



PUTTING PATIENTS FIRST

**TESTIMONY OF KENNETH E. RASKE, PRESIDENT
GREATER NEW YORK HOSPITAL ASSOCIATION
ON THE EXECUTIVE BUDGET PROPOSAL FOR 2007-08 BEFORE THE
NEW YORK STATE SENATE FINANCE AND ASSEMBLY WAYS AND MEANS
COMMITTEES**

FEBRUARY 13, 2007

PUTTING PATIENTS FIRST

**TESTIMONY OF KENNETH E. RASKE, PRESIDENT
GREATER NEW YORK HOSPITAL ASSOCIATION
ON THE EXECUTIVE BUDGET PROPOSAL FOR 2007-08 BEFORE THE
NEW YORK STATE SENATE FINANCE AND ASSEMBLY WAYS AND MEANS COMMITTEES**

FEBRUARY 13, 2007

Good morning Chairman Farrell, Chairman Johnson, Chairman Hannon, Chairman Gottfried, and other distinguished members of the State Legislature. My name is Kenneth E. Raske, President of the Greater New York Hospital Association (GNYHA). GNYHA represents approximately 250 not-for-profit and public hospitals and continuing care providers in New York and surrounding areas.

Thank you for this opportunity to testify on the Executive Budget proposal for the State fiscal year (SFY) 2007-2008. While there are very positive elements of the Executive Budget—including the avoidance of beneficiary cuts, the expansion of Child Health Plus to uninsured children in families up to 400% of the Federal Poverty Level (FPL), and much-welcomed simplification of the Medicaid re-certification process (something GNYHA has supported for many years)—I come before you at a uniquely perilous time for New York’s health care system and with great dismay that \$1 billion in payment cuts have again been proposed for the hospital and nursing home sectors. In addition, the budget proposal contains two hospital proposals that would result in potentially massive—but as yet unidentified—redistributions of inpatient case payments and indigent care pool funding.

We believe our health care system is in desperate need of reform, but that such reform must put patients first by addressing all of the issues that shape and mold our health care system—private payer wealth, pharmaceutical and medical device costs, and the spiraling costs of malpractice coverage to name a few—and not just target the institutions and their staffs who actually deliver patient care. Unfortunately, we find little but beneficiary expansions in the Executive budget that provides even a down payment on this needed reform. The budget proposes some needed additional funding for high-Medicaid hospitals but that funding is offset by the cuts in almost every situation, and the woeful under-funding of ambulatory care services—including primary care, specialty clinic, and ambulatory surgery—is not addressed at all. Our hospital system has been in crisis, as evidenced by the existence and activities of the Berger Commission, implementation of whose recommendations is still to come. Enactment of the cuts that have been proposed would devastate our providers and the care they are able to offer to their communities. Cuts are not reform. Health care cuts do not put patients first.

These cuts are not being made because the State is threatened by deficits such that difficult decisions need to be made to maintain overall fiscal health. Instead, the State is projected to end the 2006-2007 fiscal year with a \$1.5 billion surplus. And while the Division of Budget (DOB) has forecast a \$1.6 billion gap for fiscal year 2007-2008, based upon a consistent pattern of

under-estimated tax receipts in past Executive Budgets, it is reasonable to expect that this gap will close naturally as estimates of tax receipts are revised upward during the next few months. The Executive's proposal to invest \$100 million in State funds for new health care initiatives—as well as \$1.8 billion in new spending for property tax relief, education, and other initiatives—does not require \$1.3 billion in State funds cuts to our health care system, which translates into \$1 billion in all-funds harm to the State's hospitals and nursing homes.

Our extreme distress at the Executive's proposal quickly turned into horror last week when President Bush proposed his budget for the upcoming Federal fiscal year, which begins on October 1, 2007. The President's proposals would absolutely decimate New York's hospitals, particularly its teaching and public hospitals, by imposing \$1.2 billion in cuts in the coming fiscal year alone through a combination of regulatory and legislative changes to Medicaid and Medicare.

In this environment, the bottom line is simply this: Having experienced multiple years of losses, hospitals in New York continue to be among the financially weakest in the entire nation. It took many years for our hospitals to plunge this far, and there are no easy fixes to the situation, however much we might wish it to be different. Hospitals' operating margins are still negative overall, and many of them are struggling as much or more than they ever did on a daily basis to meet their most basic financial obligations including payroll, benefit costs, debt service and vendor payments—much less invest in the future. Others are “doing well” by New York standards—meaning they are not losing money but are performing at a level that is still well below the national average for hospitals and below the level needed to qualify for investment grade credit ratings. In this picture, the Executive budget would cut \$500 million from hospitals, or 4.7% of Medicaid hospital payments, and 1% of total hospital operating revenues. When your starting position is negative, an additional 1% loss cannot be absorbed without affecting patient care. If even a portion of the proposed Federal budget cuts are added, the game would, in fact, be over for New York hospitals.

In my testimony today I want to discuss the most pressing challenges facing our hospitals today, including the proposed Federal cuts, and review some of our ideas for reform. In this regard, please note that we previously sent you a copy of our reform proposal, “Shared Responsibility;” please consider this to be an integral part of my testimony. I will then describe the Executive's budget and why proposed health care cuts should be summarily rejected. Separately, Scott C. Amrhein, President of the Continuing Care Leadership Coalition, will discuss our serious concerns about the Executive Budget's long-term care proposals, which would have a devastating impact on our State's nursing homes and the elderly.

CONTEXT FOR HOSPITALS: PRESSING CURRENT CHALLENGES

Shocking Federal Cuts

As noted, just last Monday President Bush released his proposed budget for the Federal fiscal year starting on October 1, 2007. The President calls for a combination of Federal Medicaid legislative and regulatory actions, as well as Medicare cuts. We are particularly concerned with two Medicaid regulatory actions that would eliminate special payments to public hospitals and eliminate the Federal share of Medicaid payments for graduate medical education (GME). ***These two proposals alone would cut a staggering \$900 million out of New York's teaching and public hospitals—per year.*** These Medicaid actions do not even have to go through Congress, because the Bush Administration plans to implement them through regulation, making them very difficult to stop. The proposed Medicare actions, which do require Congressional approval, would reduce the inflation factor for hospitals and other providers, and eliminate payments for GME associated with Medicare HMO enrollees. These proposed cuts would slash an additional \$300 million in the first year.

Under any circumstances, the Governor's proposed Medicaid cuts should be rejected as damaging and unnecessary; facing this Federal threat, they are unthinkable.

The Berger Commission

You are all familiar with the recommendations of the Berger Commission, which are now effective and mandated by law to be implemented. I want to pause and take stock of the significance of these recommendations because the Executive's budget evidences a shocking lack of understanding about the significance of the recommendations and treats them as if they are "old news." In fact, all the hard work is ahead of us, and the Executive's budget would completely undermine this effort by plunging the hospitals subject to the report, as well as those that are counted on to preserve community access to services, into financial distress. The entire premise of the Commission and its painstaking efforts over an 18-month period was to engage in system-wide health planning and to reconfigure the hospital system by prioritizing community health and access for all communities. This was deemed preferable to allowing market forces to indiscriminately close hospitals, as was happening around the State prior to the Commission's creation. By imposing half a billion in cuts on the hospital community, the Executive's budget would completely defeat the possibility of rational and manageable implementation of the Berger recommendations.

The Berger recommendations affected 57 different hospitals and included nine outright closures, three complete conversions, and 45 re-configurations that included downsizing, new affiliations and corporate governance structures, and hospital construction. The Commission estimated that they will result in a reduction of 4,200 beds, or 7.5% of staffed beds in New York. More than 6,000 hospital staff will be affected by these recommendations. The Department of Health (DOH) has identified more than 100 actions required on its part to implement the report and estimates that it will process almost 70 related Certificates of Need (CONs).

The impact of the Commission's recommendations is more than fiscal. Some of the recommendations are incredibly complicated and interwoven, such that one action must happen in order for another to occur in order for another to be realized and so on. Some may require legislation, including those involving new public and private hospital governance structures. All have generated deep concern by workers who would be displaced by the recommendations as well as communities affected by closures in particular. Twenty one hospitals are in a limbo status where approvals unrelated to life and safety concerns may not be granted, such as CONs, licenses, and grant applications for new initiatives, pending compliance with specified actions delineated by the Commission. Some of these actions—such as entering into binding agreements with possibly unwilling entities to create new affiliations and governance structures—must happen by the end of 2007 and, if they do not, the Commissioner is directed to revoke the operating certificate of one of the parties subject to the recommendation. The Commission statute itself expires at the end of June, 2008.

To give you a sense of the chaos the Executive's proposed budget would introduce into this highly complex situation, the 45 hospitals slated for re-configuration, transformation, and new affiliations, which are intended to strengthen needed service providers, would suffer over \$100 million in losses if the Governor's proposed cuts alone were enacted. This does not even include the potential swings for funding that would result from the Governor's other proposals to recalibrate the case payment system and redistribute uncompensated care funds, which I discuss in more detail below. In this situation, it is hard to imagine that these 45 institutions would have the resources or ability to engage in rational re-configuration. The nine hospitals slated for closure, several of which are already in extreme financial distress or bankruptcy, would be hit by \$14 million in losses, making it more likely that events caused by financial crisis would overtake a planned closure process that carefully considered patient and worker needs.

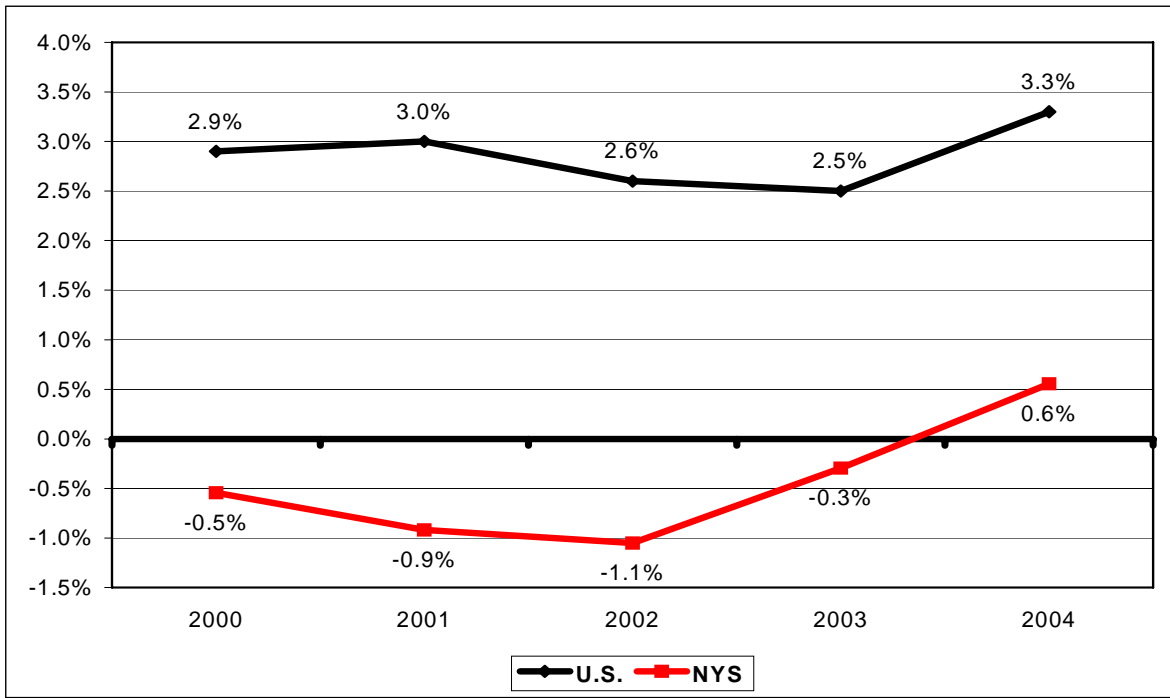
Last but not least, the Berger Commission itself estimated that its recommendations would generate \$249 million in savings to Medicaid each year, or \$2.5 billion over five years. We estimated a potentially greater Medicaid impact from all of the Commission's actions—\$460 million per year—if the Commission's recommendations regarding primary care investment and case management development were heeded. Thus, we were dismayed that not one penny was counted in the Executive's budget plan as Medicaid savings. This is a fundamental omission in the projections of State Medicaid spending in the coming and subsequent years which should be remedied.

