



Healthcare Association  
of New York State

TESTIMONY OF THE  
HEALTHCARE ASSOCIATION OF NEW  
YORK STATE  
ON THE  
2008-2009 EXECUTIVE BUDGET  
PROPOSAL  
BEFORE THE  
NEW YORK STATE SENATE FINANCE  
COMMITTEE  
AND THE  
ASSEMBLY WAYS AND MEANS  
COMMITTEE

February 6, 2008

Chairman Farrell, Chairman Johnson, and honorable members of the Assembly and Senate, on behalf of the more than 550 hospitals, nursing homes, home health, and other health care providers that comprise the membership of the Healthcare Association of New York State (HANYS), please accept my appreciation for the opportunity to be heard today.

We now know from decades of failed state and federal experiments that there are at least three essential elements, all of which must be present, to successfully navigate health reform legislation.

- First, the reform goals need to be population- or patient-centered. Our policy focus should be on the community and/or the patients' health, predicated on securing high value for our expenditures.
- Second, the implications and consequences of the changes need to be explicit and understood. We need to maximize transparency to minimize unintended, negative consequences.
- Third, we need to adequately fund the commitment to reform.

It is not enough to sail with noble goals. Without all three of these components, a reform ship of good intentions will come asunder on the shoals.

Let me address how the budget relates to all three components.

As we listen to various Administration representatives, many of their policy intentions appear to focus on the right goals for our citizens. These include:

- decreasing the number of uninsured,
- investing in primary care and prevention,
- focusing on community health status,
- improving quality outcomes,
- ameliorating the growing workforce shortages, and
- achieving malpractice reform.

So there are several important initiatives included in the proposed budget that HANYYS supports:

- Investment in ambulatory care—both hospital-based care and physicians' fees.
- Commitment to health care coverage for children, regardless of the position of the federal government.
- Doctors Across New York—critically needed help to address the shortage of physicians in numerous under-served rural and urban areas.
- Leveling the playing field, by looking to managed care plans to infuse needed funding in support of Health Care Reform Act (HCRA) public goods pools.

We also look forward to the incorporation of meaningful medical liability relief as part of this budget discussion, as the Governor indicated the recommendations of the Administration's Task Force would be forthcoming shortly.

There are other initiatives advanced in the budget, including rebasing and redesigning the inpatient reimbursement system, and reforming aid for indigent care, which HANYYS can also agree with, in principle. However, these extremely complex proposals will require a much deeper understanding of their potential impacts. This brings me to two of the aforementioned components of successful reform legislation.

- Full transparency and a thorough understanding of the patient care implications and consequences of the reforms offered. At this point, the Administration has not provided us with the data we need to analyze its proposals, estimate the potential impacts and, if appropriate, to suggest options. Real transparency requires sharing the “building blocks” of these reforms and new methodologies. We cannot accept a mere “trust me, it will all work out in the end.” This is not about trust or good faith. It is about knowledge and openness.
- As for providing the investments necessary to achieve and sustain the reform proposals, we find the budget replete with some explicit, and many opaque, hospital, nursing home, and home health care cuts, none of which constitute reform. It appears on the surface that much of the financing is really just a massive redistribution between providers. More on that in a moment.

This year, the state is faced with fiscal circumstances similar to those health care providers have endured for many years. Together, we are working to answer the difficult priority questions of what will be funded, what will be diminished, or what will be abandoned.

It is how we answer these questions that defines us as a society.

As we begin to grapple with these questions, there can be no better starting point than understanding the priorities of the people of New York.

To that end, HANYS recently commissioned the Siena Research Institute to conduct a poll of registered voters to gauge New Yorkers’ concerns and priorities.

We learned quite a bit. Primarily, we discovered how much New Yorkers understand the need for and support the Medicaid program. Our poll found that an astounding 79% said they would oppose or strongly oppose the Medicaid cuts contained in the Governor’s budget—a number that was consistent in every region in the state.

<p align="center"><b>HANYS/Siena Research Institute Poll Results on Governor’s Health Care Cuts</b></p> <p><b>Some budget analysts have said that Governor Spitzer’s budget includes an overall cut of \$1 billion for health care. What is your position on a \$1 billion decrease in New York State health care spending? Do you strongly support, support, oppose, or strongly oppose that proposed cut?</b></p>							
	STATEWIDE	NYC	WESTERN	CENTRAL	NORTHEAST	LONG ISLAND	HUDSON VALLEY
Strongly support	3%	2%	3%	4%	1%	5%	5%
Support	9%	7%	9%	15%	12%	7%	7%
Oppose	46%	48%	48%	40%	46%	40%	51%
Strongly oppose	33%	35%	29%	33%	33%	40%	29%
Don't know/No opinion	9%	8%	12%	7%	9%	8%	8%

We also asked New Yorkers, “which of the following two statements is closer to your position:”

- a. It is time the governor and legislature take steps to keep government spending down even if it means health care may have to be cut.
  
- b. The governor and legislature should be working to provide ways to improve and safeguard the health of all New Yorkers. If budget cuts need to be made, health care is not the area.”

By a margin of 73% to 21%, New Yorkers overwhelmingly said that if budget cuts are to be made, health care is not the area.

