Testimony on Health Planning and Certificate of Need

Presented at the Invitation of the
New York State Department of Health,
State Hospital Review and Planning Council Planning Committee

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I am Daniel Sisto, President of the Healthcare Association of New York State (HANYS). Chairman Kennedy and members of the State Hospital Review and Planning Council and Public Health Council (Councils), I would like to thank you for your time and interest in holding this hearing today and for the opportunity to present testimony on behalf of HANYS. I would also like to thank Commissioner Daines and other representatives of the Department of Health (Department) who have focused new attention and resources on health planning and Certificate of Need (CON) reform in a commendable effort to better match our limited health care dollars with New Yorkers' most critical needs.

HANYS represents 550 not-for-profit and public institutions, including hospitals, health care systems, nursing homes, and home care providers. Our membership comprises a wide array of providers, including academic medical centers, large urban teaching centers, suburban institutions, small community hospitals, and rural Critical Access Hospitals. Our mission is to support our membership through representation and education to advance the health of individuals and communities across New York.

As broad as the topics of health planning and CON are, we believe that the Department and both Councils recognize that those issues must be examined in light of the public interest in affordable, quality health care. Further, these topics must be considered in the context of the evolution of health services nationally. New York is not alone in trying to balance regulatory and market demands. However, New York's historical reliance on regulatory solutions and its selective approach to introducing more market-driven reform make the process especially complicated.

We appreciate that the Councils are seeking input on both health planning and CON reform. They need to be examined as separate and distinct topics, since health planning encompasses a much broader scope of issues, many of which we will highlight later. Past planning efforts have typically begun with the stated intent of being broad and all-encompassing, but those efforts inevitably evolved into institutionally-focused, bed capacity discussions. That focus, in turn, translated into regulatory exercises in institutional constraint.

At several points over the last decade—post-deregulation of the hospital reimbursement system for third-party payers and post-selective CON reform—HANYS has asked its members whether they favored a continued transition to a market-driven approach to health planning and CON, or a return to a more regulated health planning environment. Each time, the clearest response has been a strong consensus for a "level playing field." That is, that hospitals, continuing care providers, and health systems should not be placed at a competitive disadvantage with unregulated providers offering similar services, just because they are "licensed."

We recognize that the state has a limited amount of resources dedicated to managing the CON process. Therefore, in supporting bringing currently unregulated providers into the CON process, we acknowledge that the state's CON resources would be spread over a wider field of health care entities. To be a timely process, the types of projects subject to CON review would have to be prioritized, with those of lesser importance being eliminated. A broader CON process involving more providers would help level the playing field.

There is also broad concern about recreating a process similar to the past—with local Health System Agencies (HSAs)—that would add to delays and raise anxiety that decisions might be based on local politics more than objective planning standards.

However, the health care community has been divided on whether the solution should be a more complete market approach—eliminating CON for most or all services—or whether all providers, including physicians, should be subject to CON review.

HANYS was in the process of revisiting member views on the subject again when we received your invitation. We are still at the beginning of that process and therefore will submit additional commentary as we continue our information gathering and you continue your deliberations in the months to come. Our views expressed today represent preliminary input from the membership. That input reflects continued division of interest between market-based and regulatory principles, but with several caveats:

- the majority opinion appears to be moving toward market-oriented solutions; this may reflect more of a frustration with delays in moving smaller projects through the CON process versus a comment about planning goals—but we will pursue a clearer answer;
- at the same time, there continues to be a strong consensus that the state must develop a new public need methodology for freestanding ambulatory surgery centers to limit out-migration of services where it threatens the viability of critical safety net services only available in hospitals, in particular in situations where there is appropriate hospital-based capacity;
- there is an appreciation that there may be a legitimate public interest in preserving certain services, even in a market-oriented approach;
- where the planning process and certificate of need determine that a service is needed, that service should be fully funded; and
- there is a distinction between health planning and the CON process, and there is strong consensus that the latter needs streamlining and reform—even in a regulatory system—because of the need for timely action by providers and the resource constraints that limit the state's ability to handle current volumes.

