

## Appendix 3

### Commission on Health Care Facilities in the 21<sup>st</sup> Century

#### Briefing on Acute Care Reimbursement

##### Introduction

In November 2004, the Health Care Reform Working Group proposed an agenda for restructuring, reform, and reinvestment in the healthcare delivery system that would encompass:

- Restructuring and Rightsizing the Hospital System
- Maintaining the “Public Good” Functions of Hospitals
- Addressing the Rate Paradigm to Promote Provision of Essential Services
- Improving Health Information Technology
- Seeking Federal Waivers to Support Reinvestment <sup>1</sup>

The Work Group’s recommendations led to formation of the Commission on Health Care Facilities in the 21<sup>st</sup> Century, whose principal charge is to “right-size” the acute and long term care delivery systems. The Commission’s mandate is to shape a health care delivery system that meets community needs, rather than simply preserve existing institutions. The Commission also envisions new acute and long term care delivery models together with a revitalized primary care infrastructure and continuing investment in a highly trained healthcare workforce.

In addition to “right-sizing” facilities, broad systemic changes are needed. Commission members, Regional Advisory Committees, and speakers at public hearings all have noted the ways in which financial incentives affect the supply, demand, and location of healthcare services. Although reimbursement reform is beyond the Commission’s core statutory charge, members can include non-binding reimbursement recommendations in their final report. This briefing describes the current acute care reimbursement system (focusing principally on Medicaid), some of the major issues under consideration, and options for reform.

##### NYS Acute Care Reimbursement System - HCRA

In New York, acute care reimbursement is generally governed by The Health Care Reform Act of 1996 (HCRA) and its subsequent extensions. HCRA aimed to create a market-based, competitive system by de-regulating inpatient rates for commercial payers. For the first time, hospitals were required to negotiate with private payers and managed care plans. This was a major departure for New York, which previously had a fully-regulated system in which all rates were state-set. Because of concern about how this new, partially deregulated system would impact various “public goods”, including bad debt and charity care and graduate medical education, HCRA also established pools of supplemental funds to be distributed for these purposes.

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<sup>1</sup> Healthcare Reform Working Group, Final Report, Executive Summary, November 2004.

HCRA de-regulated only the commercial component of the reimbursement system. The federal government continues to set Medicare inpatient rates. Similarly, NYS continues to set Medicaid fee-for-service rates, although these cover progressively fewer Medicaid beneficiaries due to the phased implementation of mandatory Medicaid managed care.

### **Medicaid and the Reimbursement Reform Agenda**

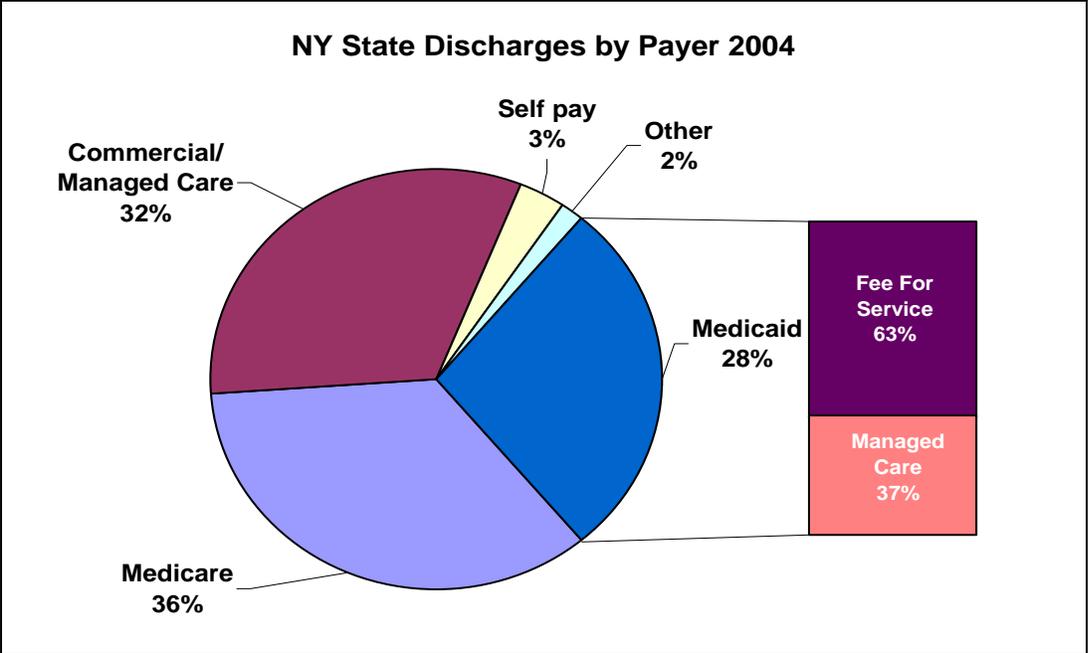
Direct state action to change the amount and distribution of funding for Medicaid and public goods would be an important first step in reforming the reimbursement system in New York. Medicaid policy has the potential to influence the actions of private and federal payors. The following facts illustrate the prominent role played by Medicaid:

