



Healthcare Association  
of New York State

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Testimony of the  
Healthcare Association of New York State  
on the  
2007-2008 Executive Budget Proposal  
before the  
New York State Senate Finance Committee  
and the  
Assembly Ways and Means Committee

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*February 13, 2007*

Thank you, Chairman Farrell and Chairman Johnson, for providing the Healthcare Association of New York State (HANYS) the opportunity to testify before this joint session of the Senate Finance Committee and the Assembly Ways and Means Committee regarding Governor Eliot Spitzer's proposed 2007-2008 Executive Budget. I am Daniel Sisto, President of HANYS, which represents more than 550 non-profit and public hospitals, nursing homes, health systems, and home care agencies throughout New York State.

For many years, I have come before this body to react to budget proposals and discuss a long list of critical issues that affect our health care system. Year after year, lawmakers and health care providers have worked together on many complicated and difficult 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, we direct our energies to continue this important effort because of our mutual commitment to the health and welfare of the people of this state. What I know to be true about this legislative body, as well as the health care providers I represent, is that we do this because we are all committed to putting patients first.

Health care providers embrace reform. We want reform that expands coverage for the uninsured. We want reform that gives all people access to basic primary care, as well as the marvels of modern medicine. We want reform that encourages efficient care of the highest quality. And we want reform in which every payer contributes their fair share of reasonable costs instead of shifting those costs onto patients and health care providers. I agree that New York's patients and taxpayers can no longer afford the absence of a meaningful reform plan that we all agree is necessary to strengthen our health care system so that it can deliver better, more efficient patient care.

However, deep payment cuts and taxes do not constitute health care reform and they are not a remedy for the ills of the system. I ask today that the members of the New York State Legislature reject across-the-board cuts and taxes, and proposals to redistribute funds that providers have committed to public priorities. And second, I ask you to seize this opportunity to make reform-related investments in our health care system.

# Double Devastation

## Albany and Washington

New York's hospitals, continuing care providers, doctors, and nurses once again face a two-front battle to protect the interests of our patients. The state and federal budget plans submitted recently by Governor Spitzer and President Bush, respectively, combine to represent a serious threat to patient care in New York by cutting billions of dollars in funding from an already fragile infrastructure.

The President's federal health care budget is a remarkable leap backward for health care. In addition to proposing significant provider health care cuts, his plan would strip away children's health insurance coverage. President Bush's proposed federal fiscal year (FFY) 2008 budget includes provisions that would reduce payments to hospitals and other providers by \$7.5 billion over the next five years, including \$2.8 billion in Medicare cuts and an additional \$4.7 billion in cuts to Medicaid payments. Under Governor Spitzer's 2007-2008 Executive Budget plan, hospitals in New York State would lose \$2.5 billion over the next five years.

The unplanned but nonetheless real combination of the President's cuts and the health care cuts proposed by the Governor would seriously damage our health care system, not cure its ills. Health care needs reform, not across-the-board cuts.

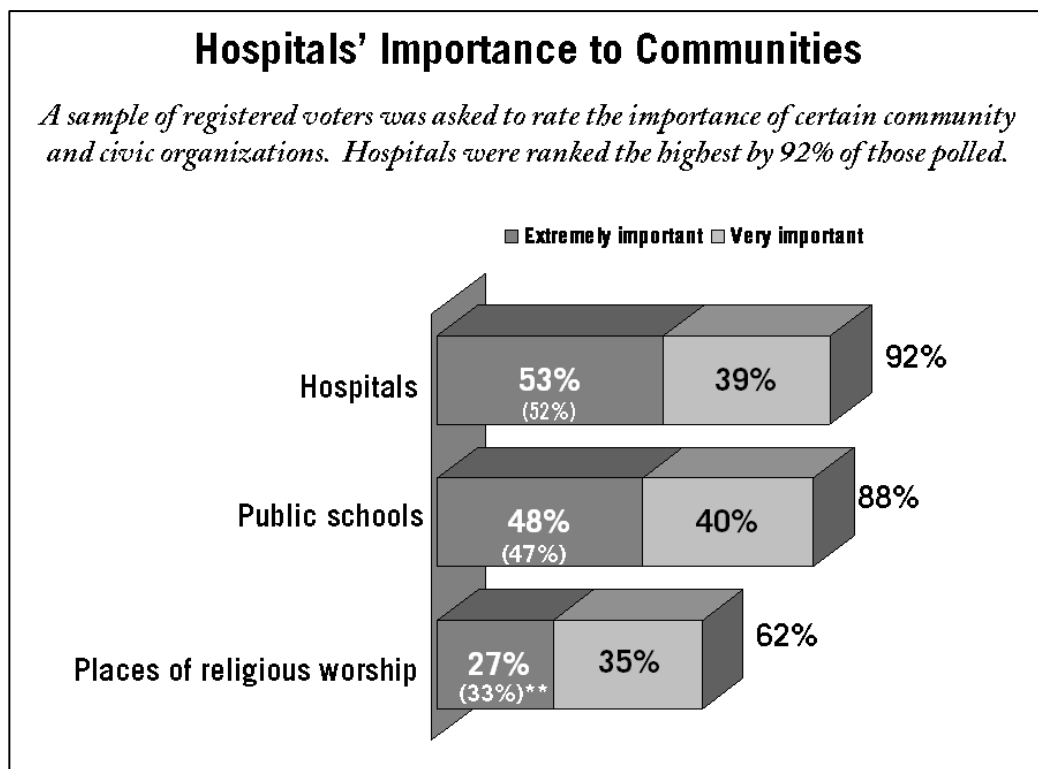
We urge the Governor to significantly modify his plan in the current amendment period. We will also continue to work with the State Legislature and Congress to address the state and federal proposals to ensure our patients have access to the best care possible.

# The Big Picture

## The State of Our Health Care System

Health care providers play a unique role in New York's health care system. New Yorkers depend on hospitals and other providers to be there in times of need—24 hours a day, 365 days a year. They are staffed by competent and compassionate caregivers who provide access to emergency care, stand ready to provide leadership during disasters, give care to the vulnerable and uninsured, invest countless dollars in community health, and strive to provide the most up-to-date medical technology and care.

Each year, millions of patients and residents are cared for and treated in their homes and, when necessary, in a hospital or nursing home. Hospitals and other health care providers are lifelines for their communities and share a special bond. This bond has been shown in public opinion polling. A 2005 survey by Opinion Dynamics Corporation of 600 New York registered voters showed that New Yorkers value hospitals more than any other institution in their communities.



There has been much discussion about the need to “rightsize” hospitals and nursing homes. The process of rightsizing began well before the creation of the Commission on Health Care Facilities in the 21st Century. This is evidenced by the closure of 16 hospitals in New York State between 2003 and 2005. During that same time period, 28 nursing homes statewide closed.

The Commission’s report included both binding and non-binding recommendations. The binding recommendations focused on rightsizing. But it was the non-binding recommendations that were truly reform-focused. These were the recommendations that should have been binding.

Rightsizing is only one component of necessary reform that benefits patients and health care consumers. True reform of the health care delivery system must span the entire continuum, and it must preserve and strengthen the ability of vulnerable populations to access health care. It cannot be focused solely on hospitals and nursing homes. All members of the provider community must participate, as must health insurers and others.

For example, Medicaid reimbursement to hospitals is based on an obsolete base year—in most cases as far back as 1981. Of course, costs and reimbursement are not aligned in every hospital for every cost every year under those circumstances. This is very similar to the situation that this Legislature addressed last year for nursing homes.

So, let’s revisit hospital reimbursement. Let’s look at the \$1.7 billion in losses from outdated emergency room and outpatient payments. Let’s look at new advances in technology and medicine that did not exist 25 years ago. Let’s look at the real cost drivers such as energy, medical liability, and pharmaceuticals. Let’s look at unfunded mandates. And let’s look at our 21st century needs for emergency preparedness. Let’s look at this system and make sure it reflects the cost of care.

# What Does HANYS Recommend?

Both the state and federal governments promote health care “reform.” New York State has moved through many models of health care over the past 25 years—from marketplace to highly regulated to a variety of hybrids—and each of the models has undergone near constant “reform.” But real answers lie with comprehensive reform that addresses coverage for all, coordination of care, and wellness.

We support the Governor’s call to provide health care coverage to the millions of New Yorkers who are uninsured, to expand primary care, to better manage the care of high-cost Medicaid beneficiaries, and to invest in health care information technology. These initiatives are critical to lasting reform.

We greatly appreciate the actions of the Legislature last year to start to address inadequate emergency room payments and to reform nursing home reimbursement. We are pleased that those items are included in the budget. These targeted investments are part of real health care reform because they directly affect access to care. Unfortunately, the proposed budget cuts more than offset these needed investments.

Last month, we shared with you HANYS’ comprehensive health care reform plan that focuses on the fundamental, long-term changes that are necessary to improve patient care and achieve lasting reform. The plan, called *Rational, Efficient, Affordable, and Lasting Health Care Reform*, or *REAL Health Care Reform*, seeks to improve the efficiency and quality of health care by recommending significant structural adjustments to the state’s health care system.

