and rely on them to assist with Public Health Planning. We have a mutual aid agreement established in this region for public health emergencies, and also do a weekly communicable disease survey throughout most of this region. From the public health side of things, these nine counties are the historical and logical region to use for health planning.

Looking at the hospital-related health planning, while the choice is not quite as clear, these nine counties represent the most logical choice as a region. While Guthrie is a growing presence in Steuben and Chemung Counties in recent years, with some folks traveling to Sayre, Pennsylvania for tertiary care, the historical pattern has been travel to Rochester, rather than out of state Pennsylvania, to receive this care.

Lastly, there is no established relationship, for health planning, or for any other relationship, for the counties proposed to be "the Southern Tier region." While we have some working relationships with Tioga County and Tompkins Counties, we have almost no relationships at all with Broome, Chenango and Delaware Counties. Public health departments from these counties do not generally relate except as part of broader state or upstate initiatives, and no one from our county travels to Broome, Chenango or Delaware County for any kind of medical care.

We strongly believe that population-based health outcomes will best be furthered by NOT changing our region of the nine county area currently served by the FLHSA.

Sincerely,

Victoria Fuerst

Victoria Fuerst, Director
Steuben County Public Health & Nursing Services

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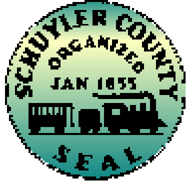
3 East Pulteney Sq, Bath NY 14810 (607) 664-2438 · 7604 Seneca Road North, Hornell NY 14843 (607) 324-5560 10 West First St, Corning, NY 14830



SCHUYLER COUNTY PUBLIC HEALTH

106 South Perry Street, Suite 4
Watkins Glen, NY 14891
(607) 535-8140 Fax: (607) 535-8157
www.schuylercounty.us

September 24, 2012

Public Health and Health Planning Council's Health Planning Committee,

I am writing regarding the proposed "Option #2: Modified Economic Development Regions" for regional health planning. The proposed region for our Schuyler County will not serve to strengthen regional health planning for several reasons.

First and foremost, the Finger Lakes/Southern Tier region that we have worked with for the last 30 years is comprised of 9 counties: Monroe, Livingston, Steuben, Schuyler, Chemung, Seneca, Ontario, Wayne and Yates. Numerous coalitions and affiliations serve all or part of these nine counties, including: the Rochester Regional NYSDOH office, Finger Lakes Public Health Alliance (FLPHA), S2AY Rural Health Network and the Finger Lakes Health Systems Agency (FLHSA). We have established strong working relationships with all of the entities, and rely on them to assist with Public Health Planning. Also, we have a mutual aid agreement established in this region for public health emergencies, and participate with weekly communicable disease surveillance. From the public health side of things, these nine counties are the historical and logical region to use for health planning.

Looking at the hospital-related health planning, while the choice is not quite as clear, but these nine counties represent the most logical choice as a region. Schuyler Hospital deals with the Rochester Regional NYSDOH office, and transfers many patients to Rochester hospitals. While Guthrie is a growing presence in Steuben and Chemung Counties in recent years, with some folks traveling to Sayre, Pennsylvania for tertiary care, the historical pattern has been travel to Rochester, rather than out of state.

Lastly, there is no established relationship, for health planning, or for any other relationship, for the counties proposed to be "the Southern Tier region." While we have some working relationships with Tioga County and Tompkins Counties, we have almost no relationships at all with Broome, Chenango and Delaware Counties. Public Health departments from these counties do not generally relate except as part of broader state or upstate initiatives and no one from our county travels to Broome, Chenango or Delaware County for any kind of medical care. Schuyler County Public Health strongly believes that population-based health outcomes will best be advanced by not changing our current nine county region, served by the FLHSA. Please reconsider Option #2 Regions.

Sincerely,

Marcia Kasprzyk Director
Schuyler County Public Health

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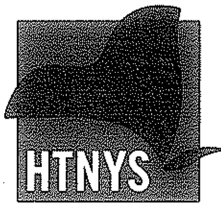

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November 20, 2012

John Rugge, M.D., M.P.H.
Chair, Planning Committee of the Public Health and Health Planning Council
New York State Department of Health
Corning Tower, Empire State Plaza
Albany, N.Y. 12237

Dear Dr. Rugge:

On behalf of Healthcare Trustees of New York State (HTNYS), which represents hospital and health system boards across the state, I write to express comments and concerns regarding the Planning Committee of the State's Public Health and Health Planning Council's discussions about health care organization governance.

HTNYS supports reducing the character and competence look-back period from the current ten years to seven years. In addition, HTNYS supports building flexibility into the decision-making process for establishment. These changes are needed to support desired service integration and to create more efficient delivery systems.

