Driving Health System Improvement in NYS: Policy Priorities and Tools

Presentation to the Public Health and Health Planning Council Health Planning Committee
New York State Department of Health
June 21, 2012
(revised)

Charge to PHHPC

- The PHHPC will conduct a fundamental re-thinking of CON and health planning in the context of health care reform and trends in health care organization, delivery and payment.
- The goal of Phase 2 is to develop and implement a regulatory and health planning framework that, together with payment incentives and other policy tools, drives health system improvement and population health.

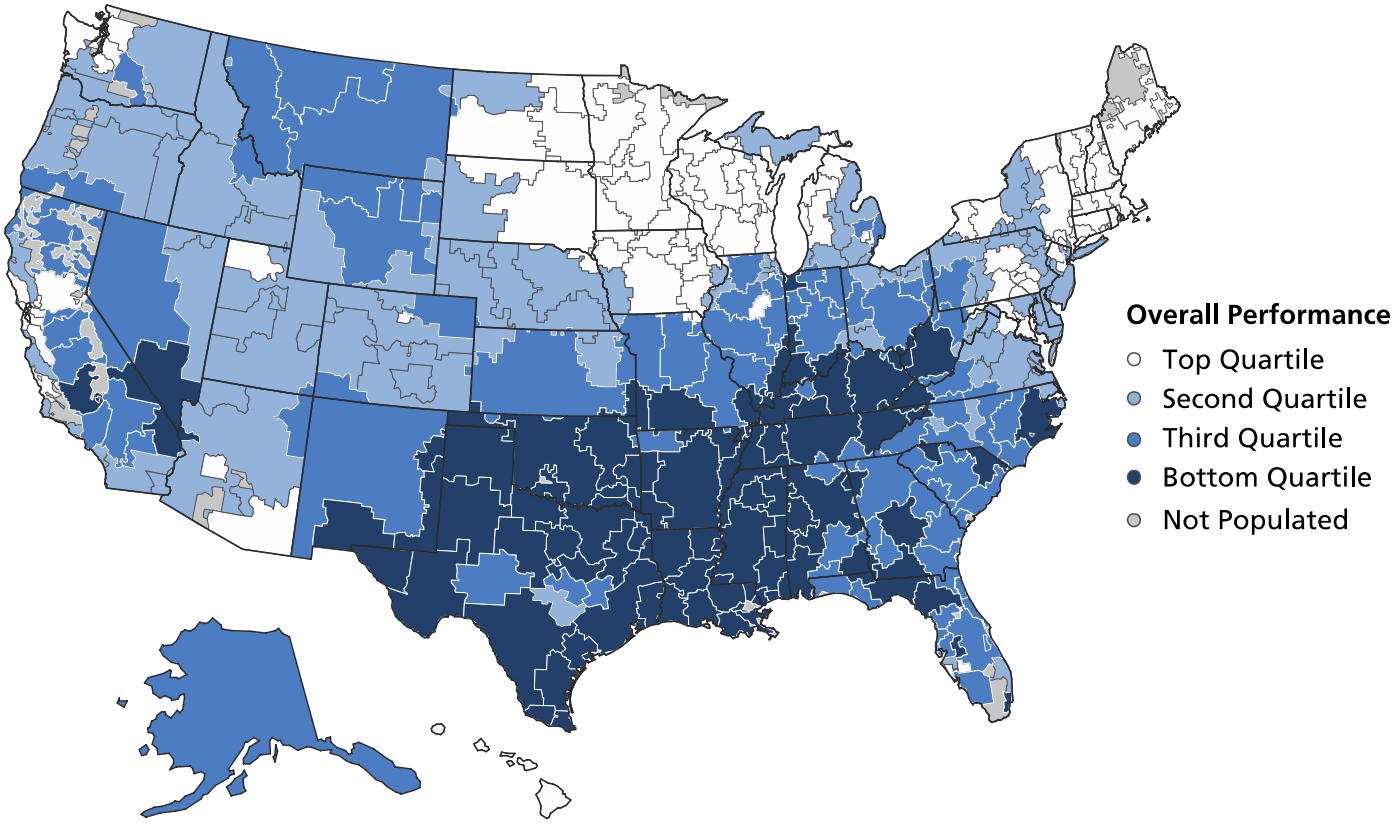
Calendar of Meetings

6/21/12 – Albany	Driving Health System Improvement in New York State: Policy Priorities and Tools
7/25/12 - Albany	Innovations in Financing and Organizing Health Care: Implications for CON and Health Care Regulation
TBD	Regional Health Planning
9/19/12 – NYC	Establishment, Governance and Financial Feasibility
10/12/12 – NYC	Access and Public Need
10/30/12 – NYC	Review Draft Report
11/14/12 – Albany	Discuss Revised Report
11/15/12 – Albany	Adoption of Report by Committee
12/6/12 - Albany	Adoption of Report by PHHPC

Health System Performance in NYS

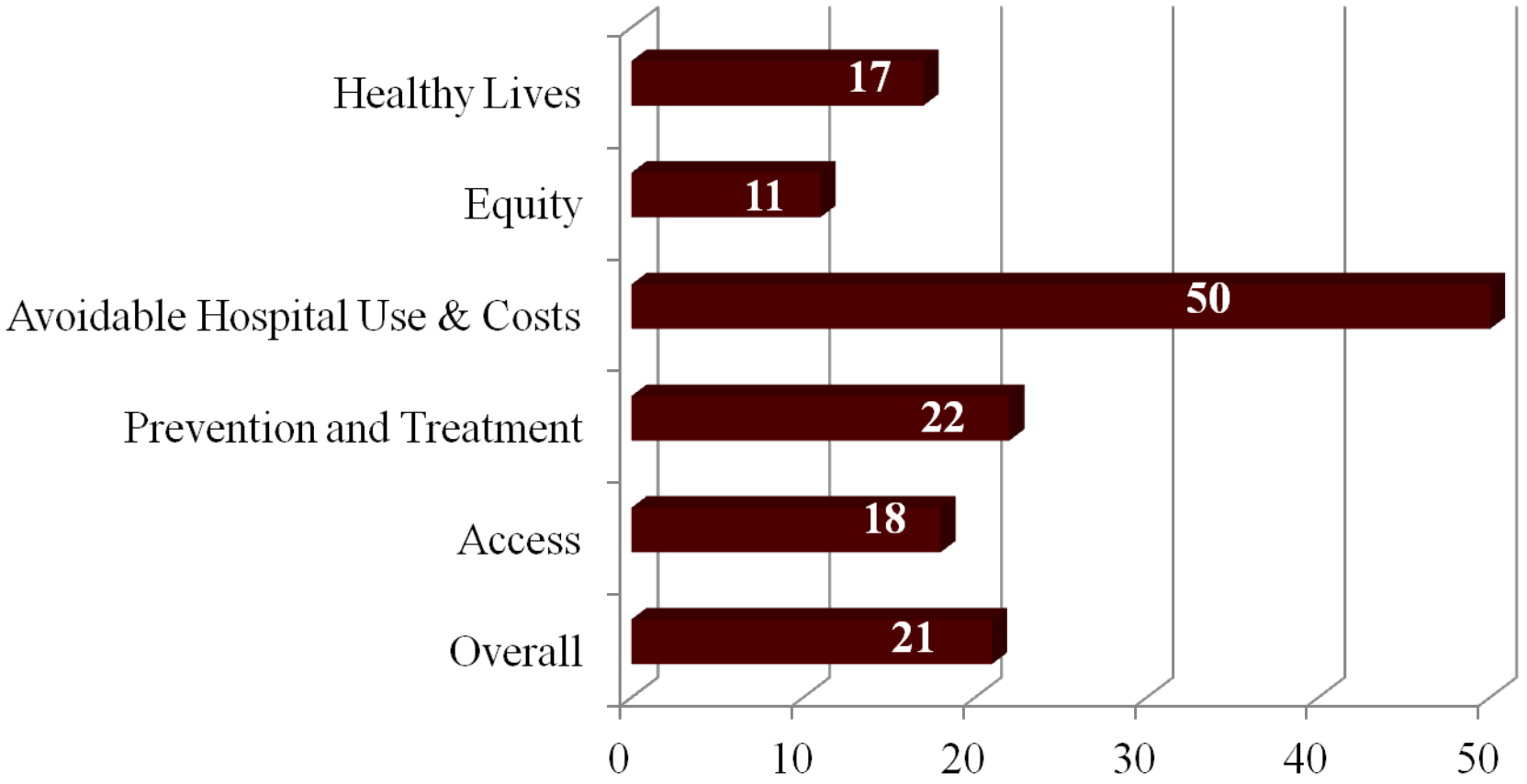
Delivery System Performance

Overall Health System Performance



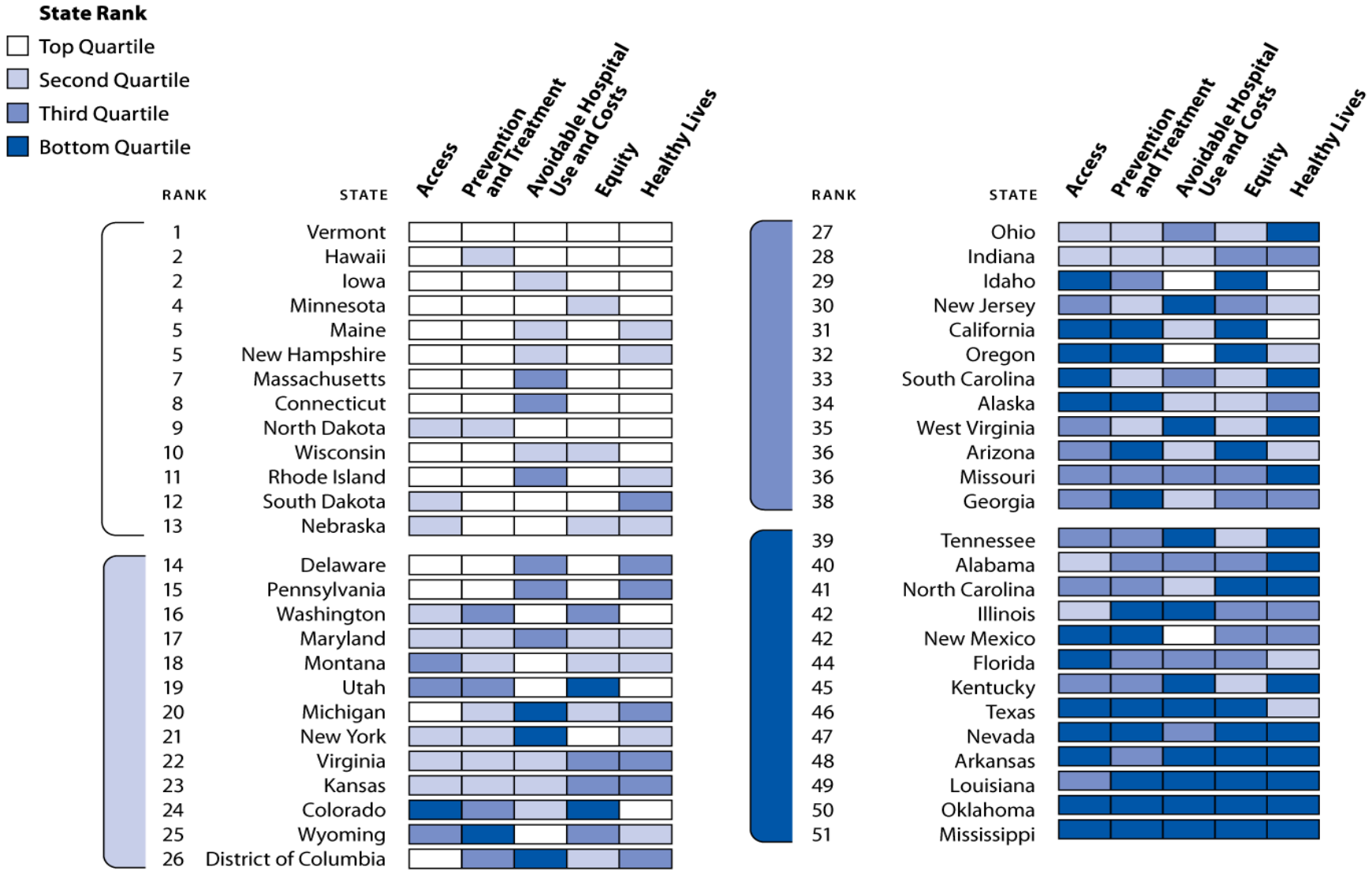
Source: Commonwealth Fund Scorecard on Local Health System Performance, 2012.

