REAL Health Care Reform:
Rational, Efficient, Affordable, and Lasting
Health Care Reform

January 2007
# HANYS’ 2007 STATE ADVOCACY AGENDA

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PLEASE NOTE that HANYS’ Medicaid Reform and HCRA recommendations are inclusive of HANYS’ overall state policy agenda. These documents incorporate similar themes so that they may be viewed as stand-alone documents.
HANYS’ STATE ADVOCACY

SUMMARY

In preparation for HANYS’ work with the new Governor and the State Legislature, HANYS has developed a detailed advocacy policy agenda in consultation with HANYS’ membership. We have worked from the premise that the year 2007 brings a renewed opportunity for policymakers and the health care community to chart a vision for the future of health care in New York State.

On a practical level, however, the state budget could present acute challenges for HANYS’ membership, along with the reauthorization of the Health Care Reform Act (HCRA). With all of these issues in mind, and in addition to initiatives and strategies that will be undertaken in relation to the state budget, HANYS’ 2007 state advocacy agenda includes the following:

- **ACCESS AND COVERAGE.** Achieve universal coverage for children and cut the total number of uninsured in half by 2010.

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

- **CERTIFICATE OF NEED (CON).** Update the CON program to increase administrative efficiency, better reflect changing technologies, address the migration of services to outpatient settings, and incorporate the latest science on quality.

- **COORDINATED CHRONIC CARE MANAGEMENT.** Develop coordinated chronic care management programs to improve the delivery of care to and efficiently meet the needs of persons with chronic health conditions.

- **HEALTH CARE REFORM ACT.** Address an escalating variety of critical challenges, including safeguarding public goods pool funding, updating hospital payment methodologies, and incorporating the many health care reforms advocated for by HANYS.

- **LONG-TERM CARE REFORM.** Restructure long-term care but in ways that support expansion of home- and community-based services and housing options; oppose proposals that may force patients to stay in a hospital for longer than is necessary due to state-created interference with efficient discharge planning.

- **MEDICAID REFORM.** Promote real policy reforms that preserve and strengthen the ability of vulnerable populations to access health care, and continue to emphasize that health care cuts and taxes are not health care reform.

- **MEDICAL LIABILITY REFORM.** Correct the long-engrained dysfunctionality of the medical liability system by providing sensible compensation more promptly, establishing an informed adjudication system, and promoting candid physician-patient communication.

- **NICHE PROVIDERS.** Level the playing field to ensure hospitals are not negatively impacted by the proliferation of freestanding, state-licensed, for-profit ambulatory surgery and imaging centers, and private office-based surgical and imaging practices.
■ **QUALITY IMPROVEMENT.** Move to a comprehensive, standardized, and integrated approach in developing quality measures and away from the narrowly focused measures that look only to compliance with administrative requirements; support a significant investment in health information technology (IT).

■ **WORKFORCE SHORTAGES.** Invest in physician, nursing, nursing faculty, and allied health care professional recruitment, retention, education, and training.
ACCESS AND COVERAGE

ISSUE

Expanding access to New York’s 2.6 million uninsured residents is a difficult task that HANYS is committed to accomplishing in partnership with the State Legislature and the new Administration. HANYS believes that a coordinated set of initiatives will accomplish the coverage goals of achieving universal coverage for children and reducing the total number of uninsured by half, by 2010.

The percentage of private-sector employees covered through their jobs is declining and enrollment in publicly funded programs, such as Medicaid, Child Health Plus (CHP), and Family Health Plus (FHP), is increasing throughout New York. Enrolling all currently eligible low-income children and adults would nearly achieve the stated goals of universal coverage for children and halving the total number of uninsured in the state.

These goals are achievable through improved outreach and enrollment initiatives, coupled with reasonable changes in initial eligibility and recertification requirements for existing programs—Medicaid, CHP A and CHP B, FHP, and Healthy New York. Simultaneously, we believe it will be important to undertake and lead a comprehensive policy discussion to address the remaining 1.5 million New Yorkers not eligible for existing public coverage or subsidy programs.

RECOMMENDATIONS

Universal Coverage for Children/Maximize Enrollment of Eligible Adults 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) modest expansion of CHP B eligibility criteria.

Simplifying Eligibility and Recertification Processes. Following 9/11, New York instituted Disaster Relief Medicaid, enrolling more than 400,000 low-income uninsured residents virtually overnight to provide access to needed health care. This worthwhile initiative was accomplished because it relied on a short, simple application, with maximum use of self-attestation and minimal documentation. While the simplified process was precipitated by an extraordinary tragedy, it nevertheless demonstrated the value of simplicity and the problems caused by requiring excessive documentation.

New York should simplify the initial eligibility and recertification processes, maximizing use of self-attestation of income and/or resources and expanding state responsibility for validation/verification using state databases, consistent with, but no greater than federal requirements.

The state should also expand the period of continuous eligibility (i.e., lock-in) to minimize unnecessary disenrollment/re-enrollment, expand the use of Express Lane Eligibility (use of linked eligibility applications), and continue to improve the seamlessness of the system (transitions from CHP A to CHP B).

HANYS also recommends that the state explore changes to income eligibility standards in Medicaid. While both CHP and FHP use gross income as the eligibility standard, Medicaid still uses net income. Using gross income as opposed to net income to define eligibility is much simpler and may enable the program to reach more eligible adults.
IMPROVING OUTREACH. Outreach is a necessary and important complement to a simplified application process. The use of facilitated enrollers has demonstrated its effectiveness in the CHP program.

The state should fund expanded use of facilitated enrollers for all programs, including expanding partnerships with community-based organizations, providers, and others. The state should also improve its use of IT linkages to other databases in New York State to identify eligible populations.

Grant-funded facilitated enrollers have proven effective in outreach efforts. To build upon past work and continue to enhance outreach, HANYS recommends training and utilizing volunteers to maximize workforce resources in this important effort.

EXPANDING ELIGIBILITY CRITERIA FOR CHP B. Several states currently have expanded subsidized coverage programs for low-income children in families up to 300 or 350% of federal poverty level (FPL). There are at least five states with eligibility levels at 300% of FPL—New Jersey and Pennsylvania each allow eligibility up to 350% of FPL. Expanding eligibility to 350% of FPL would allow New York to reach 50,000 to 100,000 more children at affordable rates. HANYS recommends increasing income eligibility levels for CHP B to 350% of FPL.

MOVING TOWARD UNIVERSAL COVERAGE. Ideally, there should be a national plan for universal access to health coverage to avoid concerns about economic competition across state borders. Several states, most notably Massachusetts, have designed plans that they hope will work to address the growing decline in employer-sponsored health coverage and to maximize total coverage within the state.

Such plans are complex and involve blending different combinations of components including coverage mandates for individuals and/or employers, expanding public programs, and enacting health insurance market reforms, among others. No state is the same, and the optimal combination of reforms for a given state cannot be determined without extensive investigation unique to the demographic and market characteristics of that state.

The hospital indigent care pool has been noted as one possible way to pay for expanded coverage for the uninsured. However, since the indigent care pool covers less than 40% of bad debt and charity care, after taking into account a hospitals’ contribution to the pool, such funding should not be considered for use unless the number of uninsured drops dramatically (for example, less than one million uninsured).

The state should create a Commission on Universal Access mandated to prepare a comprehensive plan by 2008 for coverage of all New Yorkers. Commission members should include political leadership, consumers, providers, insurers, business, labor, and others.

Securing continued and additional federal S-CHIP funding. For New York State to continue offering the wide array of public coverage programs that are now in operation, we must work to maintain and enhance federal funding.

- New York should work to reauthorize and fully fund the State Children’s Health Insurance Program (S-CHIP), which ends in 2007, to ensure that children across New York and the nation have affordable access to quality coverage.

- Federal financial participation is crucial and HANYS also recommends expanding the federal match for Medicaid—either through FMAP generally, or by increasing the floor for all children enrolled in Medicaid to the same level as S-CHIP (65% FFP)—to ensure adequate funding for programs serving New York’s children. The federal government should demonstrate its commitment to all children by providing that same level of match to children covered by the State’s Medicaid program. Doing so would increase federal funding to New York State by $650 million a year.
■ When Congress appropriates new funds for federal fiscal year 2008 and beyond, the new funding level should be set to meet or exceed the number of children currently and projected to be covered by S-CHIP.

■ States should retain the capacity to draw down from other states' unspent allocations. The redistribution pool of S-CHIP money has been a valuable means of shifting authorized federal funding between states, as they shrink and expand their programs according to state needs and budgets. The funds could be better utilized, however, if states were allowed to retain redistributed funds for longer than a year, so that they can integrate these funds into their program planning.
ACCOUNTABILITY OF PAYERS

Payer accountability is multi-faceted: involving adequate financing of the health care delivery system to support existing quality services and to keep pace with the evolution of patient care, and requiring insurers to pay provider claims responsibly.

ISSUE: ADEQUATE FINANCING

Investment in the state’s health care infrastructure is an important policy priority for HANYS’ members and their communities. Federal and state lawmakers have recognized the importance of this priority and authorized funding to restructure and improve service delivery. Specifically, both the federal and state governments are investing in the health care infrastructure through the state Health Care Efficiency and Affordability Law for New Yorkers (HEAL NY) grants and the Federal-State Health Reform Partnership (F-SHRP) waiver. Health care providers that received awards through HEAL NY are required to meet significant matching requirements. Additionally, providers use the very limited funds available from operations and from borrowing money to invest in modernization.

