

Honorable George E. Pataki
Governor, State of New York
Executive Chamber
Albany, NY 12224

November 17, 2004

Dear Governor:

In this, the third part of our report to you on Medicaid and health care, the Working Group completes its initial recommendations for reform of New York's healthcare system. For your convenience, the previous two reports are attached.

The timing of this report was planned to coincide with the Health Care Reform Act (HCRA) renewal negotiations. With HCRA set to expire in June 2005, this is an opportune time for all stakeholders in the health care system to discuss real reform. We hope that this report, calling for major reforms to the acute care system, will begin to set the stage for real discourse and a sincere dialogue between the stakeholders during the renewal negotiations.

The defining characteristic of the acute-care system, which we examine in this report, is change – inevitable, large-scale, rapid change. We can resist change, clinging to the old ways of thinking until reality finally forces us to adapt . . . or we can embrace change, anticipating its effects, looking for new opportunities to improve the system. We can fear change, or welcome change. We can direct the course of change toward solid societal goals, or let it carry us where it will.

We believe there is no real choice. We must embrace change and master it. If we do not, then the current skyrocketing annual growth of the Medicaid program, multiplied by the demographics of the aging baby boomer generation, will bring fiscal devastation to New York State and its local governments, and leave us with a healthcare system unsuited to our purposes, consuming ever greater amounts of our resources without producing demonstrable beneficial effects in the health status of New Yorkers.

We are confident that New York can master the changes in health care, but it will not be simple or easy. It will require that the stakeholders in the system – institutions, labor, provider groups, insurers and suppliers – look beyond parochial interests to the greater general purposes of the system. It will require that consumers become true stakeholders, and be given greater power to shape the system through their healthcare choices. It will mean agreeing on a new architecture for the system to replace the traditional hospital inpatient model.

There are admittedly some very complex issues involved in this effort: creating a reinvestment strategy that will use savings to finance critically needed reforms in the systems; spreading the cost burden so that everyone pays for providing core needs;

providing capital-financing mechanisms that will ensure a smooth transition to the new system; doing much more to encourage and reward high-quality care; modernizing our health information technologies; and, retraining and redeploying New York's healthcare workforce as we reconfigure the system.

This report contains recommendations in each of these areas. We also believe that, taken together, the recommendations made in the Working Group's three reports would have a major impact on system functionality and reduction of cost. Most importantly and a crucial outcome of the recommendations made in the three reports, will be an improvement in the quality of care for all New Yorkers. There are places where the three reports do not perfectly mesh. The Working Group's goal was to make architectural recommendations, knowing that the engineers will have to make operational drawings that articulate and integrate the various components.

Finally, it is critical – obviously – to have the support of the federal government in this endeavor. In particular, we need federal waivers so that the savings anticipated through these recommendations can be reinvested in reform and system reconfiguration. When the State initiated its Medicaid Managed Care Program, the federal government committed in advance to a multi-year reinvestment strategy. Here, a similar reinvestment strategy will be required.

We would be remiss if we did not thank your staff and the Department of Health for the excellent work, monumental effort, and great support they provided to us during this endeavor.

It has been a privilege for us to examine this system on your behalf and to suggest an ambitious but doable agenda for change. We thank you for this opportunity, and hope our work helps New York to make the absolutely essential changes that we believe can give us a better, fairer, more affordable healthcare system.

Sincerely,

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Table of Contents

| | | |
|-------|---|--------------|
| I. | Executive Summary | page 5 - 8 |
| II. | State of the Hospital and Outpatient Industry in New York State | page 8 - 10 |
| III. | Appropriate Sizing in the Hospital Sector | page 10 - 19 |
| IV. | Public Good Functions of Hospitals | page 19 - 21 |
| V. | The Rate Paradigm | page 22 - 23 |
| VI. | Improving Quality of Care | page 24 - 26 |
| VII. | Health Information Technology | page 27 - 30 |
| VIII. | Insurance | page 31 - 32 |
| IX. | Continuing the Work of the Health Care Reform Working Group | page 32 |

I. Executive Summary

Several stark and urgent realities drive the need for reform of New York's healthcare system.

Healthcare costs are out of control, rising at a rate that far outpaces state revenue growth and putting severe fiscal stress on the State and its localities. The problem is not lessening. Medicaid expenses are expected to grow at a staggering rate of 9.5% in 2005.

Many hospitals are in trouble. With high-profit services increasingly moving to non-hospital settings, hospitals are more and more left to provide for core health needs, which – though essential – do not produce adequate revenue under the current reimbursement system.

The hospital and acute care system has other problems. Excess capacity is expensive to maintain and yields no good result. High debt levels and uneven access to capital are problems in much of the system. There are, in addition, more uninsured patients, tougher commercial rate negotiations, more competition and greater need to focus on quality and outcomes.

Many providers are engaged in a kind of medical arms race to outdo the competition in acquiring high-profit technologies. This can lead, in any given region, to too many cardiac catheterization labs and insufficient core services for newborns and infants, for example.

There's another harsh reality. In New York, we spend far more on health care than other states, *without achieving dramatically better health outcomes for New Yorkers*. For example, we spend approximately \$18.2 billion on acute care and \$15.7 billion on long-term care. The second ranked state – California – which has roughly 15 million more residents than New York, spends less: \$17.8 billion and \$7.9 billion respectively. Over the years, attempts have been made to justify this situation. Not one of them has been very convincing. It's time to face reality. We need to get better results for what we spend. We need to trim the fat from New York's healthcare system and reinvest the savings to modernize and improve the system.

Rising healthcare costs have already had an effect nationally. All states have initiated cost-containment efforts. During the past two years, 50 states reduced provider rates, 50 states limited drug costs, 34 reduced eligibility, 35 cut benefits and 32 increased co-payments. These measures were necessary even though the federal government provided an additional \$20 billion in federal fiscal relief to states, aid that is not forthcoming this year.

Unlike the majority of states, New York, admirably, has not cut eligibility or benefits over the last two years. But the State is once again facing a multi-billion dollar deficit.

Traditionally in New York, our choices in healthcare reform have been framed as a limited either/or option: either stay the course, or implement drastic benefit cuts. We believe this simplistic analysis, while politically useful to many groups, is fundamentally flawed. We believe we can contain costs while preserving and even enhancing access to quality health care for the State's citizens. We believe the recommendations contained in our interim report, together with those we make in this report regarding restructuring the hospital and primary care system, can give New York a 21st-century, quality health care system.

All our recommendations are made keeping certain guiding principles in mind: reconfiguration, reinvestment, financial alignment, capital investment, quality improvement, modernization, and workforce retraining and redeployment. The recommendations made in this paper are wide-ranging, and it is inevitable in a state as large and diverse as New York that each recommendation will have a different effect on various parts of the State. As a result, some of recommendations are for statewide initiatives, while others are regional or community-specific. The health care needs of a community are generally best known by the stakeholders serving it. For this reason, we recommend a strategy utilizing various incentives to help stakeholders shape a health care delivery system that is efficient, effective and affordable with maximum flexibility. Additionally, in implementing these recommendations, a coordinated implementation plan needs to be developed, in consultation with regional stakeholders, to assure that unique local health delivery issues are given adequate consideration.

The long-term reform recommendations in this report build upon those published in the Working Group's interim report in January 2004, in that their implementation will yield immediate short-term savings as they build a more solid long-term foundation. It is our hope that the recommendations contained in both reports are implemented as soon as possible, generating immediate savings for the state and creating in New York the possibility of another year without dramatic cuts to eligibility and benefits.