However, HTNYS has serious concerns about the Planning Committee's discussions regarding strengthening governance by monitoring major changes in boards and increasing Department of Health (DOH) authority.

DOH already has broad authority to respond to governing body problems and that authority is fully respected by the hospital field. The vast majority of health care boards across New York State take their responsibility to effectively govern very seriously, and are making responsible decisions and providing appropriate oversight.

Thank you for the opportunity to comment.

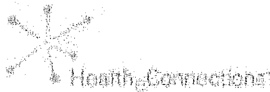
Sincerely,

Sue Ellen Wagner

Sue Ellen Wagner
Executive Director

SEW:st

One Empire Drive / Rensselaer, NY 12144 / (518) 431-7999 / (800) 360-7211 / *fax* (518) 431-7812 / www.htnys.org



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OCT 05 2012

NYS DEPARTMENT OF HEALTH
DIVISION OF EXTERNAL AFFAIRS

September 29, 2012

The Honorable Nirav Shah, MD, MPH, Commissioner
NYS Department of Health
Corning Tower, Empire State Plaza
Albany, NY 12237

Dear Commissioner Shah:

The Boards of Directors of the Central New York Health Systems Agency (CNYHSA) and the Health Advancement Collaborative of Central New York (HACCNY), operating together as **HealtheConnections**, addressed the issue of the draft regional health planning regional map to be included in New York's §1115 Waiver application to the federal government at our meeting September 24th.

It was the consensus decision of both boards that the new regional planning borders should not be based on the Regional Economic Council regions. Health planning is most appropriately linked with healthcare referral patterns. As such, we find that the Regional Health Information Organization (RHIO) borders, which were based on an analysis of referral patterns, are the most suitable borders for health planning. In the case of the Central Region, these counties are: **St. Lawrence, Lewis, Jefferson, Oswego, Cayuga, Tompkins, Cortland, Onondaga, Madison, Oneida and Herkimer**.

Furthermore, the board members overseeing **HealtheConnections** urge the NYS Department of Health to align the Health Insurance Exchange regions, the RHIO regions and the Health Planning regions as much as feasible. These three functions are significantly intertwined.

Thank you for your attention to this input. If you have questions or need additional information please contact Sara Wall Bollinger at (315)472-8099 or swbollinger@healtheconnections.org.

Sincerely,

William Conole, President
CNYHSA

Eric Hunt, President
HACCNY

HealtheConnections
109 South Warren Street, Suite 500
Syracuse, NY 13202

www.healtheconnections.org
CNYHSA (315) 472-8099
HACCNY (315) 671-2241

Adirondack
Rural Health
NETWORK
www.arhn.org

P.O. Box 3253 • Glens Falls, NY 12801 • (518) 761-0300 • Fax: (518) 480-0100

November 13, 2012

John Rugge, MD
Chairman, Health Planning Committee of Public Health and Health Planning Council
9 Carey Road
Queensbury, NY 12804

Dear Dr. Rugge,

On behalf of the Adirondack Rural Health Network, I am writing to endorse the Planning Committee of Public Health and Health Planning Council refined map of proposed regional boundaries based on Governor Cuomo's Regional Economic Development Council boundaries. The Adirondack Rural Health Network has facilitated a formal regional health planning process since 2002. It is built on commitment and collaboration from multiple community stakeholders that include payers, providers, hospitals, public health officials and other community members. This multi-county collaborative focuses on improving health and healthcare through community-based, data driven decision making.

It is my understanding that the Department of Health is working with the Planning Committee of the Public Health and Health Planning Council to develop a regional health planning framework for New York State. New York's 1115 waiver amendment application includes a regional planning component along with a map of proposed regional boundaries.

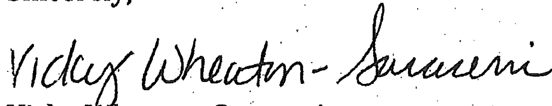
The members of the Adirondack Rural Health Network strongly urge you to endorse the modified map that accounts for existing health planning infrastructure for the following reasons:

- As a practical matter, the Eastern North Country counties have established a long-standing planning mechanism to identify and prioritize community health needs and the trust to build consensus.
- The planning model has already established a baseline community health assessment of existing resources and current service gaps. Consistent data reporting including standardized benchmarks, definitions and data measures based on research and evidence-based standards.
- The region represents a coherent service area for purposes of analysis, planning, and – most importantly – purposeful programming.

- Rapidly developing joint ventures among the hospitals, local health departments, behavioral health and primary care providers—especially the patient-centered medical home and health home.
- Convening authority that efficiently works with local health care providers, task forces and community groups to drill down to dispel or confirm perception of health care issues.