HANYS believes that improving health care should be a shared responsibility requiring the participation of all sectors, not just providers and the federal and state governments. Health care insurers are consolidating, increasing premiums, and maximizing profits to the point where their record-setting profits dwarf the operating margins of hospitals. Greater accountability would require insurers to contribute to improving health care in the communities they serve.

HOSPITALS CONTINUE TO SUSTAIN LOSSES WHILE HMOs PROFIT
While all institutions continually take important steps to make improvements, substantial investment is needed to support high performance in quality and efficiency, promote evidenced-based medicine, foster improved workforce satisfaction, and generally keep pace with the evolution of patient care, among other concerns. Significant operational efficiencies could be achieved through such additional investment by avoiding hospital admissions, shortening lengths of stay, better coordinating care across settings, and reducing complications. Third-party payers are a primary beneficiary of such provider-based investments, but inexplicably have not yet shared in its financing.

RECOMMENDATIONS FOR ADEQUATE FINANCING

HANYS is advocating for a mechanism to ensure greater third-party payer accountability. Specifically, HANYS is recommending that payers invest new funding in hospitals and health systems to make improvements in our health care system beyond what providers can currently afford or obtain from government through limited competitive grant funding. A 2005 survey by Opinion Dynamics Corporation of 600 New York State registered voters shows that 74% feel insurance companies should reinvest back into the health care system.

One such approach is the concept of a Community Reinvestment Fund, which was developed this past year by the Northern Metropolitan Hospital Association and Nassau-Suffolk Hospital Council as a regional initiative, in conjunction with the Westchester County Association, a business coalition. The Westchester County Association saw this as a business imperative—the region’s ability to attract and retain knowledge-based industries and staff depends more on a financially viable health care system (and schools) than profitable insurers.

Health care insurers in other states have set a precedent by participating in both voluntary and mandatory health care system improvement funding programs. For example, during 2005 in Pennsylvania, after a discussion of excessive profits, the state’s four not-for-profit Blue Cross Blue Shield health insurance plans reached an agreement with the state to contribute $950 million over six years to support community health reinvestment. In Massachusetts, a voluntary initiative by Blue Cross Blue Shield of Massachusetts pledged $50 million to study and support the development of electronic health records.

HANYS urges greater accountability through the creation of a community investment mechanism for third-party payers.
ISSUE: MANAGED CARE MARKET CONDUCT REFORM

Stronger enforcement and meaningful reform in the managed care industry are critical to ensure that New Yorkers are provided access to quality health care. The move toward greater consolidation in the managed care industry is having a significantly negative impact on patients and providers. That, coupled with the many other harmful industry practices and trends, is creating enormous pressures on how health care services are being accessed and delivered.

Dominant health plans with major market shares in their region have considerable leverage to dictate terms and rates to providers. The imbalance is made worse by anti-trust limitations that prevent providers from negotiating in any manner that would somewhat level the disparity between the power of the parties. Even worse, however, is the growing number of subtle and not-so-subtle practices designed to discourage members from using their benefits and/or prevent providers from dropping out of the plan’s network despite the inadequacy of reimbursement.

RECOMMENDATIONS FOR MANAGED CARE MARKET CONDUCT REFORM

Managed care organizations, whose motivation is to pay as little as possible and maximize profits or reserves (in the case of not-for-profit plans) must be held accountable for their market conduct. These reform proposals are intended to improve the current system as well as prohibit inappropriate health insurance practices or payment methods. Strengthening and improving the regulation of 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.

Consumers’ Health Care Benefits

HANYS has uncovered a number of health insurance practices that on their face may appear to be justified but when more closely scrutinized may be designed to discourage providers from exercising the right to contract, or prevent consumers from using a broader or more expensive benefit that the plans must offer. HANYS supports:

PROHIBITING PAYERS FROM CHANGING IN-NETWORK HOSPITAL COVERAGE TO OUT-OF-NETWORK BASED ON TREATING PHYSICIAN STATUS. As shown by the public discussion of Oxford Health Plans, Inc.’s out-of-network coverage practices, some health plans treat hospitalizations at a facility with which a plan has a contract as out-of-network merely because the treating doctor is an out-of-network physician. This apparently undisclosed practice (in at least Oxford’s case) results in patients finding themselves responsible for an unexpected and costly portion of the hospital bill that would normally be covered at an in-network hospital. Moreover, it results in an unearned benefit to the plan because it only pays a percentage of a discounted in-network rate it negotiated in its contract with the hospital and then requires the member to pay the remainder owed.

PROHIBITING MANAGED CARE ORGANIZATIONS FROM STEERING PATIENTS TO CERTAIN TYPES OF FACILITIES, INCLUDING PHYSICIAN OFFICES, WITHOUT A DISCLOSURE AND A CLINICAL BASIS FOR SUCH STEERING. Some health plans have sent notices to physicians in their networks informing them that they will be paid an increased fee if certain procedures are performed in the physician’s office. It is assumed that a plan’s reasoning is that patients be treated in an office setting when possible. Patient steering to less expensive treatment settings can be objectionable, particularly when the financial incentive is not disclosed to the health care consumer and when there is no clinical basis for choosing the less costly and potentially less appropriate setting.

PROHIBITING PLANS FROM CREATING POLICY LANGUAGE THAT DOES NOT PERMIT AN OUT-OF-NETWORK PROVIDER TO BE ASSIGNED PAYMENT BY THE PATIENT. A new managed care practice is emerging where health insurers are prohibiting consumers from authorizing direct reimbursement from their insurer to their out-of-network provider. The reason, the plans say, is the need to educate consumers about the true cost of their health care. The clear and objectionable result, however, will be yet another collection problem for providers who are already feeling the strain of limited resources. The not-so-subtle message to providers is to stay in a plan’s network regardless of the inadequacy of compensation.
Providers’ Rights under External Appeal Law

The current External Appeal Program within the NYS Insurance Department (SID) is dysfunctional resulting in an ineffectual and underused consumer protection statute. Currently, providers (who are in the strongest position to advocate for necessary medical care) are frequently unable to appeal adverse determinations regarding medical necessity. This is mainly because the SID does not recognize the two possible methods for a provider appeal. Specifically, SID refuses to honor designations by patients authorizing providers to appeal on their behalf, and SID deems retrospective determinations by providers to be concurrent and, therefore, barred from external review.

The administrative shortcomings of the External Appeal Law must be corrected so that its use can be maximized. Providers must have a clear right to appeal adverse determinations particularly since providers are currently prohibited from balance billing patients for covered services that are denied by the plan.

Prompt Pay Law

Under New York’s current Prompt Pay Law, insurers are required to adhere to certain deadlines and make timely payment of claims. Plans should be compelled, as they are in other states1, to pay electronic claims within a shortened timeframe. This would also serve to encourage provider investment in technology. Moreover, plans that repeatedly violate prompt pay laws should receive penalties that are effective in deterring recidivism.

HANYS recommends that the time within which an electronic claim must be paid be reduced from 45 days to 15 days. Additionally, HANYS recommends that penalties for prompt pay violations be increased to deter plans from repeatedly violating the law.

Refund Demand Limitations

There are currently no statutory limits, requirements, or prohibitions on the timing or scope of refund demands, or take-backs, issued by health plans to hospitals. Health plans should have no more than one year from the payment of a claim to demand a refund. In addition, health plans should limit the circumstances under which take-backs can occur to billing/coding errors or fraud. Under no circumstances should plans be permitted to get a second chance at utilization review in the absence of an additional appeal right for providers. Limitations need to be placed on the timeframe and circumstances under which insurers can seek a refund of claims paid or an adjustment of subsequent payments.

Administrative Denials

A plan should not be able to deny claims for medically necessary, covered services based on a technical error by the provider in the absence of demonstrable detriment to a plan’s ability to manage the care provided to an insured. HANYS recommends that plans be prohibited from denying payment for claims based on an administrative reason when the medical care provided was previously authorized.

Payment for Authorized Medical Care

Plans retrospectively review previously authorized services. Providers justifiably rely on the authorization provided by the health care plan and then are forced to spend money and time appealing the decision. Plans should be prohibited from retrospectively denying health services when the provider has obtained approval from the insurer before rendering services, unless the approval was based on a fraud or materially inaccurate or misrepresented information.

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Coordination of Benefits

HANYS has helped to draft, and continues to support, a regulation now pending before the Insurance Department Healthcare Roundtable that would address coordination of benefits issues. While not yet promulgated, the regulation would outline how to resolve the disagreement over which payer is primarily responsible to pay a claim without detriment to the provider. HANYS recommends promulgation of this regulation, as currently negotiated, and payers should be required to coordinate benefits among other payers without taking back paid claims or denying claims based upon plans’ refusal to accept medical necessity determination of other plans.

Utilization Review (UR) Law

New York State law establishes timeframes in which utilization review agents must make adverse determinations. However, the law needs to be enhanced to protect consumers and providers. The failure to make a utilization review decision within the stated time should be deemed an approved claim and not an adverse determination.