<b>HANYS/Siena Research Institute Poll Results on Health Care Cuts in General</b>							
<b>Which of the following two statements is closer to your position:</b>							
<b>It is time the governor and legislature take steps to keep government spending down even if it means health care may have to be cut.</b>							
<b>[OR]</b>							
<b>The governor and legislature should be working to provide ways to improve and safeguard the health of all New Yorkers. If budget cuts need to be made, health care is not the area.</b>							
	STATEWIDE	NYC	WESTERN	CENTRAL	NORTHEAST	LONG ISLAND	HUDSON VALLEY
Health care not the area	73%	77%	68%	70%	72%	77%	74%
Health care may have to be cut	21%	17%	25%	24%	23%	17%	21%
Don't know	6%	7%	7%	6%	5%	6%	5%

These results make clear that, contrary to the protests of misinformed or misanthropic observers, New Yorkers resoundingly support the Medicaid program.

## SHIFTING PATTERNS OF CARE

To the Governor's credit, this proposal demonstrates an earnest effort to shift, or pivot, the health care system from one that **spends** more on care provided after the onset of an illness or disease, to one that **spends** more on services intended to prevent illness and disease.

My emphasis on the word "**spending**" is intentional. It must be made clear that for too long, health care providers have stood accused of rampant **cost** increases when, in fact, hospital Medicaid inpatient **costs** grew more slowly than the rate of inflation.

Just this morning we heard from the Department of Health that from 1981 through 2005, 24 years and counting, hospitals have held Medicaid inpatient costs below inflation. That is the indirect message behind the rebasing proposal and, believe me, this is a monumental accomplishment. It is unfortunate that something as important as rebasing is being utilized as a vehicle to penalize providers—something I will later discuss in detail.

So **spending** must be understood not as an indication of provider efficiency, but rather a window through which we can see the government's pattern of funding care, and the public's pattern of accessing and utilizing care. Our goal must be to shift those patterns, but with the understanding that the effort to pivot away from hospitals may actually be a pivot back to the hospital, as the safety net provider in communities across the state.

## OUTPATIENT INVESTMENT

The critical need to invest in ambulatory care is clear. It is a public health policy imperative that stands on its own merit.

As a stand-alone proposition not linked to reductions or "savings" in other areas, HANYS supports the Governor's plan to increase outpatient and ambulatory reimbursement.

However, the Administration has linked this investment directly to savings from rebasing and other changes. The importance of investing in primary care should not be dependent on taking from the left hand and giving a portion of the same dollars to the right hand and calling it investment.

According to our recent poll, a majority of New Yorkers do not support this approach. By a five to three margin, they said outpatient investments should not be financed by inpatient cuts.

<p align="center"><b>HANYS/Siena Research Institute Poll Results on Funding Inpatient and Outpatient Care</b></p> <p align="center"><b>In some cases an increase in spending in one area of the budget can be tied to a decrease in another area. Would you be in favor of an increase in spending on primary or preventive care IF that increase in spending was financed by cutting funding to hospitals for inpatient care?</b></p>							
	STATEWIDE	NYC	WESTERN	CENTRAL	NORTHEAST	LONG ISLAND	HUDSON VALLEY
Yes	31%	31%	26%	34%	34%	31%	32%
No	53%	51%	56%	55%	54%	54%	51%
Don't know	16%	17%	18%	11%	12%	16%	17%

The investment in hospital ambulatory care, clinic, and emergency rooms (ERs), is long overdue. Indeed, an ER rate increase was authorized by the Legislature two years ago; however, hospitals have yet to see one penny of the increase. Last year, rates were supposed to increase by \$27.50 per visit, to \$125 per visit, but the federal government has yet to approve the Medicaid adjustment, so hospitals wait.

This year, the rates were to increase to \$140 per visit, then to \$150 per visit next year. Hospitals welcomed the commitment to an increase, but they have since become skeptical because the check is still “in the mail.”

Hospitals continue to lose nearly \$1.5 billion from ER and other outpatient Medicaid rates that fail to cover costs. In the ER, rates even at the promised \$140 per visit would cover just 35% of

costs. In hospital clinics, where rates have not changed in over 15 years, the shortfall is even more striking—just 28% of costs are covered.

A multi-year commitment to invest in hospital ambulatory care is welcome as an essential step toward our shared goal of promoting better access to primary care.

We urge the state to articulate and incorporate a payment goal for ambulatory care—we have suggested establishing parity with Medicare payments. The increases contained in this budget proposal in clinic payments when fully implemented would still not cover costs, but would get providers close to 65% of costs, and be reasonably consistent with the level of Medicare payments; that is a good start.

On the other hand, the additional \$20 million in the proposal for ER payments is inadequate and would still leave emergency care rates well below 50 cents on the dollar—an amount that cries for more responsible investment.

The state also proposes a major change in the method of payment for clinic and ER care—termed: Ambulatory Payment Groups (APGs), more fully discussed below. This would be a significant change that elicits numerous concerns about the ability of the state and providers to implement a new system. Beyond the mechanics, however, the state intends to create different base payment rates for upstate and downstate providers—and differentials for teaching hospitals, upstate and downstate.

The teaching differentials reflect the state's interest in promoting physician training in primary/ambulatory care settings and the value of inpatient reductions applicable to teaching hospital groups. These details are not yet available and we reserve comment until we have had an opportunity to understand the specifics of any proposal. **Needless to say, hospital-specific impacts cannot be modeled because we do not have the proposed new rates or the detailed claims information. This critical information, one of the missing elements I referred to earlier, must be provided and fully understood before we move forward.**

In addition, in order to receive the payment differential after April 2009, teaching hospitals would be required to comply with performance standards and measures yet to be developed. HANYS is ready and willing to work with the Department to ensure that any compliance measures are reasonable.