How Does NYS Rank?



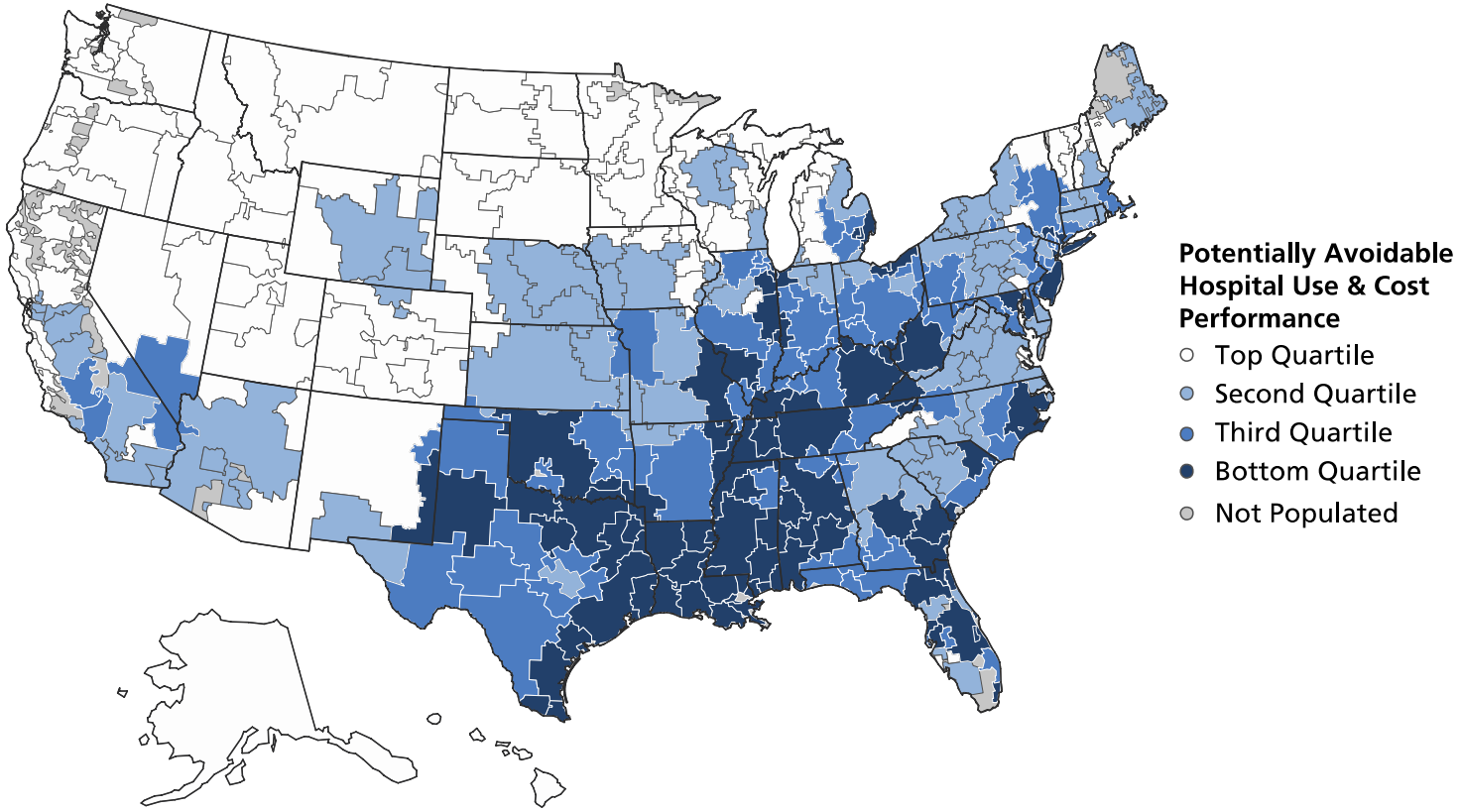
Source: Commonwealth Fund State Scorecard on Health System Performance, 2009
Data used to create graph was retrieved from http://www.commonwealthfund.org/Maps-and-Data/State-Data-Center/State-Scorecard/DataByState/State.aspx?state=NY

2009 State Scorecard Summary of Health System Performance



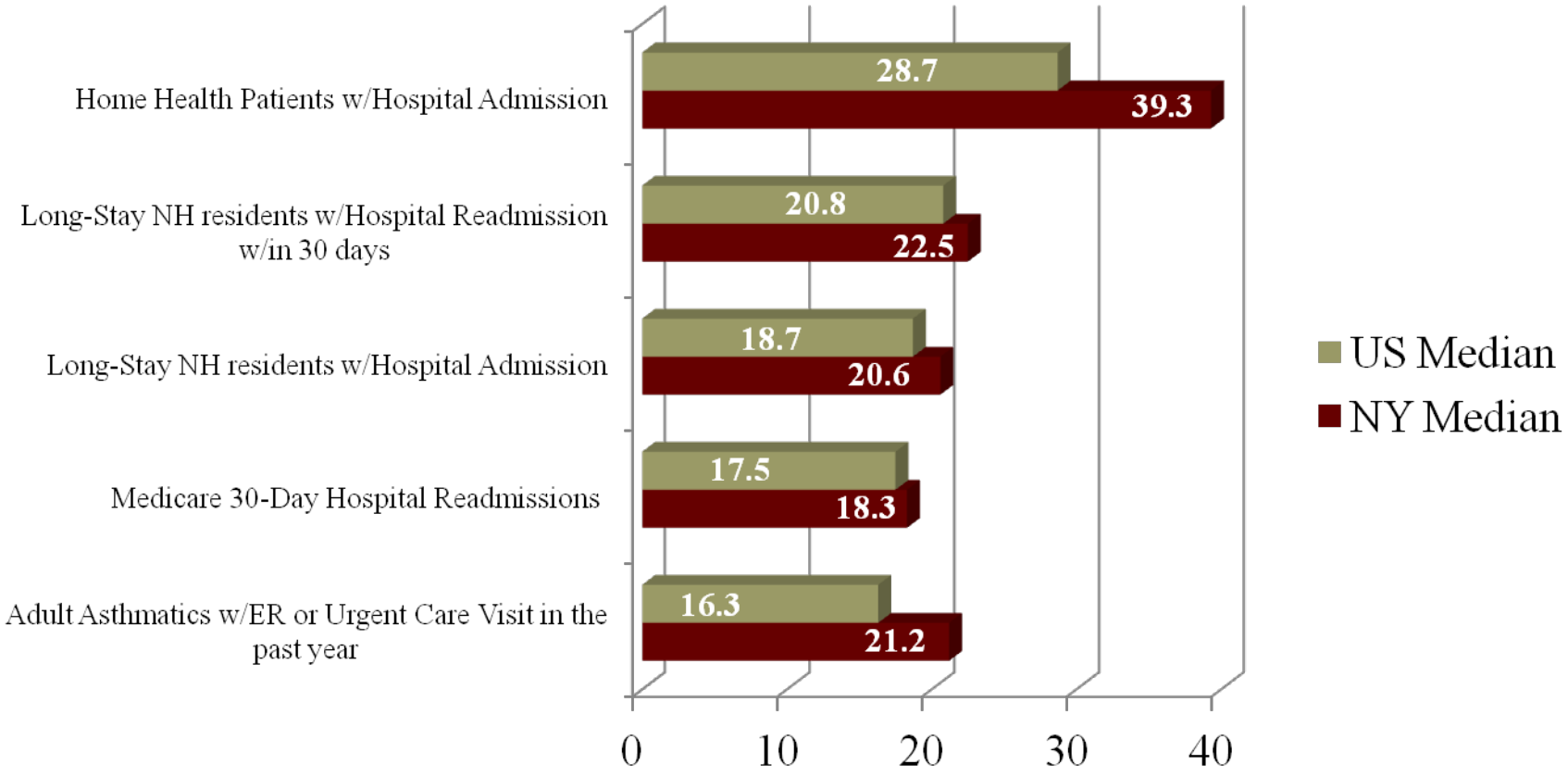
SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2009

Overall Performance on Potentially Avoidable Hospital Use & Cost Dimension



Source: Commonwealth Fund Scorecard on Local Health System Performance, 2012.