The *REAL Health Care Reform* plan is founded on the wisdom and experience of our more than 500 hospital and health care facility members, and clearly sends the message that providers are serious about being partners in instituting real reform that improves, not diminishes, patient care. There is no quick fix. Only fundamental, structural change will lead us to a stronger health care system that affords patients the very best care possible.

The primary components of HANYS' *REAL Health Care Reform* plan are:

- **ACCESS AND COVERAGE.** Expanding access to New York's 2.6 million uninsured residents is a difficult task that HANYS is committed to accomplishing in partnership with New York State. HANYS believes that a coordinated set of initiatives will accomplish the goals of achieving universal coverage for children and reducing the total number of uninsured by half by 2010. To achieve this enrollment goal by 2010, three primary actions are required: (1) simplification of the eligibility and recertification process, (2) improved program outreach, and (3) expansion of CHP B eligibility criteria.

This is an area where the President's budget proposal will make our collective job tougher. He proposes to limit federal participation in Medicaid for the State Children's Health Insurance Program (SCHIP) to children in families with incomes below 200% of the federal poverty level (FPL). The Governor proposes expansion of New York's Child Health Plus program to cover children up to 400% of FPL. We support the Governor's plan and need to work together to ensure the federal government continues to be a fully contributing partner.

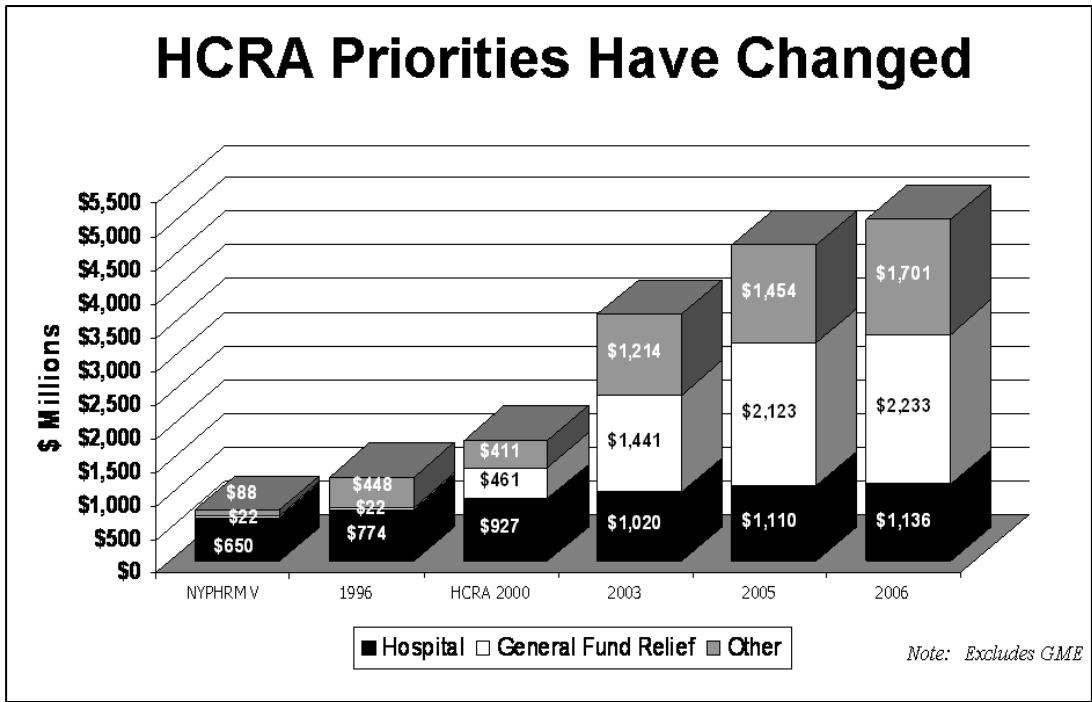
- **ACCOUNTABILITY OF PAYERS.** HANYS recommends promoting payer accountability by ensuring adequate financing of the health care delivery system to support existing quality services and to keep pace with the evolution of patient care, and requiring insurers to pay provider claims responsively.

HANYS believes that improving the health care system should be a shared investment, not just the responsibility of providers and the federal and state governments, and should create opportunities to improve a community's health care system. Additionally, managed care organizations must be held accountable for their market conduct. Strengthening and improving existing laws regulating the health insurance industry will restore balance between providers and payers, ensure providers are paid for the medical services they render, and, most importantly, ensure all New Yorkers benefit from access to quality health care.

- **CERTIFICATE OF NEED (CON).** New York's CON program is overwhelmed and understaffed, and guided by regulations egregiously out of date. Despite the best intentions of many Department of Health (DOH) staff, the system is broken and in need of repair. HANYS, working with an ad hoc group of members from across the state and allied health care associations, has recommended that DOH immediately institute a series of short-term reforms that would not require regulatory change, and then address the larger task of overhauling the regulations to reflect a new vision for rational health planning. HANYS has also recommended specific actions that would streamline and update the CON review process, and improve coordination with the DOH regional offices.
- **COORDINATED CHRONIC CARE MANAGEMENT.** About 25% of Medicaid enrollees are elderly and disabled, yet more than two-thirds of Medicaid spending in New York State is related to caring for these populations. Much can be done to improve the quality, coordination, and efficiency of care to patients. Coordinated chronic care management focuses on effective treatment (both clinical and behavioral), information and support for their self-management, systematic follow-up and assessment tailored to clinical severity, and coordination of care across settings and providers. A progressive and efficient chronic care management program will redesign the delivery system and address accountability, benefits, and long-term costs. HANYS recommends the creation and testing of various models of coordinated chronic care management and supports the Governor's call for more demonstration projects for this purpose.
- **HEALTH CARE REFORM ACT (HCRA).** HCRA expires on June 30 and Governor Spitzer has recommended, as part of his proposed budget, a nine-month extender to March 31, 2008. HANYS recognizes that the new Administration needs an opportunity to review the entirety of the reimbursement approach. We welcome a chance to participate in that review.

When HCRA was first enacted ten years ago, it was devoted primarily to hospital financing. While hospital financing is still HCRA's underpinning, the HCRA pools fund countless initiatives affecting the entire health care system. HCRA has evolved into a multi-purpose financing mechanism.

A noteworthy beneficiary of HCRA funding today is the New York State Treasury. Over the years, monies have been transferred from HCRA to support the general fund and many state programs have been moved into HCRA, including the Elderly Pharmaceutical Insurance Coverage program, public health, mental health, and other programs. In addition, HCRA funds a number of other initiatives, including Child Health Plus and Family Health Plus, Healthy NY, workforce recruitment and retention initiatives, and the excess medical malpractice coverage program. Today, the State Treasury receives approximately \$2.2 billion from the HCRA pools.



To provide a level of stability in the health care system, it is critical to maintain and preserve the public goods pools contained in the current system. 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.

There are adequate funds to ensure full funding of the public goods pools. To the degree that there is a question about the overall level of available funding, it is related to the “creative” uses for which pool funds have been diverted.

- **LONG-TERM CARE REFORM.** Reform should build on strengths and make improvements. It should maximize community resources, redefine workforce, integrate flexibility, create more opportunities for making personal choices, embrace patient-centered partnerships, and incorporate technology.

HANYS supports restructuring long-term care but not through a Section 1115 Medicaid waiver or through rigid gatekeeper models. HANYS believes that the focus on an 1115 waiver is limiting and leaves out critical issues that need to be addressed including workforce, housing, transportation, and non-medical issues. HANYS has made a series of recommendations to address issues related to community resources, service coordination and management, and long-term care service programs. HANYS supports expansion of home- and community-based services and housing options so that more New Yorkers can receive the care they need in their homes.

- **MEDICAL LIABILITY REFORM.** New York’s system for compensating patients injured by provider negligence is inequitable, inefficient, and unfair—to patients, providers, and the public. Vast sums of money pour from providers to insurers and from there to plaintiff and defense lawyers and finally into the hands of the very few patients that are compensated, some modestly and some excessively.

Systemic remedies are needed to correct the long-engrained dysfunctions in the medical liability system. In addition to continuing to support liability caps and selective “no-fault-like” approaches (i.e., neurologically-impaired newborns), HANYS also proposes that a dramatic plan be pursued to provide sensible compensation more promptly, establish an informed adjudication system, and promote candid physician-patient communication.

- **NICHE PROVIDERS.** A more level playing field in relation to niche providers is needed to ensure that the public good is met. Public need criteria applied by DOH as part of the CON process were loosened in the mid-1990s to allow the proliferation of “niche” providers. In New York State, niche providers include freestanding, state-licensed, for-profit ambulatory surgery and imaging centers, as well as private office-based surgical and imaging practices.

This proliferation has a continuing negative impact on hospitals across the state. The negative impact partly takes the form of for-profit entities “cherry picking” patients—that is, caring for less sick but better-insured patients. Not only does this erode the revenue base that hospitals depend on, but it jeopardizes the core mission of not-for-profit and public hospitals. Additionally, hospitals must operate 24 hours a day, seven days a week, and treat all patients including the uninsured and under-insured.