- Medicaid is one of the largest items in New York's state and local budgets, and accounts for more than half of all federal funding that flows to NY. Medicaid payments to health care providers and insurance plans – payments of more than \$40 billion annually – account for more than a quarter of NY's health care economy.
- In 2004, Medicaid spending in NY totaled \$41.6 billion in services, not including \$1.3 billion in administrative costs. Acute care accounted for 52% of spending on services, long-term care 41%, and disproportionate share payments – direct subsidies to hospitals serving high concentrations of Medicaid patients and the uninsured – made up the rest.
- While children and non-elderly, non-disabled adults account for 76% of enrollment, they account for less than a quarter of Medicaid spending. The elderly and disabled, who make up 24% of enrollment, account for 70% of spending.
- The federal funding formula for Medicaid -- the "matching rate" -- is based on state per capita income relative to the nation. Since New York's per capita income is relatively high, the state matching rate is the lowest allowable under federal law – 50%. The state pays most of the remaining costs, but it requires counties and NYC to pay a share. The state is currently responsible for about 32% of Medicaid costs, and local governments are responsible for about 17%. NYC is responsible for about 70% of all local government contributions to Medicaid in NYS. In 2005, NY limited county governments' future responsibility for Medicaid costs.
- The state implemented a mandatory Medicaid managed care program in the 1990s as a means of providing Medicaid enrollees with greater continuity and coordination of care and access to primary and preventive care. Currently, most New Yorkers receiving Medicaid are enrolled in managed care. However, most elderly and disabled beneficiaries – the most costly patients to cover – are not enrolled either because they are excluded or because they have opted not to enroll voluntarily.<sup>2</sup>

Using Medicaid as a lever to effect systemic change does have limitations. Medicaid is an important payer at a macro level, but it is one payer among many. Its importance and influence varies by individual hospital and community.

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<sup>2</sup> "Medicaid in New York: A Primer," Medicaid Institute at United Hospital Fund, 2005.



**Issues in Acute Care Medicaid Reimbursement**

Discussion about reforming payment for Medicaid and public goods has coalesced around the following principal issues:

- The rate calculations use a base year and service intensity weights that are many years out of date.
- The current “rate paradigm” disadvantages community hospital services and disproportionately rewards tertiary services.
- The payment rates for emergency services, while recently updated, do not cover costs.
- The payment rates for outpatient services are outdated and bear little relationship to actual costs.

## **Medicaid Fee-for-Service Inpatient Rates**

### Current Method

Each hospital has a base rate per discharge that was originally developed using that hospital's 1981 costs. These base rates have been continually updated with trend factors for inflation, enhancements to cover unanticipated costs over and above the trend factor, and rate appeals.

