



**TESTIMONY OF KENNETH E. RASKE, PRESIDENT
GREATER NEW YORK HOSPITAL ASSOCIATION
ON THE EXECUTIVE BUDGET PROPOSAL FOR 2008-09 BEFORE THE
NEW YORK STATE SENATE FINANCE AND ASSEMBLY WAYS AND MEANS
COMMITTEES**

FEBRUARY 6, 2008

Executive Summary

- We are pleased to report that the Executive branch has engaged our organization, our members, partners, and allies in thoughtful, productive, and good-faith reform discussions over the past several months.
- The Executive Budget is one of the most complicated and complex budgets we have ever seen.
- There are proposals and concepts worthy of unqualified support, including the expansion of health insurance for uninsured children, efforts to make it easier for New Yorkers to access insurance programs, targeted initiatives to better manage the care of the chronically ill, and major new investments in ambulatory care services.
- The budget proposal also calls upon all health care sectors to share the responsibility of deficit reduction, including extremely profitable HMOs and pharmaceutical companies, rather than just relying on financially struggling not-for-profit and public hospitals and nursing homes to bear the burden alone.
- Having said that, there are a number of proposals that cause great concern.
- For nursing homes, these include the continued phased elimination of workforce recruitment and retention funds, last year's elimination of quality improvement funding—funding that has improved the lives of nursing home residents across the State—and a looming change in the nursing home reimbursement methodology that will devastate nursing homes in 2009. The Continuing Care Leadership Coalition will testify today with more detail on these proposals and concerns, including extremely troubling cuts to home health care agencies.
- With regard to hospitals, major concerns include:
 - an extremely ambitious change in the way hospitals are reimbursed for Medicaid inpatient services, which will reduce payments for some hospitals, increase payments for others, and generally re-distribute funds in ways we cannot even guess at the present time, much less report to you the impact on your districts and regions;
 - a drastic and precipitous cut in payments for Medicaid inpatient detox services, which will cause great damage and harm to the hospitals that provide these services and, more importantly, to the extremely vulnerable patients they serve;
 - the phased elimination of workforce recruitment and retention funds, which have been critical to enabling hospitals throughout the State to deal with workforce shortages and cost increases;
 - the implementation of a new Medicaid outpatient reimbursement methodology on July 1. While we strongly support outpatient reimbursement reform, which is desperately needed to correct severe underfunding of essential ambulatory care services, the Administration's proposal is not yet fully developed. This means that it cannot be modeled by Assembly and Senate district, and that the requirements for implementation, which will dictate whether or not there will be serious cash flow disruptions, are not yet known;

- deep cuts in graduate medical education (GME) funding by shifting funds from teaching hospitals to other uses. Those uses, though laudable, should not be funded at the expense of teaching hospitals throughout the State that rely on these funds to ensure that HMOs pay a portion of the costs of GME—and that are already threatened with huge cuts from Washington; and
 - a new, untested distribution method for payments to hospitals for the costs of charity care and bad debts, which cannot be modeled so that legislators can know the impact on the hospitals and the patients in the districts they represent.
- Working with you and the Executive, we do not believe these defects in the Executive budget are beyond fixing, through collaboration, more realistic timelines, and replacing cuts with thoughtful and innovative reforms. As you know, we have been at the forefront of reform for many years, and do not shrink from it. We have been working extremely hard, day and night, to analyze, answer questions, and model the impact of proposed reforms on the hospitals in your districts. We do oppose, however, change for change's sake and leading our members blindly into extremely uncertain changes just to meet unrealistic and arbitrary deadlines.
 - Further, legislators should not be asked to approve, and their constituents should not be asked to accept, changes in the name of reform without any sense of the impacts. Before approving any of these changes, legislators have the right to know the precise impact on their districts and constituents. With regard to one change in particular—the proposed new methodology for bad debt and charity care funding—we already know that neither the Executive nor the hospital community will be able to give you any sense of the impact on your constituents before you pass a budget on April 1. This change, therefore, should be rejected.
 - Finally, we certainly recognize that our State and nation are in the midst of troubling economic times. Like the Governor, I believe that economic conditions will improve by the end of the year; however, you have a budget deficit to close, and we are conscious of that.
 - Therefore, we have taken the position that reductions in State revenues to our hospitals, as difficult as they are to bear, are more bearable and will cause less pain if they are accompanied by relief measures that reduce hospital costs.
 - One area that is crying out for financial relief is the high cost of medical malpractice insurance for hospitals and doctors.
 - Our hospitals have experienced a 175% cumulative percentage increase in their medical malpractice coverage costs between 1999 and 2007, with at least one hospital anticipating paying nearly \$100 million for coverage in 2008. Nearly half of these costs are due to obstetrical services.
 - Like hospitals, obstetricians similarly face extraordinary premiums. For example, an obstetrician practicing on Long Island paid \$196,642 per year for medical liability coverage beginning in July 2007. To put this in perspective, the New York State fee-for-service Medicaid program pays an obstetrician only \$1,037 for prenatal care, a vaginal delivery, and postpartum care. At that rate, the

obstetrician would have to deliver nearly 190 babies before he or she would generate enough income to cover just the obstetrician's liability coverage!

- We believe that the Executive, through the Governor's Medical Liability Insurance Task Force, headed by Insurance Superintendent Dinallo and vice-chaired by Health Commissioner Daines, has created an excellent mechanism to bring together the often opposing sides in the contentious debate about medical liability.
- We have worked very hard as a member of the Task Force to find solutions upon which all sides can agree. We look forward to a proposal from the Executive soon, based on the Task Force deliberations, that we hope will provide real, "scoreable" savings for hospitals and doctors and that we would like to see included in the final enacted budget for SFY 2008-09.