Hospitals Continue to be in Dire Financial Condition

You are well aware that hospitals in New York State have for many years trailed the rest of the country in overall financial health. The goal of financial health and stability in the hospital community is something we should all work for because it translates into better patient care and satisfaction as well as improved quality and patient safety, and because it allows institutions to make needed financial and human capital investments to be able to practice 21st-century medicine. Unfortunately, financial health is a goal that continues to elude us. As seen in Figure 1 below, while hospitals nationally enjoyed a 3.3% gain on their bottom line, New York's hospitals were essentially breakeven after years of losses. Please note that the bottom line margin reflects surpluses and losses from patient care, but also all of the extra revenue a hospital

can garner from contributions, grants, bequests, and other operations. As noted earlier, operating margins themselves are negative overall, and only the infusion of contributions and other income nudges hospitals' bottom lines into a breakeven position.

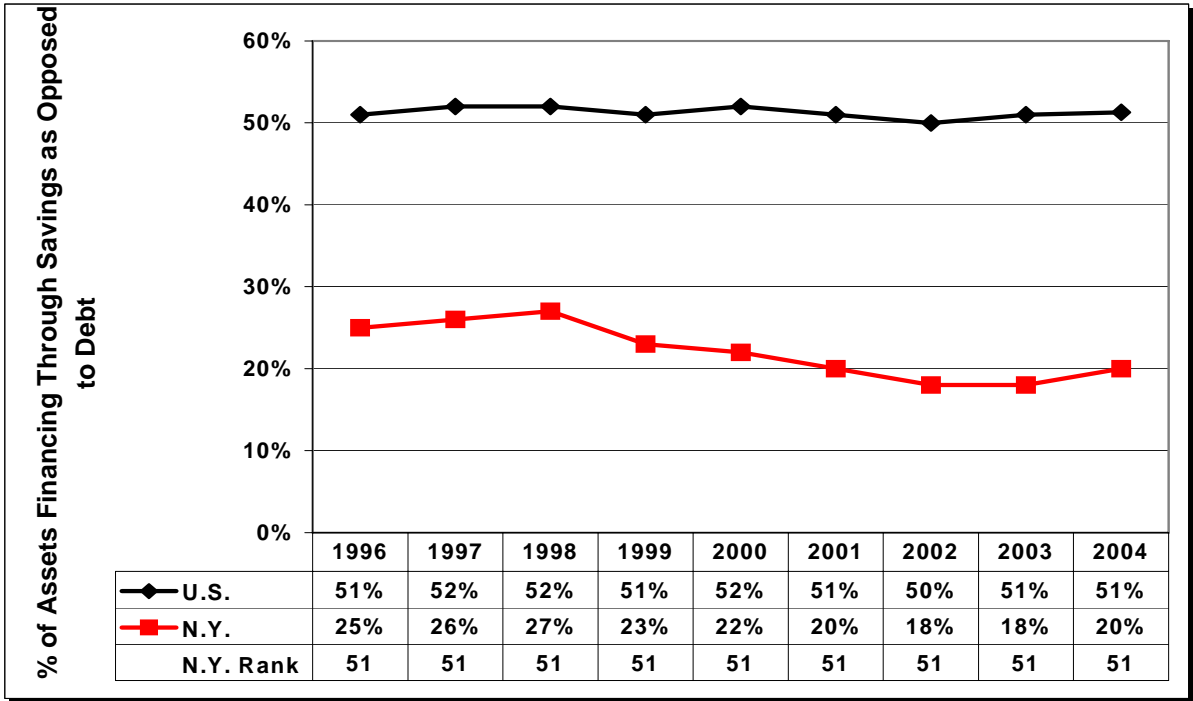
Figure 1. Hospital Bottom Line Margins, New York State and U.S.



Source: GNYHA analysis of Medicare cost reports.

The lack of profitability directly undermines hospitals' ability to make capital investments for the future, a fundamental principle of survival for any organization whether it is a publicly traded corporation, a museum, a college, a library, or a school system. For a hospital, investing in the future means maintaining and doing routine upgrades to the physical plant, implementing new information technology, expanding operating rooms to accommodate modern medical equipment, building state-of-the-art surgical suites, and the like. In 2004, while hospitals nationally financed 51% of their capital investments with equity, or surpluses accumulated through positive financial performance over the years, New York's hospitals were only able to finance 20% of their investments with equity and had to rely on debt for the balance (see Figure 2). This is because the poor profitability represented by the graph above means that hospitals do not have the funds they need to pay for basic re-investment in their infrastructures. Our hospitals' reliance on debt places us at grave risk of not being able to make needed capital investments, particularly if financial performance suffers as a result of additional losses and lenders become unwilling to extend more credit.

Figure 2. Equity Financing Ratios, New York State and the U.S.



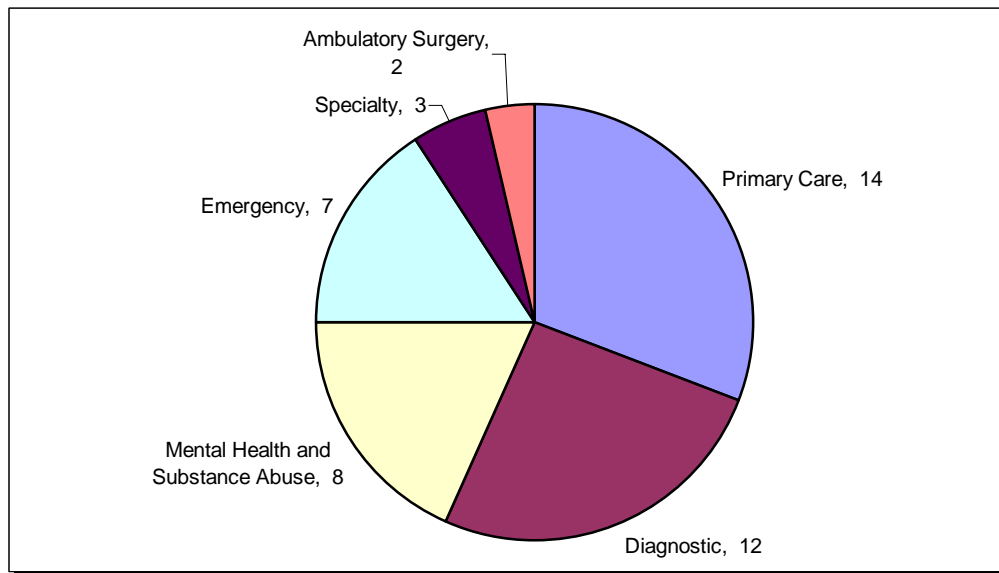
Source: GNYHA analysis of Medicare cost reports.

Medicaid is a Major Source of Hospital Losses

Unfortunately, a major contributor to hospital financial pressure is underpayment by Medicaid itself. While the Executive’s budget attempts to offer programmatic justifications for its proposed hospital cuts, I think it is critical to underscore from the start that however one might attempt to justify cuts, hospitals lose more than \$2 billion a year on delivering care to Medicaid patients.¹ While Medicaid payments for inpatient services are only 7% below cost, payments for ambulatory care—ambulatory surgery, primary and specialty care clinic visits and also emergency room visits—are a shocking 45% below cost. The fact is that hospitals rely on inpatient payments to support the ambulatory care enterprise, which provides 46 million outpatient clinic and emergency room visits each year, 14 million of which are primary care services for adults and children (see Figure 3). New York’s hospitals are a constant, steady provider of ambulatory services for all patients, whether they are insured or not, and demonstrate their commitment to primary care in particular through an extensive array of services both on the main hospital campus and in the community. In many communities, hospitals and freestanding clinics are the only source of primary care—they are the family doctor and largely continue to be so even for Medicaid patients enrolled in managed care. Medicaid reform must address the under funding of ambulatory care and refrain from cutting the inpatient rates and other funding needed to cross-subsidize it.

¹ “Caring for the Uninsured in New York,” Urban Institute (October 2006) page 37.

Figure 3. Distribution of 46 Million Outpatient Visits Provided Annually by New York State Hospitals (in Millions)



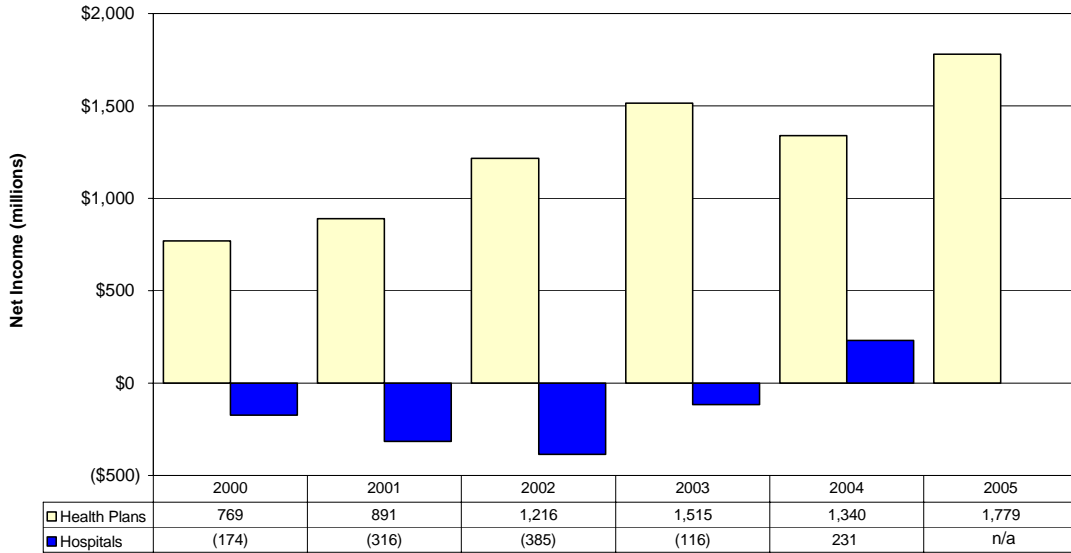
Source: 2004 New York State Institutional Cost Reports.

