

**A Report on Reform of Medicaid's Inpatient
Rate Setting Methodology and Payment Levels**

As required by
Chapter 58 of the Laws of 2008

Prepared by
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Commissioner's Report on Reform of Medicaid's Inpatient Rate Setting Methodology and Payment Levels

I. Executive Summary

This report sets forth the New York State Commissioner of Health's (the Commissioner) findings and recommendations for reforming the Medicaid reimbursement system for inpatient care. The recommendations are mandated by Section 12 of Part C of Chapter 58 of the Laws of 2008 and come at the conclusion of collaborative work of the Technical Advisory Committee (TAC) established by the Commissioner pursuant to that section.

A. Background

Section 12 of Part C of Chapter 58 of the Laws of 2008 committed the State to transition by 2012 from the current reimbursement system based on 1981 costs to a new system reflecting 2005 costs. In order to ensure that all stakeholders had an opportunity to inform the New York State Department of Health's (the Department) work, the Legislature required the Commissioner of Health, in consultation with the chairs of the Senate and Assembly Health Committees, to establish a Technical Advisory Committee (TAC) for the purposes of examining data and evaluating rate setting methodological issues in preparation for the transition to 2005 base year costs. TAC members included representatives of hospital associations, two representatives of the health care industry and three representatives of community providers and consumers (Appendix C: TAC membership).

The Commission's charge was to evaluate the inpatient reimbursement methodology, including hospital re-basing; workforce recruitment and retention funding; graduate medical education funding; peer group pricing; wage equalization factors; case mix; and such other related elements as deemed appropriate by the Commissioner. The Commissioner was also directed to examine the scope and volume of hospital outpatient services.

Role of the Technical Advisory Committee (TAC) and Commissioner Report

- Evaluate inpatient reimbursement methodology, including a review of the data which demonstrates how much inpatient revenue exceeds Medicaid inpatient costs;
- Examine the impact of proposed methodological changes on hospitals;
- Examine the role of hospitals in delivering ambulatory care services to Medicaid beneficiaries; and
- Issue findings and recommendations (Commissioner).

The State's FY 2008-2009 budget legislation did not merely call for more study. It immediately began to implement reform, requiring a minimum reduction of \$154.5 million in reimbursement for hospital inpatient services for the 2009-10 state fiscal year, based on the transition to 2005 costs and another \$70 million reduction to inpatient detoxification. The legislation also required the Commissioner to issue a report that would set forth findings and recommendations as a result of the TAC work, including divergent views of TAC members.

The TAC process was comprised of multiple informal meetings and discussions between TAC members and the Department, including three public meetings. Large volumes of data, statistics and information were exchanged, and Department and industry staff devoted hundreds of hours to data compilation and analysis.

B. Findings

The findings and recommendations contained in this report are not unexpected to those engaged in making policy, regulating or delivering health care services in New York State. In fact, the work validates many anecdotal observations and provides a path for continuation of the critical work done by the Berger Commission and the provider community to reconfigure and reduce the inpatient infrastructure in the State. Significantly, in its final report the Berger Commission observed as follows:

“Reimbursement mechanisms distort patterns of service delivery and induce facilities to pursue high margin services, sometimes at the expense of more essential community needs. The current rate paradigm is encouraging a medical arms race for duplicative provision of high-end services and discouraging the provision of preventive, primary, and other baseline services Reimbursement rates are not closely related to the costs of care.”

Since implementation of the Berger Commission recommendations, the State has worked with all stakeholders to facilitate additional restructuring; reform Medicaid reimbursement methodologies; and expand health insurance coverage for New Yorkers.

The work of the TAC reconfirmed the need to restructure how New York Medicaid pays for inpatient care, while ensuring transparency and accountability that is consistent with the State’s healthcare policy goals. The 2008 enacted State Budget committed the State to begin comprehensive reimbursement reform. In addition to requiring the Commissioner to issue this report, it increased hospital outpatient reimbursement by \$178 million; reduced reimbursement for inpatient acute care patients by \$154.5 million in the 2009-10 State Fiscal Year; reduced reimbursement for inpatient detoxification services by \$70 million; and began to reform the allocation of indigent care funds to more effectively target the funds to hospitals serving uninsured patients.

As identified by the Berger Commission and described in more detail below, the Medicaid inpatient Fee For Service (FFS) reimbursement system is broken and badly in need of repair. It does not effectively serve the interests of patients, providers or the taxpayer, and is not sustainable as a matter of fiscal policy. It spends too much money on inpatient care and allocates that money among services and hospitals ineffectively. The methodology for reimbursing hospitals for Medicaid patients is outdated and pays too much for some services and too little for others. Not only is the overall level of payment too high, but the methodology for allocating payments does not appropriately reflect the acuity of the patient or the quality of the service or the efficiency of

the hospital. Moreover, every dollar wasted and every procedure performed in an overly expensive setting is one less dollar to expand health insurance coverage and to improve care for New Yorkers.

Medicaid uses a prospective payment system (PPS) to reimburse for most inpatient care, in which a pre-determined amount is paid to a hospital based upon the acuity of each patient's illness or injury. An effective PPS is dependent upon three pillars: (1) a reliable measure of efficient costs; (2) a sensitive measure of patient acuity, reflecting the variable costs associated with each individual patient actually treated; and (3) an accurate measure of hospital-specific costs that are beyond the control of the hospital. Additionally, a strong PPS system can support other important goals such as measurement, payment and reward for quality health care.

In New York's current reimbursement system, all of these pillars are weak and contribute to a dysfunctional payment structure that constrains providers from making strategic decisions that support optimal patient care for Medicaid patients. First, average hospital costs are measured using cost data that is nearly 30 years old with annual trends and multiple "enhancements," and reference cost data that includes commercially insured patients, rather than the Medicaid-specific population for which reimbursement is being paid. Second, variable costs associated with patient acuity are measured using the outdated All Patient - Diagnostic Related Group (AP-DRG) system, which only imprecisely measures variations in patient severity. Third, current measures of hospital-specific costs, such as graduate medical education, also use outdated cost bases. In addition, the current system has accrued numerous groupings, weightings, adjustments and add-ons, some designed to overcome the imprecision of the antiquated base model (in a crude, if well-intentioned, fashion) and some based merely upon individual hospital considerations. Finally, the current system of payment is neither sufficiently refined nor transparent to permit integration of standards and incentives for quality.

These weaknesses result in a reimbursement system that does not support a value-based approach to appropriate care, in the right setting at the most efficient cost for Medicaid patients. In fact, there are aspects of the system that provide reimbursement incentives that distort care decisions. By overpaying for inpatient care as compared to outpatient care, the State incentivizes the use of inpatient care even when outpatient care might be more efficacious and economical. By using an inaccurate methodology, the State encourages hospitals to favor some services at the expense of others – encouraging hospitals to compete vigorously to expand their cardiac services, for example, while seeking at the same time to jettison less-profitable obstetrics services. The existing methodology also favors some providers over others, potentially jeopardizing the very existence of facilities that operate efficiently and with high quality, but have the misfortune of being disfavored by a flawed methodology. In sum, the current reimbursement system does not support optimal delivery of value-based health care in New York State.