The Working Group's recommendations include:

- **Restructuring and Rightsizing the Hospital System** – The competitive pressures and loss of revenues in the acute care system associated with out-migration of services to alternative providers have meant excess inpatient capacity and a struggle to maintain quality core services. We recommend the state develop measures to reduce excess hospital capacity, and adopt alternative models for hospitals to ensure access to quality care in all communities is maintained. Revenues generated by this restructuring should be reinvested in the healthcare system.
- **Maintaining the “Public Good” Functions of Hospitals** – Dramatic advances in technology, and shifting practice patterns will continue to have significant financial

impact on hospitals, affecting their ability to continue to serve the public good. To address this, we recommend a reallocation of HCRA funds -- specifically, changing the dispersal methodology of the Indigent Care Pool and the Public Indigent Care Pool, and creating a new Essential Services Pool. This reallocation is, in effect, a reinvestment of funds generated by more cost-effective practices to support critical services provided by the hospital system.

- **Addressing the Rate Paradigm** – Current Medicaid reimbursement rates for “high-end” services, such as cardiac and vascular surgery, are disproportionately generous when compared to the reimbursement rates for “safety net” services such as emergency services, births, and trauma services. This unevenness naturally prompts hospitals to acquire and over-utilize high technology specialty services to offset the low reimbursement rate of services that enhance the public welfare. We recommend revising the rate paradigm to help hospitals that provide the majority of safety net services. This fiscal alignment will not only restore fairness, but will help to ameliorate these negative trends.
- **Improving Hospital Quality** – There is a move on the national level to improve the quality of care in hospitals by rewarding good results. We recommend establishing a State Quality Improvement Council and the creation of mechanisms for the State to use its leverage and authority as both a regulator and major purchaser of health care to drive improvements in hospital quality.
- **Improve Health Information Technology (HIT)** – To ensure that health care providers develop the essential technology required to operate high quality, efficient facilities in the 21st-century, we recommend the State create information system standards consistent with Federal regulation for recording and transmitting data. We also recommend the state explore and develop alternatives for financing HIT projects with all relevant providers including risk models that permit financing against future saving.
- **Seeking Federal Waivers to Support the Reinvestment Strategy** — The federal government will realize significant savings as a result of the reform and restructuring program we recommend. It is critical to our success that the federal Medicaid and Medicare programs participate in the State’s reinvestment strategy. We recommend that the State submit waiver requests to the Department of Health and Human Services (HHS) to permit the State to retain a portion of the federal savings for reinvestment. A similar approach was used when the State initiated its Medicaid Managed Care Program in the mid 1990’s. The Federal government advanced anticipated savings into a nearly \$1.25 billion multi-year reinvestment strategy that supported ambulatory care expansion and worker retraining to enable the development of managed care. That waiver has proven to be highly successful, providing improved care while generating significant savings for our local, State and Federal governments.

II. Status of the Hospital and Outpatient Industry in New York State

The hospital of today is, in a sense, a paradox. It is too much like the hospital of yesterday and – at the same time – completely different from the hospital of yesterday. The physical plant of many hospitals embodies this phenomenon: a main building constructed perhaps a century or more ago, with wings added each decade since, all connected by a labyrinthine maze of color-coded corridors, tunnels and walkways. Many would argue that the industry is paying the price for decades of leveraged overbuilding which, when combined with advances in technology and treatment modalities and changes in payment formulas, have resulted in significant and growing inappropriate inpatient capacity. Current trends indicate that many services formerly provided on an inpatient basis will increasingly be provided in other environments.

The expense of maintaining a capacity developed on an inpatient model while supporting the costs of providing "public good" and "safety net" services with a dwindling revenue base has created a fiscal crisis in a growing number of hospitals and the industry at large. While operating margins have never been generous in New York State, these recent pressures have served to increase the number of facilities incurring losses. This weakens hospitals' ability to continue providing certain types of patient care and their access to the capital needed to sustain critical investment. Coupled with the out-migration of services into private practice settings and tough negotiating from payers, a dangerous downward cycle is evolving on the fiscal side.

There is unnecessary duplication of services across hospitals. In order to stay solvent, hospitals require the most up-to-date medical technologies as well as specialties that can provide the "high end" services, which have higher reimbursement rates. This has led to duplication of services and a veritable "arms race" between hospitals.

Market pressures worsen these trends. Because patients are often insulated from cost, they find oversupply of medical technologies both convenient and desirable, and call for continuous improvements in medical technology and the development of more convenient and accessible locations for services within communities. Such consumer driven trends are self-reinforcing.

While an increasing number of facilities are at financial and operational risk, some have reacted with aggressive competitive and business responses to preserve and enhance fiscal viability. The main challenge posed by these changes is how to balance the benefits of steady medical advances and resulting patient treatment patterns with the need to preserve and pay for the State's crucial hospital infrastructure in the midst of a market driven downsizing and reconfiguration.

The Working Group spent many hours discussing the configuration of the hospital of tomorrow. It became clear that the rapid pace of change -- with new medical technologies and new drugs brought to market constantly, and information technology systems undergoing seemingly endless, exponential advances -- leads to an almost

constant state of revolution in medicine. Rather than recommend the State lock itself into a futurist's dream hospital of the future, the Working Group recommends that capital investment needs to be focused on flexibility, interoperability and technology as opposed to "bricks and mortar." The most useful investment today is helping to create a health care delivery system – no longer centered on a building – that will help the patient navigate the various theaters of care.

As this evolution occurs, it is important to note that hospitals provide unique services that will always be needed. Hospitals have always provided 24/7 coverage, safety net services for which it is becoming increasingly difficult to secure physician coverage, emergency/disaster preparedness and training for future healthcare providers. As the pace of change continues to threaten the fiscal viability of some hospitals, we must ensure that the hospitals' ability to fulfill these core services is maintained. We must carefully consider the future role of hospitals in the healthcare system, the regulatory framework within which hospitals must compete with other providers, and financing mechanisms to assure that as hospitals evolve, they continue to provide essential "public good" services in their communities.

It is important to note that little is known about the services provided in private and non-regulated settings, either in terms of volume or quality. This stands in marked contrast to the highly regulated hospital industry. In the private setting, there is no certificate-of-need (CON) or accreditation process and, therefore, no way of monitoring quality, incidents reporting, or services provided. The lack of regulation means that as services migrate out of the hospital setting we cannot be sure if there is a loss in quality that is offsetting the gains made in cost and convenience. In addition, hospitals are competing to provide "high value" services on a playing field that is not level. Hospitals bear regulatory and public good costs that other providers do not. Additionally, hospitals treat a disproportionate number of complex and difficult high risk cases, while other providers effectively "cherry pick," profiting more from specializing in lower-risk and easier cases utilizing high value services.

Hospitals simply cannot effectively compete for these high value services from a cost perspective. This would not be problematic except for the fact that in our current system, hospitals use high value services to subsidize less profitable services that are critical to the community. Examples of these less profitable endeavors include burn and trauma centers or services that are non-income generating such as disaster preparedness. In addition, payer surcharges on high value services are used to fund other public good functions such as indigent care. As a result, increased out-migration of high value services has the potential for weakening these public good funding sources. As the ability of hospitals to cross subsidize is diminished, alternate mechanisms for financing these essential services must be developed.

All told, many significant factors affect the hospital and outpatient delivery systems in New York. These include:

Effects of deregulation and new medical technology

- Out-migration of services from inpatient to outpatient modes of treatment and non-regulated community based settings and the "cherry picking" associated with this phenomena.
- Recent development of local planning initiatives (non-government funded).
- Oversight of governmental anti-trust agencies in balancing consolidation decisions with the maintenance of adequate competition.
- Uneveled regulatory environment for new investments.

Financial pressures on the hospital system

- Deregulation of previously State-set reimbursement rates
- Federal and State deficits and cutbacks in Medicare/Medicaid programs.
- Increasing number of uninsured patients.
- Emergence of quality and outcomes as payment incentives.