The hospital's base rate per discharge is increased or decreased to account for the fact that different kinds of cases consume different levels of resources. The adjustment is done by assigning each case to one of many Diagnosis Related Groups (DRGs), each of which has a "service intensity weight" (SIW) that recognizes the typical resource consumption of that group of cases. Generally, service intensity weights are higher for surgical and interventional cases than for medical cases. For example, the DRG for a cardiac valve procedure with cardiac catheterization has a service intensity weight of 8.9205 while the DRG for heart failure and shock has a service intensity weight of 1.4947. A hospital's final Medicaid reimbursement rate for a discharge equals its base rate multiplied by the service intensity weight of the DRG for that case.

### Issues

The principal issue for inpatient reimbursement is not the magnitude of payment. Both the industry and the Department of Health consider inpatient Medicaid reimbursement to be "adequate overall." That is, it generally covers the aggregate costs of providing inpatient care even though particular services may be somewhat over or under-reimbursed.

Reliable comparative data to substantiate this "adequacy" are difficult to obtain. The American Hospital Association produces a statistical report from survey data that shows a combined inpatient and outpatient coverage ratio of 90% for NY Medicaid costs. A Hospital Association of New York (HANYS) study based on the official 2004 Institutional Cost Reports shows that Medicaid pays about 93% of costs for inpatient care and about 60% of costs for outpatient care.

Inpatient Medicaid rates may be lower in other states than in New York. However, in those states there is a policy assumption that higher commercial rates will cross subsidize the losses. In these states, commercial rates are higher than they are in New York because historically they were not regulated as they were in New York.

The principal issues of concern for inpatient rates are as follows:

- Base Year 1981

The cost base year is 1981. Over time, changes in the practice of medicine and use of new technologies have increased some hospital costs and decreased others. These changes may not have been addressed completely enough through the annual adjustments. While this is a factor of some concern, the major focus of reform attention has been on the service intensity weights.

- Service Intensity Weights 1992

The service intensity weights were last calculated in 1992. Changes in the practice of medicine since that time have not been reflected in the weights. For some DRGs, lengths of stay per case have changed. It has been suggested, for example, that open heart surgery cases may be reimbursed at a higher rate than their costs today would justify. Conversely, other kinds of cases that involve new and expensive implantable devices are grouped into DRGs that may not be weighted heavily enough to capture these new costs.

- Rate Paradigm

The current structure of the reimbursement system creates a rate paradigm that disproportionately rewards high tech, tertiary services and disadvantages baseline community hospital services like obstetrics, medicine, pediatrics and psychiatry. In order to subsidize the lower paying services, institutions are driven to compete for high-margin tertiary and interventional services, leading to expensive duplication of investment and a medical “arms race.”

### Options

- Recalculate Service Intensity Weights

Recalculating service intensity weights would more accurately reflect today’s costs. In addition, if rebasing is conducted in a budget-neutral manner, funds could be shifted from services that are paid too highly to those that are paid too little. Further, the system could build in the same mark-up on all services, thereby reducing the incentive to compete for tertiary-care business and providing a stable and fair level of support for community hospital services.

This initiative has generally (if warily) been supported by the industry and the Department of Health. A draft is under development. The impact of such a change on individual institutions and on the rate paradigm is not yet known. For individual hospitals, the impact could be substantial, creating both “winners” and “losers.” Depending on a hospital’s individual mix of cases and services, a change in the weights could dramatically change revenue, making this initiative a highly charged undertaking.<sup>3</sup>

Given the unknowns in this initiative – the impact on individual providers, the impact on “rate paradigm” problems, and the eventual costs – this effort needs to be pursued carefully. A change in payment based on a re-weighting could be phased in gradually to avoid unnecessary harm to the financial condition of needed institutions.

