2011-2012 Executive Budget Proposal

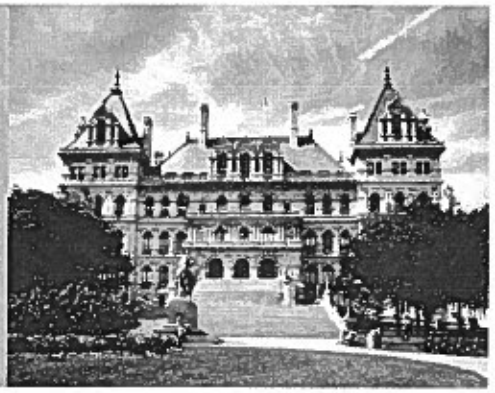
Testimony before the Joint Legislative Hearing of the Assembly Ways and Means and Senate Finance Committees

Daniel Sisto
President
Healthcare Association of New York State

February 8, 2012

HANYS
Healthcare Association of New York State

You are the policymakers



Given last year's two-year budget agreement on Medicaid spending, significant cuts and caps are already programmed into this year's budget.

This year, health policy itself becomes the opportunity for your vital focus as legislators.

At stake is the appropriate transformation and continuity of our health care system and the well-being of your constituents.

For all of us concerned about the future of our health care system, this is a year for focusing on policy.

Shared destination

We know where we are going:

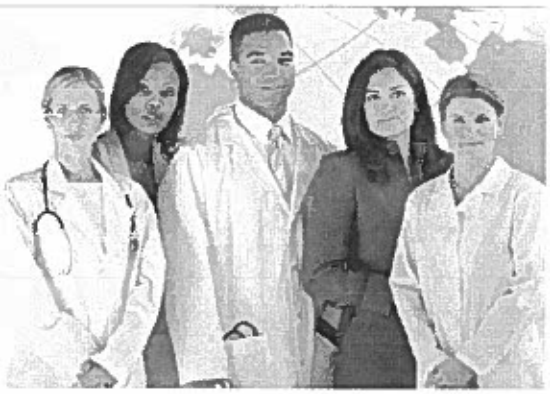
Our shared destination is a more patient-centered and efficient health care system, focused on coordinated care delivery, improved health status, and better patient outcomes.

Hospitals and continuing care providers are constantly changing, innovating unique care models, implementing more efficient processes, and building new relationships. They are working to overcome obstacles impeding our progress. But they need your help.

ENVIRONMENT:

Health care is changing rapidly, and on many fronts

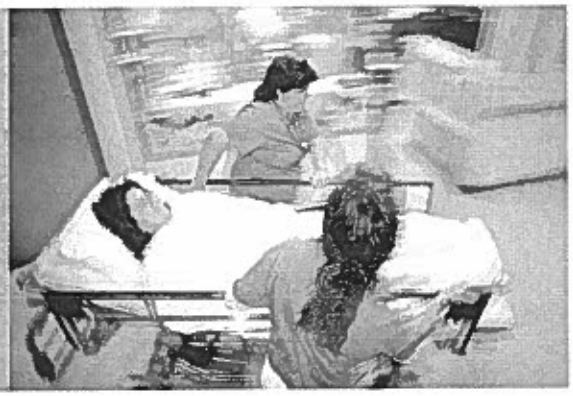
New models of delivery



New models of delivery provide opportunities and challenges:

- Health homes
- Patient Centered Medical Homes (PCMHs)
- Accountable Care Organizations (ACOs)
- Payment bundling
- Quality-based payment reform
- Various others

The value of health care providers



- Even amid this change, hospitals and health systems remain essential in providing care for our citizens, serving critical roles:
  - emergency care;
  - ensuring urban and rural under-served communities have access to care—including primary care and population health services;
  - training medical professionals;
  - treating those in need of sophisticated and complicated care;
  - preparing for man-made and natural disasters; and
  - medical research.