Introduction

Our comments today are offered in the context of several fundamentals: Hospitals and health systems share a common objective to deliver health care of high quality that is accessible to all, regardless of geographic region or ability to pay. They must accomplish this, we recognize, within a system that is financially sustainable for both providers and purchasers of health care.

Health care providers accept that our current "health planning" infrastructure needs to be responsive to local concerns and we thank the Department and both Councils again for recognizing the need to better integrate real-time data and community input into decisions that will guide the future direction of health care. We believe it is important to differentiate this new call for better health planning with reform of the CON process. The process of reviewing a CON

application, we believe, cannot substitute for effective health planning, simply because it is a tool available to compel behavior by licensed providers.

We appreciate that the Department has tried its best to incorporate local input into the decision-making process. However, CON alone is not able to fully incorporate regional health planning, despite the best attempts of Department staff who are dealing with multiple priorities in addition to CON.

With the demise of most of the formal venues for local health planning over the past 20 years, nothing has stepped in to help reliably define local gaps in services across the continuum. Alternatively, the CON process has continued to focus its attention on institutional constraints rather than being a force for innovation. Reimbursement reform and consumerism have attempted to promote market behavior. Providers are caught in the middle.

Hospitals and health systems provide a broad range of safety net services that cannot be replicated elsewhere, and for which public and private payers fail to fully reimburse. Where a pure marketplace-based system might compel the abandonment of such service lines, providers understand that there is a legitimate public interest in ensuring that these services and programs remain open and accessible in all communities. More importantly, providers recognize these obligations in their mission statements and actively seek to incorporate these community services in their operations—despite the fiscal consequences. That special commitment also necessitates that the state accept a responsibility to help institutional providers sustain needed services—with adequate reimbursement or other financial aid or franchise protection through CON, or a combination of both.

Inherent in the health planning process is the commitment to see that services identified as needed are adequately funded. That principle should apply to institutional capacity and ambulatory services alike. As has been acknowledged, it is especially problematic to promote expansion of primary care services, while allowing those services to be under-funded by public and private payers.

New York's health care laws have created an illogical system where the state is legally bound to oversee quality and other safety concerns related to certain services, but only when those services are provided in licensed facilities, such as hospitals, nursing homes, or diagnostic and treatment centers. Practitioner-based services are generally not subject to the same active quality and safety oversight—compounded by the freedom to initiate these services in the first place without the burden of CON approval. The public is generally not aware of these differences. Similar services should be regulated similarly, regardless of the business model or licensure status of the entity that is providing the services.

The current CON processing algorithms are unsustainable, given current resource commitments, and need to be revisited in any case to recognize current marketplace investment realities. Current thresholds contained in state regulation dictating which projects should receive which type of review unnecessarily overburden CON staff and create an untenable workload. This discussion should result in recommendations for a system that is commensurate with the resources available to administer it. Timeliness in the CON process must be a priority, both from the providers' standpoint to allow them to better adapt to market changes and consumer preference, but also from a cost perspective. Avoidable delays unnecessarily add costs to the system for applicants and state taxpayers.

The remainder of our comments will be organized to address two related, but distinct components: health planning and CON.

Health Planning

Models for effective health planning currently exist. For example, together with the Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services, the Public Health Foundation identified common elements of most health planning and improvement efforts. These elements were used to develop the Healthy People 2010 Toolkit. Elements include:

- identifying and engaging community partners;
- setting health priorities and establishing objectives;

- identifying and securing resources;
- obtaining baseline measures, setting targets, and measuring progress;
- managing and sustaining the process;
- communicating health goals and objectives; and
- building the foundation, leadership, and structure.

The Prevention Agenda Toward the Healthiest State, announced by Commissioner Daines in April, incorporates many of these same elements. The Department should follow models like this one, which are more representative of a true health planning process.

By contrast, the Commission on Health Care Facilities in the 21st Century, known as the Berger Commission, has provided several good lessons that should inform this process. It was an extraordinary process facilitated by $2.5 billion in funding, but with a pre-determined and focused charge to reduce capacity in both hospitals and institutional long-term care sectors. It highlighted how attempted centralized health planning, while effective in some instances, and even with an elaborate structure for regional input, cannot fully take into account the facts on the ground in a local community and the full impact of consolidations, mergers, closures, and other health system restructurings.