- Recognize and Support Safety-Net Providers and Services

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<sup>3</sup> In a recent national development, the Center for Medicare Services proposed similar changes involving re-weighting. Unlike NY’s Medicaid service intensity weights which are cost based, the Medicare weights have been based on charges. Because of the way charges for high-tech services are “marked up” in relationship to other services, the Medicare service intensity weights set a rate paradigm that even more disproportionately rewards high tech services. CMS is considering a two-step transformation process. The first would be to assign weights to DRGs based on hospital costs as NYS does, rather than hospital charges. The second step would re-weight federal DRGs to improve recognition of severity in the current DRG system. Should the proposed changes in Medicare reimbursement be adopted, they will have major, but uneven impact on hospital revenue and service delivery in NY.

Even if rebasing is successful, it may not entirely solve the rate paradigm problem or meet the needs of all providers. There are essential services that hospitals must provide that are by their nature expensive, like emergency, trauma, burn care and emergency preparedness. Others, like obstetrics, are expensive because of the disproportionate burden associated with malpractice costs. There is also a subset of hospitals that will always have structural financial problems, not because of management skills, but because of their mix of patients, payers and services. These hospitals experience severe fiscal hardship because of insufficient resources to finance losses resulting from bad debts and the costs of charity care.

Mechanisms could be devised to ensure support for these essential providers and services. One alternative that has been suggested would create an additional adjustment in the rates to provide for greater payment for community and public good services. The old “supplemental low income patient adjustment” (SLIPA) for example, was an add-on to the DRGs for non-“financially distressed” voluntary hospitals where more than 35% of discharges were from Medicaid and uninsured patients. The amount of the add-on increased where low-income discharges rose to 50%. In essence, this add-on recognized the added costs (employed doctors, social workers, etc.) of hospitals that serve the relatively largest numbers of Medicaid and uninsured patients.

Another option would be for the state to return to a system of partial regulation for a subset of institutions. This approach would assume that these institutions provide critically necessary services to their communities but, due of their mix of patients, payers and services they cannot succeed in the current reimbursement system, even with capable management. This option would establish a global budget for these facilities, essentially guaranteeing them a level of support that will allow them to remain viable community hospitals. In exchange for this level of support, the state could require a higher degree of transparency in their financial reporting in order to ensure that funds are used appropriately and effectively.

## **Medicaid Inpatient Obstetrics Reimbursement**

### Current Method

Medicaid reimburses for inpatient obstetrics care using the case payment system described above. Each hospital has a base rate per discharge used for all Medicaid cases at that hospital. This amount is multiplied by a service intensity weight based on the patient’s diagnosis related group. For example, all routine obstetrical cases are in DRG category #373 and have an intensity factor of 0.5628, which is based on the typical intensity of effort by hospital staff for an average patient. This intensity factor is uniform throughout the State.

## Issues

- Declining Availability and Access

In response to increasing malpractice costs,<sup>4</sup> access to obstetrics services is declining in many areas of the state. Increasingly, OB/GYNs report that they have stopped or decreased the amount or nature of obstetrical care they perform because they fear malpractice exposure. In NY, the number of OB/GYNs per 100,000 population caring for patients decreased by 4.1% between 1998 to 2002, while the number of patient care physicians overall per 100,000 population declined by only 1.5%.<sup>5</sup> Some hospitals report that they have limited or eliminated their obstetrics programs. Decreased access disproportionately affects patients with Medicaid and the uninsured and the hospitals that serve them. Due to Medicaid's low reimbursement for physician services and the lack of reimbursement for physician services to the uninsured, obstetricians in private practice are reluctant to treat Medicaid and uninsured patients who must rely on safety net hospital providers for care.

- Unreimbursed Costs of Safety Net Providers

Safety net hospitals fill the availability and access gap by hiring obstetricians as employees of the hospital and paying their malpractice insurance. These hospitals rely primarily on payments from the Medicaid program, and the additional costs they incur in employing obstetricians – including salary, benefits and malpractice insurance costs -- are not included in the Medicaid inpatient payment rates.