Continuing their efforts to improve the system of health care delivery, the Governor and Legislature recognized that New York State must modernize its inpatient hospital reimbursement system. The 2008-09 Budget required the Commissioner to establish the TAC, evaluate different payment methodologies and prepare for a phased transition from 1981 base costs to 2005 base costs. The Governor and Legislature also recognized that a modernized system must increase

efficiency, improve the quality of health care for New York State residents and promote a high-value, quality-driven health care system.

Accordingly, this report recommends a number of critical changes that New York State should make to its Medicaid inpatient payment methodology to ensure that Medicaid patients receive optimal care and that the State becomes a smarter purchaser of health care services on behalf of the public.

First, New York should adopt a payment methodology for Medicaid patients that reflects the current cost of these patients. Currently, Medicaid rates are based on a 30 year old, 1981 base rate, updated by regular inflationary trends and multiple add-on payments connected neither to the costs of serving Medicaid patients nor to the quality of the care delivered. In addition, the Medicaid rate reflects costs of commercially insured patients as well as Medicaid patients. Furthermore, medical costs have changed dramatically since 1981, not only in terms of actual level of spending but in terms of cost for certain treatments. For example, the relative costs of an invasive heart procedure have changed significantly since 1981 given advances in technology and better care management. Accordingly, the base cost must be updated to reflect 2005 costs for the population being treated – Medicaid patients. Updating the base year and paying for the costs of Medicaid patients only will have the effect of reducing the overall payment level while eliminating the distortions that impede quality and value-based purchasing. The updated cost base should recognize actual differences in individual hospitals' wage and power costs. These differences reflect actual differences in baseline costs that are in some measure out of the control of the individual hospitals and also reflect legitimate differences in hospitals.

Second, the reimbursement methodology should eliminate coarse proxies for patient severity, such as those based upon peer groupings, hospital-specific volume and avoidable differences in hospital-specific cost. It should also eliminate add-ons to the base rate that are not directly linked to the delivery of cost-effective care to Medicaid beneficiaries.

In place of these various adjustments, add-ons and peer grouping, the State should adopt All-Patient-Refined Diagnostic Related Group (APR-DRG) methodology for reimbursing inpatient Medicaid services. The APR-DRG system allows for a more precise stratification of patients by the acuity of their illness and their risk of mortality, thus providing a more precise method for equitable reimbursement than the current AP-DRG system. The patient-sensitive APR-DRG system can be used to ensure that facilities receive fair value for the care they deliver to Medicaid patients.

Third, the State's methodology for reimbursing Graduate Medical Education (GME) attributed to Medicaid should be updated to reflect current costs. Reimbursement of direct medical education costs – such as salaries and fringe benefits of residents, teaching costs and overhead – is currently based upon hospital-specific 2001 costs. These costs should be updated to 2005. Similarly, the formula used to determine the indirect costs of medical education – which covers less tangible expenses unique to teaching hospitals - should be updated using a more current teaching intensity ratio and costs that are attributable to Medicaid patients in 2005.

In addition to examining Medicaid reimbursement for GME, the TAC also looked at the \$282 million Professional Education Pool (PEP). Funded with all State dollars, the PEP was established in 1996 when hospital rates were first deregulated in response to concerns that commercial insurers would not recognize the additional costs associated with GME. As a result, the allocation formula drives the PEP monies disproportionately to the State's academic medical centers and largest teaching hospitals. Significantly, the academic medical centers represented on the TAC confirmed that in fact they are able to secure reimbursement rates from commercial payers that exceed the rates they receive from Medicaid, suggesting that the 1996 rationale for PEP funding is no longer relevant and the use of these critical health care dollars should be rethought.

Fourth, utilizing an updated and more precise cost base will have the effect of reducing the total amount of Medicaid FFS reimbursement paid to hospitals for acute, inpatient services. The Department, industry and individual hospitals worked together for over a year and developed multi-analyses all of which demonstrated that, as of December 1, 2008, after taking into account rate reductions in the April and August 2008 Budget actions, Medicaid inpatient rates exceed Medicaid inpatient costs while Medicaid outpatient payments do not cover outpatient costs. Accordingly, the State should, consistent with budgetary constraints, reinvest inpatient savings in primary and preventive care and other traditionally under-paid ambulatory care services in order to improve the quality of patient care, ensure adequate access to these services and avoid more costly inpatient admissions.

These four recommendations form the blueprint of reform described by this report. Implementing these recommendations will result in a more transparent and accountable reimbursement system that better serves the needs of Medicaid patients and drives state health care spending consistent with efficiency, quality and public health priorities.

In addition, the recommended reforms will provide hospitals with greater predictability of their income streams and allow the Department to publish more timely hospital rates. The more accurate, efficient and transparent system will also afford the Department an opportunity to better evaluate and pursue payment methodologies that reward higher quality of care. The report therefore recommends that the Department explore such methodologies, including utilizing the more sensitive APR-DRG system to identify potentially preventable complications and potentially preventable readmissions and adjusting reimbursement accordingly.

Given the current economic downturn, the necessity of building a durable healthcare delivery system is more critical than ever. New York State must act *now* to establish a Medicaid reimbursement system that supports the goal of quality, value based health care. Though some TAC members argued that the current economic crisis requires more delay, the crisis in fact makes it all the more imperative that New York bring down health care costs and bring up health care quality - building a high performing health care system for the 21st Century.

II. The Technical Advisory Committee Operated within the Context of a Comprehensive Health Reform Agenda

A. The “Berger Commission” Reduced Capacity and Recommended Reimbursement Reform

For the past few years, the State of New York has been engaged in the process of reconfiguring its health care delivery system. The process began in April 2005, when the State Legislature enacted legislation creating the Commission on Health Care Facilities in the Twenty-First Century (popularly known as the “Berger Commission,” after its chair, Stephen Berger). The Berger Commission was charged with undertaking an independent review of health care capacity and resources in the State and ensuring that the supply of general hospital and nursing home facilities was configured to respond to community needs. It was also authorized to make nonbinding recommendations on other issues, including recommendations for reimbursement reform.

Its assessment of the health care delivery system was bleak. It found a “system in crisis,” and reached a “stark and basic conclusion: our State’s health care system is broken and in need of fundamental repairs.”

As the report detailed, a fundamental driver of the crisis was excess inpatient capacity. New York State is over-bedded and many hospital beds lie empty on any given day. These declining occupancy rates are driven in part by shifts in the venues in which health care is provided. Health care services are migrating rapidly out of large institutional settings into ambulatory, home and community-based settings.

Accordingly, the Berger Commission issued recommendations to alter the configurations of 57 hospitals, or one-quarter of all hospitals in the state. The acute care recommendations included nine facility closures; collectively, the recommendations were designed to reduce inpatient capacity by approximately 4,200 beds, or 7 percent of the State’s supply.

While the Berger Commission’s work has concluded, the State’s interest in eliminating excess capacity continues unabated. Thus, for example, the State has made significant grant funds available to facilities that downsize or reconfigure in a manner consistent with the goals and objectives of the Berger Commission. The historical trends driving consolidations and closures are also expected to continue.