Economic impact of hospitals

- Additionally, the economic impact of hospitals and health systems is enormous.
- Statewide, hospitals and health systems support:
  - 687,000 jobs, and
  - $108 billion in economic activity.

Fiscal challenges continue to accrue

- $5 billion in state Medicaid cuts in the last 3 years.
- $17 billion over ten years in federal Medicare cuts.
- Massive additional cuts pending from federal deficit reduction actions.
- Lack of access to sources of capital financing.
- Increasing costs of workforce, technology, and operations.
- Hospitals lose 26 cents on every dollar of Medicaid care they provide.
- Policy changes that reduce reimbursement:
  - value-based purchasing,
  - readmissions penalties, and
  - hospital-acquired conditions policies.

Proliferation of audit and survey activities

STATE AUDITS

- Office of Medicaid Inspector General (OMIG)
- Medicaid audits by IPRO
- Attorney General
- DSH
- ICR
- HCRA surcharge
- Medicaid RAC forthcoming
- Additionally, commercial payers conducting audits of their own

Proliferation of audit and survey activities (continued)

ONGOING DOH SURVEYS AND INSPECTIONS

- Certification surveys on behalf of CMS
- Federal allegation surveys
- Federal validation surveys
- NYPORTS investigations
- Radiology inspections
- OMH surveillance surveys
- OASAS surveillance surveys
- Pre-opening program surveys
- OPMC investigations
- DOH narcotics control investigations
- Public health/disease control inspections

Proliferation of audit and survey activities (continued)

FEDERAL AUDITS

- Medicare RAC
- Medicaid Integrity Contractors (Audit MICs)—in NYS, this is IPRO
- Office of Inspector General (OIG)
- Medicare administrative contractors (MACs)
- Comprehensive error rate testing (CERT) contractors
- Program safeguard contractors (PSCs)
- Zone program integrity contractors (ZPICs)
- Providers may conduct self-audits to identify coverage and coding errors using the OIG Compliance Program Guidelines

TRANSITIONING TO A NEW HEALTH CARE SYSTEM

THE FIRST STEP: Payment reform

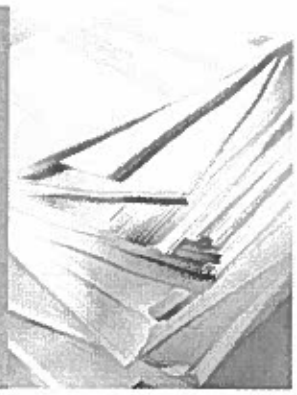
- Payment reform in New York and in Washington has been a catalyst, and providers have responded by creating and evaluating innovative new systems and models of care.
- Public policy and societal expectations demand that we move from a 200 year-old fee-for-service system to an integrated provider network focused on preventive care and improving community health status.

continued . . .

Payment reform
(continued)

- Such fundamental change requires enormous capital investment to:
  - reconfigure virtually all provider, payer, and patient relationships;
  - acquire and configure massive information technology infrastructure;
  - redeploy institutional capacity into community-based capacity; and
  - apply evidence-based medicine into coordinated care programs.
- But we must transform to this new system while we provide care to millions of New Yorkers under the old model. This is like having one foot on the dock and one foot on a boat anchored five feet off shore. The destination may be clear, but the ability to shift successfully while under attack is highly problematic.

THE NEXT STEP:
Essential regulatory reform



- The health care industry is being forced by federal and state governments to rapidly transform, but regulatory impediments remain that hinder the transformation. Examples include delays inherent in the state's Certificate of Need (CON) process, and scope of practice limitations that reduce needed workforce flexibility.
- To facilitate health care innovation and reform, we need the Legislature to clear the regulatory, administrative, and policy obstacles put in place by state agencies.
- We are spending too many hours and dollars complying with outdated rules and policies that inhibit our ability to innovate, create efficiencies, and improve care.