Testimony

Chairman Farrell, Chairman Johnson, Chairman Gottfried, Chairman Hannon, and other distinguished members of the Legislature, thank you so much for the opportunity to appear before you today to discuss the Greater New York Hospital Association's views on the Executive Budget proposal for the 2008-09 fiscal year. My name is Kenneth E. Raske and I am President of GNYHA. As you know, GNYHA is privileged to have nearly 300 members, including not-for-profit and public hospitals, nursing homes, and home health agencies throughout New York and surrounding states. GNYHA has had the honor of working closely with the Assembly and Senate through the years on many proposals, budgetary and otherwise, and is grateful for the strong support all of you have continually provided the health care community and, more importantly, the patients and residents we serve.

At the outset, I would like to report to you that we are gratified that the Executive branch has engaged our organization and our partners and allies, including 1199 SEIU and the Healthcare Association of New York State, in productive and good-faith discussions during the past several months. We strongly believe that a partnership between government and stakeholders is the key to the success of State budget and reform initiatives. Harnessing the expertise of our members—who include the best health care providers in the world—and the expertise of the staff at our Association is the best and most efficient way to move toward our shared goals of improving our health care system for the benefit of all New Yorkers.

The Executive budget proposal is one of the most complicated and complex proposals I have ever seen.

On the one hand, there are proposals that are worthy of unqualified support, including the expansion of insurance for New York's children, health insurance eligibility simplifications, and measures to make it easier for New Yorkers to access public insurance programs. The budget also takes steps to better manage the care of Medicaid beneficiaries with chronic illnesses, through a chronic care demonstration project, targeted efforts to control diabetes and asthma, and prenatal care monitoring initiatives for high-risk Medicaid beneficiaries. The Executive also proposes major new investments in Medicaid ambulatory care services, including reimbursement rate increases for hospital outpatient services as well as physician and freestanding clinic services. All of these concepts are to be applauded and strongly supported.

Further, given the economic challenges our State and nation are facing, we appreciate that the Executive has taken a more inclusive approach to deficit reduction this year than we have sometimes seen in previous years. All sectors of the health care system have been asked to share in the responsibility of balancing the budget. In particular, I applaud the Administration for taking a hard look at the enormous profits of the for-profit health insurance and pharmaceutical sectors and for asking them to step up to the plate, rather than asking the financially struggling hospital and continuing care sectors to shoulder the burden alone.

On the other hand, there are proposals in the Executive budget that cause great concern and consternation within the hospital and continuing care communities. Our nursing homes are still reeling from the phase out of worker recruitment and retention funding, which began in last year's budget; from the elimination of critical quality improvement funds, which were used so successfully by our nursing homes to improve the lives of residents throughout the downstate region; and are bracing for a huge cut set to take effect next year when the State implements a new Medicaid methodology for determining the "case mix" of residents in nursing homes, which will cost nursing homes more than \$160 million annually and we believe must be stopped. With regard to home health care, our home health providers are extremely concerned about cuts to home health care funding, including the proposed caps on reimbursement. My colleague, Scott Amrhein, the President of our Continuing Care Leadership Coalition, will testify later in more detail on the nursing home and home health care issues of concern.

With regard to hospitals, our major concerns include:

- an extremely ambitious change in the way hospitals are reimbursed for Medicaid inpatient services beginning July 1, which will reduce payments for some hospitals, increase payments for others, and generally re-distribute funds in ways we cannot even guess at the present time, much less report to you the impact on your districts and regions;
- a drastic and precipitous cut in payments for Medicaid inpatient detox services, which will cause great damage and harm to the hospitals that provide these services and, more importantly, to the extremely vulnerable patients they serve;
- the phased elimination of workforce recruitment and retention funds, which have been critical to enabling hospitals throughout the State to deal with workforce shortages and cost increases;
- the implementation of a new Medicaid outpatient reimbursement methodology on July 1. While we strongly support outpatient reimbursement reform, which is desperately needed to correct severe underfunding of essential ambulatory care services, the Administration's proposal is not yet fully developed. This means that it cannot be modeled by Assembly and Senate district, and that the requirements for implementation, which will dictate whether or not there will be serious cash flow disruptions, are not yet known;
- deep cuts in graduate medical education (GME) funding by shifting funds from teaching hospitals to other uses. Those uses, though laudable, should not be funded at the expense of teaching hospitals throughout the State that rely on these funds to ensure that HMOs pay a portion of the costs of GME—and that are already threatened with huge cuts from Washington; and
- a new, untested distribution method for payments for hospitals for the costs of charity care and bad debts, which cannot be modeled so that legislators can know the impact on the hospitals and the patients in the districts they represent.

Working with you and the Executive, we do not believe these defects in the Executive budget are beyond fixing, but solutions to these problems will require collaboration, more

realistic timelines, and replacing cuts with thoughtful and innovative reforms. As you know, we have been at the forefront of reform for many years, and do not shrink from it. We have been working extremely hard, day and night, to analyze, answer questions, and model the impact of proposed reforms on the hospitals in your districts. We do oppose, however, change for change's sake and leading our members blindly into extremely uncertain changes in order to meet unrealistic and arbitrary deadlines.

Further, you as legislators should not be asked to approve, and your constituents should not be asked to accept, changes in the name of reform without any sense of the impacts. Before passing any of these changes, legislators have the right to know the precise impact on their districts and constituents. With regard to one change in particular—the proposed new methodology for bad debt and charity care funding—we already know that neither the Executive nor the hospital community will be able to give you any sense of the impact on your constituents before you pass a budget on April 1. This change, therefore, should be rejected as part of this budget, while we all work together on a more rational system to be included in a future budget proposal.

