Public Hearing Testimony

Reforming the Certificate of Need Process

Submitted to:

The Planning Committee of the State Hospital Review and Planning Council

Presented by:

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Concourse Meeting Room #6
Empire State Plaza
Albany, New York

July 23, 2008

Introduction

Good afternoon. I am Dan Heim, Vice President for Public Policy of the New York Association of Homes and Services for the Aging (NYAHSA). Founded in 1961, NYAHSA is the only statewide organization representing the entire continuum of not-for-profit, mission-driven and public long term care including nursing homes, senior housing, adult care facilities, continuing care retirement communities, assisted living, home care, managed long term care and other community services providers. NYAHSA's nearly 600 members serve an estimated 500,000 New Yorkers of all ages annually. On their behalf, I appreciate the opportunity to appear before the Planning Committee of the State Hospital Review and Planning Council (SHRPC) on the subject of Certificate of Need (CON) process reform. NYAHSA also appreciates the leadership shown by the Department of Health (DOH) in orchestrating these discussions, and reaching out to various stakeholders to solicit their views on this important subject.

New York was one of the first states to institute a CON program intended, among other things, to estimate the need for services and oversee the development of necessary system capacity. While CON has stemmed the proliferation of health care service capacity, the state is now faced with a growing and changing demand for services, rapidly evolving care modalities and systems, and an aging health care infrastructure.

In the area of long term care, various state initiatives are being implemented to "rebalance" the system to place greater emphasis on developing home and community-based services capacity and correspondingly less reliance on adding to nursing home capacity. Indeed, NYAHSA has been an early and consistent supporter of "rightsizing" and reconfiguring the health care delivery system. We were the first organization in the state to advance a nursing home rightsizing proposal in 2003, in keeping with our endorsement of the U.S. Supreme Court's *Olmstead* decision, which addresses the need to deliver services in less restrictive, more integrated settings. NYAHSA's proposed rightsizing program was enacted as a 2,500-bed demonstration pursuant to Chapter 750 of the Laws of 2004.

However, state policies and laws can and do impede system rebalancing efforts. There are longstanding CON-related moratoria and/or limitations on developing additional home and community-based services capacity including long term home health care programs, adult day health care programs, certified home health agencies and Medicaid assisted living programs, with no immediate plans to periodically revisit these moratoria and other limitations. More fundamentally, the state's traditional approaches to managing service capacity predominantly through formulaic need methodologies are simply not responsive enough to the dynamic long term care services marketplace. In some geographic areas, for example, although the estimated need is fully met with existing and approved beds/slots, there are waiting lists, oversubscribed programs, under-served individuals and other indications of unmet need.

For these and other reasons, NYAHSA supports efforts to comprehensively evaluate the state's CON process to identify changes that may be needed to accomplish its intended objective to develop a high-quality, accessible and cost-effective health care delivery system, while avoiding the need for another forced downsizing of the delivery system. We are prepared to assist the Planning Committee, DOH and other policymakers in those efforts.

Questions Posed in the Meeting Notice

Identified below are the questions that were posed in the letter of invitation we received, along with our reactions.

1. Projects, Services and Equipment Subject to Review

a. How can the CON process be improved to respond to changes in the health care marketplace?

NYAHSA believes that there are several ways in which the CON process can be improved to be more responsive to the changing marketplace for health care services. Among these opportunities for improvement are to: (1) bring more real-time marketplace

data into the process; (2) consider the ramifications of actions across systems of care; (3) promote more uniformity of approach and process across provider types; (4) place more emphasis on responding to unmet need for services; (5) make the process itself more timely; and (6) re-examine and streamline the CON applications and reviews.

With regard to marketplace data, efforts are needed to ensure that the most currently available utilization and other data are used when developing and evaluating individual proposals against any formulas used to evaluate supply and demand for services. In a dynamic marketplace, these data can quickly become outdated. Even in the data-driven Berger Commission exercise, we saw instances when stale data led to less than optimal recommendations.

As care modalities and settings evolve, more providers enter the service system and systems of care emerge, decisions made on CON policies and individual applications can have ramifications on other types of facilities, agencies and systems. The dangers of making decisions about service capacity in one line of service in isolation of other service lines are multiplied in a complex and dynamic system. NYAHSA believes that CON process reform provides an opportunity to more thoroughly consider the implications of these decisions in the context of the broader delivery system.

The potential for the CON process to promote greater uniformity of approach and process across provider types should be evaluated. This is not to say that all types of reviews should be identical; rather, that it would be worthwhile to examine whether differing processes are leading to "silo" approaches. For instance, facilities and agencies that are established under Social Services Law (e.g., adult care facilities, assisted living residences, etc.) are reviewed under a different process than facilities and agencies established under Public Health Law. There may be legitimate reasons for these differences, or they could simply be a statutory artifact that should be reconsidered.

