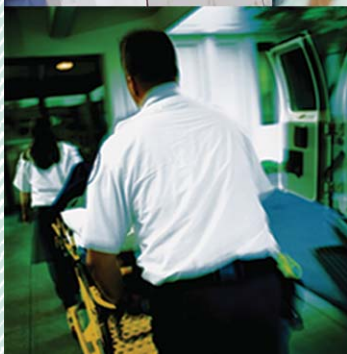


HANYS

# REAL REFORM 2008

RATIONAL, EFFICIENT,  
AFFORDABLE, AND LASTING  
HEALTH CARE REFORM



# HANYS

HANYS' STATE ADVOCACY AGENDA  
JANUARY 2008



Healthcare Association  
of New York State

# TABLE OF CONTENTS

INTRODUCTION AND SUMMARY .....	1
ACCESS AND COVERAGE .....	5
ACCOUNTABILITY OF PAYERS.....	9
Managed Care Market Conduct Reform	
Community Reinvestment	
BEHAVIORAL HEALTH .....	19
BETTER MODELS OF CARE .....	23
Primary Care and Chronic Care Management	
Clinical Integration	
Transitional Care	
Long-Term Care Hospitals	
Observation Units	
CAPITAL FINANCING.....	31
COMMUNITY HEALTH AND BENEFIT .....	35
EMERGENCY PREPAREDNESS.....	37
GRADUATE MEDICAL EDUCATION .....	39
HEALTH CARE REFORM ACT RENEWAL.....	43
Public Goods Pools	
Hospital Payment Formulas	
HEALTH INFORMATION TECHNOLOGY .....	49
HEALTH PLANNING .....	51
INDIGENT CARE POOL .....	53
LONG-TERM CARE .....	57
MEDICAL LIABILITY REFORM.....	61
OUT-MIGRATION OF SERVICES TO NICHE PROVIDERS.....	65
QUALITY INITIATIVES AND INNOVATIONS ACROSS THE CONTINUUM.....	67
Quality Improvement	
Infection Prevention and Treatment	
Pay-for-Performance	
Quality Data Collection and Reporting	
RURAL HEALTH .....	75
WORKFORCE SHORTAGES .....	77
Physicians	
Nurses and Other Allied Health Professionals	
New Workforce Paradigm	



# INTRODUCTION AND SUMMARY

## HANYS' 2008 STATE ADVOCACY AT A GLANCE

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HANYS is working to effect positive health care reform that improves patient care and strengthens providers' ability to provide care in the future.

For additional information about HANYS' 2008 State Advocacy Agenda, contact HANYS' Governmental Affairs at (518) 431-7725.

The Healthcare Association of New York State (HANYS) represents more than 550 non-profit and public hospitals, nursing homes, health systems, home care agencies, hospices, and other health care organizations throughout New York State. New Yorkers depend on HANYS' members to be there in times of need—24 hours a day, seven days a week, 365 days a year.

For more than 200 years, New York's not-for-profit and public health care providers have worked to fulfill their mission to serve those in need of care. Each year, the people employed by HANYS' members care for more than 2.6 million patients in the inpatient hospital setting and nearly 54 million patients who receive care on an outpatient basis, including more than 7.9 million treated in emergency rooms. New York hospitals provide \$1.6 billion in health care to people who cannot pay, the cost of which is only partially subsidized.

Health care providers in New York provide, often for free, services and programs for the benefit of patients, families, and communities. These include health education on diseases such as diabetes, helping people manage a diagnosis of breast cancer, reaching out to special populations in need of care, offering health screenings and immunizations, helping uninsured people find health care coverage, and many others. Hospitals, nursing homes, and home health agencies are connected to the fabric of their communities and collaborate with community groups, service organizations, volunteers, and others.

Health care providers are also economic engines in their regions and communities. Nearly 345,000 women and men work in New York's hospitals and another 120,000 work in freestanding nursing homes across the state.

For many years, HANYS has worked with state officials in both the executive and legislative branches of government on many complicated issues to ensure that sufficient resources are available throughout the state to provide patients with the right care, at the right time, and in the right place. Each year, this important effort is continued because of our commitment to the health and welfare of New Yorkers and to putting patients first.

Health care providers embrace reform. Meaningful health care reform will:

- ✓ expand coverage for the uninsured;
- ✓ give all people access to basic primary care, as well as the marvels of modern medicine;
- ✓ encourage efficient, high-quality care;
- ✓ ensure that every payer contributes their fair share of reasonable costs instead of shifting those costs onto patients and health care providers; and
- ✓ strengthen the health care system so that it can deliver better, more efficient patient care.

Deep payment cuts are not a remedy for the ills of the system and do not constitute health care reform. HANYS urges policymakers to make reform-related investments in the health care system. *REAL Reform 2008* reflects HANYS' top priorities for the year. The substance and volume of issues are extensive and include:

- **Access and Coverage.** Achieve universal coverage for children and cut the total number of uninsured in half by 2010.
- **Accountability of Payers.** Promote payer accountability by ensuring adequate financing of the health care delivery system to support existing quality services, keep pace with the evolution of patient care, and require insurers to pay provider claims responsibly.
- **Behavioral Health.** Address funding for behavioral health services, workforce shortages, and regulatory challenges and hurdles as hospitals strive to provide high-quality patient care.
- **Better Models of Care.** Improve the quality, coordination, and efficiency of care to patients through primary care, chronic care management, clinical integration, transitional care, long-term care hospitals, and observation units.
- **Capital Financing.** Improve access to capital including reauthorization of Industrial Development Agency financing and development of new capital financing opportunities at the Dormitory Authority of the State of New York.
- **Community Health and Benefit.** Support the role of hospitals as providers of care, employers, and as educators.
- **Emergency Preparedness.** Ensure the ability of health care providers to continue to improve readiness and develop a longer term strategy to address the inadequacy of federal funding levels.

- **Graduate Medical Education.** Preserve the investment in teaching hospitals so that the excellence of New York State’s medical education programs can be maintained.
- **Health Care Reform Act (HCRA) Renewal.** Address an escalating variety of critical challenges, including safeguarding public goods pools funding and incorporating the many health care reform initiatives for which HANYS advocates.
- **Health Information Technology (HIT).** Support a significant investment to develop HIT systems that improve the coordination of care and lead to better health outcomes.
- **Health Planning.** Reform the Certificate of Need program to increase administrative efficiency, enable health care providers to adapt quickly to changing technologies, address the migration of services to freestanding settings, and identify and address community needs.
- **Indigent Care Pool.** Continue to work with the State Legislature and the Spitzer Administration on any proposed modifications to the existing need or distribution methodology.
- **Long-Term Care.** Support long-term care reform that is based on principles that develop a consumer-focused, community-centered system of care that promotes timely access to needed quality services supported by sufficient funding.
- **Medical Liability Reform.** Correct the long-engrained dysfunctional nature of the medical liability system by providing sensible compensation more promptly, establishing an informed adjudication system, and promoting candid physician-patient communication.
- **Out-migration of Services to Niche Providers.** Require that freestanding, for-profit surgery and imaging centers meet community obligations to serve the uninsured and under-insured. Level the playing field to ensure that hospitals are not negatively impacted by the proliferation of such surgery and imaging centers.
- **Quality Improvement.** Move to a comprehensive, standardized, and integrated approach to developing quality measures and away from the narrowly focused measures that look only to compliance with administrative requirements.
- **Rural Health.** Help rural hospitals maintain essential health care services and address the unique challenges of providing care in rural communities.
- **Workforce Shortages.** Create innovative initiatives to address workforce shortages, support informal caregivers, and utilize technology to support patient care, education, and training.





# ACCESS AND COVERAGE

There are currently 47 million residents in the United States living without health insurance, representing roughly 15% of the population. Despite widespread agreement across the political spectrum that all Americans should have access to health insurance, diverse opinions on how best to address this problem have left the issue deadlocked for years. Although there is cause to be optimistic because of growing interest in finding a national consensus, it is clear that states, like New York, remain the primary and immediate proving ground for testing options.

New York's health care providers have long recognized the critical need to provide coverage to the uninsured. Health status disparities continue across all socio-economic strata and must be addressed to have a truly equitable and accessible health care system.

Being uninsured can have serious health consequences. Uninsured individuals are often unable to receive the primary and preventive care they need—medications to keep disease in check, mammograms and regular screenings for colon cancer, yearly visits with a primary care physician to maintain good health, and more. The uninsured are also less likely to get appropriate care when they seek it, and they have poorer health as a result. According to the Institute of Medicine of the National Academy of Sciences, approximately 18,000 people die each year from diseases that are treatable and preventable, because they do not have health insurance.

The Spitzer Administration has employed a staged approach to achieving universal coverage for the roughly 2.6 million uninsured New Yorkers: 1) covering the approximately 1.3 million uninsured adults and children who are already eligible for a public coverage program; 2) increasing the number of insured children through a Child Health Plus (CHP) income eligibility expansion; and 3) providing coverage to about 1.3 million uninsured residents who are currently not eligible for public coverage.

Additionally, Assemblymember Richard Gottfried has developed a proposal to extend health insurance coverage to all New Yorkers. The plan, New York Health Plus, would build on existing publicly-sponsored programs by merging and expanding Family Health Plus and Child Health Plus. Income eligibility limits would be removed to allow every New Yorker to enroll. Individuals who choose to enroll would pick their own participating health plan, and individuals or employers could opt out and pay for private coverage if they choose. HANYS believes that this initiative adds impetus to the dialogue on universal health care.

## RECENT ACTIONS

Legislative changes, which HANYS supported, were enacted into law during the 2007 session to begin addressing this issue. These included simplifying the enrollment process to allow Medicaid and Family Health Plus (FHP) beneficiaries to attest to residence and income eligibility at recertification. Another change now guarantees Medicaid and FHP enrollees continuous coverage through 12 months from their latest eligibility determination, if they lose eligibility for a reason other than leaving New York State. HANYS strongly supported these important changes but recommends further process simplification measures coupled with targeted outreach to a majority of the roughly 1.3 million uninsured residents who are already eligible for public coverage.

The Governor and the Legislature increased CHP income eligibility to 400% of the federal poverty level. This change, which HANYS supported, would cover an estimated 70,000 to 90,000 uninsured children. This CHP expansion has been blocked by the Centers for Medicare and Medicaid Services (CMS), and HANYS will continue to work to assist the Governor's office in getting congressional authorization for the state's expansion.

## HANYS' VIEW

Universal coverage has been an ongoing component of HANYS' advocacy efforts for years. There are several fundamentally different approaches to achieving universal coverage.

On one end of the political spectrum is a largely government-run and funded single-payer approach. At the other end of the spectrum is a largely voluntary program, employing tax credits and high-deductible insurance products. High-deductible plans attempt to address the problem of the high cost of insurance, but do so at the expense of exposing segments of the population (e.g., those with chronic conditions) to difficult and expensive choices.

In testimony this year before joint public hearings of the state health and insurance departments, HANYS has stated that there is a full range of possibilities that fall between these two extremes—options characterized by “shared responsibility”—that should be explored. HANYS recommends:

- ✓ pursuing a shared responsibility model for universal coverage including roles for government, employers, payers, and individuals; and
- ✓ assembling a consensus-building panel of representatives across all stakeholder groups—government, providers, employers, payers, and consumers—to fully explore and develop specific coverage strategies around the principles of the model.

New York has important opportunities to learn from the experience in Massachusetts and other states that are beginning to tackle the uninsured problem. Massachusetts' health reform plan included a coverage mandate for individuals that became effective this past July. As preliminary data are compiled, about 200,000 of the 550,000 previously uninsured residents have signed up for coverage (a majority in the new, highly subsidized plans), and more than 200,000 residents missed the deadline and are currently without insurance.

The ultimate success of Massachusetts' reform initiative will be determined over time. While not advocating for direct application of this plan to New York, HANYS does suggest that New York consider Massachusetts' underlying philosophy of consensus-building that guided the plan's creation.

Most important, there must be an understanding and acknowledgment of the overall cost of covering 2.6 million uninsured. Insuring all of these previously uninsured residents is not free or self-financing, and the state should not be surprised by the increased costs associated with achieving near-universal coverage. The United Hospital Fund projected the overall cost at \$4.1 billion—a reasonable estimate of the commitment required.





# ACCOUNTABILITY OF PAYERS

As public debate grows regarding how to achieve universal coverage, it is imperative that we fix the problems plaguing our current health care financing system. These problems include managed care organization (MCO) payment, steering, and utilization management practices that threaten the ability of consumers to access care and providers to render it.

Payer accountability involves ensuring adequate financing of the health care delivery system to support existing quality services and to keep pace with the evolution of patient care, and requiring insurers to pay provider claims responsibly. HANYS was pleased and encouraged by the beachhead established in the 2007 managed care reform package, Chapter 451 of the Laws of 2007. Most notable was the achievement of a requirement that an MCO pay for the medical care it approves, or pre-authorizes. However, much more needs to be done. HANYS continues to strongly advocate for payer accountability and managed care reform.

These reform proposals are intended to improve the current system and prohibit inappropriate health insurance practices or payment methods. Strengthening and improving existing laws regulating the health insurance industry will restore balance between providers and payers, ensure that providers are paid for the medical services they render and, most important, ensure all New Yorkers benefit from enhanced access to quality health care. The following proposals are among HANYS' highest advocacy priorities for 2008 and reflect substantial effort in this area by the allied associations, in particular Northern Metropolitan Hospital Association and Nassau-Suffolk Hospital Council.

## MANAGED CARE MARKET CONDUCT REFORM

### Consumers' Health Care Benefits

- **Out-of-Network Coverage Practices:** HANYS has uncovered a number of health insurance practices that appear on the surface to have a legitimate rationale, but when more closely scrutinized, are revealed to serve no purpose except to discourage providers from exercising the right to contract or to prevent consumers from using a broader or more expensive benefit that the plans must offer. As shown by the public discussion of Oxford Health Plans' out-of-network coverage practices, some health plans treat hospitalizations at a facility with which a plan has a contract as out-of-network, merely because the treating doctor is an out-of-network physician. This practice, especially when obliquely disclosed, results in patients abruptly discovering they are responsible for an unexpected and costly portion of the hospital bill that they believed was covered at an in-network hospital. This results in an unearned benefit to the plan because the plan only pays a percentage of a discounted in-network rate it negotiated in its contract with the hospital and then requires the member to pay the remainder of the amount owed. The practice results in an undeserved windfall for the plan by punishing the consumer and the provider for using the very hospital where the plan has a contracted and discounted relationship.