## Options

- This problem could be resolved via a comprehensive re-weighting of the DRGs. If it is not handled with a re-weighting, the additional cost burden could be reimbursed with an “add-on” to the base rate, the same way that capital expenses are reimbursed. Under NYPHRM, the previous reimbursement system, these kinds of extraordinary costs were typically covered with various add-ons to the overall rate. A special add-on to the rate would help preserve obstetrics services, particularly in hospitals with higher mixes of Medicaid and uninsured, and it would be relatively easy to calculate and administer.

However, there are also factors that argue against this approach. It could be seen as another way to avoid the more contentious issues of tort reform. There are also other clinical specialties that carry disproportionately high malpractice costs, and these too, could just as justifiably be reimbursed with an add-on. Further, only a portion of high malpractice costs are linked to service to Medicaid patients; the rest are linked to patients with commercial coverage.

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<sup>4</sup> The American Medical Association lists NY as one of 20 states having a medical malpractice “crisis.” Many attempts have been made to address the malpractice issue with little result. A GNYHA survey of hospitals in the downstate NY area showed that hospitals have experienced average annual malpractice insurance premium increases of 27% per year from 1999 through 2004. The consumer price index that is used to update inpatient hospital rates does not take malpractice costs into account.

<sup>5</sup> Medical Malpractice Insurance Costs and Coverage, Greater New York Hospital Association, January 2005.

- More comprehensive tort reform at the state level.<sup>6</sup>

## **Medicaid ED Rates**

### Current Method

The Medicaid reimbursement rate for hospital emergency services consists of two components, operating cost and capital cost. Capital is reimbursed on a pass-through basis, without a cap. By statute, the operating cost component for a particular rate year is based on the operating costs reported for the period two years prior to that rate year. Until recently, reimbursement had been capped at \$95.00 per visit since 1991. The final 20006-2007 state budget phases in higher reimbursement for emergency services, lifting the \$95 rate to \$125 in 2007, \$140 in 2008 and \$150 in 2009.

### Issues

- Inadequacy of Payment Rate

While emergency care has improved with progress in medicine and technology, since 1991 the increased costs associated with these improvements were not reimbursed by Medicaid. Even with the recent agreement to adjust ED rates upward, payment is still inadequate to cover the actual cost of a visit, now estimated to be \$400.<sup>7</sup> According to information provided by HANYS, New Jersey reimburses a flat rate for Medicaid-covered ED visits, and then following a retrospective review, it reimburses actual costs.

- Trauma Center Costs

The Medicaid ED rate also fails to take into account the additional costs incurred by hospitals with designated trauma centers. These are governed by strict standards that stipulate specialist availability 24/7, minimum RN ratios, and the availability of certain types of specialized equipment. Hospitals that are not trauma centers do not incur the same costs. However, Medicaid pays the same per visit rate to designated trauma centers as it does to those hospitals that are not trauma centers. While a portion of the extra costs are reflected in inpatient rates, the reimbursement is diluted because inpatient reimbursement rates are not based on current costs, but on costs in an outdated base year.

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<sup>7</sup> While important, tort reform is beyond the immediate scope of the Work Group and the Commission. The issue should be addressed in a comprehensive policy effort.

<sup>7</sup> Healthcare Association of NYS, "Hospitals on Life Support: Seven Straight Years of Operating Losses," January 2006, p. 4.

## Options

- Continue to raise rates

Continuing to raise the rate for ED visits is one option, one that was partially accomplished in the 2006-2007 Budget. While this may begin to redress the gap between costs and payment levels, the incremental impact of this increase on the state budget would be substantial additional spending. This raises policy questions about what portion of NYS revenues should be dedicated to health care as opposed to other public goods.