Administrative Burden for Emergency Department (ED) Visits

To avoid the burden and costs associated with supplying medical records for all ED visits, commercial health plans should be required to consider certain common sense factors in applying the prudent layperson standard when determining whether the medical care provided was for emergency medical services. A utilization review agent should be required to consider the time of day and the day of the week the patient presented to the emergency department, in addition to the presenting symptoms when reviewing a denial for coverage of emergency services to treat an emergency medical condition.
CERTIFICATE OF NEED

ISSUE

New York’s Certificate of Need (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. Examples of this dysfunction include the inability of DOH to triage more routine applications for quick turnaround; the lack of “bench strength” among regional staff leading to delays in on-site surveys if someone takes a vacation; the inability to retain staff due in part to excessive workload; and a perception by many applicants that they must hire expensive consultants to get their projects through the system.

New York’s CON program, which is the oldest in the country, was at one time a model program and remains one of the more comprehensive in the nation. Started before health care financing was partially de-regulated by the state in 1996, the CON program today highlights the growing tension between the community oriented, mission-based services provided by many health care institutions and their concurrent need to compete with entrepreneurs in the marketplace.

Today’s CON program is based upon a regulatory framework sorely in need of updating, both in terms of its vision and the need to better reflect changing technologies, the migration of services to the outpatient setting, patient preferences, and most notably, the latest science on quality.

RECOMMENDATIONS

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. Senior DOH officials have worked with HANYS and allied associations on some of these reforms, but progress has been slow because of competing priorities (such as the Berger Commission, HEAL grants). Key recommendations include:

- Exempt from the full CON review process any proposal that does not relate to a change in clinical services or equipment and, instead, allow for a simple notification to DOH in advance of construction.

- Change the thresholds for all categories of CON Review—for example, prior review for projects up to $3 million; limited review for projects from $3 million to $10 million; administrative review for projects between $10 million and $25 million, and full review for projects over $25 million.

- Update the regulations regarding the purchase of new or replacement technology to reflect current practice, and eliminate what are viewed as routine purchases from intensive review.

- Better coordinate activities of the regional offices in relation to pre-opening surveys; allow facilities to schedule quarterly or bi-annual surveys for a review of all new services to satisfy this requirement, and not delay putting these services in operation.

- Clarify those instances when a facility may have its own architect or engineer certify compliance with regulations in lieu of on-site visits.
Coordinated Chronic Care Management

ISSUE

Nearly one-half of Medicaid enrollees with one chronic condition also have another, often a mental health condition or problem associated with substance abuse. Data show that a small number of Medicaid enrollees with very complex health care needs account for a significant percentage of Medicaid expenditures. The presence of multiple conditions or co-morbidities increases the complexity of issues for the patient.

A fundamentally different approach must be developed to proactively manage patients with multiple chronic illnesses, including the interaction with behavioral health conditions or co-morbidities. Earlier disease management studies have shown that a planned, coordinated approach is the most effective way to address the constellation of care needs created by chronic disease and its long-term progression. New research, advances in technology, and a renewed interest from individuals to participate in their own health care offer New York State an opportunity to create innovative health care policy.

Coordinated chronic care management can address issues related to frequent health service utilizers, and future heavy users. It is important to look at the bigger picture in health care so that clinical management systems focus interventions on longer-term disease control and prevention, as well as presenting symptoms and single acute episodes. Reimbursement systems should not only pay for what is done “to” patients, but also cover the costs associated with a health professional working “with” patients to coordinate their care in a way that improves quality of life and reduces the need for nursing home, hospital, or emergency room care.

There is no single definition or model for coordinated chronic care management—there is no “one size fits all” approach. Experts use the term “coordinated chronic care management” in many ways, but the common goals are generally to:

- Engage the patient and family as active partners in their care;
- Improve patient compliance with treatment plans;
- Prevent health crises and worsening of conditions;
- Improve overall quality of care;
- Efficiently use health care resources;
- Expand use of the health care workforce, including use of informal caregivers;
- Improve patient/family satisfaction; and
- Reduce the costs of care—unnecessary nursing home admissions, hospitalizations, and emergency room use.

Coordinated chronic care management focuses on effective treatment (both clinical and behavioral), information and support for their self-management, systematic assessment and follow-up 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.
RECOMMENDATIONS

Current disease management programs and case management programs offer strong platforms on which to build coordinated care models for one or more chronic illness. Research demonstrates that “care management” and “disease management” can effectively mitigate disability and suffering, and reduce the costs associated with chronic illnesses through prevention, coordinated treatment, patient education, and self-management when possible.

Program and fiscal design should be flexible enough to accommodate Medicaid fee-for-service and managed care recipients, as well as different program structures. Program and financial parameters would need to be created to align the financial component with a coordinated care model. Program structures must be flexible depending on type of provider, the maturity of the provider in care management, populations to be served, and other variables.

HANYS recommends the creation and testing of various models of coordinated chronic care management that have different fiscal and program parameters, cover Medicaid fee-for-service and/or managed care populations, and include:

- Approval by the Commissioner of Health of providers that satisfy the standards for providing coordinated chronic care management including:
  - Collaboration and partnership of an interdisciplinary team of health professionals, the patient, and the family;
  - Designation of a care coordinator to assist the patient and/or family to navigate the often confusing maze of providers and services, and payment and eligibility rules;
- Delivery of coordinated clinical and behavioral treatment;
- Patient monitoring including the use of tele-monitoring (telemedicine, telehome-care, telehealthcare), telephone calls, and other means;
- Patient/family education and support, coaching and mentoring for understanding and treating the condition, knowledge and interventions for healthy living, and prevention of health crises through self-management;
- Information technology to improve providers’ access to patient information and to develop interdisciplinary clinical information databases to facilitate care coordination.
- Enhanced funding for approved providers who can demonstrate the ability to meet specified standards.
- Requirements for Medicaid managed care plans and prepaid health services plans to offer this service delivery option to enrollees.
- Linkages with, and funding for, community-based organizations to engage communities and provide support that reinforces self-management and healthy behavioral changes for patients.

Coordinated chronic care management promotes constructive change. It can respond positively to the changing consumerism and offer positive ways to increase patient access and satisfaction and improve quality.
HEALTH CARE REFORM ACT

BACKGROUND

When Health Care Reform Act (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 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, representing 40% of pool funding.

In preparation for the reauthorization of HCRA, HANYS’ members have identified an escalating variety of critical challenges. The major issues raised include:

- Safeguarding public goods pool funding;
- Updating hospital payment methodologies;
- Improving access and coverage;
- Establishing a community reinvestment fund;
- Improving managed care payer conduct;
- Creating better models of care management;
- Addressing the dysfunctional medical liability system;
- Alleviating workforce shortages;
- Improving quality of care;
- Leveling the playing field with niche providers; and
- Streamlining and updating the Certificate of Need process.
Public Goods Pools

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

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

There has been much deliberation about the funding and progressivity of the indigent care pool. This pool has been increased only once since before HCRA was enacted ten years ago, when the Legislature approved $82 million as a rural/high need adjustment in 2000.

The indigent care pool covers about 50 percent of uncompensated care costs. However, after considering that hospitals also contribute nearly $250 million to the pool, the coverage level is approximately 38%. At approximately 38 cents on the dollar overall, total funding is insufficient to increase progressivity for higher need facilities without jeopardizing needed support for others. Moreover, such funding should not be considered as a possible way to pay for expanded coverage unless the number of uninsured drops dramatically (for example, to less than one million uninsured).

**RECOMMENDATIONS**

**NOMINAL NEED SCALE/HIGH NEED ADJUSTMENT ARE PROGRESSIVE**
GRADUATE MEDICAL EDUCATION (GME). The excellence of New York State’s medical education programs should be a source of pride. New York State is home to many of the country’s most prestigious academic medical centers and community teaching hospitals, making our state one of the world’s premier centers for medical excellence. In addition to providing high-quality medical care, these facilities provide the finest training for physicians and serve as the foundation of a powerful biomedical industry.

GME funding underwent a major reduction when HCRA was enacted. The private sector—business and insurers—was given a 46% discount on its contribution to GME. However, the economic activity and tax revenue generated by hospital teaching programs far offset contributions by businesses and government. For every dollar paid by businesses and state or local governments, teaching hospitals generate almost three dollars for teaching or biomedical research activities from out-of-state sources. This amounts to a $3 billion infusion of money that generates an approximate $6 billion benefit to the state’s economy.

RURAL HEALTH. New York State’s rural health care providers are the centerpiece of the health care infrastructure in their communities. For the state’s most geographically isolated residents, rural hospitals and health systems are often the only providers of essential health care services to more than three million New Yorkers. 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 Critical Access Hospital to help ensure the viability of these fundamental services. Federal Medicare policies have assisted many small, rural hospitals to maintain their essential services. Yet, no similar state program exists. Comparable state Medicaid policies would further such reconfigurations.

WORKFORCE RECRUITMENT AND RETENTION. In 2002, funding was authorized to address the recruitment and retention of health care workers. These critical funds support commitments made between health care providers and their employees and must be continued (see separate paper on workforce shortages for additional recommendations).

