



Public Policy Forum

Transforming Medicaid: Key to Health Care Reform

**Presented by
Richard F. Daines, M.D.**

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Richard Nathan:

Good morning. My name is Dick Nathan and I have the honor and pleasure of being the co-director of the Rockefeller Institute of Government, which is the public policy research arm of the State University. We report to the trustees, the chancellor, and the chair of the Board of Trustees of the State University.

Let me begin by saying there's no subject, no domestic policy issue, more important, more challenging, or more difficult than the subject — health policy — that we're here to talk about today, that we work on, and that many of you here are deeply involved with.

At the Rockefeller Institute, our focus is on the leadership role and activism of states and American domestic public policy, and it's an environment people need to understand. We care about people knowing about and building knowledge bases. We're not here to advocate; we're here to educate. We work, as I said, in New York. We're working with the Health Department right now and I'll say a little bit about that.

The basic proposition for me is we can't provide more health care unless we can provide it more efficiently. That's the challenge. Many states are deeply involved in doing things that New York State is doing. Next year, assuming that health care is even more seriously on the national agenda, it is critical to know what the states are doing to make health care more effective and efficient. If we're going to do more, we have to learn from everyone

who can teach us. We at Rockefeller Institute are fortunate that we have some resource support to do this. Courtney Burke and I and others are working with Deborah Bachrach and other people in this room to try to understand how best to learn about what states are doing. That's our bread and butter. We go around the country and study with experts in various states what's happening in the states and in the domestic public policy arena. So this is a very timely talk. We are honored and pleased to have as our speaker today the commissioner of the New York State Department of Health to talk about "Transforming Medicaid: Key to Health Care Reform."

Before I came here, I used to teach almost full time. And I would tell students, "If you understand Medicaid, we'll just give you a degree." As the subtitle for this talk indicates, Medicaid is key to a lot of things that we all care about. Courtney Burke is the director of our Health Policy Research Center at the Institute. She's doing a wonderful job. When we finish, Courtney will step to the microphone and get us set up for questions with Deborah Bachrach helping out.

So let me just say a few words about the impressive background of our speaker. He is a physician, trained at Cornell, who served his residency at New York Hospital in internal medicine and critical care medicine. He's worked as a leader and administrator in health policy in a way that is perfect for coming here at this crucial time in New York State. Prior to becoming commissioner, Dr. Daines was president and CEO at St. Luke's-Roosevelt Hospital and before that he was medical director at that hospital. He served as senior vice president at St. Barnabas Hospital in the Bronx. So he's had service out there in the country where there are hard challenges every day and in many ways. We are delighted and pleased to have you speak with us today — Dr. Daines.

Richard F. Daines, M.D.:

Good morning. I'm honored to be here this morning. The Rockefeller Institute of Government has a great history in New York. I've learned over the last year about the great value it has, particularly for its respected research and analysis.

Governor Spitzer spoke here about a year ago with me in the audience. As I left, someone gave me a complimentary copy of *New York State Government*, by Robert Ward. On my way out, Joe Baker or Dennis Whalen saw me carrying it and made an offhand comment that anyone new to government was expected to master this book. So in addition to long

hours trying to master all sorts of material about my own department, every night I tried to wade through some of the 611 pages. I think I have a permanent depression in my sternum where the book rested when I fell asleep every night. I learned later that it's intended as a reference, not a read. Anyway, thank you for inviting me to participate in your series of public policy forums.

I've been asked to speak to you today on Medicaid reimbursement reform. I'm first going to take this opportunity to put the subject in the context of overall healthcare reforms. I'm joined here today by Deborah Bachrach, director, and in fact, founding director of the Department of Health's Office of Health Insurance Programs. One of the wonderful things about being commissioner is that I get to be the transmitter of all of the wisdom of people in the department, like Deborah and her staff.

I've been a medical student, an intern, a resident and attending physician, a medical director, GME chair, and a hospital CEO — all in New York. With the governor's clear vision and budget focused on truly meaningful health care reform, this is one of the most exciting times to be involved in health care.

For more than 30 years, I started almost every day by walking into a hospital. Now I drive into the Empire State Plaza and take the elevator to the 14th floor. I walk down a long corridor that has portraits of the prior commissioners. My predecessors' images appear polished, finished, and elegant — all but the last one on the left, of David Axelrod. It has a raw, unfinished look to it. He looks like he is leaning forward to grab anyone that passes by. I'm both inspired and humbled when I walk by that portrait.

If I ask myself what David Axelrod might say, I think it is the same message as the one we are getting from Governor Spitzer and from many legislators, health care industry leaders, and certainly from the public: *We owe the people of this state a better health care system, not another layer of trended investment in a broken system.*

I had the privilege of sitting in the Assembly Chamber a few weeks ago, with many of you, as Governor Spitzer delivered his State of the State address. In his words: "We must start paying for the right care in the right setting at the right price." In other words, we need to reform reimbursement.

Not too long ago, I understand you had Stephen Berger here for a mid-course evaluation of the progress of the Berger Commission report requirements. Some have forgotten that the Berger report itself strongly suggested that simultaneous to the restructuring that it mandated, reimbursement reform was a necessity. Let me quote a few of its policy recommendations:

Direct state action to change the amount and distribution of funding for Medicaid and public goods would be an important step in reforming the reimbursement system in New York.

Furthermore, Medicaid policy has the potential to influence the actions of private and federal payers. The Commission recommends that the State of New York undertake a comprehensive review of reimbursement policy and develop new payment systems that support a realignment of health services delivery.

The report states that such review should recognize these principles:

- Reimbursement reform should encourage the provision of preventive, primary, and other baseline services and discourage the medical arms race.
- The relationship between private payers and the financial viability of the health care delivery system needs to be carefully examined. Reducing unnecessary hospital capacity and maintaining critical health services are as important to the insurance sector as they are to the public sector. As such, it is reasonable to expect these companies to participate in initiatives to promote financial alignment between payers and providers, and to participate in reinvestment strategies by reimbursing adequately while maintaining adequate reserves to meet current and future health care needs.
- Future capital investments should reflect shifts in the venue of care from institutional to home and community based settings.

The Berger Commission dealt with a system that had been shaped, or misshapened, by decades of reimbursement errors. The reimbursement system shaped the system (health care system) that Berger had to deal with. The tragedy would be if we completed the Berger

restructuring and left our reimbursements in place. Over time, we'd revert back to the same system we had.