- **PRIMARY CARE.** The Medicaid payment system needs to be restructured to better promote primary care. More than ten years ago, the state embarked on an expanded effort to enroll Medicaid beneficiaries in Medicaid managed care and to provide a “medical home” for beneficiaries. However, Medicaid managed care has often been more about managing costs than managing care.

To help promote primary care, HANYS recommends a targeted increase in Medicaid reimbursement for physicians, hospital outpatient departments, and community health centers, and incentives to promote after-hours primary care. HANYS recommends that the state undertake a campaign to assess barriers to health literacy and to initiate creative ways for consumers to access information.

- **QUALITY IMPROVEMENT.** Health care providers should 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.

In the area of quality data collection and reporting, the state has a real opportunity to support a comprehensive, integrated strategy that advances quality of care. HANYS supports developing a standardized and integrated approach to quality measures and metrics. HANYS also supports aligning New York State data collection and reporting efforts with the established CMS-led Hospital Quality Alliance. We urge the state to pursue the same goal.

In both Washington and Albany, HANYS has also been working to influence health information technology (IT) policy. The driving force behind hospitals' investment in IT is not savings, but the goal of improving the quality of patient care. The barriers to achieving widespread IT adoption are vast. While some hospitals and health systems have sophisticated and comprehensive IT systems, these "early adopters" are a minority. A significant investment is needed to achieve widespread IT adoption. Among HANYS' recommendations are establishing accessible and sustainable funding streams to develop IT programs for hospitals and continuing care providers; supporting electronic prescribing; encouraging development of electronic medical records (EMRs); and developing "smart cards."

- **RURAL HEALTH.** New York State's rural health care providers are the centerpiece of the health care infrastructure in their communities. For more than three million of the state's most geographically isolated residents, rural hospitals and health systems are often the only providers of essential health care services. HCRA has been very instrumental in providing funding to rural hospitals and networks. This funding must continue. HANYS further recommends that New York create a state version of the federal Critical Access Hospital designation to help ensure the viability of these fundamental services. Federal Medicare policies have helped many small, rural hospitals to maintain their essential services. Yet, no similar state program exists. Comparable state Medicaid policies would further such reconfigurations.

- **TELEMEDICINE, TELEMONITORING, AND TELEHEALTH SERVICES.** Telemedicine, telemonitoring (including telehomecare), and telehealth can reduce barriers to accessing health care services and health education, ease workforce shortages and, in general, improve health care delivery across the continuum in a cost-effective and efficient manner. Such services are critical for the development of coordinated care models of care and home- and community-based services. Medicaid reimbursement policies are extremely limited and need to be updated to encourage appropriate and necessary use of these services.
- **WORKFORCE SHORTAGE.** The shortage of staff in hospitals, nursing homes, and home care agencies continues to be one of the most critical issues facing health care providers across New York State. The nursing shortage has attracted the most attention, but pharmacists, coders, many types of medical technicians and therapists, and other clinical workers are also in short supply. Hospitals also report increasing challenges with the recruitment and retention of physicians. As physicians retire or leave New York State, the recruitment of replacements is becoming increasingly difficult. Attracting and retaining physicians is difficult for a number of reasons, including low physician reimbursement and regulatory barriers. Among other initiatives, HANYS recommends that providers, practitioners, and policymakers work to ameliorate workforce shortages by strengthening the educational infrastructure in New York and continuing programs that support workforce development and retention. Additionally, HANYS recommends financial incentives for medical students and physicians willing to locate in shortage areas and work in needed specialties, and to increase the number of under-represented minority physicians.

These are the cornerstones of effective and lasting reform. Further details are available in our *REAL Health Care Reform* advocacy agenda document. I reiterate, deep payment cuts and taxes do not constitute health care reform.

# The Proposed State Budget

The proposed budget includes a litany of cuts that could inflict real damage on our ability to care for patients. While the Governor has advanced a number of health care reforms that are consistent with HANYS' reform agenda, the provider payment cuts that have been proposed are devastating. Nearly \$1 billion in cuts and taxes are targeted at hospitals and nursing homes, as follows:

STATEWIDE 12-MONTH IMPACT OF PROPOSED CUTS AND TAXES	
Total	(\$975,800,000)
Hospitals	(\$512,200,000)
Nursing Homes	(\$463,600,000)

These new cuts are on top of the more than \$1 billion in old Medicaid provider cuts that are proposed to be reauthorized this year.

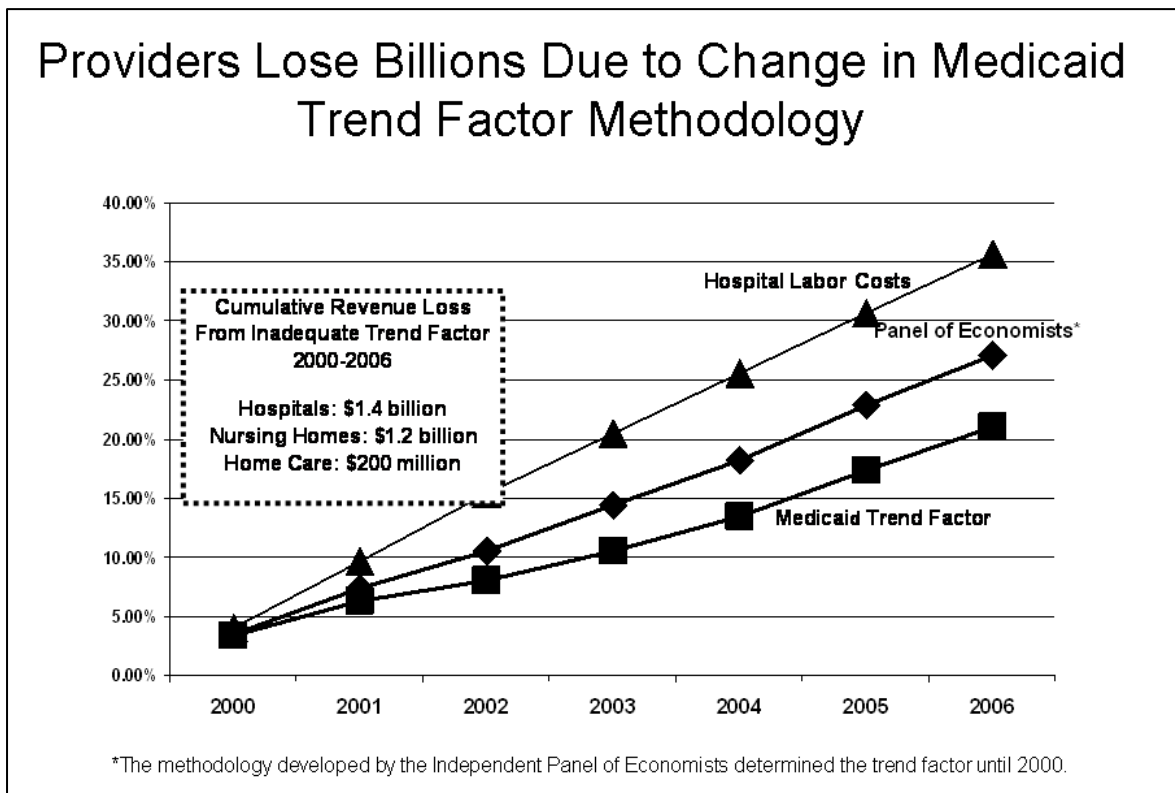
This year, the proposed budget is more complicated than simple numbers. In addition to proposing provider payment reductions, there is an additional twist. The Governor proposes a significant redistribution of funding to hospitals. This is most evident in the funding provided to hospitals for workforce recruitment and retention. The Governor also asks for authorization to implement a new bad debt and charity care methodology and to re-weight hospital Diagnosis Related Groups. Data on the impact of these proposals are not yet available, as the proposals have not been fully developed by the Administration.

## TREND FACTOR

The trend factor is an inflationary update for hospitals and nursing homes that is supposed to reflect the increase in the cost of providing care. The Governor's budget proposes to eliminate the 2007 trend factor. Despite the inadequacies of the current trend factor—and we believe there are many—it does provide essential financial relief. This is particularly important since the cost

of delivering patient care continues to grow—at a much faster rate than the trend factor the state has used—due to increasing costs for necessities such as energy, pharmaceuticals, labor, medical liability, insurance, technology, and blood and blood products.

Hospitals, nursing homes, and home care agencies have provided New York State with “hidden savings” because the Medicaid trend factor, which is linked to the Consumer Price Index, is not a health care-specific index and has shortchanged health care providers by \$2.8 billion since 2000. Rather than eliminate the 2007 trend factor, HANYS recommends that the Legislature establish a mechanism or an independent body to determine an effective trend factor in the coming years.



## GRADUATE MEDICAL EDUCATION (GME)

The state budget proposals related to GME cannot be viewed in isolation from the President’s budget. The President’s Medicare proposal would cut approximately \$1.2 billion in GME payments to teaching hospitals over five years. His Medicaid proposal, moreover, would eliminate federal funding for any GME payments in a state’s Medicaid reimbursement system.

