CON Redesign: Draft Recommendations

Health Planning Committee
Public Health and Health Planning Council
November 14, 2012

Outline

- Context underlying redesign recommendations
- Description of problems/risks posed by context
- CON role and shortcomings
- Regional planning
- Update CON/licensure to promote appropriate supply
- Update CON/licensure to reflect complexity and scope of physician practices
- Promote improvements in quality and efficiency through governance
- Update CON in relation to population health, quality, and financial oversight

Context: Triple Aim Imperative

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

Context: Federal and State Actions

- MRT and 1115 waiver amendment
- Affordable Care Act
  - Community Health Needs Assessment requirement
  - Access to affordable insurance
- New State Health Improvement Plan

Context: Delivery System Transformation

- Performance and cost-containment imperatives fuel new models of care and organization.
- Driven by value-based payment mechanisms.
- Prioritizing primary care.
- Enabled by health IT.

Context: New Models of Care and Organization

- Characterized by:
  - Focus on population health;
  - Patient engagement
    - Chronic disease management
    - Consumerism;
  - Vertical and horizontal integration;
  - Transfer of risk;
  - Importance of scale;
  - Growing influence of organized physician groups.

Risks

- Unsound risk arrangements and systems too big to fail.
- Penetration of “unregulated” providers.
- Destabilization of essential providers.
- Diminished access, especially for low-income and rural populations.
- Continuation of unsustainable cost curve and sub-optimal quality of care.

Role of CON in Addressing Risks

- Promote alignment of health care services with community needs:
  - Protect essential providers from destabilizing competition;
  - Encourage development in under-served areas;
  - Discourage closure of essential services.
- Reduce unnecessary capital development and supply-driven utilization and spending.

Shortcomings of CON in New Context

- Impacts supply, not demand; need multi-stakeholder, regional/local strategies to advance Triple Aim.
  - Does not provide funding to protect and promote needed services.
- Mismatch between providers covered by CON and development of services in marketplace.
- May delay development of licensed primary care and other needed services.

CON Shortcomings (cont'd)

- C&C reviews are misaligned with the complexity of health care organizations, the need to develop integrated systems, and the authority exerted by non-established entities.

ADVANCING THE TRIPLE AIM THROUGH REGIONAL PLANNING

Regional Planning: Principles

- Region-wide, collaborative planning;
- Focusing on health and health care, including coordination with behavioral health local planning;
- Representative of all affected stakeholders;
- Diverse governance structures based on regional circumstances and stakeholder interests;

Regional Planning: Principles

- State must be engaged in overseeing and encouraging through policy levers;
- State should develop a common data set;
- Regions must collect, analyze and display regional data in a neutral manner.
- Planning should address financial stability of delivery system.

Health Planning Entities

- Regional Health Improvement Collaboratives (RHICs)
- Convened by a neutral entity
- Governance structure representing key stakeholders: e.g., consumers, local public health officials, providers, payers, business, unions, community organizations.