Avoidable Hospital Use & Costs



Source: Commonwealth Fund State Scorecard on Health System Performance, 2009
Data used to create graph retrieved from: http://www.commonwealthfund.org/Maps-and-Data/State-Data-Center/State-Scorecard/DataByState/State.aspx?state=NY

Avoidable Hospital Use & Costs

- Hospital Admissions for Pediatric Asthma per 100,000 Children
  - **New York: 253.5 US Median: 125.5**
- Medicare Hospital Admissions for Ambulatory Care Sensitive Conditions per 100,000 Beneficiaries
  - **New York: 7,269 US Median: 6,291**
- Hospital Care Intensity Index, Based on Inpatient Days and Inpatient Physician Visits Among Chronically Ill Medicare Beneficiaries in the last two years of life
  - **New York: 1.322 US Median: 0.958**

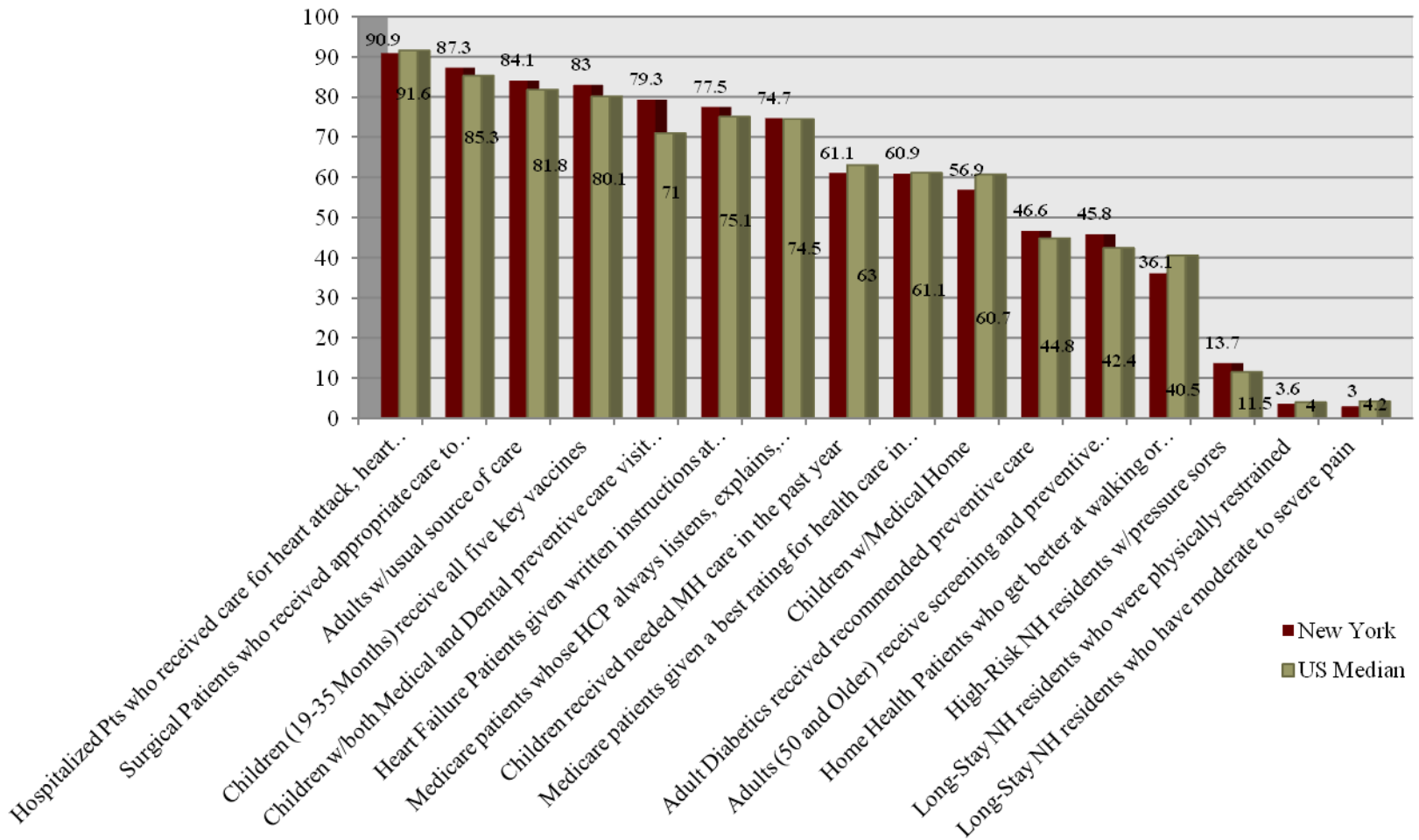
Source: Commonwealth Fund State Scorecard on Health System Performance, 2009
Data: Healthcare Cost and Utilization Project (HCUP) State Inpatient Databases; not all states participate in HCUP. Estimates for the total U.S. are from the Nationwide Inpatient Sample (AHRQ, HCUP-SID 2005). Reported in the National Healthcare Quality Report (AHRQ 2008); Analysis of Medicare Standard Analytical Files 5% Data from the Chronic Condition Data Warehouse (CCW) by G. Anderson and R. Herbert, Johns Hopkins Bloomberg School of Public Health (CMS, SAF 2006, 2007); and Dartmouth Atlas of Health Care (Dartmouth Atlas Project 2005).

Avoidable Hospital Use & Costs

- Total Single Premium per Enrolled Employee at Private Sector Establishments that Offer Health Insurance
  - **New York: 4,638 US Median: 4,360**
- Total Medicare (Part A & Part B) Reimbursements per Enrollee
  - **New York: 9,564 US Median: 7,698**

Source: Commonwealth Fund State Scorecard on Health System Performance, 2009
Data: Medical Expenditure Panel Survey–Insurance Component (AHRQ, MEPS-IC 2008) and Dartmouth Atlas of Health Care (Dartmouth Atlas Project 2006).

Prevention & Treatment



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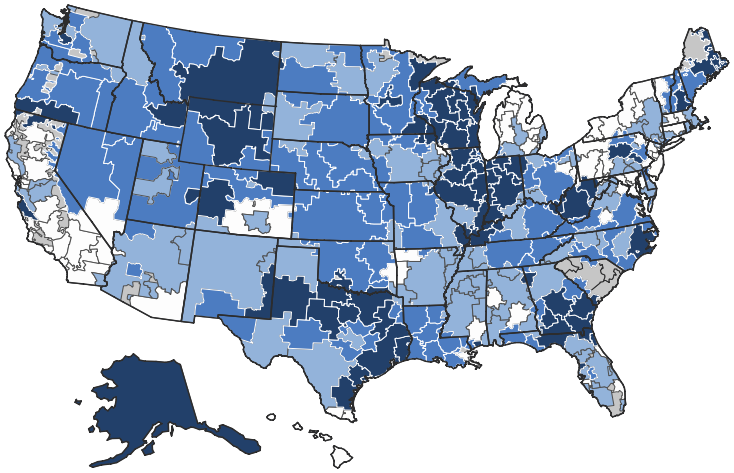
Health Care Spending in New York State

Commercially Insured and Medicare Spending per Enrollee, Relative to U.S. Median Spending for Each Population

Commercial Spending

Expressed as ratio to median commercial spending

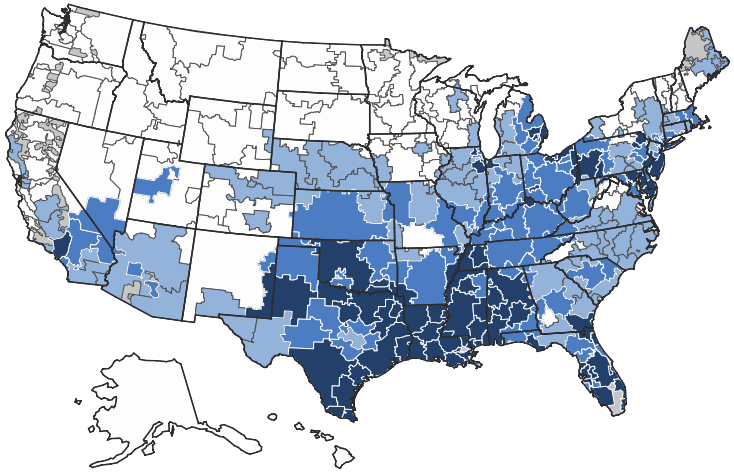
- 0.61–0.89 (71 HRRs)
- 0.90–0.99 (79)
- 1.00–1.09 (80)
- 1.10–1.53 (71)
- Not Populated or Missing Data (5)



Medicare Spending

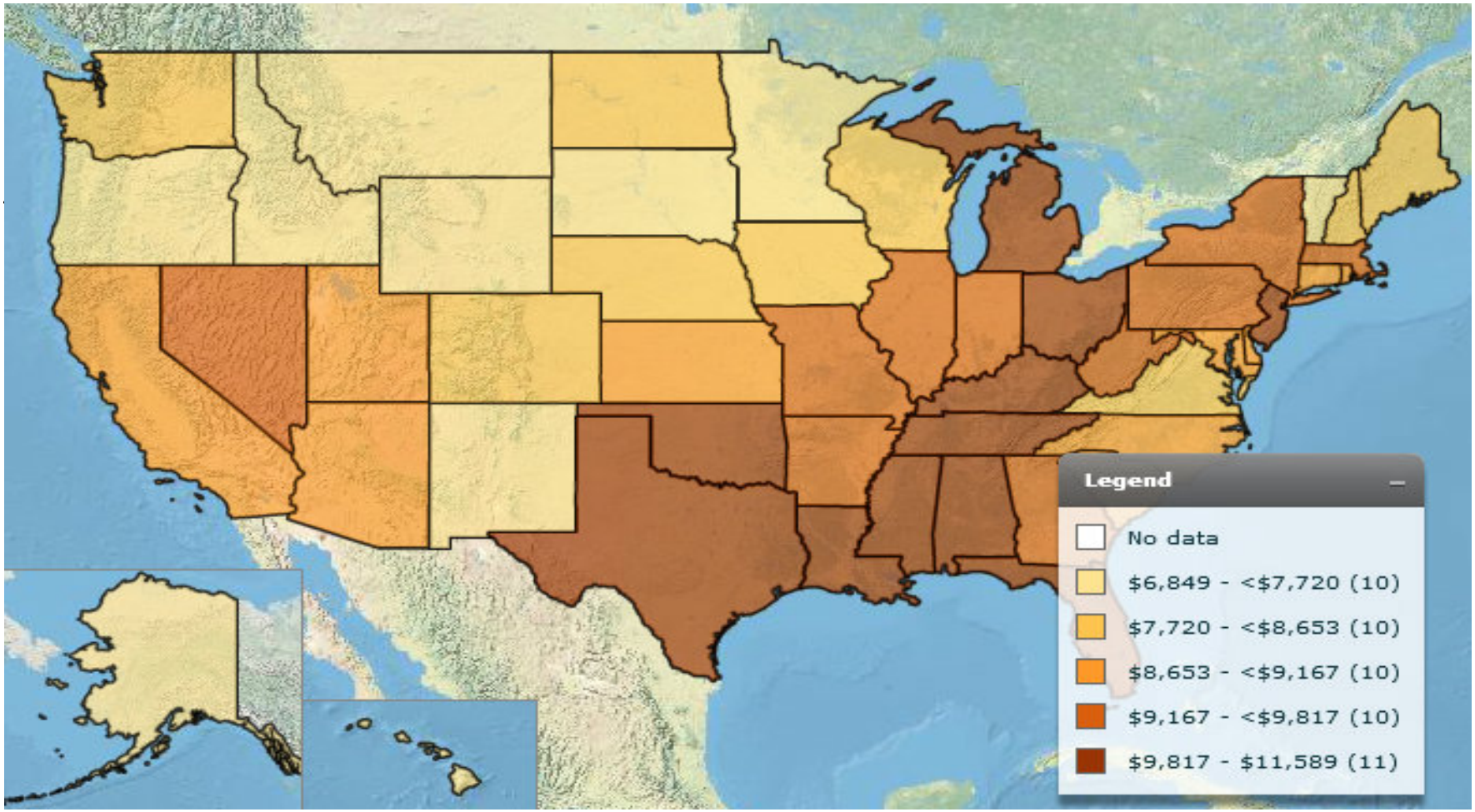
Expressed as ratio to median Medicare spending