- Establish a system of tiered rates

Another way to reform the ED payment rate would be to follow the Medicare system in implementing a tiered payment for low, medium and high intensity cases, with ancillary costs being billed separately. The advantages here would be that the change would advance a uniform payment method, and that the level of payment would be calibrated to reflect the intensity of care provided. The disadvantage from the provider perspective is that tiered rates are more complex to administer, and that insurance companies might use utilization review in order to minimize payments. And from the state perspective, just as in the “raise the rates” option, there is a question of the total overall budgetary impact of the change.

- Trauma rates

A number of states have established separate reimbursement rates for trauma centers. In Illinois, all Level I and II trauma centers are entitled to receive additional Medicaid add-on payments. The program is funded by dollars collected through traffic fines and citations issued by Illinois Counties. Because these amounts are paid as Medicaid add-ons, Illinois is eligible to receive federal matching funds for the payments.<sup>8</sup> Likewise, the Washington Medicaid program also makes supplemental payments to designated trauma facilities.<sup>9</sup> At least nine other states have established trauma care or catastrophic care funds, or both.<sup>10</sup>

- Reduce Inappropriate Utilization

There is universal agreement that reducing inappropriate utilization of hospital emergency rooms – one of the most expensive venues in which to receive treatment -- would both improve patient care and generate substantial savings to the healthcare system. Inappropriate use is a growing problem. Over the past decade and across the entire country, the number of patient visits to hospital emergency departments has been increasing steadily, driven by cultural, economic and legal factors including the erosion of public health and social welfare programs and the growing number of uninsured. The problem is not limited to Medicaid and the uninsured. The steady growth in utilization by privately insured patients represented the largest segment of increased ED visits between 1996 and 2001.<sup>11</sup>

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<sup>8</sup> Illinois Administrative Code, Title 9, 148.290

<sup>9</sup> Washington Revenue Code 70.168.

<sup>10</sup> Navigant Consulting, “Un-reimbursed Catastrophic and Trauma Care,” October 28, 2004.

<sup>11</sup> AAP POLICY Statement, “Overcrowding in Our Nation’s Emergency Departments,” p 11

Complaint urgency aside, inadequate or inaccessible primary care is frequently cited as the most common reason for use of emergency services.<sup>12</sup> One recent national research study reported that use of the ED is, for most people, an affirmative choice over other providers rather than a last resort for those without other options. The most common reasons for choosing the ED were patients' belief that their medical problem required ED care, the convenience of location, hours of operation and immediate availability, and a preference for the ED environment, staff and comprehensiveness. These reasons reflect dissatisfaction with other sources of healthcare and suggest that successful strategies for reducing ED utilization must consider altering characteristics of other providers to be more responsive to the needs of patients.<sup>13</sup>

Nationally, fully 13% of total visits were classified as non-urgent while 15.5% of Medicaid visits were non-urgent.<sup>14</sup> It had been hoped that NY's Medicaid Managed Care program would succeed in reducing inappropriate utilization by providing all patients a primary care "home." Unfortunately, this has not worked fully as planned, and ED utilization continues to increase in NY as it has nationally.

A number of strategies have been employed to reduce inappropriate utilization. Implementing these strategies has been complicated by the strict requirements of the Emergency Medical Treatment and Labor Act (EMTALA).<sup>15</sup> EMTALA was passed to redress the practice of "patient dumping," i.e., the refusal of a hospital (and/or hospital based physicians) to provide emergency care for patients who could not pay. EMTALA protects the rights of indigent patients by requiring that all Medicare-participating hospitals provide a medical screening exam for all patients who present for care to the ED regardless of their ability to pay. The law specifies that the scope of the medical screening exam should include all ancillary services routinely available to the ED, including physician consultation and inpatient care, if required. For violations of the act, EMTALA imposes strict penalties including fines (up to \$50,000 per violation) and exclusions from the Medicare program. EMTALA also provides a private right of action to individuals who suffer personal harm.<sup>16 17</sup>