Insidious Imbalance between Payers and Providers

The extreme imbalance in the relative financial condition of hospitals on the one hand and private health insurers on the other must be addressed in any reform effort, because it is a major contributing factor to hospitals' weak financial condition. Figure 4 depicts the transfer of resources from the hospital sector, among others, to the health insurance industry over time. Figure 5 depicts where at least some of this enormous profit has been going—to unallocated reserves. The bottom part of each bar represents the amounts held as statutory minimum reserves. The top portion represents amounts that were paid out as shareholder dividends. The middle portion represents the amount held in unallocated reserves, which quadrupled to more than \$4 billion between 2001 and 2005. Our reform plan calls for an immediate disgorgement of some portion of these amounts to help pay for, among other things, insurance expansions in the State. One way to recapture some of these resources, among many others, would be an increase in the covered lives assessment.

Figure 4.

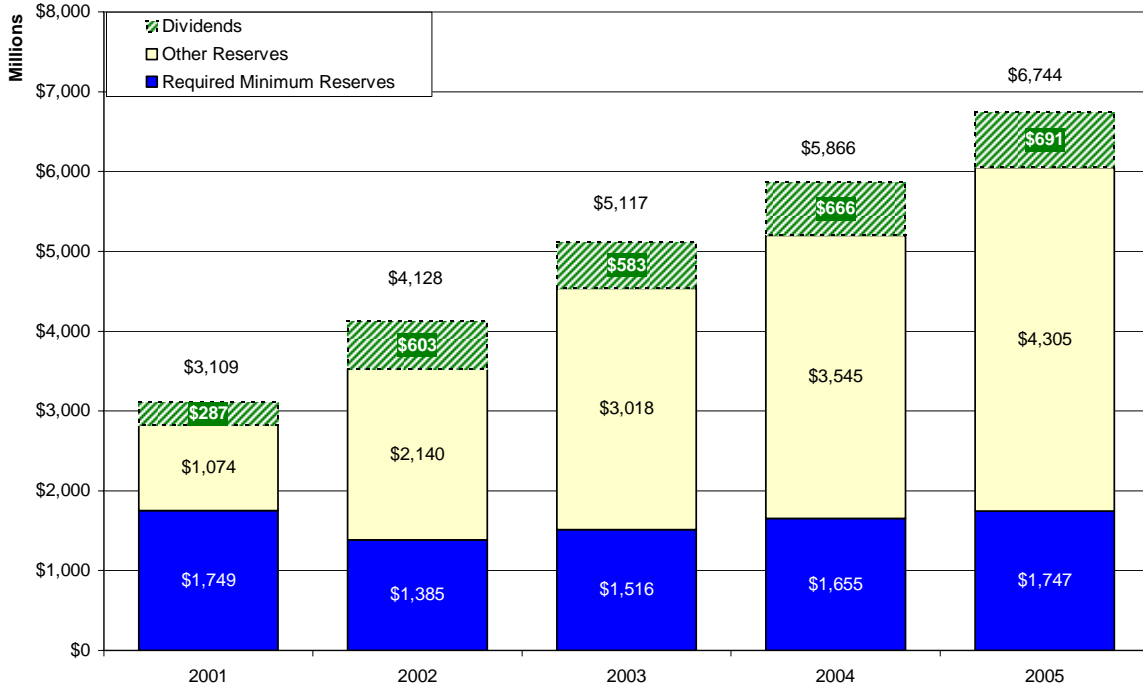
**New York State Health Plan and Hospital Financial Condition
Net Income, 2000-2005**



Note: Figures do not include Prepaid Health Services Plans (PHSPs)
Source: New York State Hospital Institutional Cost Reports (ICR); New York State Insurance Department, Health Plan Annual Statements (NAIC Statements); data includes commercial PPO, HMO and indemnity.

Figure 5.

**Growth in Health Plan Reserves Over Time
2001 - 2005**



Note: Health plans included in this analysis: Aetna; Capital District Physicians Health Plan; Cigna; Empire; Excellus; GHI; HealthNow; HIP; Horizon; Independent Health; Oxford; United (including AmeriChoice); and Wellcare. Together, these plans represent 83% of total NYS premium income, 85% of total NYS net income, and 88% of total NYS enrollee member months.
Source: National Association of Insurance Commissioners (NAIC) financial statement filings.

The gulf between the financial performance of hospitals and health plans has widened in recent years as a result of the merger and consolidation of health plans. New York has seen significant changes over the past several years in the number and nature of health insurers serving the area. These have included the conversion of Empire Blue Cross Blue Shield, the State’s largest insurer, to publicly traded status and its subsequent acquisition by the nation’s largest private insurer, Wellpoint, as well as the acquisition of Oxford Health Plans by the country’s second largest insurer, UnitedHealth Group. There have been other health plan consolidations through merger and acquisition over time and the current merger of HIP and GHI and its possible conversion to publicly traded status would be among likely future consolidation activities in the downstate region. Within a few years, it is very possible that the metro New York area will be served primarily by just four health plans.

What are the implications of this activity? As noted, the disparity between the high profits of New York health plans and the poor financial condition of New York’s hospitals is extreme. Consolidation has exacerbated this situation because it has given health insurers increased market power with which to compel providers *and consumers* to accept contracts that may have inappropriate terms and payment rates and to be forced to endure arbitrary, and possibly actionable, payment practices. It has also led to the dominance of national health insurers not domiciled in New York that are not as responsive to local network or community needs. The increased reliance of Medicaid and Medicare on private managed care companies to arrange and pay for care has also increased costs compared to the administrative efficiencies of the government fee-for-service programs and lowered hospital payments for serving these patients.

Many have complained about “New York’s broken health care system.” What is really broken is the way in which many health plans arrange and pay for health care for their enrollees and the profits they have made as a result. The sheer quantity and variety of different insurers’ payment practices and rules – as well as the additional rules required by their behavioral health and other “carve-out” subcontractors -- are mind numbing and have added unconscionable administrative costs to the system. As shown in Table 1, health plans spend almost 20% of every premium dollar on administration and profits. Because their rules are not standardized, and many are arbitrary, each dollar they spend causes a multiple of administrative cost in doctor and hospital offices everywhere.

Table 1. Health Plans Spend Almost 20% of Every Dollar On Administration and Profit: Medical Cost Ratios, 2001-2005

	2001	2002	2003	2004	2005	% Change
Aetna	86.6	80.4	76.0	81.4	69.5	-19.7
GHI	89.3	89.5	89.6	89.4	90.4	1.3
HIP	83.3	81.4	79.4	80.3	81.1	-2.6
Oxford	78.6	79.0	79.1	80.0	78.1	-0.7
United Health	88.5	84.8	81.4	82.5	82.5	-6.8
WellPoint (Empire)	88.0	85.0	84.9	85.5	85.9	-2.4

SOURCE: New York State NAIC Financial Statements

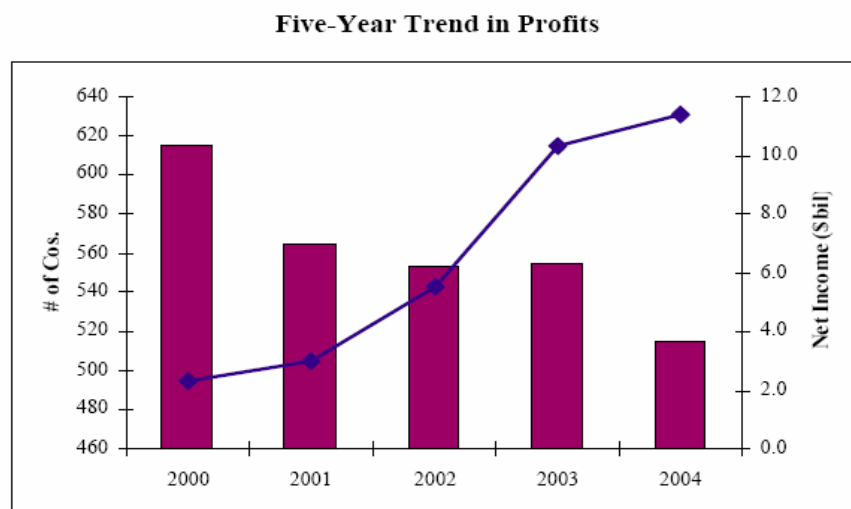
NOTES: Medical cost ratio is payments to physicians, hospitals, pharmaceutical firms, and other providers and suppliers of medical care services as a percentage of insurance premium revenue.

Payment denials for medically necessary care have also contributed to worrisome hospital losses and fiscal distress and candidly have created justifiable anger and frustration in the physician and provider community. This sense of injustice by those who actually take care of patients is well founded and inconsistent with system wide efforts to improve quality overall. We believe that if a service is medically necessary, payment should be made each and every time with a minimum of hassle. The extreme disparity between health insurer wealth and hospital losses, as well as the administrative burdens associated with private health plans, is a primary symptom of a health care system that is askew.

The Steady Rise of Health Plan Profitability

Figure 6 depicts national trends in health plan consolidation and profitability. It demonstrates why consolidation to gain market share has been an attractive strategy; net profits have risen steadily as the number of plans has decreased.

Figure 6.



Source: Weiss Ratings, 8/8/05

Cost Increases

While New York’s hospitals struggle with Medicare and Medicaid reimbursement cuts as well as unfair payment practices by insurers, their costs spiral relentlessly upward. Despite our best efforts, pharmaceutical, medical device, and supply costs are increasing at staggering rates. In addition, New York’s medical malpractice insurance affordability problem has reached crisis proportions. A GNYHA survey of our member hospitals shows that their malpractice premiums have increased 156% from 2000 through 2007. Physicians are struggling, too. While physician

premium increases are regulated by the State Department of Insurance (DOI), they start out at an extremely high level, particularly for specialties such as ob-gyn and neurosurgery. Insurers report that even the premium increases that have been granted by DOI, which have added to the unaffordability problem for physicians, have not been sufficient to cover expenses, leading to extremely poor financial performance and potential insolvency. The medical malpractice insurance problem must be addressed. In the meantime, as hospital costs increase due to a variety of factors, their revenue must not be further depressed through unwise and dangerous Medicaid cuts.

CONTEXT FOR THE BUDGET: DEFICITS, MEDICAID AND STATE SPENDING

Table 2 summarizes the major actions proposed in Governor Spitzer’s Executive Budget. Essentially, he proposed to generate resources of \$3.5 billion to close a \$1.6 billion forecasted budget gap in State fiscal year 2007–08 and to spend \$1.9 billion on new initiatives, the most salient of which would be reducing property taxes (\$1.2 billion), increasing school aid (\$400 million), and expanding health insurance for children and other health initiatives (\$100 million). The sources of funding would be: cutting existing programs (\$2.4 billion), closing revenue loopholes (\$450 million), and using reserves (\$670 million). Of the proposed \$2.4 billion in cuts to existing programs, most—\$1.3 billion—would derive from health care, with the remainder from other areas. Hospitals and nursing homes would bear the brunt of the health care cuts, accounting for \$530 million of the \$1.3 billion in State savings. Because cuts in State funding for Medicaid cost providers Federal matching funds as well, hospitals and nursing homes would actually lose almost \$1 billion.