- 0.63–0.89 (81 HRRs)
- 0.90–0.99 (72)
- 1.00–1.09 (75)
- 1.10–2.00 (78)
- Not Populated

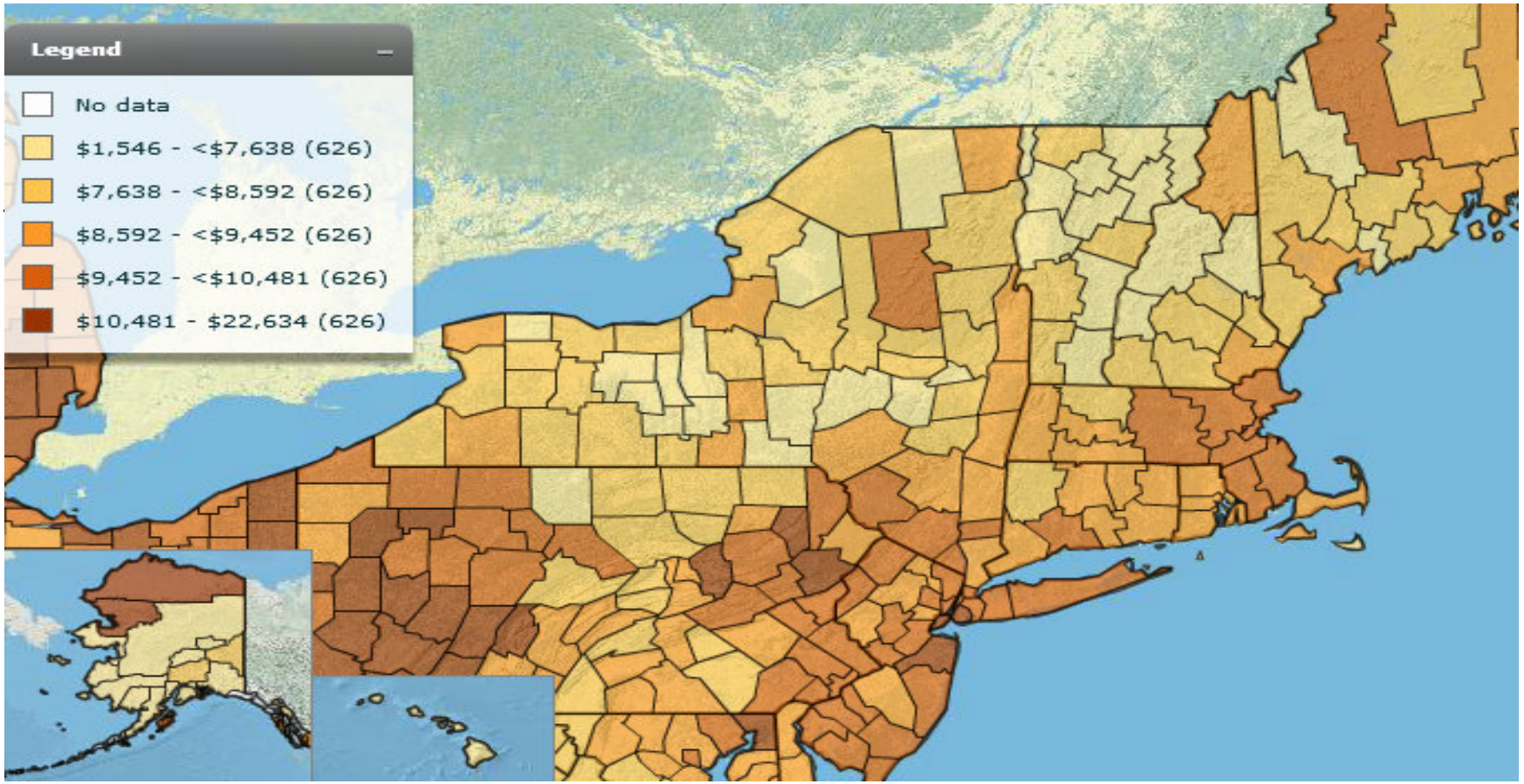


HRR = hospital referral region.
Data: Commercial – 2009 Thomson Reuters MarketScan Database, analysis by M.Chernew, Harvard Medical School. Medicare – 2008 Medicare claims as reported by IOM.
Note: Ratio values lower than 1.0 indicate lower than median spending, ratio values higher than 1.0 indicate higher than median spending. Median spending is determined separately for the commercially insured (ages 18–64) and Medicare populations (age 65 and older).

Source: Commonwealth Fund Scorecard on Local Health System Performance, 2012.



Price-Adjusted Medicare Payments per Enrollee, by Adjustment Type and Program Component
(Program Component: Overall; Adjustment Type: Price, Age, Sex & Race; Year: 2009; Region Level: State)



Price-Adjusted Medicare Payments per Enrollee, by Adjustment Type and Program Component
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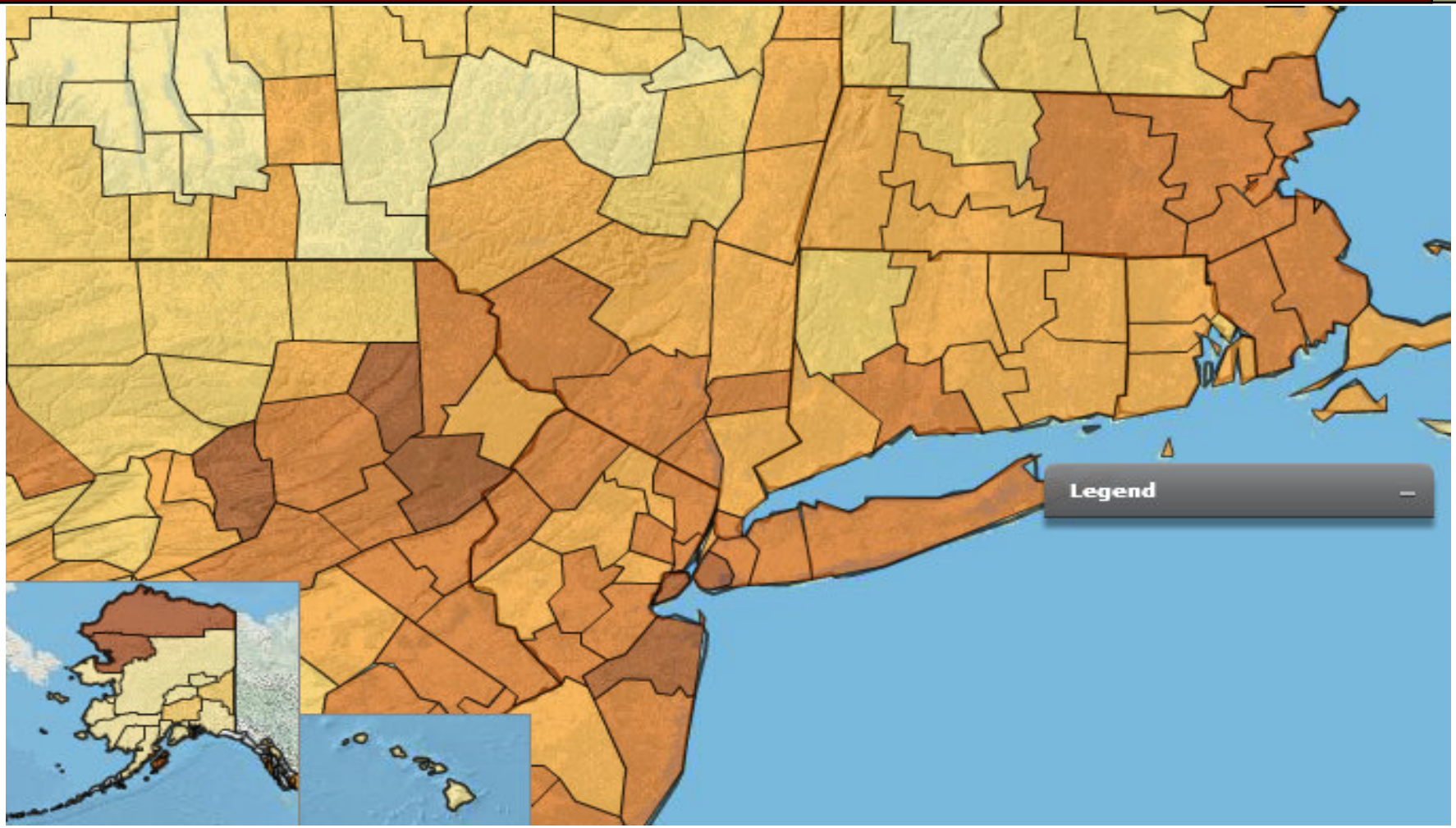