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<th>HCRA POOL SUMMARY</th>
<th>Sources of Funds</th>
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<th>Source</th>
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<tr>
<td>1% Hospital Assessment</td>
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<td>Private payer &amp; Medicaid Surcharge</td>
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<td>Covered Lives Assessment</td>
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<td>Conversion Proceeds</td>
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POOLS FUNDING. 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.

<table>
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**HCRA POOL SUMMARY**

**Uses of Funds**

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<td>Workforce $75 M</td>
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<td>CHP and Other Insurance $145 M</td>
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<td>Other $205 M</td>
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<td>Hospital Indigent Care $738 M</td>
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### Hospital Payment Formulas

HANYS continues to work closely with state policymakers to assess the impact of outdated payment formulas and suggest approaches for developing updated payment systems that more adequately reflect the true cost of providing services, including for behavioral health services.

New York State’s Medicaid case-based hospital reimbursement methodology for fee-for-service patients is based on outdated data. Also out-of-date are the bases for exempt unit payments (i.e., acute psychiatric and rehabilitation services). The diagnosis-related group (DRG) payment rate is determined using 1992 data in the calculation of service intensity weights (SIWs). Additional payments may be made for outlier patients who have an unusually long or short length-of-stay. Called outlier trimpoints, the data used are from 1992 and are particularly problematic.

The Department of Health (DOH) is working on recalculated SIWs and trimpoints based on 2004 data. The revisions could be done in early 2007, but implementation will require legislation.

HANYS supports more accurate and equitable Medicaid payments. Currently, the payment system does not reflect current costs and up-to-date treatment protocols. HANYS has met with DOH to discuss the complex methodology and data for calculating updated SIWs and trimpoints. HANYS is urging DOH to work closely with the industry to ensure the accuracy of both the data and the calculations. We are also advocating for an adequate transition period to allow hospitals to adapt to the revenue changes that will result from this revision.
Accurate and updated SIWs and trimpoints should improve payment equity. However, since it is done on a budget neutral basis, it does not address the need for additional funds to compensate hospitals for the costs of expensive new technologies and medical devices. HANYS has presented a proposal to DOH to provide a rate add-on related to treatment of patients who require these new technologies.

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

Access and Coverage

All New Yorkers deserve access to quality health care. Ensuring that principle is achieved requires continued state effort to expand insurance coverage. HANYS supports bringing New York closer to universal 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 coverage 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) modest expansion of CHP B eligibility criteria (see separate paper on access and coverage).

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 responsibly.

Adequate Financing. Investment in the state’s health care system is an important policy priority for HANYS’ members and their communities. Federal and state lawmakers have recognized the importance of this priority and authorized funding to restructure service delivery and to invest in needed improvements in communities across New York State.

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 maximize community resources and create opportunities to improve a community’s health care system.

Health care insurers are consolidating, increasing premiums, and maximizing profits and should be required to contribute to improving health care in the communities they serve. HANYS is advocating for a mechanism to ensure greater third party payer accountability. Specifically, HANYS is recommending that payers invest new funding in hospitals and health systems to make improvements in our health care system beyond what providers can currently afford or obtain from government through limited competitive grant funding.

Managed Care Market Conduct Reform. Managed care organizations, whose motivation is to pay as little as possible and maximize profits or reserves (in the case of not-for-profit plans), 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.

The following reform proposals are intended to improve the current system as well as prohibit inappropriate health insurance practices or payment methods:

- Protect consumers’ health care benefits;
- Protect providers’ rights under External Appeal Law;
- Ensure payment for authorized medical care;
- Enhance New York’s Prompt Pay Law;
- Limit refund demands;
- Eliminate administrative denials;
■ Coordination of benefits;
■ Enhance utilization review (UR) law; and
■ Reduce administrative burden for emergency department visits.
(See separate paper on accountability of payers)

Better Models of Care Management
About 25% of Medicaid enrollees are elderly and disabled, yet 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. HANYS supports:

IMPLEMENTING COORDINATED CHRONIC CARE MANAGEMENT TO PROMOTE CONSTRUCTIVE REFORM.
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 (see separate paper on coordinated chronic care management).

HANYS recommends the creation and testing of various models of coordinated chronic care management that have different fiscal and program parameters, cover Medicaid fee-for-service and/or managed care populations. This would also include approval by the Commissioner of Health of providers that satisfy standards for providing coordinated chronic care management including:

■ Collaboration and partnership of an interdisciplinary team of health professionals, the patient, and the family;
■ A designated care coordinator to assist the patient and/or family to navigate the often confusing maze of providers and services, and payment and eligibility rules;
■ Delivery of coordinated clinical and behavioral treatment;
■ Patient monitoring including the use of telemonitoring (telemedicine, telehome-care, telehealthcare), telephone calls, and other means;
■ Patient/family education and support, coaching and mentoring for understanding and treating the condition, knowledge and interventions for healthy living, and prevention of health crises through self-management;
■ Information technology to improve providers’ access to patient information and to develop interdisciplinary clinical information databases to facilitate care coordination.

Additionally, HANYS recommends enhanced funding for approved providers who can demonstrate the ability to meet specified standards as well as requirements for Medicaid managed care plans and prepaid health services plans to offer this service delivery option to enrollees. Funding should also be provided to community-based organizations to engage communities and provide support that reinforces self-management and healthy behavioral changes for patients.

EXPANDING PRIMARY CARE.
More than ten years ago, the state embarked on an expanded effort to enroll Medicaid beneficiaries in Medicaid managed care. Medicaid managed care was to provide a “medical home” for beneficiaries. On a practical level, however, Medicaid managed care has often been more about managing costs than managing care.

This is an area that demonstrates how reimbursement policies and incentives are skewed. An investment in primary care is needed. To help promote primary care, HANYS recommends a targeted increase in Medicaid reimbursement as follows: Medicaid physician reimbursement, hospital outpatient departments and community health centers, and incentives to promote after-hours primary care. Such an investment is consistent with the overall principle of rightsizing, should reduce unnecessary use of hospital emergency departments and is necessary given the enrollment of the SSI population into managed care. With the general aging of the population, it is an important element of coordinated chronic care management.
Complicating efforts to expand primary care is the growing health literacy gap, which potentially leads to the use of more expensive services and less preventive 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.

**ENHANCING 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.

**EXPANDING TRANSITIONAL CARE UNITS (TCUS).** A TCU is a unit in a hospital for patients over age 65 who have exceeded the time allowed by Medicare but need continued hospitalization for a short time period due to their medical needs or the lack of specialized nursing home services. There are currently only five demonstration programs in New York State and this limitation means that the vast majority of hospitals provide this care to patients without any reimbursement. HANYS strongly supports legislation to expand TCUs and enable federal Medicare monies to flow to New York without additional state expenditures.

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

**Medical Liability System**

New York’s system for compensating patients injured by provider negligence is inequitable, inefficient and unfair—to patients, providers and the public at large. Vast sums of money pour from providers to insurers and from there to plaintiffs 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 (see separate paper on medical liability).

**Workforce Shortages**

HANYS supports new ways to address changing workforce needs and to ensure that there are sufficient numbers and distribution of qualified health care professionals and para-professionals.

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 many communities for a number of issues, 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, work in needed specialties, and to increase the number of underrepresented minority physicians (see separate paper on workforce shortages).

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 (see separate paper on quality improvement).

In the area of quality data collection and reporting, the state has an opportunity to move away from the environment of dissimilar report cards to 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.

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. IT has the potential to reduce overall health care system costs, but evidence is lacking to support the idea that any measurable amount of savings will accrue to providers. IT will reduce duplicate testing and help prevent errors that can lead to added costs. However, savings models suggest that payers and purchasers of health insurance, including large employers, will garner the preponderance of savings.

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. The investment needed to achieve widespread IT adoption is staggering. A recent analysis of the nationwide cost of outfitting providers with comprehensive IT systems over a ten-year period was between $276 billion and $320 billion².

Globally, HANYS has actively supported a public-private partnership to achieve the goal of making the use of IT systems commonplace; supporting the continued public and private development and adoption of interoperability standards; working to ensure certification of information technology products and working with regional health information organizations.

HANYS has the following recommendations:

- **ESTABLISHING ACCESSIBLE AND SUSTAINABLE FUNDING STREAMS TO DEVELOP IT PROGRAMS FOR HOSPITALS AND CONTINUING CARE PROVIDERS.** HANYS is advocating for the dedication of funding to support IT investment.

- **SUPPORTING ELECTRONIC PRESCRIBING.** E-prescribing enables a physician to transmit a prescription electronically to the patient’s pharmacy and to obtain information about drug formularies and patient medication history. It can reduce or eliminate the need for a hand-written prescription and in turn help to reduce medication errors. These systems can serve an important preventive function of identifying errors in dosing, timing, and form, and can also flag potential allergies, drug interactions, or other patient contraindications.

- **ENCOURAGING DEVELOPMENT OF ELECTRONIC MEDICAL RECORDS (EMRS).** EMRs can facilitate communication among multiple providers, reduce unnecessary tests, and enable caregivers to better track and coordinate care. These tools can provide physicians and other clinicians with up-to-date information about their patients, improve the quality of care, and dramatically reduce medical errors.