Regions

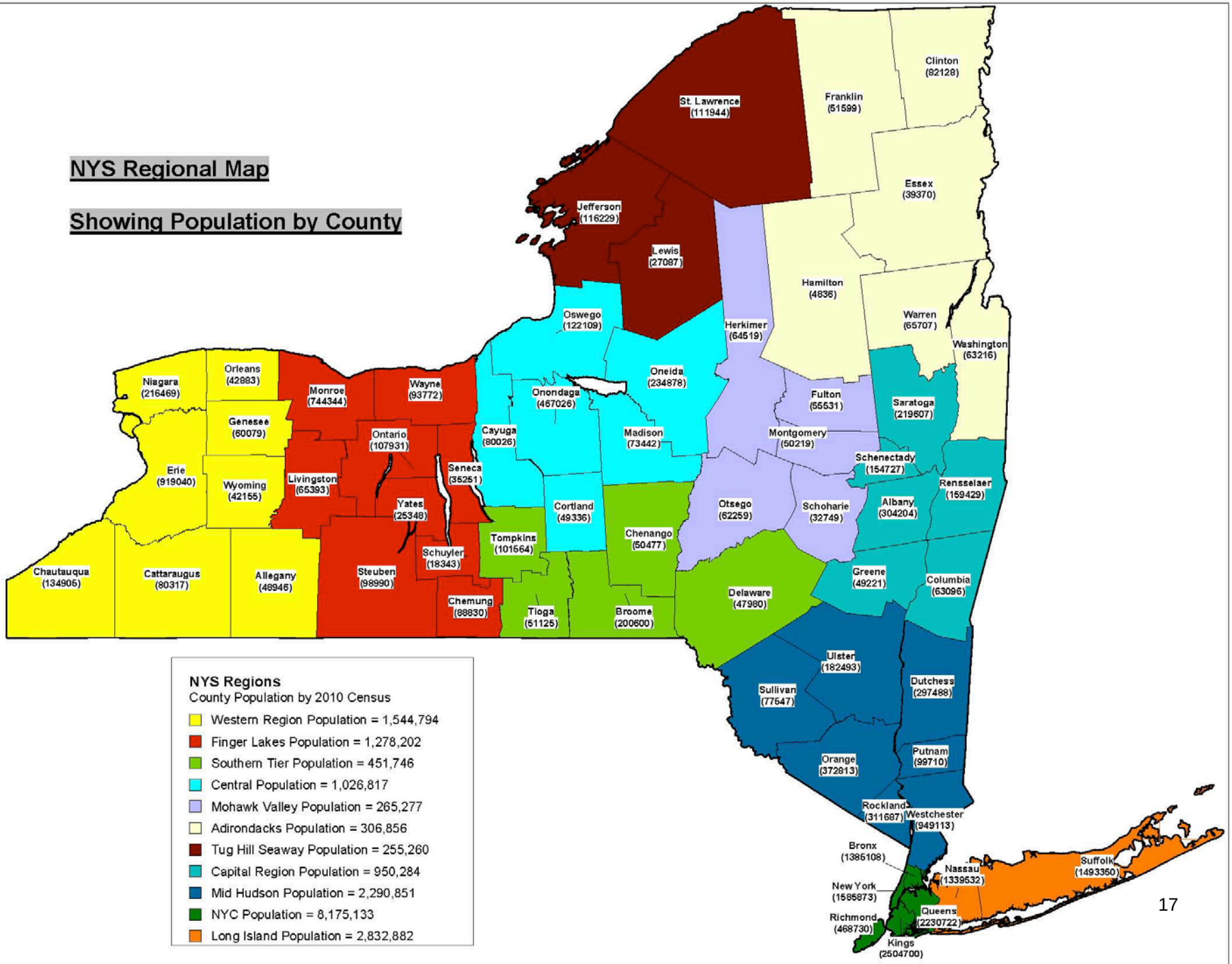
- Impossible to create perfect regional boundaries for health planning purposes.
  - Boundaries do not limit health care consumers, disease, or public health emergencies.
  - Cross-border and sub-regional activities will be important.

Regions (cont'd)

- New map based on stakeholder feedback
  - Recognizes existing health planning infrastructure and relationships.
  - 11 Regions
    - 4 regions will relate to 2 Economic Development Councils