Principles and Plans

As I lay out our principles and plans for comprehensive reimbursement reform, I invite you to hold us to a test as to whether we conform to those Berger recommendations.

The system is often described as broken. I prefer outdated, opaque, and convoluted.

So, where do we start? We start with a health care system that practically no one is happy with — not patients, providers, health plans, employers, or government. And we start — in fact started — with evaluating what can be fixed easily and what needs to be rebuilt from scratch, and perhaps over time. There's a lot of room for improvement.

- Our health care system rewards the delivery of acute care and high-tech interventions more than the provision of basic preventive and primary care. As a result, we have more of the former and less of the latter. New York lags in measures of preventable morbidity, mortality, and unnecessary hospitalizations, and is among the leaders in most measures of resource consumption overall.
- The massive programs and funding overseen by the Department of Health have too often created and reinforced this pattern, rather than attempting to break it. By comparison, our investment in public health programs has been underfunded and has not been used optimally to influence the trends.
- The health care system is inaccessible or not navigable for many.

A note of personal experience: My wife had some services at one of the fine hospitals in New York. I was an outgoing chief executive of a major hospital system and incoming commissioner of health. She's a Columbia MBA and managing director of a Wall Street firm. We couldn't understand the bills. We finally said we'll just leave them alone and if they really want us to pay something, they'll ask us again.

- New York State ranks near the top in per capita expenditure on health care. However, the state ranks only fair or below average on health care performance compared to other states.
- According to recent studies by the federal Agency for Health Quality Research and the Commonwealth Fund, New York ranks 39th on unnecessary hospital admissions and costs.
- The state ranks 30th on a range of quality measures, including appropriate receipt of preventive care for adults and children.
- New York ranks 22nd on percentage of uninsured. I didn't move from Idaho for a ranking of 22nd. I didn't leave Utah and come to New York to be told we're below average!

Deborah's folks looked at this and asked: What would we have accomplished if New York performed at the levels of the highest rated states?

- ▶ More than 450,000 additional adults would have received recommended screenings;
- ▶ 43,000 more children would be up-to-date on their immunizations; and
- ▶ 300,000 more diabetic adults would have received recommended exams and tests to prevent or delay complications.
- Despite our wealth of medical schools and our absolutely predominant position in graduate medical education, we're falling behind in biomedical research. Physician supply and maldistribution problems are apparent throughout the state.
- We have some of the best data in the world on the quality of care and outcomes among hospitals, nursing homes, and home care providers. Medicaid has virtually never used this information in making contracting and reimbursement decisions. And it has only marginally influenced decisions about certificates of need and capital investment.

The Role of Reimbursement in Reforming the System

I am a fervent believer in the role of reimbursement in creating and reforming this system. Our reimbursement streams are like those great western rivers carving canyons and defining the terrain of health care. There's a place in southwest Utah called "Hole in the Rock," where pioneers came to a virtual drop-off. To cross, they had to disassemble their wagons, lower the wagon pieces and contents and horses down to the valley, then reassemble it all. I sometimes think of our health care system like this. There's a way to kind of make it work, but at enormous, convoluted expense.

But there's another way. If we don't like the terrain our reimbursement streams have created, we need to change the reimbursement streams. Let's briefly examine the main river and its tributaries:

- Most hospital inpatient reimbursement, including Medicaid, my main subject for today, is primarily based on two relatively simple values from which we calculate a price paid for each hospital discharge.

A hospital or group-specific standard base rate is derived from the actual cost reports submitted by our hospitals to the Department of Health. To arrive at a payment for each discharge, that base rate is multiplied by a Service Intensity Weight. The Service Intensity Weight is calculated from empiric data and used to establish the resource consumption of each discharge, relative to that base rate.

- There is nothing wrong with the methodology. But, without attention, both the base rate and the Service Intensity Weight values, over years and decades, grow increasingly discordant from reality. This creates misalignments between payments and costs, odd incentives and disincentives, and requires explicit and implicit cross-subsidies.

I'm going to return to the Berger report for a minute. He wrote:

Financial incentives powerfully affect the supply, demand and location of health care services. At times, they distort patterns of service delivery. Driven by the imperative of financial survival, providers may pursue high margin services rather

than services that best align with community needs. Fiscal pressures also can drive facilities to provide otherwise redundant or unneeded services solely to cross-subsidize other elements in their service mix that are crucial, but unprofitable.

Need I say that health care has changed dramatically in the last 30 years? However, our Medicaid inpatient reimbursement rates are calculated using base rates that rely on hospital costs reported in 1981 (the year I graduated from my residency program), and Service Intensity Weights that have not been updated since 1992. So we have 1981 and 1992 financial incentives driving health care decisions and investments in 2008!

- In 1981, there was no MRI and virtually no thrombolysis, angioplasty, or minimally invasive surgery. The reported length of stay for a hip replacement was 14 days — it's only four or five days today. Most recently, we've been paying about \$29,000 for that hip replacement. Yet the reported costs are only about \$18,000.

Meanwhile, we have enormous advances in neonatal care and they're expensive. Costs to care for our most medically complex premature and low-birth babies have almost doubled.

Demand for either of these services should be elastic. We don't really think people turn on and off the need for hip replacements, nor are our premature babies born or not born because of financial incentives.

So, imagine the dilemma of a mission-driven hospital executive trying to figure out how to secure enough market share in hip replacements from competitors to generate sufficient margin to subsidize the high-risk obstetrical services that those same competitors are incentivized to de-emphasize. This same misalignment operates across the diagnostic and institutional spectrum.

I've been there, done that, and I want to fix it, not just game it.

- One of the principal tributaries to the reimbursement stream is graduate medical education (GME). New York has used GME as the vehicle to fund a range of hospital services and costs. New York's "GME spending" of \$3.4 billion, including \$1.3 billion in Medicaid and \$360,000 in other state funds, is

the highest in the nation. Anyway you want to compare it, it's practically off the charts.

As with the base rates and Service Intensity Weights, the factors used to calculate GME are long out of date. GME payments to hospitals far exceed the direct and indirect costs of providing residency training. Meanwhile, federal policy continues to threaten virtually all of Medicaid funding of GME and New York is by a vast margin a principal outlier in its dependence on GME funding.

