United Hospital Fund

Trends and Changes in New York's Health Care Delivery System and Payment Systems: Implications for CON and Health Planning

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Goals of Presentation:

- ***Describe trends in***
  - ***Health system organization and performance***
  - ***Payment systems***
- ***Discuss implications of those trends***
  - ***For the delivery system***
  - ***For NYS' regulatory priorities and tools.***

Organization of the Discussion

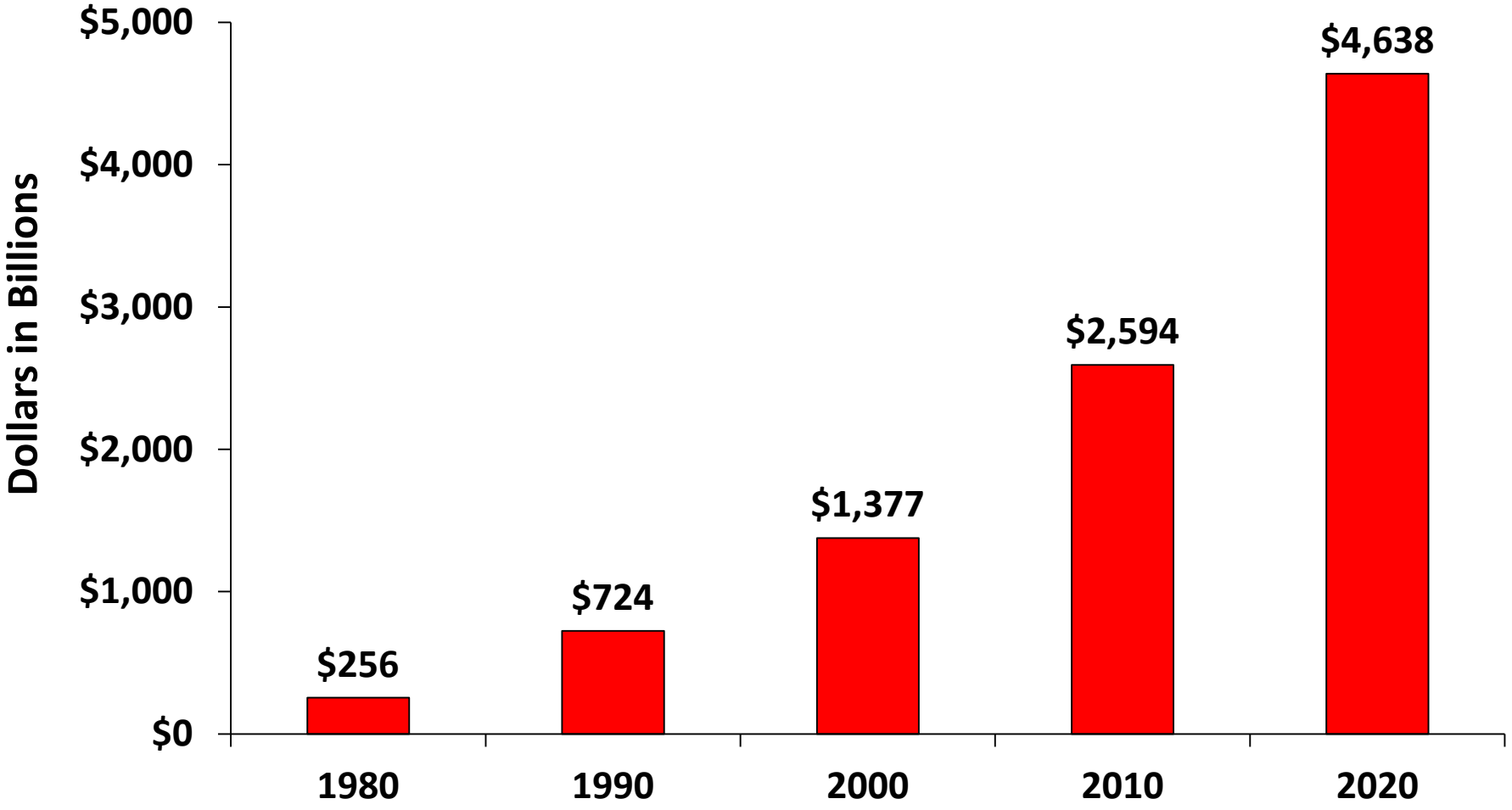
- ***Some Game-Changers***
- ***The Vision:***
  - ***What we're trying to achieve***
  - ***Levers of Change***
- ***Trends and Changes:***
  - ***Payment System***
  - ***Acute Care Delivery System***
  - ***ACO's***
  - ***Long-Term Care***
- ***Implications***
  - ***Some Scenarios and Issues for the State***
  - ***Role and Purpose of CON – Now and in Future***
- ***If Not (Only) CON, What Else?***
  - ***Other State Imperatives and Tools***
  - ***Role of Regional Planning***