That proposal alone would cost New York State hospitals \$600 million in lost federal funds per year—or \$3 billion over five years. The threat of these extraordinary and targeted cuts should obviate consideration of additional state proposals related to GME.

Cuts to GME negatively affect all New Yorkers because the state has long benefited from being a world-class center of medical education. Many of the world’s finest doctors not only trained here, but also stayed here to practice medicine. It has meant significant investment in medical research. Besides being good for our economy, New York’s teaching hospitals provide millions of dollars each year in uncompensated care to safety net populations.

The primary GME proposal would reduce payments at a select number of hospitals whose Medicaid GME reimbursement exceeded their estimated 2001 Medicaid teaching costs (trended for inflation). The origin of this proposal is a provision that was in the 2004-2005 state budget that updated the base year for GME costs from 1990 to 2001. That law held harmless hospitals whose reimbursement exceeded costs and it did not apply to public hospitals. The current proposal eliminates the hold-harmless provision that was included in the 2004-2005 state budget and makes public hospitals subject to the payment reductions.

During the 1990s, policymakers encouraged hospitals to reduce the number of medical residents they train based on the assumption that we had too many doctors. Some hospitals responded to the public policy incentive and reduced the number of residents. This budget cut would penalize those hospitals that have acted in accordance with public policy and have reduced their number of residents.

In actuality, the number of residents in New York State has increased although, on a hospital-specific basis, the numbers may vary. In 1990, teaching hospitals trained approximately 14,000 residents; in 2005, that number was 15,000. In the aggregate, we are training more doctors, not “phantoms.”

The proposed budget also includes a cut to the private payer HCRA GME pool. It should be noted GME funding already underwent a major reduction when HCRA was first enacted. The private sector—business and insurers—was given a 46% discount on its contribution to GME.

And now we find ourselves with a present and future shortage of physicians, in particular throughout upstate New York and in urban, low-income areas. The GME cuts should be rejected.

## **“SICK TAX” REINSTATED**

The sick tax is a tax, even if called an assessment, and we urge you to reject it. The sick tax is bad policy and it is not health care reform. When adopted in 2005, it was argued that the imposition of a tax was essential to satisfying the federal government to obtain a Federal-State Health Reform Partnership (F-SHRP) waiver and \$1.5 billion in federal funds. The state has received the waiver, but a “sick tax” is not a requirement imposed by the federal government. This ill-advised tax should be eliminated.

The budget proposes to continue the 0.35% gross receipts tax (GRT), which would otherwise expire April 1. When the GRT, or “sick tax,” was reintroduced in 2005 at 0.35%, it was estimated to be worth \$106 million to the state. A cap was imposed on the amount of GRT money that the state could use and, if collections exceeded the threshold of \$106 million, the excess was to be rebated back to the hospitals. It is now clear that the amount collected in GRT has been significantly higher than initially budgeted. The budget proposal also waives this reconciliation by removing the cap and capturing the money that was supposed to be rebated to hospitals.

## **WORKFORCE FUNDING**

For a number of years, health care has experienced a shortage of nurses and other direct care workers 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 working age population continues to decline. The average nurse is in his or her late forties, and the number expected to retire soon continues to exceed the number entering the field each year.

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 was distributed proportionally on the basis of overall staff payroll expenses. A legitimate public purpose was achieved through this mechanism because providers do not hire “Medicaid nurses” or “Medicaid aides.” 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.

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 or added or expanded fringe benefits to compete in the labor market for staff.

Five years later, these workforce costs are now part of the salary and benefit base for our hospitals and nursing homes. 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. But more has to be done, not less, to maintain the positive momentum, and we have many suggestions about how to deal with faculty shortages and school limitations that we would be happy to share with the Legislature.

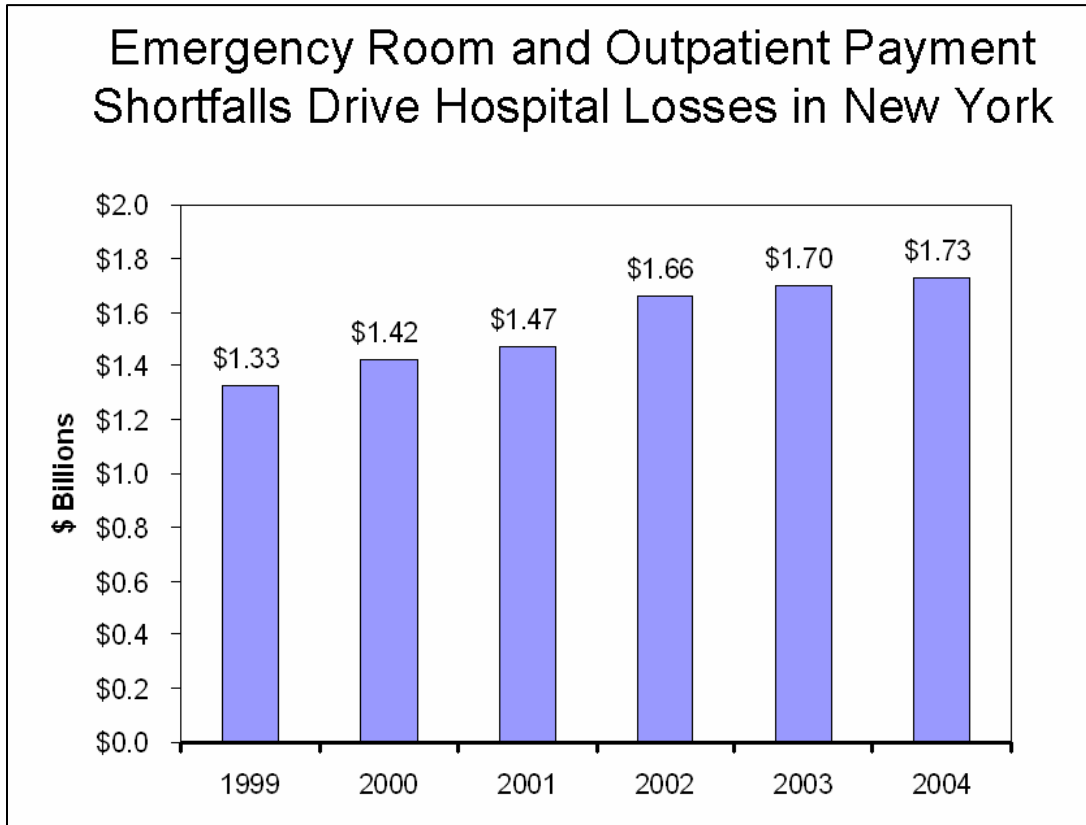
In relation to the 2002 workforce funding, the proposed budget reduces funding and redistributes it according to Medicaid discharges (vs. average wage and fringe costs for direct care staff). The 2005 workforce funding would not be cut, but it would be redistributed in the same manner. In both cases, the primary argument to redistribute funds has been that Medicaid dollars should be spent on Medicaid patients. However, the proposed cut and its redistribution effects would, if enacted, have a dramatic effect on the resources many providers have used to recruit and retain workers. The following chart shows the extent to which the 2002 funding cut and redistribution would affect hospital funding, by region.

2002 WORKFORCE FUNDING REDUCTION AND REDISTRIBUTION			
	Current Distribution	Executive Budget Proposal	Impact
Statewide	\$329,300,000	\$292,500,000	(\$36,800,000)
New York City	\$192,776,000	\$197,728,000	\$4,952,000
Western	\$18,457,000	\$13,699,000	(\$4,758,000)
Rochester	\$15,396,000	\$11,939,000	(\$3,457,000)
Iroquois-Central	\$19,050,000	\$15,702,000	(\$3,348,000)
Iroquois-Northeast	\$16,942,000	\$12,493,000	(\$4,449,000)
Long Island	\$40,644,000	\$19,006,000	(\$21,638,000)
Northern Metropolitan	\$26,035,000	\$21,933,000	(\$4,102,000)

While there are “winners” as well as “losers” as a result of the proposed redistribution, we believe the more important principle is the public policy commitment to help hospitals and other providers address workforce issues. We urge you to reject the proposed changes.

DOH has indicated its intent to redistribute funds based on the premise that high-need hospitals need support. Quite frankly, this is an admission that Medicaid rates are inadequate. We agree that high-Medicaid hospitals need support, and would need much more support if this budget is enacted, but the solution is not to weaken other hospitals by cutting their funding. The proposed redistribution would take from the weak to give to the frail.

We need to acknowledge that high-Medicaid hospitals are in trouble because Medicaid has woefully inadequate rates related to emergency room rates, outpatient clinic payments, and the trend factor. In 2004, emergency room and outpatient shortfalls resulted in hospital revenue losses of \$1.7 billion.



The emergency room rate increase in last year's final budget by the Legislature, and the Governor's inclusion in this budget, will help. But, as you can see, the losses are staggering and more work needs to be done. The proposed budget makes that job harder and more than offsets the emergency room increases from last year.