The Berger Commission did not limit its work to recommending hospital closures and reconfigurations, however. It also identified flaws in the health care delivery system and recommended necessary reforms to improve the overall quality of care. More specifically, it found that:

- “Primary care capacity is insufficient, so that some patients go without preventive and basic services. Inadequate primary care worsens health care status, allows chronic conditions to go unmanaged, and results in back-end care that is more costly and less beneficial than front-end services.”

- “Our Medicaid program, already the largest and most expensive in the nation, is growing at an unsustainable rate.”
- “Reimbursement mechanisms distort patterns of service delivery and induce facilities to pursue high margin services, sometimes at the expense of more essential community needs. The current rate paradigm is encouraging a medical arms race for duplicative provision of high-end services and discouraging the provision of preventive, primary, and other baseline services.”
- “Reimbursement rates are not closely related to the costs of care.”

The Commission recommended that New York undertake a comprehensive review of reimbursement policy and develop new payment systems that support a realignment of health care services delivery.

B. An Effective Reimbursement System is a Key Element in Improving Quality of Care

If anything, the Berger Commission understated the scope of the problem. As shown in more detail below, New York State’s Medicaid inpatient reimbursement system is highly outdated. The system relies upon hospital costs incurred nearly 30 years ago and includes non-Medicaid patients, provider classifications and rate add-ons that tend to distort, rather than improve, patient care. It is also highly inefficient; the Department has calculated that as of the date of this report, the State of New York annually spent approximately \$575 million on Medicaid inpatient reimbursement above and beyond the reasonable cost of services provided.

The true impact of the distorted reimbursement system, however, lies not only in the actual dollars spent, but on its impact on patient care. Overcompensating one phase of health care delivery at the expense of another encourages providers to emphasize the more lucrative form of care. In this case, the distortion takes three forms.

First, the current system over-compensates inpatient care and under-compensates ambulatory care, driving patients into more expensive inpatient settings at the expense of more efficient outpatient care. Shortchanging one delivery system at the expense of another not only drives inefficiency, but can also have a negative impact on patient care; patients who could be treated as outpatients can be exposed unnecessarily to the risks of hospitalization, while chronic disease sufferers are unable to access the primary care and disease management services they need.

Second, the current system creates profitable and unprofitable service lines unrelated to the actual service needs of patients. Rational hospitals compete to become leaders in providing profitable service lines and to limit their exposure to unprofitable services. The result is a hyper-competitive “medical arms-race” in profitable services, such as cardiac care, coupled with a destructive flight from other services as hospitals seek to limit their exposure to unprofitable, yet important services, such as obstetrics.

Third, the current system benefits some providers at the expense of their competitors. A hospital in a more favorable peer-grouping, for example, or one that had inflated costs in 1981, or one that successfully advanced an obscure rate appeal and secured a targeted add-on, will receive higher reimbursement than a competitor who treats similar patients. In today's highly competitive markets, these differences in reimbursement will have an effect on profitability and may even impact the disadvantaged hospital's ability to survive.

Accordingly, in response to the dual challenges described above – the crisis in health care delivery on the one hand, and the need to preserve resources on the other – New York State has for the past few years been engaged in the process of re-imagining its Medicaid program, particularly its reimbursement system. A brief description of those efforts follows.

C. The State Has Begun a Comprehensive Effort to Reform Hospital Rate Setting

The effort began in 2007, with reform of the Service Intensity Weights (SIWs). SIWs are designed to measure the relative cost of each patient by assigning a relative weight to each Diagnostic-Related Group (DRG). (The DRG system might, for example, identify one patient as having pneumonia and another as having a coronary bypass; the SIWs establish the relative cost value of those two illnesses.) By 2007, the data on which SIWs were calculated was 15 years old; the 2007 Budget authorized the Department to rebase the calculations of SIWs and related statistics immediately and to rebase continually, no less frequently than every fourth year.

While the 2007 Budget offered a start, the reforms enacted as part of the 2008-09 State Budget began the process of a more comprehensive reform. In particular, the Budget transformed the method by which outpatient services would be reimbursed; reduced over-spending for detoxification services; began the process of updating the base year for inpatient, FFS reimbursement purposes; and committed the State to evaluating new rate setting methodologies for inpatient rates in the 2009-10 fiscal year. In each case, the reform was intended to ensure that Medicaid dollars follow the Medicaid patient, buying quality care in the right setting and at the right price.

More specifically, prior to the 2008 Budget, the outpatient setting in which treatment was provided determined the method of reimbursement. For example, for more than a dozen years hospital outpatient clinics were held to a limit of \$67.50 per visit for operating expenses, no matter how intensive the treatment they provided. Diagnostic and Treatment Centers, which offer services similar to hospital outpatient departments, had reimbursement rates that varied widely and which had been frozen since 1995. Ambulatory surgery centers were reimbursed predicated on an outdated, ambulatory surgery system, based on 1993 costs.

This system made irrational distinctions both between providers in the same categories and between providers in different categories providing similar treatments. It also failed to distinguish between patients with greater or lesser needs; every visit was reimbursed the same amount. A patient who visited repeatedly for short visits was therefore more profitable than one who visited occasionally for intensive or comprehensive treatment – and the amount would vary by the setting in which he was seen. This misalignment of payment and cost neither drives

optimal treatment decisions nor supports facilities that provide high-quality, efficient care.

The 2008 Budget addressed this problem by requiring the Department to promulgate regulations utilizing an Ambulatory Patient Group (APG) methodology across all of these settings. Under these regulations, the State will pay providers for the treatment they provide, not for the setting in which it is provided nor the historical cost basis of the treating facility. The Department is using the APG methodology, which allows for the appropriate grouping of conditions and procedures, to ensure a fair and accurate reimbursement. When fully phased-in, the methodology will result in an outpatient reimbursement system that reflects the cost of medically necessary treatment, no matter where it is provided.

The 2008 Budget also addressed Medicaid fee-for-service inpatient reimbursement. Section 12 of Part C of Chapter 58 of the Laws of 2008 committed the State to transition from the current reimbursement system to a modernized system based upon 2005 base year costs by 2012 and requires this report.

III. Overview and Evaluation of the Medicaid Inpatient Reimbursement System

The TAC process focused primarily on three basic issues: (1) the principles that should govern Medicaid's inpatient reimbursement system; (2) whether the current reimbursement methodology reflects those governing principles and to the extent it does not, how it can be improved; and (3) the appropriate level of payment. This section of the report is organized around those three basic issues.

A. The Principles of a Sound Reimbursement System

In order to reform the Medicaid inpatient reimbursement system, the Department initially identified 10 principles that would govern any sound reimbursement system. As revised and agreed upon by the TAC, these were reduced to 9 reform principles:

Reimbursement Reform Principles	
<u>Medicaid Rates should:</u>	
1.	Be transparent
2.	Promote high value, quality driven health care services
3.	Pay for Medicaid patients
4.	Not cross-subsidize non-Medicaid payers
5.	Encourage care in the right setting
6.	Reinforce health system planning and advance state health care priorities
7.	Be updated periodically
8.	Comply with Federal Medicaid rules
9.	Be consistent with Budget constraints

B. The Current Inpatient Reimbursement System is Not Consistent with the Agreed-

Upon Principles of a Sound System

Measured against those principles, the current reimbursement system falls short. To understand its shortcomings, a brief description of the current system is necessary.