Some Game-Changers

Cost
Population Health
HIT
Evidence-Based Medicine
Patient Engagement

Cost: The compelling priority

U.S. National Health Expenditures: 1980–2020

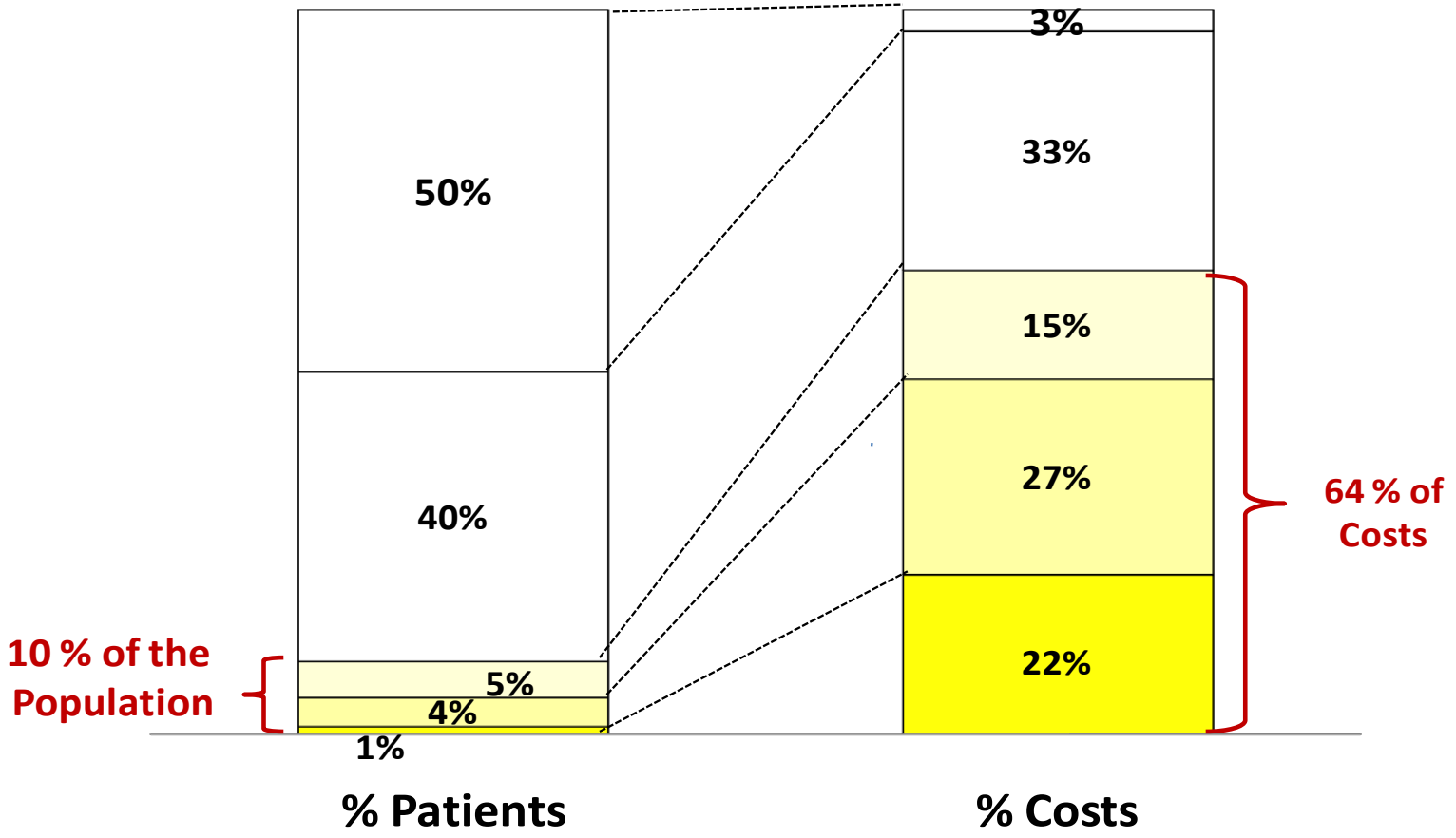


Source: United Hospital Fund analysis of CMS National Health Expenditure data.

Note: Expenditures in 2020 are projected.

The Data Suggest Where We Might Focus

Small Populations Account for a Disproportionate Share of Health Care Costs

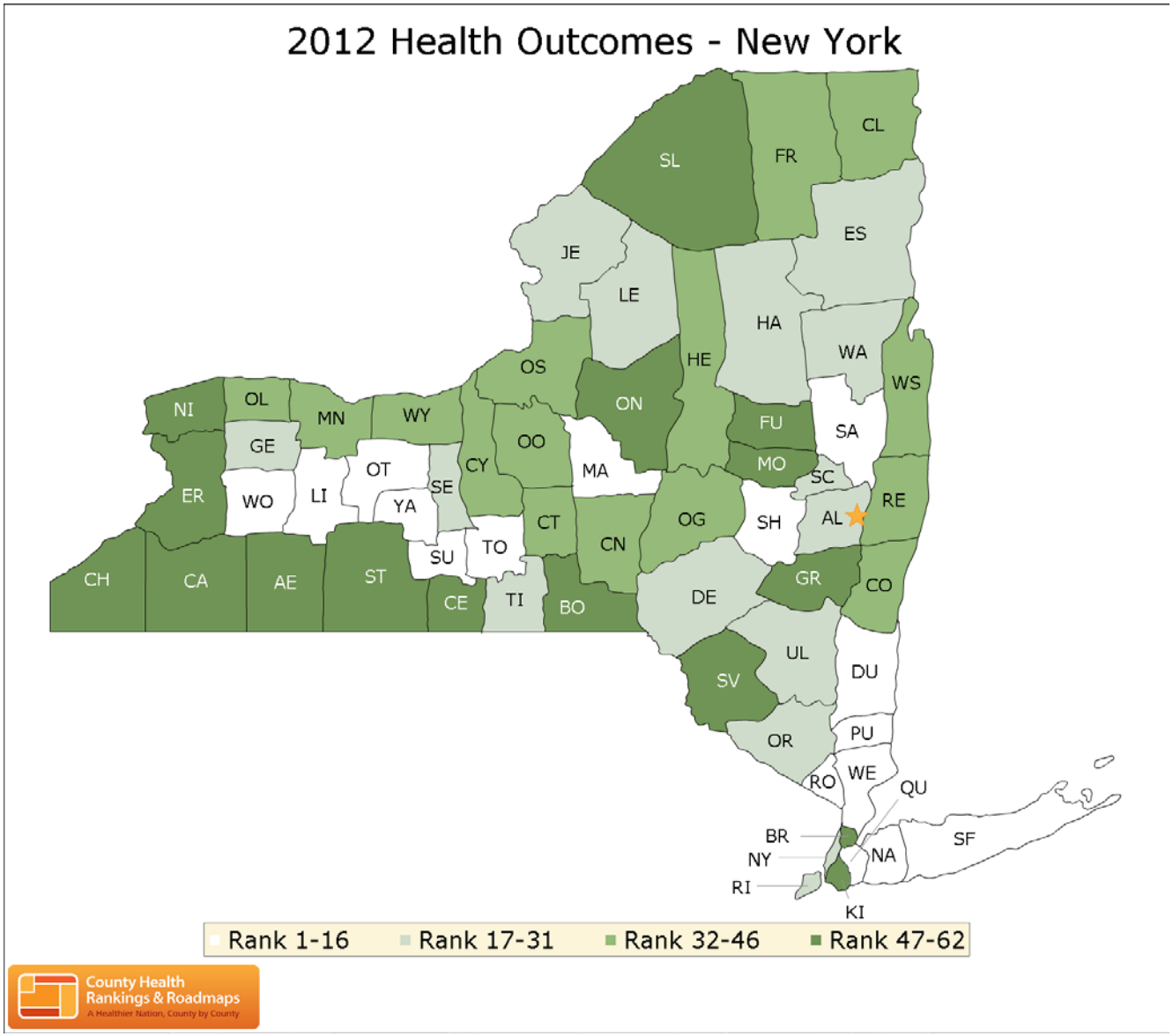


Cohen, S. and Yu, W. *The Concentration and Persistence in the Level of Health Expenditures over Time: Estimates for the U.S. Population, 2008–2009. Statistical Brief #354. January 2012. Agency for Healthcare Research and Quality, Rockville, MD.*
http://www.meps.ahrq.gov/mepsweb/data_files/publications/st354/stat354.shtml

What do you mean, "Population Health"?