These funds are quite explicitly used to cross-subsidize ambulatory care and indigent care, among other things. Therefore, any reduction in federal GME funding threatens not only GME itself but a whole fragile construct of cross-subsidies that we depend on.

Despite this level of funding, there is a physician shortage in some specialties and some regions across the State.

- We have another reimbursement tributary, New York's \$847 million Indigent Care Pool. That underwrites the bad debts and charity care losses reported by hospitals. The reports are never audited. Hospitals include in bad debts *all* nonpayments by patients, regardless of income or reason; and, it is impossible to determine under the current methodology how many uninsured patients receive care, in what setting, or at what cost.

Payments to hospitals vary wildly from year to year. They can go up 100 percent one year and can drop by 50 percent the next year. These swings sometimes coincide with the departure and arrival of CFOs, who are well-intentioned but who have highly variable interpretations of the regulations.

- Medicaid reimbursement for office-based physicians is a tiny trickle, the second lowest in the country. It may be the lowest now that New Jersey did something. This creates access problems and signals young physicians to steer clear of primary care and settings with high Medicaid populations.
- The rate of reimbursement flow to hospital-based and freestanding clinics has been frozen in amount and method for more than a decade. New York State currently reimburses clinics on a per-visit basis, with all visits reimbursed at

the same amount, thereby encouraging providers to offer more low-intensity, low-cost services. Freestanding clinics receive higher rates than hospital clinics *or* behavioral health clinics *or* physicians, which encourages licensure “shopping.”

- By every indication, our reimbursement streams channeled through managed care are effective. They reduce costs, improve services and outcomes, and co-locate resources and accountability. Yet, New York State has failed to apply this lesson to the care of the most medically complicated and expensive patients.

These are the well-known 21 percent of patients driving 76 percent of the costs. They are disproportionately exempt or excluded from managed care. Only 35 percent of Medicaid patients are still in fee-for-service Medicaid, but they are driving 84 percent of the costs.

Our department has spent more than a year analyzing these issues. I came in about mid-stream last year. We’ve had a year of analytical work by some really brilliant people in the department — and crossing over with the other departments involved in reimbursement for services for this population.

This year the governor’s budget really sets out to fix what’s broken.

I want to put this reform in the overall context of our health care agenda.

We focus on three key areas: access, affordability, and quality. Whenever we talk about one of these areas, we soon find that we have to address the others to make real progress. Access hinges on affordability. Access and affordability are meaningless paper achievements if quality, safety, and optimal outcomes are ignored. Quality without access produces disparities and injustices. So we’re working to link these together.

Access to Care

The governor’s budget lays out a clear vision to increase health care access and affordability to all New Yorkers. We are deliberately taking a building block approach. We’re not dramatically announcing a single solution, then scrambling to see if we can

actually make it happen. Events in Massachusetts and just yesterday in California reinforce the wisdom of this approach — not just going after a single solution. California just found out they can't afford it in this environment, and they appear to be back to square one. Our first step to increase access to health care for the uninsured focuses on enrolling all who are eligible for our existing public insurance programs.

One-half of New York's uninsured — 1.3 million children and adults — are eligible for programs like Child Health Plus or Medicaid, but are unenrolled, unable to get past the obstacles.

Almost 40 percent of those enrolled in Medicaid at the start of a year fall off by year's end, most not because they lose eligibility but because they stumble on one of the complex recertification requirements. Or they're moving up from Medicaid to Family Health Plus.

If you're a patient with a need and you're right in the bull's eye of one of our programs, we do a great job. But we don't do a good job when a person's on the edge of one of our programs and qualifies and is about to move up to the next one. Simplification, streamlining, and elimination of duplicative or onerous requirements are the answer.

A second building block is to reach the last large group of uninsured children — those living in families with incomes between 250 and 400 percent of the federal poverty limit. These are working families, but their employers frequently either don't offer health insurance or the out-of-pocket costs put full-family coverage out of reach.

President Bush vetoed Congressional legislation that would have allowed New York and other states to expand Child Health Plus coverage with federal funding participation. We think our waiver was denied on some pretty unreasonable grounds. For example, for families leaving employer-provided insurance — they'd have to wait a full calendar year for eligibility for the expanded Child Health Plus. They can't wait a year! There are immunizations and school checkups. It just makes no sense.

Meanwhile, in Congress, I've lost track of the number of times revisions and expansions were proposed and vetoed. So the governor stepped up and the state will pay the full federal share — some \$19 million — to extend the program, to include all children up to 400 percent of the federal poverty level.



We've had to work to make one thing clear to everybody. This isn't a giveaway. There's an escalating co-premium, so as a family approaches four times the federal poverty level threshold, the co-premium escalates significantly. The family right at that poverty threshold limit is paying \$1,800 from their \$80,000-a-year income — just for their children.

The idea that people will leave employer-based, full-family coverage to crowd into child-only coverage through Child Health Plus, that still costs them \$1800 a year, we don't think will happen. We don't think crowd-out will be a problem, but we'll watch it very carefully.

A third building block is, as you all know, our universal coverage initiative — to get affordable coverage to the 1.3 million uninsured New Yorkers who don't qualify for any of these existing programs. We've had hearings around the state. We've turned a lot of it over to consultants to crunch the numbers and come back with a number of proposals. We'll see then what's the next step.

Affordability

After we look at access, we have to look at affordability. If you can't afford it, you can't have it. New York faces a challenging fiscal environment for the 2008-09 fiscal year and beyond. Based on current trends and commitments and absent gap-closing actions, the Division of the Budget projects budget gaps of \$4.3 billion in 2008-09. In future years (and this is probably a moving target given what's going on in our economy), the gap is projected at approximately \$6.2 billion in 2009-10, and \$7.9 billion in 2010-11. The governor's Executive Budget contains a host of recommended actions to address the current budget gap and we're part of that process.

But even in a more lenient budget environment, without reforms, our rising rate of spending on acute and long-term care — which is already intolerable — would become unsustainable in the future. We simply won't have the resources to achieve universal coverage

unless we can make our health care system more affordable. And then, of course, we have to deliver quality at an affordable cost.

