



Statement by David H. Klein
Chief Executive Officer, Excellus BlueCross Blue Shield
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Thank you for this opportunity to comment on New York State's Certificate-of-Need (CON) process and the value of regional health planning and collaboration. I commend the State Hospital Review and Planning Council and its Planning Committee for conducting this forum to solicit comments from the key stakeholders of New York State's health care system.

Clearly, the Council's letter of invitation covers a broad spectrum of topics and challenges. My statement will focus on three of the specific questions cited in the Council's letter.

- How can the Department support the development of collaborative efforts to assess community health needs and make recommendations to develop and/or deploy efficiently and effectively the health care resources needed to address those needs?
- How can the department encourage more collaboration among health care providers in order to achieve economies of scale, avoid duplicative services, and improve access to care and quality?
- Are there effective local planning models the department should consider?

To address these questions, I'll first provide a brief context as to why effective health planning is needed across New York State. Then I'll outline the differences between health planning activities that should take place at the state level and those that are best addressed collaboratively on a regional, community level. Finally, I'll offer a specific proposal to create a structure to address regional health issues within a statewide context.

Why health planning is needed

New York State's health care system has clearly changed since the 1990s. With health care deregulation, competition among hospitals and health systems has increased, creating what amounts to an "arms race" for high-priced technologies. This has added unneeded capacity to the system, often resulting in the duplication of complex and expensive services.

The state's Certificate of Need process has not effectively managed capacity. Its scope has been limited to Article 28 facilities, which means the introduction and addition of technologies to non-Article 28, private practice settings has been largely unmanaged. Today's forum recognizes the importance of addressing this issue.

In terms of hospital capacity and performance, the Berger Commission Report underscores the broad variations that exist between regions and, in some cases, among hospitals within the same region. Some hospitals are seriously challenged, while others are performing very well.

The supply of physicians in New York State also varies by region and by specialty. While the number of physicians in downstate regions is growing, there is a serious shortage of physicians in some upstate regions ... particularly in our rural counties. And as the physician population continues to age, more needs to be done to encourage graduating medical students to set up their practices where they are most needed in New York State.

The introduction of new Health Information Technologies, such as electronic medical records, presents additional challenges. Health IT holds great promise to reduce medical errors and administrative costs. But at the same time, it will be very difficult and expensive to implement. With a number of pilot projects currently underway across the state, effective planning and coordination will be essential.

Finally, consumers are increasingly seeking more information about the quality and cost of local health care providers. There is a growing need to provide consumers with information to make informed decisions about the medical care they receive.

The need for statewide planning

Effective health planning is needed on statewide and regional levels. Of the issues that I have just outlined, physician supply is one that requires statewide planning. New York State's medical scholarship and loan repayment programs need to be enhanced so that we are competitive with other states. And these efforts should particularly focus on meeting the needs of the underserved areas of the state.

Health information technology is another area that demands a statewide approach. The federal government has awarded more than \$50 million in grants to six regions of New York State for different Health IT pilot projects. If each region develops a non-standard approach, the result would be missed economies of scale and unnecessary administrative cost increases.

Certain public health issues, like obesity, also would benefit from statewide health planning. Public health departments have historically played an active role in addressing health issues such as sanitation, vaccination and immunization, smoking, seat belt use and bicycle helmet safety, and these efforts should continue.

Finally, expanding health care access through the state's safety net programs will continue to require state-wide planning and coordination. Recent examples include the implementation of the new Child Health Plus expansion, and the transition of the SSI and dual eligible populations to Medicaid Managed Care.

The need for regional planning

Other health planning issues are better addressed on a regional level. For example, hospital issues and needs vary greatly from region to region. As reflected in the Berger Commission Report, some regions have too many beds and too much capacity, while other regions have access issues and inadequate facilities. Hospital finances and operational performance also vary from region to region and from hospital to hospital. Because, for the most part, hospitals serve a specific geographic region and are supported financially by the employers and families of the local community, it's important to have local input into the decisions that affect those regional facilities.

The same is true for non-hospital capacity. As physician offices and free-standing imaging centers continue to add additional technologies such as MRI, CT, and PET scanning units, it is largely the local community that pays for those technologies through their health insurance premiums. Similarly, the proliferation of freestanding ambulatory surgery centers must be evaluated in the context of their impact on local hospitals, regional health care costs, and quality of care.

And as health insurance benefit designs evolve to be more “consumer-driven,” consumers will need and demand reliable, accurate information about the quality and cost of their local health care providers.

Unlike typical “supply and demand” economics where an increase in supply fosters competition and *reduces* cost, in health care, supply often drives demand and *increases* cost. Traditional competitive market forces simply don’t work in health care.

New health care technology is also typically more expensive on a per procedure basis than older technology. For example, a CT scan is more expensive than an x-ray, an MRI is more expensive than a CT scan, and a PET scan is more expensive than an MRI.