### **PHYSICIAN FEES**

Medicaid payments for physicians' services have been even further behind—New York State perpetually ranks near the bottom nationally. A significant increase in physician fees is warranted and critical to the long-term success of the Doctors Across New York initiative. HANYS understands that the physician fee increases will be established to reach 75% of Medicare payments—a good start. In addition, HANYS supports additional proposals to incorporate differentials and even higher rates for practicing in under-served areas and for extended hours and weekend services.

### **AMBULATORY SURGERY**

The proposed budget also contemplates an increase to “full value” payments for hospital-based and freestanding ambulatory surgery. While details have not yet been provided on what the state considers “full value” (another example of a missing key element), HANYS accepts and agrees with the overall goal of encouraging full use of ambulatory surgery capacity and the interest in minimizing need for inpatient surgery wherever feasible.

However, HANYS opposes rewarding freestanding ambulatory surgery practices with the same payment increases as hospital-based programs, because these freestanding practices have traditionally avoided Medicaid patients and uninsured patients, while cherry-picking better paying patients.

The Administration's interest in accelerating increases in ambulatory surgery payments is based on an expectation that it will more than pay for itself through reductions in inpatient surgery. As study after study shows, there are similar efficiencies to be gained by improving and expanding

use of primary care. The December 2007 Commonwealth Fund study, *Bending the Curve*, concluded that if Medicare improved its investment in primary care and found a “medical home” for its fee-for-service beneficiaries, it could result in a net health system savings of \$194 billion over ten years and even “...larger if this approach were adopted by all payers.” This is why the state’s investment in ambulatory care stands on its own, and should not be dependent on savings elsewhere.

### **NEW OUTPATIENT SYSTEM—AMBULATORY PAYMENT GROUPS (APGs)**

The Administration has also proposed a major change in how clinics and ERs are to be paid. Payment would no longer be based on a flat, per visit rate. The proposed method, called Ambulatory Payment Groups, is similar to the Diagnosis Related Group (DRG) system for inpatient services.

While HANYS supports the change to a case mix and service mix-adjusted payment system, we have strongly urged that the state utilize another methodology known as Ambulatory Patient Classification (APCs), which is more commonly used, including by Medicare. This is particularly important at least until the state has demonstrated the capacity to process claims with an alternate system. This may be true even for a change to an APC-based system, with which hospitals are more familiar. Hospitals also need to be educated on how to work with an alternate approach; and some consideration would need to be found for the cost of implementation, including purchasing proprietary APG software from a sole-source vendor.

We must also understand that APGs are complicated to implement, for the state as well as for providers. At least one state, Massachusetts, had significant difficulty implementing patient-specific billing under APGs. Massachusetts experienced delays of many months to reconcile payments and ultimately was forced to completely revise the way it used the technology to get payments out to providers. That may be one reason why only a very few states and commercial insurers use APGs.

Again, the commitment to invest is critical and appreciated, but we need to be sure that the payments actually get to providers. Moreover, if an APG- or APC-based system cannot process claims when it is intended to be implemented, legislators should provide for the investment to be added to current flat rate payments. Providers should not be put at risk for unintended administrative problems.

Additionally, APGs are a proprietary product developed by 3-M, which, among other things, would mean that the decisions determining what payment providers will receive for a patient visit would no longer be in the “public domain.” It also means, as I alluded to earlier, that hospitals would have to purchase the 3-M software, essentially constituting an unfunded mandate.

It is also important to highlight that **none** of the details related to an APG approach are currently available. The lack of information has important consequences. It means that we: 1) are not able to fully understand the specifics of this proposal, and 2) cannot model hospital-specific results.

Referring again to missing essential elements, I am sure that you share my concern about approving a health care reform plan without knowing how it affects individual hospitals.

### **HOSPITAL INPATIENT REBASING AND OTHER INPATIENT REIMBURSEMENT CHANGES**

Under the label of “rebasings,” the Administration is proposing the most significant changes to hospital Medicaid reimbursement in nearly three decades. The proposed budget would rebase hospital inpatient rates and recraft hospital inpatient payments that have been in place for 25 years.

At the outset, let me state that HANYS does not oppose the idea or concept of rebasing hospital payment rates after 25 years, or making additional changes, under the assumption that it is done right. Indeed, we have asked for rates to be updated several times over that period when we

believed that hospital costs were exceeding payment increases. Now, the Administration is interested because it contends that payments exceed costs.

We believe, however, that these proposed changes need to be carefully considered in the context of both intended and unintended consequences.

In past years, HANYS has been able to produce for our members, the Legislature, and the public, facility-specific impacts of Executive budget proposals. This year, however, we still have not received the data necessary to model these impacts and, as a result, the facility-specific and system-wide impacts of these proposals are not available.

These impact calculations normally form the basis upon which we built our annual March rally here in Albany. This year, we have modified our advocacy day. Due to the complexity, redistributive impact, and policy focus of this budget, we have asked health care leaders to come to Albany on March 4 and 5 to more directly discuss with you the Governor's budget proposals.

Our intensity level is high. This proposal must be modified, and our members are counting on you, no less this year than in any year past, to protect the vital interests of their patients.

Given the many unknowns in this budget, trepidation is also quite high among our members, raising valid questions about whether the consequences of these proposals are understood at all.

We appreciate that this effort is complicated, that there are many moving parts, and that the Administration has indicated it is still working on the facility-specific impacts of its proposal.

**However, it is now nearly the second week of February and decisions that the Legislature is expected to make in less than 60 days will have a profound impact on the operations of the 220 hospitals in this state. The lack of these impacts represents another example of the Governor's plan failing to provide the necessary full understanding of its consequences.**

**Our request—our appeal—is simple: take the time needed to fully understand the impact of this complex and highly redistributive proposal.** And even then, if we agree on the numbers, understand them, and reach conclusions on details sufficient to begin to phase in reforms, it would be prudent to build in benchmarks or safety valves during implementation for the inevitable unintended consequences. HANYS is committed to working with you and the Administration to facilitate reform, and to be sure that it is done correctly.