Medicaid Quality and Cost

Look at what we've got here:

- With a \$47 billion annual price tag, Medicaid is the single largest payer in New York. It covers 4.5 million adults and children, and 31 percent of all health care costs in the state.
- Medicaid is among the most powerful levers available to the governor to transform New York's health care system.
- If Medicaid was held up to a list of Fortune 500 companies, it would rank in the top 50. If we were a public company, I wonder what our shareholders would say? If our shareholders are the state's taxpayers and Medicaid beneficiaries (many of whom are taxpayers themselves), how do you think they'd say that we've done?

Let me give an example: Avoidable hospitalizations are costing the state millions of dollars for preventable inpatient care. Data from New York hospitals and across the U.S. clearly identifies specific conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or advancement of disease. From these data, we know that New York ranks well below average on avoidable hospitalizations. And we know that there are huge disparities in the numbers of avoidable hospital admissions across the state.

I'll put a visual image on it. I can picture this myself because I spent almost 20 years in the Bronx — a community with a large proportion of patients who are insured by Medicaid. On any given day, if we walked into a Bronx hospital, we'd see patients in the emergency room with short-term complications associated with diabetes and asthma. As we walked down the corridors, we'd see patients throughout the hospital being treated for serious, in some cases life-threatening, long-term conditions that are the result of these diseases going uncontrolled.

There'd be patients being treated for *acute* symptoms of hypertension in the emergency room, and on various medical and surgical floors, and in Intensive Care, many more patients requiring care for the complications of *uncontrolled* hypertension. I used to look around my ICU and say that half the people here are here for tobacco-related disease. The same scene would be true in any hospital in the state. But here, the documented rates in this Bronx hospital for these *preventable hospitalizations* would be more the 100 percent higher than the state average. More than 100 percent more patients are hospitalized here for conditions we know are preventable.

This is certainly not in any way a reflection of the hospital. If it were, I would be accusing myself since I spent almost 20 years in a Bronx hospital. It is a reflection of the quality and accessibility of care in the service area around it — in a community with a large population of people receiving Medicaid benefits.

Blaming it on the hospitals would be like blaming the homeless problem on the parks. It's not the parks department doing something wrong here. It is a result of reimbursement streams carving the health care landscape into a forbidding tangle of canyons, sheer towers, deserts, and quicksand, with an oddly situated hospital or emergency department oasis here and there. Should we be shocked that people flock into the oasis?

Reforming the System

Today, Governor Spitzer and my department stand committed to transformational, meaningful reform of this system. With the 2006 cap on the counties' contributions for Medicaid costs, and a major reorganization of Medicaid operations, New York is for the first time positioned to operate Medicaid as the major payer in the health care market. We feel that if we can get it right with Medicaid, we can influence the way every provider and payer serves every patient in the state.

Deborah always tells me: "We want to be the best payer, the leader in the state. We want to make other payers follow us." We must become a disciplined and smart purchaser — in order to buy the right care in the right setting and at the right price. By doing so, we will improve quality and reduce costs, not just for Medicaid patients, but we'll have other payers follow us.

We're putting a value equation to our reform components. And they're incorporated in this year's budget. Look at them:

- Streamlining and expanding affordable coverage;
- Demanding transparency and accountability;
- Investing in ambulatory care and primary care;
- Coordinating and managing patient care and services;
- Improving patient safety and clinical outcomes; and
- Strengthening program integrity.

When we discuss reforms among ourselves, and even with all of the various stakeholders, it's easy to work our way into one of those dead-end canyons I've walked up in the Southwest:

- First, we're told this complex system is so interconnected that we cannot change one parameter without changing virtually all parameters. How many times have you heard that?
- Second, we're told that in a system this large, fragile, and complex, changing multiple parameters at once is too risky and unpredictable.

You're obviously in a box canyon at this point. You can't only change one factor. But changing all is too complex. This is why from year to year we've just kind of trended along and grown so far away from what a quality health care system ought to be.

Today we are moving forward, and we understand just how difficult this will be. And just as with the Berger recommendations, I invite you to test our proposals against these principles:

First, our reforms will be based on the overriding principle of putting patients first. In everything we do, look at the effects on patients. Obviously there will be effects on hospitals, labor, etc. But look at the effects on patients first.

Second, we will insist on transparency, clarity, and accountability. We have to understand how programs actually work and what they accomplish or don't accomplish. We have to call things by their correct names, track dollars from sources to destinations. Sometimes I actually think that some providers are so anxious about what transparency might reveal that they resist the effort at transparency itself.

Third, we recognize the interconnectedness and need for balance between spending reductions and investments. Just as our analysis of inpatient Service Intensity Weights, base costs, legacy programs, and graduate medical education revealed overpayment, we must also recognize that the same rigor applied to ambulatory services runs in an opposite direction. We underpay across the board for primary and ambulatory care.

Fourth, we realize the rate of change must be gradual. Changes must be phased in. The current system was not created overnight, and it won't be changed overnight. But that isn't an excuse not to get started.

Reimbursement Reform

We're paying hospitals more for many inpatient stays than what they are reporting as their actual costs, while paying too little for some other discharges and services. The Department of Health estimates that New York's rate methodologies drive more than \$600 million dollars in overpayments for inpatient care — in large part due to our failure to regularly update reimbursement rates.

Earlier, I mentioned hip replacements and neonatal care. Other examples abound. A patient hospitalized today for an appendectomy without complication may be on the way home in as little as 48 hours after surgery. But reimbursement rates for that appendectomy are still based on costs and technology that are 10 to 20 years old — when that same patient could be expected to be in the hospital for four or five days.

Reimbursement rates for the cost of a lung transplant, when updated with 2004 data, will decrease substantially. This is appropriate because of medical treatment and technology advances, as well as a significant reduction in the patient's average length of stay in the hospital.

Medicaid pays for outmoded inpatient detoxification services with a positive margin to hospitals of well more than 30 percent. No serious addiction medicine specialist defends the scale and design of these programs. Practically every year I remember, a proposal has arisen here in Albany to reform the system, but change has not happened. Quite clearly, and I speak from experience, the detox system will not change until we change the reimbursement flaws that have created and sustained the current system. Detox is a classic example. Good clinical management and policy would drive us in one direction for treatment, while the reimbursement system drives us in another direction. Year after year we've been going in that reimbursement direction. If we don't change reimbursement we'll continue to go in that direction.