1. A General Description of How the Current Inpatient Rate is Calculated

The current system begins by establishing a base rate using 1981 inpatient costs. The average cost of **all** inpatients (other than Medicare patients) is calculated, so that the base rate includes the costs of patients covered by commercial insurance for example. Those costs are then inflated from 1981 to the current year and used as a basis for calculating a hospital-specific rate and a peer-group rate. Each hospital's base rate is a blend of 45% hospital specific and 55% the hospital's peer group.

The hospital-specific rate reflects the hospital's case-mix-adjusted, cost-per-discharge in 1981; that is, it reflects the cost of treating a "generic" patient in that hospital. The peer group rate also reflects a case-mix-adjusted, cost-per-discharge in 1981, but for a "peer group" of hospitals that were then considered similar. There are seven total peer groups currently used: academic, downstate teaching, downstate nonteaching, upstate teaching, upstate nonteaching 99 beds and under, upstate nonteaching 100 beds to 300 beds and major publics. While the peer group was an attempt to infuse an element of efficiency into the formula, it was a gross attempt, at best, with the result that some hospitals were unfairly disadvantaged and others received a windfall. It also triggered numerous requests to move peer groups as hospitals sought to take advantage of a peer group that offered a higher rate. Each hospital's base rate is then calculated by combining the hospital-specific rate with the peer group average rate; the former is weighted at 45%, while the latter is weighted at 55%. The rate is adjusted for wage and power costs; a wage equalization factor (WEF) and power equalization factor (PEF) are used to adjust the base. A volume adjustment is used, so that when volume (including commercial volume) at a hospital changes, the rate is adjusted to spread fixed costs over either more or fewer discharges.

The base rate is then increased to reflect the facility's direct costs of Graduate Medical Education (GME) (such as salaries and fringe benefits, teaching costs and overhead), as those costs were incurred in 2001. As with the base rate, these costs are calculated for all patients and are inflated using the applicable trend factor.

The rate is further adjusted for Indirect Medical Education (IME) costs. IME costs are additional costs incurred due to higher use of services associated with teaching. IME reimburses hospitals for a portion of these costs, using a 1988 Medicare formula applied to 2001 costs, trended forward to the current year. (Medicare has updated its methodology several times since 1988.)

The base rate is then multiplied by the Service Intensity Weight (SIW). SIWs are the relative cost of each DRG, on average, when compared to the average cost of all DRGs. Multiplying the adjusted base rate by the SIW produces the case payment.

The case payment is then increased by various add-on components unrelated to the costs of serving Medicaid patients in inpatient settings, such as worker retention payments and other unique add-ons. Approved capital expenditures are reimbursed as a pass-through, on a dollar-for-dollar basis (except for major moveable equipment, for which a 44% reduction is taken).

2. The Current Rate Is Calculated Using Outdated, Imprecise Cost Measures and Add-ons Which Ultimately Distort the Reimbursement System and the Health Care Delivery System

The current Medicaid fee-for-service, inpatient reimbursement system fails virtually every one of the reform standards endorsed by the TAC. First, and most obviously, the system is flawed because it is based upon 1981 base year costs of Medicaid and commercial patients; that is, hospitals receive reimbursement based upon their cost structure as it existed in 1981, inflated and enhanced annually. Hospitals may thus flourish and prosper, or suffer and fail today, based in part on the historical cost structure as it existed more than a quarter-century ago.

A more effective means of encouraging efficiency is to reimburse hospitals based upon current, industry-wide costs, adjusted for appropriate differences in facilities and patients. Using current industry-wide costs allows facilities to compete with each other on a level playing field. Those who operate more efficiently will profit; those that operate inefficiently will be compelled to change their business practices or fail. At the same time, such a system does not reward hospitals for past inefficiencies, or punish them for past efficiencies. Such a system will compel hospitals to compete and improve the value of the services they provide.

This conclusion highlights a second flaw with the current reimbursement system. The current system does not use industry-wide costs, but instead uses an artificial blend of peer group costs (55%) and hospital-specific costs (45%), with some hospital-specific adjustments even within the peer group component. Peer group costs divide hospitals into eight separate categories according to mission, and hospital specific costs acknowledge hospital individual cost structure. The peer groups were a gross and ultimately unsatisfactory effort to instill some notion of efficiency.

Of course, while hospitals can and should compete based upon current, industry-wide costs, there are some costs upon which they cannot and should not compete. Wage and power markets across New York State vary considerably and of necessity impose different costs structures on different hospitals. Accordingly, the current policy of adjusting each hospital's rate to account for reasonable wage and power costs should be continued.

Similarly, the State has a long-standing public policy of supporting graduate medical education. Medicaid should continue to reimburse hospitals for the GME costs related to serving Medicaid patients.

However, some of the same flaws that are found in the calculation of a base rate are also in the calculation of graduate medical education costs. Direct medical education costs for Medicaid patients are currently based on 2001 costs; those costs should be updated to a more recent year and reflect the Medicaid share of such costs. Reimbursement for Medicaid GME costs related to Medicaid managed care patients is paid directly to each hospital based on discharges of Medicaid Managed Care patients. Similarly, indirect medical education costs, which reflect the additional ancillary services, treatment regimes and testing technology costs associated with a teaching program at a hospital, uses a 1988 Medicare formula applied to 2001 costs. The formula should be updated to reflect more recent intern and resident counts and counts of certified beds, for calculating the teaching intensity ratio, and the cost data should be updated to reflect the Medicaid-inpatient, FFS share of such costs.

The reimbursement formula also includes various add-ons directed to specific purposes or specific hospitals or regions. A recruitment and retention add-on provides additional monies to hospital inpatient rates to attempt to recognize increased inpatient and outpatient labor costs related to Medicaid, Medicare and commercial patients. Other supplements provide funds only for hospitals within specific sectors (public vs. private), specific regions (New York City or Long Island, for example), or specific hospitals and are added to inpatient Medicaid rates, again with no underlying nexus to documented costs or quality. These supplements distort the market for health care services, as the add-ons are tied neither to Medicaid costs nor to quality.

Finally, the complexity of the current system requires numerous individual calculations for each facility, some of which are inevitably challenged by the facility and all of which make timely rate promulgation virtually impossible. These rate appeals consume significant facility, Department and court resources that could be avoided with a less complex and predictable system.

3. The Current AP-DRG System Does Not Adequately Recognize Differences in Patient Need

Many of the flaws with the current reimbursement system are the product of a well-intentioned effort to remedy a different flaw in the reimbursement system: the imprecision of the current DRG system.

DRGs are the lynchpin of the modern prospective payment system. The prospective payment system is designed to measure the intensity of care that each patient needs in order to treat his illness or injury. Of necessity, no system can measure the actual care needs of each individual patient. Instead, the DRG system uses an algorithm to assign a patient to a pre-determined group of similarly situated patients and then treats all patients within those groups as having similar needs.