In order to decongest high-intensity treatment areas, busy emergency departments treat patients with minor problems in "fast track" areas away from critically ill patients. However, the segregation of patients requiring different intensities of treatment neither prevents inappropriate visits, nor obviates the need to provide a medical screening exam to all patients. In fact, the required medical screening exam must continue to be provided within the contiguous or on-campus facilities of the hospital. Even when the fast track facility is adjacent to or within the ED, EMTALA requires that the screening exam be provided to anyone presenting to the hospital "fast track" for care. It is not acceptable to triage a patient coming to the ED and send them to "fast track" without providing an appropriate medical screening exam. In addition, the screening in the fast track must be conducted by a physician or other appropriate medical staff member described

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<sup>12</sup> "AAP POLICY Statement, Overcrowding in Our Nation's Emergency Departments: Is Our Safety Net Unraveling" PEDIATRICS Vol. 114 No. 3, September 2004, pp. 878-888

<sup>13</sup> Ragin, Deborah Fish, et al, "Reasons for Using the Emergency Department: Results of the Empath Study, Clinical Investigations, Academy of Emergency Medicine, 2005

<sup>14</sup> "Advance Data From Vital and Health Statistics, Number 358, May 26, 2005, CDC

<sup>15</sup> EMTALA was included in the COBRA legislation of 1986 and was updated in 2003.

<sup>16</sup> Maruca, William H., Esq. and Batra Hershey, Tina, Esq., "Clearing the EMTALA Fog," Physician's News Digest, January 2004.

<sup>17</sup> Glover, Ralph, JD, "The Effect of EMTALA on Provider-Based Entities: Frequently Asked Questions, EM Topics, American Academy of Emergency Medicine.

in the hospital's medical staff bylaws as being appropriate for conducting emergency medical screening exams.<sup>18</sup>

As already noted, while fast-track facilities may help decongest critical care areas of the ED, they do not solve the problem of inappropriate use. Other, more direct strategies have been employed to reduce the number of inappropriate visits. In 2004, the Virginia Department of Medical Assistance Services conducted a survey of Medicaid agencies in 50 states. The purpose of the survey was to determine what policies or programs they had used to limit the degree to which Medicaid recipients use the ED for non-emergent care. Of 32 states responding to the survey, only 10 had implemented policies or programs relating to this program. The approaches utilized include the following:

1. Retrospective reviews and reduction in payments for ED claims submitted for non-emergencies.
2. Monitoring of ED use and outreach activities when there is evidence that recipients are using the ED for routine care. The most elaborate program is run by the state of Maine which quarterly identifies patients who have been seen in the ED for the top five non-emergency diagnoses. They receive letters and calls reminding them to use their primary care provider. Primary care providers are expected to provide 24-hour coverage to support the program and they receive an incentive payment for doing so.
3. Managed care organizations that work with the State of Virginia also work with beneficiaries to minimize the use of EDs for routine care. They establish limits on the number of non-emergency ED visits they will allow before an intervention is triggered. These interventions include phone and mail contact, primary care provider contact, and referral to medical management services.<sup>19</sup>

There are other examples of how improved collaboration between primary care providers and local hospitals, together with state Medicaid agencies, can significantly increase Medicaid beneficiaries' use of regular sources of care and reduce inappropriate ED use.

1. In the Appalachian region of Kentucky, patient navigators help break down barriers to care for uninsured and underinsured rural families. In its first three years, the program helped more than 9,000 patients to access services including primary health care, pharmaceuticals, dental, social, transportation and housing services, and education on disease management and prevention. As a result there has been a 95% reduction in heart disease-related ED visits. By reducing clients' uncompensated hospital admissions and emergency room visits, the program has helped save the regional hospital system alone about \$1.3 million and resulted in better health outcomes for patients.
2. A Medicaid managed care plan in Ohio implemented a multi-faceted "medical homes" initiative in 2003. Among other features, the plan established a 24-hour, 7-day nurse triage line to direct enrollees to the appropriate care setting for their condition. In the first 18 months of operation, the line alone was able to divert 58% of 13,000 callers away

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<sup>18</sup> Ibid

<sup>19</sup> Report of the Department of Medical Assistance Services, "Emergency Room Use by Virginia's Fee-For-Service Medicaid Recipients," 2004.

from the ER to a more appropriate level of care, resulting in a net savings of over \$1.7 million.