With all of the changes going on in the marketplace and individual service areas, there may be value in placing greater emphasis on the need for CON applicants seeking to initiate or expand services to identify and propose to respond to a currently unmet need

for services. Although utilization data and public need formulas can provide some insights into the supply and demand for services, CON applicants may be able to provide more direct and current information on unmet need and how that need can best be accommodated. This may also reduce the likelihood of duplicating existing services, and would dovetail with the desire to enhance local planning and input.

Finally, making the CON process itself more timely and streamlining CON applications and reviews will also enhance responsiveness to changes in the marketplace. These areas are addressed in more detail below.

b. Are there types of construction projects, medical services, or equipment that should no longer be subject to Certificate of Need review?

NYAHSA believes that the CON process should be streamlined by no longer subjecting certain "projects" to full CON review. Specific examples include the following:

- ✓ Initiating Article 28 facility-sponsored outpatient clinic services and adding dialysis services in a nursing home setting should not require full review. These services have evolved in a way that make administrative or limited review more appropriate.

- ✓ Amendments of existing construction approvals that simply represent increases in construction or borrowing costs due to timing and unit cost increases, and not changes in the actual project itself, should be reviewed administratively and not require full review.

- ✓ Organizations seeking to change their names or make other nominal changes to their corporate structures should simply be required to send notices to DOH.

- ✓ Once a construction project or equipment acquisition has been approved, project sponsors should be given reasonable flexibility to make changes that do not materially alter the approved concept by giving prior notice to DOH.

- ✓ If DOH and the relevant review body have approved an architectural design for one project of a sponsor, at a minimum the architectural review should not be repeated for additional projects undertaken by the sponsor using the same design. Similarly, DOH should consider making available to potential applicants previously approved architectural designs or basic elements of design to minimize the need for duplicative reviews and incurring of architectural design costs.

c. Are there projects, services and equipment that are currently not regulated, but should be?

NYAHSA believes that any type of facility, service, equipment, or project that is subject to CON review in one setting should be subject to CON review across all settings. In other words, the nature of the project, not its setting or sponsor, should be determinative of the need for review.

For example, look-alike Article 28 facilities sponsored by physicians that provide outpatient clinical and rehabilitative services, for which existing Article 28 providers would need to secure CON approval to offer, should be subject to review.

d. Are there types of facilities or services that should be licensed, but not subject to a need test? Are there other regulatory mechanisms or controls that might make more sense?

NYAHSA understands that there is interest in the idea of expanding the application of the need methodology to nursing home CONs involving renovation or changes in ownership of existing facilities. Under longstanding policy, need reviews are

normally limited to the establishment of new facilities and increases to the certified capacity of existing facilities.

NYAHSA is greatly concerned about this concept, particularly as it would relate to facility renovation projects. We believe it is likely to be used as an opportunity to leverage these applicants into reducing their licensed capacities, while leaving untouched the capacities of providers that do not seek to improve their facilities. In other words, we believe this could create a significant disincentive for existing operators to upgrade their facilities, undertake innovative designs and delivery models, and otherwise improve quality of care and quality of life for their residents. In the bigger context, this could diminish the integrity of the entire service infrastructure.

These types of projects should not be subject to a need determination, provided the sponsoring organization demonstrates satisfactory occupancy or articulates a reasonable plan to achieve it following implementation of the project. Medicaid—the predominant payor—reimburses nursing homes for capital costs based on the lower of actual occupancy or 90 percent, in effect already creating a utilization based constraint on certified capacity.

2. Local Planning and Public Notice

a. What are effective ways to notify interested stakeholders about pending Certificate of Need applications that are actively under review?

NYAHSA recommends 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.

SHRPC and Public Health Council (PHC) meeting agendas are finalized and published a short time before the meetings are held, which gives applicants and other interested parties very little if any advance notice or ability to provide timely input or

otherwise react. While there may be last minute adjustments to agendas, a greater effort should be made to publish these agendas earlier.

SHRPC and PHC 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) SHRPC and PHC member listings; (8) information on how to provide input on applications; and (9) summaries of DOH staff reviews and council actions.

While NYAHSA supports 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 Provider Network; and/or hosting regional "forums" in the CON area of the DOH Web site.

b. How can the Department support the development of collaborative efforts to assess community health needs and make recommendations to develop and/or deploy efficiently and effectively the health care system resources needed to address those needs?

NYAHSA does 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.

Having said that, there is a need for community-based efforts to bring providers and other stakeholders together to examine local needs and resources, identify and address emerging trends and unmet service needs, and avoid duplication of services in an apolitical way. These efforts need to be ongoing in the communities, not exercises that are one-time or that occur only when a CON is undergoing review, and could be spearheaded by a third party facilitator. The *Local Health Planning Initiatives* request for grant applications (RGA) recently issued by DOH provides an opportunity to encourage flexible demonstrations of different models.