NYS Regional Map

Showing Population by County

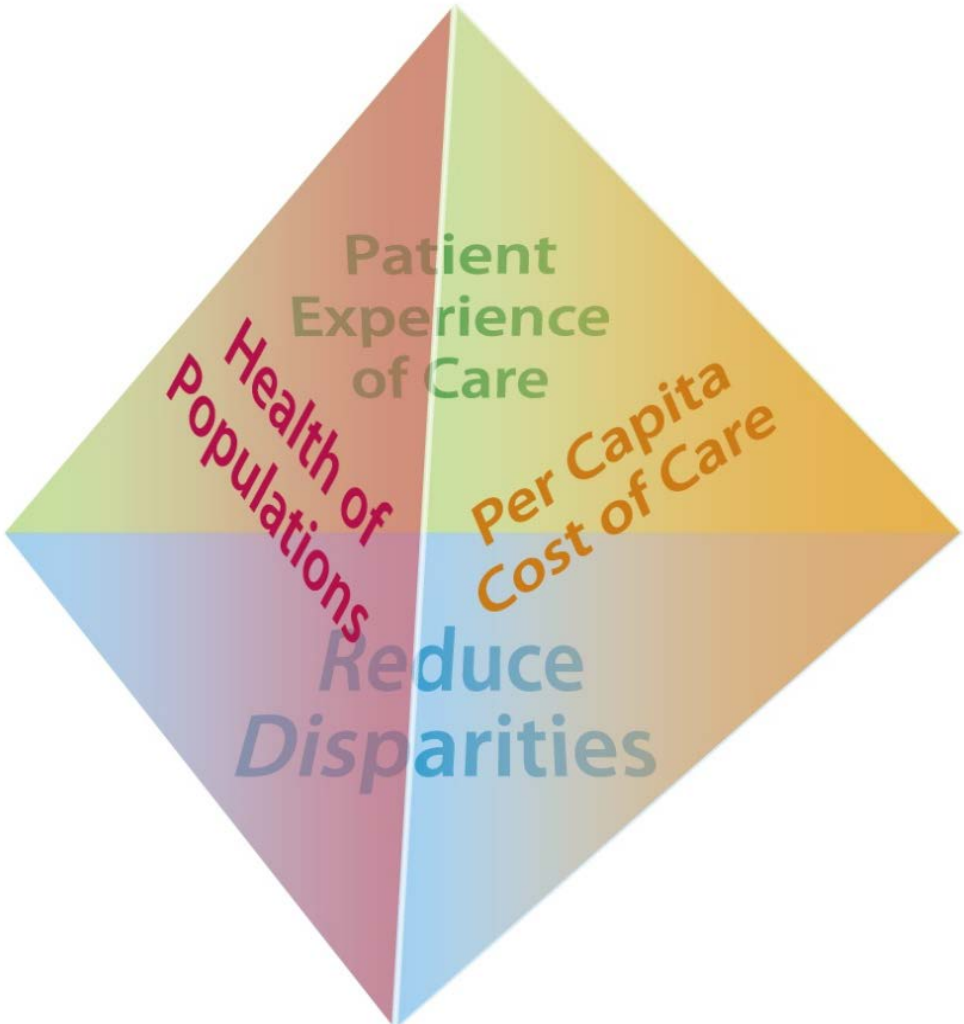


NYS Regions

County Population by 2010 Census

- Western Region Population = 1,544,794
- Finger Lakes Population = 1,278,202
- Southern Tier Population = 451,746
- Central Population = 1,026,817
- Mohawk Valley Population = 265,277
- Adirondacks Population = 306,856
- Tug Hill Seaway Population = 255,260
- Capital Region Population = 950,284
- Mid Hudson Population = 2,290,851
- NYC Population = 8,175,133
- Long Island Population = 2,832,882

RHIC Responsibilities: Advance the Triple Aim



RHIC Responsibilities: Health of Populations

- Advance at least 2 SHIP Priorities:
  - To be selected by stakeholders based on regional needs.
  - Address health disparities in connection with those priorities.

RHIC Responsibilities: Patient Experience of Care

- Examples include convening, analytics and technical support for:
  - Measurement of health system performance
  - Quality collaboratives
  - PCMH development
  - Evidence-based patient engagement strategies

RHIC Responsibilities: Per Capita Cost of Care

- Examples include convening, analytics and technical support for:
  - Strategies to reduce preventable utilization;
  - Health care needs assessments;
  - Multi-payer, value-based payment and benefit design initiatives;
  - Publication of quality, cost, spending data;
  - Collaborations that improve efficiency and financial stability of essential providers.

Regional Planning: Cross-Cutting Issues

- Health Disparities
- Workforce

Advancing the Triple Aim through CON

NYS Health System Performance

- Comparatively weak in:
  - Avoidable hospitalizations
  - Cost
  - Treatment/quality

Driving Health System Performance through CON

- CON is one of many tools
- CON, in transition, plays a role:
  - Curbing development of supply-sensitive services;
  - Channeling development in under-resourced areas;
  - Concentrating volume of highly-complex services.
- CON should:
  - Not impede development of new primary care
  - Facilitate development of integrated systems
  - Adapt to new models of care and payment

CON and Licensing: Distinct Disciplines

CON	Licensing
C&C of operator	C&C of operator
Public need	
Quality (volume-sensitive services)	Quality - program, staffing, policies/procedures
Reasonable cost	Physical plant safety
Financial feasibility	Financial resources

Updating CON to Promote Appropriate Supply

Streamlined Process for Projects that Do Not Affect Supply

- Administrative streamlining recommendation:
  - Narrowed scope of CON by exempting construction projects that don't affect supply and distribution.
  - Will not apply to nursing homes in short term.
- Retained licensing
  - Character and competence/compliance
  - Program review
  - Compliance with construction/design standards