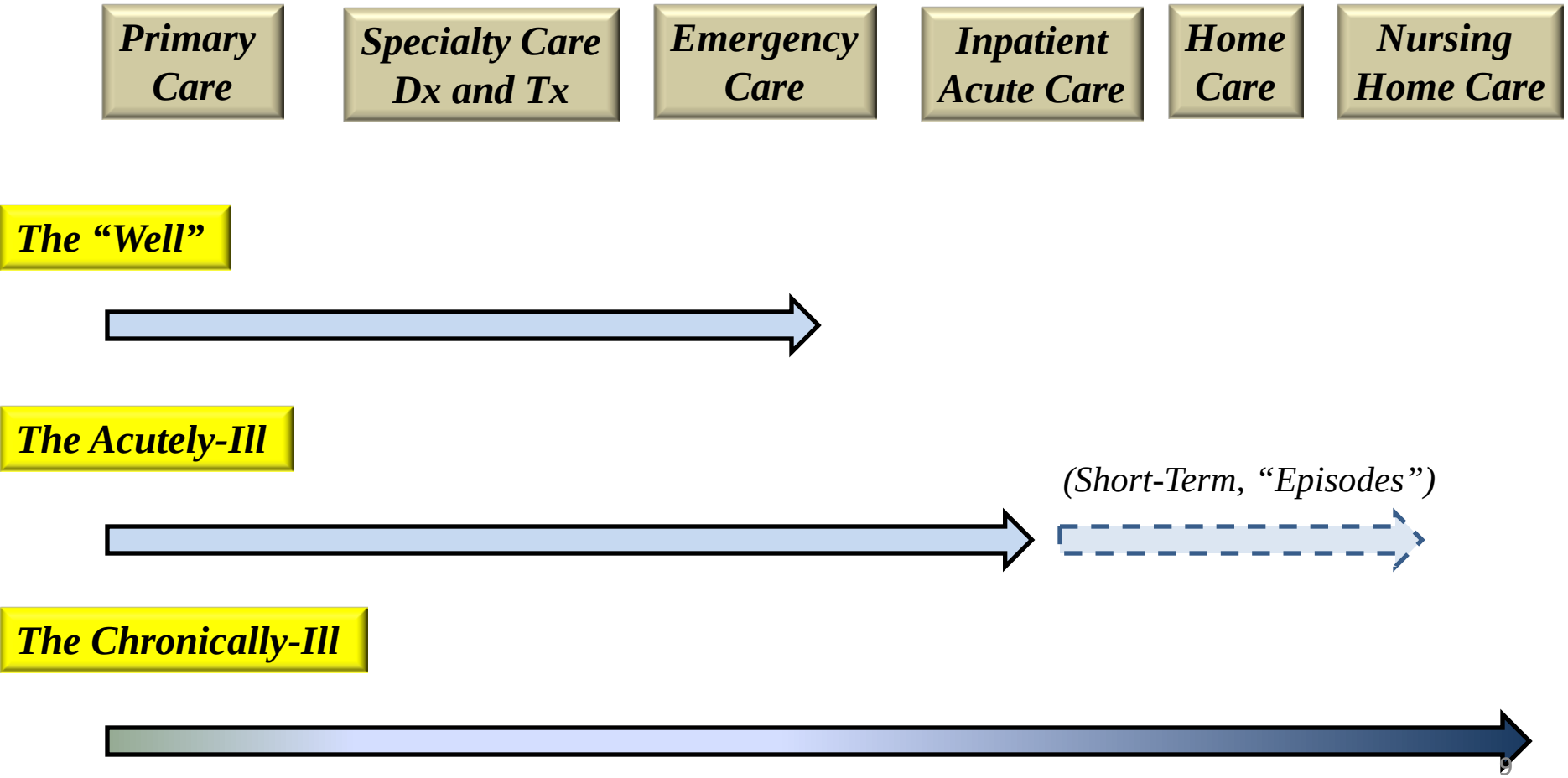
- ***Geographic***
- ***Utilization Segments***
- ***Purchasers and Payers***

Population Health: Geographies



Population Health – Utilization Segments Different Health Status

Population Segments Differ, in Term of What Services They Use, and How Much



Population Health – Insurance Segments

Medicare, Medicaid, Commercial

- ***Cover Different Populations:***
  - *Medicare: The young-old, the old-old, the disabled*
  - *Medicaid: The poor, those w behavioral health problems and those requiring long-term care (LTC)*
  - *Dual-eligible: Disabled, old and poor, also LTC*
  - *Commercial: The employed-insured, and their families (some retirees)*
  - *Uninsured*
- ***They have some of the same, and some different issues***
  - *Similar:*
    - *Chronic disease, prevention/wellness, "preventable" admissions*
    - *Need for primary care, care management for complex patients*
  - *Different:*
    - *Impact of demographics, and social determinants on health and disease*
    - *"Pain-points" – who are their "high-cost patients", cost-drivers*
    - *Parts of the health system they need, and use*
    - *Points of leverage, and interventions*

Impact of Advances in Health Information Technology

- ***"On-line": Operations improvement***
  - *EMR's and e-prescribing → improved quality and safety*
  - *Registries → targeted care management*
  - *RHIOs → communication, care coordination among providers*
  - *Telemedicine and remote monitoring → access, care management*
  - *Patient "connectivity" → patient engagement*
- ***"Off-line": Increased Accountability, Transparency***
  - *Data-mining of claims and EMR data*
  - *Can " attribute" patients, populations to providers, networks*
    - *Measure their care quality, outcomes, use and cost*
    - *And "attribute" it to specific providers and systems*
  - *Can measure, analyze, report and compare performance among providers/networks*

Impact of HIT

- ***HIT Meets Evidence-based Medicine***
  - *"Best practices" and Guidelines ➔ "benchmarks"*
  - *"On-line": EMR's, can prompt/ influence provider behavior*
  - *"Off-line": can assess performance vs. standards*
- ***Enables***
  - *Providers/systems to focus QI*
  - *Purchasers, payers to identify/reward performance*
  - *Public reporting, transparency to consumers/patients*
- ***Connecting patients with their own care***
  - *Patient portals, and e-communications improve access*
  - *Smart-phones and web*

"Patient Engagement"

- ***Patient Experience***
  - *Measured, reported, a factor in Value-Based Purchasing*
  - *The Q: What do people want?*
    - *A relationship; help with care coordination; to be heard, involved*
- ***Patients as Partners in their own care***
  - *Education, involvement, empowerment*
  - *Critical to chronic disease management*
- ***Patients as informed consumers of health care***
  - *Selecting providers on basis of quality and cost*
    - *Increased cost-sharing and "Consumer Choice" plans*
  - *Changing expectations and demands*
    - *"Choosing wisely"*