#### HANYS' VIEW

HANYS supports legislation that has been introduced by Senator Kemp Hannon (R-Westbury) and Assemblymember Richard Gottfried (D-Manhattan) (S.5119/A.8322) to prohibit payers from changing in-network hospital coverage to out-of-network based on the treating physician status.

- **Assignment of Payments:** A new managed care practice is emerging in which health insurers prohibit consumers from authorizing direct reimbursement from their insurer to their out-of-network provider. The reason, the plans say, is the need to educate consumers about the true cost of their health care. The clear and objectionable result, however, will be an enormous and entirely predictable collection and administrative burden for providers who are already feeling the strain of limited resources. Moreover, this policy pressures providers into staying in a plan's network regardless of the inadequacy of compensation.

### HANYS' VIEW

Legislation has been introduced by Senator Hannon and Assemblymember Gottfried, which HANYS supports, to allow patients to assign payment to an out-of-network provider (S.5231/A.8335).

## ADMINISTRATIVE DENIALS

A plan should not be able to deny claims for medically necessary, covered services based on a provider's technical error or failure to overcome an administrative hurdle, in the absence of demonstrable detriment to the plan's ability to manage the care provided to an insured. MCOs should not be able to circumvent their responsibility to pay claims by instituting rules and procedures that cause providers more administrative burden and to expend more resources to get paid for medically necessary, covered services they have delivered. This is particularly true when there is no actual prejudice to the payer. Only in health care does the failure to observe an obscure technical rule result in the complete denial of payment for services rendered without an opportunity to correct the defect or comply with the rule.

### HANYS' VIEW

HANYS supports legislation introduced by Senator Charles Fuschillo (R-Freeport) and Assemblymember Adam Bradley (D-White Plains) (S.5540/A.8114) that would prohibit MCOs from denying payment for claims for administrative reasons. Development of new administrative reasons for denials that are not relevant to a plan's actual case management of specific episodes of care must also be discouraged.

## PROVIDERS' RIGHTS UNDER EXTERNAL APPEAL LAW

In 2007, HANYS supported the enactment of an expansion in the External Appeal program, allowing appeal of denials for out-of-network care. This is consistent with the principle that providers are in the strongest position to advocate for necessary medical care on behalf of their patients. However, providers have frequently been unable to appeal adverse determinations regarding medical necessity because of perceived and actual obstacles to the External Appeal program. Providers continue to perceive that State Insurance Department (SID), in the last several years, has routinely refused to honor designations, seeking confirmations and reaffirmations of a designation, which was not contemplated by the statute (and thereby discouraged), or deeming retrospective determinations to be concurrent, and therefore barring some cases from external review under the statute. However, HANYS is optimistic that SID's senior staff are now interested and willing to revisit SID's internal practices and are interested in looking at the processes employed by health plans in relation to external appeals.

### HANYS' VIEW

The shortcomings of the External Appeal Law must be corrected so that its use can be maximized. Providers must have a clear right to appeal adverse determinations, particularly since providers are currently prohibited from balance billing patients for covered but denied services. To that end, HANYS is working directly with SID to improve the appeal process so that it is expeditious and streamlined, allowing providers and consumers access to this important appeal right. HANYS also supports legislative changes as delineated in S.5459/A.8231, which has been introduced by Senator Hannon and Assemblymember Gottfried.

## REFUND DEMAND LIMITATIONS

Currently there are no statutory limits, requirements, or prohibitions on the timing or scope of refund demands, or “take-backs,” issued by health plans to hospitals. Health plans should have no more than two years from the payment of a claim to demand a refund. In addition, health plans should limit the circumstances under which take-backs can occur to billing/coding errors or fraud. Under no circumstances should plans be permitted to take a “second bite” at the utilization review “apple” in the absence of an additional appeal right for providers.

### HANYS' VIEW

Limitations should be placed on the timeframe and circumstances under which insurers can seek a refund of claims paid or an adjustment of subsequent payments. Omnibus prompt-payment legislation introduced by Senator Fuschillo and Assemblymember Bradley includes this provision (S.5540/A.8114).

## PROMPT-PAYMENT LAW

Under New York’s current Prompt-Payment Law, insurers are required to adhere to certain deadlines and make timely payment of claims. In the interest of supporting and encouraging provider investment in technology, plans should be compelled, as they are in other states, to pay electronic claims within a shortened timeframe. Moreover, plans that repeatedly violate prompt-payment laws should receive penalties that are effective in deterring recidivism.

### HANYS' VIEW

The time within which an electronic claim must be paid should be reduced from 45 days to 15 days, and penalties for prompt-payment violations need to be increased to deter plans from repeatedly violating the law. Legislation has been introduced by Senator Fuschillo and Assemblymember Bradley to accomplish this objective (S.5540/A.8114).

## COORDINATION OF BENEFITS

HANYS helped draft and continues to support a SID regulation that would address coordination of benefits issues. While not yet promulgated, the regulation outlines a process to resolve the disagreement over which payer is primarily responsible to pay a claim, without detriment to the provider. However, additional coordination of benefits issues need similar resolution. While the pending regulation requires MCOs to honor each other's pre-authorization requirements, it does not make a similar requirement for medical necessity determinations. This disagreement over medical necessity can leave providers unable to receive payment for a medical service already rendered. In addition, some MCOs send post-treatment questionnaires to enrollees to determine whether other insurance exists to cover a claim for medical services that have been provided. While on its face this would appear to be a prudent business practice, it becomes less so when the MCO had an opportunity prior to the medical service to pre-authorize or check an enrollee's coverage and eligibility. When the patient inevitably fails to return the questionnaire, the claim is denied or payment is indefinitely delayed. The provider, who has already delivered the medical care and is not in a position to get this information from the patient who has left the hospital, is then left without payment, or must expend limited resources to chase it down.

### HANYS' VIEW

he regulation should be promulgated as currently negotiated between members of the SID Health Care Roundtable. Additionally, payers should be required to coordinate benefits among other payers without taking back paid claims or denying claims based upon plans' refusal to accept the medical necessity determination of another plan. Finally, plans should be prohibited from using coordination of benefits questionnaires as a subterfuge to delay and deny care for which they are fully responsible.

## UTILIZATION REVIEW LAW

Currently, New York law establishes timeframes within which utilization review agents must make adverse determinations. However, the law should be enhanced to protect consumers and providers.

### HANYS' VIEW

The failure to make a utilization review decision within the stated time should be deemed an approved claim and not an adverse determination. This provision is included in S.5459/A.8231, introduced by Senator Hannon and Assemblymember Gottfried.

## **ADMINISTRATIVE BURDEN FOR EMERGENCY DEPARTMENT (ED) VISITS**

To avoid the burden and cost associated with supplying medical records for all ED visits, commercial health plans should be required to consider certain common sense factors in applying the prudent layperson standard when determining whether the medical care provided was for emergency medical services.

### **HANYS' VIEW**

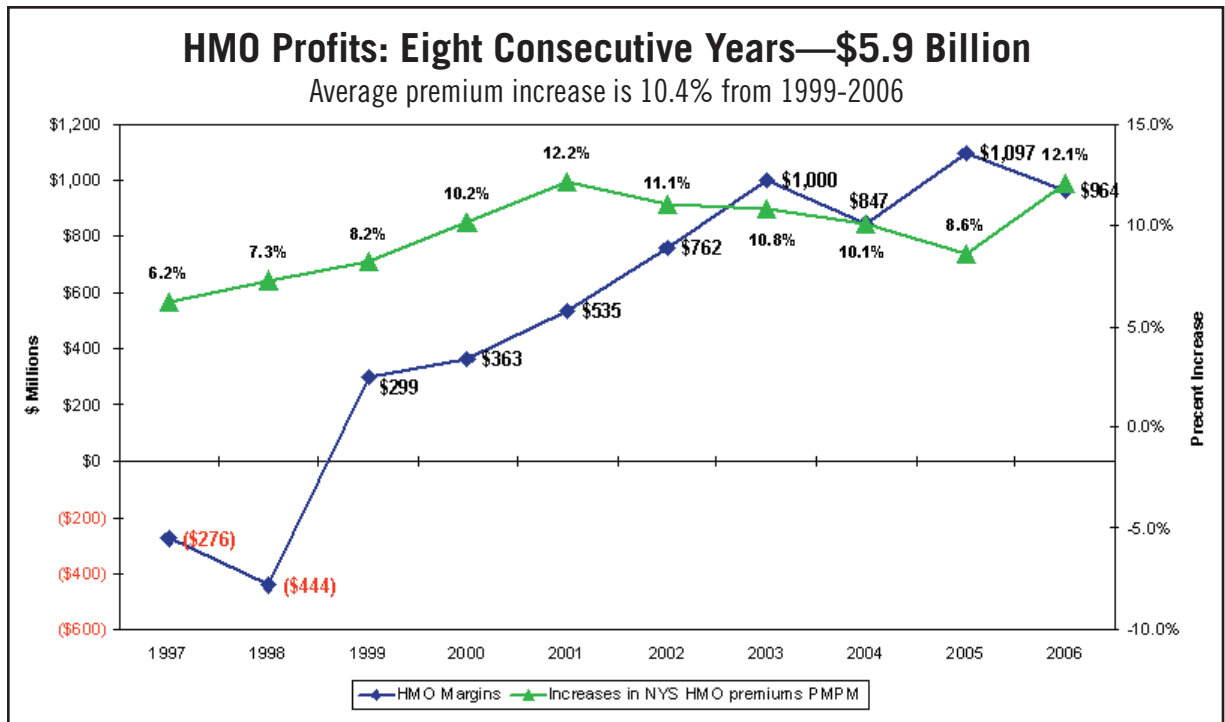
When reviewing a claim for coverage of emergency services to treat an emergency medical condition, a utilization review agent should be required to consider the time of day and the day of the week the patient presented to the ED, and the presenting symptoms. This provision is also included in S.5459/A.8231, introduced by Senator Hannon and Assemblymember Gottfried.

## **FAIR CONTRACTING**

As insurers in New York merge, providers have less bargaining power and little recourse to dispute unfair contract provisions. Some health plan contracts include provisions that allow the insurer to make changes to its policies, manuals, and contracts with little or no notice and no ability for the provider to opt out. These changes can have a significant impact on financial arrangements, quality improvement efforts, and utilization management procedures.

### **HANYS' VIEW**

HANYS supports efforts to restore bargaining power between contracting health care providers and MCOs and recommends a requirement of notice and mutual agreement to material changes to an insurer's policies and contracts.



## COMMUNITY REINVESTMENT

The ongoing need to provide better health care to all New Yorkers is a shared responsibility among providers, businesses, health insurers, and MCOs. However, many health insurers and MCOs incur substantial profits and have excess reserves, while health care providers in general struggle financially. There needs to be a balance. At the same time, additional funding is needed to improve the provision of health services in communities, including improvements in quality, workforce, infrastructure, and efficiency. Requiring payers to reinvest in health care will benefit communities across the state. Currently, government and providers are playing their part in the financing of health care operations and infrastructure improvements.

### HANYS' VIEW

HANYS helped develop legislation that has been introduced in both the Assembly and Senate that would create a community reinvestment fund. Introduced by Assemblymember Bradley and Senator Hannon, A.8704/S.6056 would help ensure that health care reinvestment becomes an equitably shared responsibility across all major payers.

## HANYS' VIEW

(CONTINUED)

Specifically, this legislation would enhance statutorily imposed medical loss ratios—a measure of the percent of a premium dollar spent on actual patient care services versus administrative costs or profits. Payers that fail to meet the new higher ratio would pay the difference between the current ratio and the new threshold into a community reinvestment fund. The funds collected from these payments would be used to improve health care in communities across the state. Regional committees would decide how these health care dollars are spent to meet the priorities and needs of local communities.

HANYS strongly supports enactment of A.8704/S.6056. This community reinvestment fund would provide the necessary mechanism to guarantee third-party payer accountability and ensure that communities continue to have access to the highest quality care.





# BEHAVIORAL HEALTH

General hospitals provide most behavioral health services in many communities today. In addition to inpatient care, hospitals operate one-fifth of the licensed mental health outpatient clinics in New York. They are major providers of emergency room crisis services. Many provide continuing day treatment, case management, crisis intervention services, family support services, specialized housing, and peer advocacy.

## BACKGROUND

More than 50 million adults—22% of the U.S. adult population—suffer from mental illness or substance abuse disorders every year. In New York State, this number is estimated to be approximately 3.5 million adults and 500,000 children and adolescents. However, mental illness is usually untreated; only one in five receives care and less than 50% of those with serious conditions. Numerous studies have shown that serious mental health and substance abuse disorders are treatable and that cost-effective, appropriate treatment saves lives and significantly improves the overall health of millions of Americans.

Caring for these individuals throughout the state has shifted dramatically over the years. At its peak in 1955, New York had more than 90,000 people housed in state-operated psychiatric hospitals. Over five years starting in 1968, New York State went from 80,000 beds in state psychiatric hospitals to 40,000. Currently, the number of state-operated psychiatric beds is approximately 3,400. This deinstitutionalization led to the growth of mental health services in Article 28 hospitals. As of 2007, general hospitals had more than 7,800 inpatient psychiatric beds (including substance abuse), which are integral to the behavioral health continuum of care.

Deinstitutionalization also led to the need to build a more effective community-based system of care. Housing, rehabilitation, case management, and other community supports were put in place to help people with psychiatric disabilities live more successfully in the community. Outpatient services were expanded in community mental health agencies, state psychiatric centers, and general hospitals.

## HANYS' VIEW

In addition to facing an ever-increasing behavioral health patient population, hospitals are faced with woefully inadequate funding for these services, workforce shortages, and regulatory challenges and hurdles as they strive to provide high-quality patient care.

- Both the Office of Mental Health (OMH) and the Office of Alcoholism and Substance Abuse Services (OASAS) have recognized these challenges, and HANYS is actively participating on the many reform workgroups that the agencies have established, including:
  - ✓ **OMH Clinic Restructuring Advisory Workgroup:** This group is beginning a process to reform how mental health clinics are reimbursed. HANYS continues to advocate for a fair and reasonable rate-setting structure.
  - ✓ **OMH Inpatient Survey Advisory Group:** This group is looking at ways to decrease burdens associated with the OMH survey process while ensuring patient safety and quality care. HANYS advocates for streamlining and decreasing duplication in the survey process and improving coordination with the Department of Health (DOH), The Joint Commission, and other agencies with oversight of inpatient mental health programs.
  - ✓ **OASAS and DOH Joint Task Force on the Continuum of Care for Alcoholism and Substance Abuse Services:** This Task Force is charged with making recommendations to redesign the substance abuse treatment delivery system to improve quality of care and patient outcomes and to improve utilization of Medicaid resources. HANYS and Greater New York Hospital Association (GNYHA) developed a draft reform paper that includes jointly-submitted recommendations.
  - ✓ **OASAS Administrative/Regulatory Relief Workgroup:** This group is charged with reviewing administrative and regulatory burdens that can be minimized to direct more resources toward quality patient care.
  - ✓ **OASAS Technology Workgroup:** This workgroup is charged with working on technology that will ensure the most effective and efficient systems of care.
  - ✓ **OASAS Steering Committee on Workforce Development:** This committee is charged with developing and implementing policies that will promote workforce recruitment, retention, and professional development in the area of addiction.