At the same time that the state has been overpaying for inpatient care, New York's payment methodologies for ambulatory care services have been frozen at levels substantially below reasonable market rates, Medicaid ambulatory care rates at both hospitals and community-based clinics have been frozen for more than a decade, and physician fees are the second lowest in the country. Medicaid pays the same for a patient's visit to the doctor, whether it's for an ear infection that takes 10 minutes or a comprehensive physical.

This isn't a system that rewards providers and institutions for cost-effective care, for bundling of evidence-based practices or positive patient outcomes. It is a system that has created inappropriate fiscal incentives to provide high-volume, low-intensity care in the outpatient setting.

In the end, we get what we pay for. We live in the health care landscape our reimbursement systems create. We pay too much for inpatient care, so we get relatively more of it than other states. We over-pay for the high-tech inpatient services, so hospitals compete aggressively to get more. We underpay for obstetrical care, so these services are continually under threat. We pay too little for good ambulatory care in the right settings, so we get too much low-value care often in the wrong settings.

New in 2008 Budget: Rationalizing Reimbursement

So, how do we change this broken system we've inherited? The first step was taken with the adoption of new inpatient Service Intensity Weights, which took effect this month and were updated for the first time in 14 years. These new rates will be phased in over the maximum three years allowed in the legislation.

The Executive Budget takes the next critical steps in reimbursement reform, emphasizing preventive and primary care. The governor's budget proposes the following:

- Recalculating inpatient base rates from the most recent cost reports available, 2005. This produces major savings on the inpatient side and we propose investing most of the savings in hospital and community-based clinic rates and physician fees. We have proposed phasing these new base rates in over four years to allow providers ample time to adjust.
- Savings from the new, rational reimbursement methodology for inpatient care will reallocate \$160 million in the first year, and \$600 million annually once fully implemented in 2011-12 — primarily for investments in ambulatory care and preventive care for Medicaid patients.
- Another \$172 million will be saved through major pharmacy initiatives, which ensure that Medicaid is an efficient and effective purchaser of drugs, and that prescribing practices improve clinical and cost outcomes.
- New outpatient reimbursement methodology will be sensitive to the intensity and quality of the services, so a comprehensive physical that includes an X-ray and lab work won't pay the same as the brief follow-up visit. For example, it will let a diabetes management program start to bundle services on a given day. When a patient comes in for a visit, they can have a doctor come in, have blood work done, they may need to see a nurse educator, maybe they need to see an ophthalmologist. And then follow-ups are needed with a dietician, maybe with a nurse educator again. We start to pay for bundled services, and we measure how well they're doing by looking at outcomes. We can start to build in pay-for-performance incentives.
- Updated physician and nurse practitioner fees will bring reimbursement closer to Medicare and market rates.
- Physician fee schedules are increased, on average, almost 50 percent above existing levels. So a basic new patient visit that currently pays \$31 will pay \$55 in year one and \$74 in year two.
- Nurse practitioner fees will be reimbursed, on average, 91 percent of the enhanced physician fees. Midwife fees will increase, on average, 37 percent.

Psychologists' fees increase, on average, 112 percent. And occupational and physical therapy fees increase, on average, 116 percent.

- Medicaid will pay enhanced rates for clinics that maintain evening and weekend hours, and a 10 percent bonus payment for office-based physicians practicing in federally defined Health Professional Shortage Areas.
- Licensed clinical social workers will be reimbursed for services for children, adolescents, and pregnant women.
- And the budget includes first-time funding for targeted priorities, such as diabetes and asthma education.

This is a major change from inpatient to outpatient reimbursement. In addition to phasing them in over time, we are matching them with major investments in a vastly strengthened ambulatory care network.

- Today we are announcing two new rounds of our HEAL/F-SHRP grants. \$250 million will be made available in two separate Requests for Applications (RFAs) to enhance primary care capacity and to support hospitals and nursing homes wishing to voluntarily restructure along Berger lines — our so-called “Berger look-alikes.”
- We have proposed a modest redirection this year of some \$15.6 million dollars of the \$362 million Professional Education Pool, that state-only tributary to the GME reimbursement stream. These dollars will be invested in a coordinated series of new and enhanced programs designed to deliver an improved supply of physicians to shortage areas.

We're investing all the way from post-baccalaureate programs to prepare promising students from underrepresented groups for entry into guaranteed medical school slots. These are promising college graduates interested in medicine who may not have the right background for a traditional medical school spot. We'll give them one year of postgraduate school, then put them in a medical school slot held for them for practice in an underserved area.

We have to get these underrepresented and rural students into medical school. And we're working with medical schools, the Council on Graduate Medical Education, and others to be sure that rural and inner-city medicine become a more attractive part of medical education.

- When they leave residency, this is where our “Doctors Across New York” program kicks in. It's a major new investment. We have a two-year program now, but it's not enough. The new five-year program includes up to \$150,000 in debt repayment, stacked toward the later years, and includes start-up funds for young physicians, practices, and institutions in these shortage areas.

The biggest pay-off comes in the fifth year, to encourage these doctors to stay in these areas once they're there. I've heard a lot from physicians and communities in shortage areas. They tell me: “If we can get these doctors here for five years, they'll put down roots, buy a house, marry. If you get them here, we'll keep them.”

Incorporating Quality and Safety

We're incorporating quality in everything we do:

- First, the Medicaid Program will begin collecting data that will allow us to deny payment for so-called “never events” — adverse events that should never have happened. Such data also will allow Medicaid to reduce payments for potentially preventable complications, such as care associated with preventable infections.
- In addition, Medicaid intends to limit contracts to specific providers when there are data that demonstrate significant differences related to quality, outcomes, and mortality, as compared to the same services by other providers.

Let me stress that these decisions will be sensitive to issues of provider capacity and beneficiary access.

Governor Spitzer's budget supports investing the funds saved in inpatient rebasing and GME reform into hospital clinics and in the community. These hospital clinics are critical.

We provide a great deal of care there. We train our residents there. And the experience these residents have there will color whether they stay in primary care or stay in New York.

We have brilliant, natural leaders in medical education in this state. We've listened to them and we're working with them. And we're working with the Council on Graduate Medical Education to set up standards for clinical care and training.

We want to make sure that properly configured residency programs are in a position to earn this money for their institutions. We don't see this as a subsidy to GME, but as proper payment for delivery of high-quality, coordinated primary care and good, high-quality residency training programs in hospital clinic settings.