The Vision

Where we are

Where we think we want to go

The levers of change

The Delivery System: Where We're Starting

Acute Care Delivery System

Long Term Care System

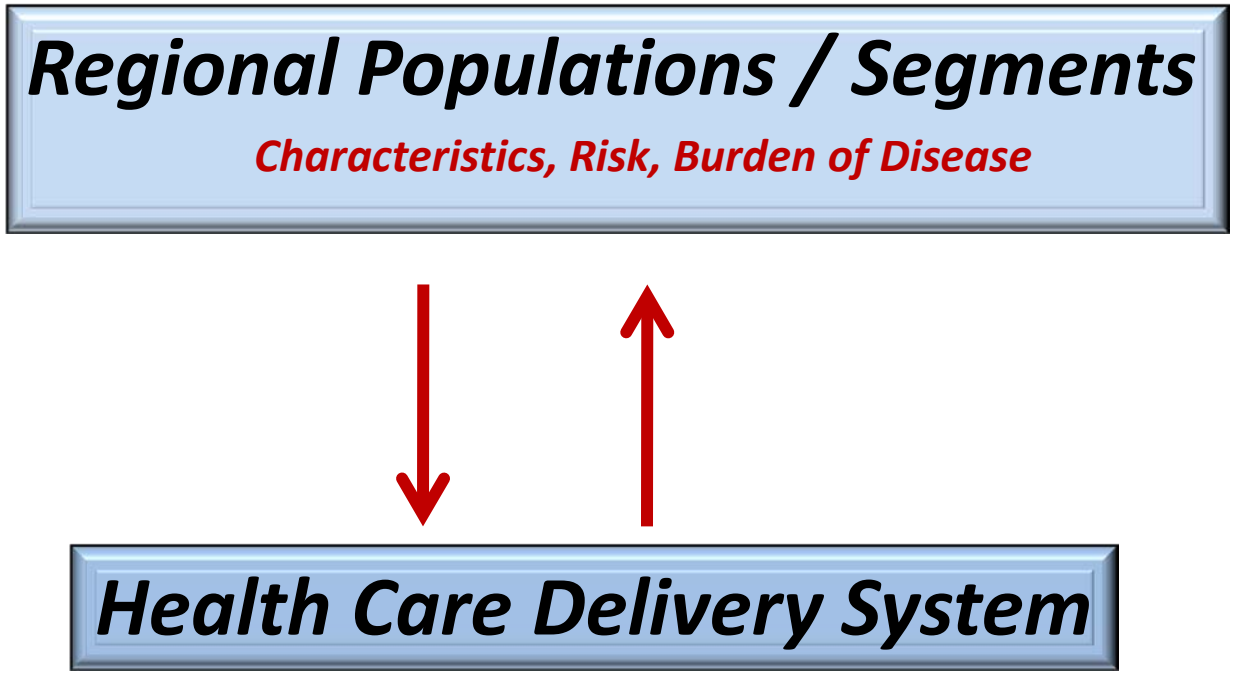
Behavioral Health System

The Vision
A High-Performing Delivery System

- ***Integrated Delivery System:***
  - *"An organized network of health care providers that provides or arranges to provide a coordinated continuum of services to a defined population and is willing to be held clinically and fiscally accountable for the outcomes and health status of the population served." (Shortell, 1996)*
- ***Pursuing the Triple Aim***
  - *Better Care, Better Population Health, Lower Costs*
- ***Across the Delivery System***
  - *Primary Care*
  - *Specialty Care*
  - *Behavioral Health Care*
  - *Urgent and Emergent Care*
  - *Inpatient Acute Care*
  - *Home Care and Nursing Home Sub-Acute and*
  - *Long-Term Care*

Improving Performance:

Improving Care and Population Health, Reducing Costs



The Goal:

- ***To improve the Performance of Regional Delivery Systems, and***
- ***How they respond to the needs of the communities they serve***