Information system weakness

- Underdeveloped, inconsistent and fragmented information technology system in many cases incompatible within institutions and among providers.
- Lack of a standardized transportable individual patient electronic medical record.

Service availability versus individual institution survivability

- Imbalances in the regulatory environment and cost of maintaining hospital mandates (e.g., emergency services) and "public good" functions.
- Difficulty in breaking the "self preservation at all costs" mentality vs. consideration of developing responsive, affordable and needed service alternatives.
- High debt load and embedded pension, malpractice, and asset replacement costs, limiting viable consolidation alternatives.
- Intermittent staffing shortages, driving up operating costs.

Pressures on the Medical Community

- Imbalance in patterns of reimbursement in the primary care system.
- Pressure of medical malpractice on physicians' income.
- Decreasing physician income.
- Increasing difficulty of specialists on call for hospitals.

III. Appropriate Sizing in the Hospital Sector

Medical progress and the associated out-migration of services from hospitals will continue. It is therefore necessary for the hospital industry and State officials to develop reconfiguration and reinvestment measures that will help hospitals reduce their excess capacity while preserving their role as providers of essential services to their communities.

A. Hospital Closure and Stabilization

The current perpetuation of inefficiencies at weaker, unneeded hospitals directly contributes to the rising costs of health care, with associated effects on affordability and accessibility, for groups and individuals. As the State seeks to reconfigure and modernize its health delivery system, some hospitals will not be able to transform themselves into the viable community institutions that are required as part of a regional medical infrastructure. It is critical that the State help devise a mechanism for distinguishing between needed and unneeded institutions, that it assist with orderly closures, and develop a financial mechanism for redirecting public resources to support other regional medical centers, along with primary and preventive services that help avoid hospitalization altogether. In the past when such facilities closed, the public resources saved as a result evaporated. We cannot afford such waste.

The looming closure of a hospital often engenders strong community opposition. However, a study by the Office of Inspector General of the U.S. Department of Health and Human Services (OIG) suggests that community concerns are often unfounded. The OIG found that of the hospitals closed nationwide in 2000, 50 percent of rural facilities and 52 percent of urban facilities were within three miles of another inpatient facility. An additional 18 percent of closed rural facilities were between four and 10 miles of another hospital, as were an additional 38 percent of the urban facilities that closed. Thus, in the majority of hospital closures, maintenance of access to inpatient care is not the primary issue.

A subsequent report by the OIG found that the most frequent reasons for hospital closures nationwide were: 1) competition with other nearby hospitals; 2) relocation, consolidation or merger with other facilities; and 3) low occupancy/low census. Hospital closures thus are generally made for business reasons and as such are undertaken voluntarily in many instances. Nevertheless, the experience in New York State too often has been that financially weak hospitals are “bailed out” by public subsidy, usually in response to intense community pressure. The result is that hospitals that should close, or at least be greatly reduced in size, are kept open at considerable expense to the taxpayer and to the detriment of efficiency in the health care system.

Every closure should include a detailed retraining and redeployment plan for healthcare workers. As part of our reinvestment strategy, programs such as the Hospital Closure Incentive Program should be employed to assist in the orderly redeployment of the workforce to programs where they are needed. Our State still suffers from shortages of certain types of specialists, nurses, direct care staff and other health professionals, especially in our more indigent communities. Every effort must be made to preserve this precious resource. In cases where new skills will be required, we must continue to assure

the availability of educational and retraining programs to enable workers to adapt to the changing health care environment.

We recommend that the State encourage and assist communities and hospitals in this restructuring of our acute care system, reducing the excess capacity in many regions of the State and supporting the restructuring of needed facilities capable of returning to financial viability. Reinvestment tools should be developed to accomplish these goals. These actions and tools could include:

- Restructuring through the redirection of taxpayer-funded subsidies for fiscally unstable and unneeded facilities to other parts of the delivery system with appropriate provision for the transition of patients to other nearby providers.
- Creation of a Hospital Rightsizing Assistance Program (HRAP) to provide financing to close or restructure hospitals. This reinvestment program would have the following characteristics:
 - The ability to borrow and disburse money to hospitals that are closing or reducing capacity, providing funds to cover both short-term closing costs and repay or restructure debt.
 - Possible use of the State's credit to raise capital inexpensively, but with repayment provided by the beneficiaries of the rightsizing, using fair and equitable formulas to attribute the benefits primarily to payers but also to affected providers. The State should make a portion of the financing available as grants to institutions that are needed but would be unable to repay a loan.
 - Eligible hospitals would need to apply for funding and, to be approved, show system-wide savings and a viable financial plan over a defined period of time.
- Development of a restructuring and reinvestment process to encourage and support hospital right-sizing and use of HRAP:
 - Analyze each of the planning regions within the State to determine where excess capacity exists. In regions of under-capacity, identify fiscally vulnerable hospitals and help develop assistance plans designed to stabilize and enhance ability to provide necessary services. In regions of over-capacity, assist communities to reconfigure the delivery of health care.
 - Create a formal group to advise communities and hospitals on issues relating to closing, consolidating and rightsizing, including alternate provision of services, financing, antitrust matters and sale of assets.

B. Restructuring through Alternative Models for Hospitals

Most communities assume that a hospital should have the capacity to provide a broad spectrum of services: ambulatory, emergency, obstetrics, chronic diseases, pediatrics, general surgery, and end-of-life care. However, the realities we have described above offer an opportunity for new ways of thinking about what hospitals should be. Inpatient primary care facilities, transitional care units (TCU's), innovative programs for the maintenance of needed emergency services, and centers of excellence are innovations that

would fall into this category. The delivery of inpatient care, the maintenance of a 24/7 emergency department, and the requirement to accept all patients regardless of ability to pay are the distinguishing features of a hospital. They are also the most costly. It is often the difficulty in maintaining these services that is at the root of a hospital's financial problems.

Some of these traditional features of a hospital may no longer be needed in every instance. Several experiences in New York State have shown that restructuring which does not include inpatient and emergency services does not necessarily result in a complete closure of the hospital facility. For example, St. Mary's Hospital of Rochester closed its inpatient services in 1999. The facility now operates as a comprehensive community health and urgent care center, which has enabled the local population to maintain access to ambulatory and outpatient care. A similar situation prevails at Amsterdam Memorial Hospital which was able to retain an inpatient rehabilitation unit, along with urgent care services and ambulatory surgery.

As we look to restructure our healthcare system, it is important not to lose sight of the forest for the trees. Neither of these surviving entities are hospitals in the traditional sense, but restructuring these facilities strengthened the area's healthcare system as a whole. Furthermore, the maintenance of outpatient and ambulatory services at the original site helped to ameliorate the economic effects of what would have been a full closure of the facility. This type of restructuring also serves as a demonstration to the affected community that access to needed health care services will be sustained. These new entities may serve as models for restructuring other weak hospitals that continue to operate at a loss.

There are other existing innovative restructurings driven by community need. For example, the State approved a proposal for full emergency services remote from a main hospital, supported by two medical/surgical beds used for observation. This model has been embraced by the community and serves the local delivery system well by providing flexibility, cost efficiency, and easy access for patients. Achieving this innovation demanded creativity from providers and flexibility from regulators.

We recommend that the State -- in conjunction with the industry, the State Hospital Review and Planning Council (SHRPC) and the Public Health Council (PHC) -- propose some of the alternative delivery models discussed above in a demonstration project mode.

An additional model that should be considered is the creation of an Emergency Hospital or Critical Access Hospital (CAH) designed to receive and stabilize emergency room patients. The State should consider where such facilities could replace larger hospitals as part of the HRAP program and whether reimbursement premiums for services would be required for financial viability.