Discussions around these issues should include an assessment of the potential implications for the local workforce, and for existing providers in terms of referrals and associated reimbursement and quality considerations. Workforce shortages are pervasive, severe and well-documented throughout the state. Any proposal to develop additional capacity needs to consider the availability of workers in the local area, since all health care providers are essentially competing for the same limited pool of workers. If existing providers lose workers to a new or expanded facility or agency, this could affect access to existing services. Additional capacity can also obviously impact on the finances, volume (quality) and referral bases of providers other than the applicant.

c. Are there effective local health planning models the Department should consider?

There is no universal model that can or should work in every region or community of the state. Some areas of the state have initiated planning processes that work in their particular communities. NYAHSA would encourage DOH to use the recently released *Local Health Planning Initiatives* RGA to fund demonstrations of a variety of different approaches, and to 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.

3. Migration of Services

a. Due to technological advances, surgical procedures and complex diagnostic services are increasingly migrating from inpatient to ambulatory settings. How should the CON process respond?

NYAHSA argues that the playing field should be leveled one way or the other for these services. The bifurcated current approach is leading to service volume generation and dispersion, and creating a competitive disadvantage for regulated institutional providers, which are for the most part required to serve anyone regardless of payor and to provide a full range of services.

If it is concluded that there is a compelling public policy need to certify these services, ensure quality, manage overall capacity and promote equitable access, then these services should be subject to CON at some level, regardless of setting in which they are offered. If, on the other hand, it is believed that a free market model should be the predominant approach, then these services should be deregulated from CON across-the-board.

The CON process needs to address not only migration of services, but also the evolution of service delivery. For example, one of the state's major reform objectives is to "rightsize" acute and nursing home service capacity, while promoting more primary, home and community-based care. This cannot be done in a construct where, for example, the hospital bed need methodology is contained in one silo; the nursing home bed need

methodology represents another silo; and multiple home and community-based services are subject to CON processing moratoria or need constraints. This is an area where understanding local and regional service and utilization patterns, as well as medical advances and technological developments, is also crucial and where CON needs to have a well-defined role.

b. In addition, tertiary care facilities are increasing their market share at the expense of community hospitals. What role, if any, should the CON process play in preserving community hospitals? How should consumer preferences be weighed in this process?

Many of NYAHSA's members are located in areas served by community hospitals, and these facilities provide services to their residents/patients when acute and primary care is needed. If these hospitals were to disappear, individuals who receive long term care services would have reduced access to hospital services in their local communities, potentially adding to transfer trauma and imposing more travel and other burdens on family members and friends.

c. How can the Department encourage more collaboration among health care providers in order to achieve economies of scale, avoid duplicative services, and improve access to care and quality?

At the outset, NYAHSA does not believe that collaboration is always a reasonable and workable expectation among co-existing organizations, nor does it necessarily lead to the most desirable outcome. The system objectives should be to promote economy and efficiency, avoid duplication and improve access to high quality services. Collaboration should be seen as but one strategy to pursue these objectives.

If encouraging collaboration connotes a predominantly passive role rather than seeking to force fit incompatible providers together, then it could be an effective policy tool under certain circumstances. NYAHSA sees opportunities to encourage facilitated discussions among providers as part of the local planning function, as well as offering

incentives where appropriate for exploring collaborative efforts, such as expedited review and regulatory flexibility.

d. In order to facilitate collaboration, should the Department exercise "active supervision" in connection with CON applications as a means of avoiding antitrust concerns?

The Office of the Attorney General has considerable expertise in the realm of addressing antitrust concerns in the health care arena. Accordingly, NYAHSA does not advocate for any change in the Department's role in this area.

e. In order to encourage collaboration, should there be changes in the Department's approach to "active" vs. "passive" parent models?

This is a complicated area, and tends to be very situation-specific. Depending on the potential collaboration, either model could be argued to be a more effective enabler. NYAHSA does not see a compelling reason to advocate for any change in the Department's approach to this issue.

In a related area, NYAHSA 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. NYAHSA has been and remains a strident opponent of 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 lapses and labor strife 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.

4. CON Submission and Review Process

a. Are there ways in which the CON review process could be streamlined and to what effect?

As previously noted, the CON process can be streamlined by no longer subjecting certain applications to full CON review, such as project cost amendments, thereby obviating the need for SHRPC and PHC reviews and the associated processes and time delays. The dollar and percentage thresholds of review should be periodically re-examined for each level of CON review, with the goal of maintaining realistic standards that could further streamline the process.