Promoting Appropriate Supply: Supporting Primary Care

- Exempt primary care clinics from CON
  - Facilities that provide high-end imaging, radiation therapy, dialysis, or surgery would not be eligible for exemption.
- Licensure requirements would apply, including prior approval of:
  - Establishment, C&C, compliance, quality
  - Physical plant compliance

Promoting Appropriate Supply: Supporting Primary Care

- Hospital and FQHC acquisition of primary care physician practices:
  - Licensing reviews should be expedited where primary care access is threatened.
  - Renovations to satisfy physical plant standards may create delays.
  - DOH should work with stakeholders to create a process that preserves access while facilities are undertaking steps to comply with physical plant requirements.

Promoting Appropriate Supply: Grant-Funded Projects

- Projects funded with HEAL and other time-sensitive capital grants:
  - If entire project was approved through RFA process, it should be exempt from public need and subject to limited financial review.
- Licensing review, including physical plant oversight, should be required.

Promoting Appropriate Supply and Quality: Technology

- NYS should be at the forefront of innovation in medical care; but:
- Capital-intensive, emerging technologies should not be widely disseminated before they have demonstrated their value.
- Volume-sensitive, complex services should be concentrated in specialized centers.
- DOH should contract with a research institute to evaluate technologies and services that should be subject to CON.

Promoting Appropriate Supply: Hospital Beds

- New payment incentives are expected to discourage development of hospital beds.
- In the future, inpatient care may not be supply-sensitive.
- During transition, CON should be retained.
- Reexamine applicability of CON to hospital beds within 3 to 5 years.

Promoting Appropriate, Supply and Quality: ACOs

- Delivery system is shifting to integrated systems of care that:
  - Implement evidence-based practices
  - Accept risk-based payments.
- Diminished incentives to develop unnecessary capacity, services.
- State certification process could promote preservation of essential services, population health, and quality.
- Re-visit CON for ACO participants once certification process is adopted.

Promoting Appropriate Supply: Updating CON

- Hospice need methodology should be updated.
- Pipeline projects should not be permitted to "bank" their CON approvals indefinitely.
  - Prevents accurate evaluation of unmet need.
  - CONs should expire, if construction is not commenced or establishment is not finalized within a specified period (e.g., 5 years).

UPDATING CON TO REFLECT COMPLEXITY OF PHYSICIAN PRACTICES

Promoting Appropriate Supply and Quality: Leveling the Playing Field

- Disparate requirements and payment for facility-based services versus physician practice-based services.
- Certain services raise issues regardless of setting:
  - Supply-sensitive and/or capital-intensive
  - Competitive concerns for hospitals
  - Unnecessary radiation exposure
  - Volume-quality associations

Promoting Appropriate Supply and Quality: Leveling the Playing Field (cont'd.)

- DOH should consider equalizing treatment based on studies regarding:
  - Relative quality and cost of OBS and ASC services.
  - Impact of ASC and OBS services on hospital viability, access and public health.
  - Impact of physician practice-based operation of high-cost equipment on costs, quality, access, and public health.

Leveling the Playing Field: Corporate Practice and De Facto Clinics

- DOH should consider updating or adding regulatory oversight of:
  - D&TC look-alikes by clarifying the criteria that define a facility subject to licensure requirements; and
  - Corporate control of physician practices.

PROMOTING IMPROVEMENTS IN QUALITY AND EFFICIENCY THROUGH GOVERNANCE

GOALS

- Rationalize “taint” rule to eliminate barriers to integration and recruitment of experienced leadership;
- Focus on track records of organizations, where appropriate;
- Streamline review processes to accommodate complex organizations and facilitate integration;
- Promote system integration and align oversight/accountability with effective control;
- Strengthen DOH authority to respond when governing body fails.

Support System Development and Recruitment of Experienced Leadership

- "Taint" Rule: Eliminate mandate based on 2 enforcements; instead disqualify individuals or organizations based on:
  - Pattern of, or multiple, enforcements; and/or
  - Poor performance on quality metrics developed by Office of Patient Safety and Quality.
- Presumption of disqualification can be rebutted based on role, experience, recent performance.

