

**Trends and Changes in the New York State Health Care System:  
Implications for the Certificate of Need (CON) Process**

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## Introduction

During 2012, the New York State Department of Health and the Public Health and Health Planning Council (PHHPC) engaged in an extensive yearlong process to review and update the state's certificate of need (CON) process, one of the most important and visible regulatory tools available to New York State to control capital expenditures by hospitals, nursing homes, home health agencies, and other organized providers of health care services. That process, led by the PHHPC's Planning Committee, was organized in two broad phases:

- Phase 1 (January through May 2012), during which the committee revised existing certificate of need (CON) regulations and processes, focusing on opportunities for administrative simplification; and
- Phase 2 (June to December 2012), during which the committee conducted a more fundamental review of the CON process, its historical role and purpose, and its potential future role in the context of changes occurring in the health care system and in methods for organizing, delivering, and paying for health care.

Phase 1 resulted in a series of specific recommendations for administrative simplification, which were delivered to the PHHPC in May 2012 and adopted in June.

Phase 2 is currently in progress. Committee recommendations are targeted for delivery to the PHHPC by year-end.

To inform the Phase 2 process, the State Department of Health asked the United Hospital Fund (UHF) to prepare a summary presentation for the Planning Committee, highlighting some of the major trends and changes taking place in the delivery and financing of health services in New York State, identifying some of their implications for the CON process.

This paper summarizes the content of a presentation delivered to the Planning Committee at a special meeting held on July 25, 2012, in Latham, New York.

## Methodology

In preparing this report, UHF staff reviewed the literature related to changes underway in New York State and across the nation, including work done by UHF during 2011 and 2012 profiling innovations underway in New York State. In addition, UHF staff conducted structured interviews with a series of experts from across the state: providers, major payers, consultants, and staff from the New York State Department of Health. Those content experts were extraordinarily generous with their time and insights, in providing background for this paper. The roster of individuals interviewed and a copy of the interview tool are appended to this report as Exhibits 1 and 2.

## Charge, Scope, and Focus

The United Hospital Fund was charged by the New York State Department of Health to prepare a presentation and report that covered five areas:

- the major trends and forces affecting the New York State health care delivery system;
- scenarios or potential futures for the evolution of the state's health care delivery system over the next 5 to 10 years;
- some issues and concerns that are likely to face the Department of Health and the PHHPC in those potential scenarios;

- some implications of those changes for the role and purpose of the CON process; and
- implications of those changes for some of the other regulatory and planning tools available to the state to influence, guide, and help shape that changing delivery system and payment system, in the interests of the people of New York State.

## **Organization of This Report**

This report is organized in six parts:

- the vision, or where we are and what we are trying to achieve;
- four game-changers;
- trends and forces in health care delivery and payment systems in New York State;
- scenarios and implications for the future;
- reflections on the CON process as a supply-side intervention; and
- assessment of CON's changing role and the State's other regulatory tools.

## I. The Vision

There is general agreement that New York's health care system is currently performing sub-optimally. It provides health care services with unacceptable variations in quality and safety; there are substantial disparities among populations in care access and outcomes; and it generates unacceptably high levels of utilization and cost.

Within the delivery system, providers tend to operate in silos, disconnected from each other; as a result, the care of patients who use different providers and types of care is not effectively coordinated. Neither patients nor providers are satisfied with their current experiences of care.

There is also general agreement on what sort of system would be better. The vision for the future is of a high-performing health care system, an integrated delivery system in which

- each of the component parts (primary and specialty care, emergency and inpatient acute care, and post-acute and rehabilitative services) provides patient centered care of high quality;
- care is well coordinated across providers and levels of care; and
- the costs of that care are more affordable for patients, purchasers, and the government.

Summarized by the Institute for Healthcare Improvement's Triple Aim, the challenge facing health care providers and payers is

- to improve care (quality, safety, effectiveness, and the experience of care);
- to improve the health of both people and populations (particularly those at high risk, and those with historical disparities in care outcomes); and
- to restrain or reduce costs.

As discussed below, a series of trends and forces that are now in play that, together with a number of innovations in the delivery and financing of care, have the potential to move the health care system substantially towards this set of interrelated goals.

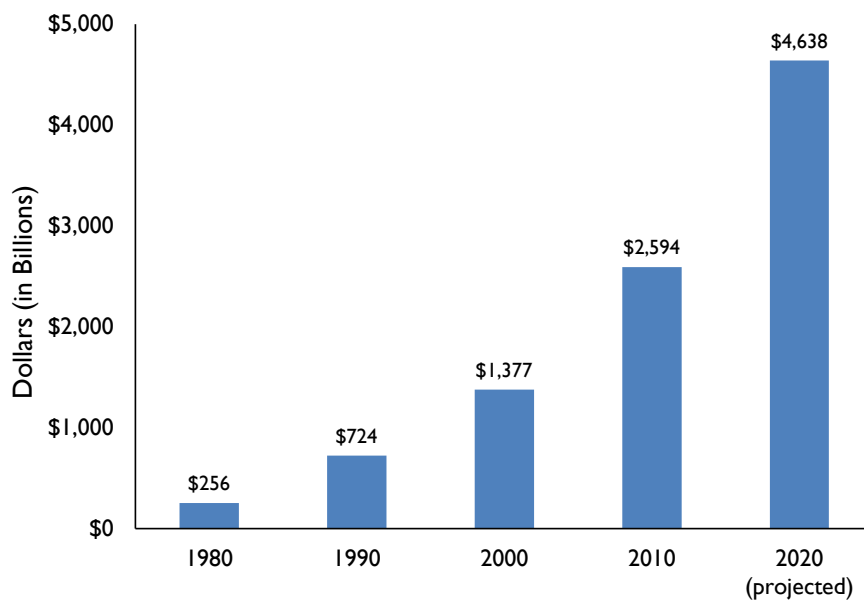
## II. Game-Changers

Before discussing sector-specific trends and changes, it is worth considering some forces that are dramatically changing the environment in which health care is delivered and paid for. Presented below is a discussion of four such game-changers: costs, population health, patient engagement, and health information technology.

### Costs

The costs of health care services and health insurance are increasingly unaffordable. Presented in figure 1 is a projection of health care cost increases over the next 10 years, based on recent trends and rates of cost increase. It is clear from this depiction and many others like it that the rate of increase in health care costs is dramatic and unsustainable, and that — left unchecked — health care cost increases will crowd out many other high-priority public goods and services.

Figure 1. **U.S. National Health Expenditures, 1980-2020**

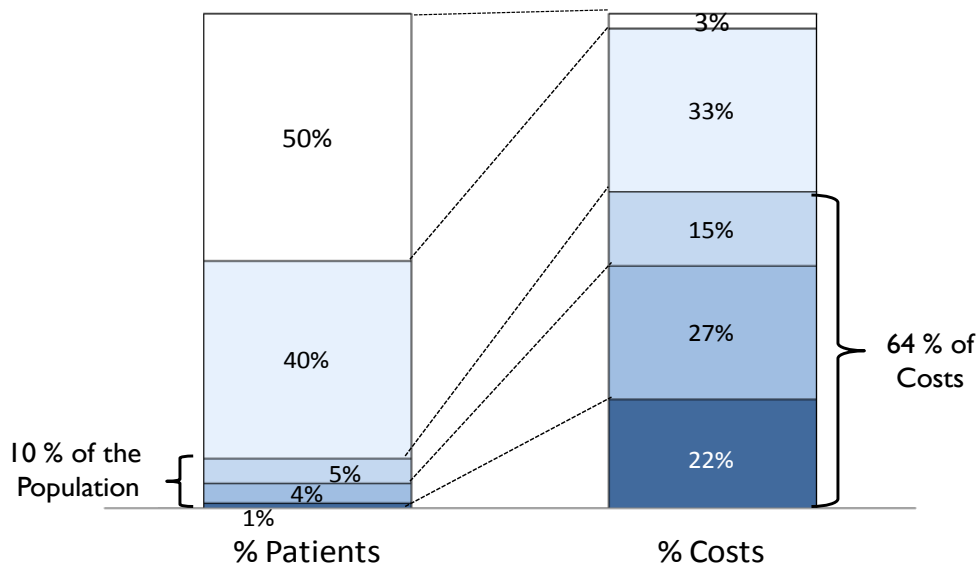


Source: United Hospital Fund analysis of CMS national health expenditure data.

Several components of this overall cost increase are gaining increased attention. One of the most important is the concentration of health care spending in comparatively small cohorts of high-cost patients. Figure 2, drawn from a recent study by the Agency for Healthcare Research and Quality, describes that phenomenon: health care costs are concentrated in very small populations: 1 percent of the population accounts for 20 percent of total health care spending, 5 percent accounts for over half of health care spending, and 10 percent accounts for nearly two-thirds of health care spending.

As pressure mounts to find ways to meaningfully reduce health care costs in the near term, this cohort of high-cost patients is getting increasing attention from providers and payers alike.