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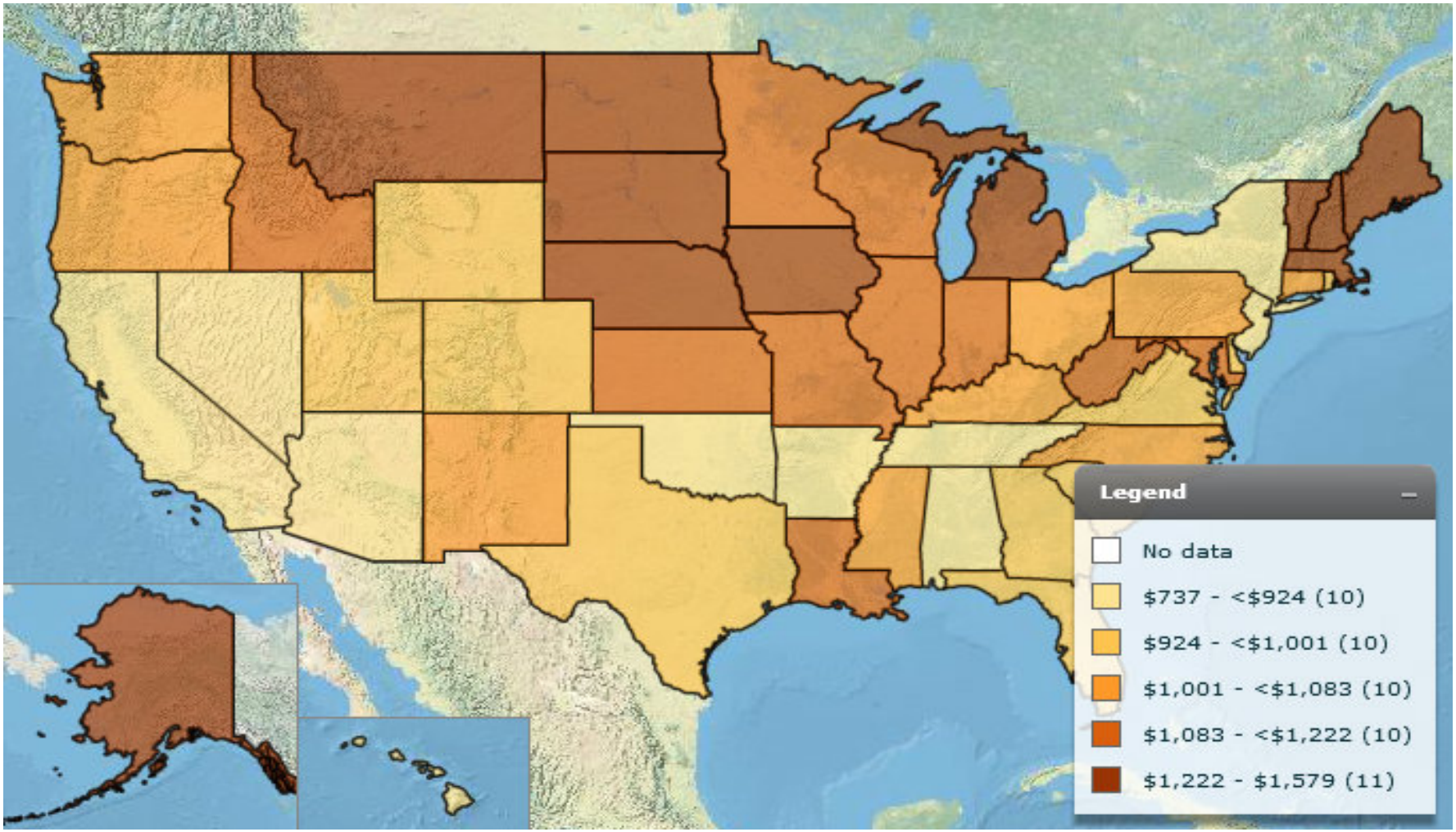
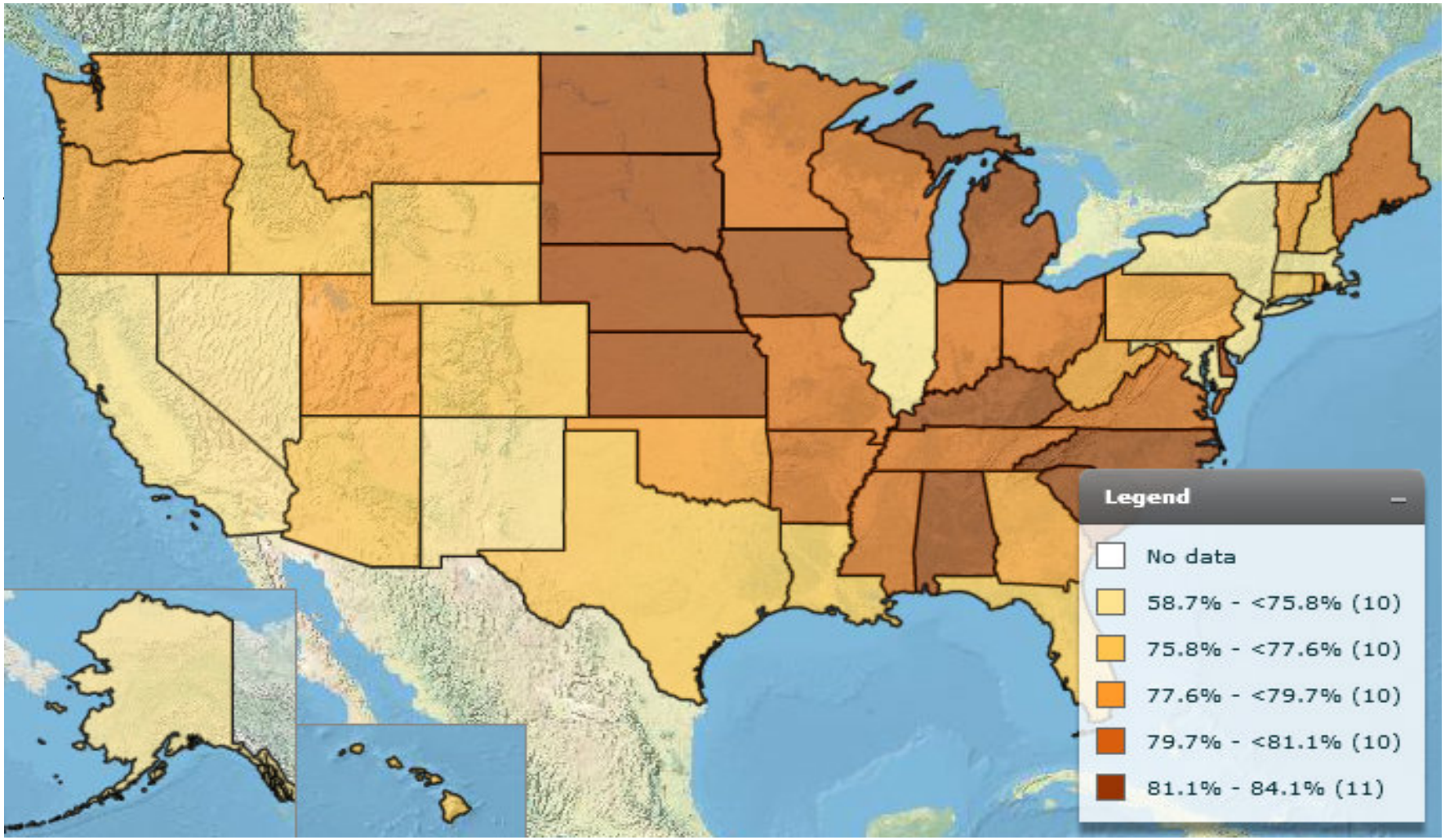


Medicare Reimbursements for Outpatient Services per Enrollee, by Gender (Gender: Overall; Year: 2007; Region Level: State)



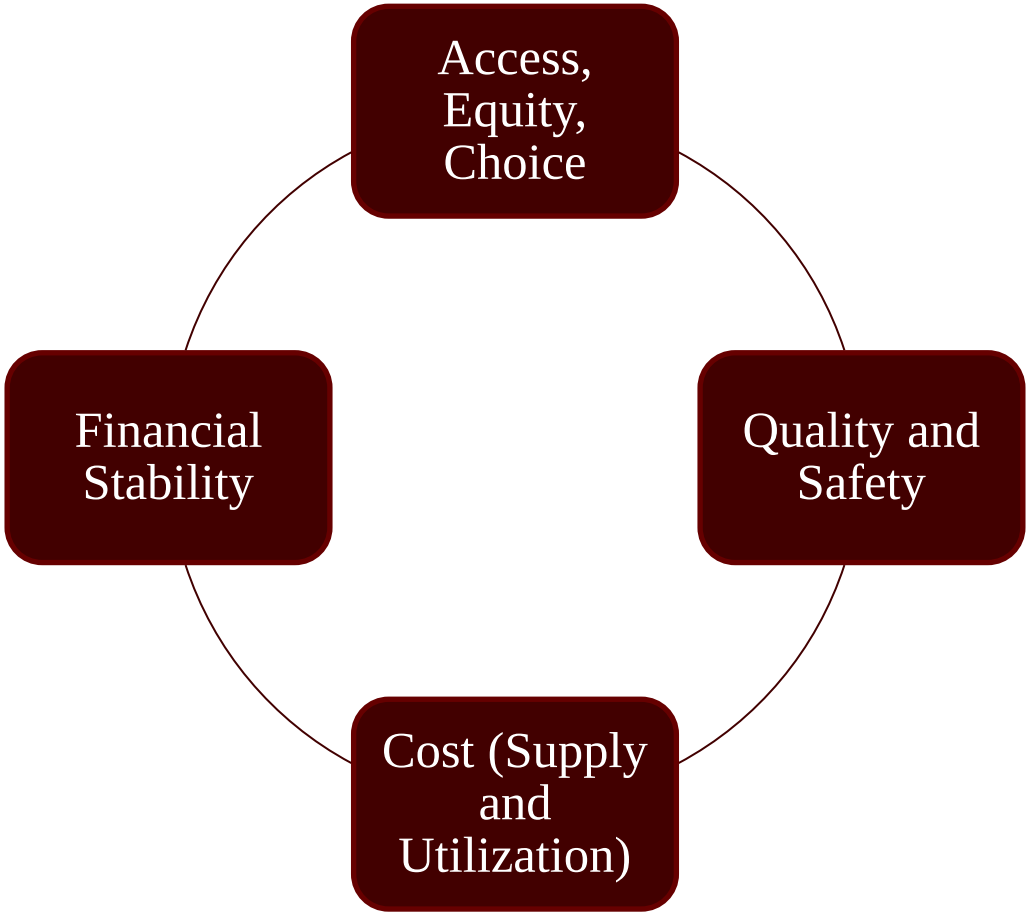
Percent of Medicare Enrollees Having Annual Ambulatory Visit to a Primary Care Clinician, by Race
(Race: Overall; Year: 2003-2007; Region Level: State)

Policy Priorities and Tools

Goals of Health Care Regulation: The Triple Aim

- Improve the patient experience of care (including quality and satisfaction);
- Improve the health of the populations; and
- Reduce the per capita cost of health care.