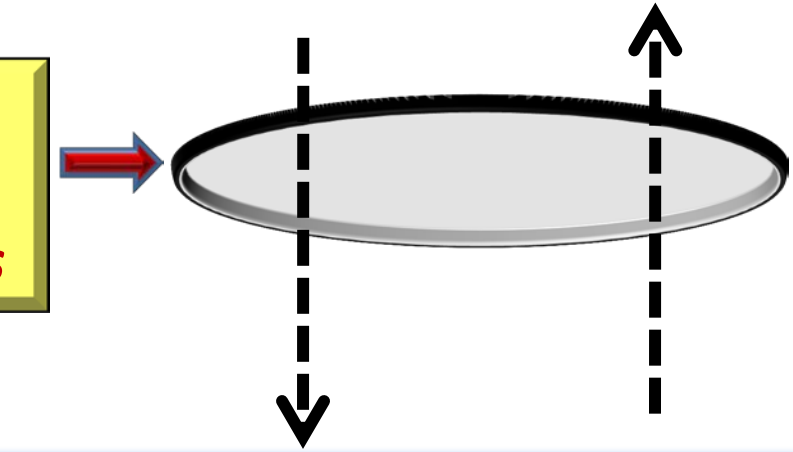
The Importance of the Payment System

Incentives, Disincentives Drive Behavior

Regional Populations / Segments

Characteristics, Burden of Chronic Disease

Payment Systems and Incentives



Health Care Delivery System

Trends

Purchasers/Payers

Acute Care System

ACO's

Long-Term Care

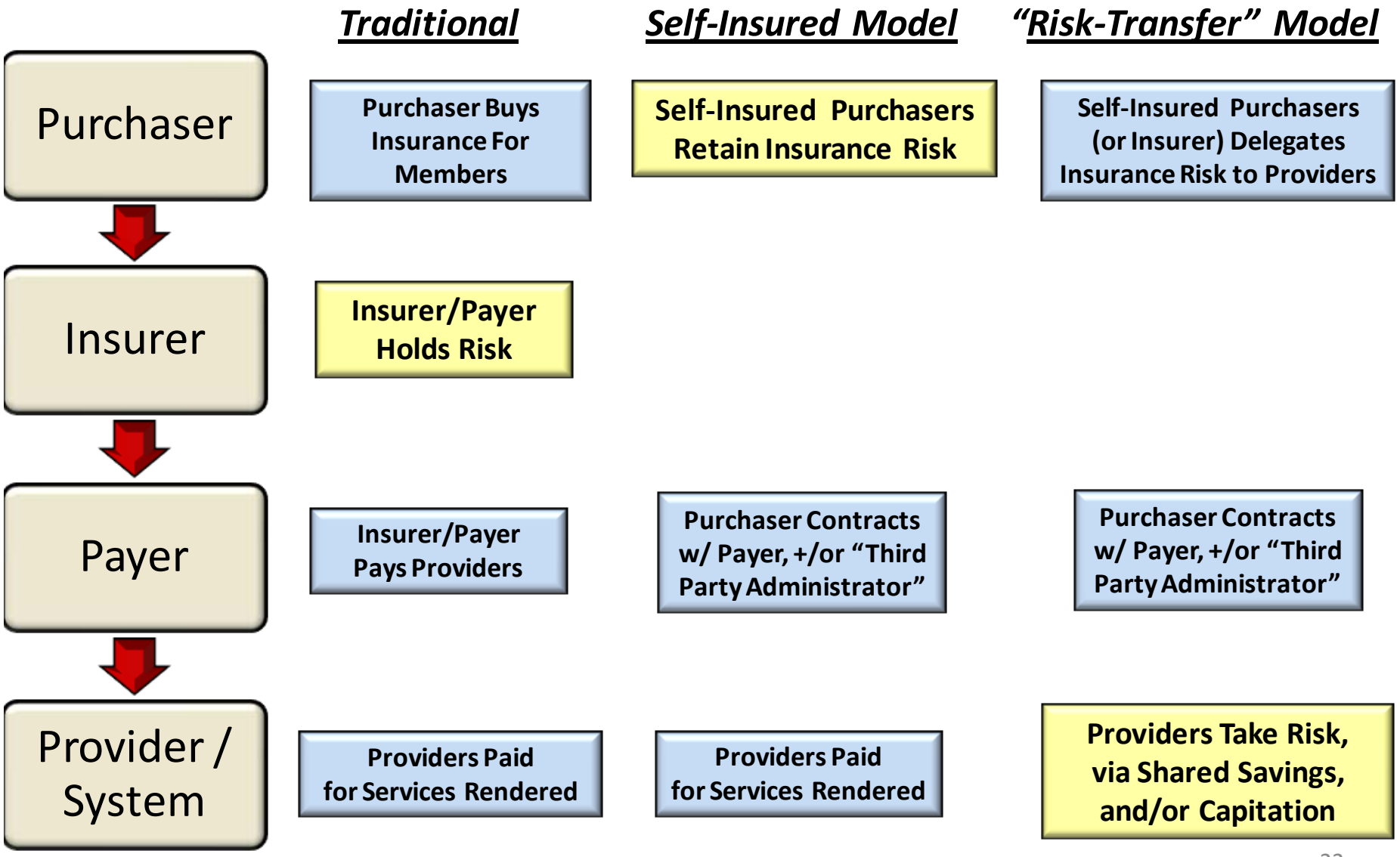
Purchaser/Payer Trends

- ***The Performance Imperative:***
  - ***Manage premium costs / Total health care spend***
- ***How:***
  - ***Prevention/Wellness***
  - ***Reducing "Potentially Preventable Events"***
  - ***A New Emphasis on Primary Care***
  - ***Chronic Care Management***
  - ***Care Management for high-risk, high-cost patients***
  - ***Patient Engagement***
- ***Measuring, analyzing provider behavior***
  - ***Attribution of patients/populations to providers/groups***
  - ***Analyzing process, outcome measures***
  - ***Identifying "high-performing" providers/systems***
- ***Driving business to high-quality, low-cost providers***
  - ***Identifying providers with those characteristics***
  - ***Offering members different products: "Tiered networks", w premium differential***
- ***Sharing/shifting risk to members – incent cost-conscious behavior***
  - ***Point of sale – co-pays and deductibles***
  - ***High-deductible plans, w HSAs***

Purchaser/Payer Trends

- ***Changing Incentives: FFS ➔ Buying Quality, and Value***
  - ***Increasing payments for primary care, additional PCMH payments***
  - ***P4P***
  - ***Medicare VBP system***
  - ***Readmissions penalties***
- ***Buying care management***
  - ***PCMH***
  - ***Health Homes***
  - ***MLTC***
- ***Changing business model***
  - ***Offering self-insured employers "ASO" services***
  - ***Offering providers data/analytics "back-room"***
- ***Partnering with Providers***
  - ***Tiered networks – channeling volume to high-performers***
  - ***Accountable care arrangements***
  - ***Co-branding***
- ***Risk-sharing/transfer to providers***
  - ***Bundling***
  - ***Shared savings***
  - ***Shared/delegated risk***

Insurance/Payment System Changes
Who Holds the Insurance Risk?



Provider System Trends

- ***The Performance Imperative: (the Triple Aim)***
  - *Improve quality and safety*
  - *Reduce unit costs*
  - *Improve patient experience*
- ***Accountability - Performance can be***
  - *Attributed to specific providers, networks*
  - *Measured, analyzed, compared to benchmarks*
  - *Rewarded, and punished*
- ***"Where the puck is going to be"***

  An "ambulatory care-centric" delivery system, managing quality, cost and patient experience for patients and populations, across the continuum

Provider System Trends
The Performance Imperative

- ***What:***
  - *Access*
  - *Coordination*
  - *Quality/Safety*
  - *Patient Experience*
  - *Utilization and Costs*
- ***How:***
  - *Process and practice redesign ➔ evidence-based approaches*
  - *A Focus on Population Health*
  - *Using HIT to support performance improvement*
- ***Where***
  - ***Within** a given provider's sites and services*
    - *Cost management initiatives*
    - *Quality improvement collaboratives*
    - *A focus on the patient experience*
  - ***Between and among** parts of the delivery system*
    - *Managing utilization and costs, across providers/levels of care*
    - *Coordinating and managing referrals*
    - *Transitions of care*