■ DEVELOPING SMARTCARDS. Smartcards are credit card-size cards that hold a patient’s medical information. Health care providers within a region can adopt standard technology that enables a patient to walk into any facility and provide his or her medical information via a Smartcard. This enables health care providers to have instant access to a patient’s medical history and eliminates unnecessary tests and medications. Additionally, HANYS supports efforts to create regionally-based virtual Smartcards.

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 the 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 also 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 (see separate paper on niche providers).

Certificate of Need

New York’s Certificate of Need (CON) program is overwhelmed and understaffed, and guided by regulations egregiously out of date. Despite the best intentions of many DOH staff, the system is broken and in need of repair. Examples of this dysfunction include the inability of DOH to triage more routine applications for quick turnaround; the lack of “bench strength” among regional staff leading to delays in on-site surveys if someone takes a vacation; the inability to retain staff due in part to excessive workload; and a perception by many applicants that they must hire expensive consultants to get their projects through the system.

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. Senior DOH officials have worked with HANYS and allied associations on these reforms over the past year, but progress has been slow because of competing DOH priorities. HANYS has recommended specific actions that would streamline and update the CON review process, and improve coordination with the DOH regional offices (see separate paper on Certificate of Need).
LONG-TERM CARE REFORM

ISSUE

HANYS conceptually supports the goal to reform long-term care. The current system is not perfect and there are many critical issues facing long-term care that must be addressed. Looking to the future, the impact of demographics alone—in terms of an aging population, longer lifespan, and the likelihood of continued and worsening health care workforce shortages—necessitates a re-evaluation of our service delivery system and regulatory structures.

Restructuring 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. Of particular relevance is the proven value of alternative community-based models to effectively complement institution-based long-term care services.

RECOMMENDATIONS

HANYS has developed its recommendations with the above issues in mind and to emphasize the need to look beyond the health care system to actually effectuate long-term care reform.

RESTRUCTURING LONG-TERM CARE BUT NOT THROUGH A SECTION 1115 MEDICAID WAIVER. The focus on an 1115 waiver is limiting, potentially disruptive, and leaves out critical issues that need to be addressed including workforce, housing, transportation, and non-medical issues. It also raises a host of unanswered health policy questions. HANYS has made a series of recommendations to address issues related to community resources, service coordination and management, long-term care service programs, and system oversight.

AVOIDING RIGID GATEKEEPER MODELS IN LONG-TERM CARE. HANYS supports enhanced consumer information, education, and navigation assistance. Patient-centered choice and decision making should be the goal. HANYS opposes gatekeeper models may force patients to stay in a hospital for longer than is necessary. Such models may increase hospital length-of-stay due to bureaucratic delays, and inhibit the transition of patients between and within acute and long-term care settings.

PROMOTING LONG-TERM HOME HEALTH CARE PROGRAMS (LTHHCPs), MANAGED LONG-TERM CARE (MLTC), AND THE PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE). Such programs have been effective at offering patients home-based health care services, providing appropriate care management, and reducing institutionalization of the elderly. LTHHCPs, MLTC, and PACE are model programs that address the complex needs of the patients they serve.

EXPANDING HOME- AND COMMUNITY-BASED SERVICES. Alternatives to institutional care, such as MLTC, LTHHCP, and other community-based models have the potential to significantly reduce overall health care costs and keep people in the least restrictive setting—their home. Moreover, bridging the gaps between health care policies and other public policy areas (such as housing, transportation, mental health, and human services) is critical to keep people in community settings and support independence.
CLOSING ELIGIBILITY LOOPOLES. Individuals and families should contribute appropriately to the cost of chronic care services and not use legal loopholes to shelter/transfer income or assets and shift the burden to the public. These areas are of particular importance given the health care costs associated with an aging population.

EXPANDING LONG-TERM CARE FINANCING OPTIONS. Expanding access to long-term care insurance would help individuals and families contribute to the cost of care.

CREATING A UNIVERSAL ASSESSMENT PROCESS FOR POST-ACUTE SETTINGS. Unnecessary nursing home and home care documentation requirements need to be eliminated; other requirements should be streamlined.
MEDICAID REFORM

BACKGROUND

Both state and federal governments promote Medicaid “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.” In fact, the health care system has experienced tremendous change, yet New York State’s health care community is in financial turmoil and there is no question that this is largely due to years of payment cuts to hospitals, nursing homes, and home care providers.

The provider environment continues to be defined by weak finances, increased demand for services, inadequate reimbursement, and a declining supply of workers—all of which affect the ability to deliver accessible, quality care. In the past, the term Medicaid “reform” has been used as a veil for payment cuts and taxes. As HANYS has said on numerous occasions, health care cuts and taxes do not constitute health care reform.

HANYS believes that true health care reform must preserve and strengthen the ability of vulnerable populations to access health care and must:

■ focus on patient and community needs;
■ ensure that all New Yorkers have access to care;
■ promote excellence in efficient delivery of care;
■ enable flexibility to adapt to changing needs;
■ create and align health care system incentives;
■ ensure adequate payment for services provided; and
■ move toward outcome-oriented measurements of health care delivery.

RECOMMENDATIONS

HANYS has developed its recommendations with the above issues in mind, emphasizing the need to reform the entire health care system—not just Medicaid. The integrated nature of health care makes it difficult, if not impossible, to undertake meaningful reform of just one piece of the system.

Access and Coverage

All New Yorkers deserve access to quality health care. Ensuring that principle is achieved requires continued state effort to expand insurance coverage. HANYS supports bringing New York closer to universal 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 coverage 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) modest expansion of CHP B eligibility criteria (see separate paper on access and coverage).
Rightsizing

HANYS has supported the concept of a rational reconfiguration of the health care system, including a reasonable downsizing of capacity. We recommended a process that emphasized local community input, was sensitive to the unique needs of each affected community, and was appropriately funded. The goal has been to achieve a stronger, more viable system configured to meet the health care needs of New York State’s 18 million citizens.

The recommendations of the Commission on Health Care Facilities in the 21st Century must now contend with the much less-controllable conditions of the real world. In particular, HANYS is very concerned that the true cost impact of the Commission recommendations has not been made clear and is, in fact, substantially understated and not immediately available. Restructuring and downsizing must be done commensurate with available resources and immediate transitional funding is essential to support an orderly realignment. Patient care is at stake in every region of the state and cannot be put at risk.

We view the release of the Commission report as the beginning, not the end, of a complex and critical process. True reform of the health care delivery system must span the entire continuum and it cannot be focused solely on hospitals and nursing homes. The non-binding policy recommendations of the Commission spell out the array of additional, necessary reforms, including providing health care coverage to the millions of New Yorkers who are uninsured, expanding primary care, and investing in health care information technology.

Accountability of Payers

Investment in the state’s health care system is an important policy priority for HANYS’ members and their communities. Federal and state lawmakers have recognized the importance of this priority and authorized funding to restructure service delivery and invest in needed improvements in communities across New York State.

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A designated care coordinator to assist the patient and/or family to navigate the often confusing maze of providers and services, and payment and eligibility rules;

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This is an area that demonstrates how reimbursement policies and incentives are skewed. An investment in primary care is needed. To help promote primary care, HANYS recommends a targeted increase in Medicaid reimbursement as follows: Medicaid physician reimbursement, hospital outpatient departments and community health centers, and incentives to promote after-hours primary care. Such an investment is consistent with the overall principle of rightsizing, should reduce unnecessary use of hospital emergency departments and is necessary given the enrollment of the SSI population into managed care. With the general aging of the population, it is an important element of coordinated chronic care management.

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DEVELOPING NEW BEHAVIORAL HEALTH COMMUNITY AND CRISIS PROGRAMS. Despite the growth in behavioral health services provided by hospitals and community programs, there continues to be a growing need for community services. There are not enough residential services, transitional services, or outpatient services to care for individuals once they leave a hospital. Investing in additional community programs would reduce costs and provide an opportunity for individuals to return to their communities.
EXPANDING TRANSITIONAL CARE UNITS (TCUS). A TCU is a unit in a hospital for patients over age 65 who have exceeded the time allowed by Medicare but need continued hospitalization for a short time period due to their medical needs or the lack of specialized nursing home services. There are currently five demonstration programs in New York State and this means that the vast majority of hospitals provide this care to patients without any reimbursement. HANYS strongly supports legislation to expand TCUs and enable federal Medicare monies to flow to New York without additional state expenditures.

SUPPORTING CRITICAL ACCESS HOSPITAL CONVERSION. Federal Medicare policies have assisted many small, rural hospitals to maintain their essential services. Yet, no similar state program exists. Comparable state Medicaid policies would further such reconfigurations.

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

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Long-Term Care Reform
HANYS conceptually supports the goal to reform the long-term care system. The current system is not perfect and there are many critical issues facing long-term care that must be addressed (see separate paper on 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. The focus on an 1115 waiver is limiting, potentially disruptive, and leaves out critical issues that need to be addressed including workforce, housing, transportation, and non-medical issues. It also raises a host of unanswered health policy questions. HANYS has made a series of recommendations to address issues related to community resources, service coordination and management, long-term care service programs, and system oversight.