Table 2. Summary of State Fiscal Year 2007–08 Executive Budget Proposals (\$ in Billions)

	State Funds		State Funds	Provider Impact
New spending	3.48	Proposals to finance new spending	(3.48)	
Close budget gap	1.61	Cut existing programs	(2.36)	
Fund new programs	1.87	Health care	(1.30)	
Property tax relief	1.21	Hospitals and nursing homes*	(0.53)	(0.90)
Increased school aid	0.37	Hospitals	(0.30)	(0.43)
Child Health Plus & other health	0.10	Nursing homes	(0.23)	(0.47)
Other	0.19	Other	(0.77)	
		Other programs	(1.06)	
		Close revenue loopholes	(0.45)	
		Use reserves	(0.67)	

* Please note that the \$900 million total hospital and nursing home loss is actually a combination of \$1.2 billion in losses offset by \$300 million in gains resulting from a) redistributions of existing funding, and b) creation of new programs for high-Medicaid hospitals.

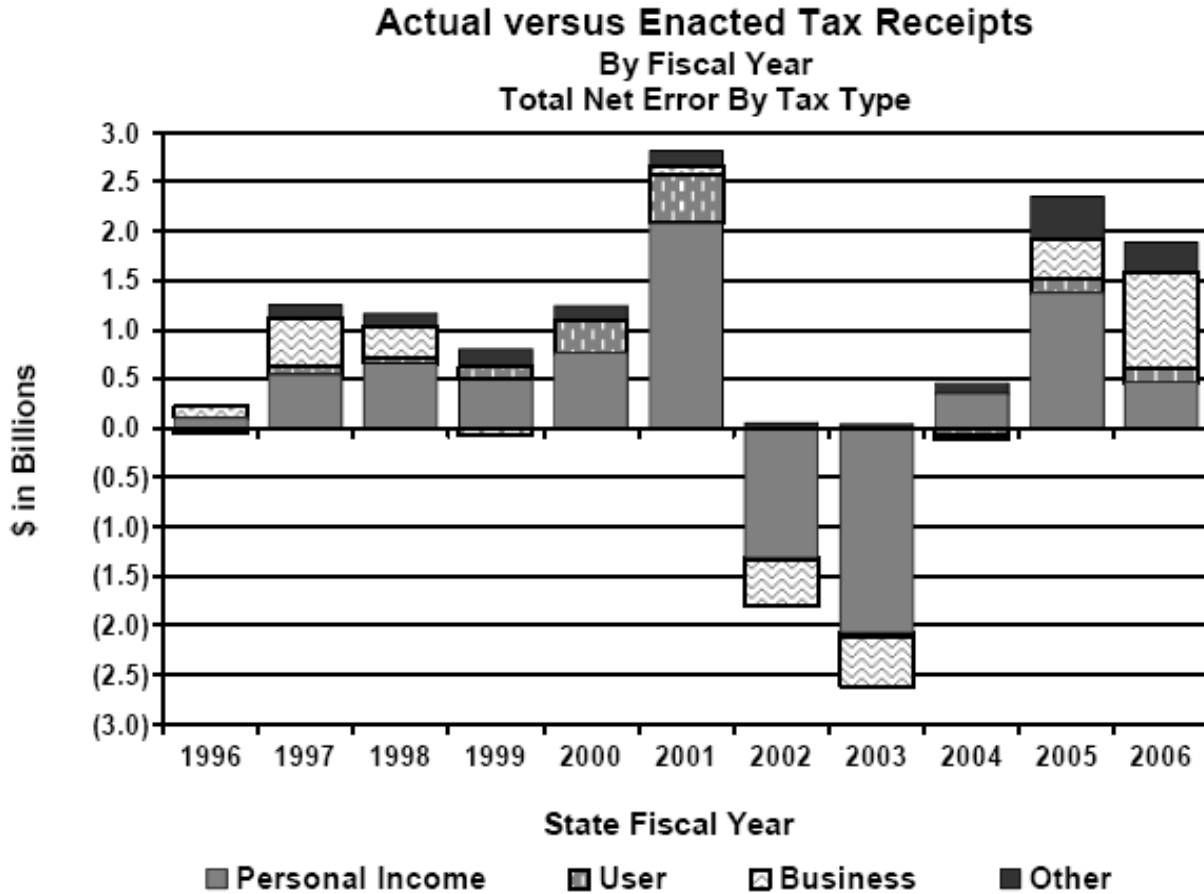
Budget Deficit Projections

We believe that the devastating cuts to hospitals and nursing homes are not only ill advised on programmatic grounds, but unnecessary as well, because the forecasted budget gap of \$1.6 billion is likely to evaporate over the next several months. The Division of the Budget has a rosier assessment of the State's fiscal health than it had in October, 2006, when it prepared the FY 2006–07 mid-year update. While the mid-year update projected a current-year surplus of \$1.1 billion, DOB now believes that the surplus will be \$1.5 billion. Furthermore, while the mid-year update projected an SFY 2007–08 deficit of \$2.4 billion, DOB now believes that the gap has shrunk to \$1.6 billion. The improvement in DOB's assessment of the State's fiscal health is almost entirely attributable to higher-than-expected tax receipts.

There is ample reason to believe that DOB will continue to make upward adjustments to its estimates of tax revenue during the next several months, since it has underestimated tax revenue in almost every non-recessionary year in the past 25 years. Indeed, in this year's Executive Budget, the Division of the Budget included an assessment of its own forecast performance. Comparing actual tax receipts with the enacted budget forecasts, DOB showed in Figure 7, below, which was excerpted from the Executive Budget, that tax receipts were higher than forecasted in nine of the past 11 years, with the underestimate exceeding \$1 billion in six of those years and exceeding \$2 billion in two of those years.

This is consistent with the principal finding of an exhaustive literature review that Edward M. Cupoli, Ph.D., recently conducted of forecasting accuracy at the national and state level. That finding was: “[R]evenue forecasters tend to be low when the economy is expanding and high when the economy is contracting.” Furthermore, with reference to the DOB analysis in the Executive Budget, Dr. Cupoli said: “As reported by New York State recently, the errors in the tax forecasts over the past 11 years have ranged from less than 2 percent to more than 6 percent. These numbers may seem small; however, based on total tax revenues of \$53 billion in state fiscal year 2005-2006, the error would be in the range of \$1.1 to \$3.2 billion. In addition, the error from their original Executive Budget forecast may be significantly larger since the Enacted Budget—the basis for their comparison—reflects a more up-to-date forecast.” Based on the fact pattern that Dr. Cupoli observed in his historical review and DOB's forecast that overall economic activity will continue to grow, Dr. Cupoli believes it is reasonable to assume that the Executive will have under-forecast tax receipts for SFY 2007–08.

Figure 7.

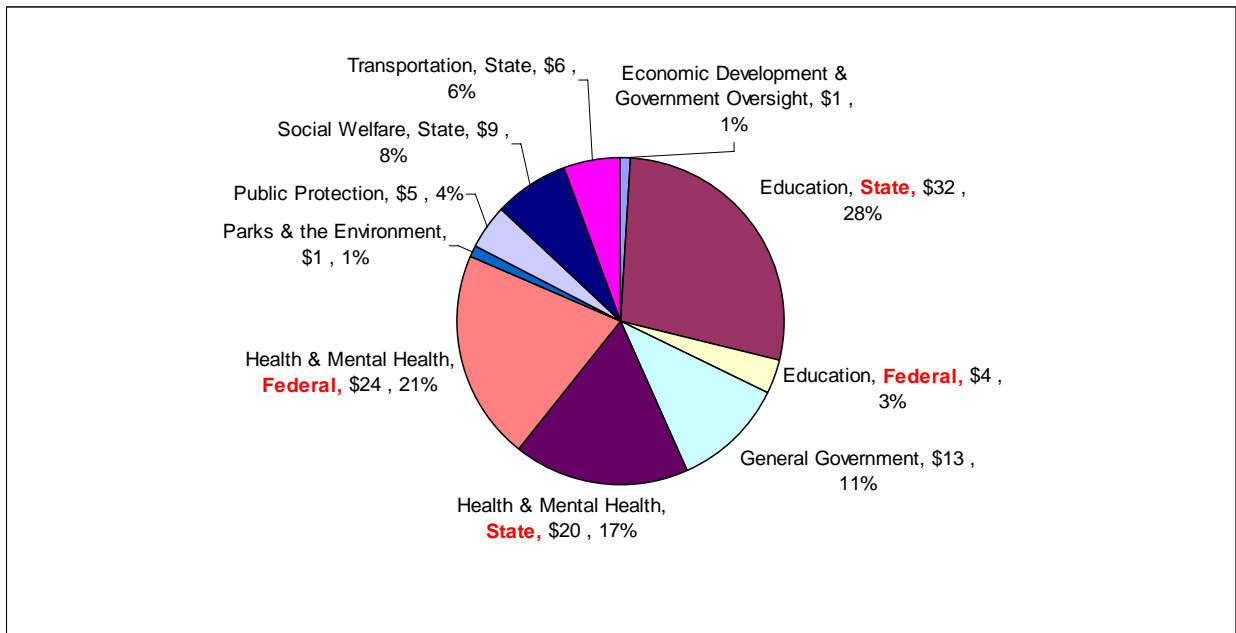


Source: State fiscal year 2007–08 Executive Budget, Economic and Revenue Outlook, page 238.

Medicaid in the Context of State Spending

In addition to believing that health care cuts are unnecessary to balance the SFY 2007–08 budget, we believe that health care spending, in general, and Medicaid spending, in particular, does not deserve to be vilified as a drain on the State budget that supplants spending in other areas and, therefore, should be cut on principle. The truth is that State spending on health care is not the largest component of the budget. State health care spending represents only \$20 billion, or 17%, of the \$114 billion SFY 2006–07 budget (see Figure 8). The largest component of the budget, by far, is State spending on education, which is \$32 billion, or 28%, of the total budget. Health care and education both leverage Federal dollars, but health care leverages far more, bringing in \$24 billion compared with education’s \$4 billion. *We believe that the correct way to characterize the Medicaid program is that it frees up State tax revenue for education and other important purposes by leveraging Federal money.* Furthermore, it is absolutely vital to the well-being of the State’s population.

**Figure 8. Components of the \$114 Billion New York State Budget, SFY 2006–2007
(\$ in Billions)**



As shown in Figure 9, among the 10 most populous states, New York has the second-highest level of economic output as measured by gross domestic product (GDP) per capita, running a very close second to New Jersey. This may be partly attributable to New York’s strategy of leveraging Federal funding through the Medicaid program, since GDP represents the sum of consumption, investment, and government expenditures, plus exports minus imports.

Furthermore, while New York has utilized the Medicaid program more than other states—and leveraged the most Federal money in so doing—its overall personal health expenditures as a percentage of GDP represents the national median, as shown in Figure 10. Therefore, while New York is unusual because its Medicaid program is the largest in the U.S., its overall personal health expenditures—from all sources—as a percentage of the State’s economy is not unusual, but rather represents the national median.

Figure 9. Gross Domestic Product Per Capita of the 10 Largest States in the U.S.