With regard to other changes, the phased rebasing of inpatient Medicaid rates, which we support in concept, could begin later than July 1, after much more thoughtful discussion and consensus on approaches is achieved and once legislators can actually know the impact on their districts (and with a more realistic timeframe for Federal approval, which, if the past is prologue, will take much longer than 3 months to secure). The Executive's proposal that workforce recruitment and retention funding should be eliminated as rebasing is phased in is of major concern, particularly given the important costs those funds were designed to cover. Legislators must know what this means to their constituents, including hospitals and the hospital workers who live and work in their districts.

Similarly, if we all work collaboratively and without unrealistic deadlines, consensus can be reached on a new outpatient reimbursement methodology that achieves the goals we all share and minimizes cash flow delays inevitably associated with new reimbursement methodologies.

With regard to inpatient detox services, the inpatient detox system has been a target of reform proposals for years, and we are more than willing to work on reforming that system rationally. Thoughtful reform, which we have been discussing with the Office of Alcoholism and Substance Abuse Services for some time, is far preferable to a drastic cut on April 1 that does not serve anyone's interest, least of all the vulnerable, challenged, and often homeless patients in need of these services.

The cuts in payments for teaching hospitals from the Health Care Reform Act (HCRA) Professional Education Pool (PEP)—cuts that grow substantially deeper in out-years under the Executive Budget proposal—are unwise and should be rejected. The PEP, originally designed to ensure that private HMOs and insurers pay their fair share of the costs of GME, has diminished substantially over time. It represents less than half of the revenues collected from the covered lives assessment, which was originally enacted to

pay primarily for GME. While the programs that would be funded by cutting funding from our teaching hospitals are laudable programs, they can surely be funded through the proposed increase in the covered lives assessment rather than on the backs of already struggling teaching hospitals. Further, these hospitals are facing huge cuts from Washington due to the President's budget and proposed regulations. The State should not be adding to the anti-teaching hospital bias emanating from the Bush Administration by piling on cuts to these vulnerable, but essential, institutions, especially at a time when our State and nation are facing deepening physician shortages.

Finally, we certainly recognize that our State and nation are in the midst of troubling economic times. Like the Governor, I believe that economic conditions will improve by the end of the year; however, you have a budget deficit to close, and we are conscious of that; therefore, we have taken the position that reductions in State revenues to our hospitals, as difficult as they are to bear, are more bearable and will cause less pain if they are accompanied by relief measures that reduce hospital costs.

One area that is crying out for financial relief is the high cost of medical malpractice insurance for hospitals and doctors.

GNYHA members have experienced a 175% cumulative percentage increase in their medical malpractice coverage costs between 1999 and 2007, with at least one hospital anticipating paying nearly \$100 million for coverage in 2008. This increase occurs at a time when the number of medical malpractice claims are actually flattening or going down in number, due in great part, we believe, to the successful efforts of hospitals and physicians to reduce adverse events to the extent possible. What is the reason for this increase in premiums? The reason is an alarming increase in the severity of payouts for the claims that are brought. It is also important to point out that 40-50% of the liability costs today stem from claims brought with respect to obstetrical services, primarily ones that relate to the delivery of neurologically impaired newborns.

Physicians, too, have experienced significant increases in premiums, with last July's 14% increase in physician premiums perhaps being a tipping point. Already there have been discussions about possibly larger increases for 2008, or at the very least, possible surcharges to be imposed on each physician because past premium increases were apparently too low. Like hospitals, obstetricians similarly face extraordinary premiums. For example, an obstetrician practicing on Long Island pays \$196,642 per year for medical liability coverage as of July 2007. To put this in perspective, the New York State fee-for-service Medicaid program pays an obstetrician only \$1,037 for prenatal care, a vaginal delivery, and postpartum care. At that rate, the obstetrician would have to deliver nearly 190 babies before he or she would generate enough income to cover just the obstetrician's liability coverage!

GNYHA believes that the Executive, through the Governor's State's Medical Malpractice Liability Task Force, has developed an excellent vehicle for bringing together the many parties interested in addressing adverse events, these spiraling medical liability costs, and the inefficiencies of the current approach to resolving claims. Chaired

by Insurance Superintendent Eric Dinallo and vice-chaired by Health Commissioner Richard Daines, the Task Force has moved methodically and thoughtfully through a work plan designed to elicit the information needed to understand the problems facing the health care and judicial systems and put forward meaningful solutions and reforms.

As a member of the Task Force, GNYHA has put forward a number of solutions and recommendations, focusing first on the commitment of our members to reduce adverse events to the extent possible. Many such initiatives are ongoing, have demonstrated significant success already, and depend heavily upon the development of a framework known as creating a culture of safety, strong staff communications, and the development of best practices across institutions. Areas of focus include reducing infections, preventing cardiac and respiratory arrests, improving critical care, maximizing medication safety, and enhancing perinatal safety. GNYHA and its members also encourage disclosure, apology, and early offers of compensation, where appropriate, as both the right things to do as well as ways to potentially reduce the costs of medical malpractice liability.

