



Community Technology Assessment Advisory Board  
c/o Finger Lakes Health Systems Agency  
1150 University Avenue, Bldg. 5  
Rochester, NY 14607  
(585) 461-3520 ext. 114  
[www.ctaab.org](http://www.ctaab.org)

## CTAAB – Lessons for CON

In the Report of the Medicaid Redesign Team’s Brooklyn Health Systems Redesign Workgroup is a recommendation to financially support a multi-stakeholder planning collaborative in Brooklyn. As one activity of such a collaborative, “it could also engage in activities to curb unnecessary health spending, such as the creation of a community advisory board for major investments in medical technology like the CTAAB in the Finger Lakes region.” This paper describes CTAAB, how its activities are similar and different from Certificate of Need, and whether it provides suggestions for how the CON program might be modified.

In 1993, Blue Cross & Blue Shield of the Rochester Region (now part of Excellus Blue Cross Blue Shield), with its IPA physician partners, established the Community Technology Assessment Advisory Board (CTAAB) to provide broad-based community input into decisions regarding the area’s need for new and additional medical technology and services and input into decisions on reimbursement. The Rochester area’s other major health plan, Preferred Care (now part of MVP), joined soon after. Because the state CON process provided oversight of requests for additional technology and services by hospitals and other licensed health care facilities, CTAAB initially reviewed solely proposals from physicians and business people. For its first eight years, CTAAB reviews were primarily related to clinical issues, such as acceptance of large-needle biopsies as a covered service.

In 2001, in response to a recommendation from the Rochester Health Commission’s Health Forum, CTAAB expanded its purview to include:

- New and incremental technology
- New and incremental services
- Major capital expenditures
- Proposals by public and private physicians and health facilities.

The CTAAB mission continues to be to augment and provide an independent, professional and community-oriented appraisal to the health care planning process. It advises payers, providers, and other interested parties on the need for and efficacy of health care services and technologies by providing non-binding recommendations to the health plans.

CTAAB is a self-perpetuating Board on 24 members representing clinicians, institutions, health plans, employers and consumers. It obtains professional input for new technologies through a Technology Assessment Committee comprised solely of primary care and specialty physicians. It obtains

professional input on health services capacity issues from its Technology Consultant, presently the Finger Lakes Health Systems Agency (FLHSA). FLHSA's analyses are informed by prospective capacity surveys, by the Agency's health planning commissions and studies, and from utilization data from databases like SPARCS and aggregated claims database.

One objective of CTAAB is to "level the playing field" in terms of review between public and private providers. To avoid "double jeopardy" situations for public providers subject to CON, CTAAB and FLHSA work closely together. CTAAB depends on FLHSA for staff support and analytic work, both in capacity reviews and recently in consideration of new technology. At the same time, FLHSA's CON recommendations to NYS Department of Health are informed by CTAAB discussion. While CTAAB has its own application form, it accepts the CON application to avoid duplication of paperwork requirements.

Examples of reviews undertaken by CTAAB in a recent year provide a sense of the present scope of the Board:

- CT scanner (5)
- MRIs (5)
- Linear Accelerators (3)
- PET/CT (1)
- Sleep Centers (1)
- Technology – Cardiac CT Angiography
- Lithotripsy services (1)
- Infusion Center (1)
- Hospital Renovations (1)
- Ambulatory surgery center (1)

The CTAAB process cannot replace CON but can act as a supplemental community review process. It does not have the force of law, and thus cannot forbid a provider to establish or expand a service. Instead, it provides advisory opinions to the local health plans, which then use the opinions to make coverage decisions. The CTAAB process is legal at least in part because there is not an "any willing provider" law in New York; thus, each insurer can choose with which services it will contract. The CTAAB opinions are non-binding on the insurers, and each insurer uses the information as it pleases. The insurers can, if they please, refuse to contract with a new provider or modify its reimbursement arrangements with an existing provider: They may withhold reimbursement for the service.

As an example of the difference between CON and CTAAB, a local orthopedic physician is seeking to install an MRI unit in his practice. If CTAAB were to find that there is not community need for this capacity, the insurers could refuse to pay for the service. Yet the physician can determine that, between Medicare, Medicaid and Worker's Comp, he can economically operate the MRI unit even without the local commercial insurance payment streams. Neither CTAAB nor the insurers can prevent him from going forward. Were the provider an Article 28 provider, DOH could prohibit the installation of the MRI and forbid Medicaid and Medicare reimbursement for the facility fee.

