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

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Presentation to the Planning Committee of the Public Health and Health Planning Council
July 25, 2012
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


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

What do you mean, “Population Health”? 

- **Geographic**

- **Utilization Segments**

- **Purchasers and Payers**
Population Health: Geographies

2012 Health Outcomes - New York

Rank 1-16  □ Rank 17-31  □ Rank 32-46  □ Rank 47-62

County Health Rankings & Roadmaps
A Multiyear Analysis, County by County
Population Health – Utilization Segments
Different Health Status

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

Primary Care  Specialty Care  Emergency Care  Inpatient Acute Care  Home Care  Nursing Home Care

The “Well”

The Acutely-Ill

The Chronically-Ill

(Short-Term, “Episodes”)
Population Health – Insurance Segments
Medicare, Medicaid, Commercial

• **Cover Different Populations:**
  – Medicare: The young-old, the old-old, the disabled
  – Medicaid: The poor, those with 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?

<table>
<thead>
<tr>
<th>Traditional</th>
<th>Self-Insured Model</th>
<th>“Risk-Transfer” Model</th>
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<tbody>
<tr>
<td><strong>Purchaser</strong>&lt;br&gt;Purchaser Buys Insurance For Members&lt;br&gt;Insurer/Payer Holds Risk&lt;br&gt;Purchaser Contracts w/ Payer, +/- “Third Party Administrator”&lt;br&gt;Providers Paid for Services Rendered</td>
<td><strong>Self-Insured Purchasers Retain Insurance Risk</strong>&lt;br&gt;Insurer/Payer&lt;br&gt;Purchaser Contracts w/ Payer, +/- “Third Party Administrator”&lt;br&gt;Providers Paid for Services Rendered</td>
<td><strong>Self-Insured Purchasers (or Insurer) Delegates Insurance Risk to Providers</strong>&lt;br&gt;(or Insurer) Delegates Insurance Risk to Providers&lt;br&gt;Purchaser Contracts w/ Payer, +/- “Third Party Administrator”&lt;br&gt;Providers Take Risk, via Shared Savings, and/or Capitation</td>
</tr>
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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

“Grouping”

Clinical Integration – MD’s and Hospitals

Integrated 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

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

<table>
<thead>
<tr>
<th>Home Health</th>
<th>Nursing Homes</th>
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<tr>
<td>Sub-Acute Care</td>
<td>Long-Term Community-Based Care</td>
</tr>
<tr>
<td>(All Payers)</td>
<td>Long-Term Nursing Home Care</td>
</tr>
<tr>
<td>Post-acute Homecare</td>
<td>Long-Term Community-Based Care</td>
</tr>
<tr>
<td>Post-Acute Institutional Care</td>
<td>Long-Term Nursing Home Care</td>
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</table>
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?**
  - **Horizontal:** Historically, more in Home Health
  - **Vertical:** 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 institutional 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

Proposed Priority Areas

- Prevent Chronic Diseases
- Advance a Healthy Environment
- Promote Healthy Mothers, Healthy Babies, Healthy Children
- Prevent Substance Abuse, Depression, and other Mental Illness
- Prevent HIV, STIs and Vaccine Preventable Diseases
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