However, these initiatives, implemented in order to deliver the best care possible to our patients, will take time to cause any meaningful reduction in medical malpractice liability costs. Some of the initiatives are “the right thing to do”—but may never result in reduced costs. Therefore, GNYHA has strongly and consistently called for action to significantly reduce the cost of medical malpractice coverage for hospitals and physicians alike *immediately*. In light of the fact that the principal driver of medical malpractice costs for hospitals and doctors is the cost of obstetrical coverage, significant focus has been placed on developing approaches to reducing costs in this area, and, in particular, the costs incurred for neurologically impaired persons. GNYHA is currently working closely with the Executive to identify a solution that will keep these cases in the current judicial system but that will minimize the coverage costs for hospitals and physicians. This approach is supported in great part by the fact that it is often unclear whether a particular injury is the result of the delivery process or some other factor and the fact that, in the end, the system at large often bears the cost of care for such individuals. Therefore, we are examining ways to minimize costs for hospitals and physicians so that they can devote greater resources to reducing adverse events where possible.

We strongly believe we should do all we can to improve the quality of obstetrical care. To that end, GNYHA, together with the United Hospital Fund, has launched a significant perinatal safety collaborative, which builds upon our successful infection control and critical care collaboratives. The purpose of the perinatal collaborative is to improve and standardize patient-centered care in the perinatal setting. Its specific goals are to:

- enhance patient safety and improve the quality in obstetrical and perinatal care by identifying the best practices for the delivery of care that can be implemented across the region;
- reduce the incidence of adverse events and the costs associated with claims in obstetrics and perinatal medicine; and

- evaluate the effectiveness of this initiative by identifying measurable outcomes that can be tracked and trended over time.

This initiative is guided by an advisory panel that includes: obstetricians, neonatologists, nurses, quality and risk management professionals, as well as representatives of the NYS Department of Health, the American College of Obstetricians and Gynecologists (ACOG), The Center for Medical Consumers, Healthcare Association of New York State, Medical Society of the State of New York, and the medical malpractice insurance carriers. We are hopeful that this initiative, which already has 30 participating hospitals, will make great strides in reducing adverse events in the delivery process to the extent possible.

In the end, however, we strongly urge the Legislature to support efforts to address the high costs of medical malpractice in the near term and as part of the budget process so that our State’s hospitals and physicians can devote greater efforts and resources to reducing adverse events in all areas of the practice of medicine. We look forward to a proposal from the Executive soon, based on the Task Force deliberations, that we hope will provide real, “scoreable” savings for hospitals and doctors and that we would like to see included in the final enacted budget for 2008-09.

EXECUTIVE BUDGET PROPOSALS FOR HOSPITALS: MEDICAID

Proposal: Medicaid Inpatient Rebasing
Hospital Loss: \$104 million

By far, the most complicated proposal in the Executive Budget is the proposal to begin “rebasing” Medicaid inpatient reimbursement rates.

Currently, Medicaid inpatient reimbursement rates, both for conditions that are grouped into diagnosis related groups (DRGs) and for those that are exempt from the DRG system (e.g., psychiatric, medical rehabilitation, and addiction rehabilitation services, as well as services provided at cancer hospitals, children’s hospitals, and long-term care hospitals), are largely based on 1981 costs for non-Medicare patients, updated each year by an inflation, or “trend” factor. Individual hospital rates are comprised of a combination, or “blend” of their own 1981 costs and the average 1981 costs of their “peer group,” e.g. academic medical centers, major public hospitals, downstate non-teaching hospitals, etc. Over time, many hospitals have been granted increases to their 1981 costs by filing “rate appeals” to cover legitimate and necessary costs that were not included in their 1981 costs. In addition, other adjustments have been made over the years, including the addition of a worker recruitment and retention “add-on” to the rates to help hospitals fund workforce costs in the face of severe staffing shortages. Some teaching hospitals also saw increases in their Medicaid rates for GME under a transfer of funding from the HCRA GME pool which enabled the State to draw down Federal funding to help close State budget gaps.

Under the Executive Budget proposal, the cost base for the rates would be updated to 2005 Medicaid fee-for-service patient care costs. New rates based on 2005 costs would be phased in over four years, with 25% of the rate based on 2005 costs beginning on July 1, 2008.

The hospital community, in concept, supports updating costs from 1981 to 2005; however, there are significant methodological and policy choices that, if made, could have dramatic impacts on hospital reimbursement and need to be worked out before such a huge change is made and before legislators can have any idea of the impact of rebasing on their constituents.

We have had many meetings with the Executive and staff from the Department of Health (DOH) on the methodological and policy implications of rebasing. We have greatly appreciated these meetings and the professionalism and dedication of the DOH staff. However, from those conversations, and the language in the Executive Budget, we have identified a number of important concerns we believe must be addressed before inpatient rebasing can go forward:

- *Overall Validation of the Data and Methodology:* DOH is using a methodology and data sources that have never been used before to set reimbursement rates. DOH has combined two data sources—hospital cost reports and the SPARCS data base—that contain data that do not match. Thus, without a huge undertaking to “clean up the data,” use of these sources may lead to erroneous conclusions, with huge implications for hospital reimbursement. Time must be taken to work with the hospital community to ensure that the cost data used to set the new rates are correct, and to allow the hospital community to validate the methodology. In addition, hospitals need to be given the opportunity to appeal their rates and the ability to revise their cost report data, if necessary, to ensure appropriate rate setting.
- *Elimination of Workforce Recruitment and Retention Add-ons:* The Executive is proposing eliminating nearly \$300 million in add-ons for workforce recruitment and retention. This is a policy decision that can have a huge impact on the ability of hospitals to recruit and retain health care personnel, particularly at a time of worsening health care worker shortages. We strongly believe that the workforce recruitment and retention add-ons should be retained.
- *GME Funds Shifted from HCRA GME Pool:* The Executive proposal contains no plan to replace funds, after rebasing, that were previously shifted from the HCRA GME pool and converted into Medicaid GME reimbursement for certain hospitals. This \$100 million shift was enacted several years ago for the express purpose of converting State-only funds—HCRA GME dollars—into Federally matchable Medicaid funds, thus allowing the State to reduce the State commitment to GME and achieve deficit reduction goals. Hospitals affected by the shift generally had their HCRA GME pool dollars reduced by the amount that their Medicaid reimbursement was increased. By ignoring this shift when rebasing, the hospitals involved will see a cut in their GME funding. To avoid

this deleterious result, the shifted HCRA pool funds should continue to be paid as an add-on to the rebased Medicaid inpatient rates.