We recognize the enormous effort and contribution made by the selected statewide and regional representatives who dedicated significant time and effort to make difficult judgments within a very limited timeframe. However, it highlighted the difficulty of trying to make system capacity decisions on a facility-specific basis with a one-time effort. In the best examples, it stimulated multi-provider discussions that may not have occurred or may have taken much longer to reach fruition, in the absence of the Berger process. In other cases, the recommendations were not well received—including with alternate views of local service needs or concerns about service gaps if consolidations or reductions were pursued. We appreciate that the Department was willing to consider new information and, in some cases, find workable solutions. However, some of the Commission's conclusions remain highly contested.

We recognize that the Department and your Councils have undertaken this discussion in part to find a better long-term approach—to avoid the need for an extraordinary effort like the Berger Commission in the future. We support that goal.

There is legitimate public interest in the size and scope of the health care delivery sector: First, to ensure that there is adequate capacity and services available in a geographically accessible way throughout the state. Identifying gaps in services, the effects of new technologies, forecasting the implications of mega-trends and new science, forecasting workforce needs, and identifying options to address likely workforce shortages on a statewide and regional basis, are obvious and important roles for both the state—and these Councils—and for a process that incorporates informed regional input.

Forecasting future needs also incorporates the potential to identify excess capacity. Regional input is especially important in this case—to state the obvious—as the simple extrapolation of national planning standards or goals is always inadequate to determine local service needs. Before the Berger Commission was established, we recommended that the state and regional effort be limited to identifying those larger capacity and structure goals and, thereafter, use positive financial incentives that were promised (Health Care Efficiency and Affordability Law for New Yorkers and the Federal-State Health Reform Partnership) to promote provider-initiated solutions.

We still prefer that voluntary incentive approach and we believe that the voluntary restructuring efforts stimulated by the Berger process will prove to be the greater successes.

We reference the Berger process to highlight several other points:

- The Commission and its predecessor group recognized the dilemma that its scope was limited to institutional providers, while the impact or role of non-regulated segments was affecting safety net services and needed to be addressed—more on that later.
- The Commission also recognized that health system restructuring could not occur without a concurrent change in payment structure, in particular related to inadequate payment for

outpatient services. That issue is being addressed as a part of ongoing reimbursement reform discussions. It is important to note that those discussions only relate to paying differently for Medicaid fee-for-service beneficiaries and do not include, even as a Department goal, to fully cover the cost of those services.

- Despite everyone's best efforts to incorporate local input and local recommendations in the Commission's findings, the Department rightly had to adjust a variety of determinations based on subsequent information or local concerns. Examples include several instances in which mental health services identified for restructuring or consolidation needed to be preserved, such as of John T. Mather Memorial Hospital/St. Charles Hospital, the preservation of obstetrics services at Auburn Memorial Hospital, and the retention of nursing home services because of geographic isolation at Lakeside Nursing Home.

The Commissioner and Councils have already taken steps to modify and improve the process going forward. We look forward to seeing the ideas presented in response to the recent Request for Grant Applications (RGA) to stimulate local health planning efforts. As previously indicated, we would have concerns with efforts that attempted to replicate the previous HSA infrastructure and responsibilities. However, there are numerous local health planning functions that we will note below that would provide constructive input to the state, the public, and providers alike.

We are also a partner in the Commissioner's Prevention Agenda, a call to action for local health departments, health care providers, health plans, schools, employers, and businesses to engage in local collaborations to improve the health status of New Yorkers. To the extent there are provider concerns with this effort, they reflect the fact that every hospital and health system already commits substantial resources to staff and subsidizes a broad range of community services. To the extent those community services align with identified prevention goals—and many clearly would—providers are eager participants. Depending on expectations, however, providers would be anxious if there is the potential for an adverse impact on other valuable community services or operations. We continue to work with the Department to ensure compatibility. In addition, this is a prime example of an effort in which institutional providers

are only one partner—yet may become a disproportionate focus because of our general mission, accessibility, and the Department's regulatory capability through CON. What, for example, should be the responsibility of third-party payers to finance greater prevention initiatives?