NYAHSA believes 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 application review functions should also be examined to identify other potential opportunities to streamline the process, such as: (1) expediting time-consuming DOH staff reports, particularly character and competence reviews, through exception reporting and enhanced staffing resources; and (2) reviewing the respective review responsibilities of the SHRPC, the PHC and the Continuing Care Retirement Community Council to maximize the value of the external review function while minimizing duplicative functions.

b. Are there aspects of the process that are duplicative, unnecessary or provide minimal marginal benefit?

We would argue that the underlying intent of the character and competence review is important, 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 makes this process of limited benefit.

NYAHSA is also concerned about the effect of the character and competence review process on volunteerism in not-for-profit facilities and agencies. 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 disqualified from serving on the board of a facility undergoing character and competence review.

We believe that further discussions need to occur on these issues—as well as the emerging standard for competence to operate a health care facility or agency—among all of the relevant stakeholders.

c. How should the CON process weigh the financial impact of a project or service on Medicaid and other payors (and ultimately consumers and taxpayers)?

The CON process should provide a better sense of whether the project or service will redistribute existing patient volume or actually add to volume, and what the potential implications would be to payors. Although it is important to consider the financial implications of a project on the payors, these implications must not be considered in isolation of other equally important deliverables including providing sufficient access to services and ensuring quality of care. In other words, the less expensive of two projects may produce less value in terms of access and quality than the more expensive one does.

Medicaid access regulations as applied to nursing home projects should be repealed. They are a policy artifact that work against efforts to promote other sources of payment for nursing home care, and are a "solution" to a problem that does not exist; namely, Medicaid utilization levels in New York's nursing homes are significantly higher than the national average and those of most other states.

NYAHSA is concerned about the concept of instituting regional competitive reviews for certain CON applications, including those involving nursing home beds. This would be a major change from the longstanding "first in – first out" reviews of most CONs for new beds/services, construction/renovation projects and changes in ownership of existing providers. Competitive reviews could place undue emphasis on financial considerations at the expense of quality of care and quality of life, and inappropriately result in the rejection of worthwhile proposals that could enhance quality and access.

On a related front, we continue to have serious concerns about the application of a higher (i.e., 25%) equity contribution requirement to nursing home projects than the standard 10 percent contribution expected of other provider types. From a public policy perspective, we do not believe that the higher equity requirement will encourage innovative approaches to nursing home renovation and replacement. To the contrary, expecting sponsors to: (1) develop smaller facilities (which costs more on a per bed basis); (2) improve quality of care through building design (which can be more costly); and (3) expand other levels of care (which requires upfront investments) is fundamentally inconsistent with imposing substantially higher equity requirements.

Furthermore, those nursing homes arguably most in need of renovation or replacement tend to have the least amount of funds in reserve to undertake such projects. Facilities with outdated physical plants that are unable to raise the substantial equity needed for renovation or replacement may gradually be forced out of existence without regard to the needs of their residents and the vital role these providers play in their local communities.

We would suggest that SHRPC and the PHC work with DOH to systematically evaluate the 25 percent equity requirement, rather than addressing it on an ad hoc basis in the context of individual projects. To put this in perspective, several months have been spent considering the new nursing home need methodology, and we believe that the equity contribution policy could have an equal if not greater effect on nursing home capacity, access, and quality of care into the future. As part of this examination, consideration should be given to actually reducing equity requirements for applications proposing cost effective capital investments (e.g., "green" construction, etc.) and innovative care delivery approaches; and for applications involving small and sole community providers, which may have the most difficulty downsizing, diversifying services and lowering their per bed project costs.

d. Should need methodologies be modified to reflect more accurately unique rural needs, increased utilization of community-based long-term care, health disparities and other similar factors?

The state should periodically re-evaluate the need for existing CON-related moratoria and/or limitations on developing additional home and community-based services capacity. Any moratorium should be revisited regularly to ensure it still represents an appropriate policy response.

In determining what the true long term care system capacity is and how many people are being served in the context of need methodologies, it is important to fully consider the full range of Medicaid funded options (e.g., nursing facility care, home care, adult day health care, managed long term care, etc.), non-Medicaid services (e.g., social day care, meals on wheels, respite, etc.) and private pay models (e.g., assisted living residence, market rate housing, retirement communities, etc.).

Conclusion

The CON process is, and can continue to be, a major implement in the development of a policy framework for health care and long term care service delivery in

New York State. Our state, like most of the country, has struggled to meet the growing and changing need for services in the face of resource constraints and growing complexity.

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 NYAHSA's 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 again for the opportunity to speak before you today. NYAHSA and its members stand ready to assist in any way necessary as you work through the process, and look forward to working with SHRPC, the PHC, DOH and other stakeholders to confront the challenge of reforming the state's CON program.