- *Reduction of Indirect Medical Education Factor:* Under the Executive’s rebasing proposal, funding for indirect medical education (IME) would be reduced by changing the factor from a 7.7% increase for every 10% increase in the ratio of interns and residents to beds to a 5.1% increase. Our own empirical research has shown that the IME adjustment should not be reduced, but should actually be increased to 7.9%. While the level of the IME adjustment has no bearing on aggregate rebased payments, it is important that it be correct to ensure accurate fee-for-service payments and sufficient funding on behalf of Medicaid managed care enrollees. Therefore, we urge the Legislature not to approve a change in the IME adjustment unless and until our analysts and DOH can reconcile the differences in their results and reach a consensus on the proper level.
- *Move to 100% Peer Group Average Rates:* The Executive proposes moving from the current 55%-45% blend of peer group costs and a hospital’s own costs when determining hospital rates to a rate based 100% on the average costs of the peer group. Because there are so many methodological and data issues to be resolved before a new rebased system can be modeled for individual hospital impacts, we cannot know the impact of this proposal on individual hospitals. There are, however, significant policy implications to decoupling the rate completely from a hospital’s own costs. Moving to a pure “price” can have a severe negative impact on hospitals with special circumstances that cause their costs to be much higher than the costs of their peer group as a whole. This is why the State created the “blend” in the first place, which creates an incentive for high-cost hospitals to become more efficient while recognizing that there may be legitimate reasons for the higher costs they incur.
- *Burn, HIV, and Epilepsy Services Folded Into DRG System:* Currently, these services are exempt from the inpatient DRG system. Under the Executive’s proposal, these services would be folded into the system. We are unsure of the impact of this proposal, which must be studied and analyzed, particularly given the fact that care for patients with these diagnoses can be extremely complex, costly, and under-reimbursed. In addition, if these services are folded into the DRG system, the State must recalculate the DRG weights, which were calculated without costs for these services included. If the Executive’s proposal to remove inpatient detox services from the DRG system is enacted, the weights must also be re-calculated to take the removal of detox into account.
- *Regional Caps on Exempt Unit Costs:* Services that have been exempt from the DRG system, including medical and addiction rehabilitation, psychiatric, and critical access services would be rebased using 2005 costs, with the same four-year phase in used for other services. The new rates for each hospital or unit, however, would be capped at the lower of the hospital’s own costs or 110% of a regional average (in the case of critical access services, the cap would equal 110% of the Statewide average).¹ This policy is currently in effect for new

¹ The methodology for psychiatric services would be a little different. Under the Executive’s proposal, in the first year the methodology would be as described above. In the second year, the Executive would begin to phase-in DRGs for psychiatric services, similar to the DRGs used under the Medicare program.

facilities or units, but has not been imposed on long-standing facilities. This policy will arbitrarily redistribute funding with no regard to the need for risk adjustment to accommodate patients needing a higher- or lower-than average level of services. We urge the Legislature to continue the policy of reimbursing hospital-specific base-year costs unless appropriate risk adjustment can be built into regional average rates.

Proposal: Reduce Reimbursement for Detoxification Services
Hospital Loss: \$70 million

The Executive Budget would slash funding for inpatient hospital detoxification services by phasing in a much lower per diem rate to replace the current hospital inpatient DRGs.

Essentially, the Executive proposal would carve out inpatient detox reimbursement from the DRG system completely, and create new per diem regional rates based on 2006 costs and statistics that would go into effect on April 1, 2008. The per diem rates would be reduced depending on the patient's length of stay. For days 1-5 of the patient stay, the hospital would be paid 100% of the regional average per diem rate; for days 6-10, the hospital would be paid 50% of the regional average per diem rate; and for days over 10, the hospital would receive no reimbursement.

In addition, under the Executive's proposal, patients would be classified into three service levels: observation, which would include up to two days of care; medically managed care, which would be an acute level of care; and medically supervised care. In the first year, all levels would be paid at the same rate. In year two, all patients would begin in observation status, and then be converted either to medically managed or medically supervised status. Medically supervised days would receive 75% of the applicable regional per diem rate, while medically managed days would receive the full regional per diem rate.

To give you a sense of the impact of this proposal, the current Statewide average payment for detox patients in 2008 is \$1,300 per day. Under the Executive's proposal, the Statewide average per diem rate would be \$900 per day (which would vary by region), with further discounts for medically supervised days and days for patients with longer lengths of stay. Potential hospital losses, then, would range from \$400-\$1,300 per day.

This cut will be devastating for hospitals that provide detox services, and, worse, will be devastating for the patients in need of these services.

The hospital community recognizes that a number of questions and concerns have been raised about the inpatient detox system in New York State. Indeed, GNYHA and other associations have been working collaboratively with the State to identify reforms of the current system to ensure that Medicaid beneficiaries in need of detox receive the appropriate level of care and also to ensure that the system is not abused. Indeed, the levels of care contained in the Executive Budget proposal are similar to levels we have discussed with the Executive for many years. However, meaningful reform efforts must

include an increase in the payment rates for outpatient detox services in order to create needed capacity in this service so that patients may be treated in the most appropriate care setting. We look forward to working with the Governor and the Legislature on proposals that will truly improve the care for New Yorkers suffering from drug and alcohol addiction. In the meantime, however, deep reimbursement rate cuts will not solve any problems, exacerbate the problems already plaguing financially struggling hospitals, and should be rejected by the State Legislature.