## HANYS' VIEW

(CONTINUED)

- ✓ OASAS and OMH Task Force on Co-occurring Disorders: This group has made recommendations for a more streamlined system of care for people suffering from co-occurring disorders. A proposal was submitted and approved by the OMH and OASAS commissioners that focuses on clinical, fiscal, regulatory, and systemic supports needed to sustain a modified system.
- Despite the growth in services provided by general hospitals and community programs, there continues to be a need for more community services. There are not enough residential, transitional, or outpatient services to care for individuals once they leave a general hospital. Investing in additional community programs would reduce costs as well as provide an opportunity for individuals to return to their communities.
- Article 28 hospital admissions should not be the “fall-back” option for people who need mental health care or substance abuse care. A general hospital emergency room is too often the level of care that is utilized due to its “24/7/365” schedule. Additional crisis services need to be developed around the state to better care for these individuals and limit access to general hospital emergency departments to true emergencies.
- Investments that restructure, refocus, and coordinate care are essential. A focus toward coordinated chronic care management and developing the appropriate incentive programs to ensure coordination of care across settings and providers is needed.

Behavioral health system reform is necessary to ensure the continued viability of those services. An infusion of new funding, regulatory reform, and a focus on recruitment and retention initiatives will strengthen the current system. HANYS supports these efforts and will continue to work toward a better, more viable system that provides high-quality patient care.





# BETTER MODELS OF CARE

HANYS believes that better models of care must preserve and strengthen the ability of vulnerable populations to access health care, focus on patient and community needs, enable flexibility to adapt to changing needs, create and align payment incentives, and move toward outcome-oriented measurements of health care delivery.

The recommendations and initiatives below highlight HANYS' view in the areas of primary care, chronic care management, clinical integration, transitional care, long-term care hospitals, and observation units.

## PRIMARY CARE AND CHRONIC CARE MANAGEMENT

Research shows that providing patients with a primary care “medical home” can reduce preventable hospitalizations, lower the rate of complications from chronic conditions, and help eliminate health disparities faced by ethnic and racial minorities and low-income patients. Yet, according to one study, nearly 75% of Americans report they lack at least one basic element of a medical home—a regular doctor or source of care; ability to contact their provider by telephone; ability to get care or medical advice on weekends/evenings; and well-organized, on-time doctors' visits.

Lack of access to primary care and poor management of chronic conditions forces many patients to rely on hospital emergency departments for episodic care, competing for time and attention in an overtaxed system. Patients without access to primary and preventive care may delay treatment until their condition worsens, forcing preventable hospitalizations. The situation is particularly dire for chronically ill patients, including patients needing behavioral health services, whose condition can rapidly deteriorate without proper coordination. A recent report by The Commonwealth Fund, which ranked New York 39th in the nation in avoidable hospital use related to several chronic conditions, highlights the need to ensure that patients have ready access to care in the most appropriate setting.

## HANYS' VIEW

Outdated payment formulas, workforce shortages, rising malpractice premiums, and other challenges have created a scenario where access to primary care, especially for Medicaid or uninsured patients, is often ensured only by the intervention of safety net institutions. These providers—hospital outpatient departments, extension clinics, and freestanding community health centers—depend upon a patchwork of subsidies to try to sustain these services.

Improving primary care can keep people healthier, thereby reducing overall health care costs by preventing avoidable ER visits and hospitalizations. However, an investment is necessary to ensure the appropriate development of primary care, which must include a better alignment between reimbursement and the cost of providing primary care. Medicaid fee-for-service payments for hospital outpatient clinics have been frozen since 1991 at \$67.50 per visit. Freestanding clinics, licensed as diagnostic and treatment centers, receive payment based on formulas that have not been adjusted for more than a decade.

Smaller hospitals, community health centers, and physician practices lack leverage with commercial payers, and often receive even less per visit than they are paid by public payers. A recent study of a sample of Federally Qualified Health Centers showed that Medicaid is paying an added “wrap-around payment” averaging \$26 per visit to the Centers to cover the difference between the Medicaid cost-based rate and what Medicaid managed care plans are paying.

Private physicians, understandably, are reluctant to devote their practice to serving the uninsured or patients on Medicaid when it means receiving just \$30 for an office visit from Medicaid fee-for-service, often less from commercial payers, and taking on additional paperwork burdens.

Working within a challenging environment, New York’s health care providers have created innovative models to serve our most needy residents, but the system is not sustainable in its current form and is not positioned to guarantee comprehensive, coordinated care.

The diversity of the state’s population means that a one-size-fits-all solution will not work as greater investment is made in the primary care infrastructure. Many hospitals and health centers are already meeting the needs of their communities and would be well positioned to continue taking care of their patients with updated rates from public payers and fair payment from commercial insurers. Any reform must contain the flexibility needed to encourage further innovation in meeting the challenge of providing patients with a true primary care home, regardless of payment source or socioeconomic status.

## HANYS' VIEW

(CONTINUED)

### ■ **BASIC CONSTRUCT FOR PRIMARY CARE AND CHRONIC CARE MANAGEMENT**

There is widespread interest in solutions that improve the effectiveness and efficiency of the health care system. The Institute of Medicine has identified care coordination as one of the key strategies for potentially accomplishing these improvements.

HANYS recommends the development of a statewide collaborative that would create a series of pilot initiatives to test a range of approaches and interventions that may be focused on patients, providers, and/or system redesign. By focusing on different populations with chronic conditions, and/or at-risk populations, the goal would be to enhance access to care and improve outcomes. Common elements of primary care and chronic care management include:

- ✓ access to an interdisciplinary team of health professionals;
- ✓ using information technology to support the provision of patient care, improve providers' access to patient information and outcome measurements, and develop interdisciplinary clinical information databases to facilitate care coordination;
- ✓ incorporating evidence-based medicine and clinical decision-making tools; and
- ✓ providing linkages with community-based organizations to engage communities and reinforce self-management and behavioral changes.

### ■ **PRIMARY CARE PAYMENT REFORM**

Providers should be supported and encouraged to create local partnerships to best meet the needs of patients, including systems with a range of supportive services in addition to physician services. Public and private payers should recognize the costs of clinical care and supportive services to sustain a comprehensive, coordinated care model. If the goal is to have Medicaid beneficiaries viewed the same as enrollees of any larger insurer, then payment reform must start by addressing the chronic undervaluing of primary care in all settings:

- ✓ Increase Medicaid fee-for-service clinic rates to more closely align with costs of providing care, including non-clinical supportive services. Parity with Medicare payment levels is a reasonable goal. It is also reasonable to modify the current flat rate structure to incorporate case-mix/service-mix differentials, the same as or similar to Medicare. Facilities paid on a Products of Ambulatory Care Services (PACS) basis as part of a state demonstration should be paid the higher of their PACS rate or the newly designed rate.

## HANYS' VIEW

(CONTINUED)

- ✓ Compel managed care plans receiving Medicaid payment increases for primary care to spend it on primary care.
- ✓ Increase Medicaid fees for physician services, not only for primary care physician visits, but also for specialty physicians, with parity to Medicare payments as the goal.
- ✓ Update payment for health centers licensed as diagnostic and treatment centers, which are not designated by the federal government as a Federally Qualified Health Center model, to better align with costs.

### ■ CHRONIC CARE MANAGEMENT

In New York's Medicaid program, a small percentage of enrollees account for a disproportionately high percentage of expenditures. Additionally, nearly half of Medicaid enrollees with a chronic illness struggle with additional conditions, often accompanied by a behavioral health disorder.

Modifying the basic clinic reimbursement methodology to incorporate patient complexity and service mix is an important step to better link payment to services provided. Moreover, case-mix differentials reflect a degree of linkage of connected services and have the potential to be modified further to aggregate bundles of care that are more clinically appropriate.

However, to maximize opportunities to incorporate innovative approaches to chronic care management of the most clinically complex patients, the state needs to develop innovative payment mechanisms and levels of payment that encourage participation in care coordination, better recognize "whole person care," and reimburse for the cost of coordinating care. Options to be tested include:

- ✓ care management fees to clinics and appropriate health care practitioners;
- ✓ capitation arrangements, including those based on the severity of the individual's condition;
- ✓ bundled payments for specific conditions (similar to the Prenatal Care Assistance Program);
- ✓ sharing any savings with providers;
- ✓ recognition of efforts that include monitoring and follow-up activities, education, social work, group therapy, and other supportive services as part of care management;
- ✓ support for telehealth expansion for at-home care and care coordination of patients with chronic conditions, especially in areas under-served by certain specialties;

## HANYS' VIEW

(CONTINUED)

- ✓ support for co-location of health/mental health services to enhance patient compliance and continuity of care;
- ✓ enhanced rates for facilities or centers that have evening and weekend hours; and
- ✓ enhanced payments for those centers with electronic health records.

## CLINICAL INTEGRATION

The integration of clinical care across providers and settings can foster collaboration and, consequently, improve the quality and efficiency of care. Providers strive to ensure continuity of care through efforts including coordinated chronic care management programs and investment in primary care. Clinical integration can further these efforts and offer the potential benefit of joint contracting. The Federal Trade Commission (FTC) has issued guidelines for both clinical and economic integration as the basis for joint contracting among independent providers.

## HANYS' VIEW

Clinical integration is attractive to health care providers because it is viewed as an effective remedy to fragmentation. Clinical integration involves providers working together in an interdependent fashion so that they can pool infrastructure and resources and develop, implement, and monitor protocols, “best practices,” and various other organized processes that can enable them to furnish higher quality care in a more efficient manner than they likely could achieve working independently.

Broad-reaching clinical integration, focusing on improving patient safety, quality of care, and clinical processes, can offer the added advantage of market differentiation—measurable improvements in quality and/or reductions in cost. Clinical integration benefits patients, employers, health plans, physicians, and hospitals. Benefits include:

- ✓ fostering collaboration to improve care quality;
- ✓ improving quality and efficiency for independent providers;
- ✓ enabling providers to perform well in pay-for-performance and other public reporting initiatives;
- ✓ gaining experience in forming provider organizations responsible for an entire episode of care or population of patients;

## HANYS' VIEW

(CONTINUED)

- ✓ providing a vehicle for a hospital to work more closely with members of its medical staff; and
- ✓ enabling providers to obtain reimbursement that covers the added costs of their efforts and which recognizes the increased value of the services they offer.

There is no single approach that will fit all clinical integration programs. Hospitals will vary with respect to the extent to which they have historically collaborated with their medical staff, the interest of primary care providers and specialists in joining a clinical integration program, the amount of available information technology and infrastructure already in place, and other factors.

Independent physicians or hospital-physician networks can deliver clinically integrated care to their patients, but it requires commitment, mutual agreement to comply with evidence-based guidelines, and infrastructure to assure compliance. This new role can be a natural evolution of pre-existing networks or an opportunity to establish a new one. Networks that can demonstrate sufficient, improved clinical quality and patient safety or the potential to achieve these goals are able to jointly contract with MCOs.

HANYS will continue to promote provider awareness of the benefits of a clinical integration model, and work with policymakers on this initiative.

## **TRANSITIONAL CARE**

Medicare beneficiaries often have additional conditions, known as co-morbidities, that can complicate and extend an acute hospital stay. Complications that destabilize patients must be monitored daily and treated with supportive clinical services that are only available in a hospital's transitional care unit (TCU). Patients suitable for care in a hospital TCU include those recovering from acute heart and lung illnesses, needing care for tracheotomies or weaning from a ventilator, having major wounds that fail to heal due to complications from diabetes or infection, or are in recovery from major surgeries that are complicated by age and/or co-morbidities.

A TCU is a unit in a hospital for patients over age 65 who have exceeded the time allowed by Medicare but need continued hospitalization for a short period due to their medical needs or the lack of specialized nursing home services. This post-acute level of care is a "stepping stone" for clinically fragile patients who are between the acute care setting and a lower level of care such as home or nursing home care.

New York is one of only two states that have not included transitional care as a formal component of the hospital service infrastructure. This lack of transitional care creates a gap in the continuum of care for New York patients. Hospitals in New York have attempted over several years to address this gap in the care continuum as well as the attendant financial loss by advancing proposals to expand the range of available post-acute services.

Although New York's nursing homes and home care providers have actively worked to fill this gap, patients with complex conditions and clinical fragility need interim post-acute hospital services and supports to recover properly and be clinically able to recuperate in a less intensive level of care.

Additionally, hospitals are challenged to find ways to make room for more patients seeking hospital care. More hospitals are experiencing patient backlogs and diversions in emergency departments, prolonging necessary patient admissions to inpatient beds. One essential tool to combat these patient "throughput" issues is using TCUs to move post-acute care patients appropriately and quickly to this lower level of care.

In April 2005, New York State authorized in legislation a transitional care demonstration in five hospitals. The demonstration allows hospitals to identify the clinical characteristics of the Medicare population in their community that need transitional care services, and to provide and be reimbursed by Medicare for those services.

### **HANYS' VIEW**

**The establishment of TCUs fills a community's gap for patients needing post-acute services and ensures that hospitals receive some reimbursement for the needed care provided. HANYS urges the expansion of transitional care as a formal level of care in New York.**

## LONG-TERM CARE HOSPITALS

Long term care hospitals (LTCHs) care for medically complex patients, whose average length of stay usually surpasses 25 days. LTCHs treat many patients requiring respiratory therapy, head trauma, pain management, and other care.

The number of LTCHs has grown nationally, though there are very few located in New York State. Interest in LTCHs is growing at the same time that CMS is re-examining their role in the continuum of care, and a moratorium on new LTCHs has been imposed at the federal level.

### HANYS' VIEW

LTCHs can improve continuity of care and are an important model of care treating critically ill and high acuity patients. New Yorkers should have greater access to this model of care.