Addressing Needs of Medically Complicated Patients

We need to build on our managed care models. We've moved into managed care our patients with the simplest care needs. We've left out of managed care many of our most medically complicated individuals. The health and care of these patients are often complicated by multiple chronic medical conditions. And more than 70 percent of these individuals also receive mental health or substance abuse services.

Historically, unmanaged care for this population has led to both insufficient and ineffective services and tremendously wasteful spending. Remember, while medically complicated patients make up some 21 percent of Medicaid beneficiaries, they are driving 76 percent of the program's costs.

Many of these people remain in Medicaid fee-for-service, where their care goes virtually uncoordinated and unmanaged. Mental health is carved out of the managed care benefit package for some of the sickest patients. And licensure requirements make it difficult, or in some cases impossible, for providers to secure the licenses they need to integrate medical and behavioral health.

The State Health Department soon will issue a request for proposals for the development and implementation of interventions to better coordinate and manage the care of medically complex patients. And we are committed to implementation of license and certification reform to ensure that physical health and behavioral health are appropriately coordinated.

The Executive Budget also includes initiatives to improve birth outcomes for the close to 50 percent of births in the state that are paid for by Medicaid. Women insured by Medicaid have higher rates of infants with complicated and costly neonatal intensive care.

We're making a major investment in a new standardized system of early identification of clinical and psycho-social risks for poor birth outcomes. And we'll work to link high-risk women to effective services and special care coordination. And we're investing in the Family Nurse Partnership Program, which puts a registered nurse in the home of first-time mothers. It walks them through a very explicit curriculum developed in New York, throughout that pregnancy to get a better outcome.

Transparency and Accountability

Transparency is a theme that must run throughout all initiatives to reform New York's health care system. It will be evident in everything we do. Here are two examples:

For the first time, we will require that institutions prepare and submit GME budgets to bring clarity to this often contentious area. This will permit the state to establish standards for the investment of GME dollars in outpatient training and care, while advancing the goals of transparency and accountability. I've been both a GME director and a CFO and I know the game. All we want is a budget for transparency.

We've proposed a restructuring of the \$847 million Hospital Indigent Care Pool — not taking a penny out of it. It converts the current opaque accounting methodology to one that pays for discrete services actually rendered — in the same way the 95 percent or more of care for insured patients is funded.

For the first time, we'll be able to distinguish between true charity care, legitimate inability of insured patients to pay their share of costs, versus institutional shortcomings or inappropriate insurance industry products and policies. We'll be able to prioritize — a high priority to the uninsured; some priority but less to true bad debt; practically no attention to the carve-outs, denials, etc.

Earlier I challenged you to hold us to a series of tests. First, did we meet the imperatives posed by the Berger report?

- We have proposed a major change agenda both for Medicaid and for state programs such as GME.
- We proposed to reduce the rate of growth of Medicaid — we have held the trend factor down by 25 percent.
- We limit diversion of dollars out of health care — most of inpatient savings are redirected to ambulatory care.
- We protect vulnerable populations — primary care rates are increased; last year’s reimbursement enhancements of reimbursements to institutions are left in place; and physician shortage problems are addressed.
- Our reforms encourage preventive and primary care and discourage the medical arms race.
- We are making enormous capital investments available in primary care, a restructured institutional landscape, and health information technology.
- Berger said we should expect private payers to make a fair contribution. We have proposed closing the loophole by which for-profit HMOs avoid provider assessments and we’ve asked for a larger covered lives contribution.

I asked you to hold us to the test of reasonability and feasibility:

- I believe our proposals really do put patients first.
- Changes are phased in gradually and capital is made available to support change.
- Each of our proposals incorporates principles of transparency, clarity, and accountability.
- We are sensitive to the bottom-line institutional and workforce impact of these proposals.

I’ve scored my own test, and passed it. I invite you to do the same. Evaluate the Executive Budget proposals. Listen to the arguments and counterarguments we are certainly going to hear. Make your own decision.

I'd be happy to take questions. I'm going to ask Deborah Bachrach to join me for any questions.

Courtney Burke:

Thank you for your remarks. You have quite an agenda ahead of you. As the moderator, I'd like to take the opportunity to ask you the first question and then I will turn it over to the audience. You've touched on a lot of different issues that are cost drivers and there are three things in particular that I think drive a lot of the costs. I'll call them HIP for short. The first is high-cost populations. You said you are doing a lot to try and manage care for this population. The second is integrated care. How will the reimbursement changes that you're talking about help integrate care? And then the third would be practice patterns. As you know, research from Wennberg and colleagues at Dartmouth shows how practice patterns affect the care that we get. I was wondering how the changes in reimbursement will affect practice patterns and variation in cost?

Richard Daines:

Well, I think we have covered all of this. I also want to say, enveloping all of this is our information technology strategy. We have a department where health care information technology is not its own thing sitting off there, but infuses it all. We need better, more coordinated information technology across the industry and more managed care. It's been proven to be effective in improving quality, controlling cost, and increasing satisfaction across the board. More managed care and coordinating with other agencies such as OASAS or mental health, where we can co-locate high-risk populations, is important.

Deborah Bachrach:

The only thing that I would add to that is, as the commissioner said, we've been very successful with Medicaid managed care, but our neediest patients for the most part are outside of managed care. We'll see more of our neediest patients start to go into managed care and we've already started that process. But for the Medicaid fee-for-service population we are instituting a number of important back-end reviews.

Deborah Bachrach:

Right now, almost 100 percent of all requests for overrides are granted. And our override thresholds have nothing to do with the disease state of the patient. We have proposals in to change that and to automate the process. It's going to be easier for clinicians to use the system. We expect that 99 percent will be granted, but for those that aren't, it will go to clinical review and will be reviewed based on the needs of the patient, not on some arbitrary limit that we set. Those are fee-for-service patients.

At the back end, we're going to enhance our reviews of all of our ambulatory care claims for pharmaceuticals, for labs, for all ancillaries, and for the clinician claims themselves. And we're going to take the claims and put out an RFP for someone to review them across clinical standards and resource tests. And when we see a problem, we're not going to say, "There's a problem. End of story." We're going to contact the clinician and have a discussion about why this practice pattern is happening, should it be changed, and if we have clinicians who repeatedly are noncompliant, we will no longer contract with them. What we're trying to do is build into the system all the reimbursement reforms the commissioner talked about and for clinical and utilization reviews to use reimbursement to drive care.