The initial DRG system was developed with support from the Federal Department of Health and Human Services (HHS) and focused on diagnoses and costs related to the Medicare (elderly and disabled) population. In 1987, the Department concluded that Medicare-based DRGs were not an appropriate basis for the general population and retained the 3M Corporation to develop a new, non-Medicare DRG system. The result was the All-Patient DRG system, or AP-DRG.

After 20 years, the AP-DRG system is now widely viewed as providing only a relatively coarse measure of patient severity. Patients who are treated in academic medical centers, for example, require on average more intensive treatment than patients in non-teaching hospitals, even if they share identical DRGs. To accommodate this, the State developed the peer-grouping system to supplement the DRG system as a means of measuring patient severity. Various other provisions of the rate reimbursement system were also adopted in order to respond to unmeasured patient need. However, these adjustments are not based on patient characteristics and represent flawed proxies for measuring patient severity.

In the past few years, a number of companies have devised far more precise DRG systems that measure patient severity. Accordingly, Department staff evaluated the various alternative DRG systems to identify a potential successor to the AP-DRG system. In conducting its analysis, the Department relied upon a Rand Corporation report “Evaluation of Severity-Adjusted DRG Systems,” prepared for the Centers for Medicare and Medicaid Services to evaluate the off-the-shelf, severity-adjusted DRG systems that might be considered for Medicare’s PPS system.

One important evaluation criterion addressed by the report was how well each DRG system explains differences in cost; another was how much money would be redistributed based upon more precise measurement of patient severity. The report found that the All Patient Refined – Diagnostic Related Group (APR-DRG) methodology created by 3M Corporation had the highest explanatory power and would more precisely distribute Medicaid inpatient funds than any other DRG system. In addition to its high level of precision, the APR-DRG system offers an additional advantage; it contains policies to encourage precise coding and not reward hospitals for complications resulting from substandard care.

To create the more refined methodology, 3M first collapsed the existing 684 AP-DRGs into 314 base APR-DRGs by consolidating categories that were previously differentiated by clinical complications, patient age and death. (For example, there were separate DRGs for “pneumonia” and “pneumonia with complications.”) It also expanded some DRGs based upon pediatric and mortality distinctions.

The 314 base DRGs are then grouped into four sub-classes, reflecting severity of illness. (The subclasses are “Minor,” “Moderate,” “Major,” and “Extreme.”) Patients are assigned to severity levels depending upon the type and number of their secondary diagnosis, their age and the intensity of their illness (based upon the interaction of the severity of the primary diagnosis, the interaction among the primary and secondary diagnoses, their age and the intensity of procedures). Reimbursement may vary significantly across the four categories of severity. For example, a coronary bypass might range in average cost from approximately \$22,000 (with an average length of stay of 7 days) to \$37,214 (with an average length of stay of 14 days, nearly double the length of stay for a “minor” coronary bypass).

The APR-DRG system thus affords the State the opportunity to more precisely reimburse hospitals based upon patient acuity. This direct measure of patient acuity and legitimate hospital cost can replace the more imprecise measures currently in use, such as peer groupings.

C. The Current Reimbursement System Overpays for Inpatient Care and Underpays for Outpatient Care

The third important issue considered by the TAC was the overall level of payments made in the current system. Principles three and four of the TAC provide that the Medicaid, fee-for-service reimbursement system should pay for the costs of Medicaid patients. However, according to the Department’s analysis, the current reimbursement system reimburses hospitals for more than their costs – currently, an excess payment amount of approximately \$575 million for calendar year 2008, even after factoring reductions to Medicaid inpatient payment rates in the April and August 2008 Budget actions.

In theory, determining Medicaid’s fair share of hospital costs is relatively simple: compare the amount that the State reimburses hospitals for these patients with the total costs these hospitals incurred on behalf of those patients.

Accordingly, the Department, guided by suggestions from the hospital industry, undertook the calculation of those costs and payments. A description of the mechanics of calculating the difference between Medicaid inpatient costs and Medicaid inpatient revenue is in Appendix A. The bottom line is that after working on this analysis for well over a year, permitting hospitals to amend their cost reports and using various permutations requested by the hospital industry, the data continues to show that, as of December 1, 2008, after taking into account rate reductions in the April and August 2008 Budget actions, Medicaid inpatient rates exceed Medicaid inpatient costs by close to \$575 million. (See Appendix A for detail.)

IV. Reform Efforts Must Continue

The analysis demonstrates that New York provided reimbursement for Medicaid *inpatient* fee-for-service patients in an amount that exceeded hospitals’ costs of treating those patients as of the end of 2008. Moreover, when the data and methodology used to calculate the difference between Medicaid inpatient costs and revenue is applied to hospital *outpatient* costs and revenue, it shows that Medicaid outpatient costs exceed Medicaid outpatient revenue by

approximately \$400 million¹. However, some TAC members have argued that recent and/or future budget cuts will eventually eliminate the inpatient gap. Additionally, some members argued that outpatient investments paid for by reductions in inpatient payments cannot be absorbed by the industry particularly at this point of dramatic economic downturn. Spiraling costs such as pension obligations and medical malpractice coupled with decreasing investment values were also cited as major obstacles in moving ahead with reform at this time.

While these arguments are not without some merit, they do not justify delaying reimbursement reform. The gap highlights the fact that the current reimbursement system is flawed and does not support treatment in settings that are of the most value to the patient. Delaying reform because of what might – or might not – happen in the future is simply “more of the same.” Moreover, there can be no dispute that, at present, inpatient rates exceed costs and outpatient rates are below cost, presenting a reimbursement paradigm at odds with public policy and sound clinical evidence supporting the critical importance of quality primary care. Additionally, it is clear that even without the challenges currently being faced, the industry needs a period of time to complete a transition to a new model of health care service delivery. This period needs to be supported with transitional funding to assist hospitals in bringing their services in line with New York’s health care priorities and their costs in line with revenues.

Some TAC members have also argued that some of the distortions represent policies and promises that were promoted by previous Governors and Legislatures and that hospitals have relied on those promises in making their own commitments. For example, the workforce recruitment and retention add-on to Medicaid inpatient rates subsidizes inpatient and outpatient labor costs for all patients (Medicaid, Medicare and commercial) receiving inpatient services not just fee-for-service. Similarly, payments for graduate medical education may subsidize expenses beyond those of educating residents.

However, the use of Medicaid, fee-for-service reimbursement payments to meet other goals arises from a misapprehension of the basic purpose of this program and contributes to a distortion of patient care while undermining transparency and accountability. These distortions should be eliminated, and the most accurate system – one that targets dollars to high-quality, cost-effective care for Medicaid beneficiaries - should be implemented as quickly as reasonably possible. Furthermore, New York cannot continue to overpay for inpatient services and to underpay for outpatient services.

As required by statute, this report must reflect divergent opinions to those offered in the report. To accurately capture these, Appendix B contains the positions of TAC members as transmitted in letter and memo format.

¹ Estimate based on uninflated 2005 figures which do not include 2008-09 outpatient investment of \$178 million.

V. Recommendations for Reforming Medicaid Inpatient Rates

For the reasons described above, the New York State Department of Health (the Department) recommends the following reforms to the Medicaid inpatient reimbursement system.