In these restructuring efforts, as in closures, there must be a commitment to retrain workers in new systems of care. Highly trained, motivated, and specialized healthcare

workers should not become obsolescent when staffing patterns and job functions change. Workers should be retrained in the skills necessary for the new jobs in these alternative models of care. Reconfiguration strategies should include retraining funds to ensure that this valuable resource is not lost to the community.

- **Role of Specialty Hospitals in Reconfiguration of Healthcare System**

Out-migration of services from traditional general hospitals has led to the recent emergence of the specialty hospital. The General Accounting Office (GAO) estimates that approximately 100 of these facilities exist nationwide. In contrast to traditional specialty facilities such as children's hospitals and rehabilitation hospitals, these facilities are typically dedicated to one of four categories of services: orthopedics, cardiac care, women's medicine, and surgery.

As with the out-migration of services to the ambulatory and office-based settings, operators of general hospitals contend that specialty hospitals siphon away healthier, well-insured clients, leaving full-service hospitals with higher-risk, uninsured and Medicaid-eligible patients – a phenomena called “cherry picking.” It is also contended that such hospitals generally specialize in profitable specialty fields, leaving general hospitals to perform lower-reimbursed services. Both of these issues are discussed in later sections of this paper on Public Good Functions of Hospitals and the Rate Paradigm. These arguments seem to be supported by GAO's findings that, relative to general hospitals, specialty hospitals as a group are much less likely to have emergency departments, treated smaller percentages of Medicaid patients, and received a smaller portion of their revenues from inpatient services.

There are only a handful of specialty hospitals in New York State: the Hospital for Joint Diseases (Manhattan); Bellevue Woman's Hospital (Schenectady); the Hospital for Special Surgery (Manhattan); and the New York Eye and Ear Infirmary (Manhattan). The reasons for this are not clear, but their small number is likely due to the general features of the hospital market in New York State: a strong not-for-profit tradition; a certificate-of-need (CON) program of long standing; and a prohibition on the ownership of hospitals by publicly traded corporations.

It is worth noting that most of the for-profit specialty hospitals in other states are operated by publicly traded corporations such as Tenet and HealthSouth, often in combination with local physician investors. There is considerable controversy in Washington over these facilities, due to the economics described above and the problems of physicians referring patients to hospitals where they have a financial interest. The Centers for Medicare and Medicaid Services (CMS) has issued a moratorium on these hospitals pending further analysis. Conversely, a recent report by OIG's offered support for specialized hospitals in the name of greater market competition and recommended the removal of CON restrictions. Publicly traded corporations are also able to access a significant source of capital that is not available to New York hospitals. Additionally, proponents of specialty

hospitals argue that their dedicated focus to a specific area of medical practice enables them to provide superior care and create medical innovations.

These issues need to be continually reviewed in light of their relationship to other factors, particularly the equitable reimbursement of costs. However, it is the opinion of the Work Group that given the over capacity of existing hospital infrastructure in New York State, the introduction of a for-profit incentive, at this time, would not produce solutions to our problems. We believe other approaches can support high quality care and innovation, as described in the section below.

- **Medical Centers of Excellence to Enhance Quality and Align Incentives**

There seems to be little need for specialty hospitals in New York State beyond the several already established. However, there is merit to an approach that would allow the concentration of high-technology, specialty services (e.g., cardiac surgery, organ transplantation) in selected general hospitals on a regional basis. This model has the potential to increase access to care without undue cost and to promote quality in the services delivered. At the same time, this approach aligns incentives properly, encouraging providers to expand only those services for which they are recognized as high-quality providers of care. It therefore tempers the “medical arms race” for more and more advanced services, which in the end diffuses medical expertise, reduces overall efficiency and increases health care costs. Approval of limited numbers of such centers on a regional basis can promote access, ensure quality and reduce costs.

A growing body of literature - much of it based on research done on services in New York State - shows a high correlation between volume and proficiency for many of the more advanced medical services. Outcomes are better in the centers of excellence that perform more procedures. In this sense, quality of care is well-served by confining specialized services to a limited number of hospitals where “practice makes perfect.”

The concept for centers of excellence is based on the successful Regional Perinatal Centers. These centers provide highly specialized care for high-risk neonates and also serve as technical resources for perinatal programs in hospitals within their regions. The RPCs also collect and analyze data on perinatal care and birth outcomes from hospitals in their individual networks, a function critical to the improvement of prenatal and perinatal services throughout New York State. It is expected that other designated centers of excellence (e.g., stroke, cardiac) would serve a similar function in the prevention of major health problems and in the improvement of care for all New Yorkers.

New York State has recently completed a pilot program for the designation of stroke centers. This effort is being expanded to include all eligible general hospitals that meet the criteria and protocols developed in the pilot project. New York State is also in the early stages of considering a model for the designation of cardiac centers.

The centers of excellence approach requires a major change in the mindset of New York’s health care institutions. This task is not easy. Boards and leaders tend to focus solely on their own institutions, striving for excellence and continuous improvement and seeing themselves as competitors for patients and reimbursement dollars rather than parts of a regional health delivery system. Changing these long-established attitudes and practices, which are reinforced by the current reimbursement system, will be one of the toughest aspects of reform. But without this change, true reform is impossible.

Of course, any consideration of embracing a centers of excellence approach that is more encompassing must be sensitive to the federal and state anti-trust regulations over market share and preservation of competition. But these considerations should not stop us from discussions on “state action immunity.”

The Working Group recommends that the State, SHRPC and PHC amend existing CON policies and regulations to ensure that other specialized services where there is a distinct correlation between quality and volume will be delivered only in designated centers of excellence. An RFP approach should be employed to encourage these centers and ensure that they are properly distributed throughout the State.

- **Transitional Care Units—Restructuring to Improve Quality**

Another issue affecting both quality of care and financial viability of certain hospitals revolves around transitional care units (TCUs). TCUs generally serve elderly patients who need short-term care as a steppingstone from a hospital to a less intensive clinical setting. Most TCU patients’ charges are reimbursed under Medicare. Forty-six other states have TCUs.

New York State does not currently have such units, primarily because of the many highly skilled nursing homes in the State. However, there are certain areas of the State where hospitals struggle to discharge this type of patient because suitable nursing home care is lacking. These hospitals are hurt financially by having to retain patients beyond their reimbursed length of stay.

As part of the restructuring process, we recommend the creation of three to five TCU demonstration projects to test the effects of such units on both the quality of patient care and the finances of hospitals and nursing homes. The location of these demonstration projects should be determined by an RFP process, and sited in areas where placement of these patients outside of hospitals is not currently sufficient.

C. Restructuring: Addressing Constraints Created by Debt with a Debt Retirement Alternative

Hospitals that close are often strapped with debt related either to “bricks and mortar” and/or working capital, some of it publicly guaranteed. These liabilities remain a burden on the health care system until they can be retired.

One strategy for easing the burden of hospital closure is found in Maryland. The Maryland Health Care Commission approves voluntary, viable closure plans, provides temporary operating money to the affected hospital or system, and charges a revenue-based assessment on all other hospitals, spread over many years, to retire the hospital's long-term debt and other embedded costs. The concept is simple – by providing a long-term financing mechanism and a fair distribution formula for spreading the costs among all affected parties, everyone shares in the long-term benefits of a more efficient and appropriate sized hospital sector at reasonable and affordable current costs.

While the single payer concept makes administration easier, existing HCRA pools and funding mechanisms in New York certainly lend themselves to modifications to accommodate the concepts outlined above. Any program to address debt during restructuring should also consider all long-term debt. Unneeded hospitals are not necessarily limited to just those with state-backed obligations.