**Figure 2. Small Populations Account for a Disproportionate Share of Health Care Costs**



Cohen S and WYu. January 2012. *The Concentration and Persistence in the Level of Health Expenditures over Time: Estimates for the U.S. Population, 2008–2009. Statistical Brief #354.* Agency for Healthcare Research and Quality, Rockville, MD. [http://www.meps.ahrq.gov/mepsweb/data\\_files/publications/st354/stat354.shtml](http://www.meps.ahrq.gov/mepsweb/data_files/publications/st354/stat354.shtml)

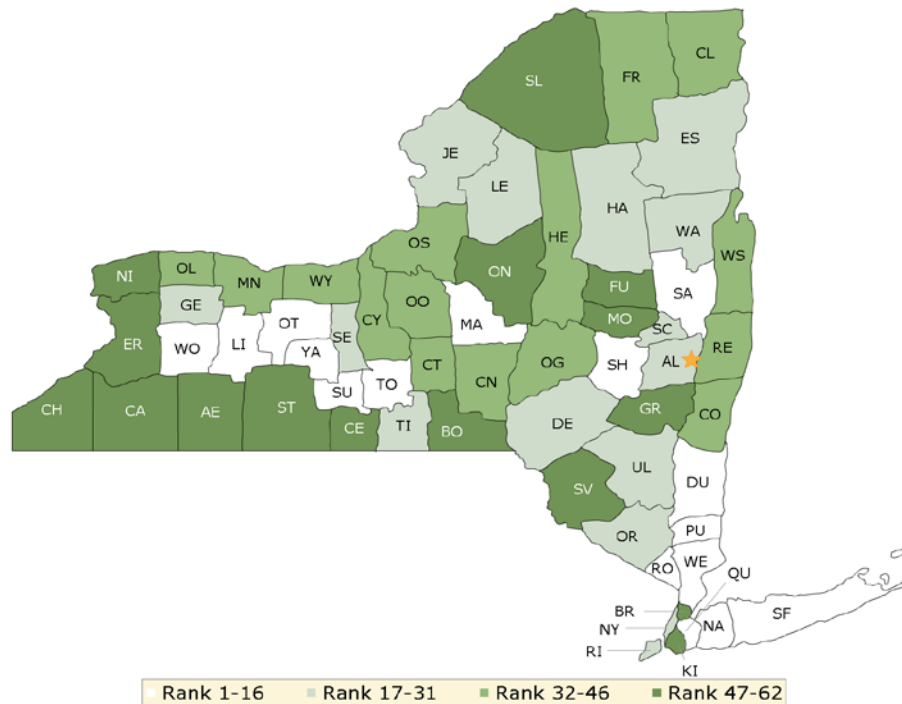
Another focus for controlling health care costs is “potentially preventable” utilization. It has been argued that many visits to emergency departments, many hospital admissions and readmissions, specialty ambulatory visits, tests, and procedures could have been avoided, if appropriate care had been provided, earlier. Reducing potentially preventable events, which occur with highest frequency in historically underserved patient populations, and those with multiple chronic conditions, is a focus for quality improvement and other efforts to control utilization and cost.

### Population Health

There are a number of ways to think of population health, a term central to the Triple Aim, three of which are described below.

Traditionally, the term population health is applied in geographic or demographic terms. When one looks through such a lens (as the University of Wisconsin has done in its County Health Profiles program — see Figure 3), using a composite measure of population health, substantial variations in care quality, outcomes, and costs become apparent. Using such techniques to compare the health status, utilization and costs of care of different geographic and demographic cohorts can help sharpen the focus on specific problems and disparities, on specific geographic areas and/or demographic cohorts, and help guide interventions that respond to them.

Figure 3. New York State County Health Rankings, 2012 Health Outcomes



Source: [www.countyhealthrankings.org](http://www.countyhealthrankings.org)

Another way to look at population health is to segment a population in terms of health status, patterns of disease, utilization, and costs of care. In the simplest model, one can consider the health care market as being made up of three broad segments of people: the well, the acutely ill, and the chronically ill.

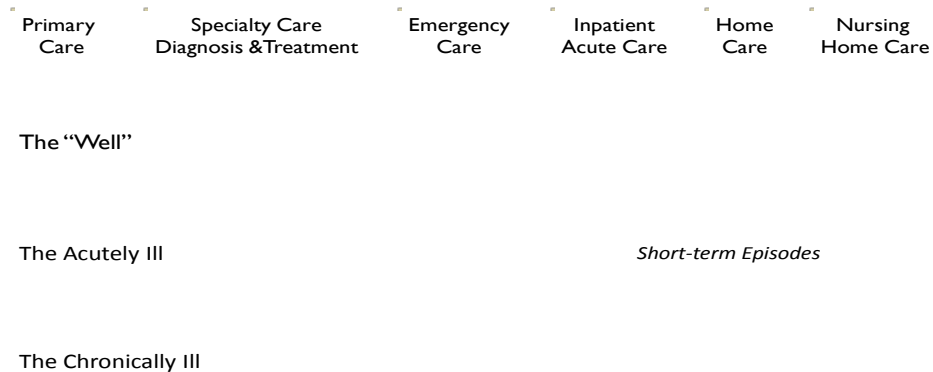
As illustrated in Figure 4, these three population segments have different needs and require different interventions from the health care system; they use the delivery system quite differently, and generate vastly different levels of utilization and costs.

With improved techniques for predictive modeling and risk-stratification, providers can now identify specific patient populations – such as those with multiple chronic diseases – who require particular attention, and they can “tailor” services to better anticipate and meet their needs.

This targeting can greatly improve the effectiveness of the care delivery system; but it also adds to the complexity of organizing and delivering health care services, since programs and interventions designed to address the needs of one sub-population may not address those of another.



Figure 4. Population Health: Utilization by Health Status



A third way of looking at populations and population health is by insurance segment: which major payers are responsible for paying for the care of which specific populations of members or enrollees. This is a critical perspective, since payment methods and incentives influence provider behavior, and differences among payers in the nature of the patient populations they cover — their members’ specific health care needs, cohorts who represent their high-cost patients — influence their design of payment systems and incentives.

Different payers have different problems, “pain-points” and priorities, and their payment methods and incentives differ, accordingly. This adds a layer of complexity to delivery system operations, since providers must be able to accommodate to those often-differing payment methods and incentives.

To appreciate these differences, consider the three major insurance lines of business: those insured by Medicaid, those insured by Medicare, and those with employer-based, commercial insurance. These three populations differ in many ways; and different proportions of their enrollees fall into the utilization segments (well, acutely-ill and chronically-ill) noted above.

Those covered by Medicaid are by definition poor; but within the Medicaid population there are different subpopulations: comparatively healthy, low-cost young families and children; a complex population with one or more chronic medical conditions, often combined with behavioral health and developmental problems, a group that includes many high-cost patients; and those receiving long-term care in the community or in institutions. Medicaid is the primary — essentially the only — payer covering community-based and institutional long-term care. Medicaid’s highest cost patients include those in the long-term care system, and those with multiple chronic illnesses, particularly those with co-occurring behavioral health problems.

Those covered by Medicare are elderly, disabled, or both. Again, there are distinct subpopulations — younger recipients who are comparatively healthy; older recipients, many of whom have multiple chronic illnesses and, often, behavioral health problems; and the disabled, such as those with end-stage renal disease, who require substantial care for their chronic illnesses

and disabilities. While end-of-life care is not unique to Medicare, it is much more prevalent as a driver of high-cost care in Medicare than elsewhere.

Those covered by commercial (generally employer-based) insurance are quite different. Most are younger, working-age individuals and their families. This population has a number of advantages relative to what have been termed the social determinants of health: they have higher levels of education, income, housing, and nutrition. They tend to be a healthier population, with lower utilization rates of and costs for chronic illness and virtually no costs for long-term care. While aging and an increasing prevalence of chronic diseases is an issue for this group, most of the high-cost cases in the commercially insured population arise from acute and catastrophic illnesses, episodes, and events, such as neonatal intensive care, cancer care, or trauma.

Providers and payers are becoming much more sophisticated in market segmentation — learning how to assess the characteristics and needs of specific populations, and how to craft programs that respond to those needs in a more targeted manner. What they need are delivery systems that can tailor their services to address those needs.

## **Patient Engagement**

Another new term in the health policy vocabulary, “patient engagement,” has a number of definitions that differ in important ways.

The patient experience of care is being measured using increasingly sophisticated tools to gauge patient satisfaction with the care process, and that information is being used in a number of ways. Providers’ patient satisfaction scores are being used by payers such as Medicare to drive payments under value-based purchasing payment systems. Providers are paying more attention to these measures, and are working to understand better what drives patient satisfaction and to increase their patient satisfaction scores, both to respond to financial incentives and to increase the loyalty of their patient populations in an increasingly competitive environment.