Recommendation 1:

New York State should adopt a prospective payment rate that reflects reasonable, efficient costs for delivering inpatient care to Medicaid patients. The rate should be based on 2005 costs (rather than the 30-year-old costs currently being utilized), should reflect the cost of Medicaid patients only, should be updated regularly and should recognize a limited number of appropriate and critical differences in facilities.

Recommendation 2:

The base rate should eliminate distinctions based upon peer groupings (e.g. teaching vs. non-teaching), regional variations in spending, hospital-specific volume and hospital-specific cost. It should also eliminate add-ons to the base rate which are unrelated to the inpatient costs of delivering efficient and effective care to Medicaid patients.

Recommendation 3:

New York State should replace the current, outdated, All-Patient Diagnostic Related Group (AP-DRG) payment methodology for reimbursing inpatient Medicaid services with the All-Patient-Refined Diagnostic Related Group (APR-DRG) methodology. The APR-DRG more precisely stratifies patients by the severity of their illness and their risk of mortality, thus providing a more precise method for equitable reimbursement.

Recommendation 4:

The Medicaid reimbursement system should cover the reasonable costs of both direct and indirect costs of graduate medical education related to Medicaid patients.

Recommendation 5:

The Department should use the APR-DRG system to integrate quality into the payment system. In particular, the Department should explore development of a program that utilizes the more sensitive APR-DRG system to identify potentially preventable complications and potentially preventable readmissions and that adjusts reimbursement accordingly, in a manner sensitive to patient variation among facilities.

Recommendation 6:

Consistent with budgetary constraints, savings achieved through inpatient reimbursement reform should be re-invested in ambulatory care settings. These settings have historically been under-reimbursed and the State should fulfill its commitment to improving outpatient reimbursement in order to ensure timely access to these critical services.

Recommendation 7:

Changes to the Medicaid inpatient reimbursement system should be implemented in a manner that enables hospitals to transition reasonably to the new system.

Recommendation 8

Armed with a transparent, predictable and efficient reimbursement system, the Department should work with industry representatives to ensure that an improved data management system is accurate and efficient and therefore serves the needs of the Department, the health care delivery system and the general public.

This report comes at a time of great hope and uncertainty. New York State is in the process of implementing historic reforms to all sectors of its health care delivery system, reconfiguring its institutions, rethinking and revising its reimbursement system with the singular goal of providing New Yorkers with a high-quality health care system they can afford. These reforms are inexorably linked with Governor Paterson's commitment to make health insurance accessible to all New Yorkers. Fortunately, New York's goals find support in the health care goals advanced by President Obama. The economic crisis New York is facing makes health care reform all the more urgent. If the system is not reformed, an opportunity will have been lost and all New Yorkers will be the poorer.

Appendix A
Medicaid Fee for Service (FFS) Costs and Payments

1. Medicaid Fee-for-Service Costs

An appropriate measure of the costs associated with treating Medicaid inpatient FFS patients requires some precision. It would not suffice merely to take the ratio of Medicaid patients to total patients and assign costs based upon that ratio, since patients vary considerably in the amount of services they utilize. For example, the fact that 10% of a hospital's patients are Medicaid, fee-for-service, does not tell us that 10% of hospital costs are attributable to them; it may be much more or much less, depending on the type of patients.

Fortunately, the Department tracks costs on a service level through Institutional Cost Report (ICR) reports that hospitals are required to submit to the Department annually. Accordingly, the Department began its analysis with the ICRs.

Due to these reports not currently being used to determine rates, the industry raised concern about their usage in this context. In order to ensure accuracy, the Department worked at great length with hospital associations and individual hospitals to compile more accurate ICR data; this process consumed hundreds of staff and industry hours over the summer and resulted in cost totals that the Department believes are as accurate as possible.

Once costs had been established for each service at each hospital, it was necessary to determine Medicaid's proportionate share of those costs. To calculate this amount, the Department relied upon hospital charge data. Hospitals typically charge a set amount per procedure; though many insurers negotiate significant payment discounts, the initial charge for each service to each payer is identical.

**Calculating Medicaid-only Costs by Using a Ratio of Cost to Charges
(RCC)**

For each service, an RCC is calculated as follows:

Step One:

Total Hospital Department Costs ÷ Total Hospital Department Charges
(Billing) = RCC Factor

Step Two:

Reported Charge from Medicaid Billing x RCC Factor = Total Medicaid Costs

Thus, the Department calculated the ratio of *costs* incurred by each service area to the *charges* generated by that service area. This ratio - the ratio of costs to charges, or RCC - allows a determination of how much it costs to produce each dollar of services that was charged. The RCC was then multiplied by the total Medicaid charges that the hospital had charged to Medicaid, by service area, to produce the total Medicaid costs that each service area incurred.

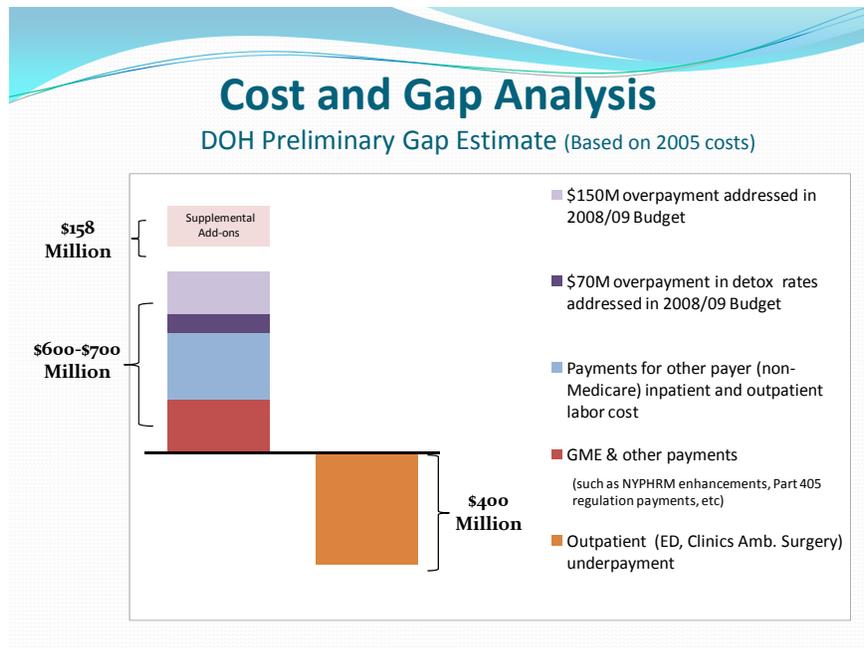
This process allowed the Department to determine costs for Medicaid, inpatient, fee-for-service patients at the most precise level – the service level of each individual hospital. Once this had been determined, the amounts could be aggregated to the hospital level and then system-wide, to determine the actual cost incurred by hospitals in treating the relevant population.