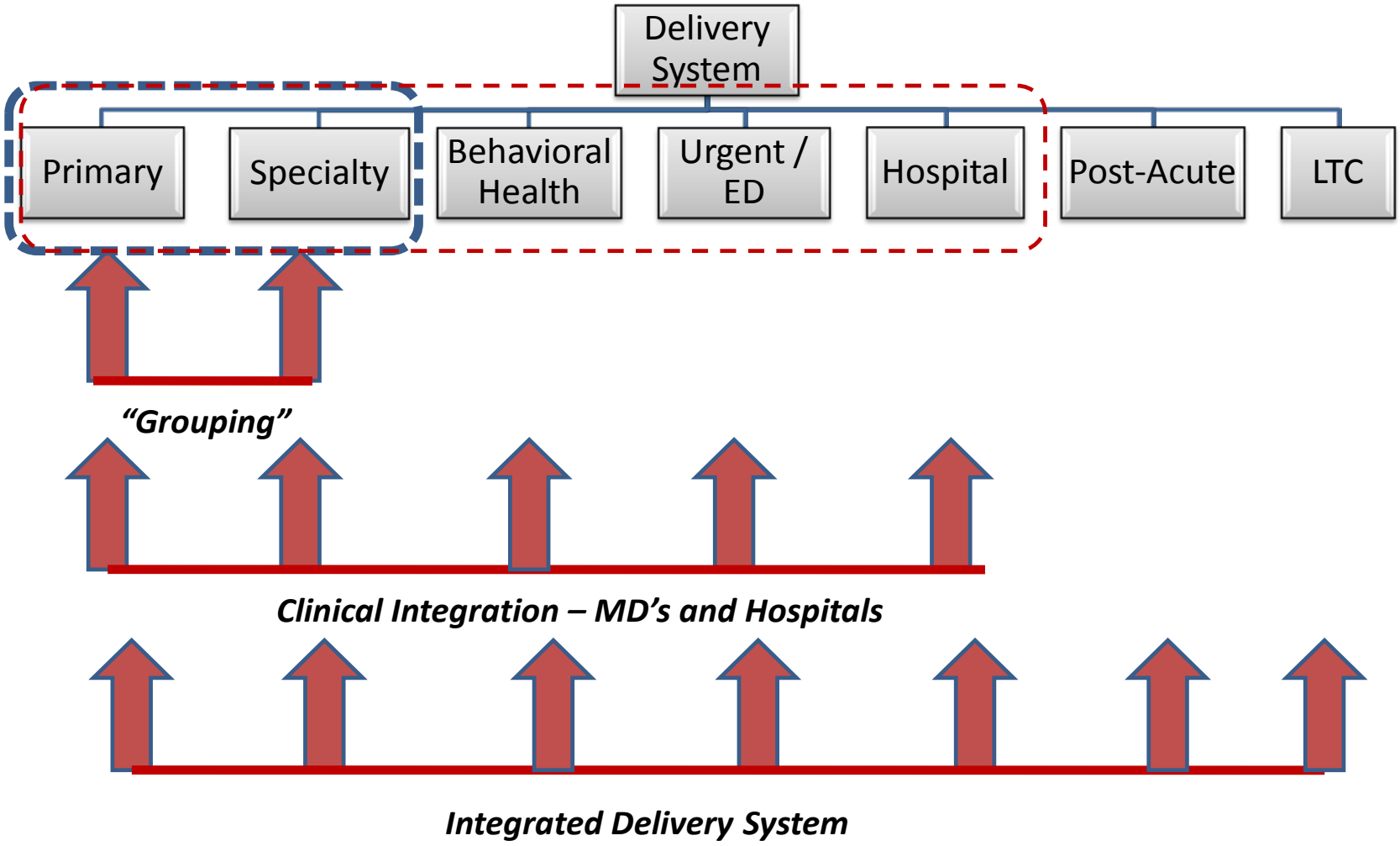
Provider System Trends

- ***New competencies***
  - *Understanding, managing "total costs of care"*
  - *Population health management*
  - *Chronic disease management*
  - *Care management, across the continuum*
  - *Patient engagement*
- ***New program models***
  - *Patient-Centered Medical Homes*
  - *Health Homes*
  - *Integrated delivery systems*
- ***The importance of scale***
  - *Required to support new infrastructure*
    - *HIT – EMRs, registries, RHIOs*
    - *Care management*
    - *Patient education and engagement*
    - *Ability to track and manage utilization, and costs*
    - *Ability to measure, report performance*
  - *Needed to participate in new models, payment schemes*

Provider System Trends
New Organizational Models

- **Consolidation/Integration**
  - Horizontal: Among providers of the same service
    - Purpose: to achieve scale, gain economies
    - Examples:
      - Primary care, Specialty care groups
      - Hospitals
      - Home care
  - Vertical: Across different parts of the delivery system
    - Purpose: Manage, improve care, across delivery system
    - Examples:
      - Multi-Specialty Groups and IPAs
      - Physicians partnering with/employed by hospitals
- **New Organizational Forms and Relationships**
  - Physicians "grouping" into MSGPs and IPA's
  - Physicians employed by / partnering with hospitals
  - "Health Systems"
- **Growth of Regional Integrated Delivery Systems**
  - Purpose: Gain scale, Manage Population Health

Integrating the Delivery System



Accountable Care

- **Defined:**
  - Partnership between organized group of providers and a purchaser or payer to accept responsibility for care and costs of a defined population
  - By definition, a contract between a (single) payer and a provider group
- **Approaches**
  - Basic idea: Health Care "on a budget"
    - If "total health care spend" < Target, providers get to retain some or all savings
  - Focus:
    - Managing a population's total per-capita costs of care (Insurance POV)
    - Target: The "preventable's" – particularly hospital admits
  - Risk-sharing Models
    - Shared savings only
    - Shared risk
- **Organizational Models for Contracting**
  - With organized physician groups (MSGP or IPA)
  - With Integrated Delivery Systems
- **Implications of Risk-Sharing Varies by Model**
  - Shared savings has little/no down-side risk
  - Risk-transfer has downside risk
    - Implications different for provider contracting w payer, vs. w an employer/purchaser

Medicare ACO's in New York

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

Examples of ACO Relationships with Commercial Insurers

- ***Westmed Medical Group:***
  - *Accountable care contracts with both Cigna and United Healthcare/Optum.*
- ***Weill Cornell Physician Organization:***
  - *Partnering with Cigna on a Collaborative Accountable Care initiative*
- ***Kaleida Health:***
  - *Accountable care initiative with BlueCross BlueShield of Western New York.*
- ***Montefiore :***
  - *Managing care of Emblem Health members under full-risk capitation contract*
- ***Participating in Premier's ACO Implementation Collaborative:***
  - ***Rochester General Health System / GRIPA***
  - ***North Shore - Long Island Jewish Health System***

LTC Providers
A Foot in Two Worlds

A Mixed Model, Different Populations, Products, and Payers:

	Sub-Acute Care (All Payers)	**Long-Term Care** (Mostly Medicaid)
Home Health	**Post-acute Homecare**	**Long-Term Community-Based Care**
Nursing Homes	**Post-Acute Institutional Care**	**Long-Term Nursing Home Care**

Long Term Care

- ***The Performance Imperatives:***
  - *Improve quality, patient experience, cost*
  - *In sub-acute care: reduce readmissions*
  - *In LTC: Improve quality, safety, maintain function, and quality of life*
- ***The Focus:***
  - *Improve Quality, Reduce hospital use by Medicaid, Duals in LTC*
    - *But, for dual-eligibles, that only benefits Medicare*
  - *Expand use of community based care alternatives*
  - *Build Community Care Systems*
    - *Close connection with other social/supportive services*
    - *Limited by availability (affordability) of supportive housing*
- ***Consolidation/Integration?***
  - *<u>Horizontal</u>: Historically, more in Home Health*
  - *<u>Vertical</u>: Providers of LTC partnering ➔ LTC Systems*
    - *With each other, integrating levels of care*
    - *With managed care plans - MLTC*
    - *With housing initiatives – Assisted Living*
    - *With community-based services*

The Long Term Care System

- **The Challenges:**
  - LTC system includes very high-cost patients
  - It is essentially "owned" by Medicaid
  - Institutional LTC system under financial stress
    - Substantial pent-up capital needs, and Medicaid still pays for capital
  - Both LTC sectors serve many dual-eligibles
    - But Medicare pays only for acute care and limited post-acute services
    - FIDA would combine Medicare w Medicaid in unified managed care program
  - Both LTC sectors generate "preventable" admits
- **The Initiatives**
  - MLTC
    - MLTC consolidates variety of programs into unified managed care program
  - FIDA
    - Initial focus on Medicaid and dual-eligibles living in community
    - Future option to extend FIDA, for duals, to nursing homes
  - CMS initiatives focusing on LTC and Community Care
    - Increasing payment for community-based care
    - Reducing hospital admits by nursing home residents

Summary : Trends and Changes Under Way

- ***Some of the drivers***
  - ***Costs***
  - ***HIT***
  - ***"Population Health"***
  - ***"Evidence-Based" Care***
  - ***Patient engagement***
- ***Delivery and payment systems are clearly changing***
  - ***Providers:***
    - ***The "Performance Imperative"***
    - ***"Grouping" into systems, new models for organizing and delivering care***
    - ***Managing populations' health, accepting performance-based risk***
  - ***Payers***
    - ***Buying value, incenting quality and cost-effectiveness***
    - ***Partnering with providers, to improve performance, for their "covered lives"***
- ***Not an "on-off" switch, a rheostat***
  - ***Different communities moving at different speeds***
    - ***Some will get "there" sooner than others***
  - ***Meanwhile, the "old" ways and behaviors will remain***
    - ***FFS payments***
    - ***Specialty-driven***

Implications

Scenarios

Issues

CON: Then, Now, and Future

Where to, from here?