## **POSSIBLE REVISION TO BAD DEBT AND CHARITY CARE METHODOLOGY**

The proposed legislation would permit DOH to modify the formula for distribution of indigent care funds. 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 process, but a tough debate about how funds should be targeted. This proposal would transfer legislative prerogatives to DOH.

DOH has indicated that attempts to develop a specific proposal were unsuccessful because of inconsistencies in the data. That situation will not change before April 1. HANYS asks the Legislature to defer action until a fully developed proposal, including impacts, is available for discussion, and any contemplated change only be done in statute.

Each year, 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. Bad debt and charity care, or indigent care pool funding, has been increased only once since HCRA was enacted ten years ago. It covers about 50% of uncompensated care costs. However, after considering that hospitals also contribute nearly \$250 million to the pool, the actual coverage level is only about 38%.

## **HOSPITAL DRG RE-WEIGHTING**

DOH has also been working on updating Medicaid Diagnosis Related Group (DRG) weights for some time. HANYS and the allied associations have been supportive of a collaborative effort to update the basis for reimbursement. However, no information on the results of re-weighting has been shared. Any update could have significant redistribution effects, especially after such a long time between updates. A recent Medicare experience is informative. Last year, CMS proposed a similar updating of Medicare DRG rates (albeit with a different methodology). A substantial redistributive effect was the result. With significant input, CMS modified its methodology but also phased it in over several years to allow providers to adapt to the changes.

The effects of a substantial change in DRG weights need to be fully understood. DOH has indicated that it may still be weeks before information is available for consideration. Again, HANYS asks the Legislature to defer action until a fully developed proposal, including impacts, is available for discussion.

## NURSING HOMES

The Executive Budget includes cuts worth an estimated \$464 million annually to nursing homes in three general areas: eliminating a 2007 inflation adjustment (previously discussed), reducing payments for case-mix complexity, and two cuts to workforce related funding.

Last year, the Governor and Legislature enacted an historic adjustment to nursing home reimbursement—rebasng the entire system for the first time in over 20 years—incorporating numerous other features to reflect the needs of the current-day nursing home, and providing for periodic future adjustments to hopefully meet the needs of the nursing home of the future. HANYS, New York Association of Homes and Services for the Aging (NYAHS), and New York State Health Facilities Association (NYSHFA) collaborated on the development of the reform proposal that was enacted and we appreciate the overwhelming support it received. The enacted reform committed to a \$454 million increase in funding to be phased in over several years. We are especially pleased that the Governor chose to honor that commitment going forward. The additional funding and other changes were critical for an institutional long-term care sector that is an essential part of the continuum of care now and in the future.

The current budget proposals would reduce funding by more than the same amount (\$464 million), all in one year. Needless to say, this would be a tremendous setback to our collective effort. More important, it would take us backward to a point worse than last year, where the financial viability of numerous providers and the services they provide to thousands of frail elderly were in jeopardy. Nursing homes have supported in principle the need for downsizing, and we strongly favor the Governor's interest in expanding home- and community-based services. But it should not be done through budget cuts.

In addition to eliminating the 2007 trend factor, the budget proposes to calculate the aggregate case-mix index (CMI) for Medicaid payments using only a facility's Medicaid residents. This is not a new issue. It is the same proposal that has been presented for several years, and rejected by the Legislature each time. This proposal does not consider the reality of how nursing homes are staffed. Staff in nursing homes provide care for all nursing home residents, including residents whose care is paid for by Medicaid. There is no Medicaid nurse or nurse's aide; nor should there

be. Calculating a component of the rate based on a false premise may yield savings to the state, but it ultimately hurts providers and residents alike. Moreover, the full-annual cost of last year's reform legislation explicitly includes the value of using the facility case mix for all nursing home residents. If the state disagreed with continuing the current system, it should have made it known then. We urge you to reject this proposal and preserve the changes that you enacted last year.

Finally, the budget proposes to reduce and phase out nursing home recruitment and retention funding. Also similar to hospitals, nursing home providers made permanent commitments for wages and/or fringe benefits that are simply not reversible. The combined cuts to recruitment and retention rate adjustments and quality improvement grants will have a serious adverse impact on services, and should be rejected.

## The State Budget Numbers Game: Err on the Side of Accuracy

The fundamental goal of governmental health care budgeting is to responsibly fund access to quality health care for everyone. To meet that goal, New York's annual state budget-making process must be founded on realistic estimates of available resources.

Certainly, making predictions of any kind is risky, and predicting something as complex as the state's economy is especially difficult. It is also natural to expect the Executive's fiscal arm—the Division of Budget (DOB)—to be conservative in its projections.

However, a disturbing pattern has emerged in recent years: DOB, with remarkable consistency, has significantly underestimated available revenues, and as a result, draconian health care cuts have been proposed that, when exposed to the full light of day, were not appropriate (and in most cases ultimately defeated).

In fact, DOB has predicted multi-billion-dollar deficits every year since 2003, and every year the state has had a surplus. More telling, in almost every recent year there has been a multi-billion-dollar difference between what was initially predicted and the final, actual number (see chart below).

This pattern is problematic because DOB’s estimates play a very important role during the state budget process. Health care policy and reimbursement is driven in part by available funding; therefore, estimates of multi-billion-dollar budget deficits that never materialize can significantly harm health care.

No one expects predictions to hit the mark every time, but we at least expect them to be in the ballpark. The following table, using DOB’s published figures, speaks for itself.

<b>DOB TRACK RECORD</b>			
<b>Year</b>	<b>Projections Made Prior to the Start of the State Fiscal Year</b>	<b>Periodic Budget Updates/ Projections During the Fiscal Year</b>	<b>Year-End Number</b>
2003-2004	\$9.3 billion deficit (January 2003)	<ul style="list-style-type: none"> <li>• \$900 million deficit (May 2003)</li> <li>• \$261 million surplus (January 2004)</li> </ul>	\$308 million surplus
2004-2005	\$5.1 billion deficit (January 2004)	<ul style="list-style-type: none"> <li>• \$434 million deficit (October 2004)</li> <li>• \$170 million surplus (January 2005)</li> </ul>	\$1.2 billion surplus
2005-2006	\$4.2 billion deficit (January 2005)	<ul style="list-style-type: none"> <li>• Budget in balance (October 30, 2005)</li> <li>• \$1 billion surplus (October 31, 2005)</li> </ul>	\$2+ billion surplus
2006-2007	<ul style="list-style-type: none"> <li>• \$5.8 billion deficit (January 8, 2005)</li> <li>• \$2.5 billion (October 2005)</li> <li>• \$751 million deficit (January 2006)</li> </ul>	<ul style="list-style-type: none"> <li>• \$550 million surplus (July 2006)</li> <li>• \$1.1 billion surplus (October 2006)</li> <li>• \$1.5 billion surplus (January 2007)</li> </ul>	?
2007-2008	<ul style="list-style-type: none"> <li>• \$3.2 billion deficit (July 2006)</li> <li>• \$1.6 billion deficit (January 2007)</li> </ul>	?	?
2008-2009	<ul style="list-style-type: none"> <li>• \$5.4 billion deficit (July 2006)</li> <li>• \$3 billion deficit (January 2007)</li> </ul>	?	?

# Medicaid Fraud and Abuse

Medicaid funds lost to fraud, waste, and abuse are funds lost by low-income, elderly, and disabled individuals in New York State who need and deserve access to the health care that Medicaid provides for them. Beneficiaries, providers, and government have an obligation to ensure that Medicaid dollars are used for their intended purposes.

In his 2007-2008 budget, the Governor proposes three new Medicaid fraud laws: a state version of the federal False Claims Act, a “Martin Act” for health care, and new health fraud crimes. Given the abusive tactics by federal regulatory agencies under the federal False Claims Act and the challenge to certain civil liberties under the proposed Martin Act, HANYS urges the Legislature to resist the temptation of enacting qui tam and Martin Act provisions. These are very disturbing proposals that do not align the “punishment to fit the crime.”

- **FALSE CLAIMS ACT.** While New York has many laws against filing false or fraudulent Medicaid claims, the state does not have any qui tam provisions. Qui tam laws provide monetary awards to private “bounty hunters” who bring cases as if they were government prosecutors. Under the False Claims Act proposal in the Governor’s budget, the qui tam may be awarded 15% to 30% of any amount recovered by the government. HANYS believes that individuals who may have participated in inappropriate billing practices should not be rewarded for that behavior, or be provided with incentives to delay reporting problems to their supervisors. The use of effective corporate compliance programs, which were approved by the Legislature last year, require all employees to report problems as soon as possible so they may be corrected. Qui tam provisions provide contradictory incentives.
- **MARTIN ACT.** The second proposal is a so-called Martin Act for health care. Originally enacted in 1921, the federal Martin Act was designed to combat the rampant securities fraud that was engulfing the investment community. At the time, federal securities laws did not exist and each state was left to devise its own laws. The Martin Act has been called the most sweeping investigatory and prosecutorial law of its kind, state or federal.

The circumstances surrounding the need for a Martin Act in New York in 1921 do not apply to the state's powers or ability to administer and police the Medicaid program. The state already has numerous comprehensive laws and regulations to fight Medicaid fraud. Health-related enforcement agencies have many legal tools to maximize fraud detection and prosecution efforts, including whistleblower protections and a variety of civil and criminal sanctions.