Proposal: Cut 25% of the Medicaid Trend Factor
Hospital Loss: \$40 million

The Executive Budget proposes cutting the Medicaid “trend factor,” or inflation adjustment, for calendar year 2008 by 25%. It should be pointed out that this cut will compound the ill effects of earlier trend factor cuts that have been enacted in prior years, including a 25% cut in last year’s budget.

Beginning in 2000, another cut was implemented by changing 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. The use of an inflation factor that does not cover medical cost growth has contributed to the growing inadequacy of Medicaid payments, making even worse 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 covering 50% of actual costs. The Executive proposes increasing outpatient rates, which is an excellent development; however, we have not yet seen a proposal that would reimbursement hospitals “at cost” for both inpatient and outpatient services. Thus, trend factor cuts exacerbate the problem of Medicaid underpayments.

We would note that we are pleased that the Executive has proposed, as part of its inpatient rebasing proposal, to update rates from 2005 costs by the Medicare market basket update, which is a more appropriate inflation factor than the trend factor currently used by New York State. We would strongly support substituting the Medicare market basket or another more appropriate inflation factor in the future for the trend factor currently in use.

Proposal: Eliminate Outpatient Mental Health Day-Night Rates
Hospital Loss: \$4.2 million

According to State officials, there are 10 hospitals in the State with outpatient mental health programs that are dually licensed by the Department of Health and the Office of Mental Health and that receive a so-called day-night rate add-on for certain outpatient mental health day treatment services. Under this proposal, payments to these programs would be reduced to the Medicaid outpatient rate, which is \$67.50 per visit, rather than

paying the higher rate currently in effect. This proposal would cost these hospitals \$4.2 million annually and would jeopardize access to these services, which could result in otherwise avoidable psychiatric admissions.

Proposal: **Restructure Outpatient Reimbursement Rates**
Hospital Gain: **\$120 million**

The Executive Budget proposes restructuring the Medicaid outpatient hospital reimbursement system in a way that would increase payments for such services by \$120 million.

Currently, hospitals lose approximately \$1.4 billion annually providing outpatient services to Medicaid beneficiaries. This is mainly because Medicaid reimbursement for most general clinic services is capped at \$67.50 per visit, plus hospital-specific capital costs. This rate is woefully inadequate to cover hospital costs for clinic care. Some hospitals receive higher rates under the products of ambulatory care, or PACs, program, and some specialty rates exist for HIV, cancer, and prenatal care providers. For ambulatory surgery services, hospitals are reimbursed under the products of ambulatory surgery, or PAS, system, though PAS rates only apply to procedures performed in a fully operational operating room generally used for complicated inpatient surgeries. With regard to emergency services, reimbursements under current law are capped at \$140 plus capital costs; however, because the Federal government has not yet approved the increase, which was approved by the State Legislature in 2006, hospital rates are still reimbursed \$95 per emergency room visit.

The principles behind the Executive Budget proposal for outpatient care are to be applauded and supported. These principles include reforming the per visit reimbursement system so that it is no longer blind to scope and intensity of services provided; improving ambulatory care payments to encourage the migration of services from the inpatient setting to outpatient; and investing in ambulatory care in order to improve care for individuals with chronic illnesses.

Specifically, the Executive proposes using savings from its inpatient Medicaid hospital rebasing proposal to invest a greater amount of funding in outpatient care. The proposal would do this by implementing a new reimbursement system based on ambulatory payment groups, or APGs. Under this system, each visit or “encounter” would be assigned to an APG based on a patient’s diagnosis; APGs would be weighted based on the relative resource consumption needed to treat patients in each diagnostic group. The weight would then be multiplied by new rates determined by the State, based on amounts budgeted. There would be different base operating rates for ambulatory surgery services, clinic services, diagnostic and treatment center services, and emergency services, with rate add-ons for teaching hospitals. New regulatory requirements for continuity of care in teaching hospital clinics would go into effect on April 1, 2009.

The Executive proposes full implementation of the ambulatory surgery and emergency service APGs on July 1, 2008, and January 1, 2009, respectively. For general clinic

services, the Executive budget provides for a four-year phase in, with rates based 25% on the new APG methodology beginning on July 1, 2008. For non-hospital providers, APGs would be phased in over four years for freestanding clinics, and physician APGs would be phased in over two years, with the goal of reaching 75% of the Medicare rate for physicians by the second year.

As mentioned, we are extremely supportive of investments in woefully underfunded ambulatory care services. However, we have questions and concerns about the Executive Budget proposal that we believe must be addressed, including:

- *Tie to Inpatient Rebasing Savings and Federal Approvals:* The Executive ties new investments in outpatient services to expected savings from the inpatient rebasing proposal. The Executive Budget specifically states that the outpatient investments are contingent upon implementation of the inpatient rebasing proposal. We strongly believe that the outpatient investments, to the extent they are funded by inpatient savings, must take place at the same time that the inpatient savings begin, to avoid unwarranted and damaging cuts to hospitals. Further, given the extremely long time it has taken to gain Federal approval for Medicaid changes—it has been nearly two years since DOH submitted its request for approval for nursing home rebasing and increases in emergency department rates, for instance, neither of which has been approved—the Executive Budget timeframes for both inpatient rebasing and ambulatory care reform seem extremely aggressive and unrealistic. Since implementation will not occur before Federal approvals are received in any event, we believe it is imperative that the Legislature not permit payment changes to be implemented retroactively to an arbitrary date. This principle is important for budget and program planning.
- *Shift of Funding from Hospitals to Other Providers:* GNYHA supports increased investment in ambulatory care services such as freestanding clinic and physician services; however, given the chronic underfunding of hospital services overall—which would not be alleviated by this budget, and, actually, given the hospital savings contained in the budget, would be exacerbated by the proposal—it is highly inappropriate to shift funding from hospitals to non-hospital uses. We would strongly advise paying for increased ambulatory investments through the payer assessment increases contained in the Executive Budget so that hospital savings would be re-invested in hospital services.
- *Complexity of Implementing APG System in an Extremely Short Time:* Neither DOH nor the State's hospitals have any experience with APGs. Medicare uses a completely different system for outpatient services, and, as mentioned, Medicaid uses a combination of flat, capped rates, PACs rates, and PAS rates. Major systems changes would be required for both DOH and providers. When Medicare implemented a new outpatient reimbursement system several years ago, it took almost two years to roll out; the Executive Budget envisions implementing APGs on July 1, a mere three months after enactment of the 2008-09 budget. Further, the implementation of the APG methodology in other states gives us pause. We understand that in Massachusetts, hospitals went without any payment for outpatient services for months before the state completely gave up on

implementing APGs due to the complexities of implementation and systems issues. It is extremely important that DOH and the providers are ready for implementation before it begins to protect against an unnecessary negative impact on provider cash flow.

- *Impacts by Hospital Unknown:* The hospital community does not have access to the data to determine the impact of the new APG system by hospital and legislative district. Therefore, the interactive revenue effects of inpatient rebasing and outpatient reform by institution are unknown. In addition, for hospitals that already receive PACs rates, or specialty rates for HIV, cancer, and prenatal care, it is unclear if the new system will entail increases, reductions, or budget-neutral impacts. Hospitals that provide only specialty services, e.g., cancer and children's hospitals, may require special consideration or supplemental payments in the new system in order to protect access to these services for Medicaid beneficiaries.
- *Adequacy of New Reimbursement Rates to Achieve Reforms:* As mentioned, we strongly support the Executive's goal of encouraging greater use of ambulatory care settings. What is unclear to us at this point, however, is how close to covering outpatient costs the proposal will come. This is extremely important in order to understand if the proposal will actually achieve its goals. For instance, while we do not know how close to covering actual costs the reforms will bring outpatient reimbursement rates for hospitals, we understand that the goal is to bring physician reimbursement rates up to 75% of comparable Medicare rates. Due to inadequate Medicare rates, we understand that more and more physicians are refusing to accept Medicare reimbursement. If physicians are refusing to accept Medicare rates, it is highly unlikely that paying them a Medicaid rate equal to 75% of the Medicare rate will have an appreciable impact on the willingness of physicians to accept Medicaid patients. Similarly, if hospitals are still woefully underpaid for outpatient services, even after welcome investments, the ability of those hospitals to meet new requirements for outpatient care contained in the budget must be questioned.

Having pointed out problems and concerns, we would like to reiterate that we look forward to working with the Executive and the Legislature to resolve these problems so that are mutual goals can be met.

EXECUTIVE BUDGET PROPOSALS FOR HOSPITALS: HCRA

Proposal: Shift Funding from HCRA GME Pool to Other Uses
Hospital Loss: \$15.6 million

The HCRA GME, or Professional Education Pool (PEP) is currently funded at \$329.7 million, down from \$494 million when originally created in 1996. Funding from this pool is allocated to teaching hospitals by a formula designed to help them cover the GME costs associated with caring for patients enrolled in private health insurance plans. The pool is funded by the covered lives tax, though the pool now comprises less than half of the amount the State collects through the covered lives tax (\$850 million under current law). In addition to the PEP, teaching hospitals are eligible to apply for funds from the

GME Incentive Pool, which is currently funded at \$31 million, down from \$54 million when the pool was created 12 years ago.

Under the Executive Budget proposal, \$15.6 million in 2008 would be diverted from the formula-driven PEP for teaching hospitals to be used for other purposes, including physician loan repayment, physician practice support in medically under-served areas, training in non-hospital sites, workforce studies, and other uses. The diversion would increase to \$50.6 million in 2009 and \$58.6 million in 2010. While the use of the diverted money is laudable, we strongly oppose diverting funds from teaching hospitals to pay for them. Already, as mentioned, the PEP has declined in value precipitously since 1996. Teaching hospitals are under attack from the Federal government, with literally billions in Medicare and Medicaid cuts aimed directly at teaching hospitals in the President's budget released on Monday. We strongly urge the Legislature to consider funding new workforce programs out of the increases in the covered lives tax contained in the Executive Budget, rather than diverting precious funding from our State's teaching hospitals and perpetuating and adding to the anti-teaching hospital bias emanating from Washington.

The Executive Budget also requires each teaching hospital in the State to jointly prepare and submit with its major affiliated organization (e.g., medical school) an annual report to DOH that specifies the revenues and expenditures associated with GME. Up until the release of the Executive Budget, industry representatives had been working with DOH and the New York State Council on GME (COGME), which advises DOH, to identify what steps might be taken to promote better transparency of GME funding with the goal of addressing the concerns of DOH, residency program directors, and other stakeholders. The teaching hospital community and COGME members expected that those discussions would continue in a collaborative fashion. Unfortunately, this budget provision short-circuits those collaborative discussions by prescribing a DOH-directed process that is far-reaching and presents significant administrative challenges.