2. Medicaid, Fee-for-Service Payments

Along with the cost data analysis, the Department also needed to identify the amount that it had paid for Medicaid services. Two data sources were available for this purpose. The Statewide Planning and Research Cooperative System (SPARCS) data is medical record data submitted by hospitals for all patients and contains clinical, charge and demographic information for each patient treated. The Electronic Medical Claims System (EMEDNY) is the Department database used for submission and payment of Medicaid claims, including submission to the federal government for federal financial participation (FFP). It includes actual claims data for all Medicaid inpatient and ambulatory care services provided to Medicaid eligible recipients (including charges and diagnosis-related data on each claim).

After the analysis of each data system and at the request of the hospital associations, the Department concluded that the EMEDNY data was the more precise measure of actual payments. Using that data and the updated ICRs, the analysis revealed that for the 2005 rate year, providers received \$750 million more in reimbursement than they incurred in costs. (Please refer to chart on page 22.)

The Department also attempted to isolate the impact of individual policies on the overpayments. It found that excess graduate medical education costs accounted for \$100 million of the surplus; recruitment and retention payments for other patients, such as those covered by commercial insurance, totaled \$240 million; overpayment for detoxification services totaled \$70 million; overpayments associated with outdated data totaled \$200 million; and an additional \$153 million resulted from payment add-ons in the 2008-09 enacted Budget.



3. After Modifying the Analysis to Reflect Recent Medicaid Cuts, the System Overcompensated Inpatient Care by \$575 Million

However, this analysis neglected to take into account the recent cuts to Medicaid reimbursement. To update this analysis, the Department inflated hospital costs and reimbursement rates using the current methodology to 2007; with this modification, the system continued to show an approximately \$750 million overpayment.

Medicaid Inpatient Overpayment Analysis
(Acute Care only - Excluding Exempts)

2007 Costs (2005 RCC based - trended to 2007 using Consumer Price Index)	\$ 2,501,345,000
2007 Payments Under Current Methodology	\$ 3,259,919,000
Payment over Costs (Overpayment)	\$ 758,574,000
Less Adjustments since 2007:	
Rebasing Adjustment (2008-2009 Final Budget)	\$ \$154,000,000
Detox Reduction - Full Implementation (2008-2009 Final Budget)	\$ 55,697,000
1.3% Reduction on Final 2008 Trend (August Special Session)	\$ 97,149,000
Reduce 2009 Trend by 1% (August Special Session)	\$ 34,696,000
Adjusted Overpayment:	\$ 417,032,000
Plus Payments not in Gap:	
2007-08 Legislative Adds	\$ 158,000,000
Net Adjusted Overpayment:	\$ 575,032,000

The Department then subtracted the rebasing adjustment contained in the 2008-09 final Budget, in the amount of \$154 million; the reduction in reimbursement for detoxification services, in the amount of \$55 million; and reductions to the annual trend factor increases in 2008 and 2009 in the amount of \$97 million and \$35 million respectively.

With these reductions, the Medicaid, inpatient, fee-for-service reimbursement exceeded its associated costs by \$575 million. That is, as of the date of this report, the State of New York provided reimbursement for Medicaid, inpatient fee-for-service patients in an amount that exceeded hospitals' costs of treating those patients by approximately \$575 million.

This analysis confirmed the conclusion that the flaws of the current system resulted in overpayments to the Medicaid FFS inpatient system. Indeed, the Department analyzed the data in various ways: using the original ICRs, then using modified ICRs at the request of the industry; using SPARCS data and then using EMEDNY data, again at the request of the industry. The results of these various preliminary and modified analyses were all similar and confirmed the Department's ultimate conclusion: Medicaid, inpatient, fee-for-service reimbursement currently exceeds associated costs by \$575 million.

Appendix B
TAC Member Position Letters and Memo



Healthcare Association
of New York State



IROQUOIS
Healthcare Alliance

October 21, 2008

TO: Hospital Rate-Setting Technical Advisory Committee (TAC) Members

FROM: Daniel Sisto, President, Healthcare Association of New York State (HANYS)
Kenneth Raske, President, Greater New York Hospital Association (GNYHA)
Gary Fitzgerald, President, Iroquois Healthcare Alliance (IHA)

SUBJECT: Technical Advisory Committee Recommendations

Prior to the last TAC meeting, HANYS provided comments focused primarily on the dispute over the value of rebasing inpatient hospital rates. We stand by our position that no additional inpatient reimbursement reductions should occur from rebasing, and we continue to endorse as a top priority the need for additional investment in outpatient services—hospital, clinic, and physician-based services.

As we approach the final scheduled meeting of the TAC, HANYS, GNYHA, and IHA want to take this opportunity to state broader concerns and offer a recommendation for your consideration. In short, that recommendation will be to extend the work of the TAC through this coming year, including extending the deadline for recommendations on the details of reform, and continue the productive work with the industry and TAC to get it right.

At the last TAC meeting, you heard concerns expressed from hospital Chief Executive Officers and the Associations about the difficulty of managing significant reform in a period of financial turmoil and the expectation that providers will be looked to for additional sacrifice. Since that last meeting, the economic situation has gotten immeasurably worse and the Governor has had to call for another “special session” to deal with the state’s financial crisis. As you know, hospitals and other health care providers are directly affected by the current financial crisis, the extent of which is still unknown, even as the state looks for an additional “shared sacrifice.”

It is in that context that our three Associations offer the following comments and recommendations:

- First, we reiterate our support for rebasing the hospital inpatient reimbursement system and for reasonable reform of that payment system.
- Our support for rebasing rates to 2005 or any more current year is predicated on our position that rebasing would result in no additional inpatient payment reductions.

- Taking into account the Medicaid budget cuts of April and August, and appropriately carving out policy-based Medicaid initiatives (e.g., workforce and GME funding), effectively eliminate the argument that Medicaid inpatient payments exceed cost.
- Furthermore, cutting inpatient fee-for-service rates in order to finance increases in outpatient fee-for-service rates results in net losses to *all* hospitals because inpatient cuts are matched in the Medicaid managed care system while outpatient increases for clinic services are not.
- Hospital losses from outpatient services continue to be undervalued—in large part because the state continues to ignore the growing portion of services covered by Medicaid managed care plans. According to 2006 hospital cost reports, outpatient Medicaid losses exceed \$2.0 billion.
- There is still no consensus on the reliability or validity of the data that would be used for rebasing and reform of the payment system. The state deserves credit for an important effort to clean up the 2005 data to be used. But the timeframe (4-6 weeks) and scope of that clean-up was extremely limited. The state has only just sent the results of that effort back to hospitals and the Associations for their review. That information will take months to reconcile. However, based on a preliminary review, it appears that DOH has reduced its estimate of aggregate 2007 inpatient fee-for-service costs since last winter significantly; this change requires validation.
- Reliable and valid data are critical to understanding the merits of various reform proposals. None of the options have been modeled or, if they have, the impacts have not been shared with the TAC. Based on the principles discussed at the last TAC meeting, we believe the various reform options need to be judged for reasonableness, fairness, and equity. This applies to changes related to:

Grouping—whether peer groups would be maintained, modified, or eliminated;

Wage differentials—how wage differences across regions will be accounted for;

Pricing—whether or not a blend of statewide or peer group price and hospital-specific costs will be maintained;

IME—whether IME factors should be changed, especially if peer grouping is proposed to be eliminated;

Severity-Adjusted DRGs—how severity-adjusted DRGs impact the distribution of funds—a new issue introduced at the last TAC meeting.