Among its provisions that are included in the Governor's budget proposal are:

- ✓ The courts have held that there is no right to have an attorney present during an interview since at that stage it is only an investigation, not a criminal proceeding.
  - ✓ The Attorney General has complete discretion to determine if an "interview" of a witness will be in the privacy of the Attorney General's office or in open court before the public.
  - ✓ The law makes it a criminal offense to "unreasonably" refuse to answer a question or produce any document that has been demanded.
- 
- **FRAUD CRIMES.** The Governor also proposed a series of new fraud-related crimes that closely mirror those contained in the existing Martin Act. The significance of the Governor's measures is that they do not require intent to defraud, yet are punishable as felony offenses. In addition, the Governor's budget would increase the punishment for these felonies to exceed comparable offenses that require intent to commit a criminal act. The current Martin Act crimes are all lesser misdemeanors.

Last year, HANYS made a series of recommendations on ways to prevent fraud and abuse and on proposals under consideration in the State Legislature. Some of these recommendations were enacted into law. All were and continue to be guided by five major principles:

- ✓ HANYS' members are committed to acting honestly and support government's role in preventing, uncovering, and eliminating Medicaid fraud and abuse.
- ✓ HANYS' members aim to combat fraud, minimize billing errors, and comply with thousands of pages of Medicaid and Medicare rules and guidance.

- ✓ Efforts to combat fraud must not confuse mistakes for fraud. HANYS' members take seriously both fraud and billing mistakes, but mistakes and fraud are not the same.
- ✓ Providers have an obligation to self-disclose if either fraud or billing errors are found.
- ✓ Efforts to combat fraud must not lose sight of the importance of New York's Medicaid program in ensuring access to care for our most vulnerable populations.

It is important to prevent, uncover, and eliminate fraud. However, the real faces of Medicaid are the honest providers and beneficiaries who appropriately participate in the Medicaid program, and live and work in our communities.

## When Will It End? Eight Straight Years of Hospital Losses

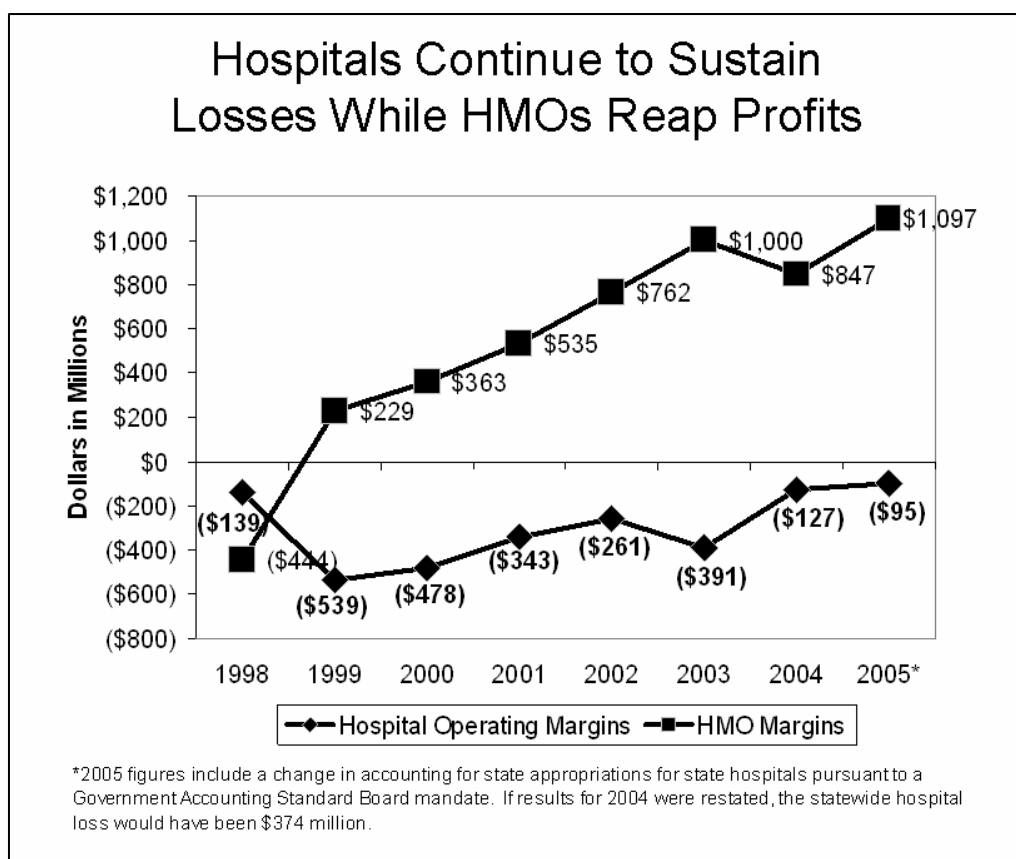
HANYS annually assesses a variety of financial indicators to evaluate the fiscal condition of hospitals and, over the years, HANYS has focused on operating margins and other financial indicators to describe the financial condition of hospitals. Reimbursement from government and private payers for patient care comprises 90% of a hospital's revenue.

Unfortunately, HANYS' most recent analysis shows that the financial condition of hospitals in New York continues to be weak.

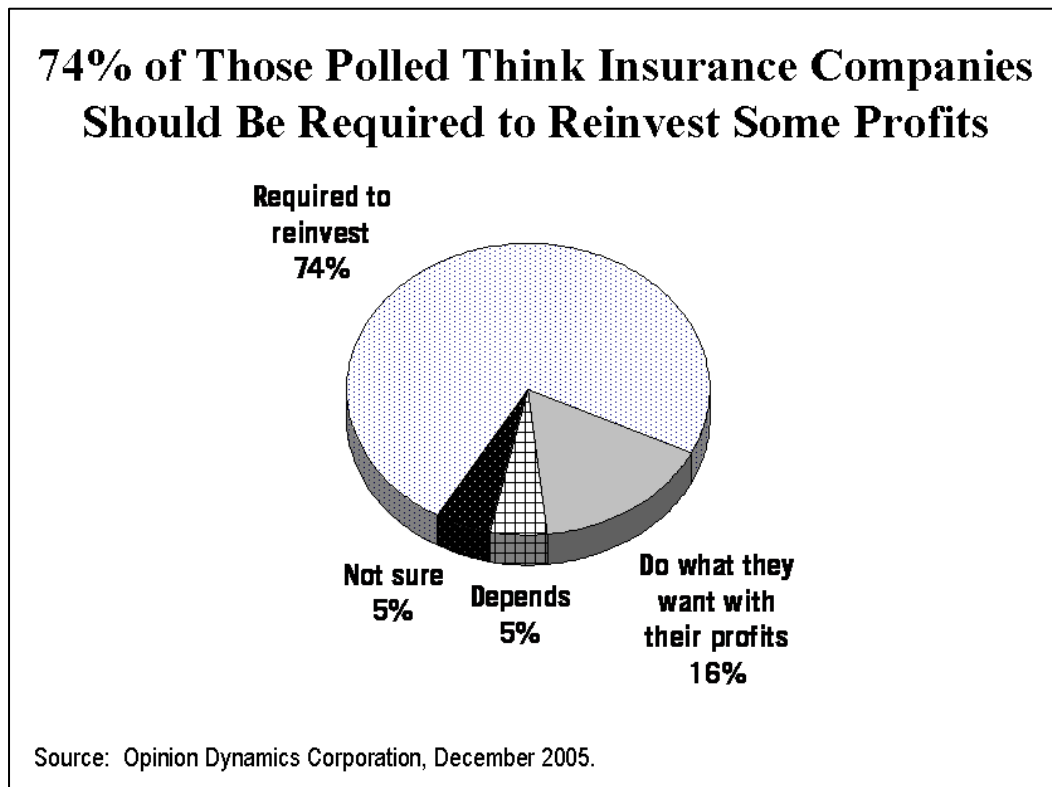
- For the eighth consecutive year, hospitals lost money providing patient care in 2005. Overall, the 217 hospitals in New York State lost \$95 million in 2005—an operating margin of minus 0.2%, bringing total losses to \$2.4 billion since 1998.

*Ongoing financial losses have serious implications for patients, staff, and communities when needed improvements cannot be made and patients and community needs go unmet.*

- Fifty-six percent of hospitals were losing money, breaking even, or operating in a precarious condition with financial margins of 1% or less, which is well below the 4% that health care economists recommend. In the aggregate, 86% of hospitals in New York State were below the 4% level in 2005.
- New York now ranks second-worst in the nation when compared to hospital operating margins in all other states, which average a positive 3.7%.
- In stark contrast, the health insurance sector, particularly health maintenance organizations (HMOs), achieved record profits in 2005, receiving more than \$1 billion in profits. Over the past six years, New York HMOs have reaped \$4.8 billion in profits, after meeting reserve requirements.