We would request that this provision be modified to direct COGME to develop recommendations to DOH on promoting transparency in GME funding by December 1, 2008. In this way, COGME, the teaching hospital community, and their affiliates can continue on their deliberative path to proposing a thoughtful mechanism that will serve the worthwhile goal of transparency.

Proposal: **Phase-In Changes to the Bad Debt and Charity Care Pool
Allocation Methodology**

Hospital Impact: **Unknown Re-distributional Impacts**

What is known as the HCRA bad debt and charity care, or Indigent Care Pool is actually two pools, one for voluntary hospitals, funded at \$708 million annually, and the other for public hospitals, funded at \$139.3 million. The voluntary hospital pool is further divided into four sub-pools, the "main" pool funded at \$579.7 million, the high need pool, funded at \$72 million, the teaching hospital pool, funded at \$27 million, and the rural pool, funded at \$29.3 million. Funding is allocated to public hospitals based on their

distributions from the pool in 1996. Funding for voluntary hospitals from the main pool is based on non-Medicare bad debts and charity care reported on hospital cost reports and scaled so that hospitals that provide a higher percentage of bad debt and charity care relative to their total costs receive higher amounts of their uncompensated care, as defined by the State, covered.

Funding from the other voluntary sub-pools is allocated differently. The high need pool is distributed only to hospitals with bad debt and charity care costs in excess of 6% of total costs. The teaching pool is funded from a straight transfer from the HCRA GME pool, and allocated to hospitals based on their proportionate share of payments from the GME pool. Under the rural hospital pool, each rural hospital receives a flat grant of \$140,000 with additional funding based on bad debt and charity care costs, weighted by the number of beds in each facility.

The pool is funded through a combination of a 1% tax on hospital revenues and assessments on patient care services. The Executive Budget estimates that hospitals will contribute \$288 million of the total amount dedicated to hospital bad debt and charity care, thus self-funding a significant amount of this program.

The Executive Budget proposes phasing in a new distribution methodology beginning January 1, 2009, with full implementation of the new methodology on January 1, 2011. First, for purposes of the new methodology, three of the voluntary hospital pools—the main pool, the teaching hospital pool, and the high need pool, would be combined into one. In 2009, the new methodology, which would account for 25% of hospital payments, would no longer be based on bad debt and charity care costs reported on cost reports, but rather on units of service provided to the uninsured valued at average Medicaid rates offset by patient collections. There would be no recognition of bad debt amounts in the new portion of the pool payments implemented in 2009. In 2010, when payments from the pool would be based 50% on the new methodology and 50% on the current methodology, pool payments would be split, 85% for costs associated with fully uninsured patients and 15% for bad debt amounts from underinsured patients or insured patients who cannot afford copays and deductibles. Also beginning in 2010, only costs associated with patients who qualified for the hospital's financial assistance policy in 2008 would be considered when determining payments from the pool.

The hospital community has identified major concerns with this proposal:

- *Unknown Impacts on Hospitals:* This proposal represents a major change in the distribution methodology for funding from the Indigent Care Pool; yet the data do not exist to model impacts from the new methodology on individual hospitals or legislative districts. We strongly believe that legislators should not be asked to approve a major new distribution methodology for this important program without any way of knowing the impact on their constituents. For this reason alone, we believe this proposal should not be approved this year.
- *The Split Between Uninsured/Underinsured is Arbitrary:* Under the proposal, 85% of funding from the pool would be dedicated to covering costs associated

with fully uninsured individuals, with only 15% dedicated to covering the costs of bad debts from underinsured individuals. There are no data to support this split. The split is completely arbitrary, and may have a huge re-distributional impact on hospitals across the State.

- *Tie to Individuals Who Qualify For Financial Assistance:* As experts on the uninsured are fully aware, many uninsured individuals do not fill out financial assistance forms; therefore, there will be many uninsured and underinsured individuals treated by hospitals who qualify for financial assistance, but for whom there are no data to prove that they qualify. Thus, requiring eligible costs for purposes of pool payments to be associated only with patients a hospital knows qualified for their financial assistance policy will penalize hospitals unfairly and potentially put hospitals and the patients they serve at risk of unjustified funding cuts.
- *Valuing Services at the Medicaid Rate:* Medicaid ambulatory care payments, even with the new investments called for by the Executive Budget, are well below costs; therefore, using Medicaid rates as a proxy for costs is inappropriate and highly inaccurate, significantly understating the true costs of uncompensated care.
- *Combining Main, High Need, and GME Pools:* The high need and GME sub-pools were created for specific policy reasons and to help specific hospitals with unique patient populations. Collapsing these pools into the main voluntary hospital pool will surely have major re-distributional effects on these institutions, which, unfortunately, cannot be modeled at the present time. The elimination of the high need pool will also significantly reduce the progressivity of the distribution formula that is a key element of the current pool methodology.

For all of these reasons, we strongly oppose including changes to the Indigent Care Pool in the final 2008-09 final budget legislation.

Having said this, GNYHA is very willing and eager to work with the State on proposals to enhance transparency and accountability in the bad debt and charity care pools. Definitions and regulations need to be updated to ensure that all hospitals are reporting properly and consistently. Such changes, which would enhance the public's trust in the bad debt and charity care program, are in everyone's interest, and GNYHA is committed to working with the State on such proposals.

Thank you again for allowing me to testify today. I look forward to working with you and the Executive on all of these issues to ensure that the final budget agreement truly improves care, enhances efficiency, and provides relief for hospitals and physicians from the high cost of liability insurance.