Some Scenarios for the future?
It Depends…

- *On how strong financial / performance improvement incentives prove to be*
  - *Near-term, a mixed model, FFS + VBP*
    - *Old revenue-seeking, volume-seeking behaviors are burned-in, will be hard to change*
    - *"Managing in the middle" is tough, providers taking steps to reduce their own revenues*
  - *Is a multi-payer alignment of incentives needed, achievable?*
- *On how well physicians (and hospitals) can work together, as systems*
  - *Will they be able to overcome old behaviors, to increase FFS revenues?*
  - *Will they collaborate, or - in a constrained fiscal environment - compete?*
  - *Will they be able to create effective systems of care?*
  - *Who leads, who follows: Hospitals, physician groups*
- *On where you are, in the state (resources, needs, issues differ)*
  - *Rural*
  - *Suburban*
  - *Urban, multi-hospital/multi-system*
  - *NYC*
- *On what time frame you're looking at*
  - *Near-term – 1-2 years*
  - *Intermediate term – 3-5 years*
  - *Longer-term*

Some Risks to be Considered in This New World

- ***As the new systems get stronger ➔ the only game in town***
  - *Market power => price increases*
  - *How well will they include the uninsured, underserved*
  - *What to do about providers that are "left out"?*
- ***The weak increase in number and fragility***
  - *If and as hospitals close, how deal w jobs, and "stranded capital"*
- ***Systems are not just NY-based providers***
  - *Border counties already dealing w out-of-state partners*
- ***If and as systems take on risk,***
  - *Who's watching the impact*
  - *How and by whom is that regulated?*
  - *What to do when systems "too large to fail", do?*
- ***In a competitive market (2+ systems competing)***
  - *On what basis are they competing?*
  - *Who manages the conflict?*
  - *Who watches the public goods?*
- ***As physician groups move into accountable care…***
  - *Who watches, analyzes, reports on, regulates their activities?*

CON - A "supply-side" intervention

- ***CON's Foundations:***
  - ***Protect the public's health***
    - ***Assure character and competence***
    - ***Limit diffusion of services where strong volume-quality relationship***
    - ***Distribute services, based on Need***
    - ***Protect "safety net" providers and vulnerable populations***
  - ***Protect the public's purse***
    - ***Constrain, manage capital spending*** *(Capital Reimbursement)*
    - ***Manage supply of beds, high-tech equipment against "need"*** *(FFS system)*
- ***Focus: Capital Projects and Service Changes***
  - ***Reactive process: First, providers must apply for CON approval***
  - ***Focus: capital projects and service changes, in state-licensed facilities and services***
  - ***For each project, review of four key elements***
    - ***Need, Character/Competence, Financial Feasibility, Code Compliance***
- ***Perceptions of the effectiveness/impact of the CON vary***
  - ***Impact on quality and cost control debatable***
    - ***But, CON is "the cop on the beat"***
  - ***Limits "destructive competition"***
  - ***We still have "market failures"***
    - ***Needed providers at risk, and failing***
    - ***Populations at risk, and disparities***

A Changing System
Demand-side Interventions

- **Delivery system changes**
  - From hospital-centric to ambulatory care-centric systems
  - New organizational forms, including physician groups accepting risk
  - Managing care and reducing preventable use of hospitals, specialty care
- **Payment system changes**
  - No cost-based capital reimbursement (except Medicaid, for now…)
  - FFS being replaced by "value-based" payment systems
    - Incentives to provide quality care, cost-effectively
    - Dis-incentives to over-use, with a sharp focus on "preventables"
- **HIT and public reporting: increased transparency**
  - Quality, cost reporting of providers' and systems' performance
- **Purchasers, payers provide incentives to patients /"members"**
  - To select and use high-quality, cost-effective providers/systems
  - To participate in wellness programs, and avoid unnecessary utilization
- **The net effect (in theory):**
  - Increased demand for organized ambulatory care (mostly non-Article 28)
  - Reduced use of / spend on hospitals, ED's, specialty care
  - Increasing concerns about financial viability of hospitals

What do we need CON for, Going Forward?

1. *To assure projects, services, facilities are "needed?"*

2. *To manage distribution of services, control unbridled competition?*

3. *To assure adequate character and competence?*

4. *To control capital costs?*

What do we need CON for, Going Forward?

1. ***To assure projects, services, facilities are "needed?"***
   - *In future, facilities/services will drive costs more than revenues*
   - *In interim (as FFS-skewed payment systems wind-down) may be an issue*
   - *Competition for volume may drive unnecessary development*

2. ***To manage distribution of services, control unbridled competition?***

3. ***To assure adequate character and competence?***

4. ***To control capital costs?***

What do we need CON for, Going Forward?

1. ***To assure projects, services, facilities are "needed?"***

2. ***To manage distribution of services, control unbridled competition?***
   - *Legitimate issue, as strong systems get stronger*
   - *Future issues may be more about*
     - *Reduction/closure of inpatient services and facilities*
     - *Location and access to ambulatory care facilities*
   - *An issue for regional planning?*

3. ***To assure adequate character and competence?***

4. ***To control capital costs?***

What do we need CON for, Going Forward?

1. ***To assure projects, services, facilities are "needed?"***

2. ***To manage distribution of services, control unbridled competition?***

3. ***To assure adequate character and competence?***
   - ***Clearly important, but an establishment/ licensure function***
   - ***Issues:***
     - ***New organizational models, beyond current scope of Article 28***
     - ***Out-of state providers/systems partnering w NYS physicians, facilities***
     - ***Physician organizations accepting risk***

4. ***To control capital costs?***

What do we need CON for, Going Forward?

1. ***To assure projects, services, facilities are "needed?"***

2. ***To manage distribution of services, control unbridled competition?***

3. ***To assure adequate character and competence?***

4. ***To control capital costs?***
   - *Less of an issue, going forward, since capital is increasingly tight*
   - *Less incentive to over-do projects, w/out capital reimbursement*
   - *Less incentive to over-build, as FFS-driven utilization declines*
   - *But, competition for volume may drive unnecessary development*
   - *In LTC, nursing home renovations are a real issue*

What do we need CON for, Going Forward?

5. *To manage utilization and costs?*

6. *To assure that institutions don't take on non-feasible projects, that could destabilize institutions?*

7. *To improve quality?*

8. *To assure that capital projects meet code requirements?*

9. *To improve access, and reduce disparities?*

What do we need CON for, Going Forward?

5. ***To manage utilization and costs?***
   - ***CON's role is based on Roemer's Law***
   - ***But payment system changes likely to be better at that***

6. ***To assure that institutions don't take on non-feasible projects, that could destabilize institutions?***

7. ***To improve quality?***

8. ***To assure that capital projects meet code requirements?***

9. ***To improve access, and reduce disparities?***

What do we need CON for, Going Forward?