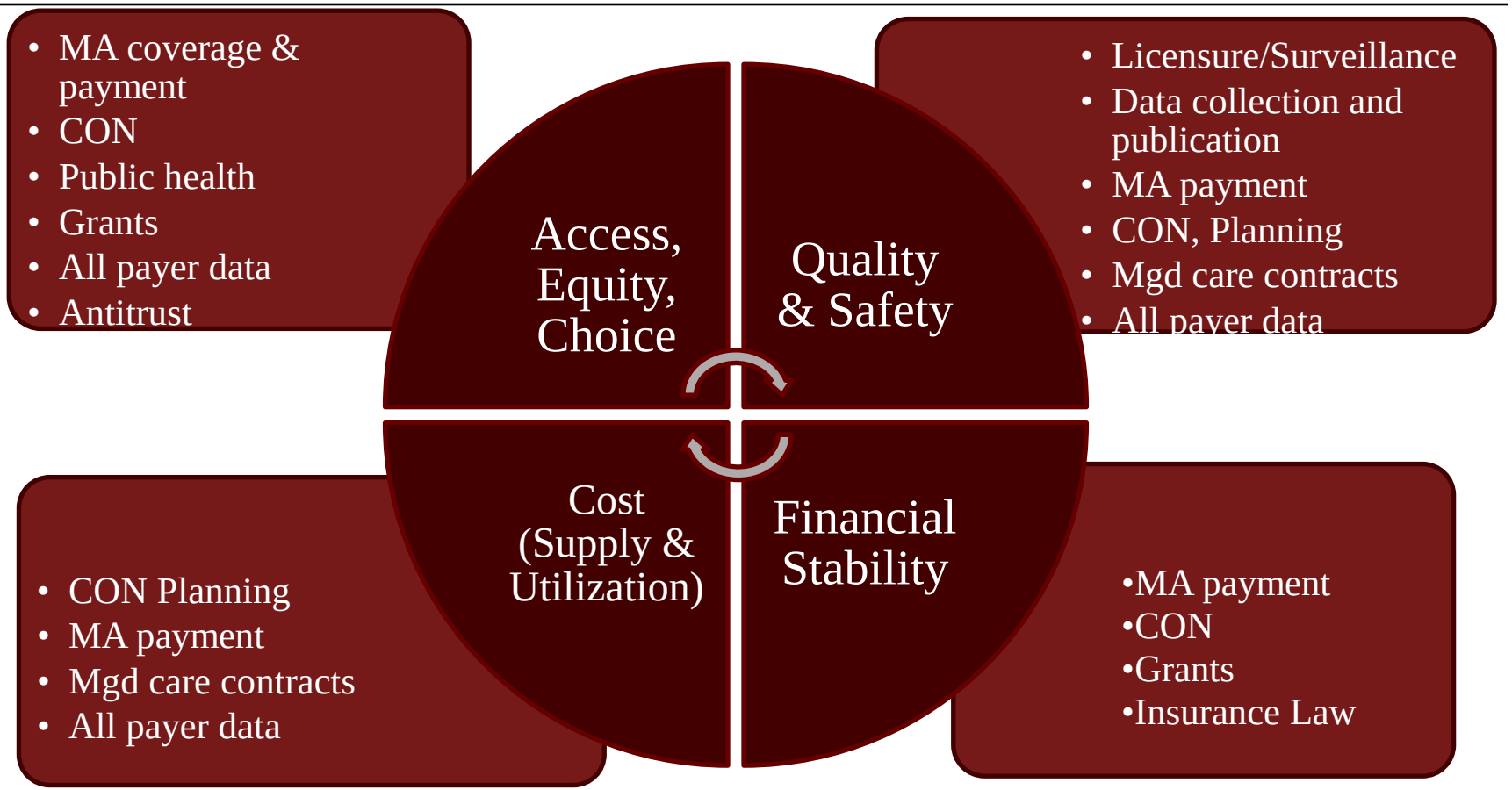
Targets of Regulation to Achieve the Triple Aim



Policy and Regulatory Tools

- Certificate of Need
- Licensing and surveillance
- Medicaid payments
- Medicaid managed care plan contracts
- Health plan regulation
- Public health initiatives
- Health planning, Community Service Plans, CHAs
- All-Payer Database; data collection and publication
- Antitrust, Certificate of Public Advantage
- Grants

Targets and Tools



Lessons

- NYS Health System Performance:
  - Scores well on access and equity and poorly on avoidable hospital use and costs.
  - Scores at the median on prevention and treatment.
  - Significant regional variation in health care spending. Medicare spending is concentrated on inpatient care and highest downstate.
- Variety of regulatory tools to address access, quality, cost, and financial stability.

Certificate of Need – Functions and National Comparison

CON and Policy Targets

- Cost
  - Restrain capital spending
  - Limit excess supply → Reduce overtreatment
- Access
  - Geographic
  - Financial
  - Preserve safety net
- Quality
  - Consolidate volume and expertise
- Financial Stability
  - Promote rational borrowing and investment decisions

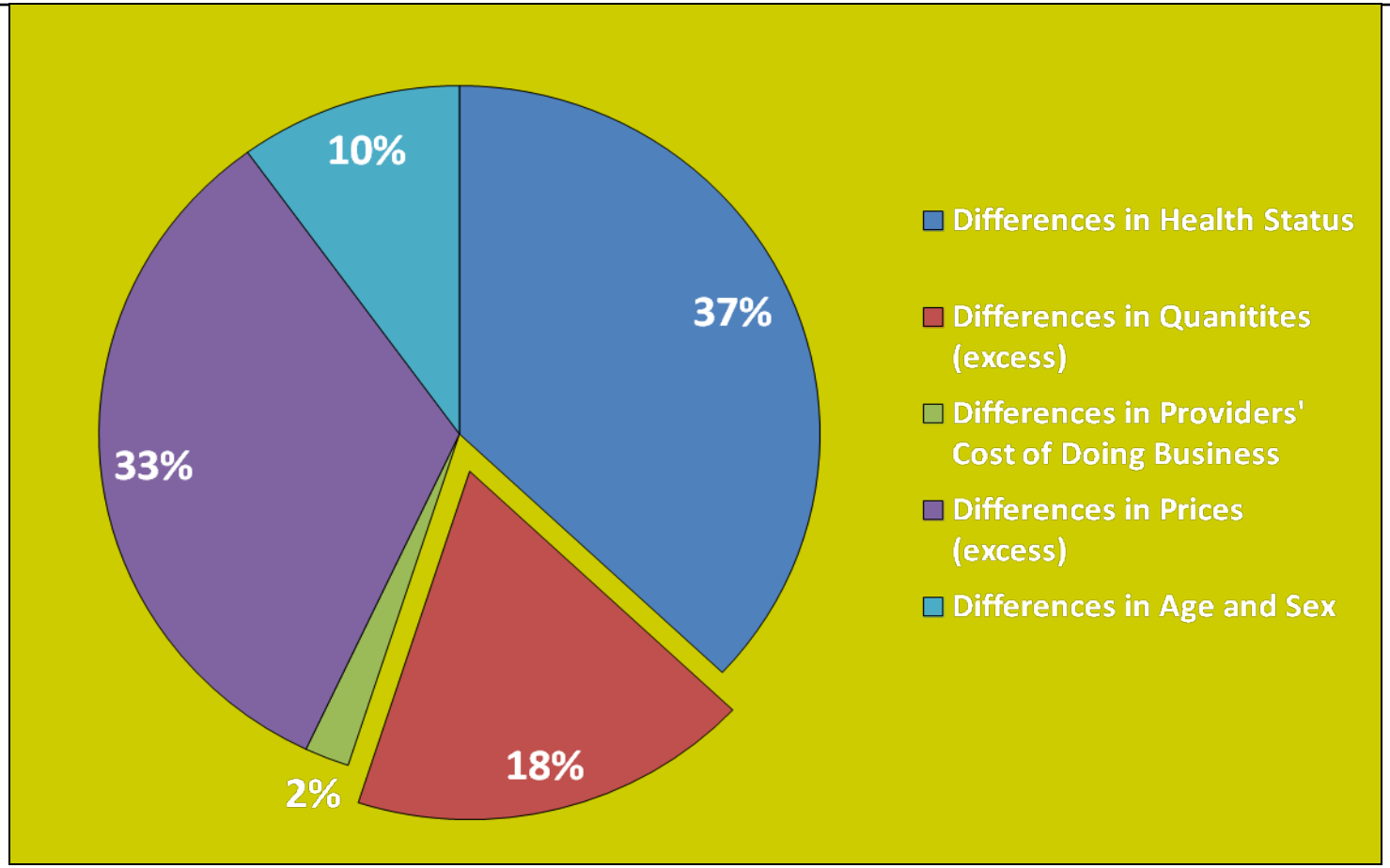
Economic Rationale for CON

- Health care market forces do not operate to optimize supply and costs:
  - Consumers lack sufficient expertise to make informed choices.
  - Services are not price-sensitive:
    - Third parties pay for them;
    - Consumers view them as essential.
  - Physicians order services and often receive payment for them.

Association between Supply, Utilization, and Spending

- "The single most powerful explanation for the variation in how patients are treated is the fact that much of the care they receive is "supply-sensitive"; that is, the frequency with which certain kinds of care are delivered depends in large measure on the supply of medical resources available."
- "Nationally, supply-sensitive care accounts for well over 50% of Medicare spending."
- Hospitalizations for most medical admissions, ICU stays, physician visits, specialist referrals, diagnostic tests, home health care, and long-term care facilities belong to the "supply-sensitive" category of care. (Wennberg, et al., 2008)

Association between Utilization and Spending



White, Chapin, *National Institute for Health Care Reform* (2012) *(Modified from the original in order to focus on "Quantities.")*

Autoworkers' Health Care Spending Per Enrollee in 19 Selected Communities, 2009 (White, Chapin 2012)