HANYS is also interested to see the Department's Prevention Quality Indicator (PQI) tool, designed to map ambulatory care-sensitive hospitalizations and better focus investment in primary care. Hospitals have always been interested in this information and previous analyses to identify ambulatory care-sensitive conditions. There was great interest among the membership in the preliminary analysis we distributed last year that highlighted PQI data by county for cardiac care, asthma, and diabetes. Data-driven tools are necessary for providers in determining gaps in services within their communities and we look forward to learning more about the potential uses of this tool. Again, the primary caveat would be the extent to which the Department decides to integrate it into specific CON decisions, e.g., the extent to which hospitals are expected to be accountable for primary care physician capacity in their areas, how that is supposed to work where there are multiple providers in a county or service area, whether a CON for an unrelated and legitimate purpose would be held up based on an identified need, etc.

As you begin to integrate these various initiatives into the health planning process and we continue a dialogue with our members on the merits of a more market-based approach versus a regulatory approach, we ask you to consider some suggestions and concerns related to potential health planning initiatives—including where local or regional input could be most valuable:

- **Long-term capacity/service need planning**—The most traditional of health planning activities, projecting service needs based on population and utilization trends, remain at the core of health planning work. There is a significant benefit to credible data collection and up-to-date analyses to project health care needs and service requirements.
    - This is an activity, obviously, that could be improved by having local stakeholder input—provider, consumer, business, etc. Local forums should be created where stakeholders could discuss and advise the state on local conditions or modifications needed and promote local solutions. Such activity could foster CON development in cases where applications would be required.

- We would recommend, however, that this process not recreate a specific role in reviewing and commenting on specific CONs. This is based in large part on concerns raised by the prior HSA experience.

- **Service gap analysis**—This issue was highlighted in the Berger discussions, but was never fully completed as part of that process. Identifying and highlighting service gaps, in particular in the continuum of long-term care services, is critical to the development of an efficient and effective delivery system. The PQI tool would be one approach to identifying needed primary care services, but a more complete process—with local input—would be beneficial.

- **Assessment of the impact of new technologies/emerging science**—These related but distinct topics are activities probably best handled at the state/council level, but local input is relevant where questions of geographic access arise.

- **Proactive interest in innovation**—Several years ago, the State Hospital Review and Planning Council created an ad hoc Emerging Issues Committee to consider the merits of new or emerging services or technologies. Its activities were absorbed by other committees with competing priorities. There remains a concern that the current process and CON rules inhibit innovation, rather than stimulating new ideas. There are other service configurations—not so new—that the state continues to resist, like transitional care units and long-term care hospitals. As hospitals struggle to move clinically complex patients efficiently and effectively through the continuum of the services needed, the state has consistently resisted using service configurations in wide use nationally. Providers should not have to go to the State Legislature to compel the state to authorize these services. More important, the Department and Councils should be seen as promoting new ideas. This is also an area where local interest in innovative approaches may prove valuable.

- **Proactive development and use of health information technology (HIT**)—New York is far ahead of the rest of the country in providing seed funding for certain types of HIT applications—but only certain types. That activity needs to be integrated into the health planning process with support for both organization-specific investment as well as regional initiatives.

- **Evolution of physician/hospital relationships**—The challenge of out-migration of certain services (e.g., ambulatory surgery) is a much-discussed element of this subject. However, a broad health planning effort needs to discuss the rapidly changing environment of physician-based services and physician-hospital relationships. This includes the impact of increasingly larger multi-specialty group practices, formed in part to respond to payer challenges, but also able to dictate terms with hospitals. It also involves a discussion of the growing separation of many primary care and specialty physicians from roles in hospitals—including willingness to be on-call in the emergency department or provide coverage services elsewhere—leading to a significant growth in the use of hospitalists.

- **Development of a better health planning database**—The past and present focus on institutional care is partly based on the ability to more easily collect service information from hospitals and nursing homes. The Statewide Planning and Research Cooperative System (SPARCS) has been an invaluable resource. However, as the focus appropriately shifts to ambulatory care, service information is lacking. Insurers, including Medicaid, have access to the missing ambulatory care elements, but it is not collectively available for state or local health planning consideration. There would be significant value in discussing opportunities to aggregate public and private insurance data into a single health planning database. This information is critical to health planning and its current unavailability is a readily correctable item. The Department should take the lead in making this important tool available to providers.