## OBSERVATION UNITS

Licensure of observation units would ease pressures on emergency departments and help bridge traditional inpatient and emergent care. Currently, a time-limited waiver is the only mechanism for allowing such units to function. This creates uncertainty for those currently in operation and may be a deterrent to the creation of others. Medicare currently reimburses for observation services; Medicaid does not, due to this lack of official recognition.

### HANYS' VIEW

HANYS recommends that a formal licensure category for observation units be developed. In the interim, HANYS has urged DOH to create a Medicaid observation rate on a demonstration basis.



# CAPITAL FINANCING

New York's health care providers urgently need access to capital. To keep pace with the restructuring and health care reform efforts of recent years, access to capital is needed to improve quality, enhance emergency preparedness capabilities, update aging facilities, and invest in health information technology.

HANYS has a strong interest in ensuring and improving access to capital for its hospital and long-term care members. Hospitals and nursing homes access tax-exempt financing through two primary vehicles—the Dormitory Authority of the State of New York (DASNY) and Industrial Development Agencies (IDAs). Both are invaluable. Having access to multiple financing options is critical and the tax-exempt financing offered by DASNY and the IDAs helps to avoid the higher interest rates associated with commercial loans. Sustained access to tax-exempt capital financing helps to contain health care costs and ensure that New York's health care providers can meet long-term patient and community needs.

IDA financing is an important funding option for providers, including those that deliver care in under-served communities. Hospitals and nursing homes currently access this financing through specific provisions within the IDA law, which is scheduled to expire January 31, 2008. IDA financing is subject to a \$20 million cap on individual projects, which often discourages the longer-term capital planning that is desperately needed in health care.

The shift from inpatient to outpatient care has required hospitals to reconfigure their existing physical plant. These changes have the potential to improve the quality, safety, and efficiency of health care, but cannot occur without access to low-cost capital.

HANYS' long-term care members seek less costly and less time-consuming options to finance needed improvements. The shift in the demographic composition of New York continues to have serious implications for health care delivery, especially in the long-term care arena. Improving capital financing options is increasingly important to meet these important needs.

For small and rural health care providers, access to capital has historically been very difficult. Tax-exempt financing has fulfilled an important role for some of the smallest health care facilities.

Recently, a serious impediment has emerged with the implementation of a DOH financial management fee. In 2002, the state authorized bond issuance fees for Article 28 capital projects financed or refinanced through DASNY or an IDA, both of which would be reimbursable by Medicaid as an allowable capital cost. At the same time, DOH was authorized to implement an administrative fee related to inspection, supervision, and audit functions. This tax was put into effect during 2007, thereby raising the cost of financing and effectively imposing a tax on what traditionally was a tax-exempt financing vehicle. The annual fee is always calculated on the initial project amount. For a \$20 million project financed over 30 years, this translates into an added project cost of \$1.8 million.

### HANYS' VIEW

The long-term financial struggles of New York's hospitals and nursing homes have forced providers to focus their resources on operations, leaving little to invest in the future.

- Adequate reimbursement is vital to capital formation. HANYS supports responsible reimbursement by Medicaid, managed care, and other payers that meets the cost of care.
- HANYS supports the availability of low-cost, low-hassle capital financing options to uphold health care system reform efforts, facility rehabilitation needs, and to meet consumer demands for the latest and most advanced technology and patient care procedures.
- The current 44% discount in Medicaid capital reimbursement related to movable equipment should be eliminated. This old Medicaid cut conflicts with the state's interest in promoting investment in health information technology and other medical treatment technologies.
- HANYS strongly supports preservation and enhancement of IDA financing. HANYS further supports elimination of the current \$20 million cap on capital projects financed under IDAs for hospitals and nursing homes.
- HANYS will work with DASNY to develop new capital financing opportunities for health care providers. Under consideration are new incentives to encourage a collaborative of smaller, rural hospitals to make "green" investments with the help of DASNY financing by pooling arrangements for facilities with lower credit rating requirements.

## HANYS' VIEW

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- The additional tax on DASNY and IDA financing unnecessarily increases provider spending and in turn increases Medicaid spending. Although Medicaid recognizes this expense as an allowable capital cost, the portion actually recovered by a provider through Medicaid represents only a fraction of the total cost, leaving hospitals to shoulder the majority of the expense. This hidden tax should be repealed.
- HANYS supports the further development of programs to provide access to low-cost capital financing for hospitals, health systems, continuing care providers, and medical schools. Both direct grants and revolving low-interest loan funds can facilitate the purchase of IT, facility modernization, and emergency readiness.



# COMMUNITY HEALTH AND BENEFIT

## FACTS: HOSPITALS CARING FOR THEIR COMMUNITIES

Annually, New York's hospitals:

- treat 2.6 million inpatients;
- provide 54 million outpatient visits, including 7.9 million emergency room visits;
- deliver 250,000 babies;
- provide \$1.6 billion in health care to people who do not pay, the cost of which is only partially subsidized;
- provide an array of screening, prevention, and other community health and service programs, saving individuals and their communities millions of dollars in treatment costs and lost earnings; and
- generate and support nearly 672,000 jobs throughout the New York State economy (almost twice the number directly employed) and through whom more than \$4.5 billion is paid in state and local personal income and sales taxes.

New York State's health care providers are vital to their communities—in addition to providing patient care, they are employers, educators, and advocates for patients. Virtually all New York hospitals are not-for-profit, governed by their communities through voluntary trustees or local governments. New York hospitals provide, often for free, services, outreach programs, and screenings for the benefit of patients, families, and communities. These programs and services include managing a diagnosis of breast cancer or diabetes care, reaching out to special populations, offering health screenings and immunizations, and helping uninsured people find health care coverage.

## COMMUNITY BENEFIT

In recent years, there has been heightened interest in and scrutiny of hospitals' community benefit. Questions about health care providers' billing and collection practices for the uninsured, tax-exempt status, and accountability and transparency have contributed to increased attention to hospitals' provision of community benefit. This has gained increased visibility from members of Congress, consumer groups, and others. Most recently, the Internal Revenue Service (IRS) proposed changes to its Form 990 by creating a Schedule H that would require hospitals to quantify community benefit.

All New York hospitals are required to annually submit a Community Service Plan to DOH. These plans describe the health care needs of the community and how the hospital will address those needs. In February 2006, HANYS published *Above and Beyond—Community Service and Volunteerism of New York State's Hospitals*, which summarizes the hundreds of community service projects listed in Community Service Plans that help make communities healthier, safer, and happier places to live, work, and thrive.

HANYS annually presents a Community Health Improvement Award to recognize excellence in the provision of services to the community. Each year, dozens of hospital projects that increase access to care, assist children and youth, provide health education and outreach, and emphasize prevention and wellness are nominated for this award. Case studies of each project are published to serve as an example of best practices and excellence. HANYS applauds the many services hospitals provide to improve the health status of their communities.

## ECONOMIC IMPACT

Hospitals and health systems contribute significantly to the economy. As economic anchors, hospitals are often the largest or one of the largest employers within their communities. Hospital employees' spending and tax payments significantly impact the economy, as do local purchases by the hospital.

According to HANYS' most recent analysis, New York State's hospitals and health systems generate more than \$101.1 billion and 672,000 jobs per year for the state and local economies—about 10% of the gross state product. This substantial economic impact derives not only from direct hospital employment and spending—payroll, medical supplies, food, construction, etc.—but also from the “ripple effect” of that money moving throughout the larger economy, generating additional jobs and spending, as well as tax revenue.

## HANYS' VIEW

Hospitals accept the responsibility to demonstrate value and accountability to their communities. Community benefit is a demonstration of hospitals' commitment to their mission of community service.

- Community Service Plans are a necessary part of hospitals' community engagement and commitment.
- HANYS is working with DOH to modify the current Community Service Plan statute to encourage hospitals to work with county health departments to assess community needs and streamline the financial reporting process.
- Hospitals across New York State are very proud of the community benefits they provide and believe the new IRS Form 990 and Schedule H will allow hospitals to report the great diversity of community benefits they provide. In response to concerns raised by more than 300 members of the U.S. House of Representatives, HANYS, the American Hospital Association, and the overwhelming majority of hospitals, IRS will allow the value of Medicare underpayment and patient bad debt to be reported on a community benefit reporting form. This inclusion, along with additional space for hospitals to calculate and describe the full value of their programs and activities, should promote greater transparency and community accountability. The IRS will also delay for one year the most burdensome reporting requirements on Schedule H. HANYS will launch a series of education initiatives regarding the new Form 990 and Schedule H to assist New York hospitals in properly filling out and filing the forms.

# EMERGENCY PREPAREDNESS

In addition to functioning as community safety nets on a daily basis, health care providers are expected to be ready to respond to disaster situations, whether created through acts of terrorism or natural events. Since 2001, hospitals, nursing homes, and home care agencies in New York State have steadily improved their readiness.

Following the terrorist attacks of September 11, 2001, the American Hospital Association (AHA) conducted a comprehensive analysis of the future cost of ensuring hospitals across the country were prepared to handle different kinds of mass emergencies. Using the AHA model, HANYS calculated that it would cost as much as \$850 million for all New York hospitals to reach an adequate state of preparedness.

While funding has fallen far short of the projected need, hospitals have continued their preparation. Hospital activities have included: stockpiling personal protective equipment, development of Comprehensive Emergency Management Plans (CEMPs) including internal and regional surge capacity plans, and developing evacuation plans. Hospitals are now spending time and resources exercising their plans with simulated disasters and mass casualty events. These activities have been hampered by the limited availability of resources.

While hospitals in New York State receive good grades for their efforts, more needs to be done. To speed up the pace, additional funding is needed. Federal funding to New York State was reduced by more than \$4 million for the 2007-2008 grant year, in addition to an \$800,000 reduction in 2006.

## HANYS' VIEW

In April 2007, HANYS convened the first meeting of HANYS' Statewide Emergency Preparedness Advisory Committee. The committee was formed to identify and provide input and guidance on critical policy and operational issues regarding emergency preparedness that are the focus of interest to health care providers, lawmakers, and regulators. The committee functions in an advisory capacity to HANYS and represents the hospital and continuing care community statewide.

## HANYS' VIEW

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The Advisory Committee's first action was to recommend a set of deliverables for 2007-2008 that would foster progress toward preparedness and would be aligned with identified needs. This process resulted in a recommendation that the main deliverable for each hospital be to reassess and assure completeness of its CEMP. HANYS also emphasized that the role of any individual hospital would vary within a region based on capabilities and circumstances and urged DOH to allow the ability to tailor deliverables.

In addition, nursing homes and home care agencies have been asked to play a bigger role in the health care community's overall emergency planning and response. They have registered on the Health Provider Network to receive emergency communications directly from DOH at any time. Nursing homes have also provided DOH with data and resource information that is critical to the health care community's ability to respond to a pandemic flu event by supplying the hospital community with added surge capacity. In 2007, HANYS partnered with DOH in a grant to bring emergency preparedness education and training to all nursing homes in the state, both members and non-members, through a series of statewide Webconferences.

HANYS strongly believes that there needs to be a longer term strategy to address the inadequacy of current funding levels. Current federal funding designated for hospitals has been helpful, but inadequate to fully support the activities and associated costs of health care emergency management planning and response. Even existing federal funding levels are under constant threat to be reduced or redistributed away from New York. The responsibilities and staff time dedicated to emergency management in all settings have increased significantly and will continue to do so. To better assure consistent implementation of contract deliverables and emergency management plans, an individual dedicated to fulfilling these responsibilities is needed in most organizations. HANYS will continue to work with DOH and the state's congressional delegation to increase federal funding to a level that is adequate to support these critical staffing needs.

# GRADUATE MEDICAL EDUCATION

New York State is home to many of the country's most prestigious academic medical centers and community teaching hospitals. These institutions draw the highest quality professionals to the state and serve as the foundation for attracting billions of dollars in medical research. New York's targeted investment in Graduate Medical Education (GME) has produced many of the world's finest doctors and has attracted the talented researchers that make New York a leader in medical research.

In 2005, New York trained more than 15,000 medical residents. In all, New York trains 15% of medical residents in the country, and 75% of the physicians currently practicing in New York were trained in New York.

The complex mission of teaching hospitals requires the delivery of the highest quality care to the community while serving as a state-of-the-art training ground for the next generation of physicians. The two-fold nature of the teaching hospital mission demands additional service components to serve the comprehensive training needs of medical residents. Teaching hospitals must keep pace with cutting-edge technologies and research to attract research opportunities and to train future generations of physicians.

According to a recent study by the Association of American Medical Colleges (AAMC), New York's academic medical centers yielded the highest economic contribution of any state in the country in 2005, generating hundreds of thousands of jobs and tens of billions of dollars.

## **COUNCIL ON GRADUATE MEDICAL EDUCATION (COGME)**

GME continues to be a focus of the Spitzer Administration. Based on comments by Commissioner of Health Richard F. Daines, M.D., the cost of GME and the amount spent per New York resident will be at the heart of discussions. Commissioner Daines enlisted the help of COGME to develop recommendations on GME public policy and funding issues.

COGME is a 30-member advisory body that provides advice to the Governor and Commissioner of Health on the formulation and implementation of state GME policies. HANYS and GNYHA have been actively working with COGME.

The recommendations of COGME are based on the work of five work-groups it established, each dealing with a specific issue relevant to GME: transparency and accountability, quality of GME, physician supply, biomedical research, and cultural competency and diversity in medicine. Based on months of deliberations, COGME is developing a final report with more than 30 recommendations. Some of the primary issues under consideration include:

- ✓ improving institutional transparency in GME budgeting between hospitals and sponsoring institutions;
- ✓ developing a funding mechanism to support medical resident training opportunities in hospital and freestanding ambulatory care sites, with payments to support medical malpractice insurance coverage for retired volunteer physicians;
- ✓ assuring quality in patient care and resident education;
- ✓ the importance of biomedical research and skill building;
- ✓ increasing the amount of funding available through the GME reform incentive pool to enrich teaching practices and address quality of care, physician supply, biomedical research, and cultural competence and diversity training;
- ✓ enhanced upweighting for primary care programs to be directed at supervising faculty;
- ✓ creating a voluntary downsizing demonstration program for struggling GME programs that prefer to devote their resources to patient care;
- ✓ holding providers accountable for delivering a single standard of care that improves continuity of care regardless of a patient's socioeconomic or insurance status;
- ✓ regional collaboration to increase physician training and access to health care services in under-served areas;
- ✓ expanding and improving existing physician recruitment and retention programs and developing new strategies; and
- ✓ supporting and sustaining a statewide assessment of physician supply, demand, residency program capacity, and future resource planning efforts.