Otherwise, selective rate modernization and rebasing may produce little more than a cloaked health care cut with unintentional and damaging community health consequences.

That said, we agree that investment in preventive and outpatient care can in time reduce hospitalizations and inpatient costs, but it most certainly will not occur instantly. As I have said, the public's patterns of access and utilization must be changed, and that will take some time to achieve. The transitioning of our health care system to a more preventive paradigm of care, which most of us envision, is not nearly complete.

Or more simply stated, our health care system today is similar to the Tappan Zee Bridge. It needs to be replaced, but we cannot begin to rip away its supports until a replacement span is built. This budget begins to tear down the old bridge before the new one is ready.

## **REBASING**

The Governor also proposes to achieve savings from rebasing the hospital inpatient system—an estimated \$104 million in the next state fiscal year and a stated \$600 million when fully implemented. This is an overwhelming sum that, if true, means, as I alluded to earlier, that hospital inpatient costs have actually grown slower than the rate of inflation over the last 25 years. Had this growth been greater than that rate, rebasing to 2005 would yield a spending increase, not a reduction.

As the Legislature has thankfully understood, inpatient costs have been held in check over the years. Ironically, though, for nearly three decades, through various administrations, budget

makers told you that Medicaid hospital inpatient care is driving up costs beyond reason or inflation, and therefore must be cut. In most years, the Legislature would reject these inpatient cuts.

Now, in a rather stunning reversal, there is an effort by some to defend their new cuts by saying the exact opposite, i.e. Medicaid costs have been held in check since 1981 and therefore can be cut.

No good deed shall go unpunished.

You can understand the bewildered look I get when I explain this to my members.

At present, representing another lack of critical information, we do not yet have the state's documentation for their projected savings of \$600 million by rebasing to 2005 costs. However, we do know enough to understand that the proposal involves more than just rebasing costs.

In fact, we believe that a significant portion of the savings identified relates to policy decisions on whether or not to continue several program initiatives and legislative commitments from prior years.

We understand, for example, that the state would appropriately continue several new funding pools that were part of last year's budget process.

On the other hand, a significant portion of the "rebasement savings" is really related to a decision by the Administration to discontinue hospital workforce recruitment and retention funding that was first negotiated in 2002, and then renegotiated and recommitted as part of last year's budget process. The full value of that funding is approximately \$290 million for voluntary and public hospitals, and at least \$245 million is reflected as "savings," which is really a cut.

To receive this workforce funding, hospitals had to attest that the money would be spent on recruitment and retention, usually in the form of wage and/or benefit increases, the costs of which continue to this day. HANYS believes that, as part of any rebasing initiative, it is essential to confirm your commitment to continue this needed funding.

Similarly, we believe another portion of the rebasing savings comes from providers' willingness to help the state balance its budget in 2005 by shifting certain Graduate Medical Education (GME) funding to Medicaid. Now, teaching hospitals would be penalized and lose a portion of that funding. Again, we believe the Legislature should confirm its prior action.

We also believe there are other prior commitments that would be impacted by rebasing. HANYS urges close review of the details, once they become available, for similar issues that require policy decisions that should be determined with the full participation of the Legislature.

As I said, these policy issues go beyond the concept of "rebasing."

Another important issue is that the state's analysis only relates to the impact on Medicaid fee-for-service rates and excludes any potential effect on Medicaid managed care payments. The ultimate financial impact of real rebasing, as opposed to those policy commitments delineated above, is likely to be doubled because of the significant proportion of Medicaid managed care contracts.

Many contracts link inpatient payments to the fee-for-service rates and, by law, the default rate in the absence of a contract is the posted Medicaid fee-for-service rate.

### **"REBASING PLUS"**

The state is also proposing to not only rebase the inpatient rates, but also to substantially change the construct of those rates. Each one of these changes moves money around; but again, the Administration has failed to provide the details necessary to fully understand the potential impact. These are extremely technical proposals that redistribute a diminished amount of

funding. For hospitals across the state, this proposal is a gamble, and very few, if any, are feeling particularly lucky.

To give you some idea of the changes, the proposal involves dividing hospitals into peer groups (upstate, downstate, teaching, non-teaching, etc.), and moving Medicaid rates to 100% of the peer group average (or 100% pricing). That means that **even if rebasing results in no change in the total amount of Medicaid payments within a group of hospitals, 50% of the hospitals will be paid more and 50% of the hospitals will be paid less. In fact, every hospital's Medicaid payments will change under this proposal by an unknown amount.**

The state's proposed reforms include (1) modifying peer groups; (2) eliminating adjustments for wage differences across regions when trying to compare "peer" hospitals; (3) pricing payments at 100% of the group average, rather than a blend of hospital-specific costs and peer group costs; and (4) modifying the treatment of GME costs in the formula. **Each of these changes has significant re-distributional effects on payments among providers.**

Some of the changes, specifically related to the GME components, may result in cuts from Medicaid managed care separate from the re-distributional effects on Medicaid fee-for-service payments, and therefore need to be addressed. There are also proposed changes for exempt units, such as psychiatry and rehabilitation, which need attention to the details. The proposed changes for detoxification services are discussed later.

It is impossible in testimony to give you a complete understanding of the many changes that are proposed and the complexities of their interrelationships. We are committed to working with both houses of the Legislature to discuss all of these issues in greater detail. However, it is critical that the Executive provides us with the data points and other information necessary to develop our own impact numbers. Again, we urge you to take the time needed to fully understand the implications of the proposed changes on providers' ability to meet patient care demands.