A second dimension of patient engagement is focused on providing patients with the skills needed for them to be effective partners in the care process. Under the patient-centered medical home model, specific emphasis is made on working with patients — educating, involving, and empowering them and their caregivers to take on expanded roles in managing their own chronic diseases. Improved patient engagement is critical in the management of chronic diseases, since adhering to therapy and adopting needed changes in diet, exercise, and lifestyle — difficult things to change, because they are often culturally-based — can determine whether a chronic disease remains under control or generates potentially preventable utilization.

Increased patient engagement is also central to a new strategy, to enable patients to act as educated consumers of health care services. As discussed further below, payers and employers are using a variety of economic levers (copayments, high-deductible health insurance plans coupled with health savings accounts, and consumer-directed health plans) to increase the involvement of patients in decisions about their own health care utilization and costs. These techniques give patients economic incentives to choose the right and most cost-effective health plans, providers, and treatments.

Efforts such as the American Board of Internal Medicine (ABIM) Foundation’s Choosing Wisely program are intended to encourage consumers to discuss treatment choices with their physicians in order to help change their expectations and dampen demand for specific services (e.g., overuse of antibiotics, high-technology imaging, and diagnostic and treatment procedures) for which

there is no compelling evidence base. The intent of this initiative is to correct for the propensity of insured populations to seek more and newer treatments by giving them better information, involving them in decision-making and increasing their exposure to the economic consequences of those choices.

## **Health Information Technology**

Finally, the enormous expansion and diffusion of health information technology (HIT) over the past five years has fundamentally transformed health care's delivery and payment systems.

Use of electronic medical records and other “on-line” health information technology to assist in the delivery of patient care has had an enormous impact on the quality and safety of care, the application of evidence-based medicine, and the cost-effectiveness of care. Electronic medical records with electronic prescribing capacities, which include evidence-based prompts and alerts, have helped reduce medical errors and some of the variations in practice that can drive poor outcomes.

The ability to transfer clinical information between providers of care (from primary care physicians to specialists, between and among treating physicians, and between emergency departments and primary care physicians) has greatly increased the coordination of services between providers, improving quality and safety, as well as enhancing the patient experience of care during care transitions.

Similarly, the development of methods for patients to communicate with their physicians via email and web portals, have electronic visits, be monitored remotely via telemedicine, and access their own medical information have all greatly increased patients' access to their physicians, their ability to be active partners in their own care, and to receive active care management and ongoing support.

The “off-line” uses of health information technology have had an equally transformational impact on both delivery and payment systems. Using new tools to mine electronic medical record and claims databases, providers and payers are increasingly able to measure, track, report, analyze, and compare provider performance to benchmarks, using standardized measures of quality and safety, patient experience, utilization, and costs.

Two other recent breakthroughs have added to the utility of HIT: the capacity to attribute patients to specific providers and networks of providers, and an increased ability to access and use evidence-based guidelines and benchmarks as comparators. These capabilities are being used by providers to target their performance improvement efforts, by identifying variations in practice and focusing their quality improvement efforts in specific areas.

These capacities underpin pay-for-performance payment systems. Payers can now attribute care processes, outcomes, utilization and costs to specific providers, and compare those providers' performance against peers and benchmarks. This enables payers to identify “high-performing” providers in terms of quality, patient satisfaction, utilization, and cost, and — using a number of different techniques — to reward them for that performance.

Those two capacities — the ability to establish accountability for the care of patients and patient populations, and the ability to measure and compare provider performance to standards and benchmarks— are the foundation for many of the payment and care delivery innovations discussed in the sections that follow.

### III. Current Trends and Forces in New York’s Health Care Delivery and Payment Systems

One of the major underlying problems in the health care delivery system is that the prevalent fee-for-service (FFS) payment system encourages providers to generate volume; rewards high technology, specialty care, and interventions far more than prevention and primary care; and neither rewards nor punishes providers for the quality of services they provide.

Any effort to effect real health system change — to achieve and sustain a higher level of performance by the health care delivery system — requires alignment between two different sets of actors: providers need to change what they do and how they do it, and payers need to change what they cover and how they pay for it. This is a threshold issue in health care reform.

As it has become possible to measure, report, analyze, and compare the performance of providers, physicians, and hospitals, the transparency of providers has increased greatly; they are increasingly being held accountable for the care they provide. At the same time, payers, purchasers, and the government are recognizing the need to move away from fee-for-service, value-neutral payment systems toward value-based payment systems that reward providers for high-quality, patient-centered, cost-effective care.

These two linked phenomena are foundational to the changes occurring in the state’s health care delivery and payment systems, themes that recur throughout the sections that follow.

#### Payment System Changes

##### The Performance Imperative

To succeed in the future, payers must develop and offer products that perform substantially better, improve care quality and patient-centeredness, and — most important in the near term — restrain increases in the total costs of care and premiums.

Their efforts fall into two broad categories: those focused on the consumer or member and those focused on the provider system.

##### Consumer/Member Strategies

Payers are using two basic tools to improve quality and reduce health care spending by their members: design of the benefits and covered services, and financial incentives to increase their members’ involvement in decisions relative to their use of services and provider systems.

In terms of benefit design, payers are investing in a variety of approaches to improving population health management, and reducing utilization and costs. They are, for example, increasingly covering routine prevention and wellness services with reduced or no copayments, to encourage members to maintain their own health, and — over the long term — to reduce potentially preventable utilization and costs.

Over the past decade, many payers have also built programs that focus on disease management, and on managing the care of high-risk members. These efforts are often coupled with programs of patient education and self-management training for those with chronic conditions. Payers are continuing to support such programs, but are now moving to locate those services closer to the point of care. This shift involves either paying for and embedding care managers in provider sites, or purchasing those services from providers.

Payers are also using a number of techniques to more effectively involve members in decisions about service utilization or in the selection of high-quality, cost-effective providers. An example of the first approach can be seen in the increasing prevalence of defined-contribution health plans, high-deductible plans, and plans with substantial copayments, which are intended to increase their members' sensitivity to the costs of care and have the potential to reduce their demand for discretionary services and treatments.

These economic incentives are amplified by efforts like the ABIM Foundation's Choosing Wisely initiative, now being expanded through a partnership with *Consumer Reports*, to educate consumers about common but possibly unnecessary tests and procedures. The intent of these efforts is to encourage members to discuss with their physicians the need for specific services (e.g., routine EKGs) for which there is not a strong evidence base. These are all part of an effort to increase members' awareness and involvement in such decisions, at the point of sale.

Examples of the second approach — encouraging members to select high-quality, cost-effective providers — include payers offering their members plans based on tiered networks, more limited networks of providers that the payer has identified as high-performing in terms of quality, patient satisfaction, and cost. Payers are offering members substantial premium discounts, up to \$600 or more per year, if they select a high-performing provider network. This has the potential to drive more members to enroll in and use such networks.

### Provider-Oriented Strategies

Payers are using a number of different approaches with providers to improve quality and patient satisfaction while reducing the total costs of care.

The major trend in this area is a clear movement on the part of most payers away from fee-for-service to payment systems that are value-based. The most prevalent approaches are pay-for-performance arrangements, in which providers receive incentive payments if they can demonstrate that they are providing care in keeping with specific process guidelines (e.g., foot care or retinal screening for diabetics) or achieving specific clinical outcome measures (e.g., blood pressure control or levels of hemoglobin A1c).

The broadest application of this approach can be seen in the Medicare program, which is using a variety of innovative payment methods (e.g., increasing payments for primary care and medical homes; bundling of hospital and physician payments, the Shared Savings program) to improve quality and reduce costs. Starting this year, hospitals are being financially rewarded (or punished) under the Value-Based Purchasing system, based on their achievement of specific targets in quality and patient experience. Medicare is using a slightly different approach to reduce readmissions: it is using a disincentive, reducing payments to hospitals whose rates of readmissions for specific conditions exceed regional and national norms.

Payers are also changing the way they pay for promising innovations in health care delivery, like the patient-centered medical home, chronic care management, and the integration of mental health services into primary care. In such initiatives, providers who offer specific new services — including expanded access, quality improvement and reporting programs, care management, and programs to enhance patient education and self-management skills for those with chronic conditions — receive augmented payments to help cover their increased costs.

## Provider System Changes

### The Performance Imperative

The imperative for providers is to improve their performance in the quality, safety, and patient-centeredness of the care they provide, and to increase patients' and families' satisfaction with their care. And, perhaps most important in the near term, they must reduce the costs of care.

Significantly, the performance imperative for providers also includes a new challenge to a historically balkanized health system: they need to improve the health of not just the patients they see, but the populations they serve; to improve coordination of care between and among different providers; and to reduce the total costs of care. These are imperatives that require providers who have traditionally operated in silos to work together more effectively as a system.