Moreover, at the November 2007 COGME meeting, the group highlighted the importance of medical malpractice reform as a critical practice environment factor that must be addressed.

## HANYS' VIEW

Today, we find ourselves with a present and future shortage of physicians, in particular throughout upstate New York and in urban, low-income areas. The investments made in teaching hospitals through GME must remain intact if we are to secure New York's position as a leader in physician training and research. Funding for GME already underwent a major change when the Health Care Reform Act was enacted. The private sector—business and insurers—was given a 46% discount on its contribution to GME.

In the midst of many competing budget priorities, it is essential to preserve the foundation of our health care system to train tomorrow's physicians and to assist in the pursuit of tomorrow's cures.

All of New York's hospitals share a common mission—a responsibility to care for the uninsured and the under-insured. In addition to serving as the training ground for future physicians, teaching hospitals provide millions of dollars in uncompensated care—82% of the uncompensated care delivered annually in New York is provided by major teaching hospitals.

- HANYS and GNYHA have worked with COGME to clarify what GME dollars buy. In addition to the traceable costs of a GME program (such as resident salaries, supervisory physician costs, etc.), there are Indirect Medical Education (IME) expenditures to support service lines that meet community health care needs and provide practical patient treatment experience for medical residents.
- HANYS can support a voluntary demonstration that downsizes the number of programs if it preserves critical federal and state financial support to participating hospitals and maintains the total number of residents being trained in New York State. It is important, however, to ensure that state and federal funding—including Medicaid and Medicare managed care funding—is committed for an extended period sufficient to recruit replacement staff.
- HANYS supports increasing funding through the GME Incentive Pool to promote expansion of physician supply in under-served areas, as well as primary care and selective specialty physicians in short supply statewide, quality of care, training opportunities in biomedical research, and cultural competency and diversity in medicine.
- HANYS supports an increase in reimbursement for primary care (hospital-based, clinic, or physicians) and new payments to recognize graduate medical resident training that occurs in outpatient settings, but these efforts should be distinct from existing GME dollars. Critical GME funding should not be reduced or redistributed to pay for reimbursement increases in primary or ambulatory care settings.

## HANYS' VIEW

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- HANYS supports the continuation of GME funds to enhance medical resident training in medical research and evidence-based practices. If GME funding is directed away from research training—an essential component of a resident's training—and the funding gap created is left unaddressed, the state could quickly lose its place as a nationally recognized leader in biomedical research. Research and skill building are integral components of a comprehensive graduate medical resident training program.
- Traditional methods of learning, discovery, and health care delivery will continue to be augmented by new paradigms that are increasingly technology-based, team-driven, and complex. Spurred by public demand for quality, safety, and cost-effectiveness, the paradigm of physician education is shifting from teaching to learning, with increasing emphasis on competency, interdisciplinary team-based care, and system skills.

AAMC is calling for increased enrollment in medical schools. Prospective medical school students and graduates looking for residency placement want only the best programs with the strongest capabilities to access technology and research opportunities. Any decrease in funding for research and technology would create an added challenge for New York's academic medical centers when competing with other states.

The excellence of New York State's medical education programs is a source of pride, making our state one of the world's premier centers for medical excellence. In addition to providing high-quality medical care, these facilities provide the finest training for physicians and serve as the foundation of a powerful biomedical industry.

# HEALTH CARE REFORM ACT RENEWAL

The enactment of the Health Care Reform Act in 1996 marked a major shift in health care policy in New York State by making significant changes in the way the state finances essential health care programs and in how hospitals were reimbursed for providing care. It is a unique law nationally and is slated to expire in 2008. HANYS urges its extension and the preservation of its funding for “public goods” in health care—indigent care, medical education, health care workforce, rural health, Child Health Plus, Family Health Plus, and many other programs.

HCRA was originally focused primarily on hospitals and the public goods that hospitals provide. While hospital financing is still HCRA's underpinning, the public goods pools provide funding for countless initiatives affecting the entire health care system. HCRA has evolved into a multi-purpose and complicated financing mechanism that funds \$5.7 billion in programs, in contrast to \$1.8 billion in 1997.

Over the years, its scope has broadened greatly. HCRA now supports the New York State Treasury and many state programs, including the Elderly Pharmaceutical Insurance Coverage program, public health, mental health, and other programs. In fact, the largest beneficiary of new HCRA funds has been the State Treasury, which receives approximately \$2 billion, representing over 35% of pool funding.

## HANYS' VIEW

New York's non-profit and public hospitals have a long and meaningful history of providing leadership to address New Yorkers' health care needs and an unparalleled commitment of caring for its uninsured and neediest residents. In addition, hospitals and their employees provide enormous economic benefits to New York State. The upcoming HCRA renewal provides an opportunity to ensure that public policy supports the safeguarding and fostering of patient care and community health.

### ■ PUBLIC GOODS POOLS

The need for public goods pools is greater today than ever before. The public goods pools include funding for indigent care, rural health, medical education, insurance, and other initiatives. In addition, special funding for public hospitals must continue. While not a component of a specific pool, public hospital funds are legislatively authorized in HCRA.

## HANYS' VIEW

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See the Indigent Care section for additional issues under consideration.

✓ **Indigent Care.** New York's hospitals provide about \$1.6 billion in health care to people who do not pay, the cost of which is only partially subsidized. Nevertheless, for several years hospitals in New York have been challenged to demonstrate that they acted responsibly in providing financial aid to low-income, uninsured patients. HANYS developed and promoted a series of guidelines for financial aid and collections practices. In 2006, legislation was enacted to create uniform standards. New York hospitals responded to the challenge and have universally updated their policies and practices.

There has been much deliberation about the funding and progressivity of the indigent care pool. This pool is funded at \$847 million and has been increased only once since HCRA was enacted ten years ago, when the Legislature approved \$82 million as a rural/high need adjustment in 2000. The indigent care pool covers about 50% of uncompensated care costs associated with uninsured and underinsured patients. However, after considering that hospitals also contribute nearly \$250 million to the pool, the real coverage level drops to approximately 38%. At approximately 38 cents on the dollar overall, total funding is insufficient to increase progressivity for higher need facilities without jeopardizing needed support for others.

DOH has developed draft recommendations that continue to support an aggregate annual funding commitment of \$847 million, as follows: maintaining current funding amounts for major public hospitals (\$139 million) and rural hospitals (\$27 million), and collapsing several pools into a single voluntary/minor public hospital pool of \$681.2 million that is further allocated between an "Uninsured Pool" and a "Co-Pay and Deductible Pool" highly weighted toward the uninsured pool. An anticipated new formula would incorporate uninsured units of service, a price proxy, and recognition of bed size for rural hospitals.

For each of the above pools, DOH is expected to propose changes to the formula that would result in redistributing funding among hospitals. The principle of progressivity is expected to be maintained and is supportable. Concerns have been raised that each pool had a specific rationale when established that needs to be considered before modifying.

More controversial, DOH continues to be interested in valuing indigent care need utilizing units of service for certain uninsured patients, priced at facility-specific Medicaid rates, less patient collections. HANYS continues to emphasize the inadequacy of using Medicaid rates as a proxy for emergency room or clinic services and the need to value services to the uninsured at cost or the negotiated rate reflected in hospital financial aid policies.

## HANYS' VIEW

(CONTINUED)

DOH is expected to recommend phasing in the new need determination and distribution methodology. Much of the information required to modify the methodology is not available from existing sources. Any modifications to the existing need or distribution methodology require legislation—presumably as part of the HCRA renewal discussions in 2008. HANYS will continue to advocate that changing the methodology remain a legislative, not a regulatory, function.

In the past, proposed methodology changes have been controversial, resulting in redistribution of funds between hospitals and regions. The Legislature has wrestled with the economic, geopolitical, and health policy complexities of distributing monies for uncompensated care across the state. It has been an open and transparent discussion, but a tough debate about how funds should be targeted.

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See the Graduate Medical Education section for additional issues under consideration.

✓ **Graduate Medical Education.** The investments made in teaching hospitals through GME must remain intact if we are to secure New York's position as a leader in physician training and research. GME funding underwent a major reduction when HCRA was enacted—the private sector contribution to GME from business and insurers was reduced by approximately one-half. Even in the midst of many competing budget priorities, it is essential to preserve the foundations of our health care system to train tomorrow's physicians and to assist in the pursuit of tomorrow's cures.

The excellence of New York State's medical education programs is a source of pride. New York State is home to many of the country's most prestigious academic medical centers and community teaching hospitals, making our state one of the world's premier centers for medical excellence. In addition to providing high-quality medical care, these facilities provide the finest training for physicians and serve as the foundation of a powerful biomedical industry.

The current shortage of physicians is expected to escalate, in particular throughout upstate New York and in urban, low-income areas. HANYS would support a voluntary downsizing program as long as it preserves critical federal and state financial support to participating hospitals and maintains the number of residents being trained in New York.

Investment in GME continues to generate significant economic activity and tax revenue. According to a recent study by the Association of American Medical Colleges, New York's academic medical centers yielded the highest economic contribution of any state in the country in 2005, generating hundreds of thousands of jobs and tens of billions of dollars.

## HANYS' VIEW

(CONTINUED)

✓ **Workforce Recruitment and Retention.** During the 2007-2008 state budget debate, the formulas were modified and funding levels reduced for the workforce recruitment and retention funding originally authorized in 2002. The modified formula distributes funding 50/50 proportionally on the basis of overall staff payroll expenses and Medicaid discharges (vs. 100% on the basis of overall staff payroll expenses), but at a reduced funding level. Still awaiting federal approval for the change in formula, it is critical that no further changes are made and that both the funding levels and formulas used to distribute those funds are stabilized.

HANYS believes that it is critical to maintain the public policy commitment to help hospitals and other providers address workforce recruitment and retention issues.

Today's shortage of nurses and other direct care workers is different from the cyclical shortages of the past. Affecting all provider types, the current shortage is more pervasive, as an aging population increases demand for services and the proportion of the working age population continues to decline. Critical staff shortages affect all patients equally, including Medicaid patients, and the state has a direct interest in ensuring that services are adequate for all.

In 2002, the Governor and Legislature responded to the need and added funds for recruitment and retention of direct care workers. The funding went to hospitals, nursing homes, personal care, and, later, for other home health care.

The funding helped to cover labor contracts downstate and it responded to the shortage of nurses and other staff in upstate New York. As a condition for receiving the funding, providers were required to attest that the funding would be invested in the recruitment or retention of direct care staff. Providers generally used these funds for wage or salary increases and added or expanded fringe benefits to compete in the labor market for staff.

The infusion of dollars has been effective. While shortages are still projected to be a problem for the foreseeable future, the number of students entering the nursing field has increased and nursing schools have increased slots. More must be done, not less, to maintain the positive momentum and HANYS, in collaboration with the New York Organization of Nurse Executives, has developed a legislative proposal to deal with faculty shortages and school limitations.

## HANYS' VIEW

(CONTINUED)

✓ **Rural Health.** New York State's rural health care providers are the centerpiece of the health care infrastructure in their communities. For the state's most geographically isolated residents, these providers are often the only source of essential health care services to more than three million New Yorkers. HCRA has been instrumental in providing funding to rural hospitals and networks. This funding must continue.

Nationally, federal Medicare policies have helped many small, rural hospitals to maintain their essential services by obtaining Critical Access Hospital designation. Yet, no similar state program exists. HANYS has helped develop a legislative proposal to create a state Medicaid version of the Critical Access Hospital to help ensure the viability of these fundamental services. The legislation (S.5061/A.8783) has been introduced in both the Senate and the Assembly.

### ■ HOSPITAL PAYMENT FORMULAS

✓ The 2007-2008 state budget required DOH to develop a budget-neutral Diagnosis Related Group (DRG) re-weighting plan. The re-weighting would update the Service Intensity Weights (SIWs), which are currently based on 1992 data, using 2004 data. DOH was required to consult with the hospital community and develop an appropriate phase-in period, no longer than three years, based on a review of the impact of the changes. The budget also provides for rebasing of the weighting factors for each DRG at least every four years.

HANYS has recommended that the new weights be phased in over a three-year period. HANYS' analysis of the new weights, including their ripple effect on Medicaid managed care, Workers' Compensation/No-Fault, and commercial carriers determined that the impact will be significant for many hospitals. As a result, HANYS has recommended that the phase-in for the majority of DRGs be one-third new/two-thirds old weights in 2008 (with a delayed start it would be 25% new/75% old in 2008), two-thirds new/one-third old in 2009, and full value in 2010.

HANYS' recommendations address problems identified with the revised weights for specific services including the orthopedic surgery DRGs, psychiatry and rehabilitation DRGs, and AIDS DRGs. In addition, HANYS recommended that DOH incorporate a regulatory provision or otherwise document the methodology it will follow to achieve budget neutrality. The enabling legislation requires that the application of revised weights be budget-neutral for Medicaid.

## HANYS' VIEW

(CONTINUED)

HANYS continues to work with DOH to correct remaining identified errors in the weight calculations and review subsequent releases of the DRG weight calculations for accuracy. Additionally, HANYS is working to formulate short-term and long-term solutions to problems that have been identified for specific services such as orthopedic, psychiatric, rehabilitation, and AIDS DRGs.

- ✓ HANYS recommends that the Medicaid hospital reimbursement methodology be updated to eliminate volume adjustments (with certain exceptions) and the case-mix cap, both of which are relics from an antiquated reimbursement system.
- ✓ Additionally, issues such as rebasing may also be considered.



# HEALTH INFORMATION TECHNOLOGY

The successful implementation of health information technology (IT) systems in hospitals and health systems has been proven to dramatically reduce medical errors, improve the quality of care, and increase efficiency. The widespread sharing of electronic health information across hospitals, physician offices, pharmacies, and other stakeholders could improve the coordination of care and lead to better health outcomes. HANYS believes that health IT adoption is a public good and should therefore be invested in by all stakeholders.

Hospitals and health systems throughout the state are at varying stages of IT adoption and data exchange. Some organizations are on the forefront of these efforts while others are just beginning. Several technological, social, legal, and financial barriers to widespread and successful IT adoption exist. The financial barriers are the most significant.

DOH, through the newly created Office of Health Information Technology Transformation, is pressing forward with a strategic plan to pursue widespread IT adoption and interoperable data exchange across communities, regions, and the state. HANYS is encouraged by the strong leadership New York State has shown in developing a vision for making widespread adoption possible and by providing funding through the Health Care Efficiency and Affordability Law for New Yorkers (HEAL NY) program. HANYS is committed to working with the state and federal governments and HANYS' membership to address health IT challenges facing providers.