Although the notion of a revenue-related assessment on hospitals may not initially be popular, payers may be persuaded to see a longer-term self-interest. Easing the removal of inefficient providers from the system will foster a more financially stable environment for those remaining. This funding stream can be seen as a reinvestment program, and it will also ensure that financial alignment remains fair during restructuring, as the burden is distributed to those who will directly benefit from the closure of inefficient competitors.

D. Access to Capital

A significant amount of the long-term debt issued for hospital construction projects emanates from the Dormitory Authority of the State of New York (DASNY), a public benefit corporation authorized to issue lower-cost, tax-exempt bonds on behalf of qualified not-for-profit hospital borrowers. While legislation has increased the availability of hospital debt issued through the local Industrial Development Authorities (IDA), DASNY is still considered the primary issuer for hospitals.

Except for certain direct state-secured bonds (secured hospital and moral obligation bonds), the borrower must, generally, be able to secure a rating of A minus or better in order to access DASNY financing.¹ In the vast majority of cases, outside credit enhancement is needed, in the form of Federal Housing Administration (FHA) insurance, private bond insurance, or a bank letter of credit, to achieve the A minus rating. At present only a few hospitals in NYS meet the minimum rating on their own. While this requirement may impose longer timeframes to completion, it does result in lower interest cost for the state, federal and taxpayer-supported purchasers of healthcare.

In 2000, the FHA program insured over 70% of hospital credits issued through DASNY; in fact, over 60% of FHA-insured debt nationwide is in New York State. Private

¹ DASNY has recently revised its policies and under certain circumstances will issue debt below A minus if the client is an existing client and the debt is supported by a sound business plan justification.

insurance had made slow but steady inroads into the market, but has since retreated after the Allegheny Health, Education and Research Fund (AHERF) default in Pennsylvania in 1999. Bank letters of credit are technically available; however, they comprise a small part of the overall hospital credit profile and are generally available for shorter time periods than the debt that they secure. Even though DASNY attempts to “work out” potential problem loan situations, and therefore prevent calls on FHA or private insurance, the continuation of historically thin operating margins in New York State have made the traditional forms of credit enhancement increasingly difficult to secure. Concomitantly, the State's hospitals can ill afford a further decrease in access to capital financing for rightsizing, reconfiguration initiatives and technology investment. The current environment led the Work Group to consider several questions regarding policies for future access to capital:

- Would capital access or cost be negatively affected if the current practice of strong regulatory interference in problem situations were replaced by a more moderate approach that allowed market forces for health care services to play out?
- Should the policy of preventing calls on insurance at almost any cost be reconsidered, possibly replaced with a more balanced mix of preserving needed facilities vs. allowing the market to close or reinvent unneeded facilities?
- Would a more balanced approach of market forces vs. regulatory involvement incentivize a return of private bond insurers, therefore decreasing the reliance upon FHA as primary credit enhancement?
- Should consideration be given to the development of DASNY financing programs which provide access to smaller loans to facilities below the minimum A-rating that were deemed necessary, if these facilities had a viable financial plan?
- Are out-of-state obligated groups avoiding capital investments in NYS facilities due to the policy requiring Article 28 character and competence review of all out-of-state directors? Does the regulatory support for problem hospitals reduce the capital these groups commit to their New York facilities?
- Should consideration be given to the potential source of capital afforded by publicly traded corporations, currently prohibited from direct operation of hospitals in NYS?

We recommend that the State engage in a formal study of policies and regulations guiding the approach to capital financing, with the goal of developing alternatives designed to preserve and expand access to low-cost capital. Policies governing the regulation of out-of-state obligated groups should be revisited, in the interest of expanding access to capital while preserving appropriate accountability for quality of care.

E. Restructuring via Certificate of Need (CON) Process while Maintaining Access to Capital

Operators of hospitals, nursing homes, clinics and other services still indicate that CON requirements hamper their ability to respond in a timely manner to business opportunities and to the actions of competitors. Many applicants also lose potential revenues while awaiting CON approval of new facilities and services.

The Work Group recognizes the continued need for CON review as a means of guarding against excess capacity and increased costs in the health care system. The CON program is especially valuable in protecting the taxpayer interest represented in Medicaid funds that support capital investments and State-guaranteed debt for health care facilities. It further serves the interests of consumers by evaluating whether proposed services would meet a true public need, be offered by competent operators and delivered in a quality manner. There is a need to balance these taxpayer and consumer interests in CON with the legitimate needs of health care providers in an increasingly competitive health care system. The Work Group recommends that new policy and regulatory options be developed to achieve this balance and increase the efficiency of the CON process.

We believe that options for streamlining the CON process would be broadened if the Medicaid capital pass-through provision, as discussed in the Working Group's initial paper on long term care, were replaced by a capital pricing methodology. The Medicare program phased out capital pass-through over a ten-year period, which allowed hospitals to transition from an over-dependence on Medicare for capital purposes to a reliance on more market-oriented arrangements. The potential risk of Medicaid moving to a price arrangement would be a net reduction in funds available to service debt, especially those debts for projects that have recently come on line. In addition, the credit markets could, at least on a temporary basis, reduce their overall lending until the new system sorted itself out. These concerns must be balanced against the potential long-term benefits of such a significant change in reimbursement policy, a reconfiguring that makes capital more accessible by better utilizing market-based resources.

We also recommend that policy and regulatory options should be developed that balance the taxpayer and consumer interests represented in the CON review of public need, operator character and competence, and financial feasibility with the needs of health care providers to respond to rapidly changing conditions in an increasingly competitive health care system. These options should include alternatives to the current Medicaid capital pass-through arrangement.

IV. Preserving Public Good Functions of Hospitals through Reinvestment

New York has long recognized that its hospitals perform functions and provide services that are essential to their communities and valuable to society as a whole. As a result, New York has a history of supporting the public good functions of hospitals and

developing mechanisms to assure that these functions are not solely dependent on Medicaid funding, but receive broad-based payer support. The nature of the public goods supported and the mechanisms for financing them have evolved to keep pace with the changing nature of health care and the demographics of the Medicaid and self-pay population.

It is once again time to revisit these programs and to ask if the public goods funded or the financing mechanisms need to be restructured. Is the State providing sufficient funds and are the sources of these funds appropriate? Is the distribution formula directing these monies to the areas with the most need and are such funds supporting the services that are most needed by the indigent?

Currently, these “bad debt and charity care” (BD&CC) pools are funded through the deregulated hospital rate system established in 1997 under HCRA, which is set to expire in June 2005. HCRA substantially deregulated the inpatient hospital reimbursement system and allowed most payers to negotiate reimbursement rates for inpatient hospital services directly with hospitals. However, HCRA also continued the long standing policy of funding support for public good functions of hospitals.

Under HCRA, all non-Medicare payers are required to make surcharge payments to subsidize an Indigent Care Pool and a second pool for funding Health Care Initiatives such as Child Health Plus, workforce retraining, emergency medical services, rural health care initiatives and health facility restructuring. The surcharge varies by payer type and applies to an array of health care services including inpatient and outpatient services of general hospitals, all services of diagnostic and treatment centers, and all ambulatory surgical services.

As health care delivery in New York evolves, public policy must evolve as well, ensuring that savings generated through efficient restructuring are reinvested in strengthening the health care system. The shifting of services from hospital to non-hospital settings will continue to have significant financial impacts on hospitals and the ability of those hospitals to continue to provide “public good” services. To assure the continuance of the public good functions of hospitals we recommend, as a reinvestment strategy, the methodology for the Public Indigent Care Adjustment be updated and that it be distributed based upon 2002 cost and statistical data. Since 1996, there has been no change to methodology or adjustments.