Streamline Review Processes to Accommodate Complex Organizations

- Character & Competence Reviews of Established NFP Operators:
  - Require established NFP operators to conduct C&C reviews of new board members at appointment;
  - Require operators to update C&C review prior to any establishment action.
  - Instead of DOH verification, require attestation and disclosure by operator.

Streamline Process to Accommodate Complex Organizations (cont'd)

- Character and Competence Review of Proprietary Organizations with Corporate Ownership (e.g., dialysis, home care):
  - Review individuals in the regulated entity and direct parent (or grandparent if parent is holding company);
  - Secure attestation from ultimate parent(s) concerning organizational compliance history, including controlling shareholders and related entities, and C&C of directors and officers and any individual controlling shareholders.

Character and Competence Review of Proprietary Organizations with Corporate Ownership (cont'd.)

- Verify attestation through:
  - Independent review by auditor, accrediting body, or other appropriate entity; or
  - DOH review.

Strengthen Governance: Passive Parent Models

- Encourage governance models that support integration of services, quality, and efficiencies.
- Some oversight of passive parents is warranted.

Strengthen Governance: Passive Parent Models

- Require established health care facilities to submit a notice to DOH 90 days prior to commencing a passive parent relationship.
- Include entities involved, board members and affiliation agreement.

Strengthen Governance: Passive Parent Models

- DOH would have 90 days to recommend disapproval. If no action were taken, transaction would be deemed approved.
- Approval would be time-limited (i.e., 3 years), with opportunity for extension.

Strengthen Governance: Passive Parent Models

- Grounds for disapproval would be:
  - Poor compliance or quality record;
  - Financial instability.
- If disapproval were recommended, application would be submitted and advanced to PHHPC.

Strengthen Governance: Existing Passive Parents

- Grandfather approved passive parents of existing affiliates.
- Conduct periodic review (i.e. every 3 years), including satisfactory quality, financial and compliance record among affiliates.
- Poor track record could result in revocation of approved status, temporary operator, or appointment of new board members.
- Existing passive parents affiliating with new entities would be subject to 90-day review.

Strengthen Governance: Passive Parent Models and Clinical Integration

- Require passive parents that negotiate health plan contracts on behalf of their affiliates to be clinically integrated.
  - May require change in passive parent powers.
  - Would require standards for clinical integration.

Strengthen Governance: Monitor Major Changes in Boards

- Create more structured process for annual board membership filings.
- Require operators to report any change of 25 percent or more in board membership within a 12-month period.

Strengthen DOH Authority to Respond to Failures in Governance

- Ongoing monitoring and authority to intervene are more effective tools in promoting quality, integrity, and financial stability than character & competence reviews.

Strengthen DOH Authority to Respond to Failures in Governance

- Enact legislation that would permit DOH to appoint a temporary operator or replace board members of a hospital or D&TC under limited circumstances, when:
  - Health and safety of patients is at risk;
  - Financial instability threatens patient care.

Strengthen DOH Authority to Respond to Failures in Governance

- Expand use of limited-duration operating certificates:
  - Establishment of new operators;
  - New models of care; or
  - Compliance or quality concerns are identified.

UPDATE CON IN RELATION TO POPULATION HEALTH, QUALITY, AND FINANCIAL OVERSIGHT

Incorporate Quality and Population Health into CON and Licensure

- Incorporate quality and population health considerations into CON and licensure using measures appropriate to the project.

Incorporate Quality and Population Health into CON and Licensure

- Require satisfaction of quality benchmarks prior to approval of new capacity or services;
- Expand “public need” schedule to include relationship to SHIP priorities;
- Require implementation of certified EHR and connection to SHIN-NY;

Incorporate Quality and Population Health into CON and Licensure

- Require SPARCS submission as condition of CON or licensure of new services or sites;
- Require prior approval of clinical construction to assure physical plant safety.

Promote Financial Stability

- Monitor financial status of hospitals and nursing homes, using standard metrics.
- Conduct more calibrated approach to financial feasibility reviews, focusing on financially-weak providers.
- Consider impact of risk-based payments.
- Provide greater flexibility in review of debt structures for financially strong hospitals.

Promote Financial Stability and Cost-Effective Collaborations

- Relax prohibition on revenue sharing with non-established entities.
  - Permit collaborations among providers in connection with care coordination and value-based reimbursement;
  - Permit commercially-reasonable arrangements with vendors.
- Require review of terms or limits on revenue sharing, but not necessarily establishment.