### Individual Provider Initiatives

Providers across New York State are focused on improving the quality and safety of the care they provide. Physicians and hospitals are using EMR systems that include prompts and alerts that anticipate potential problems, enabling physicians avoid common medical and prescribing errors, using new tools like electronic prescribing. Physicians in practice are using EMRs equipped with registries to help them manage the care of patients with chronic conditions, including systems that use evidence-based protocols to help them to identify and close gaps in recommended care. Hospitals are investing in quality improvement (QI) programs and working in QI collaboratives — such as those sponsored by organizations like the Hospital Association of New York State, the Greater New York Hospital Association, and the United Hospital Fund — focused on reducing rates of hospital-acquired infections, improving care for patients with sepsis and other conditions, and improving the safety of surgical procedures and hospital-to-home care transitions.

As hospitals experience continuing pressure on operating revenues, improving operational efficiency will be critical. Hospitals are also using joint purchasing and new systems such as just-in-time inventory control and improved supply chain management to reduce their supply costs; new techniques, such as LEAN and Six Sigma, to improve quality and operational efficiency and to reduce unit costs; and they are using improved care management pathways to reduce lengths of stay.

Finally, hospitals and physicians are paying close attention to their measures of patient satisfaction, implementing programs and operational changes focused on improving the patient experience of care. Such efforts are of increasing importance, as pay-for-performance programs and efforts such as Medicare's Value-Based Purchasing program begin to tie revenues to their scores on those measures.

### Improving Care Coordination

Providers are also focusing on improving the coordination of care for patients undergoing care transitions: those being referred from primary care to specialists, patients discharged from hospitals, and patients with multiple chronic conditions cared for by multiple providers.

Miscommunication and discontinuities in care transitions can lead to potentially dangerous errors in medications and treatment, and to preventable hospital readmissions. Poor communication between providers can also lead to duplication of tests and procedures and to increased cost. The development of regional data exchanges across New York State has the potential to greatly

enhance the ability of treating clinicians to share patient information at the point of care, which can make a real difference in avoiding errors, and reducing duplication of costly tests and procedures.

### **New Models of Care**

A range of new care models are currently being adopted across New York State; many with the potential to substantially improve quality and patient experience and to reduce costs of care. Three such efforts are discussed below.

Across the state, primary care providers have been adopting a new care model, the patient-centered medical home (PCMH), which transforms a primary care practice in a number of ways: improving patient access to care, implementing structured processes for ongoing collection and reporting of quality measures, improving coordination of care, and providing care management, patient education, and support as needed. The PCMH model improves care for all of the patients in a practice, but its greatest value is for those with chronic diseases.

New York leads the nation in the adoption of this approach; over 5,000 primary care providers in New York — nearly a quarter of all primary care providers in the state — currently work in practices that have been recognized by the National Committee for Quality Assurance as PCMHs. The willingness of payers to change the way they pay for primary care services to support the PCMH's infrastructure and added costs has been critical to the development of this model of care in New York, and it will be critical to its sustainability, in the future.

New York State has also stimulated the creation of a statewide system of health homes. Health care and mental health care providers have organized themselves into regional health home networks (many including social service and housing providers) to provide greatly enhanced care management and care to the Medicaid program's most complex and costly patients.

Physical and mental health care have traditionally operated as separate systems, which has resulted in sub-optimal care for patients with co-occurring health and mental health conditions, who are among the most costly. In recent years, providers in the state have undertaken a series of initiatives to better integrate the two service sectors, either by providing health care services at sites specializing in the care of the seriously mentally ill, or by integrating mental health for conditions like depression and anxiety into primary care settings.

In each of these examples, providers have begun to offer types or intensities of services not covered by current reimbursement systems, using models that have been shown to reduce preventable utilization and costs. In doing so, providers are adding often substantial operating costs for services, such as care management, for which there is often no additional payment.

The Medicaid program has taken the lead in each of these areas, and other payers have begun to recognize and pay for these services; but such efforts are currently limited to pilot and demonstration projects. For these promising initiatives to be more broadly adopted and sustained, they will need to receive more consistent and broad-based support from a larger proportion of the state's payers.

### **New Perspectives, New Tools, New Skills**

Providers tend to experience the health system vertically, within their own silos; patients, on the other hand, experience the health system horizontally, as their care involves different providers in different settings. Aligning the two perspectives is one of the core challenges of health reform.



It requires that providers shift their frame of reference to encompass that of an insurer, and ultimately to that of the patients for whom they care.

The health care delivery system of the future will be an integrated delivery system centered on ambulatory care, in which populations of patients receive high-quality, cost-effective, and comprehensive care from organized groups of physicians who are capable of providing or managing all of their care needs, either directly or through relationships with hospitals and other providers. This requires new capabilities and new skills, and new partnerships between and among providers.

Physician offices — the likely center of the new delivery system — require a range of new capabilities and skills: they need functional EMR systems that can support the new team-based care processes of the PCMH and that can support the routine collection, reporting, and analysis of utilization and quality indicators, enabling providers to participate in pay-for-performance and other incentive programs. They need to establish and maintain registries of patients with particular chronic conditions for specific attention, systems and staff to support care management and patient education, and the ability to communicate and exchange information with patients and with other providers involved in the care of their patients. These are capacities that require resources well beyond the reach of most solo and small group practices; they require scale.

Reducing potentially preventable events also requires changes in relationships between and among providers. Reducing preventable hospital admissions, for example, requires an intervention outside the hospital — in a primary care physician's or specialist's office, where active care management anticipates impending problems and responds to them in a timely manner. Reducing potentially preventable emergency department visits depends at least in part on the timely availability of primary care. Reducing preventable hospital readmissions involves the hospital, but it also requires care management and support of the patients and their caregivers across the care transition, medication management, a timely visit to their physician in the community, and often, the involvement of other community services and agencies.

These are systemic issues that require systemic responses. Such a challenge forces providers to move beyond their historical perspective to a broader one, focused on what they can accomplish together. This shift will require new partnerships among historically independent providers.

### **New Organizational Forms**

These two related imperatives — the need for scale and the need for partnerships — are driving major changes in the structure and function of the delivery system in New York State.

One obvious phenomenon is the grouping of physicians: primary care physicians are forming or joining groups, single-specialty and multi-specialty group practices are forming and growing rapidly, and physicians are banding together to form or join independent practice associations (IPAs). These are examples of horizontal integration, aggregations of similar providers that can help them achieve scale. Physicians need scale in order to acquire and distribute as shared services a range of resources and capacities — EMRs, care management, patient education services, and the like — that small practices need but cannot afford. Grouping also enables participating physicians to negotiate more effectively with payers around rates and participate in various pay-for-performance efforts.

Such organized structures benefit from scale, spreading overhead costs across a larger practice base and positioning the group to acquire and deploy health information technology across the



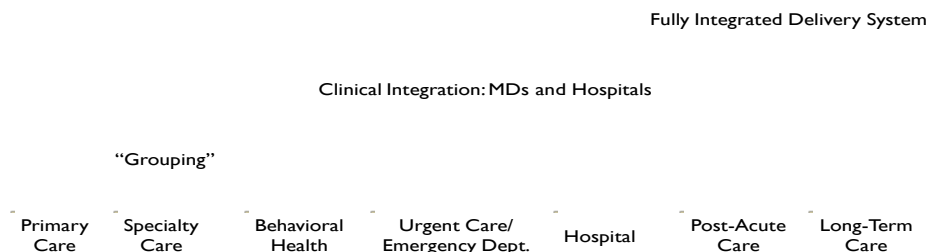
practice sites. Groups with scale have the capacity to support organized quality improvement programs, staff development, and performance improvement processes, and they can employ systems to collect, analyze, and compare data on their providers' performance compared to that of their peers and to external benchmarks using evidence-based measures of quality and performance.

A second example of horizontal integration is the trend toward consolidation of the state's hospital base. As some of the state's larger hospitals/systems have grown stronger, many others have become much weaker. In some cases, struggling hospitals have closed; more often, however, they have partnered with stronger neighbors through acquisition or merger to create larger hospital systems. Hospitals and physician groups along the state's border areas are also beginning to partner with providers and systems in other states, creating new systems that span state boundaries.

A third major trend is the move toward vertical integration - partnering between different types of providers or levels of care. Across the state, there has been a sharp recent increase in the employment of physicians by hospitals. Hospitals are seeking to improve clinical integration with admitting physicians, in order to improve care processes within the hospital and to improve care transitions as patients are admitted to or discharged from the hospital. Physician groups and IPAs are partnering with hospitals in their service areas to improve care, increase their bargaining power with payers, and better position themselves for accountable care ventures. Hospitals are partnering with nursing homes and home health agencies to improve the quality and safety of transitions following acute care. Hospitals are partnering with providers of community-based service providers and housing agencies to help support patients for whom they care in the communities.

These organizational trends are depicted in Figure 5, below.

**Figure 5. Integrating the Delivery System**



The organization of the health care system is changing from its historical composition — separate free-standing hospitals, independently practicing community-based physicians, and separately organized nursing homes and home health agencies — toward much larger aggregations of physicians, hospitals, and hybrid organizations, all moving toward organized health systems.