- **Workforce implications**—The current health planning process acknowledges, but does not directly focus on long-term workforce issues. Within a broad statewide context, this is an especially relevant topic for regional stakeholder discussion. Projections of future workforce shortages may be global, but solutions tend to be local. Coordinated local efforts are needed to identify workforce needs, promote educational solutions, and promote health care careers—otherwise service gaps are likely to grow.

- **Access to capital**—The health planning process is similarly largely passive when it comes to ensuring access to needed capital. Providers are expected to find a source of capital for investments. Now, with the loss of a frequently used vehicle for accessing

tax-exempt financing—Industrial Development Agency (IDA) financing—the state needs to be proactive in filling that gap. There is ample evidence that New York providers have the most limited access to capital markets and the oldest physical plants, compared with providers in every other state—largely due to non-existent margins. Publicly-supported programs have filled the gap—Federal Housing Authority insurance, the Dormitory Authority of the State of New York, and IDAs. One of those options is now gone. We urge the state and Councils to elevate this issue as a priority.

- **Clinical integration**—We believe there are health system and public benefits to horizontal and vertical clinical integration: horizontally across non-corporate-related providers and vertically between hospitals and physicians or hospitals and continuing care providers. The potential benefits are both economic—a more efficient system—and qualitative—with more consistent use of clinical standards by physicians and organizations. Providers are hampered at almost every turn, however, by anti-trust and competitive issues. The state could help by developing a mechanism to promote cross-provider discussions. We believe this topic should also be high on the Councils' health planning agendas.

- **Third-party insurer consolidation**—As third-party insurers continue to consolidate and grow into mega-entities, their influence and impact on health planning and system development grows. This growing influence affects the configuration of the health delivery system, as the focus may shift more toward economics and less on access to care. We ask the Department and Councils to review this impact and discuss the appropriate role of third-party insurers in health planning. That includes payers' responsibility for full payment of needed services.

Many of these topics are relevant to a state health planning activity whether or not the system is more market-driven or regulatory—and several represent new but potentially important focus areas for the Councils. We have also tried to highlight those topics where local input would be most relevant: service gap analysis, long-term care system gaps, workforce needs, and promotion of service innovation. Clearly, access to comprehensive, current data is a critical factor in successful local health planning. These data represent a powerful tool to assist

providers in identifying and ultimately addressing the health care needs of the communities they serve. As previously stated, full reimbursement for services determined to be needed is also critical.

Certificate of Need

HANYS and the Department have worked in partnership over the past several years to identify areas of particular frustration and concern within the CON process and to suggest alternatives for streamlining the system. In recent years, activities of the Berger Commission have understandably taken center stage within the Department and efforts to reform CON have not progressed as quickly as we all might wish.

Already, we have come to agreement on regulatory changes that would:

- eliminate certain non-clinical projects, such as parking garages and building exteriors, from the CON process;
- eliminate the requirement for full review processing of initial purchases of magnetic resonance imaging equipment and allow for administrative processing; and
- allow relocation of extension clinics within the same service area without CON.

We appreciate the Department's work to come to agreement on these changes and urge a renewed commitment to bringing these changes into regulation.

We also appreciate the many measures already undertaken to streamline the process through policy changes, including the efforts to better coordinate ambulatory services co-licensed by more than one state agency. In addition, our members have specifically noted the recent accelerated processing of Limited Architectural Reviews, which has been a helpful improvement that we hope will continue.

Yet, as all of us in this room know, the process is still rife with bottlenecks due to a host of factors, including overburdened staff, outdated rules, lack of coordination among some regional offices and the Department's central office, and a tremendous paperwork burden—which is an anachronism in today's electronic world.

Level Playing Field

Before I provide specific recommendations on CON, I would like to address the issue of out-migration of services to a freestanding setting and the operational consequences that result when physicians seek to own and operate their own ambulatory surgery centers or office-based surgery practices in competition with the local hospital. We have frequently commented on this issue in the past and we repeat our concerns here.