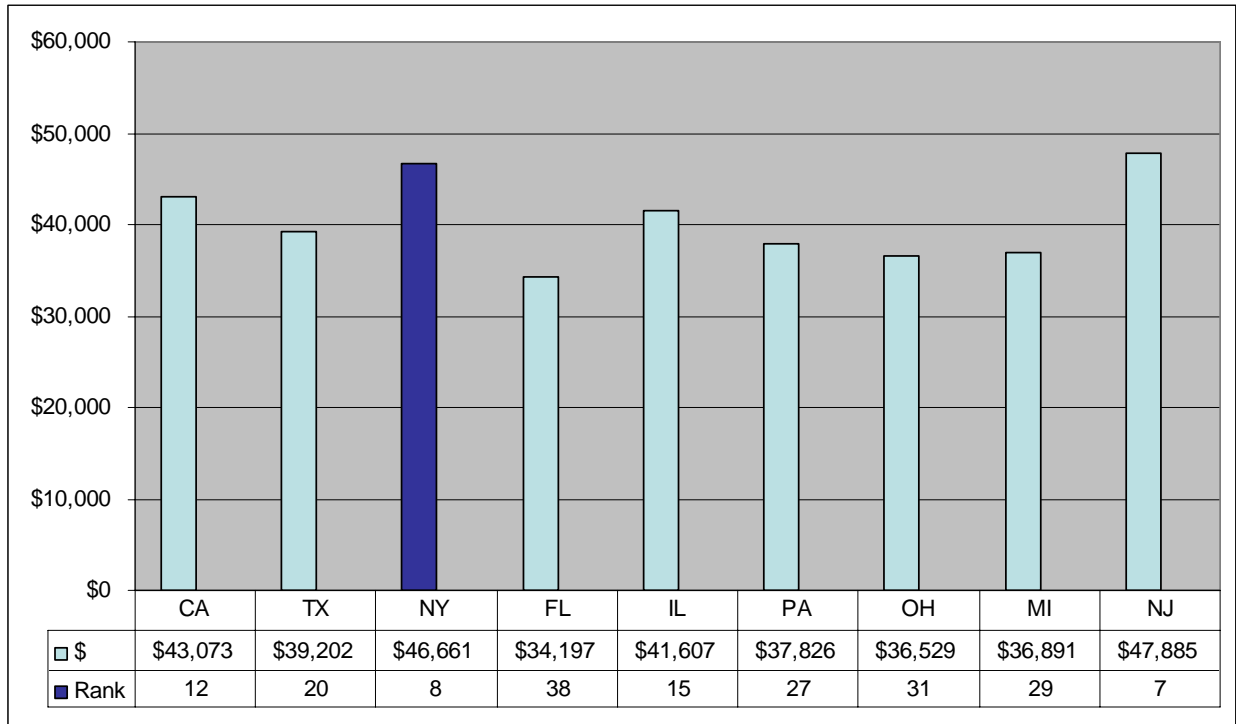
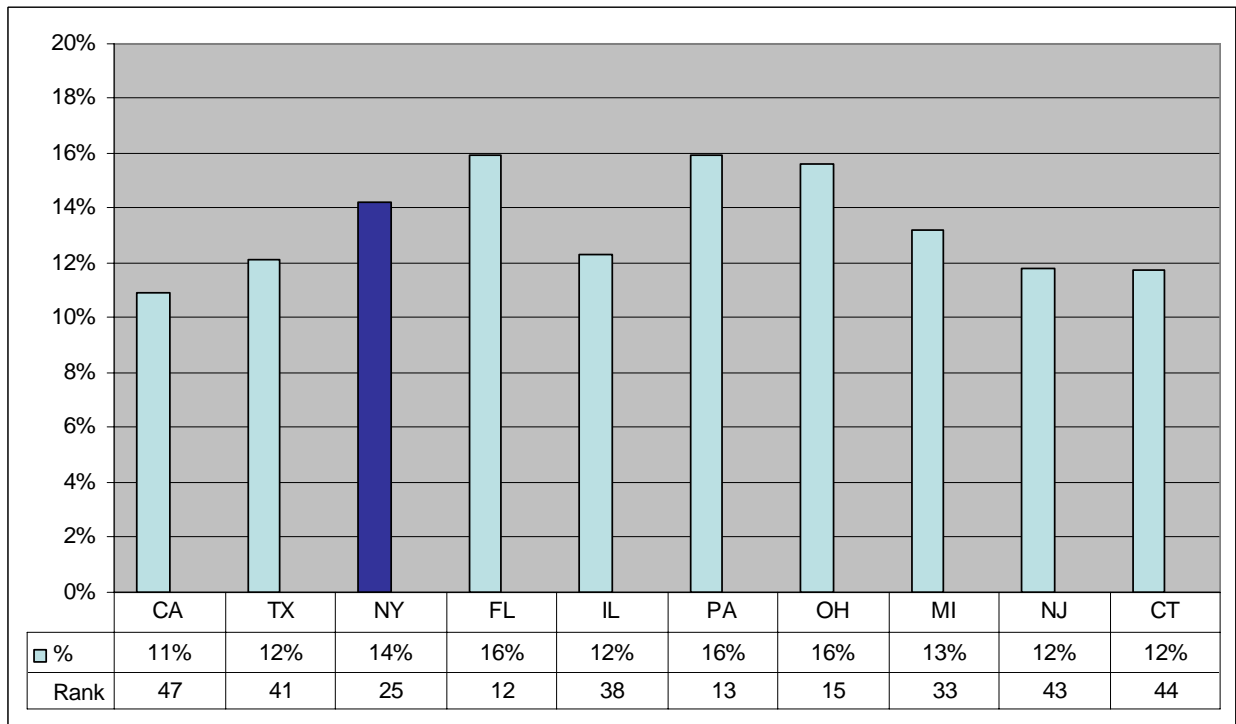


Figure 10. Total Personal Health Expenditures as a Percent of GDP



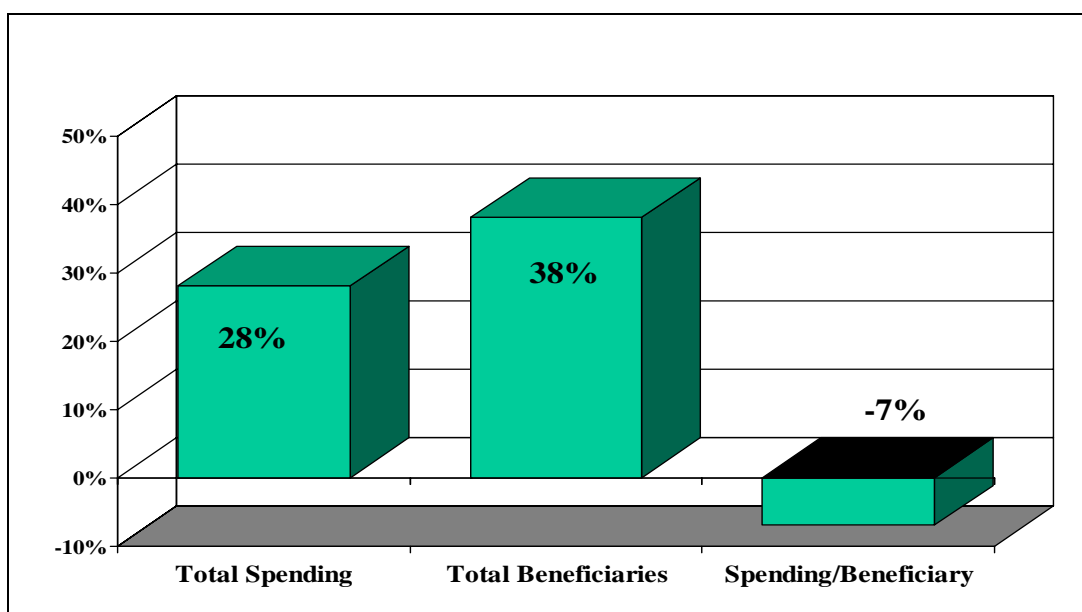
Sources: 2004 data from the U.S. Census Bureau and the U.S. Department of Health & Human Services.

What is really happening in the Medicaid program?

Let me set forth below some basic facts about our Medicaid program so that we can cut through the statements that spending is out of control.

First, growth in total program expenditures over the past several years has been driven by enrollment expansions, principally through Family Health Plus, which now enrolls about 500,000 people, rather than out-of-control payment rates or per-beneficiary utilization. Medicaid enrollment for children has grown 51%. This is how New York State has come to *lead every other state in the nation* in reducing its number of uninsured residents—mainly by adding people to the Medicaid rolls, including those who were dropped from private insurers or who lost health insurance due to a precipitous decline in the number of employers providing health care insurance for their employees². Medicaid spending overall has grown as a result of a deliberate State policy to take care of its uninsured—a decision that Governor Spitzer supports and is looking to expand upon. Thus, while total spending in absolute dollars increased by 43% from 2000-2004 (the last year for which uniform Federal data are available), 38% is attributable to the enrollment increase and only 5% to inflation and per-beneficiary utilization. Moreover, on an inflation-adjusted basis, we see that spending per beneficiary actually declined by 7%. (See Figure 11.)

Figure 11. Growth in Total Expenditures, Beneficiaries, and Spending/Beneficiary, Adjusted for Inflation (2000-2004)



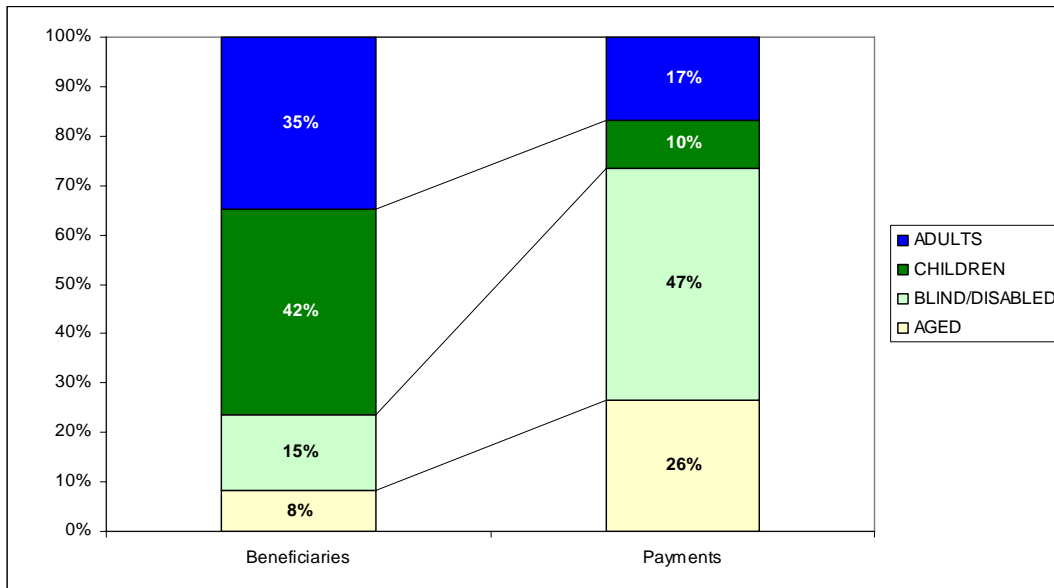
Note: Adjusted for change in Consumer Price Index

Source: Center for Medicare and Medicaid Services: Medicaid Statistical Information System (MSIS) report.

² Fiscal Policy Institute, *Fiscal Policy Notes: New York Makes Real Progress on Health Care Coverage*, September 2006.

Second, 73% of Medicaid spending is for services to 23% of Medicaid enrollees who are blind, disabled, and aged. These are needy populations and include some of the most medically complex and fragile of the State's residents. Weakening the providers who actually serve them through arbitrary payment cuts is counter-productive and does not get at real program needs. (See Figure 12.)