Also, with respect to impacts, changes need to be modeled and valued for their effects on Medicaid managed care payments, both aggregate payments and direct payments for GME. By focusing only on Medicaid fee-for-service payments, the state significantly underestimates the potential adverse impact on hospitals.

For all the reasons cited above, **HANYS, GNYHA, and IHA recommend that the state continue to work with the industry—and the TAC—over the next year to get it right.** Re-setting the deadline for a reform proposal to the end of 2010 would be more realistic.

Changing a system that has been in place for 25 years is not easy; it is not a criticism of the work that has been done to date to recognize that more work needs to be done. That includes the job of cleaning up the data to be used and testing the impacts of all the options for reform under consideration. It would also allow the state to pre-audit the cost base to be used, and avoid the prospect of subsequent cost audits and continuous payment adjustments.

This coming year will be a challenge for providers and the state alike as we both struggle with financial realities. The state's resources are already stretched, dealing with the state's budget crisis and implementing several significant payment reform proposals already underway. Hospital and Association staff are similarly engaged. Taking more time to get this important initiative correct is a prudent course in this tumultuous environment.

Our Associations pledge our continued support for inpatient payment reform and to work with the Department and TAC to accomplish that reform in a meaningful and responsible manner.

DS:kh

Medicaid
Medicaid Matters New York
Matters

22 October 2008

The economic downturn has rattled all of us. Concern about the economic future affects all of us, including hospitals. The hospital associations are suggesting that New York State should not move forward with plans to rebase hospital inpatient rates this year because of uncertainty about what the immediate future holds. While I appreciate anxiety about the economy, maintaining the status quo in hospital reimbursement rates continues to reward a hospital-based health care delivery system that is not aligned with the needs of New Yorkers. We cannot afford the status quo. It wastes health care dollars at a time when we can ill-afford any waste in state spending. It starves community-based providers who are critical to a more responsive health care delivery system. It does not meet the needs of New Yorkers who rely on Medicaid for their health care.

The Department of Health has enumerated the principles behind their intended rate reforms. No one has expressed significant disagreement with the principles. In recognition of the need for stability within the hospital sector, the state's proposal for hospital rate rebasing has a four-year phase-in. The external financial environment is extremely volatile, and may remain so for the foreseeable future. The idea that a one-year delay in beginning the four-year transition to a new rate-setting methodology would provide hospitals with significant financial protection seems misplaced. We can always find excuses for avoiding change. But we do so at our own peril.

The need to rebalance the health care delivery system in New York State is a decades-old issue. Our failure in this regard has put New York at the top of state Medicaid spending and near the bottom in addressing the health needs of its vulnerable populations. New York spends more on Medicaid than any other state, in large part because of the heavy reliance on inpatient hospital care. Data from the Kaiser Family Foundation indicate that New York ranks 40th nationally in hospital admissions (133 admissions per 1,000 population) and 47th in days spent in the hospital (960 days per 1,000 population). This reliance on hospital care comes at the expense of other parts of the health care delivery system, especially community-based primary and preventive care. Despite being the leader in overall Medicaid spending, New York ranks fifth from the bottom in Medicaid spending on primary care. Primary care physicians in New York are the fifth lowest paid in the country. These spending patterns have health care consequences as well. Perhaps most tellingly, New York ranks 39th nationally in avoidable hospital admissions.

New York's last two budgets made significant strides in beginning to reshape the health care delivery system. Last year the Governor and the Legislature committed the State to addressing the historic underinvestment in New York's primary and preventive care system, including a four-year agenda of ambulatory care payment reform. The "patient first" agenda has been moving New York toward a more efficient and effective health care system that will ultimately achieve better health outcomes at less cost. Any budget decisions that

move New York State back to a more hospital-centric system would be severely misguided.

I fear that the current economic climate will diminish the State's commitment to health care reform. Yet reform is the only means of addressing the crisis we face. Continuing this commitment, and wisely spending New York's Medicaid dollars, becomes all the more urgent as policymakers are called upon to make difficult choices in the face of a fiscal and budget crisis of unknown proportions.

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Community Health Care Association of New York State

TO: New York State Department of Health
Hospital Rate Setting Technical Advisory Committee

FROM: Elizabeth Swain, CEO, Community Health Care Association of
New York State

Subject: Technical Advisory Committee Recommendations

Date: October 22, 2008

For decades New York State has urgently needed to rebalance its health care delivery system from one reliant on expensive emergency and inpatient care to one that makes available strong, effective, affordable primary and preventive care.

Failure to do so has put New York at the top of state Medicaid spending and near the bottom in addressing the health needs of its vulnerable populations. New York spends more on Medicaid than any other state, yet ranks fifth from the bottom in Medicaid spending on primary care. Primary care physicians in New York are the fifth lowest paid in the country.¹ Avoidable hospital use and cost of care places New York State at 39th in the US², a statistic which represents billions of wasted dollars.

Now is the time to move forward on implementing the important reforms which have been laid out in the last two budgets. Community health centers - an essential network of primary care providers serving the most vulnerable New Yorkers - will play an increasingly vital role in caring for newly uninsured, underinsured and Medicaid patients as the economic crisis unfolds.

Other resources - such as indigent care funding for D&TCs - are already grossly inadequate and will only be further stretched with rising demand. Community health centers and other D&TCs are compensated at roughly half the rate on the dollar as hospital services. This makes no sense. The foundation of the safety net is eroding and will be unable to maintain current programs, let alone respond to any new demands.

Recent 6% cuts to programs which support community health center services have been deeply felt already and endanger care to the most vulnerable people in our state.

We fear that further delay in implementing these essential reforms will cause serious damage to an already weakened, underfinanced system in the primary care and prevention safety net. The status quo is not a possibility and failure to act is not a viable option for this part of the system. The State must honor its commitment to reform; it is the only wise means of addressing the crisis we face.

¹ Kaiser State Health Facts

² Commonwealth Fund

Appendix C

Hospital Rate Setting Technical Advisory Committee (TAC) Members

Alan Aviles
President and CEO
NYC Health and Hospitals Corporation

James Barba
President
Albany Medical Center

Roseanne Berger, MD
Senior Associate Dean for GME
Graduate Medical/Dental Education Consortium of Buffalo
SUNY @ Buffalo

Charles Brecher
Executive Vice President
Citizens Budget Commission

Gary Fitzgerald
President
Iroquois Healthcare Alliance

Arthur A. Gianelli
President
Nassau University Medical Center

Lee Goldman, MD
Executive Vice President for Health and Biomedical Sciences
and Dean of the Faculties of Health Sciences and Medicine
Columbia University

Vito Grasso, CAE
Executive Vice President
NY Academy of Family Physicians

Martin Hickey
Sr. Vice President of Government Programs and Health Innovation
Excellus

Ronda Kotelchuck
Executive Director
Primary Care Development Corp.

Paul Kronenberg, MD
President and CEO
Crouse Hospital

Kenneth Raske
President and CEO
Greater New York Hospital Association

Steven M. Safyer, MD
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