## Provider-Payer Relationships

Over the last few years, as providers begun to grapple with such issues as population health and total costs of care (historically the realm of insurers), relationships between providers and payers have begun to change. The most widely publicized and potentially far-reaching of those changes has been the phenomenon of providers accepting risk-based payments through vehicles such as accountable care organizations, but there have been other changes in those relationships as well. These changes signal a shift in the historical role and business model of the payers, and an increasing interest by payers and provider groups in partnering with each other.

### Risk Transfer

Over the past 20 years, there have been a number of changes in the basic model for providing health insurance and in the role of the health plans. Among the most important are changes in where the insurance risk is housed. Three basic models are shown in Figure 6.

- In the traditional model, health plans offer health insurance products to employers and purchasers, with the insurance risk (exposure to higher- or lower-than-expected utilization and costs vs. the actuarially determined premium) held by the health plan.
- With the passage of the federal ERISA legislation, another model emerged in which the insurance risk is held by self-insured employers, with the plans hired to serve as third-party administrators (TPAs) providing a range of administrative services (e.g., network management, claims processing, and various analytics) for an employer’s health insurance product.
- In the third model, either the purchaser or the health plan contracts with a provider group that has agreed to accept responsibility for providing some or all of the care required by the population covered by the contract. Under such risk-transfer arrangements, the purchaser/payer transfers some or all of the premium and insurance risk to a provider group, which — depending on the arrangement — accepts varying levels of risk against that fixed budget.

Figure 6. Insurance/Payment System Changes: Who Holds the Risk?

	Traditional Model	Self-Insured Model	“Risk-Transfer” Model
Purchaser	Purchaser buys insurance for members	Self-insured purchasers retain insurance risk	Self-insured purchasers (or insurers) delegate risk to providers
Insurer	Insurer/Payer holds risk		
Payer	Insurer/Payer pays providers	Purchaser contracts with payer and/or third-party administrator	Purchaser contracts with payer and/or third-party administrator
Provider/System	Providers paid for services rendered	Providers paid for services rendered	Providers take risk, via shared savings and/or capitation

While most people think of health insurance — including Medicare and Medicaid — in terms of the traditional model, dramatic changes are occurring across this landscape.

The first is the penetration of self-insured plans, in which the plans provide administrative services only (ASO) to purchasers, assuming none of the insurance risk. Based on estimates by the New York State Department of Health, over 40 percent of the employer-based insurance in New York State is now offered under the self-insured model. Such arrangements are not under the direct control or oversight of the Department of Financial Services, which regulates health insurance in the state.

The second change is the increasing willingness by providers and provider groups to assume varying types and levels of insurance risk from plans and purchasers. Such arrangements, which are the basis for the Medicare Accountable Care Organization (ACO) program, carry different levels and types of financial exposure for the provider group, including:

- One-sided risk, in which the provider group shares with the payer in any savings generated but has no downside risk for over-expenditures vs. the pre-established budget;
- Two-sided risk, in which the provider group can increase the share of the savings that it can earn, but is also exposed to the risk of over-expenditures vs. target;
- Partial capitation plus shared savings, in which providers (e.g., primary care physicians) receive risk-adjusted capitation payments intended to cover their costs of caring for a given population, often with a pay-for-performance incentive, and they have an opportunity to share in whatever savings they can generate in that population's total costs of care, vs. the established target; and
- Full-risk capitation (or global capitation/payments), in which the provider group receives a portion of the premium and is able to retain any savings generated, but also accepts responsibility for absorbing any over-expenditures.

The first two models generally use some variant of the fee-for-service payment system to pay participating providers (physicians, hospitals, and other providers) with the shared savings calculated and distributed on a periodic basis (often following the close of the contract year). Under the full-risk model, the provider group receives aggregate, population-based payments from the payer, and can pay its participating providers in any manner it chooses. Partial capitation is a hybrid model in which providers (in this example, primary care physicians) receive payments under a population-based system, but with their shared savings calculated retrospectively, in a manner similar to the first two models.

### Accountable Care

There has been substantial movement in recent years on the part of the state's providers and payers to create accountable care relationships. An accountable care arrangement is a contract between a payer and an organized group of providers under which the provider group agrees to accept responsibility for providing or arranging all services covered under the payer's contract required by a given population, and to held be accountable for their quality of care, utilization, and costs of care. The theory behind accountable care is that organized groups of providers are best positioned to effect changes in health care quality, utilization, and cost for populations they care for; and that they are more likely to generate those savings if they are given an incentive to do so by sharing in the savings they generate.

The best-known accountable care program is Medicare’s ACO demonstration, which was included as a provision in the Affordable Care Act. That program was initiated in late 2011, with the selection of the first 32 Pioneer ACOs, followed in 2012 by the selection of 116 participants in the Medicare ACO Shared Savings program. In New York, 15 provider groups across the state (see Figure 7) have been selected to date to participate in Medicare’s ACO program.

Figure 7. Medicare ACOs in New York State

	Location
<b>Medicare Pioneer ACOs (1 in New York of 32 nationwide)</b>	
Bronx Accountable Healthcare Network (BAHN)	Bronx, Westchester
<b>Shared Savings ACOs, Round 1 (5 in New York of 27 nationwide)</b>	
Accountable Care Coalition of Mount Kisco, LLC	Westchester
Crystal Run Healthcare ACO, LLC	Middletown
Accountable Care Coalition of the North Country, LLC	Canton
Chinese Community Accountable Care Organization	New York City
Catholic Medical Partners	Buffalo
<b>Shared Savings ACOs, Round 2 (9 in New York of 89 nationwide)</b>	
Accountable Care Coalition of Syracuse, LLC	Syracuse
WESTMED Medical Group, PC	Westchester
ProHEALTH Accountable Care Medical Group, PLLC	Nassau
Mount Sinai Care, LLC	New York City
Balance Accountable Care Network/Independent Physicians ACO	New York City
Beacon Health Partners, LLP	Lake Success
Healthcare Provider ACO, Inc.	Garden City
Asian American Accountable Care Organization	New York City
Chautauqua Region Associated Medical Partners, LLC	Jamestown

Two characteristics of this group of ACOs are particularly noteworthy:

- **Sponsorship:** Of the 15 Medicare ACOs in New York State, two-thirds are led and sponsored by physicians; physician groups or IPAs are the organizations with which CMS is contracting. Less than one-third are sponsored by systems that include hospitals or are formal partnerships between a physician group and a hospital or system.
- **Risk-sharing Model:** In the first few years of their operation, all of the Medicare ACOs in New York State will be operating on a one-sided risk basis. Providers will continue to be paid directly by Medicare using its fee-for-service payment system, but the ACOs will be eligible to share in any savings vs. the projected target expenditures, to be calculated after the close of the first full year of operations.

These two characteristics have a number of implications.

First, in most of New York’s Medicare ACOs, physicians and groups — not hospitals or systems — are in control of program implementation. This is a substantial shift in the locus of power and control away from hospitals. It is also a shift in the control of many such arrangements from an Article 28 DOH-regulated provider, to a largely unregulated sector.

Second, physician groups — whose strategy for achieving savings will likely focus on reducing preventable hospital admissions and readmissions — stand to benefit financially from reductions

in hospital use, and under the physician-controlled models they will not need to share those savings with the hospitals.

Beyond the Medicare ACO program, hospitals, systems and physician groups are increasingly partnering with private payers (e.g., Emblem, Blue Cross, Aetna, and United/Oxford) on a variety of accountable care ventures. These agreements are not all called ACOs (Cigna, for example, calls its version “Collaborative Accountable Care”), and their provisions do not have all of the same organizational, governance, or administrative requirements. Over the last year, provider groups and private payers across the state have announced the initiation of a number of these arrangements. The composition of the providers participating in these ventures is similar to the Medicare program experience; some have been with hospitals and systems, but most have involved physician groups.

### **Provider-Payer Relationships**

Accountable care strategies also illuminate the evolving nature of payer-provider relationships. As providers accept risk and responsibility for population health, utilization, and expenditures, they must develop the infrastructure and systems required to identify, track, and manage the care of those populations. This requires the ability to access, analyze, and use insurance claims data, to develop mechanisms for utilization management, member services and network management, skills previously unnecessary for providers. And it requires sophisticated systems and staff to provide care management. Providers participating in such arrangements can either build those capabilities or buy them from and an insurer, payer or third-party administrator.

A number of payers have identified this development as a business opportunity, enabling them to generate revenues from the infrastructure they already have in place. Aetna has begun to position itself to provide such back-room services to providers interested in accountable care. In New York, UnitedHealthcare/Optum and Westmed are partnering on Westmed’s Medicare ACO, and Collaborative Health Systems (a division of Universal American, a Medicare Advantage plan) is providing those services to three of the state’s Medicare ACOs.

A logical extension of these new partnerships between payers and high-performing providers is the development and marketing of co-branded products that combine health insurance with a specific provider group or delivery system. This development is already under way in New York State, with co-branded offerings being developed and marketed in Westchester County, in Buffalo (Kaleida Health System, with BlueCross BlueShield of Western New York), and on Long Island (United Healthcare and North Shore-LIJ).