Richard Daines:

I will touch on integrated care and practice patterns together because that's really what we're trying to do — make practice patterns fit into integrated care. I'll use two major areas we're focusing on, diabetes and asthma, where we're going to be issuing RFAs. I left an institution that was developing a terrific diabetes management program and showing excellent results. I was amazed at how short the return on investment was. Within a year the patients are hospitalized less, and their conditions have improved. The problem was the reimbursement system. Our Medicaid reimbursement system only accidentally matched up with any part of disease management. There are some terrific clinicians. They've sought out the best diabetes disease management programs with the idea to bring that back and retrofit the reimbursement system so it supports the disease management model that we want and that comes up with that new ambulatory reimbursement system, the acronym is APG (Ambulatory Patient Groups). Then you can bundle the services that diabetic ought to need in a single visit, reward paying the cost of doing that, and we're integrating a proper practice pattern in integrating the care. Again, our information technology is so important because of

the way patients move between institutions and settings. As fast as possible, Lori Evans is bringing up that whole information technology infrastructure that we need to support this.

Paul Sorum:

Hi, I'm from Albany Medical College and I applaud what you're trying to do and hope you succeed. But I have some concerns. As a primary care provider, it seems to me there are at least three disincentives for me to see Medicaid patients. First, the reimbursement system, particularly for Medicaid patients, requires too much paperwork. Overrides are particularly difficult. It's immensely important to change incentives, including not adding more paperwork, which will be an increasing disincentive. But I wonder how that's going to be possible given the fact that as long as you have Medicaid as a population that is defined and is paid for by public monies, basically you have taxpayers paying for patients who don't show up for appointments. In a time when there are concerns about how to reduce the budget, how are you really going to put this into effect?

Richard Daines:

Well, in terms of reimbursement rates, there's something that feeds into your point about difficult patients. We're doing as much as we can within the constraints of reality: moving money into ambulatory care; having rates rise toward Medicare as the benchmark. I think it'll actually be some of the lower-paying commercial payers' rates that we're bumping up against because some had their rates in Medicare minus Medicare Plus, like a lot of them do. So we're doing what we can.

In the budget process, this is my first full cycle. I've told people if you can, get it right about how much we're increasing versus cutting. There's an anecdote about a medical student working for and operating with Michael DeBakey. He was supposed to cut the sutures. DeBakey would tie one and then he'd say "cut," and the medical student would cut it and he'd say, "too long," meaning the tails were too long. He'd tie another one and the student would cut it and he'd say "too short." It would go on: too long, too short, too long, too short. Finally, the next time DeBakey said "cut," the medical student said, "Dr. DeBakey, do you want it too long or too short this time?"

And that's the reaction I read on the budget. It's too much and it's too little and it's kind of coming in balance. We'll do what we can with those rates. The real complex Medicaid

patients probably are going to be better served in our managed care constructs or in the clinic settings where we can put our APG system in, which bundles a lot of care. For private doctors, it's just going to be a matter of increasing the rates and we may not catch up with the most complex patients. Remember, most Medicaid patients these days are working people. Actually, we've had constrictions on enrollment in Medicaid that come from the old welfare days where you're supposed to do alcohol and drug testing and you were excluded from Medicaid if you tested positive. So we got a medical model for treatment of a disease and we exclude you from Medicaid if you have the disease. So, in terms of it being a difficult population, many are employed just like everyone else and many are moving up and down into that Family Health Plus and Child Health Plus range. One of the things I've been struck by in trying to understand poverty in New York is the year-to-year variability in incomes of poor people. They swing up and down by 100 percent. Most of us don't have years like that where we go up 100 percent and then back down. People at the edge of poverty do that and we've found so many that drop out of public programs and we're trying to address that.

We're going to have to have utilization controls, prior approvals, preferred drug lists, and online applications.

Deborah Bachrach:

I think one of the points the commissioner made at the beginning was the first thing we did when we came in was to create the Office of Health Insurance Programs. We vowed to operate Medicaid as a mission-driven, well-run health plan. And part of it does not, though it's sort of behind the scenes and critical to the reform we've been able to propose, is that we are for the first time going to hire someone to be in charge of provider relations for Medicaid. We used to treat our providers as if they were out to defraud us. We'd make it impossible to enroll, and the way we treated people was outrageous. We don't want fraud, but on the other hand we should treat our professionals as if they share the same mission. So, we are bringing on someone who's going to run provider relations for Medicaid and start to meet with providers and address some of the unnecessary barriers we put in the way. So, it's really started with our infrastructure change. If we didn't have that, none of these reforms would be on the table.

Richard Daines:

If you talk to Jim Sheehan, who runs the office of Medicaid Inspector General, of course, he calls it designing integrity into the system, not simply being there to catch and trap people who don't show integrity. The way you design integrity is to have a transparent, well-documented system with reasonable utilization controls. So there's a utilization control either in the software or in the people that says when the dentist goes to fill the 53rd filling on the same day, maybe we ought to have a red flag go off somewhere.

Barbara Crozier:

I'm with the Cerebral Palsy Association (CPA) of New York State. I wanted to thank you. We've benefited from all the work that you've done on durable medical equipment and moving forward on our ambulatory clinics. I represent people with disabilities of all ages in various programs. One of the things you talked about was moving the chronically ill and medically involved so they could benefit from a managed-care system. Many years ago, under the Cuomo administration, CPA of New York State actually got a grant to look at managed care for people with disabilities, because we recognized that many of them have complex medical needs, are very involved cognitive issues. Under the Pataki administration, the study really didn't go anywhere. But, obviously, when you have these individuals who are very complex under the managed care plan, the reimbursement has to be richer. I was wondering what your thoughts were in looking toward moving these individuals into managed care. We agree that in many instances we can provide comprehensive services across the board in a true medical home in addition to what we provide in our clinics. I was wondering if you've thought more about how to go about moving these individuals into a managed-care system and were you going to do a pilot or go statewide?

Richard Daines:

I'll have Deborah address how we're doing that.