I referenced above the need for a clearer state policy to reflect the necessity of adequately reimbursing for, subsidizing, or otherwise protecting safety net services that all our health care institutions provide, including "24/7" emergency care, refuges in times of emergency, and primary care for the underinsured or uninsured.

It is through a CON franchise that New York has traditionally accomplished this, though not with a clearly articulated policy. The uncertainty over when to let the market decide the distribution of health care services and when to "protect" a service through licensure is understandably a point of contention. But the results of the state's "experiment" in deregulating ambulatory surgery services demonstrated the problem of unforeseen consequences.

Without reliving too much history, when the state eliminated a need test for ambulatory surgery it projected an increase of 35 sites—about doubling the existing need-based capacity. Since 1998, approximately 100 new freestanding ambulatory surgery centers have been approved. While we applaud the state's effort to make the review process more rigorous over the past several years, much of the damage has now already been done.

There is not significant competition for every service. Very few are lined up to provide free clinics or to offer surgical services to Medicaid or uninsured populations. Hospital-based ambulatory surgery is a service that helps subsidize safety net services—emergency department losses, clinic losses, and services to the underinsured and uninsured. Even with ambulatory care reimbursement reform, the state does not plan to fully reimburse for outpatient services. Moreover, even if it did, it could not compel other payers to do the same. The licensure process is the only available tool in this case to protect safety net services. The Department needs to view this issue from the larger public good perspective and not allow duplication of services where existing capacity is already adequate.

Even among hospitals inclined to support moving toward a more market-based CON process, the strong consensus has been in favor of re-regulating ambulatory surgery—and we endorse that approach.

HANYS has urged in the past and we will continue to recommend that the CON process incorporate a better measure of need, including an assessment of existing capacity, when looking at these proposals. We understand this can cut both ways, as we saw recently when a hospital proposed to expand radiology services and a private physicians' group wrote to the Department saying it already had these services in the community and the hospital program was not needed.

Recommendations on CON

For our discussion today and to address some of the questions you posed in the invitation letter, HANYS has recommendations that we believe would improve the current CON process. Most of these recommendations relate to creating a system that focuses on preserving access for all, providing fair treatment for all applicants, and designing a system that can process applications within a reasonable timeframe.

Timeliness is an overarching concern. There simply has to be a way to process non-critical projects within 90 days—and more important projects (involving significant issues on significant investments) within a predictable, reasonable timeframe.

Our recommendations are:

- Eliminate the need for CON review for projects that do not result in changes to the beds or services already on the facility's license.
- Update or eliminate need methodologies that do not adequately account for local capacity, patient migration patterns, patient preferences, practice standards or technological changes. Currently, some bed need methodologies use county lines as proxies for planning areas, where patient migration patterns indicate otherwise. Other need methodologies for certain equipment that has become routine, are no longer enforced or are unevenly enforced.
- Inform CON with more "social" aspects of health care, such as data on payer mix, quality concerns, and need to preserve accessibility.
- The Department recently indicated an interest in introducing more transparency to the CON system. HANYS supports these efforts and would urge creation of a Web site including more narrative about proposed projects, and a more efficient means of communicating in real-time with applicants what issues are outstanding with their projects and which steps are completed.
- Eliminate the need for CONs for one-for-one equipment replacements, such as mammography.
- Raise the thresholds for all categories of CON to reflect changing costs of construction and equipment and to make the program more workable for existing staff and applicants.
- Conduct more education and training for regional and central office Department staff to better standardize knowledge and interpretation of regulations pertaining to CON.
- Update references to the Life Safety Code and other building code considerations to be consistent with state and federal codes.
- Eliminate the process of writing letters to request permission to start construction (allow "All Contingencies Met" letter to satisfy this process).

- Allow more self-certification of project elements by facility engineers and architects and eliminate the need for site visits for each CON completed; consider quarterly or semi-annual visits by the Department's surveyors to assess compliance.
- To increase resources, fees paid by applicants should be reinvested into the CON program and not diverted to the General Fund.

Conclusion

Our patients, employers, and all of us recognize we have to be smarter about how we spend our health care dollars and we need to show better results for the money we spend.

HANYS has in the past and we once again commit our resources and the expertise of our members to assist you in any way that we can as you move forward with this ambitious and welcome agenda.