			Quantity				Price		
Community	Health Spending Per Enrollee	Enrollees (000s)	Quantity Index (1.00 = Average)	Age-Sex Index (1.00 = Average)	Quantity Index (Age-Sex Adjusted, 1.00 = Average)	Health-Risk Index (Age-Sex Adjusted, 1.00 = Average)	Price Index (1.00 = Average)	Cost-of-Doing-Business Index (1.00 = Average)	Excess-Price Index (1.00 = Average)
Buffalo, N.Y.	$4,500	10.4	0.83	1.10	0.76	0.67	0.93	0.97	0.96
Syracuse, N.Y.	$4,900	2.4	0.87	1.12	0.78	0.90	0.97	0.97	0.99
Rockford, Ill.	$5,000	6.9	0.72	0.78	0.92	0.88	1.18	0.96	1.23
Grand Rapids, Mich.	$5,100	7.2	0.85	1.03	0.83	0.69	1.03	1.02	1.01
Youngstown, Ohio	$5,400	11.9	0.98	0.99	0.99	0.88	0.95	0.95	0.99
St. Louis	$5,400	12.8	1.01	0.89	1.14	1.05	0.92	0.95	0.97
Lansing, Mich.	$5,400	9.1	0.87	0.99	0.87	0.81	1.08	0.99	1.09
Wilmington, Del.	$5,400	4.0	0.93	0.94	0.98	1.05	1.01	1.05	0.96
Saginaw, Mich.	$5,600	6.2	1.00	1.06	0.95	0.86	0.96	0.98	0.98
Warren, Mich.	$5,800	51.0	1.00	1.00	1.00	1.09	0.99	1.02	0.97
Monroe, Mich.	$5,800	2.9	1.03	0.98	1.04	0.96	0.97	1.01	0.97
Flint, Mich.	$5,900	20.9	0.98	1.01	0.97	0.89	1.02	1.03	0.99
Akron, Ohio	$6,000	2.1	1.18	0.92	1.28	1.33	0.87	0.96	0.91
Cleveland	$6,000	6.4	1.02	1.06	0.96	0.88	1.01	0.96	1.05
Toledo, Ohio	$6,000	11.2	1.08	0.89	1.22	1.20	0.96	0.96	0.99
Detroit	$6,200	37.4	1.07	1.03	1.04	1.17	0.99	1.06	0.93
Kokomo, Ind.	$6,700	6.0	1.00	0.85	1.18	1.32	1.15	0.95	1.22
Indianapolis	$7,900	7.0	1.12	1.17	0.96	0.88	1.22	0.97	1.26
Lake County, Ill.	$9,000	2.4	1.21	1.05	1.15	1.08	1.27	1.05	1.21
All Communities	**$5,800**	**218.0**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**

GM, Ford and Daimler Chrysler Studies Found Correlation between CON and Lower Health Care Costs

Certificate of Need: Endorsement by DaimlerChrysler Corporation (July 2002)

Location	Adjusted 2000 Cost*
Kenosha, WI	$3,519
Indiana	$2,741
→ Newark, DE	$2,100
→ Michigan	$1,839
→ Syracuse	$1,331

***Age, Gender, and Geographically Adjusted.**

See also, Ford Motor Co., CON Study (CY 2000); Statement of General Motors Co. on CON Program in Michigan (2002).

Effectiveness of CON in Relation to Costs

- Evidence is equivocal.
  - Difficult to control for market conditions, stringency of program, and other variables that drive costs.
- Studies have reached conflicting conclusions. CON:*
  - Reduces or has no effect on beds;
  - Makes hospitals more efficient;
  - Reduces acute care spending, but not overall spending; reduces charges for elective surgery; reduces per capita health care expenditures.
  - Decreases LOS or has no effect; and
  - Increases, decreases or has no effect on cost/admission.

* E.g., Yee, et al, NIHCR, 2012; Ferrier, 2008; Hellinger, 2009; Fric-Shamji, 2008; Conover, Sloan, 2003; Conover, Sloan, 1998; Lewin-ICF, 1992; Begley, et al. , 1982.

CON and Access

- Few studies on impact of CON on access. There is some evidence that CON:
  - Protects access in urban and rural areas by shielding community and safety net hospitals from competition and preventing exodus to suburbs.
  - Provides opportunity to condition license on services to Medicaid beneficiaries and uninsured.
  - Provides opportunity to prevent decertification of services and beds.

Yee, et al., NIHCR, 2012; Fric-Shamji, 2008.

Effects of Repealing CON

- Varies based on stringency of CON program, existing capacity, relative spending, type of facility or service, demographic trends.
- Some states experienced surges in beds, construction of new hospitals, ASCs, cardiac services, dialysis; some surged and retrenched.
- Some experienced above average growth in hospital spending post CON repeal; others did not.
- Ohio: 15 hospitals closed, 11 in urban areas, some migrated to suburbs. Substantial growth in ASCs.

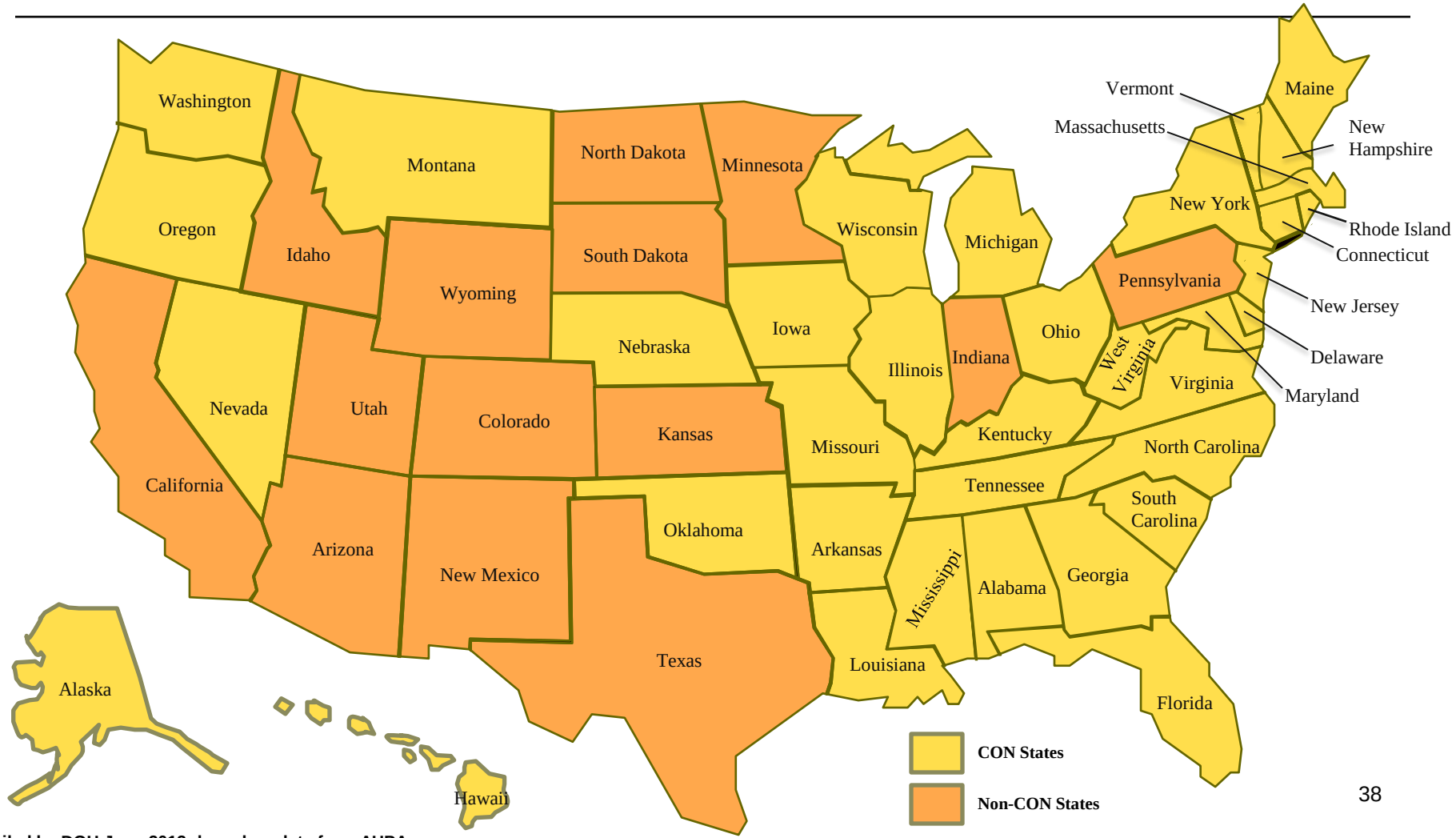
Conover, Sloan, 2003.

CON and Quality

- Higher volume is associated with lower mortality for a variety of conditions and procedures; magnitude of the association is greater for certain high-risk procedures and conditions. (Halm, et al. 2002)
- Majority of studies show positive association between volume and outcome for CABG, coronary angioplasty. (Ibid.)
- Open heart surgery mortality was 22% greater in states without CON regulations as compared to states with continuous CON regulations. (Vaughn-Sarrazin, et al. 2002)
- Marginally significant reduction in operative mortality for CABG in CON states; but accounting for state variation as random effects reduced significance of difference in mortality. (DiSesa, 2006).
- Lower NICU bed numbers and lower all infant mortality rates were found in states with CON compared with states without CON (Lorch, P, 2012)

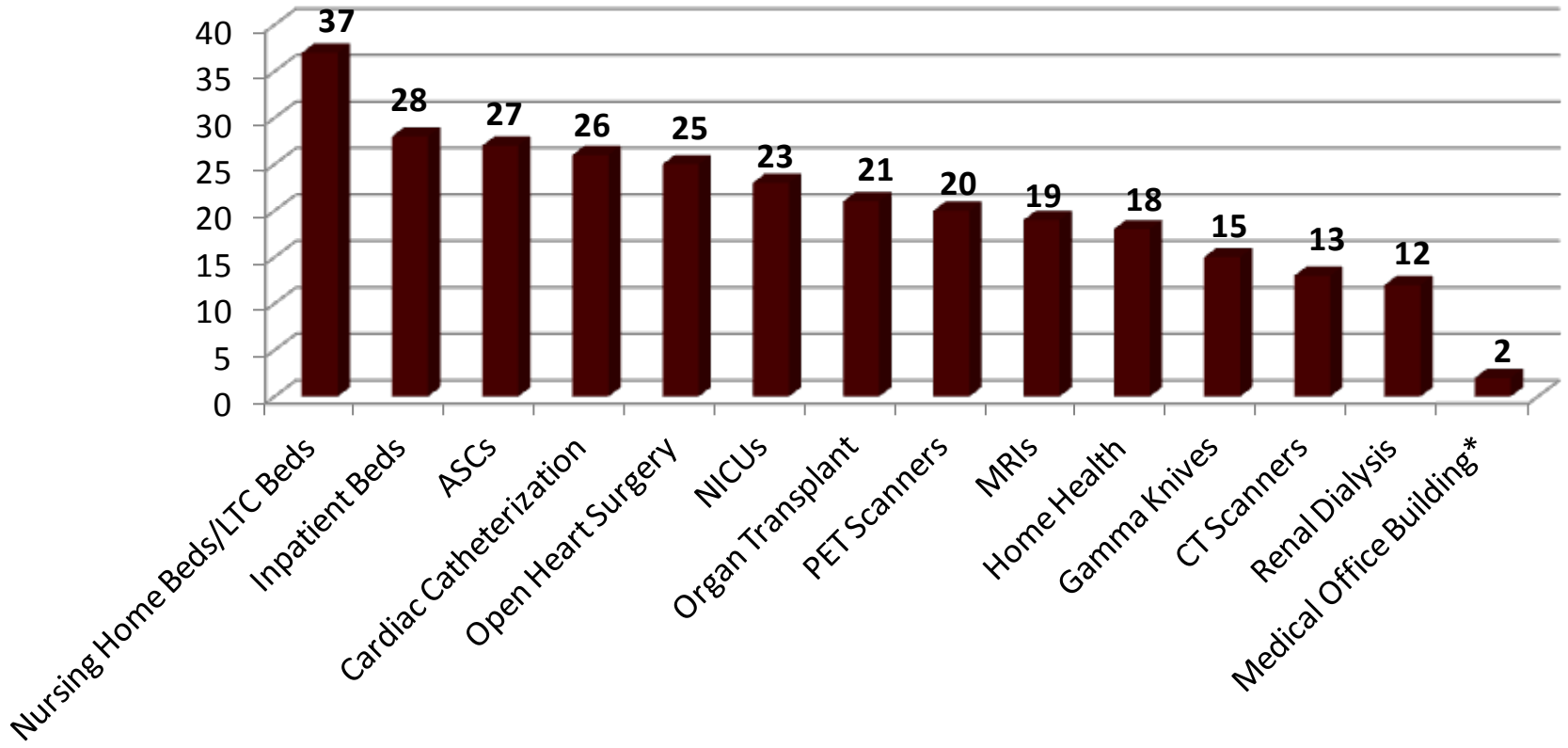
CON: National Scan

State CON Health Laws, 2012



Compiled by DOH June 2012; based on data from AHPA

CON Scope: National Scan



Data compiled from AHPA, 2011.
***New York requires CONs for clinics and their services, but no CONs are required for "Medical Office Buildings."**