We also recommend an adjustment to the Indigent Care Pool Allocation methodology. The current methodology includes a “high-need” adjustment, which first pays those facilities that have a higher than average BD&CC need. This component should be modified to ensure facilities with 35% of Medicaid or self-pay inpatient discharges would have their BD&CC need paid for at a higher coverage ratio.

This method would distribute funds to hospitals providing services to the Medicaid and uninsured patients, thereby assuring continued access to safety net services. The BD&CC

need used in this calculation for the major public hospitals would be net of Medicaid payments received from the Public Indigent Care Adjustment discussed above.

The proposed revisions to the BD&CC pools outlined above would accomplish the following:

- The current amount paid to major public hospitals would remain the same in total but would be allocated on an updated basis thus shifting funds to those public facilities that have increased their BD&CC with funds from those facilities that have decreased such services. These redistributed amounts would be used to reduce the amount that each of these public facilities would be eligible for from the BD&CC pool.
- The second proposed modification would pay more pool funds to those facilities that provide a greater amount of services to the Medicaid and self pay population which utilize more of the safety net services of providers.

In addition, as the role of hospitals changes, there are essential services that hospitals must continue to provide. Hospitals must continue to provide for advanced emergency care, trauma services, burn center services and emergency preparedness, though not every hospital need provide all these services. We recommend that these essential services be considered part of the “public good” functions of hospitals and that a broad-based reinvestment mechanism for assuring adequate financing of these services be developed.

Specifically, we recommend reallocating other HCRA funds. The Health Care Initiatives pool, funds a wide array of programs that should be reevaluated for need. To the extent it is possible to free up funds from pools that have unexpended funds, they should be redirected.

We also recommend the creation of an Essential Services Pool (ESP) that would be used to subsidize hospitals providing specified essential services such as emergency services and disaster preparedness. This pool should be funded by imposing certification or licensing fees for providers wishing to perform certain procedures or services in their private offices. In order to continue to assure that physician coverage for emergency care is adequate, the State should also consider mandating coverage commitments as a condition for participation in the physician excess malpractice insurance program and as a requirement for certification to perform designated surgical procedures in private offices.

These recommended strategies are another reinvestment mechanism to ensure adequate funding for public-good services – in this instance, through a realignment which assures that everyone subsidizes these services, for the common good.

V. Reconfiguring the system through the Rate Paradigm

• Inpatient Medicaid Payments

As indicated earlier, Medicaid reimbursement rates for high end services such as cardiac and vascular surgery are very generous, and much less generous for safety net or public good services, such as emergency room, trauma, burn, and obstetrics. This contributes significantly to the medical arms race among institutions. Often hospitals that serve the Medicaid population provide high-end services in order to offset low reimbursement rates for safety net/public good services. This practice diffuses medical expertise, reduces overall efficiency and increases healthcare costs. As discussed in an earlier section, outcomes are better in the centers of excellence where a higher volume of specific procedures are performed. Revising the rate paradigm would help hospitals that provide the majority of safety-net or public-good care, and encourage the development of centers of excellence.

Safety-net/public-good services for the Medicaid population are increasingly being provided by hospital-employed physicians rather than in private-practice settings. The growing inaccessibility of these services in the community has led to increased long-term disease expense, as diseases are not prevented or treated early, but treated in hospital-based settings when they are at more advanced stages.

In the previous section, we outlined reinvestment strategies to provide adequate reimbursement to those hospitals that treat a significant portion of these patients. Here, we propose a financial realignment to allow the safety net hospitals to maintain fiscal viability and continue to provide these services to the community.

We recommend realigning the overall payment system to more accurately reflect the current clinical costs of treating various conditions. This alignment should be based upon updated cost and statistical data for 2003, with an additional adjustment made to provide for greater payment for community and public good services. A Medicaid rate add-on should be developed to recognize the proportion of hospitals' caseload that fall into the safety net service categories. Concomitantly, a mechanism to reallocate a portion of Medicaid funding from all hospitals to safety net hospitals that provide public good/community service should be developed. Additionally, we should develop a clear understanding of what constitutes a public good/community service.

• Ambulatory Care Medicaid Payments

Significant changes in the delivery and financing of health care are creating new challenges and opportunities for the ambulatory care sector. As advances in technology, diagnostic procedures, treatment regimes for chronic disease, and medical care interventions have proliferated, ambulatory care has emerged as one of the largest and most critical components of the State's health care system.

The reimbursement methodology for ambulatory surgery services has not been updated or amended since 1993 and is based on procedures being performed in an operating suite. As a result, many Medicaid payment policies create perverse situations, forcing providers to provide some ambulatory procedures on an inpatient basis in order to receive payment.

These situations arise because ambulatory care is difficult to fit into a systematic, universal scheme. The inability to describe the underlying dynamics driving resource use in ambulatory care has resulted in one large component of the health delivery system being financed based on historical costs and arbitrary limits, rather than differentiated according to actual patient and service resource patterns. Basing reimbursement for care upon site of service with no relation to the medical reason for visit and intensity of services provided has resulted in a system where the State is unable to assure that quality care is being provided.

We recommend that the state evaluate the numerous methodologies which govern Medicaid payments to providers for outpatient services, focusing on simplifying the system and creating an alignment with modern medical practices and the benefits of preventive care. In many cases, the fragmented system formulates payment based on the venue of care rather than on measures of clinical efficacy and the level of prevention or treatment, leading to revenue maximization as the primary incentive for hospitals. Resource allocations for preventive care are unaffordable for hospitals under the current construct.

Often private physicians decline participation in the Medicaid program due to the low payment rates, leading to a cycle of more expensive episodic, unmanaged care in hospital emergency rooms. A more uniform consolidated methodology should be considered, which reconfigures incentives to provide preventive care. Maintenance of access to all patients must also be a guiding philosophy in developing the new methodology.

The creation of a more balanced payment system would mean a redistribution of dollars among the different types of primary care providers, with a goal of budget neutrality within total Medicaid payments for outpatient services. However, consideration should be given to the development of "hold harmless" limitations, which protect this critical element of the health care infrastructure. Given the expected long term benefits attendant to a simplified preventive care outpatient payment model, consideration should be given to reinvestment of inpatient cost savings if necessary to promote this truly needed reform.

VI. Improving Hospital Quality

There has been much focus in recent years on the variation in health care quality across the country. Numerous articles have addressed the lack of uniform standards of care; the need for efforts to promote evidence-based practice; the incidence of medical errors; social, economic and cultural disparities in care; and, the importance of centers of excellence in assuring quality outcomes. New York State is fortunate to have some of the

finest hospitals in the world and has been a national leader in trying to measure and improve hospital quality. Yet clearly more can be done in this area. While hospitals themselves engage in numerous quality improvement activities, they have limited financial incentives to do so. In fact, in many cases, medical errors in hospitals can actually generate higher reimbursement. What is more, there has not been a systemic approach to hospital quality improvement. Any effort to reform the New York State hospital system must include a focus on quality improvement. There are a number of interesting national initiatives that warrant consideration.

- **The Leapfrog Group**

The Leapfrog Group is an organization founded by The Business Roundtable with support from the Robert Wood Johnson Foundation. Leapfrog's goal is to use employer purchasing power to achieve breakthroughs in patient safety and overall improvements in healthcare quality and value. Leapfrog attempts to address what it sees as an historic failure by purchasers and consumers of healthcare to seek out and reward quality providers. The Leapfrog Group also encourages providers of healthcare to adopt modern methods of quality management. Leapfrog is initially focusing on four initiatives: Computer Physician Order Entry (CPOE), Evidence-Based Hospital Referral, ICU Physician Staffing, and National Quality Forum's (NQF) safe practices.

Leapfrog seeks to have purchasers, health plans and providers jointly focus on these identified areas with a variety of financial incentives in an attempt to achieve leaps in quality improvement.