5. ***To manage utilization and costs?***

6. ***To assure that institutions don't take on non-feasible projects, that could destabilize institutions?***
   - *Mgmt, boards and lenders are likely to be more conservative*
   - *Future issue will likely be more focused on <u>institutional</u> financial viability*

7. ***To improve quality?***

8. ***To assure that capital projects meet code requirements?***

9. ***To improve access, and reduce disparities?***

What do we need CON for, Going Forward?

5. ***To manage utilization and costs?***

6. ***To assure that institutions don't take on non-feasible projects, that could destabilize institutions?***

7. ***To improve quality?***
   - ***CON's impact on quality is unclear***
     - ***Strongest case has been in volume-quality-sensitive services***
   - ***Changes in quality reporting, analysis, coupled with regional planning, and payment system incentives may be more effective approach***

8. ***To assure that capital projects meet code requirements?***

9. ***To improve access, and reduce disparities?***

What do we need CON for, Going Forward?

5. *To manage utilization and costs?*

6. *To assure that institutions don't take on non-feasible projects, that could destabilize institutions?*

7. *To improve quality?*

8. *To assure that capital projects meet code requirements?*
   - *May be other/better ways to do that, via architectural review , "licensure"*

9. *To improve access, and reduce disparities?*

What do we need CON for, Going Forward?

5. *To manage utilization and costs?*

6. *To assure that institutions don't take on non-feasible projects, that could destabilize institutions?*

7. *To improve quality?*

8. *To assure that capital projects meet code requirements?*

9. *To improve access, and reduce disparities?*
   - *CON's effectiveness is unclear*
   - *Insurance, access and attention to social determinants better*
   - *Regional Planning may have a role, here*

Where To, From Here?

- ***There are risks inherent in all this change***
- ***The State's role:***
  - ***To protect its citizens, and***
  - ***To help shape the systems that serve them***
- ***Need to focus where "the market" traditionally fails***
  - ***Fragile providers, systems and populations***
    - ***Safety net providers and rural hospitals***
    - ***At-risk populations***
  - ***The State has a number of tools available***
- ***The Role of CON***
  - ***Long-term, questions about its relevance as currently constructed***
  - ***Intermediate-term, may need it, to protect against unintended consequences***
  - ***Need to focus CON where it matters, where it can make a difference***

If Not (Only) CON, What Else?

Other Tools

Regional Planning

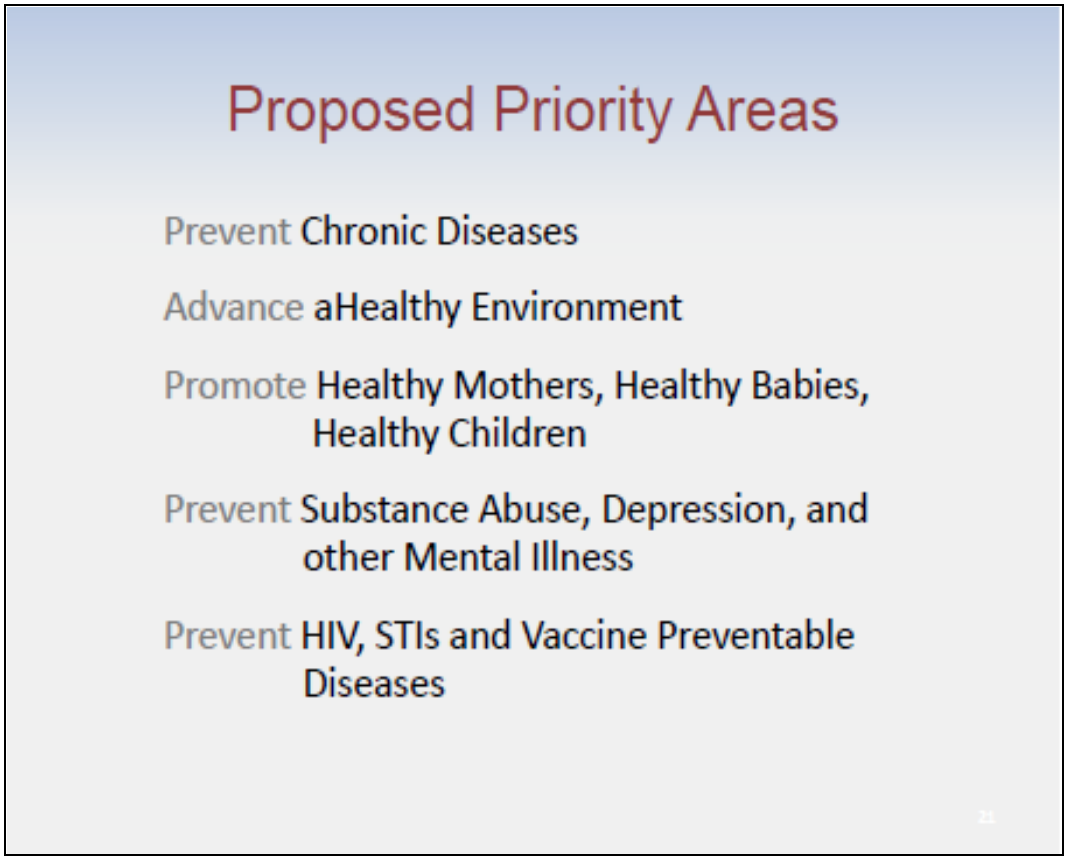
Some Other Tools Available to the State

- ***Health information technologies***
  - ***Collect, analyze, benchmark, report performance***
  - ***All-Payer Database***
- ***Finances, payment systems and targeted grants***
  - ***Stimulate , incent, reward positive delivery system change***
  - ***Tracking financial status of providers, and systems***
- ***Licensure, surveillance, reporting***
  - ***Character, competence, performance***
- ***Insurance coverage, and the regulation of plans, and risk***
- ***State-level and regional planning***

Future of Regional Health Planning

The State Health Improvement Plan

- ***Well-grounded and focused Public Health Plan***
- ***Focused on key determinants of health and disease***



Future of Regional Health Planning

- ***NYS is articulating priorities for the delivery system***
  - ***What issues, imbalances, goals, priorities, statewide?***
  - ***What expectations of the delivery system?***
  - ***What expectations of payers?***
- ***Regional Planning***
  - ***All health care is, in fact, local***
    - ***Needs, resources, communities vary greatly, across regions***
    - ***Local and regional constituencies for delivery system change***
      - ***Providers, purchasers, payers, communities***
  - ***Core functions of regional planning***
    - ***Data, analytics, reporting, benchmarking***
    - ***Identifying local/regional issues – quality, access, cost***
    - ***Convening, focusing attention, setting agenda, building momentum***
    - ***Crafting local responses to local issues, including community resources***
  - ***State support for regional planning***
    - ***Framework and overall priorities***
    - ***Data and analytics support***