Cost Thresholds

- Range from $0 (Connecticut) to $16M (Virginia)
- Some have separate thresholds for medical equipment and services, ranging from $400,000 (NH) to $5.8M (DE)
- NY: $6M for Admin.; $15M for Full;
  - Recent streamlining recommendation would eliminate CON for certain construction projects regardless of cost.

Approaches to Public Need Determinations

- NY uses administrative rule-making to establish public need methodologies.

- Some states establish public need through the development and publication of a State Health Plan.

North Carolina Medical Facilities Plan

- Projections of need for acute care, long-term care, and major medical equipment
- By county, or multi-county planning areas, depending on bed or service category
- Updated annually to reflect increases or decreases in capacity in preceding year

North Carolina Medical Facilities Plan Services Covered

- Acute Care Facilities and Services
  - Hospital beds, ORs, open heart surgery, burns care, transplants, inpatient rehabilitation.
- Long-term Care Facilities and Services
  - Nursing homes, adult care homes, home health care, hospice, ESRD facilities, psychiatric inpatient, chemical dependency treatment, ICF/DD facilities.
- Technology and Equipment
  - Lithotripsy, Gamma knife, linear accelerator, PET, MRI, cardiac catheterization.

North Carolina
Medical Facilities Plan

- Relatively narrow in scope
- Focus is on facilities, beds, equipment and specialty services
- Not a planning document for other elements of the health care system (e.g., prevention, health care reform, payment/reimbursement).

Maine State Health Plan

- Issued Biennially
  - Current Planning Period 2010-2012
- Broad Scope
  - Addresses five major areas
  - Sets forth goals for each area and strategies and tasks for achieving

Maine State Health Plan

- Reduce Waste and Inefficiency
  - Reduce Inappropriate ED Use
  - Strengthen Primary Care
  - Eliminate Duplicative Testing
- Strengthen Public Health and Prevention
- Payment Reform
- Align Policies and Systems
  - Workforce Development
  - Data Infrastructure
  - Health Information Technology
  - Certificate of Need
- Implement Federal Health Reform

Maine:
CON Linked to State Health Plan

- The Commissioner shall approve an application for a CON if the project:
  - Meets financial feasibility and public need;
  - **Is consistent with the State Health Plan**;
  - Ensures high-quality outcomes and does not negatively affect the quality of care delivered by existing service providers; and
  - Does not result in inappropriate increases in service utilization.

Maine: Criteria for CON Project Consistency with SHP

Projects that meet more will receive higher priority if they:

- Focus on population-based health
- Reduction of avoidable and inappropriate ER use
- Consolidation, collaboration or right-sizing to improve efficiency and lower cost of care
- Improve access to necessary services
- Favorable impact on regional and statewide insurance premiums

Maine: Criteria for CON Project Consistency with SHP (cont'd)

- Reduce unwarranted use of high-cost, high-variation outpatient services in the service area
- Applicant demonstrates a culture of patient safety
- Applicant employs or has concrete plans to employ HIT to enhance quality of care and patient safety
- Applicant has regularly met voluntary cost control targets set forth in statute.

CON and Batching Applications

- Proactive
  - Florida - for certain types of beds, based on need.
- Periodic
  - Virginia - based on a published schedule
- Reactive
  - Michigan and New York - based on applications for the same services in the same service area.

CON and Physician Practices: NYS

- Education Law
  - Bans corporate practice of medicine, except through established health care facilities.
  - Limits DOH regulation of physician practices.
- Public Health Law – Requires establishment and licensure of health care facilities.
  - Regulations identify characteristics that define an outpatient facility requiring establishment and licensure.

Physician Practices: NYS

- DOH oversight limited to issues such as: professional misconduct, medical records, OBS accreditation, radiation equipment, and public health threats.
- Generally, no “facility fee” reimbursement.
- No CON requirement.
- No HCRA surcharges.
- No indigent care reimbursement.

Physician Practices: Other States

- Many CON states require CON approval and/or licensure of physician practices that operate:
  - Ambulatory surgery services (e.g., GA, MA, MD, MI, NJ, VA);*
  - Linear accelerators or radiation therapy (e.g., CT, RI, MI, VA);*
  - Imaging equipment (e.g., CT, MI, VA, GA)*; or
  - New technology (e.g., ME, MA)*

***These are examples only and not a complete survey of all 50 states.**

HEALTH CARE FACILITY LICENSURE

CON and Licensure

CON	Licensure
Cost (supply, capital spending)	Quality
Access (financial, geographic)	Physical Plant Safety
Financial Stability	
Quality	

Health Care Facility Licensure in NYS

- Character & Competence
- Physical Plant Safety
- Staffing and Program
- Pre-Opening Survey
- Accreditation and Deeming

Possible Accreditation by Facility Type

Facility Type	Accreditation Required?	Can be Deemed?
Hospital	No	Yes. Must undergo Triennial Survey by AO to ensure compliance with Federal COPs and AO Standards. Must pay additional annual fee to AO.
Ambulatory Surgery Center	Yes	Yes. Must undergo Triennial Survey by AO to ensure compliance with Federal COPs and AO Standards. Must pay additional annual fee to AO.
Other Diagnostic and Treatment Center	No	No
Rehab Agency (OPT/SP) or RHC	No	Yes. Must undergo Triennial Survey by AO to ensure compliance with Federal COPs.
ESRD, CORF	No	No

Surveys by Accreditation Type

	Unaccredited Facility	Accredited Facility	Deemed Facility
Federal Periodic Survey	Conducted by NYSDOH based on CMS scheduling rules	Conducted by NYSDOH based on CMS scheduling rules.	Conducted by AO every three years to ensure compliance with COPs.
Federal Validation Survey	N/A	N/A	Conducted by NYSDOH based on random sample selected by Federal Government
Federal Complaint Investigation (for alleged non-compliance with Federal Conditions of Participation)	Conducted by NYSDOH. No authorization required.	Conducted by NYSDOH. No authorization required.	CMS must authorize NYSDOH to conduct investigation
Re-Accreditation Survey	N/A	Conducted by AO every three years to ensure compliance with AO Standards.	Conducted by AO every three years to ensure compliance with AO Standards. (Simultaneous with AO Federal Periodic Survey)
State Periodic Survey	Conducted by NYSDOH on appropriate cycle. Simultaneous with Federal Survey when possible.	Permitted under the Collaborative Agreement, however NYSDOH usually accepts the AO Triennial in lieu of conducting a survey.	Permitted under the Collaborative Agreement, however NYSDOH usually accepts the AO Triennial in lieu of conducting a survey.
State Complaint Investigation (for alleged non-compliance with NYS regulation or statute)	Conducted by NYSDOH.	Conducted by NYSDOH.	

Certification and Surveillance Process for NYS Nursing Homes

- Skilled nursing facilities (SNFs) and nursing facilities (NFs) must:
  - Be licensed under PHL Article 28;
  - Comply with Article 28 and 10 NYCRR Part 415, etc.;
  - Comply with 42 CFR Part 483, Subpart B to receive payment under the Medicare and Medicaid Programs.

Certification and Surveillance of Nursing Homes in NYS

- To certify a SNF or NF, the state survey agency (NYS DOH) must complete:
  - Life Safety Code (LSC) Survey
  - Standard/Recertification Survey
- Federal surveys are:
  - Unannounced and occur every 9-15 months (penalties involved if breached).
  - Can be conducted on weekends, or at any time 24 hours a day.
- Accreditation is voluntary; no deeming.

Nursing Home Complaint and Incident Investigations in NYS

- Determine compliance with all applicable **Federal and State** program requirements.
- Process involves medical record review, document review, observation, interview with residents, staff and key personnel, policy & procedure review.
- Concerns that are investigated and identify findings of non-compliance with state or federal requirements will result in the provider receiving a statement of deficiencies, which may require the provider to respond with an acceptable plan of correction.

Licensing in Massachusetts

- Licensed providers:
  - Hospitals
  - Nursing homes and rest homes
  - Hospice programs
  - Clinics
  - ASCs
  - Dialysis
- Not home care agencies
- Licenses issued for 2-year terms

Massachusetts Process

- Determination of need
- Architectural plan review
- Determination of suitability
  - Compliance record of operator
  - Criminal history
  - Financial capacity
  - Compliance with governance, public hearing, and community benefit requirements (acute care hospitals only)

Licensing in Pennsylvania

- No CON
- Licensed providers:
  - Hospitals
  - Nursing homes
  - Birthing Centers
  - Home health/hospice agencies
  - Ambulatory surgery centers
  - Cancer treatment centers

Pennsylvania Process

- Applicant background information
  - Business structure and controlling person
  - Managers
  - Compliance record in operating health care facilities
  - Charity care intentions

Pennsylvania Process (cont'd)

- Architectural plan reviews conducted prior to construction for all construction projects;
- Review of policies and procedures, staffing
- On-site, occupancy survey for any new facility, new service or construction. Some projects are inspected during construction too.
- Licenses issued for a 2-year period.
  - Provisional licenses may be issued for up to 6 months.

Observations

- CON's impact is contextual
- Depends on:
  - Implementation
  - Payment incentives
  - Other market forces
  - Regulatory/policy environment
- We need mutually reinforcing policies to drive health system improvement.