### **Summary: Trends and Changes**

New York’s health care delivery system is in the midst of a period of dramatic change. As the priorities, imperatives, and incentives shift from a focus on specialty care and acute interventional care to a focus on reducing potentially preventable utilization by a large and growing population of patients with chronic conditions, it is moving from a system centered on hospitals to one centered on ambulatory care. With HIT-supported increases in public reporting, providers are becoming more accountable for the quality, experience, and costs of care.

As providers pursue scale and the infrastructure they need to accept risk and coordinate and manage care across the continuum, they are consolidating in new organizational forms, including large and increasingly capable multispecialty group practices, IPAs, hospital-physician organizations, and regional health systems.

Payment systems are also changing. Fee-for-service is being replaced by value-based payment systems that include incentives for providers to deliver higher quality, more cost-effective care. Using payment innovations such as pay-for-performance, bundling, shared savings, and a variety of other risk-transfer techniques (including accountable care models), payers are giving providers strong incentives to employ evidence-based approaches and to better manage the care of patients and populations.

Increasing support by payers for innovative models like the PCMH gives primary care practitioners incentives to transform their practice, improve access, quality, and coordination of care and improve the satisfaction of patients and their experience of care. Payers are also supporting efforts by providers (and, in some cases, by community organizations) to manage the care of the chronically ill patients who are the health system's highest-cost patients.

Payers are encouraging members to take advantage of prevention and wellness services, and they are using co-payments, and new products like high-deductible plans, to dampen demand by increasing members' sensitivity to costs. They are offering their members less expensive plans with more limited, tiered networks; encouraging members to choose wisely in selecting high-performing providers and networks; and putting in place a variety of new payment incentives and disincentives to encourage both members and providers to avoid interventions that are not evidence-based, and to reduce potentially preventable utilization and costs.

Advances in health information technology have greatly increased the capacity of providers, physician groups, and systems to monitor and improve the quality and safety of care, and to better coordinate the care of patients during care transitions.

Advances in data aggregation and the mining of clinical and claims databases have ushered in a new age of transparency in which providers, payers, and the public can assess the quality and cost-effectiveness of care delivered by individual providers, provider groups, and networks. Measures of quality, patient experience, utilization, and costs are now routinely collected, reported, analyzed, and compared with peer performance and benchmarks, identifying high- and low-performing providers.

The interactive effect of these and other similar interventions — at least in theory — will be:

- An increase in the demand for organized ambulatory care;
- A migration of enrollees and patients to high-performing providers and networks;
- An increase in the influence of capable organized physician groups (most of which operate outside Article 28 regulations), with many positioned for risk-based payment schemes;
- Reductions in the use of hospitals for potentially-preventable admissions;
- Decreases in the use of emergency departments, specialty care, and discretionary tests and procedures that are not evidence-based;
- Increased consolidation among hospitals, an increase in both employed physicians and hospital-physician partnerships, and the emergence of increasingly-strong regional health systems; and
- An increase in the number of weaker, financially challenged hospitals and safety net providers.

## IV. Scenarios and Implications

The trends and forces noted above are reasonably clear. Both providers and payers are faced with a number of challenges, particularly the need to improve quality and reduce costs. The changes under way in payment systems and in the organization and function of the delivery system would seem to be leading toward larger and more capable regional health systems (led by hospitals or by physicians and groups), able to accept more accountability, and operate under risk-based payment systems for the care of defined populations.

Precisely how these trends will play out across the state, however, is not yet clear.

New York State is an extraordinarily diverse state, made up of communities, health care delivery systems, and payers that vary greatly from one region to another. There are rural areas facing twin challenges of poverty and geographic access, which have longstanding shortages of providers; suburban communities with a much greater supply of providers in which hospitals and physician groups will need to strike a new balance; mid-sized urban areas in which mixed populations of the poor, middle class, and well-off are served by two or more competing provider networks.

And then there is New York City, a complex and diverse city in which health care has historically been dominated by large and powerful teaching hospitals and academic medical centers. A large and capable safety-net delivery system and a growing number of small, financially challenged hospitals are two other pieces of the picture.

One thing that is clear: the pace of change will depend on location. Resources, needs, and issues differ substantially among rural, suburban, and urban multi-hospital environments; and all of those will likely differ from what happens and how it happens in New York City.

The pace of change in these diverse communities will also depend on the strength of the payers' financial and performance improvement incentives, and how quickly and how well providers respond to them. In the near term, we are likely to see the continuation of a mixed model, in which the fee-for-service payment system will co-exist with new, value-based payment systems, giving providers mixed messages and incentives.

It will likely take years for payers, provider groups, and emerging systems to evolve from where they are today into mature systems and accountable care organizations capable of accepting and managing full-risk, global capitation for the care of entire populations. In the near term, most provider groups and systems pursuing accountable care are more likely to be operating under far less challenging models, such as shared savings, whose incentives are far less powerful.

In the near term, most providers will need to manage in the middle, with some of their revenues driven by incentives of a fee-for-service payment system that encourages volume, and some driven by various methods of value-based payment that reward improved quality, reduced utilization, and lower costs.

Responding to value-based payment systems calls for more than a change in technique; it requires a change in culture and deeply ingrained behaviors. The real challenge that providers face — at least during this period of transition — is figuring out how to invest time and capital to adopt new behaviors that, if successful, will reduce their own current fee-for-service revenues.

This argues that payers must successfully implement two fundamental changes. Each payer needs to move more rapidly from fee-for-service to value-based payment systems; and the

various competing payers must be able to work together to better align their incentives, measures, and payment methods, to give providers a clearer and more consistent message regarding performance expectations.

The speed and effectiveness of the transition to a higher-performing health care delivery system also depends on how well physicians can work together to create systems capable of providing effective population-based care, and how well they can work together with hospitals and with other providers to create real systems. To do so, they will need to overcome historical incentives for each provider to increase its own volume and fee-for-service revenues, and — difficult in an increasingly constrained fiscal environment — learn to collaborate, rather than compete, with each other and with hospitals.

## **Implications and Risks**

As these forces continue to play out, a few implications and challenges for New York State are becoming increasingly evident.

First, as the new, consolidated regional health care delivery systems gain strength, they have the potential to become essentially “the only game in town.” In other parts of the country, such consolidation has led to increased market power and price increases.

Conversely, as the strong get stronger and capture more market share, it appears that the system’s weak providers will continue to get weaker, increasing in both number and fragility. There is a growing potential that as demand for inpatient care declines, more hospitals will struggle, and that some, perhaps many, will close. This will cost their communities badly needed employment, and leave the state and the system to deal with issues of access, as well as concerns about publicly held capital debt for which there may be no source of repayment.

Particularly in border counties, the trend toward partnership between New York based providers and provider systems in other states poses a challenge for the reach of the state’s regulatory systems.

As physician groups and systems take on down-side risk (rather than one-sided risk arrangements like the shared savings program), there is the potential that their expenses under these arrangements will exceed their revenues, which in turn could affect their own viability.

In the current regulatory system, it is not clear which state agencies are monitoring those trends, and how and by whom those arrangements would be regulated. The state may need to confront an issue similar to one faced by the banking industry: What happens when systems deemed “too large to fail” in fact do?

In regions where two or more systems are competing, they will most likely be competing mainly for insured populations. It is unclear whether, how, and by whom those systems will be held accountable for serving the uninsured and medically complex populations, or providing other public goods.



## V. Reflections on the CON Process — A Supply-Side Intervention

The certificate of need (CON) process is based on two fundamental state responsibilities:

First, the process is intended to help protect the public's health by ensuring that licensed providers are organized and governed by boards that have adequate character and competence; that there is a limited diffusion of services (like cardiac interventional services) where there exists a strong relationship between volume and quality; that health care facilities are built and maintained, and that health care services are operated in keeping with state codes for their construction and operation; that the distribution of services is equitable and based on need; and that safety-net providers and vulnerable populations are protected.

Second, the CON process must protect the public's purse, by constraining and managing capital spending (under payment systems that include capital reimbursement based on facility-specific capital expenditures); and by managing the supply of beds, and high-tech equipment (on the theory that supply generates demand, as it has under the fee-for-service payment system).

The CON process is a supply-side intervention, focused on managing capital projects and major service changes. It is also a reactive process in which providers must first apply for CON approval for capital projects and service changes in state-licensed facilities and services. For each project, DOH staff, and eventually the PHHPC, conducts a review of four key elements: need, character/competence, financial feasibility, and code compliance.

As discussed in the previous sections, however, many of the changes under way in the state's health care delivery system and payment systems approach the problems of quality and cost from a different perspective, from the demand side. Increasingly, those incentives — loosely based on a competitive model — are designed to reduce unnecessary and potentially preventable utilization. This mismatch has caused many to question the utility and continuing relevance of the CON process, in the future.