Recently, the U.S. Department of Health and Human Services (HHS) awarded the New York eHealth Collaborative (NYeC), a \$2.8 million contract to demonstrate a model of a secure health information exchange. NYeC brings health care stakeholders across New York together to collaborate on state and regional health IT implementation. Two HANYS' member chief executives, Pamela Brier, President and Chief Executive Officer of Maimonides Medical Center; and Thomas P. Quinn, President and Chief Executive Officer of Community General Hospital, serve on the NYeC board.

## HANYS' VIEW

HANYS has been working to influence IT policy at both the state and federal levels, and promotes coordination between the two. HANYS supports:

- ✓ fostering a public-private partnership to achieve widespread use of IT systems. The delivery of quality health care is a public good, necessitating this partnership;
- ✓ establishing accessible and sustainable funding streams to be used by hospitals and health systems for IT adoption and exchange. In both Albany and Washington, HANYS is advocating for dedicated funding to support IT investment;
- ✓ continuing public and private development, harmonization, and adoption of interoperability standards;
- ✓ encouraging the development of IT systems to better meet the needs of clinicians, rather than a one-size-fits-all approach;
- ✓ meaningful certification of IT products to help providers make purchasing decisions—health care providers seeking to adopt IT systems must navigate a complex and often volatile health care IT marketplace;
- ✓ ensuring the interests of providers are represented in public and private organizations, including the New York Health Information Security and Privacy Collaborative, which develops privacy and security policies—these policies should both protect and secure confidential health information and be available to clinicians at the site of care;
- ✓ developing sustainable health information exchanges on the community, regional, and state levels;
- ✓ funding research to demonstrate best practices and sustainability models for the use of health IT data;
- ✓ updating state and federal medical privacy laws and regulations to clearly define allowable electronic sharing of information; and
- ✓ encouraging electronic prescribing, which enables a physician to transmit a prescription electronically to the patient's pharmacy and to obtain information about drug formularies and patient medication history. It can reduce or eliminate the need for a hand-written prescription and help reduce medication errors. These systems can serve an important preventive function of identifying errors in dosing, timing, and form, and can also flag potential allergies, drug interactions, or other patient contraindications.



# HEALTH PLANNING

New York's health planning infrastructure is beginning to adapt to New York's changing health care environment. Certificate of Need (CON) processing has been expedited to fulfill the recommendations of the Commission on Health Care Facilities in the 21st Century, and DOH listened to concerns and is moving forward on short-term regulatory changes that will allow more routine projects, such as information systems and roof repairs, to move ahead without CON review.

Still, more needs to be done. DOH is updating old payment methodologies and realigning its services to better respond to the changing health care environment. Health planning tools, including CON, must follow suit. Building a more patient-centered health care system means providers must be able to adapt quickly to patient needs and preferences. Regulatory impediments need to be relaxed.

The state's health planning structure needs to be streamlined in a way that does not eliminate opportunities for thoughtful deliberation and public input, but still results in a timely analysis of all necessary factors when assessing the need for investment in new or expanded health services.

HANYS has offered to host additional educational programs with DOH, when appropriate, to communicate changes in CON application procedures and to discuss ways to facilitate a more efficient system that does not place unfair disadvantage on regulated providers.

## HANYS' VIEW

HANYS has been working with a group of members to identify short- and long-term proposals to reform the CON system and has conveyed each of these proposals to DOH. These proposals include developing ways to better coordinate reviews among various state agencies, designating a lead contact for each project, and raising the monetary thresholds that trigger more rigorous and time-consuming state reviews. Some of these proposals have been put into place or are in the regulatory review process. HANYS believes that a broader look at reforming the state's health planning process is needed and recommends:

## HANYS' VIEW

(CONTINUED)

- ✓ conducting a system-wide review of CON, starting with revisiting the objectives of CON in the context of health planning and assessing where the current system is, or is not, meeting those objectives. Rather than simply controlling the supply of services provided by certain sectors of the health care community, health planning should be a comprehensive effort to identify and address community needs;
- ✓ identifying which selective health care services, due to the impact on the state's Medicaid system or concern for the public welfare, should require extensive state review and opportunities for public input;
- ✓ ensuring that all providers of these services adhere to comparable requirements;
- ✓ instituting new written guidance to reflect shifting policies, including plans to issue a "request for proposals" when regional analyses show a need for expansion or development of new services; and
- ✓ hiring new staff or realignment of existing DOH staff to ensure timely review of proposals for health services that require state review and approval.

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Also see section on Out-Migration of Services to Niche Providers.



# INDIGENT CARE POOL

New York's hospitals provide about \$1.6 billion in health care to people who do not pay, the cost of which is only partially subsidized. Nonetheless, for several years hospitals in New York have been challenged to demonstrate that they acted responsibly in providing financial aid to low-income, uninsured patients. HANYS developed and promoted a series of guidelines for financial aid and collections practices. In 2006, state legislation was enacted to create uniform standards. New York hospitals have responded to the challenge and have universally updated their policies and practices.

There has been much deliberation about the funding and progressivity of the indigent care pool. This pool is funded at \$847 million and has been increased only once since HCRA was enacted, when the Legislature approved \$82 million as a rural/high-need adjustment in 2000. The indigent care pool covers about 50% of uncompensated care costs associated with uninsured and underinsured patients. However, after considering that hospitals also contribute nearly \$250 million to the pool, the coverage level drops to approximately 38%. At approximately 38 cents on the dollar overall, total funding is insufficient to increase progressivity for higher need facilities without jeopardizing needed support for others.

## 2007-2008 STATE BUDGET

The 2007-2008 state budget required the Commissioner of Health, in consultation with the chairs of the health committees of both houses of the Legislature, to establish a technical advisory committee (TAC) to assist in the evaluation of the services provided and costs incurred by hospitals in relation to the receipt of indigent care pool distributions. Commissioner of Health Richard Daines, M.D., is required to issue a report setting forth conclusions and recommendations.

Thirteen members were appointed to the TAC—seven from the hospital community, five consumer advocates, and one health economist. The first two TAC meetings were held in June and September and the final meeting was held in November. In addition to the TAC meetings, DOH held two public hearings to solicit input. The Commissioner’s report is not meant to be a report of the TAC but, instead, it will suggest a course of action lawmakers can take to refine the indigent care pool payment methodology.

DOH’s draft recommendations discussed at the November TAC meeting continued to support an aggregate annual funding commitment of \$847 million, with several sub-allocations:

- ✓ a major public hospital sub-allocation would be maintained at \$139.3 million, but the distribution methodology would be changed to incorporate uninsured units of service and a price proxy, similar to changes proposed for other categories;
- ✓ a rural hospital sub-allocation would be maintained at \$26.5 million, but the distribution methodology would similarly be changed, including recognition of bed sizes; and
- ✓ all the remaining funding (\$681.2 million) would be collapsed into a single voluntary/minor public hospital pool, to be further sub-allocated between a low-income “Uninsured Pool” and a “Co-Pay and Deductible Pool,” with allocations heavily weighted toward the uninsured pool.

Several dedicated components of the current indigent care pool would be combined to create this \$681 million pool. They include the existing voluntary hospital pool (\$562.7 million), two high-need allocations (\$72 million), a supplemental indigent care pool related to GME (\$27 million), and an additional supplemental pool worth \$19.5 million.

For each of the above pools, DOH is expected to propose changes that would result in redistributing funding among hospitals. The principle of progressivity is expected to be maintained and is supportable. Concern was raised that each of the component pools was established with a specific rationale that needs to be considered before modifying the pool.

More controversial, DOH continues to be interested in valuing indigent care need utilizing units of service for certain uninsured patients, priced at facility-specific Medicaid rates, less patient collections. HANYS continues to emphasize the inadequacy of using Medicaid rates as a proxy for emergency room or clinic services and the need to value services to the uninsured at cost or the negotiated rate reflected in hospital financial aid policies.

DOH is expected to recommend phasing in the new need determination and distribution methodology. Much of the information required to modify the methodology is not available from existing sources. Any modifications to the existing need or distribution methodology require legislation—presumably as part of the HCRA renewal discussions in 2008—and HANYS will continue to advocate that it remain in legislation.

In the past, proposed methodology changes have been controversial, resulting in redistribution of funds between hospitals and regions. The Legislature has wrestled with the economic, geopolitical, and health policy complexities of distributing monies for uncompensated care across the state. It has been an open and transparent discussion, but a tough debate about how funds should be targeted.

All of the above is subject to change when the Commissioner releases his report.

### HANYS' VIEW

HANYS believes that the current definition of indigent care need and the corresponding aid allocation formula do a reasonable job in directing subsidies to hospitals providing uncompensated care. That does not mean that the current methodology is perfect or cannot be improved. Changes to the definition of need or distribution formula should be carefully evaluated to ensure that they improve the provision of aid for indigent care. DOH continues its interest in shifting to a service-based methodology; consumer advocates demand a more direct link between payment and patient services.

HANYS and the allied associations held numerous meetings with hospital financial staff to solicit input and evaluate the feasibility of data reporting refinement and have developed the following recommendations:

- ✓ continue to recognize both charity care and bad debt for both the low-income uninsured and underinsured in the need formula;
- ✓ value charity care and bad debt at cost or the negotiated rate (not charges)—HANYS continues to emphasize the inadequacy of using Medicaid rates as a proxy for emergency room or clinic services and the need to value services to the uninsured at cost or the negotiated rate reflected in hospital financial aid policies;
- ✓ a “direct write-off” approach for valuing bad debt should produce better service statistics;
- ✓ agree on mechanisms for clearer reporting of service statistics, including a process for certifying or validating the data;
- ✓ clarify that third-party denials and disputes should be excluded from institutional need;

## HANYS' VIEW

(CONTINUED)

- ✓ expand the scope of covered services to include charity care or bad debt from referred ambulatory;
- ✓ preserve a progressive distribution formula; and
- ✓ continue to support funding for special need categories (i.e., rural and GME).

Many of the above changes require time to collect and validate data to be used for distribution purposes. HANYS has recommended that the state pursue accounting/reporting changes starting in 2008, for use in the formula no earlier than 2010.



# LONG-TERM CARE

HANYS supports the goal to reform the long-term care system. Demographics, social trends, legislation, and court decisions are driving the growing need for high-quality, consumer-responsive long-term care. Limited resources and government's desire for meaningful reform are fueling interest in long-term care. Compelling forces are shaping the future of long-term care:

- The aging of the “baby boomers” combined with longer life expectancies is resulting in more people needing long-term care.
- Fewer informal supports, such as family caregivers, are available to help provide long-term care.
- An increasing demand for non-institutional care alternatives for the elderly and for young adults with disabilities adds to the current unmet need for home- and community-based services (HCBS).
- Federal legislation and court decisions, including the Americans with Disabilities Act and the *Olmstead vs. LC* Supreme Court decision, are driving reform that requires more HCBS.
- The likelihood of continued and worsening health care workforce shortages necessitates a re-evaluation of how care is delivered.

## HANYS' VIEW

Long-term care reform should be based on principles that promote a consumer-focused, community-centered system of care that emphasizes timely access to needed quality services supported by sufficient funding. It should maximize community resources, create a new workforce paradigm, create more opportunities for making personal choices, embrace patient-centered partnerships, and integrate flexibility. Moreover, it should bridge the gaps that now exist between health care policies and the provision of other needs such as housing, transportation, mental health, disabilities, and substance abuse. Effective coordination and delivery of all these services help keep people in community settings and support independence.

## HANYS' VIEW

(CONTINUED)

Recent state initiatives to reform long-term care have focused on reducing institutional capacity and promoting the use of HCBS. This shift must be supported by changes to the service delivery system and regulatory structures. As efforts to expand HCBS through initiatives such as the nursing home transition and diversion waiver move forward, sufficient community capacity must be available to meet consumer needs.

HANYS' vision of long-term care reform builds on strengths, eliminates barriers to care, provides for care management and quality improvement, and supports patient-centered care.

HANYS continues to provide leadership to develop state policy on long-term care by:

- working in partnership with policymakers and stakeholders, in part through HANYS' appointment to various state advisory councils, including the New York State Long Term Care Advisory Committee and the NY Connects Statewide Advisory Council;
- developing recruitment and retention initiatives for nurse educators as well as health care workers, supporting informal caregivers, re-engaging retiring health care workers in new roles, addressing ways to maximize workforce potential, creating a qualified health care worker with more flexibility to work in similar jobs in multiple settings, creating a volunteer health service corps, and providing tax credits;
- promoting care coordination and eliminating financial and regulatory barriers to achieving better care management;
- achieving renewal of and updating the federal waiver for the long-term home health care program, which has been an effective model of coordinated community-based, long-term care for more than 20 years, to modernize and improve the efficiency of the program, as follows:
  - ✓ streamline assessment and approval processes and create a universal assessment process for post-acute settings;
  - ✓ eliminate the redundant and costly requirement for local social service districts to conduct patient assessments already completed by long-term home health care programs;
  - ✓ ensure that the services needed by a patient enrolled in a waiver program can be obtained in the most coordinated fashion with minimal fragmentation, particularly when a patient needs both physical health and behavioral health services;

## HANYS' VIEW

(CONTINUED)

- ✓ utilize appropriate calculations of currently collected data to calculate program-specific quality measures; and
- ✓ enable flexibility in the calculation of budget caps.
- promoting programs such as managed long-term care and the Program of All-Inclusive Care for the Elderly (PACE) as models that address complex patient needs, provide appropriate care management, and reduce institutionalization;
- supporting consumer decision-making and self-management of care;
- supporting enhanced consumer information, education, and navigation assistance;
- avoiding rigid gatekeeper models and policies in long-term care that inhibit transition of patients between and within acute and long-term care settings;
- promoting the development of community-based alternatives to institutional care, including appropriate reimbursement;
- encouraging appropriate use and financial support of telemedicine and telemonitoring to increase patient engagement and decision-making and make better use of a limited workforce, and reduce hospitalizations and emergency room use, thereby improving the quality of patient care and administrative efficiency;
- providing incentives to develop models of care combining housing with health care services;
- providing incentives to adapt existing structures that can be utilized in a consumer-responsive manner;
- encouraging participation by nursing homes and home health agencies in quality improvement initiatives;
- providing funding for collaborative performance and outcome-based initiatives across care settings;
- encouraging adoption of health information technology to improve the quality of patient care and improve administrative efficiency;
- providing incentives for increased personal and family responsibility for care; and

## HANYS' VIEW

(CONTINUED)

- implementing the new nursing home payment methodology—challenges in securing federal approval of the first year's phase-in (\$137.5 million) have raised concerns about the future of this much-needed investment in nursing homes. HANYS, New York Association of Homes and Services for the Aging, and New York State Health Facilities Association will continue to help the state in satisfying CMS' questions about the value of the new methodology.