AVOIDING RIGID GATEKEEPER MODELS. HANYS supports enhanced consumer information, education, and navigation assistance. Patient-centered choice and decision making should be the goal. HANYS opposes gatekeeper models that may force patients to stay in a hospital for longer than is necessary. Such models may increase hospital length-of-stay due to bureaucratic delays and inhibit the transition of patients between and within acute and long-term care settings.

PROMOTING LONG-TERM HOME HEALTH CARE PROGRAMS (LTHHCPS), MANAGED LONG-TERM CARE (MLTC), AND THE PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE). Such programs have been effective at offering patients home-based health care services, providing appropriate care management, and reducing institutionalization of the elderly. LTHHCPS, MLTC, and PACE are model programs that address the complex needs of the patients they serve.

EXPANDING HOME- AND COMMUNITY-BASED SERVICES. Alternatives to institutional care have the potential to significantly reduce overall health care costs and keep people in the least restrictive setting—their home. Moreover, bridging the gaps between health care policies and other public policy areas (such as housing, transportation, mental health and human services) is critical to keep people in community settings and support independence.

CLOSING ELIGIBILITY LOOHOLES. Individuals and families should contribute appropriately to the cost of chronic care services and not use legal loopholes to shelter/transfer income or assets and shift the burden to the public. These areas are of particular importance given the health care costs associated with an aging population.

EXPANDING LONG-TERM CARE FINANCING OPTIONS. Expanding access to long-term care insurance would help individuals and families contribute to the cost of care.

CREATING A UNIVERSAL ASSESSMENT PROCESS FOR POST-ACUTE SETTINGS. Unnecessary nursing home and home care documentation requirements need to be eliminated; other requirements should be streamlined.

Workforce Shortages

HANYS supports new ways to address changing workforce needs and to ensure that there are sufficient numbers and distribution of qualified health care professionals and para-professionals.

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 many communities for a number of issues, 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, work in needed specialties, and to increase the number of underrepresented minority physicians (see separate paper on workforce shortages).
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 (see separate paper on quality improvement).

In the area of quality data collection and reporting, the state has an opportunity to move away from the environment of dissimilar report cards to 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.

In both Washington and Albany, HANYS is 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. IT has the potential to reduce overall health care system costs, but evidence is lacking to support the idea that any measurable amount of savings will accrue to providers. IT will reduce duplicate testing and help prevent errors that can lead to added costs. However, savings models suggest that payers and purchasers of health insurance, including large employers, will garner the preponderance of savings.

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. The investment needed to achieve widespread IT adoption is staggering. A recent analysis of the nationwide cost of outfitting providers with comprehensive IT systems over a ten-year period was between $276 billion and $320 billion.

Globally, HANYS has actively supported a public-private partnership to achieve the goal of making the use of IT systems commonplace; supporting the continued public and private development and adoption of interoperability standards; working to ensure certification of information technology products and working with regional health information organizations.

HANYS has the following recommendations:

- **ESTABLISHING ACCESSIBLE AND SUSTAINABLE FUNDING STREAMS TO DEVELOP IT PROGRAMS FOR HOSPITALS AND CONTINUING CARE PROVIDERS.** HANYS is advocating for the dedication of funding to support IT investment.

- **SUPPORTING ELECTRONIC PRESCRIBING.** E-prescribing enables a physician to transmit a prescription electronically to the patient's pharmacy and to obtain information about drug formularies and patient medication history. It can reduce or eliminate the need for a hand-written prescription and in turn help to reduce medication errors. These systems can serve an important preventive function of identifying errors in dosing, timing, and form, and can also flag potential allergies, drug interactions, or other patient contraindications.

- **ENCOURAGING DEVELOPMENT OF ELECTRONIC MEDICAL RECORDS (EMRS).** EMRs can facilitate communication among multiple providers, reduce unnecessary tests, and enable caregivers to better track and coordinate care. These tools can provide physicians and other clinicians with up-to-date information about their patients, improve the quality of care, and dramatically reduce medical errors.

- **DEVELOPING SMARTCARDS.** Smartcards are credit card-size cards that hold a patient’s medical information. Health care providers within a region can adopt standard technology that enables a patient to walk into any facility and provide his or her medical information via a Smartcard. This enables health care providers to have instant access to a patient’s medical history and eliminates unnecessary tests and medications. Additionally, HANYS supports efforts to create regionally-based virtual Smartcards.

Medical Liability

New York’s system for compensating patients injured by provider negligence is inequitable, inefficient and unfair—to patients, providers, and the public at large. 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 (see separate paper on medical liability).

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, and 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 also 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 (see separate paper on niche providers).

Certificate of Need

New York’s Certificate of Need (CON) program is overwhelmed and understaffed, and guided by regulations egregiously out of date. Despite the best intentions of many DOH staff, the system is broken and in need of repair. Examples of this dysfunction include the inability of DOH to triage more routine applications for quick turnaround; the lack of “bench strength” among regional staff leading to delays in on-site surveys if someone takes a vacation; the inability to retain staff due in part to excessive workload; and a perception by many applicants that they must hire expensive consultants to get their projects through the system.

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. Senior DOH officials have worked with HANYS and allied associations on these reforms over the past year, but progress has been slow because of competing DOH priorities. HANYS has recommended specific actions to that would streamline and update the CON review process, and improve coordination with the DOH regional offices (see separate paper on Certificate of Need).

Pharmaceuticals

For primary and acute care services, the state’s major purchasing strategy has been to channel Medicaid beneficiaries into managed care plans. This also applies to Child Health Plus and Family Health Plus. There are additional, responsible opportunities for Medicaid to reduce the cost growth from pharmaceuticals.

Spending on prescription drugs and supplies is the fastest growing component of Medicaid. Between 2001–2005, Medicaid spending increased by $2.4 billion, or 88%. Prescription drugs account for 21 cents of every new Medicaid dollar spent. Growing drug costs place a financial burden on taxpayers, consumers, providers and employers that provide health care coverage to their employees.
New York State has always been at the forefront in providing access to needed drugs for the poor and elderly. However, it may be difficult to maintain that role unless the escalating costs related to prescription drugs are addressed. The state could strengthen its preferred drug program to help ease cost growth in this area while maintaining access. Another initiative that the state could consider, although not related to Medicaid, is to use the purchasing power of the state to bulk purchase prescription drugs. This could maximize the purchasing power of consumers to help make prescription drugs more affordable.

**Federal Actions**

Actions in Washington can complement or threaten state Medicaid efforts. This is demonstrated by the continuing intent of the Bush Administration to reduce Medicaid funding to states. The Center for Medicare and Medicaid Services (CMS) was expected to release regulations to limit certain state Medicaid funding mechanisms (i.e., provider tax reductions and IGT limits), despite the objections of the majority in Congress. The Administration’s proposal would have cost New York as much as $1.1 billion in federal Medicaid funding per year.

After months of aggressive advocacy by HANYS, the American Hospital Association, and the National Association of Public Hospitals, both houses of Congress passed legislation that would block $750 million per year in Medicaid cuts to New York State. The legislation prevents the Bush Administration from issuing regulations cutting Medicaid funding to states by limiting the allowable level of provider taxes.

HANYS’ advocacy efforts and the leadership of Senators Charles Schumer (D-NY) and Hillary Rodham Clinton (D-NY) were critical to ensuring the inclusion of the Medicaid provider tax language in the Act. For the past several months, HANYS worked with the New York State Congressional Delegation, several members of which took leadership roles in the effort to block the cuts, and our partners in a number of other state hospital/health care associations to press Congress to prevent these cuts.

Despite our success in blocking the Medicaid provider tax regulations, the Bush Administration is still expected to issue other Medicaid regulations in the coming weeks that would reduce the use of Medicaid intergovernmental transfers (IGT) to public hospitals. If promulgated, the regulations would significantly reduce direct federal funding to one New York health care institution: New York City Health and Hospitals Corporation. HANYS, with the leadership of the incoming Chairman of the House Ways and Means Committee, Charles Rangel (D-Manhattan), and the entire New York State Congressional Delegation, will fight to protect New York’s ability to use IGTs.

Additionally, HANYS has long argued that an inadequate federal match to New York State for its Medicaid program through the Federal Medical Assistance Percentage (FMAP) contributes to Albany’s fiscal problems. The federal government does not contribute its fair share to New York State’s Medicaid program. The federal government pays only 50% of New York’s Medicaid costs for most services, the lowest share for any state. Forty-one states have higher FMAP, with the highest being 77%. HANYS has been and continues working with the New York State Congressional Delegation to advocate for an increase in New York’s FMAP.

The inappropriate restriction of New York State’s FMAP is intensified by the state’s overall balance of payments to the federal government. A 2006 report by the Tax Foundation that compared the federal tax burden in each state with each state’s federal spending finds that New York State contributes billions more money to the federal government each year than it receives. It found that New York received 79 cents for every dollar of taxes paid in 2004. New York’s total balance of payments deficit to the federal government was more than $32 billion per year.
For New York State to continue offering the wide array of public coverage programs that are now in operation, we must work to maintain and enhance federal funding. New York should work to reauthorize and fully fund the State Children’s Health Insurance Program (S-CHIP), which ends in 2007, to ensure that children across New York and the nation have affordable access to quality coverage. Federal financial participation is crucial and HANYS also recommends expanding the federal match for Medicaid—either through FMAP generally, or by increasing the floor for all children enrolled in Medicaid to the same level as S-CHIP (65% FFP)—to ensure adequate funding for programs serving New York’s children.
MEDICAL LIABILITY REFORM

ISSUE

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

These dollars come from the public at large—as taxpayers funding government health programs that partly pay for providers’ liability insurance premiums and as purchasers of health insurance that also partly pay for those premiums. As consumers of health services, we undergo the “defensive medicine” that the system now compels; as members of local communities we witness the erosion of access to medical care; and as citizens we experience the “ripple effect” that the burden malpractice litigation places on our judiciary.