The cost impact of new technologies is also additive. For example, there are many cases where a more expensive scan does not replace a less expensive scan, it is performed as an additional test. And the availability of the latest technologies is frequently viewed by providers as a competitive advantage leading to a costly “medical arms race”.

All of the foregoing underscore the need for oversight at the local level. The bottom line is that if a community does not manage capacity, costs will increase, services will be duplicated, the volume of services will increase, and there will be less reason for providers to collaborate. Having more capacity will not guarantee better quality or access to care.

The current environment

Today, New York State is making progress at both the statewide and regional levels.

At the statewide level, the Doctors Across New York initiative that was funded as part of the state’s 2008/2009 budget will help address some of the physician supply concerns. This \$15.31 million commitment includes a \$1.96 million physician loan repayment program, a \$4.9 million physician practice support program, a \$4.9 million ambulatory care training program, \$1 million in new funding for the New York State AHEC program, and a \$1.96 million on new funds for a Post-Bac pre-med initiative for minority and economically disadvantaged students. It also included funding for a Physician Workforce Study.

Another statewide need, Health IT, will get a boost from the infusion of \$105 million in HEAL V grants to 19 communities across New York State. Five upstate organizations will receive 25 percent, or \$27 million, of these funds. Combined, this funding will affect 2,500 physicians, 43 hospitals, 10 long-term care facilities and nine health plans by helping them move from a fragmented, paper-based system to a connected system supported by interoperable health records.

At the regional level, local health planning will benefit from \$7 million in new HEAL grants that target community health needs. Indeed, local health planning initiatives are already in place in many upstate regions. For example,

- In the Rochester region, the Finger Lakes Health Systems Agency (FLHSA) has been one of the most active health planning agencies in the state and it has already been awarded a grant of \$1 million to support community planning efforts. FLHSA is planning to seek additional grant funds to further expand its efforts.
- In Central New York, HACCNY is pursuing a \$1million Large Project grant to develop a master plan based on an assessment of local health needs and resources.
- In the Greater Binghamton area, the Chenango Health Network is applying for a grant in the far eastern end of the region to examine the health status of its rural population and make recommendations to match resources with needs.
- In Western New York, The Community Health Foundation is partnering with other local participants to submit an application for a Large Project grant to focus on both rural and urban needs, including public health priorities, access to preventive primary care and other ambulatory care services.

While all of these local health planning initiatives are promising, there remains a need for the state to provide for a structure that will promote local collaboration within the context of a statewide strategy.

Regional Health Commissions: A model for collaboration

It's important to recognize that while the issues we face are complex, local issues require local solutions. Local solutions, in turn, require collaboration among all stakeholders, including businesses, community leaders, providers and health insurers. If all of the stakeholders are not committed to address local issues, any effort is likely to fall short.

Notwithstanding the challenges, it's clear that local health planning can work. The Finger Lakes Health Systems Agency (FLHSA), for example, has demonstrated that local health planning can help communities effectively manage capacity. Recognizing that Rochester faced a looming crisis with emergency room overcrowding, all three hospital systems operating at full capacity and costs continuing to rise, the FLHSA took the proactive step of convening the Community Health System 2020 Commission, which brought together a broad array local stakeholders to address the health care needs of the northern Finger Lakes region and recommend the best course of action. That collaboration led to a thorough and comprehensive assessment of local community bed need that resulted in buy-in of all three hospitals and consensus on bed need requests that were significantly less than each hospital system had originally proposed. The 2020 Commission's consensus recommendation formed the basis of the Health Department's need assessment in evaluating the CON applications of each hospital system, and led to the innovative step of "batching" these application for consideration by the State Hospital Review and Planning Commission.

Another successful local planning model is the Rochester region's Community Technology Assessment Advisory Board. CTAAB is a voluntary board comprised of local businesses, providers, and payors that assesses proposed capacity increases by both regulated entities (e.g., hospitals), and non-regulated entities (e.g., private practices). Particular focus has been on incremental capacity for CT scanners, MRIs and PET scanners. While the

recommendation of CTAAB regarding need for these modalities is not binding on providers, its recommendations are used by local payors in making decisions whether to reimburse providers for this incremental capacity. In the 15 years that CTAAB has been operating, surveys of CT, MRI and PET capacity and utilization performed by the FLHSA have consistently demonstrated a beneficial impact on per capita capacity and utilization in the CTAAB region as compared to other upstate regions, and as measured by statewide and national averages.

These models can be enhanced and built upon, which brings me to the proposed model. New York State should authorize the establishment of pilot Regional Health Commissions, comprised of key community stakeholders, to focus on the issues of access, quality and cost.

The intent of the local Regional Health Commissions is not to suggest that a “one size fit's all” approach is appropriate. Quite the opposite in fact is necessary to be successful. Inasmuch as health care is intensely local, the intent behind the creation of Regional Health Commissions is for each locality to establish its own entity for health planning. That entity could and likely will take various forms, such as an HSA in Rochester or perhaps a business led entity in Syracuse. The key success factors are that the entities must have broad community representation (provider, payor, business and community), they must be collaborative in their approach with a focus on building local consensus on key issues. In regions where these entities exist and are functioning as desired, such as Rochester, they should be supported. In regions where these entities do not currently exist the State should support their creation. Additionally, although the planning activity will take place at the local level, the state could play an important coordinating role by devising a mechanism for communication and sharing of best practices among the local health planning entities.