# MEDICAL LIABILITY REFORM

The need for a system to provide swift, fair, and adequate compensation to individuals injured as a result of medical negligence is self-evident, as is the need to reduce the crushing burden of medical liability insurance costs. Aligning compensation for negligently-caused injury and eliminating litigation of dubious validity are unassailable social goals. The adversarial adjudication system fails miserably on all three counts and is riddled with incentives and disincentives that almost ensure that these principles are not met.

The time-worn “tort reform” of the 1970s and 1980s may have slowed the deterioration of the compensation system, but has not prevented it. Increasingly, policymakers are proposing provocative solutions to address the stubbornly complex and politically charged “malpractice problem.” Efforts to spread the system’s enormous financial burden to a general population base certainly have merit.

In September, the Superintendent of Insurance and the Commissioner of Health convened a Task Force, on which HANYS was asked to serve, to make recommendations on medical liability reform. The Task Force met several times and focused on specific problem areas: malpractice insurers’ financial viability; quality improvement initiatives; physician supply and access to physician services; and the litigation system. HANYS and numerous provider representatives have uniformly described physician access and supply problems, quality initiatives, and litigation system deficiencies.

It was noted that the state’s malpractice insurers have a collective deficit of \$1.5 billion, which Insurance Superintendent Eric Dinallo has emphasized must be restored if claims are to continue to be paid. Superintendent Dinallo has warned that without meaningful, “scorable,” immediate solutions, the State Insurance Department may be forced to impose significant surcharges on every physician in the state or double-digit premium increases over the next five years just to eliminate the prior year deficits.

## HANYS' VIEW

Within the Task Force, HANYS is advocating for the adoption of meaningful recommendations that ultimately will be subject to the legislative process. While a cap on non-economic damages is the foundation of real reform, the likelihood of passage at this time is remote. Consequently, to provide immediate relief, HANYS is one of several organizations, including the Medical Society of the State of New York (MSSNY), American College of Obstetricians and Gynecologists (ACOG), GNYHA, Federation of Jewish Philanthropists (FOJP), Medical Liability Mutual Insurance Company (MLMIC), and others that participated in developing reform recommendations included in *Civil Justice and Medical Liability Insurance: Reform is the Prescription!*. HANYS endorses the proposals in this document, such as tort reform related to disclosure of expert witnesses' identity, mandatory qualifications for serving as an expert witness, mechanisms to shield physicians' financial exposure to large premium rate increases, and several quality improvement initiatives.

HANYS urges the adoption of a medical indemnity fund, which would provide an alternative financing mechanism for specific, high-cost cases involving neurological impairments, as well as proposals for a "sorry works" program and specialty tribunals, as described below.

### ■ **MEDICAL INDEMNITY FUND**

HANYS continues to support the range of tort provisions and other reform included in the multi-provider coalition package. Chief among those is the potential to shift the funding for high-cost cases involving neurological impairments to a separate medical fund. Medical expenses would be reimbursed on a "pay-as-you-go" basis rather than the traditional overstated projection method. The pool would be funded from all insurers within New York State.

### ■ **"SORRY WORKS"**

Experience is beginning to show that prompt expressions of remorse, apology, or other candid acknowledgement that negligence may have occurred or a standard of care was not met have a beneficial effect on patients and their families. Under some "sorry works" programs, these candid communications may be followed by an offer of compensation without the need to resort to the litigation system. Inherent in this proposal is that such early disclosures cannot be used or considered in any subsequent litigation regarding the incident.

## HANYS' VIEW

(CONTINUED)

### ■ SPECIALTY TRIBUNALS

Another topic gaining increased interest is the creation of “specialty courts” to hear and decide medical malpractice disputes. The term “specialty court” has been applied to a wide variety of forums, from administrative reviews to special federal courts.

One model calls for convening specialty tribunals consisting of a judge, an attorney, and a practitioner with knowledge of the specialty of the practitioner in question. The aggrieved patient would file an application, and demand for pertinent records would be automatically issued directly from the tribunal. Independent examinations and peer review activities would be handled by a roster of experts from which the tribunal would draw.

Rather than being a forum in which adversaries try to prove positions before a court, the tribunal would spearhead a transparent process, with the cooperation of the disputants, to arrive at a well-informed decision. Because these tribunals would operate within the judicial system, decisions would emanate from the judge after reviewing the reports and recommendations of a specialist in the area under review and an attorney.

The medical malpractice litigation problem has plagued patients, the courts, and practitioners for decades. Clearly, sweeping changes are called for. HANYS believes that many proposals merit serious study and refinement, is pleased to offer these contributions to the debate, and urges their close scrutiny.





# OUT-MIGRATION OF SERVICES TO NICHE PROVIDERS

As a result of modification about a decade ago of the public need test that is part of the Certificate of Need requirements, expansion in the number of Article 28-licensed freestanding ambulatory surgery centers has been dramatic, with more than 100 new centers approved, 80% of which are for-profit ventures. Before 1998, a population-based need methodology was used to determine whether new freestanding ambulatory surgery centers should be established. At that time, there were 31 licensed centers in operation. Changes to the rules in 1998 eliminated the population criterion and allowed public need to be determined based on a finding of a three-year financial feasibility. The adequacy of existing community resources is not a consideration under the new rules.

HANYS believes the creation of excess capacity for profit-making motives is counterproductive and, ultimately, an example of unnecessarily adding costs to the health care system. It is essential that hospitals generate revenues from certain areas of their operation, such as outpatient surgery, to subsidize mission-based services they are in the best position to provide, including primary care for under-served communities and emergency care.

Hospitals have obligations and commitments to their communities that far exceed those of niche providers. This is particularly important at a time when the state is taking a comprehensive look at health care delivery, especially the need to provide better primary and preventive care.

Compounding this already serious problem is the continued growth in the number of office-based practices operating outside of Article 28 licensure and regulation. These private practice models range from office-based surgery practices to the latest iteration of retail-based health clinics. While legislation passed this year will bring some degree of oversight of certain office-based surgery practices, HANYS has urged DOH to enforce existing regulations that designate “criteria for determining the operation of diagnostic or treatment center” under Article 28 of the Public Health Law (10NYCRR 600.8).

## HANYS' VIEW

- Amend the CON public need test for ambulatory surgery centers to take into consideration all existing community resources, with approval only granted where unmet community need can be demonstrated.
- Physician owners of freestanding centers should be required to provide emergency department coverage for hospitals with which the center has a back-up/transfer agreement.
- Rules prohibiting treating physicians from referring patients to facilities in which the physicians have an ownership interest (known as physician self-referrals) must be tightened and enforced by the state.
- DOH should enforce existing rules and seek additional statutory authority, if necessary, to require that office-based practices providing the same services as licensed entities be required to obtain the same approvals and operate under the same rules as licensed facilities.
- Licensed freestanding centers should be required to meet the commitments they promised in their CON application to treat Medicaid and uninsured patients.
- Previous approvals of centers should be withdrawn if a center fails to proceed to construction within a reasonable timeframe.

# QUALITY INITIATIVES AND INNOVATIONS ACROSS THE CONTINUUM

New York State's health care providers continue to demonstrate their leadership and commitment to quality improvement and public reporting of quality data. Hospitals, nursing homes, and home care agencies have implemented many evidence-based practices that are leading to clinical improvements and increased patient/resident safety. The HANYS Quality Institute is aggressively pursuing efforts to identify and assist members with implementation of new evidenced-based practices to improve the quality of care.

The recommendations and initiatives below highlight HANYS' view in the areas of quality improvement, infection prevention and treatment, pay-for-performance, and quality data collection and reporting. HANYS' advocacy also recognizes the critical role of health information technology (IT) to improve the quality of patient care.

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Health IT is more fully discussed in a separate section.

## QUALITY IMPROVEMENT

Health care providers continually focus on quality improvement and delivering high-quality, evidence-based care. Information about quality improvement and care-enhancing strategies should be widely available and shared among health care organizations and providers.

- **Institute for Healthcare Improvement (IHI) 5 Million Lives Campaign:** HANYS and its member hospitals are nationwide leaders in the Institute for Healthcare Improvement (IHI) 5 Million Lives Campaign. As IHI's designated statewide coordinator, HANYS is working with statewide partners such as DOH and IPRO to disseminate to every hospital education, tools, and successful practices to help hospitals implement ongoing improvements. New York hospitals have implemented a number of IHI's 12 initiatives, such as preventing hospital-associated infections and implementing evidence-based protocols. Based on IHI's data, New York State hospitals surpassed IHI's targeted goal of lives saved by 15% in the first 100k Lives Campaign and continue to lead the way in the 5 Million Lives Campaign.

## HANYS' VIEW

HANYS continues to work to support the alignment of the IHI initiatives with CMS and The Joint Commission measures, including providing its members with linkages, examples, techniques, and impact data.

- **Obstetric Quality Improvement:** Although advances in medical care have resulted in striking improvements in maternal outcomes over time, studies suggest that substantial quality improvements can still be made. For example, New York State's maternal mortality rate in 2004 was 20.5 per 100,000 live births, exceeding the national rate of 13.1 and the Healthy People 2010 rate of 3.3 maternal deaths per 100,000 live births. Improvement initiatives to reduce the rate of pregnancy-related death may include better surveillance and reporting of deaths, assessment of the causes of deaths, education, and implementation of medical best practices.

Commissioner of Health Richard Daines, M.D., met with HANYS' Board of Trustees in September 2007 and challenged HANYS and its member hospitals to take a visible lead to elevate standards of outcome measurement, patient safety, and documentation. The Commissioner repeatedly stressed the need for a unified, statewide provider effort on quality improvement. He also differentiated the ongoing concern about liability reform from quality improvement, which is the natural imperative and responsibility of the provider community.

## HANYS' VIEW

HANYS has joined forces with the American College of Obstetricians and Gynecologists, District II/NY to expand beyond current joint efforts to develop a broad-based statewide quality agenda that promotes evidence-based improvements in quality and patient safety. New York's hospitals have already implemented numerous effective quality improvement programs in obstetrics, such as crew management principles that address teamwork training concepts, communication, the application of safety tools, certification of the obstetric team on the nomenclature for fetal heart rate monitoring, risk management courses in shoulder dystocia, and the implementation of a rapid response to maternal hemorrhage. This initiative will build on existing activities and incorporate best practices from around the state.

- **Nursing Home and Home Health Quality Improvement:** HANYS' nursing home and home health members have increased participation in quality improvement through CMS' Nursing Home Quality Improvement (NHQI) and Home Health Quality Improvement (HHQI) initiatives. The NHQI initiative is focused on pressure ulcer improvement; the HHQI initiative is centered on reducing acute hospitalizations for home care patients. HANYS has worked with the New York State quality improvement organization in supporting provider efforts to improve quality and measure patient/resident outcomes. HANYS is also partnering with other associations as part of a national nursing home quality improvement campaign called "Advancing Excellence in America's Nursing Homes" and is a convener of the Empire Quality Partnership.

#### HANYS' VIEW

HANYS continues to engage its nursing home and home health members in quality improvement activities and to collaborate with government and other organizations as partners to enhance these efforts.

- **Teamwork and Technique: Achieving Critical Care Excellence:** HANYS has advanced an innovative educational series, *Teamwork and Technique: Achieving Critical Care Excellence*, to help hospitals reduce adverse events and complications in critical care units. Through the integration of aviation industry crew management principles with evidence-based clinical practices drawn from the IHI quality initiatives, the educational series features strategies that focus on teamwork, communication, and protocols to prevent hospital-associated infections, complications, and mortality.

#### HANYS' VIEW

The critical care unit is a microcosm of the entire hospital and lessons learned in this initiative can be spread to other areas of the hospital. In addition to improving quality and patient safety, the successful management of key critical care processes enhances operational efficiencies and reduces costs. This educational series is designed to help hospitals meet CMS' quality reporting requirements, The Joint Commission standards, and other top initiatives including the IHI 5 Million Lives Campaign.

## INFECTION PREVENTION AND TREATMENT

New York's health care providers have been actively involved in initiatives to prevent infection including regional projects to prevent methicillin-resistant *Staphylococcus aureus* (MRSA) and central line-associated bloodstream infections, and a HANYS-led initiative to prevent ventilator-associated pneumonia (VAP). In the Teamwork and Technique project mentioned previously, hospitals are engaged in activities designed to reduce infection in critical care units—this includes all of the above-noted infections, as well as sepsis and decubitus ulcers. With the assistance of grant funding, HANYS initiated a VAP Prevention Project in October 2007, which involves a pilot group of hospitals completing regional training and action plan sessions to sustain early improvements and enhanced evidence-based changes. VAP prevention has been identified as a top quality management priority to decrease morbidity and mortality, thus also resulting in decreased hospital days and costs. HANYS attributes early success of the project to hospitals' commitment to enhancing their VAP prevention process. Hospitals also continue to actively participate in the CMS Surgical Care Improvement Project (SCIP), a national quality partnership of organizations interested in reducing surgical complications and infections.

In recent months, there has been an increased public attention on the prevention and treatment of multidrug-resistant organisms (MDROs) such as MRSA vancomycin-resistant Enterococci, and certain gram-negative bacilli. The prevalence and risk of MDROs varies by geography, health care setting, and types and levels of care, and, as a result, the Centers for Disease Control and Prevention (CDC) recommends a tiered approach to MDRO prevention to allow each organization to design an infection control program to meet the needs of its population. DOH has provided guidance to health care organizations and schools regarding methods to prevent infection, including an emphasis on hand hygiene.

### HANYS' VIEW

The prevention and treatment of infections remains a high priority for New York's health care providers. HANYS will continue its commitment to partner with and educate providers on the various methods to reduce infection and will work to encourage and support new research and the development of best practices. To effectively eliminate drug-resistant infections, it is clear that the entire community must work together, including health care providers, schools, and community organizations. HANYS believes that New York State should implement a public health awareness campaign to educate the public regarding how they can reduce infection transmission. HANYS does not support legislation that would limit progress and impede rapid response to local epidemiological trends and changes by dictating specific methods by which hospitals should prevent and treat infections.

## PAY-FOR-PERFORMANCE

The Deficit Reduction Act of 2005 (DRA) required CMS to develop a value-based purchasing (VBP) program—a broader pay-for-performance type program. The goal is to improve quality and efficiency through financial incentives across the continuum of care.