Essential regulatory reform
(continued)

- A prime example of how CON requirements are an obstacle involves a medical center that has been waiting for a pre-opening survey since October. Everything else is in place—a new facility has been built, equipment has been purchased and installed, and physicians and nurses have been hired. Yet, thousands of patients wait for months . . . for a simple DOH site survey.
- Another example highlights rampant, unnecessary duplication of regulation: the state's Wadsworth Laboratory duplicates surveys already carried out by national lab accrediting organizations, all at the expense of the provider community.
- HANYS is grateful to the Legislature's actions last year to begin tackling the reforms necessary in the CON process. But much remains to be done.
- CON policy should be reconfigured to incentivize and support health system transformation.

Essential regulatory reform
(continued)

Governor Cuomo recognizes the need for change:

"The more I've seen, the worse the situation is with the state agencies. This is going to be a ground-up reorganization. The system has just gotten to a point where it is not operational. We need a government that performs better and costs less."

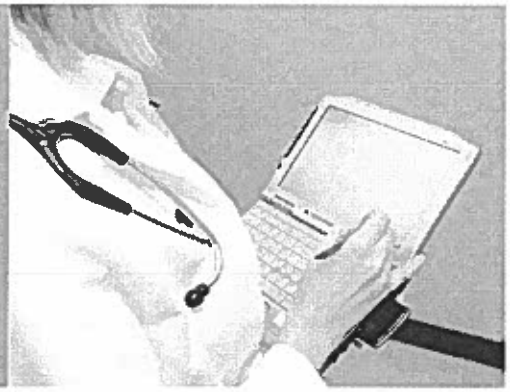
~ Governor Andrew Cuomo
2012 State-of-the-State Address

<u>Your role as legislators will be critical in addressing this issue.</u>

Essential regulatory reform
(continued)

- We must better enable providers to tailor their services to meet their patients' needs, rather than to conform to bureaucratic processes.
- Needed changes include, but are not limited to:
  - better coordination among state agencies in overseeing and paying for health care services;
  - more flexibility to allow behavioral health and medical services to exist within shared spaces; and
  - coordination and synchronization of state and federal oversight functions, especially where costly and duplicative requirements currently divert staff and regulators from their core duties.

Practice reforms



- The regulation of medical practice has not kept pace with clinical, educational, and technological advances. HANYS has been working with state policymakers to clear the regulatory and payment barriers that prevent innovation and efficiency.

  Examples include:

  - Current scope of practice rules prevent practitioners from performing to their highest level of skills and training.
  - The use of technology, such as telemedicine, should be recognized and supported to allow providers more flexibility in providing access to specialists in short supply in many parts of the state.

HANYS and our members are your partners

Agency leaders and personnel are faced with increasing workloads and decreasing resources. HANYS has been and will continue to be a productive partner to help them succeed in their missions.

But, agencies, including the Departments of Health and Education, need to scale their regulatory functions to their available resources and capacities, or the entire system becomes paralyzed.

SPECIFIC BUDGET AND LEGISLATIVE ISSUES

Two-year Medicaid plan and the global spending cap

- Providers will continue to operate under the payment reduction imposed in last year's two-year Medicaid agreement, which included cuts totaling $700 million.
- Providers have reduced state reimbursement by an additional $640 million by keeping expenditures under the global cap.
- Providers have kept expenditures under the global cap, even as Medicaid enrollment has increased by nearly 100,000 beneficiaries.
- We must ensure health care fiscal and policy decisions are made accurately, fairly, and in an open manner, particularly concerning key global cap questions, such as:
  - How will the cap be calculated in the future?
  - How will any future cap account for factors beyond provider control, e.g., enrollment growth, inflation, or local share takeover?
  - What actions will be triggered if the cap is pierced?