Membership of these Regional Health Commissions should include representation of local employers, consumers, hospitals, physicians and health plans ... with the majority of members representing business and consumers. These commissions should be first established on a pilot basis in certain select regions. In determining pilot regions, it should be recognized that that the traditional HSA regions may be too large. In many areas upstate, “local” may be a very small geographic area defined by unique and singular planning needs and priorities. Examples might include the Watertown region or the eastern southern tier.

The pilot Regional Health Commissions would have several roles. First, they would advise state government of their recommendations regarding regional health needs and issues. They would propose legislation and regulatory reforms based on the collective input of all the local stakeholders. The Commissions also would assess the community need for proposed projects, choosing projects to review based on its defined local health planning priorities.

Regional Health Commissions should work to facilitate collaboration among hospitals and physicians. This collaboration could include:

- The exploration of regional centers of excellence for certain types of services, such as transplants, cardiac surgery, burn units, trauma, brain injury, and neonatal care;
- The establishment and monitoring of community standards of care to reduce unwarranted variations;
- The exploration of community-wide facility sharing of common services ... such as laboratory, radiology and supply purchasing ... to achieve quality, cost-effective care; and

- The review of expensive new equipment in both hospital and physician settings to determine necessity based on community need.

Another role of the regional commissions would be to provide consumers with reliable and accurate information on provider quality and cost. With the participation of local hospitals, physicians and insurers, the commissions will be in an excellent position to gather and evaluate regional health care information. Once the data is gathered, the commissions would coordinate the dissemination of the information to consumers. The goal is to help local residents engage in healthy behaviors and navigate the local health care system in an effective way.

While the state may take the lead to address public health issues like obesity, the Regional Health Commissions could coordinate with the local health departments to address regional health issues. As previously noted, public health departments have historically played an active role in addressing a variety of health issues. In addition, the commissions would work with local health departments to lead community efforts in prevention and wellness education. This could include, for example, the establishment of local initiatives to reduce hospital admissions for ambulatory care sensitive conditions identified through the Department's Prevention Quality Indicators data. It could also coordinate initiatives to implement the Department's Prevention Agenda.

With multiple regions of New York State are currently developing different Health IT pilot programs, there's potential for non-standard approaches to unnecessarily add administrative costs and challenge our ability to achieve economies of scale. The state Health Department's current work overseeing local RHIOs will help ensure that regional pilot programs are coordinated and follow inter-operability standards. This should include national Health IT consensus standards like those recently endorsed by the National Quality Forum. But while Health IT is coordinated at the state level, implementation will take place at the local level. The Regional Health Commissions could play a useful role in providing guidance and inter-regional collaboration.

In terms of financing, initial funding for the establishment of the Regional Health Commissions could be done through a planning grant on a block basis. Downstream funding could be based on multi-year programmatic budgets funded by the Health Department.

As I previously mentioned, without the commitment of all stakeholders to address local issues, any effort is likely to fall short. For this reason, it's important to provide incentives to help encourage meaningful participation. For example:

- Certificate-of-Need applications would require the approval of the local Regional Health Commission on the issue of community need;
- While the Councils would retain final decision-making authority regarding the need for a particular project, the recommendation of a Regional Health Commission would create a rebuttable presumption as to need that could only be overruled based on defined, narrow grounds (e.g., compelling state public health need);
- As to private practice projects, and similar to the CTAAB mechanism, a decision by the Regional Health Commission would not be binding, but could be used by both private payors and the Medicaid program to make payment/participation decisions related to the incremental capacity;

- Credit enhancement would be provided to all future Dormitory Authority mortgages to facilities that participate and abide by Health Commission determinations;
- HCRA funds would be made available to employers and others in participating regions for wellness and education programs; and
- State funding for health information technology projects and selected other grants would require the approval of the local Regional Health Commission.

While the Regional Health Commissions will play a lead role in assessing and addressing community health needs, it will be important for the State to continue to act in an oversight capacity. This supervisory role will be a critical element so that state action antitrust immunity can be obtained to permit the effective collaboration of all stakeholders.

Please allow me to conclude with one final thought. Many have opined that we are approaching a “perfect storm” in health care: surging demand driven by aging and obesity; attractive, but costly technology that can aid in satisfying this demand; aging infrastructure, especially in upstate New York; and a flat to down economy that will make affordability a real challenge.

Health care, however, has been characterized as a local business. This proposal offers the possibility of harmonizing all of these competing interests ... to help communities do the best that they can.

To not allow communities the opportunity to solve their own problems guarantees the inevitability of the storm. Even with community action, the possibility of the storm remains real. At least on a pilot basis, we urge state policymakers to give this idea a chance.

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