The health planning districts are vital for health system reforms that will create and sustain better health care at lower costs for everyone. We urge you and the Public Health and Health Planning Council to support and encourage the linkages historically established for health planning purposes.

Sincerely,



Vicky Wheaton-Saraceni
Director of the Adirondack Rural Health Network
Director of Corporate Planning and Services, Adirondack Health Institute

Cc: Nirav Shah, MD, MPH, NYS Commissioner of Health
William Streck, MD, Chairman/Public Health and Health Planning Council

FDRHPO
Fort Drum Regional Health Planning Organization
"Building a Strong North Country Healthcare System"

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Maria Roche
Board Member – Carthage Area Hospital

Denise Young
Executive Director FDRHPO

Ms. Karen Lipson, Director, Division of Policy
NYSDOH Office of Health Systems Management
Corning Tower, Empire State Plaza
Albany, NY 12237

November 9, 2012

Dear Director Lipson,

Please note the enclosed resolution: "A Resolution by the Fort Drum Regional Health Planning Organization to the New York State Public Health and Health Planning Council on the delineation of Health Planning Regions for Northern New York State" which was adopted by Executive Action of our Board of Directors on November 7, 2012.

The Fort Drum Regional Health Planning Organization (FDRHPO) provides a platform to analyze the existing healthcare delivery options and to seek opportunities for coordinating and leveraging healthcare resources to carry out a regional healthcare approach that meets the needs of the military and civilian residents in Jefferson, Lewis and St. Lawrence Counties. Seven hospital's chief executive officers, multiple physician representatives and representatives of every rural community healthcare sector actively participate in the FDRHPO's board of directors and committee governance structure.

The Fort Drum Regional Health Planning Organization's seven member hospitals encompassing Jefferson, Lewis and St. Lawrence Counties are currently undertaking an extensive process to develop a plan for shared governance to improve the delivery and reduce the cost of care through a NYS Department of Health HEAL 21 award. Moving regional planning away from Western Northern New York would jeopardize the current regional planning being undertaken in Jefferson, Lewis and St. Lawrence Counties

Our organization strongly urges the New York State Public Health and Health Planning Council to act to ensure that Jefferson, Lewis and St. Lawrence Counties be designated a separate planning region in the best interest of the health and well-being of the population of Western Northern New York.

Thank you for your attention to this matter.

Sincerely,

Denise K. Young
Executive Director

120 Washington Street, Suite 302
Watertown, New York 13601
www.fdrhpo.org

(315) 755-2020 office
(315) 755-2022 fax

A RESOLUTION BY THE FORT DRUM REGIONAL HEALTH PLANNING ORGANIZATION TO THE NEW YORK STATE PUBLIC HEALTH AND HEALTH PLANNING COUNCIL ON THE DELINEATION OF HEALTH PLANNING REGIONS FOR NORTHERN NEW YORK STATE

WHEREAS, the New York State Public Health and Health Planning Council is considering the delineation of health planning regions in New York State that will impact critical and ongoing health planning being undertaken in the Western Northern New York Region; and

WHEREAS, There is already a proven, effective regional health planning organization in Jefferson, Lewis and St. Lawrence Counties focused on the CMS triple aim; to improve the experience of care, to improve the health of the population, and to reduce the per capita costs of health care, the Fort Drum Regional Health Planning Organization; and

WHEREAS, Seven hospitals encompassing Jefferson, Lewis and St. Lawrence Counties and the Fort Drum Regional Health Planning Organization, are currently undertaking an extensive collaborative process to develop a plan for shared governance to improve the delivery and reduce the cost of care through a NYS Department of Health HEAL 21 award; and

WHEREAS, moving regional planning away from Western Northern New York would jeopardize the current regional planning being undertaken in Jefferson, Lewis and St. Lawrence Counties; and

WHEREAS, the rural population served in Jefferson, Lewis and St. Lawrence counties is substantially demographically different and has substantially different health indicators than the population of central New York; and

WHEREAS, moving support for health planning from rural northern New York to an urban center would significantly diminish the ability of rural health planning to develop a population based system of health care delivery that preserves existing critical services; and

WHEREAS, poorly executed planning would lead to cutbacks in the availability of already limited rural health care services and increased financial instability and inefficiency of service delivery;

NOW, therefore,

BE IT RESOLVED, that we urge the New York State Public Health and Health Planning Council to act to ensure that Jefferson, Lewis and St. Lawrence Counties be designated a separate planning region in the best interest of the health and well-being of the population of Western Northern New York.

Adopted: By Executive Action of the Board of Directors on November 7, 2012