Without these details, the Governor is asking the Legislature to sign a long-term contract that has not been fully disclosed to you.

## **INDIGENT CARE**

Moving on, the 2008-2009 Executive Budget continues the commitment of overall funding at \$847 million per year in support of hospital indigent care (bad debt and charity care) over the next three years. HANYS appreciates the continued recognition of and support for the level of uncompensated care that hospitals provide throughout the state.

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. Indigent care pool funding has been increased only once since HCRA was enacted over ten years ago, and nearly one-third of funding (\$270 million) is what hospitals themselves contribute to the pool through a 1% assessment on hospital revenues. The total pool, including the hospital contribution, covers about 50% of uncompensated care costs. However, after considering the hospital contribution to the pool, the actual coverage level is only about 38%.

The Executive Budget proposes significant changes in the definition of facility need and the formula that would distribute funding from the indigent care pool. 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 debate continues concerning how these funds should be targeted.

Unfortunately, and despite the best efforts on the part of Department of Health and the industry, **no one can tell you what the effects of the proposed indigent care changes will be for at least two years**, caused in large part by accounting conventions. As a result, it is not possible to determine if the proposed indigent care changes are an improvement. Yet another unknown.

Given that the data necessary to fully understand the re-distributional effects of the proposed changes will not be available until after the Legislature is expected to act on the proposal, HANYS is compelled to recommend that we use the next year to collect the utilization data necessary to redesign the distribution methodology, and then consider any potential, and more fully understood, changes as part of next year's budget. HANYS therefore asks the Legislature to defer action until a fully developed proposal, including impacts, is available for discussion, and that any contemplated changes be implemented only by statute. We commit to assisting in that data collection and deliberative process.

As authorized in last year's budget, the Commissioner convened a Technical Advisory Committee, which included industry representatives, to analyze and consider changes to current definitions of need and distribution methodology. HANYS testified at a hearing of that group and had numerous opportunities to provide input.

Absent data, HANYS has nevertheless provided the following additional comments and concerns about the Administration's indigent care proposal:

- HANYS supports the concept of linking aid more closely to services provided to low income, uninsured, and under-insured patients.
- Creating fixed amounts for the uninsured (85%) and under-insured (15%), is arbitrary—absent information on the current share for each. While HANYS can conceptually support weighting the distribution modestly in favor of the uninsured, we should start by knowing where we are now. One concern is that hospitals face increased exposure from losses attributable to insured patients with high-deductible coverage, and this change will not inhibit that trend.
- The proposal to change the definition in the second year to count only service statistics related to uninsured “eligible for financial aid” threatens to eliminate a significant portion of a hospital's uncompensated care for patients who fail to complete applications for aid.

- Valuing the cost of care at the Medicaid rate significantly undervalues a hospital's commitment for those services.
- The proposed distribution formula is less progressive than currently—it should be at least as progressive.
- Changes to components of the current formula that were designed to address specific needs (i.e., rural, teaching) should be evaluated in the context of their initial intent.

### **NURSING HOMES**

As you know, the nursing home rebasing plan you passed in 2006, along with the hospital emergency room rate increase, was submitted more than a year ago to the federal government for necessary approvals. And while the Administration here in Albany remains committed to securing federal approval for the ER rate increase, it has essentially reneged on the nursing home rebasing plan. As a result, the proposed budget cuts nursing home funding by \$202 million, of which \$170 million is related to nursing home rebasing.

While all regions will be impacted, upstate communities will suffer most due to greater shortfalls between costs and Medicaid payment rates. As you will hear from other organizations today, a great many nursing homes have been counting on that funding, with every reason to believe they would receive it.

# 2008-2009 Executive Budget Proposal

## Regional Nursing Home Summary (\$ Millions)

	<b>Executive Budget Proposal</b>	<b>Recapture Nursing Home Rebasing Adjustment *</b>	<b>Reduce Trend Factor by 25%</b>
<b>New York State</b>	<b>\$202.0</b>	<b>\$170.0</b>	<b>\$32.0</b>
<b>New York City</b>	<b>\$61.0</b>	<b>\$45.3</b>	<b>\$15.7</b>
<b>Western New York</b>	<b>\$21.9</b>	<b>\$19.8</b>	<b>\$2.1</b>
<b>Rochester Region</b>	<b>\$19.7</b>	<b>\$17.9</b>	<b>\$1.8</b>
<b>Iroquois-Central NY</b>	<b>\$25.4</b>	<b>\$22.9</b>	<b>\$2.4</b>
<b>Iroquois-Northeastern</b>	<b>\$21.2</b>	<b>\$19.3</b>	<b>\$1.9</b>
<b>Northern Metropolitan</b>	<b>\$24.2</b>	<b>\$20.8</b>	<b>\$3.4</b>
<b>Long Island</b>	<b>\$28.7</b>	<b>\$23.1</b>	<b>\$4.6</b>

\* Note: The recapture covers those adjustments that would have been distributed from January 1, 2007 through December 31, 2007 (\$137.5 million statewide), as well as those additional adjustments that would have been distributed from January 1, 2009 through March 31, 2009. Instead the proposal would distribute \$180 million statewide from January 1, 2008 through March 31, 2009.

It is imperative that the Legislature act to restore this funding to the levels previously committed to as a matter of law.

### HOME CARE

The proposed budget cuts funding for home care services by \$82 million. As you know, home care services are critical for transitioning patients from the hospital to home, and in some models, providing an alternative to traditional nursing home care.