Deborah Bachrach:

As you alluded to, we're moving more of the Supplemental Security Income (SSI) population into managed care and we're doing it carefully. The commissioner talked about

that with home care and personal care we have to look at it differently as we start to move into needier populations. We know we will have some populations and probably a lot of the patients that you serve will remain in fee-for-service. So we're also looking at how to better manage those high-need populations who will stay in fee-for-service. A specific example in managed care is the question of carve-outs. Right now there are a lot of carve-outs for mental health services and substance abuse services. We said to Commissioner Michael Hogan, of the Office of Mental Health (OMH), "Well, what do you think? Should it be in? Should it be out? What's the best way to do it? We've got it half in and half out with these studies and none of that seems to make sense." And the answer from the folks at OMH was, "Well, we're not sure either." So we're doing a joint study right now to look at how other states handle mental health services for their highest-need populations with respect to managed-care plans. I think the thing that drives everything is that we're trying to actually look at the data, talk to the providers, talk to the consumers, and then make an informed judgment. So you may disagree with us, but the one thing I can promise you is that we're really trying hard to look at the data and get it right.

Richard Daines:

The ferment around health care all over the country and in our federalized system I see as an advantage because there's so much going on. We can look at the results in other states that do their work here and learn from their experience, and they're going to learn from us. We were just talking to Richard Nathan about a need to do that because I think it's a real advantage of the federal system. I'm sort of an incrementalist and a federalist at heart, so I'm very comfortable taking that approach.

Karen Schimke:

I'm with the Schuyler Center for Analysis and Advocacy. I really appreciate hearing what you've said today. Sometimes things have happened in the past and we didn't know it. So thank you. If you will recall from the listening tour around the state, one of the really severe physician shortage areas is child social work and psychiatry. So I'd be interested your comments.

Richard Daines:

Let's see, rates across the board go up. Paying for clinical social workers and nurse practitioners will put mid-levels and others into that when we're so short of physicians. There's other investment that I didn't touch on but the shortage in children's mental health services is addressed.

Deborah Bachrach:

Our "Doctors Across New York" program will include psychiatrists and psychologists in our underserved communities and underserved specialties. We work a lot with OMH and I know Barry wants to say one or two things, so I'm going to let him comment. But there was a lot of pressure on the department to expand coverage for licensed clinical social workers. We had to strike a balance between a bad budget year and what we needed, and the area we focused on with OMH was coverage for children and adolescents. So I think you'll see an overall increase in some of the specific initiatives and a lot of the reform coming out of OMH. In licensure reform, one of our problems has been feeling the freeze on Article 31 licenses. That is being lifted and we have a lot more that we're about to announce in terms of coordinated licensure reform and that will help. Karen, you know better than anyone there's no silver bullet. But we have pieces in place.

Barry Brauth:

I'm with the Office of Mental Health. Actually, in the budget there are a couple of different initiatives to support psychiatrists, nurses, and nurse practitioners to relocate to rural areas to provide services. I've spent my career in healthcare reimbursement strategies in trying to develop reimbursement systems that contain incentives to improve behavior, and I've been in many of those box canyons. Focusing on the institutional and provider side is critical, and I'm delighted to hear everything you've said today. There also is the patient's side, where we're digging our graves with our forks and knives. We're choosing to purchase those subprime insurance policies. Are there initiatives that could be undertaken on the public health side and the incentive side to encourage healthier lifestyles and healthier choices?

Richard Daines:

I didn't go over our whole public health investment strategy today, which encompasses a bunch of other things. I think what is relatively new, perhaps, is that in addition to investing in things like the obesity epidemic, lead poisoning, and other similar problems, we have a very high integration of public health with public policy and reimbursement. We are going to look at a diabetes disease management program in New York City next week. Something like 1 percent of health care goes to public health. You just never have enough money to do the big programs. \$47 billion is in the Medicaid program but we're having the public health people guide and steer that whenever they can to improve it. Some of the other larger societal changes about exercise, nutrition, food prices, and school nutrition always seem to transcend the Department of Health. The governor has assembled several subcabinets that address a lot of these issues. The children's subcabinet is one where we try to figure out a lot of children's issues. Together we have an economic security subcabinet and a nutrition group. We're trying to make sure that things are coordinated across departments.

Ron Guglielmo:

I'm from the New York State Catholic Conference. I have a question for you, commissioner. You had characterized the state's efforts with regard to handling health care for people in various programs as great if they fit on the bull's eye; I think was the way you had described it. What about for those, as you said, who are perhaps on the edges of programs or where programs overlap? Are there some initiatives in place?

Richard Daines:

Well, maybe Deborah can describe this in more detail. I specifically meant people who are moving from the Medicaid level eligibility to a little better — like Family Health Plus. It was amazing to me how the upper limit for Medicaid eligibility doesn't match the lower limit for Family Health Plus. Deborah, maybe you can say more about what you're doing with that.

Deborah Bachrach:

One of the problems with improving the delivery of care is keeping individuals enrolled. Here's a perfect example: You can now recertify your eligibility for Medicaid by mail. You

send in your form, you've done everything just right, which is not easy, you get it in, it's being reviewed, and they say, "Oops, you're not eligible for Medicaid anymore. You're now eligible for Family Health Plus." You're in the Medicaid managed care plan and that plan offers a family health plus. We can't put you in Family Health Plus. We drop you and you become uninsured until you file a new application for Family Health Plus. So, we have a piece of a proposal in this year's executive budget to allow us to auto assign these folks to Family Health Plus.

Richard Daines:

Like the foster care example.

Deborah Bachrach:

Right.

Richard Daines:

When you're in foster care, you've got Medicaid until age 18. You turn 18, you're emancipated from foster care. We cut you off of Medicaid. You may qualify to reapply but you know, 18 year olds, how are they going to do this? How many 18 to 25 year olds drop back on to the family policy and resources. The foster care, by definition, doesn't have it, so we propose to extend their Medicaid eligibility automatically up to age 21. That's not our department — foster care — but can we smooth it so we don't have that gap where when they have a crisis they have no choice but to show up in an emergency department for a late stage or preventable condition.

Deborah Bachrach:

We have a series of boring technical proposals in this year's budget that you would not believe we had to put in.

Richard Daines:

And when you put them all together, it sings like a symphony. It's really a lot of little pieces in some ways, but there is a theme to them. It's working across those gaps, closing the gaps,

reorienting towards primary and preventive care, having better information, transparency, and accountability. It really all fits in those themes.

Courtney Burke:

Well, you certainly have an ambitious agenda. Thank you for sharing it with us today.