CMS recently released a proposal to implement a VBP program for hospitals. The proposal, which would require congressional action to be implemented, describes several options that Congress may pursue over a three-year period to transition from a pay-for-reporting program to a pay-for-performance program. However, this proposal does not offer any new funds to reward quality. HANYS has repeatedly called for a plan that includes new funding for quality incentives and does not cut current hospital payments.

In the long-term care arena, CMS anticipates implementing a three-year Nursing Home VBP Demonstration under which participating nursing homes will be offered financial incentives to provide high quality care and to improve the level of care they provide. With the assistance of Abt Associates, CMS has designed a Home Health Pay-for-Performance Demonstration to determine the impact of incentive payments to home health agencies (HHAs) for improving the quality of care of Medicare beneficiaries who receive home health services.

In a broadening of its pay-for-performance focus, CMS has also created a cross-setting project called the Post Acute Care Payment Reform Demonstration (PAC-PRD). PAC-PRD will focus on developing a setting-neutral payment system that is hinged on the application of a single, standardized patient assessment tool called the Continuity Assessment Record and Evaluation (CARE) Instrument. Data collection using the CARE tool and other resource utilization tools will be conducted in selected markets nationwide through 2009.

In New York State, the Medicaid program has approved five pay-for-performance demonstration projects. Moreover, the state is expected to recommend payment reform similar to Medicare, in which providers would not be paid a DRG differential for a selected set of eight hospital-acquired conditions. Sooner or later, the state is also likely to consider VBP reform similar to Medicare. For nursing homes, HANYS has worked with DOH and stakeholders on draft regulations for a quality incentive payment for nursing homes. The proposal, which is under evaluation by the Spitzer Administration, would apply incentives for both attainment and improvement in the area of pressure ulcers and uses a research and evidence-based, risk-adjusted methodology that modifies a current CMS measure.

## HANYS' VIEW

Pay-for-performance initiatives must reward, not punish, providers and be based upon evidence-based measures. If pay-for-performance programs are implemented in a more comprehensive way in New York State, the methodologies must incorporate meaningful incentives to reward performance improvement and attainment. Such a program must also align financial incentives, implement information technology interoperable systems, and promote integration and consistency of health care outcomes across settings.

## **QUALITY DATA COLLECTION AND REPORTING**

Hospitals, nursing homes, and home care agencies participate in a variety of quality measurement and reporting initiatives designed to develop information to improve care and consumer decision-making. In fact, with HANYS' endorsement, New York was one of three states to initially pilot the CMS Hospital Quality Initiative to publicly report quality data. An expanded version of these indicators is now encompassed in a national public reporting system. HANYS continues to work with the Hospital Quality Alliance, a national organization that includes CMS and AHA, to promote and test new measures for an expanded set of indicators.

However, the number of publicly released hospital reporting initiatives has proliferated, resulting in an escalating commitment of hospital resources, without coordination among efforts. For example, the recently enacted state requirement that hospitals institute a new data collection system for infection reporting does not build off the infection data hospitals already report to CMS. This fractured approach of different quality reporting methodologies has resulted in a duplication of efforts, a significant waste of scarce resources, and it undermines the potential for improvement in quality and cost efficiencies. Furthermore, the current system can sometimes lead to conflicting and erroneous information that is confusing to consumers.

## HANYS' VIEW

The state has the opportunity to move away from the environment of dissimilar report cards to a comprehensive integrated strategy that advances quality of care. HANYS supports development of a standardized and integrated approach to develop quality measures and metrics. Measures should be supported by a consistent methodology and one comprehensive, standardized, and integrated system for data collection and reporting. HANYS remains committed to working with DOH, the Legislature, providers, and consumer representatives to align New York's data collection efforts with national efforts—something that is not currently happening.

## HANYS' VIEW

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Senator Kemp Hannon has introduced legislation (S.4879) that would direct DOH to develop and maintain the official hospital comparative data report for the state. HANYS strongly supports this legislation. The real opportunity for patient care and quality improvement lies in the confluence of the various quality indicators into a single standardized and integrated system.





# RURAL HEALTH

New York's rural health care providers are the center of the health care infrastructure in their communities. Rural hospitals and health systems are often the only providers of essential health care services to more than three million New Yorkers in geographically isolated areas.

Health care providers in rural areas face many of the same challenges as their urban counterparts, yet often have fewer resources at hand. They also have other concerns, such as lower volumes of patients, added difficulties recruiting and retaining workforce, and often are treating an older, less healthy population.

In many instances, rural hospitals form the hub around which much of the health care is provided in rural communities. They not only provide traditional inpatient services, but employ or subsidize primary care providers and form the backbone of community health initiatives. Having a viable hospital is also often a key to economic development, a vital priority in much of upstate New York.

Rural hospitals are becoming increasingly creative as they seek ways to continue providing these safety net services to their communities, including emergency rooms, obstetrical services, and other care that might otherwise be hours away. By employing telehealth, rural providers can bring specialists to their patients without the expense of paying a provider for around-the-clock coverage at the hospital. Financial considerations are forcing new partnerships, consolidations, and models to provide basic care in some communities where a full-service hospital may no longer be possible to sustain.

## HANYS' VIEW

New York State has a tradition of supporting rural hospitals through its allocation of federal grant programs, through grants that have been part of HCRA funds, and most recently, by supporting creative “rightsizing” proposals that preserve essential health services wherever possible. HANYS strongly supports continuing these state and federal programs as New York looks to reform its payment system to better recognize the cost of providing care across different settings. Over the long term, it will be necessary to continue certain rural subsidies, recognizing the financial limitations of providing care in rural communities and the need to ensure all residents have access to quality health care.

HANYS recommends that New York create a state Medicaid version of Critical Access Hospitals to help ensure the viability of these fundamental services. Federal Medicare policies have assisted many small, rural hospitals in maintaining their essential services. Yet, no similar state program exists. HANYS helped craft state legislation to achieve this purpose that has been introduced in both the Senate and Assembly (S.5061/A.8783).

HANYS also recommends an increase in Medicaid payments for primary care providers to ensure availability of primary care in under-served areas of the state.



# WORKFORCE SHORTAGES

Workforce shortages have a real impact on patient care, as the ability of health care providers to deliver timely, quality care is stressed.

New York State's population age 65 and older increased by 25% between 1980 and 2000. The population over age 80—the frail elderly needing the most intense health care services—is expected to double by 2020. According to the New York State Department of Labor, the total number of jobs needed in health care is expected to grow 18% by 2012—more than twice the rate of growth of all other occupations.

New York State needs to take extraordinary action to address health care workforce shortages. A multi-faceted approach is necessary to ensure communities have access to a diverse workforce of physicians, nurses, and other health care professionals and paraprofessionals that meets the needs of all New Yorkers. Health care institutions and communities are confronting the immediate shortages with a variety of strategies. However, short-term strategies cannot address the overall long-term workforce shortage. To meet the needs of the future, New York State needs a comprehensive and creative strategy to increase the health care workforce.

The recommendations and initiatives below highlight HANYS' view in relation to physician and nursing shortages, as well as the need to develop a new workforce paradigm that supports informal caregivers, re-engages the workforce, and incorporates technology.

## PHYSICIANS

Hospitals across New York State report increasing challenges with the recruitment and retention of physicians to their communities. The number of physicians nearing retirement is growing at the same time as communities struggle to find replacements for retirees. In addition, more and more physicians are choosing to leave New York State to practice in other parts of the country. Attracting and retaining physicians is difficult for many communities for a number of reasons, including:

- insufficient recruitment of candidates to New York medical schools who are predisposed to practice in primary care, other shortage specialties, and under-served New York communities;

- an inadequate number of New York medical school programs with goals to attract students to primary care and under-served New York communities;
- staggering debt from medical school;
- stagnant pay and declining reimbursement in New York;
- overall quality-of-life concerns in certain areas of New York State, including professional isolation; and
- the practice environment, including growing on-call responsibilities in a shortage environment and New York's onerous administrative and regulatory requirements.

In some regions, severe shortages are widespread. In other areas, the worst shortages are specific to primary care or certain specialties. A study by the State University of New York's Albany Center for Health Workforce Studies on physician supply from 2001 to 2005 provided notable examples:

- The number of physicians declined 6% in the nine-county Finger Lakes region and 9% in the five-county Western New York region. At the county level, the number of physicians declined by 8% in the Bronx, and 49% in Washington County.
- The declining number of primary care physicians is a growing problem in regions such as the seven-county North Country, which saw an 8% decline, in addition to declines in both the Finger Lakes and Western New York regions.
- The number of obstetrician/gynecologists is declining statewide, most noticeably in the nine-county Southern Tier by 18%, and Western New York by 13%.
- The number of general surgeons declined 10% statewide. The number declined by 16% in New York City and a similar decline was found in the six-county Mohawk Valley, North Country, Southern Tier, and Western New York regions.

Compounding these shortages, more than one-third of New York's active patient care physicians are age 55 and older; 14% are age 65 or older. In several counties, such as Washington, Montgomery, and Sullivan, more than 50% of physicians are age 55 and older.

Patients are feeling the brunt of these shortages in many communities. Certain specialties are either no longer available in their communities or have limited available hours with growing waiting periods for appointments. Additionally, hospitals are having increasing difficulty with finding specialty physicians willing to take evening and weekend emergency calls, often forcing hospitals to transfer patients away from their local communities for treatments that would have been available at home in the past.

### HANYS' VIEW

HANYS is partnering with the Associated Medical Schools of New York, Medical Society of the State of New York, and other representatives of New York State's health care provider community, including medical schools, physician groups, hospital groups, health workforce researchers, and public and private sector policy experts to address physician workforce issues. These groups make up the New York State Ad Hoc Physician Workforce Planning Group and have developed the following preliminary recommendations:

- ✓ expand the number and size of pipeline programs to encourage people to choose a career in medicine and practice in under-served communities;
- ✓ increase the percentage of medical students and medical residents who are predisposed to stay in under-served areas by identifying the right student candidates at the time of enrollment;
- ✓ increase the number of clinical teaching sites in physician shortage areas;
- ✓ encourage experienced physicians to teach and mentor medical students and residents in under-served communities and provide financial support to replace income lost as a result of voluntary teaching activities;
- ✓ increase the availability of medical student scholarship and loan forgiveness programs for those who commit to serving in urban, rural, and other under-served shortage areas;
- ✓ define an enhanced service program that helps match physician scholarships and loan service commitments with under-served areas, and significantly expand the definition of under-served area to reflect New York's diverse areas with unique physician needs;
- ✓ increase Medicaid payments for physicians' services, especially with regard to primary care, to a level commensurate with cost;
- ✓ implement medical malpractice reform;
- ✓ increase funding to expand Area Health Education Centers; and

## HANYS' VIEW

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- ✓ provide state-funded subsidies and tax credits for physicians in shortage areas to establish practices, purchase office-based information technology, fund telemedicine partnerships, and establish online continuing medical education and networking collaboratives.

## **NURSES AND OTHER ALLIED HEALTH PROFESSIONALS**

The shortage of staff in hospitals, nursing homes, and home care agencies continues to be a serious problem for health care providers across New York State. While the nursing shortage has attracted the most attention, other allied professions including pharmacists, coders, many types of medical technicians and therapists, and other clinical workers are beginning to reach crisis levels of short supply. Unless significant action is taken, these shortages are projected to grow with the looming retirement of baby boomers.

One of the most critical issues affecting the pipeline for nurses relates to nursing schools' ability to admit qualified applicants. While increases in graduation levels are projected for the next few years, nearly two-thirds of all nursing programs in New York State had to turn away qualified applicants. Thousands of qualified nursing school applicants have been turned away in recent years in New York State due to lack of faculty, a limited number of clinical practice sites, and lack of campus space. Moreover, the average age of a nursing faculty member is 53 and a number of New York universities have closed their nursing programs in recent years. The Health Resources and Services Administration projects the nation will need 90% more nursing graduates to address a national shortage of nurses that is expected to intensify through 2020. An investment in schools of nursing is critical.

## HANYS' VIEW

To address nursing shortages, HANYS and the New York Organization of Nurse Executives (NYONE) have collaborated on a legislative proposal (S.4994-A, Maziarz/A.8645, John) to improve recruitment and retention of nursing faculty and clinical staff. This legislation would authorize funding to schools of nursing, other educational institutions, and health care providers to ensure adequate faculty, administrative, and capital resources to prepare future generations of entry and advanced level nurses. Funding would be contingent upon a budget appropriation and could be used for:

## HANYS' VIEW

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- ✓ recruitment and retention incentives that expand faculty capacity;
- ✓ initial costs related to the development of new and/or expanded programs, including equipment and capital costs;
- ✓ development of clinical simulation laboratories in both new and existing programs;
- ✓ academic and clinical partnerships to increase the use of expert clinicians to expand faculty capacity;
- ✓ development and expansion of nursing education that is Internet-facilitated and/or provided through satellite course work;
- ✓ initiatives to retain retiring nursing faculty and those expert nurses leaving clinical practice to function in educator roles;
- ✓ financial assistance to prepare nurses for an academic career; and
- ✓ early mentoring programs between school districts, nursing education programs, and health care providers to introduce students to nursing careers.

HANYS further supports strategies to recruit under-represented minorities into nursing and other health care professions, including leadership positions. Also recommended is the appointment of a statewide task force to study and make recommendations to address the shortage of non-nursing professional and paraprofessional health care workers, such as pharmacists, coders, medical technicians, and therapists, and other allied health care professionals.

HANYS continues to strongly object to legislation that would mandate staffing ratios, restrict unavoidable overtime, or require the reporting of a variety of staffing and clinical information. HANYS and NYONE continue to urge the Legislature to reject these kinds of legislation because they are not real solutions. Passage would make workforce problems worse and confuse the real issue—the workforce shortage.

## A NEW WORKFORCE PARADIGM

HANYS supports new ways to address changing workforce needs. A new workforce paradigm that moves beyond traditional thinking is needed to:

- support informal caregivers, including the provision of respite care;
- re-engage retiring health care workers in new roles;
- address ways to maximize workforce potential;
- incorporate the use of technology in patient care, education, and training, including home care monitoring, emergency assessment and diagnosis, expert consultations, and distance learning;
- create a more flexible health care caregiver qualified to work in jobs in multiple settings;
- create a volunteer health service corps;
- provide tax credits to caregivers at home; and
- create incentives to increase informal caregiving and support for those living in their communities.

**HEALTHCARE ASSOCIATION OF NEW YORK STATE**

One Empire Drive | Rensselaer, NY 12144

(518) 431-7600 | [www.hanys.org](http://www.hanys.org)