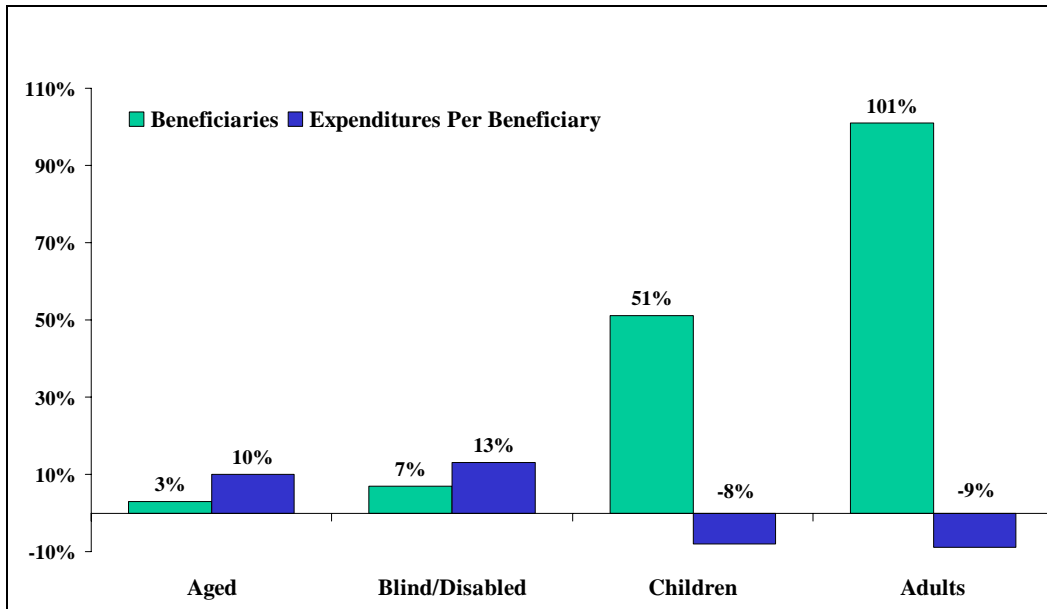
Figure 12. Total Medicaid Expenditures by Eligibility Category, 2004



Source: Center for Medicare and Medicaid Services: Medicaid Statistical Information System (MSIS) report.

The importance of carefully reviewing how best to meet the needs of these populations—what mix of services, what degree of case management, which non-health care resources such as supported housing—is underscored by the spending trend for the aged blind and disabled. Thus, while enrollment for non-aged and non-disabled adults and children grew dramatically, absolute spending per beneficiary was flat and inflation-adjusted spending had declined. This was not true of the aged, blind and disabled, however, where spending, even on an inflation-adjusted basis, significantly outpaced enrollment growth. (See Figure 13.)

Figure 13. Growth in Beneficiaries and Expenditures/ Beneficiary, Adjusted for Inflation 2000 – 2004, by Eligibility Category



Note: Adjusted for change in Consumer Price Index

Source: Center for Medicare and Medicaid Services: Medicaid Statistical Information System (MSIS) report.

In our reform proposals, therefore, we call for real reform that emphasizes utilization and case management for high cost populations, especially the aged, blind and disabled.

PROPOSED HOSPITAL CUTS IN THE EXECUTIVE BUDGET

Table 4, below, summarizes the Executive’s proposed hospital actions. A detailed description and discussion of each proposal follows the summary table. I want note at the outset that in addition to cuts, this year’s Executive budget also proposes to make two major overhauls of the payment system as of January 1, 2008, one for inpatient hospital diagnosis-related group (DRG) payments and the other for uncompensated care, or bad debt and charity care (BDCC), pool funds, and that we do not know what the impacts of these proposals would be. Both would be redistributive, though we are alarmed that the Executive’s proposed budget neutrality language for DRG re-weighting would place a ceiling, but not a floor, on the changes, an approach that could lead to an overall cut in funding to inpatient rates and with which we strongly disagree. While we have supported the concepts behind DRG re-weighting and have discussed this complicated initiative with responsible DOH staff over the past two years, we are very concerned that the Executive (a) calls for full implementation of these changes as of January 1, 2008, without any provisions for a transition and (b) has shared neither its analysis nor the impacts of re-weighting with us or other hospital representatives despite a standing request for this information. As a result, there has not been an opportunity to review the methodology and technical computations of this incredibly complicated two-year endeavor or to understand what the impacts would be.

Re-weighting makes conceptual sense because more recent costs and statistics would be used to determine the relative resource consumption among, and therefore payments for inpatient cases. However, re-weighting can be expected to increase weights (and payments) for some cases and decrease them for others, and the mix of its pluses and minuses will determine whether a hospital is an overall winner or loser. These changes would affect about eight billion of dollars in Medicaid hospital fee-for-service and associated managed care payments. Significantly, it would *also* flow directly into those commercial health insurance case payments, which are contractually tied to the New York DRG system. Thus, in the case of revenues from commercial payers, there will also be swings in payment both up and down, with the ultimate outcome on a hospital dependent on its particular mix of pluses and minuses. Therefore, the actual impact of re-weighting, even assuming it is perfect in concept and execution, must be expected to be massive.

With respect to the BDCC pool, more than \$700 million in payments to non-public, voluntary hospitals would be redistributed based on the principle that the pool should no longer pay for bad debts but on units of uninsured care valued at the Medicaid rate. Yet there is no definition of “uninsured” and there is no data source for making these changes.

I will discuss both of these proposals in more detail at the end of my description of the individual hospital cuts but want to note here that we believe that even the best-intended and conceptually appealing proposals can result in undesired outcomes once they move beyond the stage of principles and into reality, particularly when extremely complicated payment formulas and data sources are used. Thus, we believe it is essential that methodologies and impacts be fully shared with the Legislature and any interested party prior to adoption. Legislators must have the ability to understand the impact of these changes on their communities prior to adoption. The importance of transparency is evidenced by Medicare’s experience when it proposed to change the way it determined DRG weights last year; it published its methodology with underlying data for comment, and outside analysts, including ours, found mistakes and suggested alternative methodologies, some of which Medicare subsequently adopted in its final, three-year transition plan, and which led to the creation of ongoing efforts to continue to refine and improve the methodology. We believe that the Legislature and the health care community must have full and complete information about these complicated payment changes so that methodologies can be validated and outcomes replicated and so that there is an opportunity to make technical improvements.

Table 3 summarizes the fiscal impacts of the Executive’s proposed hospital actions in SFY 2007-2008, which will result in nearly \$475 million in aggregate net losses. Please note that this year’s proposed budget has additional complexity due to individual hospital losses and gains associated with redistributions of worker recruitment and retention funding and new funding for high Medicaid hospitals. The table is followed by a detailed description and discussion of each proposed cut.

**Table 3. Hospital Fiscal Impacts from Proposed Executive Budget Actions
(\$ in Millions)**

Proposed Executive Action	Impact of Proposed Action		
	Net	Losses	Gains
Total Actions	(473)	(498)	296
Reduce GME to Cost	(80)	(80)	-
Trend Factor			
<i>Fee-for-service</i>	(172)	(172)	-
<i>Managed Care Payments</i>	(84)	(84)	-
<i>Workers' Compensation/No-Fault</i>	(15)	(15)	-
Changes to 2002 Worker R&R Payments (R&R I)			
<i>Cut Funding</i>	(37)	(37)	-
<i>Redistribute Funding</i>	-	(70)	70
Changes to 2005 R&R Payments (R&R II)			
<i>Renew Funding</i>	128	-	128
<i>Redistribute Funding</i>	-	(30)	30
Renew 0.35% Gross Receipts Tax (GRT)	(135)	(135)	-
Forgive GRT Collections over the Statutory Cap	(44)	(44)	-
Cut the HCRA GME Pool	(24)	(24)	-
Create High Need Pool for Public Hospitals	48	-	48
Update Distribution Methodology for Voluntary High Need Pool	-	(20)	20
Eliminate Workforce Grants	(18)	(18)	-
Eliminate Health Facility Restructuring Pool	(20)	(20)	-
Eliminate Worker Retraining Funds	(20)	(20)	-
Update DRG Service Intensity Weights	-	?	?
Change Distribution of Hospital Indigent Care Pool	-	?	?

Note: Analysis based on estimates provided by the Healthcare Association of New York State.

Proposal: Reduce GME Payments to Cost
Hospital Loss: \$82 million

This permanent cut to hospital inpatient rates has been dramatically described as eliminating payments for “phantom doctors.” The cut would be felt by teaching as well as non-teaching hospitals around the State, and, believe it or not, the hospital-specific loss would range from less than \$50 to more than **\$10 million** per year. The rhetoric justifying this proposed action is simply a smokescreen for a completely irrational slash in payments that originates in the fact that hospitals have reported their costs differently over two decades in time. Table 4 shows some of the largest losers from this single cut.

Table 4. Losses from Cutting GME in Selected Hospitals' Medicaid Rates

Hospital	Loss (\$ in M)
Brooklyn Hospital Center	\$10.8
Staten Island University Hospital	\$10.0
Beth Israel Medical Center	\$9.4
Interfaith Medical Center	\$7.5
New York Methodist Hospital	\$5.3
Nassau University Medical Center	\$3.5
Wyckoff Heights Medical Center	\$2.0
Calvary Hospital	\$1.0
St. Peter's Hospital, Albany	\$0.4
Highland Hospital	\$0.4
NYC Health and Hospitals Corporation (combined)	\$27.0

These institutions cannot sustain this cut. Brooklyn Hospital, for example, is struggling to emerge from bankruptcy; its chances of doing so would be severely, perhaps unalterably, damaged if this cut were permitted to go through. This result would undermine the finding of the Berger Commission that Brooklyn Hospital is an essential community provider. In fact, the Berger Commission found that all the hospitals taking major hits from this cut are essential providers.

Aside from the unacceptable hardship it would cause, this cut is simply not justified. Hospitals are essentially paid a global rate for taking care of Medicaid patients. By and large, that rate is based upon the costs hospitals reported in their hospital institutional cost reports (ICR) in 1981, updated for inflation and other factors over time. Under this proposal, the Executive would selectively update the cost base from 1981 to 2003 for just the GME component of the rate. For any hospital whose Medicaid GME payments exceed Medicaid-related GME costs, Medicaid payments would be cut. This approach is simplistic and neglects to consider changes in non-GME costs that have occurred since 1981.

The reason the State identifies “GME” in the rate in the first place has to do with the complicated technical mechanics of computing case payment rates.³ The important thing to know is that GME is not an extra payment that is made on top of the regular Medicaid payment. Rather, it is a label used to identify a portion of hospital costs that have already been recognized for the care of Medicaid patients. Say the global rate thus identified is \$5,000 a case. The State deems a portion of the \$5,000 to be for “GME.” In my hypothetical example, say that this exercise produced a GME label for \$800 of the \$5,000 rate. The State would say that \$800 of the

³ In a case payment system, the State goes to the trouble of labeling some of the cost as GME because it combines and averages about half of the hospital-specific payments of peer groups of hospitals to produce a more homogenized case rate for that peer group. Costs labeled as GME are generally not subject to this partial blending, which by definition produces rates that are both a bit higher and a bit lower than the individual hospitals' starting rates. In the above example, if a hospital has \$800 labeled as GME, \$800 is held aside and \$4,200 is blended. Whether the blended rate is higher or lower, \$800 is added back at the end. If \$500 is identified as GME, then \$4500 is subject to the blend and \$500 is added back at the end. The GME label simply determines what portion of total allowable patient care costs are not subject to the blending process.

payment is for GME and \$4,200 is for everything else, not that the payment is \$5,000 plus an additional \$800.