But home care is much more than a potential savings mechanism. For thousands of New Yorkers, it is the mode of care that allows them to stay in their own homes. The home care cuts in the proposed budget are just that—cuts. No matter the intent or complexity of the mechanism by which they are achieved, these cuts are contrary to public policy objectives to expand home-

and community-based services. It is critical to continue to make the investments necessary to ensure that home care remains available to every New Yorker who can benefit from it.

### **CHILD HEALTH PLUS**

Governor Spitzer is to be commended, however, for continuing with his planned expansion of the Child Health Plus program, even without federal participation. The Bush Administration's misguided refusal to provide the federal share of funding for this expansion might have formed a basis to abandon it. The Governor has stayed his course, however, and demonstrated a commitment to our children that is lacking in the White House.

### **PHYSICIAN SHORTAGES/HCRA GME FUNDING**

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.

We commend Governor Spitzer and Commissioner Daines for the "Doctors Across New York" initiative, which provides a package of incentives to support physician workforce recruitment and retention that includes rural and urban underserved areas. Doctors Across New York includes a loan repayment program, funding for practice support and ambulatory care training, diversity in medicine/post-baccalaureate program, and physician workforce studies. Additionally, the funding would be increased for other reforms including the Empire Clinical Research Investigator Program (ECRIP) that supports clinical research in New York's teaching hospitals.

The coordinated advocacy of a broad spectrum of interested parties has heightened awareness of the desperate need for physicians in many New York communities. Many of these initiatives are similar to those promoted by the New York State Ad Hoc Physician Workforce Planning Group, which is led by HANYS, the Associated Medical Schools of New York, and the Medical Society

of the State of New York. The workgroup represents an impressive array of stakeholders working together to assess and to make recommendations on physician recruitment and retention.

While HANYS strongly supports the proposed initiatives, little in this budget comes without qualifications.

HANYS has concerns that these initiatives are proposed to be self-funded by cutting GME funding to teaching hospitals from the HCRA Professional Education Pool. Specifically, the budget redirects \$15 million away from GME this year, growing to \$57 million. We believe it is a non sequitur to address physician shortages by reducing funding for physician training.

We recommend, as an alternative, that the state look to the proposed increase in the covered lives assessment as the primary source to support these initiatives, rather than from hospital-specific allocations.

Just last week, HANYS testified at two hearings related to the conversion of HIP/GHI from a not-for-profit managed care plan to a publicly-traded corporation. We acknowledged that this conversion is inevitable, and that a substantial portion of the proceeds will be added to the HCRA public goods pools. Those proceeds could also be tapped for the Doctors Across New York initiative. We also highlighted the need to incorporate improved performance standards for this conversion, including establishing monetary penalties for failure to improve, with such funds also directed to public goods pool purposes.

Data from our recent poll suggests strongly that the overwhelming majority of New Yorkers will support the goal of these proposals.

## HANYS/Siena Research Institute Poll Results on Funding for Doctor Training

**Would you strongly support, support, oppose, or strongly oppose state budget policies that cut funding for training new doctors?**

	STATEWIDE	NYC	WESTERN	CENTRAL	NORTHEAST	LONG ISLAND	HUDSON VALLEY
Strongly support	5%	8%	4%	4%	3%	2%	6%
Support	15%	14%	15%	19%	11%	15%	18%
Oppose	51%	49%	53%	42%	52%	53%	50%
Strongly oppose	23%	26%	22%	26%	29%	21%	18%
Don't know/No opinion	6%	4%	6%	10%	5%	8%	7%

We also recognize these elements as important first steps in a series of interventions that are necessary to fully address current and looming physician shortages.

### MEDICAL LIABILITY

And while not directly addressed in this budget, I would like to discuss the issue of medical malpractice insurance costs, including as it relates to physician supply—a very real problem in many of our communities. It is a point of fact, not speculation.

While I would not argue that the escalation of medical malpractice premiums is the sole cause of this shortage, I would argue that skyrocketing medical liability costs are a key ingredient and have plagued patients, the courts, and practitioners for decades.

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.

HANYS was very pleased to be a member of this Task Force. We hope this process will yield a solution that is fact-based and fair to patients, providers, and the millions of New Yorkers who are the ones who really pay the bills.

We recognize that the Governor has indicated meaningful reforms would be forthcoming based on the work of the Task Force. We look forward to the inclusion of and action on the recommendations within the timeframe of the budget.

### **NURSING SHORTAGE**

In each of the past several years, nursing schools in New York State have turned away more than 3,000 qualified applicants due to lack of faculty, a limited number of clinical practice sites, or a lack of campus space. Indeed, the most critical issue affecting the pipeline for nurses relates to the capabilities of nursing schools to admit qualified applicants.

Our recent poll also shows tremendous awareness of the nursing shortage affecting virtually every area of the state. A full 73% of voters surveyed indicated they were aware of the shortage. More compelling, however, is how galvanized New Yorkers are when it comes to supporting funding to address the shortage.

Our poll found that 88% of voters support increased funding for nursing education.

## HANYS/Siena Research Institute Poll Results on Funding for Nursing Education

**Many potential students cannot get into New York’s nursing schools due to a shortage of nursing faculty. Would you strongly support, support, oppose, or strongly oppose New York State investing more money in nursing education?**

	STATEWIDE	NYC	WESTERN	CENTRAL	NORTHEAST	LONG ISLAND	HUDSON VALLEY
Strongly support	38%	39%	32%	33%	42%	43%	36%
Support	50%	52%	52%	54%	48%	40%	55%
Oppose	7%	4%	10%	6%	6%	9%	5%
Strongly oppose	1%	1%	2%	2%	2%	2%	1%
Don't know/No opinion	4%	4%	3%	5%	2%	6%	3%

Senator Maziarz and Assemblywoman John have introduced legislation that HANYS strongly supports that would begin to address the nursing shortage by making the investments necessary to expand the capacity of our nursing schools. We hope the Legislature and the Governor will support this legislation and make it law this session.