RECOMMENDATIONS

Systemic remedies are needed to correct the long-entrenched 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.

An Efficient and Informed Adjudication System

Patients deserving compensation should receive it promptly. Providers accused of professional negligence should be evaluated and judged fairly. A dedicated review system, a “special court,” distinct from the everyday civil system, may meet these goals. The essential characteristics of the system should be:

- An accelerated process for adjudicating cases, reaching decisions, and compensating deserving patients;
- A transparent process in which experts’ identities and qualifications are divulged and their credibility more closely scrutinized; and
- A “judge and jury” consisting of individuals knowledgeable about the issues presented—the legal issues, clinical issues, and as relevant, the social issues.

Practitioner-Patient Communication

One concept that is gaining increased acceptance is that open and candid communication between practitioners and patients can reduce the adversarial atmosphere that often ensues when an untoward clinical event occurs. Several states are considering, and some have adopted, legislation to promote early and honest discussion with patients and families. In addition, legislation is being considered by Congress to establish an early disclosure process.

Experience is increasingly indicating that a “sorry works” approach, which may include early offers of compensation, provides rapid compensation to patients and is a disincentive to lengthy and costly litigation. HANYS proposes that policymakers examine and develop a state-based early communication process under which providers promptly and forthrightly disclose issues and problems to patients and their families. To have any potential for success, the system must include meaningful incentives and legal protections against misuse of statements to encourage providers to participate.
NICH E PROVIDERS

ISSUE

Public need criteria applied by the Department of Health (DOH) as part of the CON process were loosened in the mid-1990s to allow the proliferation of “niche” providers. Niche providers include freestanding, state-licensed, for-profit ambulatory surgery and imaging centers, as well as unregulated 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 also 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.

In other words, hospitals have obligations to their communities that far exceed those of niche providers. While niche providers are willing to compete with hospitals for certain patients and services, they do not share the commitment to the community of New York State’s not-for-profit and public hospitals.

On numerous occasions, HANYS has asked DOH, the State Hospital Review and Planning Council, and the Public Health Council to address this situation, where all the advantages seem to be with these limited service for-profit niche providers. While the review process for regulated entities has become more rigorous—with more opportunities to raise concerns about the impact on existing providers—more needs to be done or we may irreversibly threaten the hospital safety net.

RECOMMENDATIONS

To create a more level playing field, and to ensure that the public good is met, HANYS makes the following recommendations:

- The public need test applied through the state’s Certificate of Need (CON) process must be modified to take into consideration all existing community resources, with approval for new facilities being granted based on a demonstration of unmet community need.

- Physician owners of centers must be required to provide emergency room coverage for hospitals with which the center has a transfer/back-up agreement.

- Rules prohibiting treating physicians from referring patients to facilities in which the physicians have an ownership interest (known as physician self-referrals) must be formulated or tightened and enforced by the state.

- DOH should enforce existing rules, and seek additional statutory authority, if necessary, to require that office-based practices providing the same services as licensed entities be required to obtain the same approvals and operate under the same rules as licensed facilities.

- Niche providers should be required to meet the commitments they promised in their CON application to treat Medicaid and uninsured patients.

- Previous approvals of centers should be withdrawn if the center has failed to proceed to construction.
QUALITY IMPROVEMENT

ISSUE

New York State hospitals continue to demonstrate their leadership and commitment to quality improvement and public reporting of quality data. Hospitals have implemented many evidence-based practices that are leading to clinical improvements and increased patient safety. The HANYS Quality Institute is aggressively pursuing efforts to identify and assist hospitals with implementation of new evidenced-based practices for quality of care.

Institute for Healthcare Improvement (IHI) 100k Lives Campaign

HANYS and its member hospitals are nationwide leaders in the Institute for Healthcare Improvement (IHI) 100k Lives Campaign. More than 90% of eligible hospitals have implemented one or more of IHI’s six evidence-based quality improvement changes. These process improvements—in areas such as avoiding medication errors and hospital-associated infections—are proven to enhance patient safety and reduce adverse patient outcomes.

HANYS is the coordinator of New York’s efforts, working with statewide partners including the Department of Health (DOH), to disseminate education, tools, and successful practices to every hospital to help them implement proven process improvements. Sharing of lessons learned with every hospital in the state has been key to the IHI Campaign’s success. Based on IHI’s data, New York State’s hospitals have surpassed IHI’s targeted goal of lives saved by more than 15%.

Quality Data Collection and Reporting

Hospitals participate in a variety of quality measurement and reporting initiatives designed to develop information to improve care and consumer decision making. Over time, the number of publicly-released reporting initiatives has proliferated along with an escalating commitment of hospital resources, with no coordination among efforts. Unfortunately, this result has often been conflicting and sometimes erroneous information that is frequently confusing for consumers.

HANYS supports the development of a standardized and integrated approach to develop quality measures and metrics. Measures should be supported by a consistent methodology and one comprehensive, standardized, and integrated system for data collection and reporting. The current fractured approach has resulted in misinformation and wasted resources, and undermines the potential for improvements in quality and cost efficiencies.

With HANYS’ endorsement, New York was one of three states to initially pilot the Centers for Medicaid and Medicare Services (CMS) Hospital Quality Initiative. An expanded version of these indicators is now encompassed in a national public reporting system. HANYS continues to work with the Hospital Quality Alliance, a national group that includes CMS and the American Hospital Association, to promote and test new measures for an expanded set of indicators.

HANYS remains committed to working with DOH, providers, and consumer representatives to align New York State data collection efforts with national efforts—something that is not currently happening. For example, the new state requirement that hospitals institute a new data collection system for infection reporting does not build off the infection data hospitals already report to CMS. This is resulting in duplication of efforts, significant waste of scarce resources, and inconsistent requirements at the state and federal level and between infection control and quality improvement programs—ultimately resulting in conflicting public information.
Health Information Technology

Health information technology (IT) includes computer-based tools developed specifically for health care delivery. These tools can provide physicians and other clinicians with up-to-date information about their patients, access to cutting-edge medical knowledge and best practices through decision-support systems, and other benefits. The successful implementation of IT systems in hospitals and continuing care settings has proven to dramatically reduce medical errors, improve the quality of care, and increase efficiency. IT can enable public health officials to move quickly to identify and respond to threats from naturally occurring diseases, the effects of natural disasters, and potential bioterrorist attacks.

In recent years, the federal government and the private sector, including health care providers, advanced the establishment of goals for nationwide implementation of health IT. President Bush accelerated this effort by calling for the widespread adoption of interoperable computerized medical records within ten years and establishing the Office of the National Coordinator (ONC) for Health Information Technology, which is led by David Brailer, M.D., Ph.D.

In recognition of the importance of advancing IT adoption, and the need for government funding to assist providers in this effort, the state budget has provided additional capital for technological advances through the Health Care Efficiency and Affordability Law for New Yorkers (HEAL NY) program. Additionally, New York State recently secured a federal waiver, through which a portion of funding has been proposed for IT.

Evidence supports the goals of widespread health IT adoption. A 2005 Price Waterhouse Cooper study found that hospitals that invested more in technology had lower lengths of stay, fewer medical errors, improved clinical processes and outcomes, and higher operating revenues. Improved information systems will enable better coordination of patient care, improved flow of patient information, and help avoid errors, duplication, and waste. IT will also ease the clinical data collection needed to support on-going research to find and implement the latest breakthroughs and quality innovations.

The benefits to be gained by health IT adoption clearly warrant a significant investment by both public and private stakeholders. HANYS believes that health IT adoption is a public good.
RECOMMENDATIONS

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.

Quality Data Collection and Reporting
The state has the opportunity to move away from the environment of dissimilar report cards to a comprehensive integrated strategy that advances quality of care. HANYS supports:

DEVELOPING A STANDARDIZED AND INTEGRATED APPROACH TO QUALITY MEASURES AND METRICS. DOH should engage in partnerships that develop and spread evidence-based best practices that can be applied across the state to save lives, improve patient outcomes, and increase the efficiency of the health care system. Narrowly focused quality measures or metrics that look only to compliance with administrative requirements impede the quality environment and do little to improve patient care processes.

ALIGNING NEW YORK STATE QUALITY DATA COLLECTION AND REPORTING EFFORTS WITH THE ESTABLISHED CMS-LED HOSPITAL QUALITY ALLIANCE. DOH should work in partnership with responsible national and state organizations to evaluate, streamline, and integrate data reporting requirements and eliminate the incompatible data silos, conflicting reports, and disparate reporting streams that currently exist.