Perceptions of the historical effectiveness of the CON process vary; its impact on quality and its ability to control both capital and operating costs have been the subject debate for decades. However, CON remains “the cop on the beat.” It has limited excessive capital expenditures and helped limit destructive competition. Nonetheless, the state continues to experience market failures, needed providers are at risk or failing, at-risk populations are experiencing poor access to care, and disparities persist in health care and outcomes.

### **CON's Role and Impact in the Future**

Assessing the need for and impact of the CON process turns on a number of basic questions, noted below:

1. Can CON help ensure that projects, expenditures, services, and facilities are needed?

In the future, particularly as providers move toward accepting risk, excess facilities and services will be seen as driving costs more than generating revenues. In such a scenario, CON would probably have a less important role. In the near term, however, as FFS-skewed payment systems wind down, and as providers continue to compete for volume, perhaps leading to unnecessary development, CON may continue to be an important tool for the state.

2. Can CON help manage the equitable distribution of services?

This is and will likely remain a real issue, particularly as demand for hospital care softens, the strong systems get stronger, and the weak systems get weaker. Future questions of distribution may not be about adding or expanding services but about reducing and closing them. This may be an issue more appropriate for regional planning.

3. Can CON help improve access and reduce disparities?

CON's effectiveness in this area is unclear. Historically, expanding health insurance coverage has been a far better tool for increasing underserved populations' access to needed services. Populations with health care insurance coverage face far fewer impediments in accessing care than those without such coverage. Expanding the supply of primary care services can also be accomplished far better and more quickly using targeted state-sponsored grants than through the CON process.

Expanding insurance coverage, changing payment systems, targeted grant programs, and greater attention to social determinants of health are all likely to be much more effective than the CON process in responding to these needs. Regional planning may also have a meaningful role, in this area.

4. Can CON help ensure adequate character and competence?

This is an important issue and concern, but when coupled with CON and the establishment process it tends to focus on the initial (rather than the ongoing) licensure of a provider of services. In other states, this function is often handled outside the CON framework, as part of the licensure process.

In the future, the State will be challenged by a number of new organizational forms, including new organizational models that are outside the current scope of Article 28; there will be an increase in the role of out-of state providers and systems partnering with New York State physicians and facilities; and there is likely to be an increase in the power and importance of physician organizations, particularly those accepting risk. These are new challenges to the historical role and reach of the CON process.

5. Can CON help to control capital costs?

Controlling excessive capital expenditures is likely to be less of an issue than it has been in the past. Access to capital has become increasingly tight for many providers in New York State, and for most payers, capital reimbursement is no longer based on institution-specific expenditures, effectively uncoupling the costs of capital projects (which are an institution's responsibility) from their payments. In addition, as demand for hospital care continues to soften, there will be less incentive for providers to overbuild.

Nonetheless, in the near term, competition for volume and market share, and for specialty services that continue to be well reimbursed under the fee-for-service system, may continue to drive unnecessary development.

The costs of capital projects undertaken by nursing homes will be a particular problem for New York State. There is a substantial pent-up demand to rebuild nursing

homes, and Medicaid (which still uses a facility-specific capital reimbursement methodology) is their major payer.

6. Can CON help ensure that institutions do not take on non-feasible projects, whose expenditures could destabilize institutions?

As capital becomes tighter and financial sustainability more of a concern, hospital management and boards — and the lenders — are likely to be more conservative in approving and making capital expenditures that are not financially feasible. In the future, the concerns of institutional management and boards, lenders and the state will likely focus more on tracking and monitoring institution-wide, than project-specific, financial viability.

7. Can CON help manage utilization and costs?

Historically, CON's presumed impact on utilization and operating costs role is based on Roemer's Law, which postulates that "a built bed is a filled bed." While that may or may not have been true under an open-ended, fee-for-service payment system, under value-based payment systems, and certainly under risk-based payment systems, the incentive to build additional capacity in order to generate additional volume (and income) vanishes. Changes in the payment system are likely to be better at controlling unnecessary utilization than the CON process.

8. Can CON help to improve quality?

Historically, CON's impact on quality has been unclear. The strongest case for CON in this area has been in controlling the supply of services — like cardiac surgery — where there is a reasonably well-established relationship between volume and quality.

Advances in HIT have made possible the public reporting and analysis of providers' quality data. This may prove to be more effective than CON, as a tool for quality improvement. With the development of the all-payer database, the state will have substantially better and more powerful tools to report, monitor, and assess providers' relative performance in terms of quality.

Similarly, payment system changes and incentives that reward providers for high-quality care, and innovations (e.g., tiered networks) that drive business to high-performing providers and systems are also likely to be much more effective than CON in stimulating and sustaining quality improvements.

9. Can CON help ensure that facility and equipment projects meet code requirements?

This has been and remains one of the core roles of the CON process, with staff from the DOH reviewing plans in advance, and then, upon project completion, inspecting facilities for code compliance. This is something that all states do; in states without active CON processes, it is handled using different mechanisms for architectural and facility review under licensure functions.

## VI. Assessment of CON's Changing Role and the State's Other Regulatory Tools

The New York State Department of Health and the PHHPC are charged to protect the health of the state's citizens, and to help shape the systems that serve them, in the public's interest. In focusing their attention and in setting priorities for action, the State DOH and PHHPC must carefully consider how best to address areas where the health care market has traditionally failed: in protecting fragile safety-net providers and the at-risk and underserved populations for whom they care, particularly those in rural areas and inner city neighborhoods.

Major changes under way in the state's health care delivery payment systems have the potential to substantially improve the performance of both providers and payers. These trends could move the state's health care delivery system toward the Triple Aim. However, that changing health system also has real risks, many of which lie outside the historical reach of the CON process.

Over the long term there are serious questions about CON's continuing relevance in this new environment. It is increasingly clear that a process focused primarily on regulating and controlling capital expenditures and service changes by hospitals, nursing homes, and other organized providers will not be as important in the future as it has been in the past.

In the near term, however, there are a number of reasons to keep the CON process in place, among them the need to protect against familiar provider behaviors carried forward (at least until they change), and to protect against the unintended consequences of decisions made by regulators, purchasers and payers, or the providers who make up the delivery system. But the CON process should focus where it can make the most difference.

There are other priorities to which New York must respond, to help shape and guide the evolution of the state's health care delivery and payment systems, and there are a number of tools available to do so. CON is only one of those tools. The challenge, at a time of limited resources, will be to find and allocate the resources required to build or strengthen those other capacities (particularly those related to data collection, analysis, and reporting) rapidly enough to keep up with the delivery system changes already under way.

### Payment Systems

Of all the tools available to the state, expanding insurance coverage and changing the payment system are probably the most important for the future. With increasing insurance coverage through the Health Insurance Exchange, steps are being taken to increase access to care; and with a refocusing of payment systems to reward value rather than volume, payers are putting in place incentives to improve its quality and cost-effectiveness.

Building on the Medicaid Redesign Team (MRT) process, New York State is implementing a range of extraordinary reforms in the Medicaid program that have the potential to significantly improve the way the delivery system serves its members. With over 5 million enrollees, the state's Medicaid program is a large and important payer in New York State, but its ability to effect change in the delivery system by itself has some limits. One of the state's core strategies is to include as many Medicaid members as possible in managed care; using managed care plans as intermediaries, however, reduces the state's ability to influence provider behavior directly.

In addition, the Medicaid program, while large, still only covers one segment of the market, and it is not of equal importance, as a payer, to all providers. It will be important, going forward, for the state to align its Medicaid strategies with those of other payers. Achieving multi-payer

alignment among Medicaid, Medicare, commercial insurance, and products offered by the new insurance exchanges, will be critical to achieving more broad and consistent support for delivery system change.

## **Insurance Regulation and Oversight**

The State faces two additional challenges in managing and influencing health insurance:

First, there is limited oversight or control by the State over self-insured plans, which represent an increasing proportion of employer-based insurance; and

Second, there is a need to develop and refine the State's tools for overseeing and managing the assumption of insurance risk by providers and groups.

## **Monitoring “At-Risk” Facilities**

As more institutions become more financially challenged, and particularly as more and different types of organizations begin to assume risk, the State will need to pay closer attention to their financial status in real time. Putting into place systems to track the financial status of providers and systems will be increasingly important in the coming years.

## **Grants**

Providing targeted incentives and grants has historically proven to be very effective in stimulating positive change. During the 1980s and 1990s, state grants and RFP processes stimulated an expansion in primary care and improvements in the care for patients with HIV infection; more recently, the state's HEAL program has been extraordinarily effective in stimulating HIT adoption and use, and a series of other programmatic goals.

## **Health Information Technology**

Health information technology is an increasingly important tool for change.

The State is well positioned to make use of the HIT capabilities it helped stimulate and develop with its HEAL program. The State's ability to collect, analyze, benchmark, and report data on providers' and plans' performance — in quality, patient experience, utilization, and costs — remains a critical capacity. Public reporting of that data can help inform and guide purchasers' and consumers' decisions about which plans and providers to use, for what services. This all falls well within the role of the State Health Department.