Specifically, this bill would authorize funding for schools of nursing, educational institutions, and health care providers for the development of initiatives to increase the number of nurses in New York State. This proposal would allow the funding to be used for myriad purposes, including: recruitment and retention efforts to expand faculty capacity; the development of new nursing programs; academic and clinical partnerships to increase the use of expert clinicians to expand faculty capacity; and the development of much needed infrastructure, such as clinical simulation labs.

I would also note that HANYS supports the proposed funding in the SUNY and CUNY budgets to expand nursing programs. However, the \$2 million allocated for SUNY and CUNY combined should be viewed as only a modest down payment.

## **BEHAVIORAL HEALTH**

Also of concern are elements of the budget proposal that would significantly affect the ability of many hospitals to continue providing current levels of behavioral health services, particularly alcohol and drug detoxification services.

The proposed budget would reduce payments for acute detoxification services by \$70 million in state fiscal year 2008-2009 alone. In addition, it proposes to reduce funding by more than \$4 million for continuing day and day treatment mental health outpatient programs.

It is also important to note that there is no support in the budget for the expansion of outpatient programs, which is a goal articulated by the Administration's own Office of Alcoholism and Substance Abuse Services (OASAS). Instead, the budget cuts hospitals where the majority of care is provided. We fear this may lead to unit closures or reductions in services.

The interest in reforming the delivery system for detoxification services has been ongoing for several years. HANYS believed that one concern—that inpatient per-discharge payments were too high—would be addressed by the recent updating of DRG weights. That undertaking, authorized in last year's budget, resulted in a revised payment (to be phased in) with an average savings to the state of 11%. That is supposed to reflect the most current, real cost of those detoxification services.

We were therefore surprised that this budget seeks additional cuts.

HANYS does not oppose treating detoxification services as exempt services—thereby converting to a per diem payment. Indeed, the industry recommended several changes previously to create a separate observation period, and to distinguish between medically managed care and medically supervised care—also goals of OASAS. While OASAS also seeks to develop more community-based alternatives, that development has been slow. We believe, therefore, that maintaining a multi-year plan is appropriate, and have the following specific recommendations:

- The effects of rebasing and reweighting for detoxification services should be phased in over multi-year periods, the same as all other services.
- The state should use the same cost-finding approach as it proposes to use for all other services—not a unique approach to further reduce one service.
- The specific length-of-stay discounts proposed would have a significant adverse impact on current providers. They should be revisited with the benefit of current facility-specific data and include the extent to which aftercare services are available on a regional basis.

HANYS remains prepared to work on all of the above with the appropriate agencies.

Too many of our fellow citizens suffer from the ravages of addiction, and for a great many of them, recovery and hope for a restored life begins at a hospital. We urge you to fully support these services on their behalf.

### **DOUBLE DEVASTATION**

At a time when so many health policy changes are being contemplated in New York, it is important to also be mindful of the outright assault on providers that is again taking place at the federal level.

A few days ago, President Bush proposed **\$180 billion** in cuts to the nation's hospitals and other health care providers over the next five years. New York's share of those cuts is approximately **\$10 billion**. While we know that the New York State Congressional Delegation will join with us in strongly opposing those cuts, the health care leaders in Congress are already battling the White House on many fronts.

Congress has already had to temporarily block the President's regulatory efforts to end federal financial participation in Medicaid GME and to eliminate a critical source of public hospital funding. If implemented, these regulations would cost New York State \$4.8 billion over five years. The congressional moratorium on these regulations is scheduled to end this spring and the

Bush Administration has made clear that it will proceed the moment the congressional prohibition expires.

HANYS is focused on an extension of the moratorium; however, the onus is on Congress to act. With health care under attack on so many fronts, and the President boldly using his veto pen, blocking all of the cuts will be difficult, underscoring the need for full support at the state level.

## **CLOSING**

In closing, the Executive Budget proposed by Governor Spitzer—like no other before it in recent memory—includes numerous, significant structural changes to the reimbursement system that cannot be readily understood in terms of the impact they would have on patient and resident care.

The principle that guides physicians—“first do no harm”—must apply to decisions about the diagnosis and treatment of systemic ills.

The public solidly supports the more cautious approach, as our recent poll found. We asked New Yorkers what they would do when faced with the scenarios that now confront you. Seventy-five percent (75%) of New Yorkers agreed with us that the state should more thoroughly study these policy changes before enacting them. Just 14% supported enacting the changes now, without further study.

## HANYS/Siena Research Institute Poll Results on Unintended Consequences of Governor's Budget Proposals

**Some of the budget changes the governor seeks would affect the manner in which hospitals are reimbursed through Medicaid for the services they provide to low income New Yorkers. Many health care providers are concerned that if the governor's suggestions are adopted as is, patient care could suffer. They suggest careful study. Are you more in favor of immediately enacting the governor's suggested changes or would you favor following the recommendation of health care providers who suggest studying the issues?**

	STATEWIDE	NYC	WESTERN	CENTRAL	NORTHEAST	LONG ISLAND	HUDSON VALLEY
Enact immediately	13%	14%	18%	16%	9%	11%	11%
Study the issues	75%	72%	70%	77%	80%	79%	77%
Don't know	11%	13%	12%	7%	11%	9%	12%

By more than a 5 to 1 margin, the public is telling us that the state budget should not be a vehicle for health care policy experimentation. We agree. Moreover, no responsible corporate or research organization would engage in such structural and systemic changes as these without modeling and testing them to ensure that all the implications and risks are fully understood.