Health Information Technology (IT)
The driving force behind hospitals’ investment in IT is not savings, but the goal of improving the quality of patient care. IT has the potential to reduce overall health care system costs, but evidence is lacking to support the notion that any measurable amount of savings will accrue to providers. IT will reduce duplicate testing and help prevent errors that can lead to added costs. However, savings models suggest that payers and purchasers of health insurance, including large employers, will garner the preponderance of savings.

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.

The investment needed to achieve widespread IT adoption is staggering. A recent analysis of the nationwide cost of outfitting providers with comprehensive IT systems over a ten-year period was between $276 billion and $320 billion.

HANYS has been working to influence IT policy. Broad areas of focus for HANYS are:

■ SUPPORTING A PUBLIC-PRIVATE PARTNERSHIP TO ACHIEVE THE GOAL OF MAKING THE USE OF IT SYSTEMS COMMONPLACE. The delivery of quality health care is a public good, necessitating this partnership.

■ SUPPORTING THE CONTINUED PUBLIC AND PRIVATE DEVELOPMENT AND ADOPTION OF INTEROPERABILITY STANDARDS. HANYS is encouraged by activity taken by the American Health Information Community (AHIC) to award a contract to the American National Standards Institute to bring together standards development organizations to develop a “harmonization” process for achieving widely accepted and useful IT standards. As applicable, HANYS encourages DOH to align any standards setting or harmonizing initiatives it may undertake with those of AHIC. HANYS is working with the New York State Congressional Delegation and others in Congress to press AHIC to speed its work.

■ ENSURING CERTIFICATION OF INFORMATION TECHNOLOGY PRODUCTS. Health care providers seeking to adopt IT systems must navigate a complex and often volatile health care IT marketplace. With the support of the Office of the National Coordinator (ONC) for Health Information Technology, the private Certification Commission for Healthcare Information Technology (CCHIT) was established by the American Health Information Management Association, Healthcare Information and Management Systems Society, and National Alliance for Health Information Technology. CCHIT has been developing certification for IT systems that are used in a number of settings. HANYS is encouraged by this activity and is closely monitoring the effect it may have on the vendor marketplace.

■ WORKING WITH REGIONAL HEALTH INFORMATION ORGANIZATIONS (RHIOS). ONC believes the widespread adoption of electronic health records in a National Health Information Network (NHIN) will be based on linking 100-200 regional, community-based health information exchanges among providers, called RHIOs. Community-wide projects are being developed across the country with guidance from ONC, many in New York with HEAL NY support.

To complement these efforts, HANYS has the following specific recommendations:

■ ESTABLISHING ACCESSIBLE AND SUSTAINABLE FUNDING STREAMS TO DEVELOP IT PROGRAMS FOR HOSPITALS AND CONTINUING CARE PROVIDERS. In both Albany and Washington, HANYS is advocating for the dedication of funding to support IT investment.

■ CREATING A STATE “CABINET-LEVEL” OFFICIAL TO OVERSEE AND LEAD NEW YORK’S EFFORTS TO PROMOTE THE ADOPTION OF HEALTH IT.

■ SUPPORTING ELECTRONIC PRESCRIBING. E-prescribing enables a physician to transmit a prescription electronically to the patient’s pharmacy and to obtain information about drug formularies and patient medication history. It can reduce or eliminate the need for a hand-written prescription and in turn help to reduce medication errors. These systems can serve an important preventive function of identifying errors in dosing, timing, and form, and can also flag potential allergies, drug interactions, or other patient contraindications.

■ ENCOURAGING DEVELOPMENT OF ELECTRONIC MEDICAL RECORDS (EMRS). EMRs can facilitate communication among multiple providers, reduce unnecessary tests, and enable caregivers to better track and coordinate care. These tools can provide physicians and other clinicians up-to-date information about their patients, improve the quality of care, and dramatically reduce medical errors. Storing and sharing records electronically is also more efficient.

■ DEVELOPING SMARTCARDS. Smartcards are credit card-size cards that hold a patient’s medical information. Health care providers within a region can adopt standard technology that enables a patient to walk into any facility and provide his or her medical information via a Smartcard. This enables health care providers to have instant access to a patient’s medical history and eliminates unnecessary tests and medications. Additionally, HANYS supports efforts to create regionally-based virtual Smartcards.
WORKFORCE SHORTAGES

ISSUE

Nurses and Other Allied Health Professionals
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. These shortages are projected to grow unless significant action is taken.

According to HANYS’ 2006 Workforce Advocacy survey, the vacancy rate for RNs has remained high at more than 9% since 2002. The shortages in other disciplines is similarly alarming. Nearly two-thirds of hospitals responding to HANYS’ surveys reported difficulty recruiting pharmacists, almost half had trouble recruiting medical technologists, and one-third had trouble finding coders. HANYS’ members reported that laboratory technicians and diagnostic and medical imaging technicians are in particularly short supply as well.

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

Physicians
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 many communities for a number of issues, including low physician reimbursement and regulatory barriers.

New York State cannot wait to see if a comprehensive long-term national strategy is developed to increase the overall health care and physician workforce. Many health care institutions are trying to deal with immediate shortages and place a high priority on developing strategies to attract new and retain existing physicians and health care workers.

New York State needs to take extraordinary action to address workforce shortages, including the development of aggressive advocacy to recruit and retain both physicians and other health care workers, and taking steps to improve the ethnic diversity of the health care workforce.
Nurses and Other Allied Health Professionals

Workforce shortages have a real impact on patient care and health care providers, as the ability to deliver timely, quality care is stressed. New York State’s population age 65 and older increased by 25% between 1980 and 2000. The population over age 80—the frail elderly needing the most intense health care services—is expected to double by 2020. According to the New York State Department of Labor, the total number of jobs needed in health care is expected to grow 18% by 2012—more than twice the rate of growth of all other occupations.

To address workforce shortages, HANYS and the New York Organization of Nurse Executives (NYONE) have been collaborating on a number of initiatives to improve recruitment and retention of nursing faculty and clinical staff. HANYS makes the following recommendations:

- Maintain and expand schools of nursing by creating incentives for the recruitment and retention of nursing faculty and provide funding for nursing programs to pay for equipment modernization and capital infrastructure needs such as clinical simulation.
- Provide support for partnerships between health care providers and educators to compensate experienced individuals willing to serve as instructional resources.
- Implement strategies for the recruitment of under-represented minorities into nursing and other health care professions and leadership positions.
- Appoint a task force to study and make recommendations for addressing the shortage of non-nursing professional and paraprofessional health care workers, such as pharmacists, coders, medical technicians, and therapists, and other allied health care professionals.
- Develop opportunities and incentives for nurses who want to pursue advanced education to encourage the development of advanced clinical, educational, and administrative expertise with on-site, off-site, or Internet distance learning programs.

Physicians

Communities across the state are reporting growing physician shortages. In some regions, severe shortages are widespread. In other areas the worst shortages are specific to primary care or certain specialties. A study of physician supply between 2000-2004 by the State University of New York’s Albany Center for Health Workforce Studies provided notable examples:

- The total number of physicians declined by 6% in the eight-county Finger Lakes region and 10% in the five-county Western New York region. At the county level, the total number of physicians declined by 8% in the Bronx.
- The number of OB/GYNs declined by 36% and the number of general surgeons declined by 27% in the six-county Mohawk Valley. The nine-county Southern Tier region saw corresponding declines of 28% and 15%.
- The number of general surgeons declined by 15% in New York City.
- The seven-county North Country region lost 11% of its primary care physicians.

Compounding these shortages, more than one-third of New York’s active patient care physicians are age 55 and older; 14% are age 65 or older. In several counties, more than 50% of physicians are age 55 and older.
In many communities, patients are feeling the brunt of these shortages. Patients are being forced to travel as certain specialties are either no longer available in their communities or have limited available hours with growing waiting periods for appointments. Primary care physician shortages are requiring patients to rely on expensive emergency rooms for primary care. Hospitals are having increasing difficulty finding physicians willing to take evening and weekend emergency calls, often forcing hospitals to transfer patients away from their home communities for treatments that would have been available at home in the past.

HANYS makes the following recommendations:

- medical student scholarships and/or loan forgiveness programs;
- re-invent the State Health Service Corps;
- reserving residency slots for people predisposed to stay in under-served areas; and
- increasing graduate medical education payments in shortage areas.

HANYS is advocating for corresponding changes in federal policy such as a significant expansion of the National Health Service Corps (NHSC) and the designation of additional Health Professional Shortage Areas (HPSA).

- Develop state-funded subsidies for physicians in shortage areas to establish practices, purchase office-based health IT, and physician recruitment.
- Advocate for physicians, hospitals, and other providers to be able to collectively negotiate contracts with payers that are currently able to dominate negotiations and dictate payments.
- Advocate for the elimination of barriers to physician recruitment created by state corporate practice of medicine laws, antitrust statutes, and private inurement rules. HANYS is advocating for complementary changes to federal “Stark” regulations, antitrust laws, and private inurement rules.

**A New Workforce Paradigm**

A redefinition of workforce is needed that supports informal caregivers, re-engages retiring health care workers in new roles, addresses ways to maximize workforce potential, takes steps to create a more flexible health care caregiver qualified to work in jobs in multiple settings, creates a volunteer health service corps, provides tax credits to caregivers at home, and creates incentives to increase informal caregiving.