The creation of a statewide, all-payer database will add another dimension, the ability to look at specific populations and their needs, and at specific providers and provider networks, and to benchmark their performance. This will enable the state, local planning agencies, providers, payers and consumers to compare provider performance within a region and across the state, both to identify problems that need attention and to identify success stories.

## **Licensure and Surveillance**

The State has traditionally performed its licensure, surveillance, and reporting roles well, and it will need to continue doing so. Particularly important will be evaluating competence as measured by performance, asking the question, “Can this provider perform in this role, in this new environment?”

In addition, if and as the State decides to reduce the role of the CON process, a number of functions currently included in it (e.g., ensuring character and competence; the code compliance of plans, facilities, and programs) will still need to be performed. In other states, these are part of the licensure function. In the event that the CON process is substantially reduced, attention will need to be paid to adequately resourcing the licensure function, so it can continue to perform these core functions.

## **Regional Planning**

Finally, New York is now reconsidering the role and purpose of state-level and regional planning. Development of the State Health Improvement Plan is an excellent start; it is a sharply focused plan for public health priorities that addresses some of the key determinants of health and disease: preventing chronic diseases; advancing a healthy environment; promoting healthy mothers, healthy babies, and healthy children; preventing substance abuse, depression, and other mental illness; and preventing HIV, STIs, and vaccine-preventable diseases.

Regional planning for health and health care services can add another dimension to that effort. All health care is local, and the different parts of the state differ markedly from each other in terms of their populations and health status and needs, their provider bases and payers, and the purchasers of care. These are local constituencies for health care system change. Providers and systems in the state tend to be local or regional; and payers tend to be regional as well, with specific geographic footprints, which vary from one payer and region to another. There is a strong case to be made for local and regional planning, to reflect and adapt priorities to address local and regional needs.

The core functions of regional planning include data analysis and benchmarking; identifying local issues of quality, access, and cost; and setting agendas, building momentum, and crafting local responses to local issues, including community resources. The best-developed example of the new role of regional health planning is the Finger Lakes HSA in the Rochester area, but there are other local planning efforts under way in Western New York, Syracuse, and the Capital District.

The State has already indicated its support for an expansion of regional health planning, including support for such efforts in its recent 1115 waiver request; it now needs to better define the expected role, focus, and priorities of regional planning entities, and be prepared to provide them with much-needed data and analytic support.

## Exhibit I: Roster of Individuals Interviewed

Category	Organization	Name	Title
Consultants	Manatt, Phelps and Phillips	David J. Oakley	Counsel, Healthcare
	Brown & Weinraub, PLLC	Neil Benjamin	Government Relations
	Nexera Consulting	Bruce Vladeck	Senior Advisor
Associations	HANYS	Dennis Whalen	Executive Vice President
		Frederick Heigel	VP, Regulatory Affairs, Rural Health and Workforce
		Jeffrey Gold	VP and Special Counsel, Managed Care
		Steven Kroll	Vice President, Government Affairs & External Relations
	LeadingAge New York	James Clyne	President and Chief Executive Officer
	GNVHA	Susan Waltman	EVP, Legal, Regulatory & Professional Affairs & General Counsel
		Kathleen Shure	Senior Vice President, Managed Care & Insurance Expansion
		Elizabeth Wynn	Senior VP, Finance & Reimbursement
		NY Academy of Medicine	Jo Ivey Boufford, MD
Payers	Wellpoint	Mark Wagar	President and Chief Executive Officer
	Aetna	Lonny Reisman, MD	Senior Vice President & CMO
	NYS OHIP	Gregory Allen	Director, Program Development & Management, OHIP
Long-term Care	Harvard University	Carol Raphael	Advanced Leadership Fellow
	St. Peter's / Northeast Health	Jo Ann Costantino	Chief Executive Officer
	Isabella Nursing Home	Mark Kator	President & Chief Executive Officer
Physicians/Groups	Crystal Run Medical Group	Hal Teitelbaum	Managing Partner and CEO
	Taconic IPA / THINC	Susan Stuard	Executive Director
	The Institute for Family Health	Neil Calman, MD	President
	Hudson Headwaters Health Network	John Ruge, MD	Executive Director
Providers/Systems	Northshore-LIJ Health System	Jeffrey Kraut	Senior Vice President Strategy
	Kaleida Health	James Kaskie	President & Chief Executive Officer
	URMC/Strong	Peter Robinson	Exec. Director of Government Relations
	Bassett Healthcare	William Streck, MD	President and Chief Executive Officer
	Chautauqua County Health Network	Ann Morse Abdella	Executive Director
Regional Planning	P-2 Collaborative of Western New York	Shelley Hirshberg	Executive Director
Foundation	Health Foundation of W-CNY	Ann Monroe	President & Chief Executive Officer

## Exhibit 2: Interview Guide

### Health System Changes in New York State, and CON

#### Interview Guide

##### 1. The “High-Cost” Patients

There is increasing attention to the populations of chronically ill, who drive a large portion of health care costs.

- Is this a sensible focus?
- Do we know enough about how to organize and deliver care to that population, to be able to meaningfully improve quality and reduce their costs of care?

##### 2. Health System Organization and Performance:

The organization of NY’s primary and acute care delivery system is changing: physicians “grouping”, hospitals employing physicians, hospitals affiliating with each other and with providers of post-acute care services, much of this apparently in search of scale, to organize themselves into ambulatory care-centric integrated delivery systems.

In parallel, with developments in HIT, it is now possible to measure and attribute population-based performance to providers, for providers to measure and benchmark their own performance and that of their “networks”, and for payers to reward high-performers.

- How do you see these trends playing out, over the next five years?
- Is this likely to improve performance?
  - Will innovations like PCMH have a real impact on cost, quality, experience?
  - Will providers and networks be able to meaningfully reduce “preventable” use of specialists, EDs and hospitals?
  - Are reductions in utilization, and potential shifts in market position going to weaken hospitals, put them at risk for closure?
- What do you feel are the implications of these new “systems”? What do you see as the advantages and disadvantages/risks of that evolution?
- Are there likely to be differences between upstate and downstate?

The long-term care system is also undergoing major changes in its organization and function, and - with MLTCs and the proposed changes for dual-eligibles – in its financing.

- How do you see this trend playing out, over the next five years?
- What do you think will be the respective roles of / balance between home and community-based services and institutional care, and the relationship between those two sectors?

##### 3. Financing and Payment Systems:

The historical role of the insurance company seems to be changing, with more purchasers self-insuring, changes in coverage (including Exchanges) benefits (high deductible plans with HSAs) and more providers seeking to accept risk.

- How do you see this trend playing out, over the next five years? What do you think will be the role of the payers in that future?



- ACO-type arrangements between payers, purchasers and organized provider groups will co-exist with traditional insurance options, from which consumers may choose. What will be their penetration, as “products”, over the next 5 years? 10 years?
- Are there likely to be differences between upstate and downstate?

There is broad agreement that payment systems need to move from fee-for-service to “paying for value”. This is being done in a number of different ways, ranging from pay-for-performance to bundling, to “shared savings”, to risk-transfer and capitation.

- How do you see this trend playing out, over the next five years?
- What do you expect the balance will be between “FFS plus P4P” payment systems, and risk-transfer arrangements?

#### **4. Role of Government, Including CON:**

New York State has historically used CON and other regulatory and payment tools to advance public policy goals, including improving access to care for the poor, uninsured, high-risk and undocumented populations; helping sustain vital access providers and hospitals; assure a rational, regional distribution of acute care and LTC services; assure quality and safety of care; as well as controlling the system’s capital and operating costs. With changes in capital reimbursement and increasingly powerful incentives to reduce utilization and costs, some are questioning the need for CON, in the future.

- What is your perspective on this issue?
  - Will CON still be relevant and important, in the “new” health care delivery and payment system you see in the future?
  - If so, what should be its role and focus?
- What other available tools (licensure, regulation, payment systems, grants and RFP’s) should the state use and enhance to support its public policy priorities?
- Does the development of large, regional integrated delivery systems pose specific challenges to the state’s current regulatory systems, and if so, what would you identify as the key challenges and risks?

#### **5. Regional Health Planning:**

Health care delivery (and, to an extent, health insurance plans) are local/regional. There is evidence that regional planning and “regional health improvement collaboratives” – that organize providers, payers, employers/purchasers, local government, and communities to identify locally defined health priorities and take meaningful action - can make a difference in improving access, quality, coordination and costs of care.

In addition, with the increasing availability and public reporting of cost and quality data on the performance of providers and networks, such groups are also playing a role as an “honest broker” in analyzing and reporting such data.

- Should New York State actively support development of regional health planning efforts?
- What would you see as the most important roles of these “collaboratives”?
- Are there likely to be differences between upstate and downstate, and in areas where there are a number of competing providers/systems, and more rural areas?