We, too, should know how deep the water is before we jump.

As I said at the beginning of my remarks, the Governor's budget proposal is mixed, containing flat cuts that we oppose, and numerous reform initiatives founded on laudable goals that, as yet, are neither fully understood nor adequately funded. We look to the Legislature to address those elements to ensure that any action we take improves, not diminishes, the ability of our health care system to provide the care our communities need.

I believe the path to a better and more efficient health care system is clear, and I believe that path has been expressed best with the Governor's own terms. The Governor has defined his plan to improve our public education system this way: "Investment plus accountability equals excellence."

We think he is right. And we think this same approach applies equally well to our health care system.

There is one last thought I would like to share with you today. And that is what I see as an exceptionally rare alignment of opportunities.

One opportunity is the merger and for-profit conversion of the GHI and HIP health plans, which holds the potential of generating billions of dollars for investment over the next several years. These dollars could help fund our shared goal of transitioning to a more effective and efficient health care system; to properly maintain the existing bridge and help build the new one.

Another opportunity is that we have a Governor and Health Commissioner who, like you, have shown sincere interest in achieving reform.

Another is the fact that we have a health care system also ready to support and embrace meaningful policy reform.

These elements of opportunity align in a manner that I believe presents the Legislature with a rare chance to craft watershed public health policy that establishes long-term goals and provides the resources necessary to achieve them.

Too often, our policy options are limited by the lack of resources, or the lack or divergence of participant will. Not so today.

Our will is aligned, our vision is aligned, and our resources are available, were we to only reach out and seize them.

I encourage you to consider this opportunity as the budget discussion moves forward.

Thank you for the opportunity to testify today. I am happy to answer any questions.

# 2008-2009 Executive Budget Proposal

12-Month Impact

## Statewide Impact

	<b>SFY 2008-09</b>	<b>Fully Implemented</b>
<b>Net Impact on Hospital Medicaid Fee-For Service (FFS) Payments</b>	<b>(\$244,600,000)</b>	<b>(\$606,600,000)</b>
<b>Hospital Reductions</b>	<b>(\$371,600,000)</b>	<b>(\$1,068,600,000)</b>
Rebase and modify hospital FFS reimbursement	(\$104,000,000)	(\$600,000,000)
- eliminates hospital workforce recruitment and retention (R&R)	part of above	part of above
- reduces graduate medical education and other funding	part of above	part of above
Reduce payments for inpatient detoxification services	(\$70,000,000)	(\$160,000,000)
Reduce and transfer HCRA GME funding	(\$15,600,000)	(\$58,600,000)
Reduce trend factor by 25%	(\$40,000,000)	(\$44,000,000)
Eliminate public hospital workforce R&R	(\$12,000,000)	(\$48,000,000)
Eliminate mental health specialty rates	(\$4,000,000)	(\$4,000,000)
Implement efficiency reductions (selective contracting, never events)	(\$26,000,000)	(\$26,000,000)
Impose new coding requirements for billing	(\$14,000,000)	(\$14,000,000)
Account for savings from Berger Commission recommendations	(\$86,000,000)	(\$114,000,000)
Redistribute indigent care funding	see note below	see note below
<b>Hospital-Based Ambulatory Care Investment</b>	<b>\$127,000,000</b>	<b>\$462,000,000</b>
Increase outpatient clinic rates with new payment formula	\$62,000,000	\$330,000,000
Increase ambulatory surgery rates with new payment formula	\$52,000,000	\$70,000,000
Increase emergency room rates with new payment formula	\$6,000,000	\$20,000,000
Allocation to hospitals of primary care investment	\$7,000,000	\$42,000,000
<b>Other Investments</b>	<b>\$56,600,000</b>	<b>\$338,600,000</b>
Increase rates for physicians , clinics and non-hospital-based ambulatory surgery	\$41,000,000	\$280,000,000
Increase funding through GME Innovations Pool (Doctors Across New York , ECRIP)	\$14,600,000	\$57,600,000
Increase funding for AHECs	\$1,000,000	\$1,000,000
<b>Nursing Home Reductions</b>	<b>(\$222,000,000)</b>	<b>(\$232,000,000)</b>
Reduce funding for nursing home rebasing	(\$170,000,000)	(\$170,000,000)
Reduce trend factor by 25%	(\$32,000,000)	(\$36,000,000)
Account for savings from Berger Commission recommendations	(\$20,000,000)	(\$26,000,000)
Restructure funding formula for disadvantaged nursing home funding	see note below	see note below
<b>Home Care Reductions</b>	<b>(\$82,000,000)</b>	<b>(\$134,000,000)</b>
Reduce trend factor by 25% - home care	(\$8,000,000)	(\$10,000,000)
Reduce trend factor by 25% - personal care	(\$12,000,000)	(\$16,000,000)
Reduce A&G cap for CHHAs and LTHHCs	(\$10,000,000)	(\$14,000,000)
Impose new ceiling on CHHA reimbursement	(\$40,000,000)	(\$44,000,000)
Implement personal care utilization management	(\$12,000,000)	(\$50,000,000)

Note: The funding for hospital indigent care and for financially disadvantaged nursing homes would not change on a statewide basis, but would be highly redistributive among hospitals and/or nursing homes, as applicable, due to proposed funding formula changes.