A CTAAB-like model existed in the Buffalo area for a period, but the insurance plan-sponsors discontinued the process when an FTC complaint was filed by a provider. There was never an FTC ruling on its legality.

The CTAAB scope is both similar and different than CON, which may provide some insights to its success.

	CTAAB	CON
Legal Basis	Advisory only	Established by state law
Membership	Consumer, Employer, Health Plan, Institutional Providers, Health Professionals, with non-provider majority; self-perpetuating	PHHPC: Providers and Consumers, with consumer majority; Governor appointed with Senate confirmation
Parties covered	Public and Private Health Care Providers	Public Health Care Providers
Services Covered	New technology and services; incremental technology and services; major capital expenditures	New technology and services; incremental technology and services; major capital expenditures
	Does not cover non-clinical infrastructure; does not cover LTC services; review not required for equipment replacement	Does not cover non-clinical infrastructure  review not required for equipment replacement
“Always Review” list	Cardiac Cath labs, operating rooms, D&TCs, transplant services, hospital beds, MRI, PET, CT scanners, sleep lab beds, lithotripters, and hyperbaric oxygen therapy (HBOT)	The addition of beds, therapeutic radiology equipment, adult or pediatric cardiac surgery, cardiac catheterization, kidney, heart, liver, or bone marrow transplantation, burn care, AIDS centers, epilepsy service.
\$\$ Cost Threshold	\$750,000	LT \$6 million; \$6 million-\$15 million; GT \$15 million
Review Criteria/ Considerations	Community need; financial impact; quality of care; access	Community need; financial impact; quality of care; access
Letter of Intent	Yes—Allows for competition/ avoids first-in/first-out issues	No
Conflict of Interest Mechanism	Yes	Yes
Open Meetings	Yes, by request	Yes

## Discussion

CTAAB, then, is an independent and multi-stakeholder review board, with independent (i.e., non-insurer) expert staff and analysis and with ties to local prospective health care planning. It can be proactive in seeking services development where prospective planning has been done.

The CTAAB process has served the Rochester region well. Studies have shown that the region has newer/more capable equipment than national averages<sup>1</sup>, and access to services appears to be as good or

<sup>1</sup> Go to [www.flhsa.org](http://www.flhsa.org) for publications comparing imaging equipment inventory and use to national data.

better than other areas, yet duplication has been reduced and overall utilization has been reduced compared to other parts of Upstate New York<sup>2</sup>.

Some other considerations regarding the CTAAB process:

- The Letter of Intent process is an important feature, in that it facilitates competition to provide a service, often within a prospectively-defined community need. It also avoids the phenomenon of the first applicant getting approval to provide a service, effectively shutting out subsequent applicants. Yet it adds at most one month to the process.
- The current dollar threshold, \$750,000 for either capital cost or incremental annual operating cost, is getting to be too low in some instances, such as minor renovation, leading to “passes” given by the insurance plan sponsors. Yet the low dollar threshold, combined with the “always review” list, permits local review of projects such as the re-opening of “mothballed” hospital beds (beds still on the hospital license but not set up for inpatient care) and low-cost/low capability imaging units.
- Yet there is a sense that CTAAB may no longer be reviewing some of the most important cost drivers, such as expensive pharmaceuticals or implanted devices. Consideration is being given to re-invigorating the new technology aspect of CTAAB review to look at these emerging cost drivers.
- While financial impact is a review criterion, CTAAB staff must be careful not to divulge too much proprietary financial information, to avoid any anti-trust issues in the setting of prices by the insurance plans.
- As it is presently constructed, CTAAB requires participation<sup>3</sup> of a majority of insurers to be effective. This may be difficult to assemble in areas with many plans involved.

---

<sup>2</sup> “Capacity and Use of High Tech Medical Services in Upstate NY, 20005, Finger Lakes Health Systems Agency.

<sup>3</sup> Participation is defined as (1) the ability to take CTAAB recommendations into consideration in coverage and network decisions and (2) financial contribution to support CTAAB operation.