- Health insurers should be required to pay provider claims responsibly. Payer accountability must involve adequate financing of the health care delivery system to support existing quality services and keep pace with the evolution of patient care. The survey by Opinion Dynamics Corporation of registered voters shows that 74% feel insurance companies should reinvest back into the health care system.



## Conclusion

I have attached two items as addendums to my testimony. The first is a listing of the proposed hospital and nursing home cuts. The second document, entitled “Medicaid in New York State—Separating Fact from Fiction,” is an analysis that will hopefully answer many of your questions about the Medicaid program.

In conclusion, the true test of any reform will be whether it improves the lives of those who depend on the health care system. The care provided by and the economic impact of health care

providers cannot be taken for granted. In this time of tremendous uncertainty and restructuring, payment cuts jeopardize the ability to continue providing quality, accessible care and to meet community needs. Public and private payers must adequately fund the cost of providing care.

Thank you for the opportunity to comment today. I would be pleased to respond to any of your questions.



## ADDENDUM A

### Hospital Proposals (12-Month Impact)

<u>Hospital Impact</u>	<u>(\$512,200,000)</u>
Eliminate 2007 trend factor	(208,700,000)
Reduce Medicaid GME payments	(82,700,000)
Reduce GME HCRA pool payments	(24,000,000)
Reinstate gross receipts tax (GRT)	(136,900,000)
Capture prior year GRT payments over statutory cap	(44,300,000)
Reduce and redistribute 2002 workforce recruitment and retention	(36,800,000)
Continue and redistribute 2005 workforce recruitment and retention	121,000,000
Continue 2005 rural workforce payments	7,000,000
Eliminate special workforce grants	(18,000,000)
Establish new public hospital priority restoration pool	48,000,000
Redistribute existing non-public priority restoration pool	-0-
Eliminate restructuring pool	(20,000,000)
Reduce HCRA workforce retraining	(20,000,000)
Potential reduction in Medicaid managed care, Family Health Plus, and Child Health Plus payments	(81,500,000)
Reduction in Workers' Compensation and No-Fault Payment	(15,300,000)
Update DRG weights	Not Available
Redistribute indigent care funding	Not Available

### Nursing Home Proposals (12-Month Impact)

<u>Nursing Home Impact</u>	<u>(\$463,600,000)</u>
Eliminate 2007 Medicaid trend factor	(166,200,000)
Implement Medicaid-only case mix	(190,000,000)
Reduce and phase out workforce recruitment and retention	(44,000,000)
Eliminate nursing home quality improvement grant	(62,500,000)



## ADDENDUM B

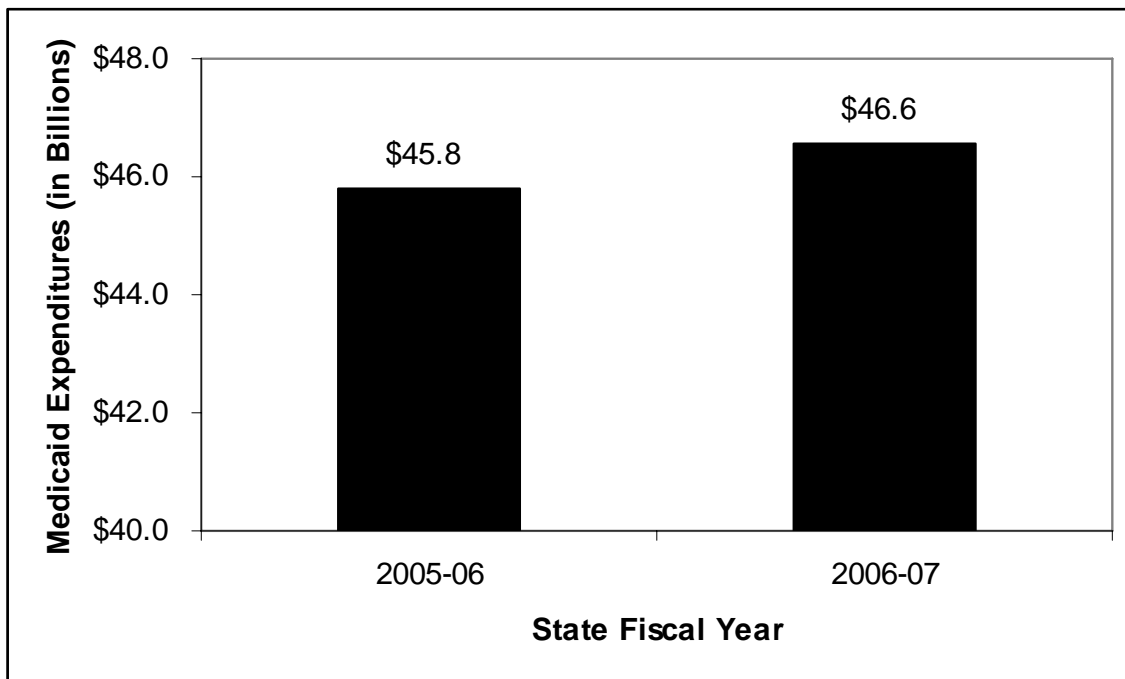
### Medicaid in New York State—Separating Fact from Fiction

New York’s Medicaid program is under attack, with some challenging the costs and benefits of the program. New York’s program has an unparalleled record of caring for the most vulnerable in our communities by providing health care coverage for low-income children and adults, expectant mothers, disabled individuals, the blind, the low-income elderly, and people struggling with mental illness. In all, almost one in five New Yorkers receive their health care through Medicaid, Child Health Plus, or Family Health Plus.

#### HOW MUCH HAS MEDICAID SPENDING INCREASED?

The State’s Medicaid projections for the current fiscal year show significantly lower growth rates than originally projected. Current estimates represent only a 1.7% increase over state fiscal year 2005-2006. This compares favorably to Medicaid spending growth nationwide. Total Medicaid spending for all states increased by an average of 2.8%, according to the Kaiser Foundation.

### New York Medicaid Expenditures Increased by Only 1.7%



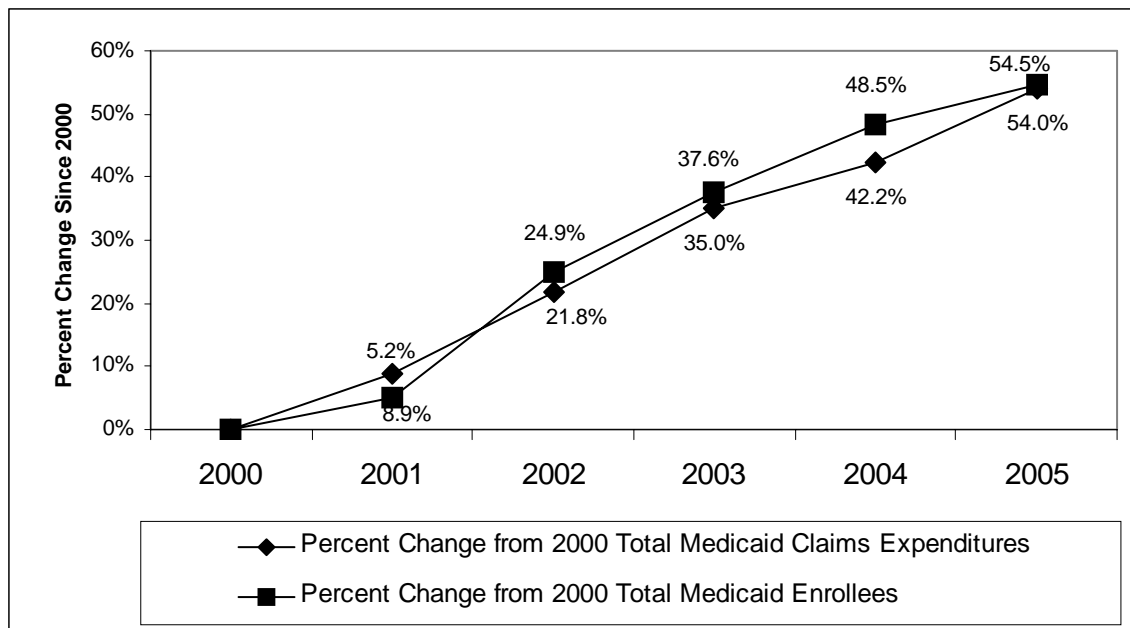
Between 2000 and 2005:

- The number of uninsured New Yorkers dropped from 3.1 million to 2.6 million.
- The number of Medicaid enrollees grew 54%, from 2.7 million to 4.2 million, largely through enrollment in Child Health Plus and Family Health Plus.
- Family Health Plus enrollment grew to more than 530,000 and enrollment of children in Medicaid grew by 500,000.

#### WHAT IS THE PRIMARY REASON FOR THE GROWTH IN MEDICAID?

The dominant reason behind Medicaid growth has been related to enrollment. Medicaid claims expenditures and enrollment from 2000 to 2005 have been nearly identical—increasing at rates of 54% and 54.5%, respectively.