- **Medicare Quality Incentive Demonstration**

Recently, CMS initiated a three year demonstration project that provides financial rewards to hospitals demonstrating high quality performance in providing acute care services. Under the demonstration, hospitals will receive bonuses based on their performance on quality measures in five areas – heart attack, heart failure, pneumonia, coronary artery bypass graft and hip and knee replacements. Hospitals in the top 20% of performers will receive financial rewards with hospitals in the top decile receiving a bonus of 2% on their Medicare payments and hospitals in the second decile receiving a 1% bonus. In addition, in year three of the demonstration, hospitals that do not achieve the cut off scores established in year one for the lowest 20% of performers will be penalized with reduced payments for the specific clinical conditions where they performed poorly.

While the Leapfrog and CMS initiatives are too recent for results to be fully evaluated, the Work Group believes that the concepts of paying for performance, giving consumers incentives to choose quality providers and focusing purchasers, health plans and providers on specific quality improvement activities have value. Furthermore, the Work Group concurs with the Leapfrog tenet that quality improvement initiatives are likely to be most successful when embraced jointly by payers, providers, government and consumers. New York is a major purchaser of hospital services through the Medicaid,

the Family Health Plus and Child Health Plus programs and as a purchaser of coverage for State employees through New York State Health Insurance Program (NYSHIP). As such, the State is well positioned to use its purchasing power to influence improvement in quality.

We recommend that the State establish a State Quality Improvement Advisory Group to create specific target areas for quality improvement. The advisory group should include representatives from the provider, payer, consumer and business communities, as well as external experts in the area of health care quality improvement. We also recommend that the State join Leapfrog. Membership will require the State to encourage plans and providers to complete Leapfrog's quality reports no later than 2005 and to adopt their initiatives over a three-year period so that they are fully implemented wherever possible by 2008. The State should also actively participate in the national deliberations with regard to best practice and quality improvement initiatives.

In addition the State should utilize its authority as both a regulator and a major purchaser of health care to drive improvements in hospital quality. Specifically, the State should:

- Revise the Medicaid payment system to incorporate enhanced payment rates for hospitals that achieve performance benchmarks in the targeted area and to eliminate enhanced reimbursement for services in which complications result from hospital error.
- Incorporate into NYSHIP financial incentives for hospitals to improve quality and to encourage consumers -- through waivers of co-payments and deductibles -- to access hospitals that have achieved quality benchmarks.
- Require managed care plans to incorporate financial incentives for improved performance in the targeted areas established by the advisory group in the contracts they negotiate with hospitals. Insurers should also be required to include State designated centers of excellence in their provider networks or permit access to these centers out of network.
- Promote the availability of health insurance products for employers that encourage the use of providers with demonstrated high quality performance. Examples of this are products that waive co-payments or deductibles for consumers using designated centers of excellence.
- Disease Management

In addition, as New York State focuses on transforming Medicaid from a purchaser of health services to a purchaser of health outcomes, disease management should play an increased role in ensuring high quality health outcomes while lowering costs.

In New York State, as nationwide, a few chronic diseases generate a disproportionate share of healthcare costs. Chronic illnesses such as diabetes and asthma are more prevalent among the Medicaid population and treatment of their complications is a large driver of acute care costs. At the same time, there is wide recognition that care for chronically ill individuals is sporadic, uncoordinated and does not conform to best practices.

When chronic diseases such as asthma and diabetes are properly managed, patients remain healthier and avoid expensive complications. By applying best practices and intensively managing the care of Medicaid recipients with certain diseases, New York can contain costs while providing better health outcomes for chronically ill individuals.

There is little experience to date in applying disease management models to the Medicaid population. Additionally, there are several identified barriers to effective disease management, such as lack of continuity as a result of Medicaid “churning,” lack of availability of primary care services and possible resistance to disease management from providers of fee-for-service acute care.

It is the Working Group’s recommendation that the Department of Health institute additional demonstration projects beyond the demonstrations included in the 2004–2005 Enacted Budget.

The additional disease management demonstration projects should fully explore different models of disease management to determine which approach best improves quality while containing costs. Demonstrations should include disease management programs that operate through a Medicaid insurance plan, and should also include disease management interventions led by a hospital or provider group. If hospitals and providers are able to reinvest the savings they generate through effective disease management, there is a potential to transform the way they provide care in their community and increase the focus on preventive medicine. Because healthcare differs throughout the state, demonstrations should be conducted in all major regions of New York State. All of these demonstrations should reflect best practices and all should integrate health care information technology.

VII. Reinvestment Strategies to Support Health Care Information Technology (HIT)

Medical technology has advanced rapidly in the past ten years, from robotic and laparoscopic surgery to drug-coated stents. In general, however, the health care industry lags well behind other industries in its investment and use of information technology. Industries such as financial services have invested 10% or more of their revenues into information systems, while the health care industry is estimated to have invested less than 4% of its revenues.

This gap has begun to receive a great deal of attention in recent months. HHS convened a meeting in late July and presented their strategic plan for developing a national network so that an individual's electronic medical record can be available at points of care across the country. It is clear that much of the work to be done on HIT will be done on a national level, and that states such as New York should be actively involved stakeholders in the debate.

The need for improvement in the use of information technology has been well publicized in the past few years. The largest healthcare corporations in the country have shown that the effective use of information technology can have a significant impact on improving the quality of care and reducing medical errors. HMOs and insurance companies are also actively pursuing this course.

Quality improvements and the reduction of medical errors have normally been the driving force behind most of the clinical applications of HIT, which provide better and more timely access to information. Cost savings are also a major goal, although one that has not been measured as well. Enhanced sharing of information throughout the continuum of care is also a significant benefit conferred by HIT.

Today, most quality initiatives involve investment in or use of information technology. The Medicare program took the broadest step in this regard when, starting in 2004, it agreed to reimburse hospitals participating in its quality improvement program at a higher rate than those hospitals that chose not to participate. Not surprisingly, they have already achieved over 90% participation. While this program is primarily a data-gathering effort at this point, it presages a broader movement to utilize HIT to link quality of outcomes to payments. Investment in HIT has been frequently used as a proxy for quality outcome data, and it may be possible to create demonstration projects in New York where both Medicare and Medicaid participate in incentive payment projects.

The delivery of health care in New York State occurs in many different settings, from physician's offices to hospitals, and from Manhattan to rural upstate towns. As patients cross these lines, there is a crucial need for timeliness and standardization of data in order to pass relevant information to care providers in a clinically useful form. Reconfiguration of the healthcare system places higher demands on information sharing as patients are moved into different settings based on their changing clinical needs. This desirable diversity of settings and increased mobility of the patient population require that standards be put in place so that providers can easily and securely access this information.

In addition, the ability of the State to monitor potential epidemics, bio-terrorism and general health trends can be significantly improved by the electronic availability of timely, standardized information. As information becomes more accessible to medical professionals, researchers will finally be able to study the effectiveness of various interventions in a real-world setting. This will lead to better interventions, and will help clinicians more effectively tailor their interventions to individual patients' needs.

New York State is widely recognized as having one of the most comprehensive health information databases in the country, primarily because of its SPARCS system. Nevertheless, full advantage has not been taken of this system, particularly in its ambulatory surgery information and the soon to be implemented emergency room data system. In addition, the out-migration of services from Article 28 facilities has meant that important data on certain outpatient procedures, including ambulatory surgery, are not included in the system. NYPORTS, New York's incident reporting system for hospitals, has similar issues.

Improving the State's own data infrastructure will be critical to the development of effective HIT in New York. Monitoring quality and outcomes will require a broad database that will allow individual institutions, as well as the State, to monitor their performance against statewide benchmarks. It will also be important to monitor public health problems, such as potential epidemics and bio-terrorism. Researchers should have appropriate access to the systems. Data integrity, confidentiality and availability must, of course, be assured, and HIPAA-compliant privacy considerations must be adhered to.