Another quirk in this GME-labeling process is that the statutory definition of GME includes the costs of medical residents, teaching doctors, *and* provider-based, or salaried, doctors. The inclusion of employed doctors gives rise to the claim of “phantom residents” since many non-teaching hospitals employ physicians to take care of patients and have never claimed to be teaching hospitals. However, it is the State that has defined them as teaching hospitals in the first instance due to this artifact of the Medicaid law.

For this proposed cut, the State has identified the “GME” portion of the 2003 *payment rate*, which in turn is based on the cost report lines and schedules the hospital filled out in 1981. To identify 2003 *cost*, the State looked at the same lines in the hospital’s 2001 report and projected those costs to 2003. If the resulting 2003 costs didn’t match the 2003 payments (which were based on 1981 costs), the State says Medicaid is paying for a phantom resident. But the most that can really be said is that there is not a match between how a portion of costs were reported in 1981, trended forward, and how those costs were reported 20 years later. In the case of at least one hospital subject to the cut, that is exactly what happened: the costs that corresponded to the 1981 cost report were simply on a different schedule in 2001.

What the State did not do was to look at the other lines and schedules of the cost report to see if non-GME costs had increased. That is, if GME costs went down by \$500 per case did non-GME costs go up by \$500, or more? We believe a fairer examination would, at most, yield a different placement of the label of what is GME and what are other patient care costs, i.e., if \$500, not \$800 is GME, then \$4500, not \$4200, is other patient care cost. In any case, the total payment would not change, just the label of the component parts of the payment. However, under the Executive’s approach, the total rate would actually be reduced by \$500.

An analogy for the approach taken in this cut would be if I had a job in 1981 and worked 40 hours a week, 15 doing computer data entry and 25 doing other things around the office. In 2001, I have the same job, except now I spend five hours doing computer data entry and 35 hours on other tasks. By focusing exclusively on computer data entry, the Executive budget’s proposal would result in my being paid for 30 hours a week, not the 40 I actually work, because it would say, “You used to work 15 hours on computers and now you work 5, so that means you are working 10 fewer hours a week.” This may seem like a silly example but it is exactly the approach being taken in this proposed cut. We urge you to completely reject this unwarranted cut.

Proposal:	Eliminate the 2007 Medicaid Trend Factor
Hospital Loss:	\$172.4 million associated with fee-for-service patients
	\$83.6 million associated with Medicaid managed care patients
	\$15.3 million associated with Workers’ Compensation/No-Fault

The Executive Budget proposes eliminating the Medicaid “trend factor”, or inflation adjustment, of 2.5% for calendar year 2007 and permanently lowering the base of payments subject to future

inflation updates. This cut is unwarranted and dangerous because it would compound the ill effects of another trend factor cut that was enacted at the beginning of the Pataki administration.

The first cut changed the proxy used to derive the annual inflation increase from an amount recommended by the former New York State panel of economists, which carefully evaluated the mix and price levels of hospital inputs in deriving its recommendations, to the Consumer Price Index for all urban consumers (CPI-U). The change to the CPI-U has yielded annual increases far less than the actual increases faced by hospitals, which has contributed to Medicaid inpatient rates falling short of actual costs. Just last year, for example, the medical care CPI-U was 4.0% and the hospital component of this factor was a staggering 6.4%. However, accounting for the 0.25 percentage point reduction in the trend factor last year, hospitals received only a 3.01% inflation update to their Medicaid rates, or less than half of actual inflation. This difference has compounded over time, such that while nine-year compound growth in the *medical* CPI-U from 1995 through 2004 was 47%, growth in the CPI-U for *all consumers* used for the Medicaid trend factor was only 27.1% (source: U.S. Bureau of Labor Statistics).

The use of an inflation factor that does not cover medical cost growth has contributed to the growing inadequacy of Medicaid payments; we estimate that aggregate inpatient Medicaid costs exceed payments by 7% today. This underpayment does not, of course, reflect the extreme underpayment of outpatient clinic, emergency room, and ambulatory surgery care provided by hospitals where capped and constrained rates that are not even eligible for an inflation update are only 55% of real costs.

Because the current trend factor already fails to cover medical cost inflation, the current proposal to eliminate it altogether would cause tremendous hardship. Pharmaceutical costs alone are projected to increase between 5% and 7% for outpatient drugs, 14% to 16% for clinic-administered drugs such as chemotherapy, and between 4% and 6% for inpatient drugs, all reflecting a mixture of price increases, volume and mix, and new drugs on the market.⁴ Aggressive efforts to negotiate volume discounts from device manufacturers will still result in price increases for medical devices and supplies of much more than 2.5%, in some cases reaching double digits. Workforce costs (due to severe workforce shortages), and medical malpractice insurance costs are also rising much faster than the CPI-U; as noted earlier, based upon GNYHA's survey of medical malpractice costs, there has been a 156% compound increase between 2000 and 2007 in this component of hospital costs.

In the face of chronic underpayment for normal medical inflation, and despite the imperative to receive adequate inpatient payments in order to cross-subsidize outpatient losses, the Executive Budget proposes to deny hospitals even this inadequate inflation update. The Legislature should not only reject the Executive's proposal, it should support replacing the trend factor with an inflation update that truly accounts for the rising costs hospitals are experiencing. At the very least, I urge the Legislature to reject this damaging cut.

⁴ American Journal of Health-System Pharmacists, Vol. 64 (February 1, 2007), p. 312-313.

Proposal: Cut and Redistribute Worker Recruitment and Retention Funding
Hospital Impact: \$37 million cut, \$100 million redistribution

Starting in 2002, the State Legislature and Governor Pataki agreed to augment Medicaid payments for hospitals, nursing homes, freestanding health centers, and personal care and home health agencies to address the crisis of severe labor shortages and difficulties experienced by providers in recruiting and retaining appropriate personnel. For hospitals, the Worker Recruitment and Retention (R&R I) adjustment begun in 2002 provided \$330 million in 2006. Within the \$330 million, \$52 million is earmarked for public hospitals and the balance is for voluntary hospitals. The Executive proposes to cut the total funding amount by \$37 million to save \$18.5 million in State funds. For the remaining funds, the distribution formula would be changed from one based upon a hospital's share of Statewide labor costs to one based upon a hospital's share of Statewide Medicaid discharges. This would result in shift of nearly \$70 million from voluntary to voluntary hospitals and also from public to public hospitals.

In 2005, a second, two-year R&R adjustment (R&R II) was enacted that provided \$121 million in funding to private and public hospitals and \$7 million in supplemental funding to rural hospitals. R&R II expired at the end of 2006, and was distributed the same way as R&R I, except for the rural hospital supplement. The Executive budget proposes to continue the R&R II adjustment in aggregate but to change the distribution formula for the \$121 million, non-rural portion, so that it is also based upon Medicaid discharges rather than labor costs. The \$7 million rural hospital pool would be unchanged. We estimate that \$30 million would be redistributed among hospitals as a result of the formula change.

GNHYHA opposes the reduction in R&R I funding. According to a recent survey of labor needs by the Center for Health Workforce Studies⁵, hospitals statewide continue to experience severe shortages in a number of key positions, particularly for nurses, pharmacists, respiratory therapists, and certain technicians. Positions that were the hardest to retain were experienced registered nurses (RNs), nursing aides, and new RNs. This situation can only be expected to worsen over time; the New York State Department of Labor has projected that there will be a demand for about 7,000 new nurses per year through 2012,⁶ a demand that will be difficult to meet given the flat admissions rates for nursing schools in the State. Seventy three percent of hospital survey respondents reported difficulty hiring workers for the night shift, and two-thirds reported difficulty filling evening shift positions. This is confirmed by GNYHA's own survey of nurse staffing trends among our member hospitals, in which hospital survey respondents reported that they had the greatest difficulty recruiting for nurses for the overnight shift in critical care (66%) and emergency services (64%); on average it took respondents more than three months to fill these positions. With respect to retention, 89% of GNYHA respondents reported that tuition assistance – a program supported by R&R funding – was somewhat or very effective in retaining nurses.⁷ In healthcare, investments in human capital are critically important and a well-trained staff with low turnover is essential to quality and patient safety. Given the continued labor shortage, we urge the Legislature to reject the proposed cut to R&R funding.

⁵ "The Healthcare Workforce in New York State: Trends in the Supply and Demand for Hospital Workers," The Center for Health Workforce Studies (November, 2006).

⁶ *Ibid.* at page 8.

⁷ "Survey of Nurse Staffing in GNYHA Member Hospitals," Greater New York Hospital Association (April, 2006).

Proposal: Re-enact and make permanent the 0.35% tax on gross receipts
Forgive collections over statutory cap
Hospital Loss: \$135 million annually from re-enactment of tax
\$44.3 million from collections over statutory cap

In 2005, the Legislature and Governor imposed a temporary 0.35% assessment on hospital gross receipts for two years in the face of deficits and pressure on State revenues. The gross receipts tax (GRT) is set to expire on March 31, 2007. In addition, understanding that no more than what was absolutely required to be collected should be taken out of the hospital system, collections were capped at \$106 million and any collections over the cap are under current law to be returned to hospitals in proportion to the amounts they paid.

The Executive budget proposes to eliminate the March 31, 2007 sunset date of the current GRT and make the tax permanent, for a projected collection of \$135 million per year. In addition, the Executive would forgive amounts collected above the statutory cap for the current two years of the GRT. The Executive estimates that the State has collected \$44 million above the cap.

Given the harsh financial reality faced by hospitals around the state and the fact that they will contribute approximately \$268 million this year to fund the Hospital Indigent Care Pool under the Health Care Reform Act (HCRA) through a 1% tax on inpatient revenues, extending and making the GRT permanent would be a burdensome cut, particularly when the wealth associated with acute care services resides in private health plans and suppliers and not hospitals. GNYHA urges the Legislature to reject extension of the GRT and also to reject forgiveness of the \$44 million in collections above the statutory cap. As noted above, aside from the cuts proposed in this budget, there is a significant redistribution of one-quarter, or nearly \$100 million, of all R&R funding among hospitals in the state that is not reflected in the overall net loss estimates because redistribution is budget neutral to the State. Hospitals that lose funding under the redistribution would be particularly burdened by the imposition of an extra tax as well as the State's retention of overcollections and I therefore urge you to reject these proposals.

Proposal: Cut HCRA GME Pool by \$24 M to Fund a High Medicaid Public Hospital Pool
Hospital Impact: Redistribution

The Executive proposes to create a new Medicaid high need pool for public hospitals with Medicaid inpatient shares of 35% or more. GNYHA unequivocally supports the creation of this special adjustment to recognize the missions and financial challenges facing public hospitals that provide disproportionately high amounts of care to Medicaid patients. The high Medicaid inpatient share represents a high rate of inpatient care provided to Medicaid clients but also serves as a proxy for high volumes of terribly under-reimbursed Medicaid outpatient clinic, emergency room, ambulatory surgery, and other ambulatory services delivered on the hospital main campus as well as in the community. These payments will also help support eligible institutions to fulfill their associated missions to uninsured and underinsured patients, who tend to be seen in higher proportions by high Medicaid providers.