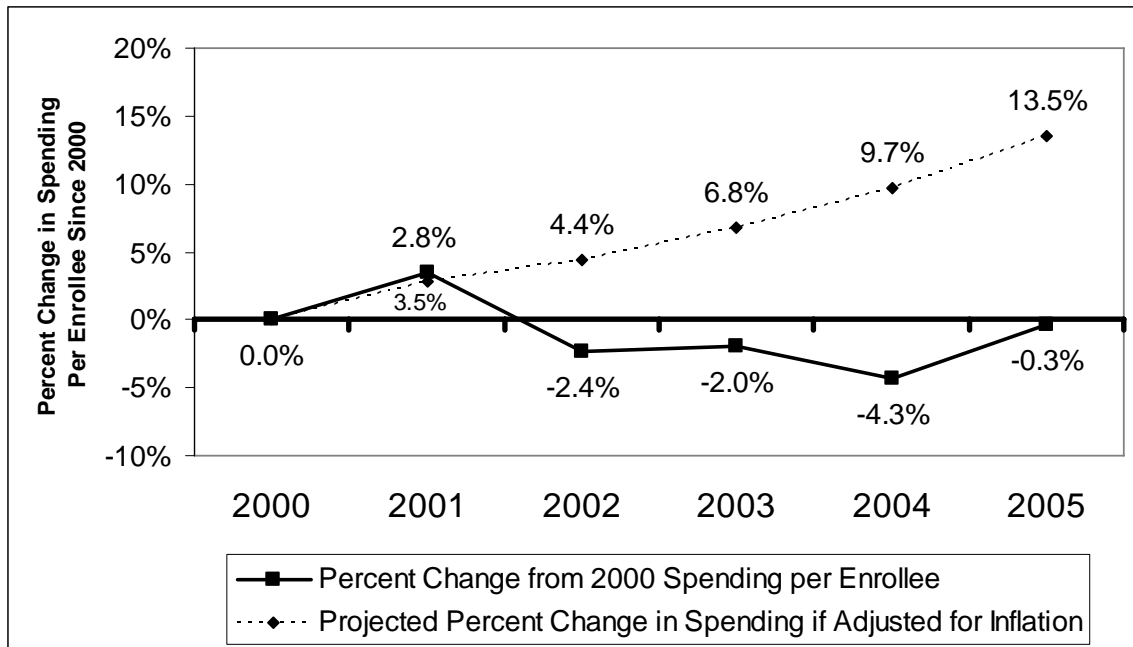
### Increases in Medicaid Spending and Medicaid Enrollment Almost Identical



#### DID MEDICAID SPENDING PER ENROLLEE INCREASE BETWEEN 2000 AND 2005?

From 2000 to 2005, Medicaid's cost per-enrollee remained virtually unchanged. If the 2000 cost per enrollee was adjusted for inflation for the period, however, the cost per enrollee should have increased by 13.5% by 2005.

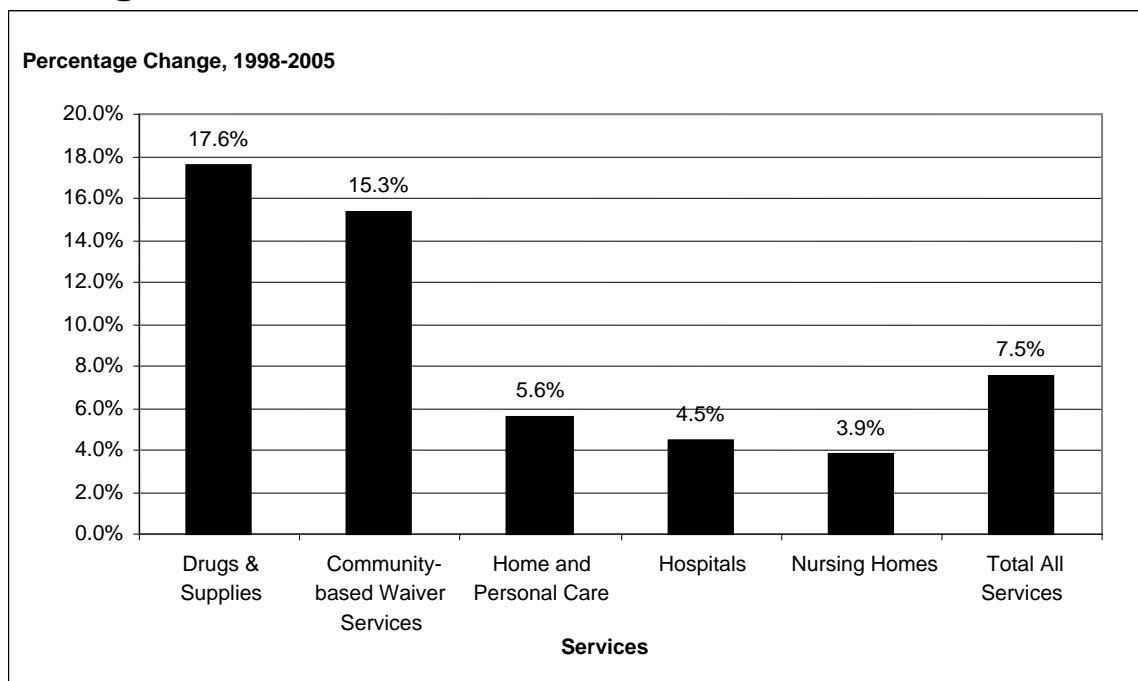
## Medicaid Cost Per Enrollee Flat Despite Inflation



### WHAT ARE THE MEDICAID COST DRIVERS?

Even looking at a longer time period, Medicaid spending for hospitals and nursing homes was not the driver of Medicaid growth between 1998 and 2005. In fact, Medicaid spending growth for hospitals and nursing homes was substantially lower in comparison to pharmaceuticals and community-based waiver services—and far less than the average increase in enrollment over the period. Average annual Medicaid spending grew by 7.5%, while spending for hospitals and nursing homes grew by 4.5% and 3.9%, respectively—effectively driving down the total average growth.

## Average Annual Medicaid Growth for Services, 1998-2005



### WHY DOES MEDICAID COST MORE IN NEW YORK?

The health care community is routinely criticized for the cost of Medicaid in New York State. However, there are many factors influencing the cost of Medicaid that are beyond the control of health care providers.

- New York has consistently made conscious policy decisions to ensure that more people have access to quality health care and needed services while upholding a standard of quality that everyone deserves.
- New York has a higher cost of living than most states. New York's higher cost of living and higher cost of doing business directly influence the cost of the Medicaid program. The resources required to care for patients, on average, cost significantly more in New York. This is evidenced by the Medicare area wage index, which adjusts Medicare payments for labor costs. The average of all the area wage indexes in New York State is 1.20, meaning the average labor cost for New York hospitals is 20% above the national average.

- New York’s Medicaid population has a higher concentration of elderly and disabled beneficiaries. The correlation between enrollment composition and the high cost of New York’s Medicaid program is best demonstrated in Medicaid’s elderly and disabled population. The majority of higher per-beneficiary spending is due to public policy choices to serve a higher proportion of disabled and elderly, and to offer more benefits through Medicaid.

Data show that a small number of Medicaid enrollees with very complex health care needs account for a disproportionately high percentage of Medicaid expenditures. Although the elderly and disabled comprise only 24% of the covered Medicaid population, the cost of their care accounts for 65% of total spending (approximately \$22 billion). Nearly one-half of Medicaid enrollees with a chronic condition struggle with additional conditions, often accompanied by a mental health condition or substance abuse. The presence of multiple conditions or co-morbidities increases the complexity of issues for the patient. A fundamentally different approach to care management must be implemented to coordinate appropriately the needs of these high-cost beneficiaries while controlling costs.

- New York maximizes federal participation in the Medicaid program. New York has devoted extensive efforts to maximizing federal Medicaid matching dollars to help provide health care coverage and to support health care programs. HANYS estimates that about \$9 billion of total annual Medicaid spending in New York State is attributable to state policies to obtain more appropriate federal financial support. This is critical, given New York State’s low federal matching rate for its Medicaid program. Examples include:
  - ✓ securing an annual investment of \$300 million for five years with the 2006 F-SHRP agreement dedicated to restructuring New York’s health care system;
  - ✓ supplementing the state’s hospital indigent care pool, which is used to partially offset hospital costs incurred for providing uncompensated care;
  - ✓ providing health insurance to more than 500,000 adults who otherwise were unable to access coverage;

- ✓ using intergovernmental transfers (IGTs) to bring additional federal Medicaid funds to the state without placing new financial burdens on localities—New York is now in a battle in Washington, D.C., to preserve IGT in support of public safety net services, with hundreds of millions of dollars at stake;
- ✓ allowing the nursing home gross receipts tax to be reimbursed by Medicaid inflates Medicaid spending on nursing home care, but the state benefits financially by receiving the tax revenue;
- ✓ obtaining federal support for state-sponsored mental health services for the developmentally disabled inflates Medicaid spending for these services—however, the state benefits financially from doing so; and
- ✓ moving the “home relief” population into Medicaid managed care, which resulted in lower overall state and local expenditures.

Federal maximization efforts give the impression of higher spending, when, in reality, the need for additional state funding is reduced. Obtaining more appropriate federal financial support is critical, given New York State’s low federal matching rate for its Medicaid program.