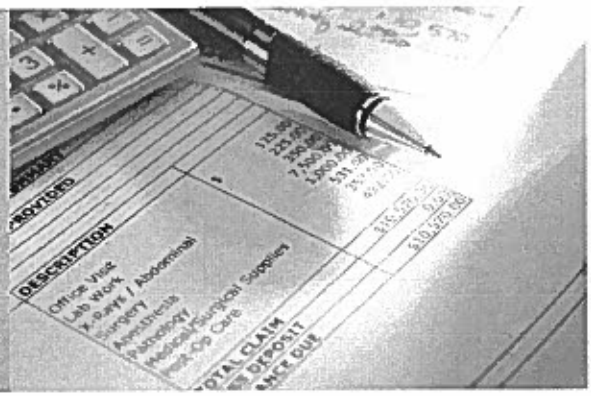
Two-year Medicaid plan and the global spending cap (continued)

- Providers are not getting a 4% raise.
  - The 4% Medicaid spending increase in the budget does not include any provider payment increases.
  - The increase will be consumed largely by increased Medicaid enrollment.
  - Provider payment cuts imposed in the two-year agreement will continue.

Medicaid Redesign Team (MRT) and payer issues

- HANYS appreciates the opportunity to work with the Governor and Legislature to tackle the deficit last year. The first phase of the MRT (MRT-I) was an essential element in meeting such a daunting fiscal challenge.
- The global cap agreement should be perceived as a two-year experiment to be evaluated and assessed for extension or modification.
- The Legislature must now take an active role in measuring its effectiveness and determining the appropriate next steps.
- MRT phase two (MRT-II) is a wholly different enterprise, however, tackling not a short-term fiscal crisis, but permanent health system change and reform. Here, too, the Legislature must take an active role.

Payer reforms



- HANYS seeks your support for key health insurance payment reforms, including proposals necessary to:
  - limit administrative denials that unfairly deny necessary health care services;
  - prohibit unilateral payer down-coding that reduces reimbursement without considering the appropriateness of care provided; and
  - require payers to respond to a provider's claim within the legally stated timeframe, and if payers fail to make a determination within that time, the submitted claim would be approved rather than denied.

Health Benefit Exchange

The executive budget includes provisions that set up the framework for a Health Benefit Exchange. In addition to your deliberations over this budget provision, the Legislature's role will be crucial concerning additional, key decisions.

- What exchange purchasing model will the state adopt:
  - clearinghouse?
  - selective purchaser?
  - active purchaser?
- Will the state make a Basic Health Options Program available through the exchange?
- What essential health benefits will the state adopt?
- How will the exchange be financially self-sufficient?

Other proposals of concern

- Proposal to Grant the Commissioner of Health the Authority to Remove Hospital Boards
  - An unprecedented proposal granting extraordinary powers
  - Time-honored due process protections removed
  - Commissioner of Health would supplant Attorney General as governance watchdog
  - Direct state involvement in nonprofit governance decisions
  - Standards for state intervention undefined
  - May have significant implementation challenges

Other proposals of concern
(continued)

- Proposal to Limit State Reimbursement to Support Executive Compensation
  - The Executive proposal would present implementation issues. The proposal ignores current IRS requirements for compensation, and responsibilities of the Attorney General. In health systems with multiple providers and facilities offering programs involving several regulatory agencies, it will be challenging to determine how much state reimbursement is supporting executive compensation.
  - Existing IRS rules and current Attorney General authority should provide an adequate basis for intervention in egregious cases.

Other proposals of concern
(continued)

- Proposed Budget Savings Couched as Quality Measures
  - Continuation of existing readmissions penalty based on budget target, rather than quality metric;
  - Continuation of potentially preventable negative outcomes penalty, again based on budget target and not based on quality metric or threshold; and
  - A new proposed open-ended authorization for DOH to institute an outpatient potentially preventable conditions policy—fear that this also may end up as a targeted budget-driven cut, rather than a quality improvement policy.

HANYS looks forward to working with the Legislature and the Governor on all of these important matters.

Thank you.

Daniel Sisto
President
(518) 431-7800
dsisto@hanys.org

HANYS Healthcare Association of New York State