We therefore urge the Legislature to enact it. The cost to the State is \$24 million to fund the State share of the new Medicaid adjustment.

We do not agree that the source of the new adjustment should be the HCRA GME pool, however. The HCRA GME pool is funded by completely by private payers to address a portion of their share of GME costs at teaching hospitals, including public hospitals. One of the principles articulated in the Executive's health care address a few weeks ago was that private payers had to pay for their own share of costs and we agree. We believe that cutting the only private payer-funded initiative that explicitly supports private payers' share of certain costs is a clear contradiction of this principle and would be a dangerous precedent. We therefore urge the Legislature to use a source other than the HCRA GME pool to fund the State share of this vitally needed public hospital adjustment.

Proposal: Update Distribution of Voluntary Hospital High Need Pool
Hospital Impact: Redistribution

The Executive also proposes to change the distribution formula for an existing \$48 million Medicaid pool for voluntary hospitals with high Medicaid shares. Similar to the public hospital high need pool, this Medicaid adjustment would be paid to hospitals with at least a 35% inpatient Medicaid share. The proposal would result in a \$20 million redistribution of funding among voluntary hospitals receiving the funding today and others.

Proposal: Eliminate HCRA Health Facility Restructuring Pool
Hospital Loss: \$20 million

The Executive proposes to eliminate the HCRA Health Facility Restructuring pool, which has provided \$20 million in annual revolving loan funds for financially stressed hospitals undergoing restructuring and turnaround efforts. Instead, the Commissioner of Health would be provided with a \$3 million emergency fund to address pressing situations. We assume that the elimination of this pool is related to the fact that there are restructuring funds available through the HEAL-NY grant program as well as the Federal-State Health Reform Partnership (F-SHRP) program. More needs to be learned about whether the important projects that had been supported by the restructuring pool will in fact continue to be carried out in an appropriate manner using these other funding sources.

Proposal: Cut HCRA Worker Retraining Funds
System Loss: \$20 M

The Executive proposes to cut funding for worker retraining programs by \$20 million. These funds have supported critical retraining initiatives by hospitals and other providers, initiatives that have helped workers adjust to the fast-changing health care delivery system and the profound restructuring of New York's hospital and nursing home communities. Some of the funding has been used to train workers for positions in professions that are experiencing severe workforce shortages, including nursing and pharmacy. We support continuing to fully fund this program.

PROPOSALS TO CHANGE DRG WEIGHTS AND CHANGE BDCC POOL DISTRIBUTION FORMULA

Proposal: Update DRG Service Intensity Weights (SIWs)
Hospital Impact: Redistribution, possible loss

The case payment system classifies hospital patients into diagnostic-related groups (DRGs) according to the similarity of their clinical conditions and the costs of caring for them. New York's All-Payer DRG system has more than 650 DRGs. DRGs are assigned a cost weight that reflects resource consumption for that DRG relative all other DRGs. A cost-neutral weight is 1.0; since a coronary bypass operation costs almost 9 times more than the average case, the case weight for this complicated bypass surgery is 8.9422, while the lower case weight of .5691 for a normal newborn delivery reflects the lower costs of that service relative to the average. These weights are called service intensity weights, or SIWs. The relative cost basis of SIWs in New York's DRG system was last updated in 1992 and GNYHA has supported efforts to update the data used to set the relative weights to 2004 costs and statistics as a first step in reforming the Medicaid inpatient case payment system. Legislation is required to change the year whose costs and statistics data is used to set the weights from 1992 to 2004.

As noted earlier, we have several concerns with the way in which the Executive is proposing to move forward with re-weighting of the DRGs.

First, the Executive proposes that if the result of re-weighting produces aggregate spending that is higher than aggregate spending on inpatient services today, an adjustment will be made to cut all payment rates so that aggregate spending after the change is no higher than before the change. However, there is no floor on this adjustment so that if aggregate spending is found to decrease, the State would not apply a similar adjustment to maintain true budget neutrality, thus effectuating an across the board cut in rates that already are below hospital costs. This is highly unusual; when the Medicare program changed its weighting scheme this past year, for example, it did so in a way to ensure that Medicare spent the *same* amount because the purpose of adjusting the weights is to achieve greater accuracy in identifying *relative* resource consumption, not to cut rates. We strongly urge the Legislature to reject the approach of placing a ceiling, but not a floor, on aggregate changes. The State should spend at least the same aggregate amount on inpatient services after re-weighting as it does today.

Second, we are extremely disappointed that no one has been granted access to the State's fiscal impact analysis, the new weights, or, importantly, the resulting change in rates. Because of New York's unique rate-setting system, hospital payment rates will actually need to be re-calculated using the new weights. Neither we nor other hospital associations are able to model these changes because the State conducted a proprietary study of costs to supplement publicly available data and due to the intricacies of the rate-setting system.

The new weights and rates would affect over eight billion dollars in Medicaid fee-for-service and associated Medicaid managed care payments. Of tremendous significance as well, however, is that the new weights would also automatically change the payments made by *private* health plans that have contractually tied their case payments to the New York State DRG grouper through

multi-year contracts. In such a case, the private payer might have its own case mix neutral starting rate, e.g., its own payment amount for a DRG weighted at 1.0, but it would rely upon the New York State DRG weights to say how much more or less than the 1.0 it should pay for a particular service. If Medicaid cardiac surgery weights decrease, for example, then a hospital that provides high volumes of cardiac surgery services to commercially insured patients would lose private payer revenue. Conversely, if the weights for pneumonia increase, then hospitals that serve privately insured patients with this ailment would see their payments increase. As with Medicaid, whether a hospital is an overall winner or loser would depend on its particular mix of patients. As for the private payer sector, depending on the mix of services used by the payer's patients, a private health plan could realize unplanned-for windfall profits.

We are on the record providing our conceptual support for the use of the most current costs and statistics for our Medicaid reimbursement system and continue to believe this is appropriate and warranted in order to improve payment accuracy. However, as with most things but especially with payment systems, the devil is in the details. Given the enormity of the potential swings in revenue that would result from DRG re-weighting, both in Medicaid payments *and* in private health plan payments, we emphatically believe that the methodologies, data, and analyses must be entirely shared with interested parties to allow them to: (a) validate and replicate the technical computations and (b) understand the effects on hospitals and, therefore, the communities they serve so that appropriate transition and other fine-tuning can be crafted. These steps should occur before enactment of such a major change.

As noted, the Executive calls for full implementation on January 1, 2008. Even if the new system were perfect, there is no question that there will be swings in Medicaid and private health plan payments for individual hospitals both up and down and that a transition period to the new system would be critically important to mitigate and prevent drastic changes that could not be managed in such a short time period. In addition to refining its methodology after considering public comments, Medicare chose to phase its new system in over three years.

Therefore, we urge the Legislature to call for full transparency and disclosure of the analyses, outcomes, and fiscal impacts of the State's proposal prior to considering the change; to reject the Executive's proposal to set a ceiling but not a floor on aggregate payment changes and to ensure that Medicaid spends no less in the aggregate after re-weighting than it does today; and to make appropriate modifications, including a transition period and other technical improvements, before any changes are agreed to.

Proposal: **Change Distribution of Hospital Indigent Care Pool for Voluntary Hospitals**
Hospital Loss: **Redistributive**

The second major payment system change that the Executive proposes to implement on January 1, 2008 is more vague and lacking in detail than the DRG re-weighting proposal. HCRA funds an \$847 million hospital indigent care, or bad debt and charity care (BDCC) pool (partially funded by the hospitals themselves through a 1% hospital tax). Within the pool, \$139 million is allocated to public hospitals and the balance of \$708 million is for non-public hospitals. Distributions to non-public hospitals are made based upon uncompensated care costs (not the

higher amounts posted as charges) resulting from free care to the uninsured as well as bad debts from uninsured patients who cannot pay their bills, including reduced charge bills, and from underinsured patients who cannot afford their cost-sharing and deductibles. Costs are calculated by the Department of Health from a special schedule on the hospital cost report and subjected to a formula that pays more to hospitals as their uncompensated care costs rise in proportion to their total costs. According to these calculations, hospital uncompensated care costs amount to \$1.7 billion a year, meaning that the pool only covers 50% of uncompensated care cost on average, and even less once hospitals' 1% pool tax contribution of \$268 million is considered.

The Executive would change the distribution formula for non-public, voluntary hospitals by eliminating coverage of bad debts and limiting pool distributions to help cover services to the uninsured. Uninsured units of services would be valued at the applicable Medicaid rate up to available resources in the pool.

We have several difficulties with this proposal. As a threshold matter, we disagree that bad debts should be eliminated from consideration for pool payments. Uninsured patients often fail to pay for a portion of their bill, even at reduced charges pursuant to hospital financial assistance policies, and these are bad debts. Insured patients are increasingly subjected to high deductible health plans and increased cost-sharing, and there often is not a lot separating these patients from those who are uninsured in terms of their ability to afford the cost of their care. Many hospitals make heroic efforts to qualify uninsured patients for Medicaid whenever they can such that the bulk of their uncompensated care is for the underinsured. Finally, we believe it is important to be cautious about the notion of eliminating coverage of bad debts lest this create the unintended consequence of causing hospitals to feel pressured to exercise more vigorous collection efforts. Finally, the State acknowledges that there is no current source of data to make these changes. There is no way of knowing, therefore, whether a new methodology would be sound or what kinds of payment swings the new concept would produce. We strongly believe that legislators have the right to know what impact such swings would have on their communities before allowing the Administration to go forward with this proposal.

I also wish to emphasize that just last year, a landmark piece of legislation was passed setting minimum standards for hospital financial assistance for those unable to pay their bills. I would be happy to brief any of you in more detail as to the complexity, challenges, and unknown effects of this law on hospital uncompensated care but I can tell you that we are concerned that already inadequate pool resources will seem meager in the face of our new statutory obligations. Among these are requirements that financial assistance be provided for emergency services for any New York State resident. In addition, there are requirements to provide statutorily defined financial assistance to eligible patients living in a broad geographic area for any non-emergency service that the hospital provides that can be deemed medically necessary. For any hospital in one of the five boroughs of New York City, the geographic area whose uninsured residents below 300% of the Federal Poverty Level are entitled to discounted care for scheduled, non-emergency inpatient, ambulatory, and hospital services encompasses the entire City, Nassau and Westchester. For hospitals in the rest of the State, responsibility would be owed to residents of the county in which the hospital is located and all contiguous counties. This final guidance was just decided by DOH and we are candidly concerned about the potential impact on uncompensated care need that may result. It has always been our position that New York should

extend insurance to all of its residents and to that end we lobbied for Family Health Plus and have proposed an entire program, Cover New York, to achieve truly universal coverage. It has also always been our position that hospitals must and do extend financial assistance to those in need wherever possible, but there is a limit to what institutions can do if they do not have resources.

Given the lack of detail, data source, or firm idea of what possible methodologies or impacts might result from the Governor's proposal, and especially in light of the new financial assistance law, which only became effective on January 1, 2007, we think it would be unwise to agree to a major distributional change in limited pool funds at this time.

Thank you for the opportunity to present this testimony to you this morning. GNYHA looks forward to working with the Legislature and the Governor to stabilize and improve our health care system, including implementation of real reform.