Improving HIT in New York State requires the State not only improve its internal data systems, but also that it take an active leadership role in bringing about effective change statewide. Individual electronic medical records are a key element to this equation, and are getting a great deal of attention. Every week a region, hospital or large physician practice in New York announces that it has instituted, or developed plans to institute, such a system. There is a broad coalition of interested parties involved in the "eHealth Initiative" to set standards. The Federal government has stated at this point that they believe it is the province of such a group, including both government and private sector entities, to develop electronic medical records standards.

The effectiveness of information technology is severely constrained if health care providers cannot share information with each other. As New York develops its HIT infrastructure, it must ensure that the systems used by providers are able to communicate easily with one another, using open architecture and embracing the principle of interoperability. This access to data, however, must be managed within the context of HIPAA and privacy concerns. To date, many providers, especially large providers, have embraced this concept within their sphere of operations. They allow information to flow freely when authorized between their physician's offices and their hospitals for the sake of efficiency and quality of care improvements. There is, however, little or no incentive to assure that the information is available outside of their network. The state's role here will be critical. It is not in the public interest for individual health information to become a commodity, or for information systems to become balkanized.

HIT systems are costly and require significant investment in hardware, software and trained staff. Furthermore, HIT is a high-risk proposition: implemented properly, it can yield incredible results, but failed implementation can be catastrophically expensive and time-consuming. As a group, New York's hospitals have the lowest operating margins in the 50 states, and their access to capital is limited in many cases. The adoption of

sophisticated HIT by independent providers requires a powerful combination of money and expertise.

In New York, where hospitals are virtually all not-for-profit, tax-exempt borrowing is the obvious and most advantageous way for those institutions to raise money, either directly or through the State. In most HIT scenarios such as electronic medical records, linkage to private physicians is also crucial to achieving quality through the continuum of care. However, any use of tax-exempt financing by private-practice physicians would nullify the tax exemption. Financial strategies need to be developed to deal with this issue.

Finally, the State's serious budget issues and existing debt position argue for supporting the investment in HIT as much as possible outside of the State's credit.

To assure that New York State health care providers develop the essential technology required to operate high quality, efficient facilities in the 21st century, we must accomplish the following objectives:

- Establish HIT standards that are built on existing practice and are based on Federal standards, open architecture, interoperability, data integrity, standardized information, and confidentiality. These standards must assure that patient records can be communicated and understood across health care settings, as authorized and required, without violating data security and confidentiality requirements.
- Assure that all viable and necessary providers in New York State have access to the financing required to invest in HIT at a reasonable cost. The State must assist providers in securing funding from outside sources, existing State sources and also by developing new sources.
- Develop existing New York State databases to meet the new and increasing needs of patients, providers, insurers and researchers. Human, financial and systems resources must be provided to accomplish this objective.
- The State should evaluate using State financing to initiate the use of a statewide smart card that would contain basic patient information and medical history. All health care providers would be required to acquire technology systems that would be able to read the smart card and convey the information into their own information systems.

In order to create information system standards, the State should have representatives involved in the committees currently being formed by HHS and the National Coordinator for Health Information Technology. We recommend that the State convene meetings with both payers and providers to ensure that reporting requirements are as simple and non-duplicative as possible. Initially, standards should be developed for electronic medical records, national and local health information networks, e-prescribing, computerized physician order entry and related capabilities.

We also recommend that the State review and expand its existing financial programs for hospitals and develop alternatives for financing HIT projects with all relevant providers, specifically DASNY's TELP program and pools of funds available from the Federal government, Gen*NY*sis/NYSTAR, the New York Center for Growth, and private foundations. If these sources prove insufficient to assist providers in securing financing, as we expect they will, the State should spend a year analyzing the progress being made in Washington and how the new standards can best be implemented in New York. The State should assist providers in attracting financing for investments meeting the state's requirements. Such a financing mechanism should include the following principles:

- Reasonable rates to all adopters of approved technology.
- Financing limited to systems able to integrate with other local providers and meeting national standards.
- Accountability and measurability of results by the recipient.
- Repayment source from all the beneficiaries of the program, especially among all affected payers, linked to use of HIT or improved quality.
- Minimization of impact on the State's credit through identification of expected payment sources.
- The State should also utilize its own funds, federal grants and private funds to develop an implementation grant program to assist providers.

VIII. Insurance

- Medical Malpractice

We would be remiss in our discussion of quality improvement if we failed to mention the effect of malpractice. Our system for handling malpractice has done little to improve quality or protect patients from medical error, and has become an impediment to meaningful quality improvement initiatives. For too long, medical harm has been addressed primarily on an individual basis, with lawyers attempting to assign specific instances of error to individual doctors or hospitals.

Furthermore, the intensely adversarial nature of the court system has led to a "bunker mentality" among physicians that has stymied attempts to improve quality. Malpractice premiums are incredibly expensive, especially for safety net services. This wastes resources that could be better spent on patient care and system improvement and possibly drives physicians out of certain markets or specialties altogether. Because malpractice judgments are often capricious, fear of malpractice suits does not lead hospitals and

physicians to practice better medicine, but to practice “defensive medicine,” leading to an increase in medically unnecessary care. Many attempts have been made to address the malpractice issue with little results. Yet, the problem is now critical and it is threatening the viability of entire institutions as well as individual health care practitioners.

It is our opinion that malpractice reform is needed in New York State. However, for all its effect on the healthcare system, the issues in malpractice are fundamentally legal and insurance issues, and not within the scope of the Working Group.

- Role of Insurers

At a time when many New York health care providers have been struggling financially, many private health insurers are reporting financial success. The Working Group believes the relationship between private payers and the financial viability of the health care delivery system needs to be carefully examined. Private health insurers have a stake in the reform proposals included in this report. Reducing unnecessary hospital capacity and maintaining critical health services are as important to the insurance sector as they are to the public sector. As such, it is reasonable to expect these companies to participate in initiatives to promote financial alignment between payers and providers, and to participate in reinvestment strategies. It is equally critical that private payers are reimbursing adequately and maintaining adequate reserves to meet current and future health care needs.

In the environment of not-for-profit conversions to public companies and subsequent corporate mergers, it is hard to keep track of premium dollars collected from young and healthy populations that have been removed from the pool of reserves that will be required to pay for care later in life. This is especially relevant as we approach the bubble of baby boomers entering their senior years.

While the Working Group felt that the corrective action required to address insurance related issues were outside the scope of its report, it feels strongly that the issue of financial success is inextricably linked to the viability of our health care delivery system. The State needs to study further the issue of the correct balance between the financial success of the insurance sector and the viability of health care providers and take action if it is required.

IX. Continuing the Work of a Health Care Reform Working Group

The research and analysis we have done over the past year has illustrated the many and diverse opportunities that exist to improve the delivery of health care services in New York State. The speed of change in health care, driven by changing technology, populations and finance, makes it essential that the work of reforming the system and regulatory framework must be continuous and part of the mechanism of government.

Finding and analyzing these policies presents the continuing opportunity to improve the quality and efficiency of the system. Broad topics to consider include:

- Specific NYS Medicaid payment and program policies including, the administration of the program;
- Waste, Fraud and Abuse;
- Opportunities to cooperate with other payers, especially Medicare; and
- End of Life Care, specifically palliative care.

We therefore recommend that the Governor's staff create an internal work group consisting of staff from various agencies to seek out these opportunities and make recommendations to improve them. Input should also be solicited from various stakeholders and regions to determine the nature of the issues in their sector and the practical effects of recommended changes. The objective should be to improve the quality and reduce the cost of health care for all residents of New York State.