3. The establishment of a community health center in an Oklahoma community reduced uninsured visits to the local ED by almost 40%. Even after 10 years, uninsured ED visits remained 25% lower than before the CHC was started.<sup>20</sup>

### **Medicaid Reimbursement for Hospital Outpatient Visits**

Because of a shortage of community based and private practice alternatives, the Medicaid-insured and uninsured populations continue to use hospital outpatient and emergency departments as their primary sources of care. In 2004, New York's hospital outpatient departments provided roughly 14.7 million clinic visits, of which more than 3.2 million were paid by Medicaid fee-for-service, more than 2.4 million were paid by Medicaid Managed Care, 2 million were paid by Family Health Plus, Child Health Plus and Healthy New York, and 1.4 million were self-pay or charity care.<sup>21</sup>

#### Current Method

By statute, hospitals are reimbursed for outpatient services at a per visit rate consisting of two components: operating costs and capital costs. The operating cost component for a particular rate year is based on the operating costs reported on the cost report for the period two years prior to that rate year. However, the operating component of the clinic Medicaid rate has been capped since 1985, first at \$60.00 per visit, and then, beginning in 1991, at \$67.50 per visit. Capital is reimbursed on a pass-through basis, without a cap, except that hospitals are only reimbursed 56% of major moveable equipment costs.

A few hospitals are reimbursed under a different methodology, the Products of Ambulatory Care Services (PACS) reimbursement system. Established in 1991, as an experiment in rewarding higher quality, PACS offered enhanced Medicaid reimbursement for outpatient visits provided by hospitals that met Preferred Primary Care Provider criteria including ensuring access by the medically indigent and Medicaid eligible, provision of continuity of care, provision of specialty and ancillary services, and expanded hours. In 1995, as part of a cost containment effort, PACS was eliminated except at a handful of facilities.

#### Issues

- Inadequacy of Payment Rate

The operating cost of the clinic rate has been capped at \$67.50 per visit since 1991. This payment is inadequate to cover current costs, which are estimated to be closer to \$200 per visit.

- Payment Differs by Licensure of Provider

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<sup>20</sup> "Reducing Inappropriate Emergency Room Use among Medicaid Recipients by Linking Them to a Regular Source of Care," Partnership for Medicaid web site.

<sup>21</sup> 2004 ICR Data

Today, the amount of payment differs by provider license, not by the level of care delivered. The same care is reimbursed at a higher rate if it occurs in a facility licensed as a diagnostic and treatment center than if it occurs in a facility licensed as a hospital outpatient department.

### Options

- Increase outpatient rates

It has been proposed that the outpatient clinic rate be raised to more adequately reflect today's cost per visit. While this will bring reimbursement more in line with costs, any such increase would have a substantial impact on the State budget. As such, this option raises questions about the proportion of the State's revenues that should be directed to healthcare as opposed to other worthy purposes.

- Implement a new "products of ambulatory care" approach that adjusts the payment based on the extent and complexity of the care delivered, regardless of venue.
- It has also been suggested that the current system of varying payment by licensure, rather than by the intensity of that service, is fundamentally unjust. According to this way of thinking, dollars should be attached to services, not to sites. Here too, however, any change would have a direct impact on the State budget.

### **Public Goods**

In response to concerns about supporting "public goods" under a partially deregulated system, HCRA established supplemental "pools" funded through surcharges and assessments on private payers and the provider community. The \$847M Hospital Indigent Care Pool for 2006 allocates funds as follows:

General Hospital Indigent Care Pool \$765M  
High Need Indigent Care Adjustment \$82M

## Methodology

Conceptually, as a hospital's need rises – the more charity care its caregivers provide – the higher the percentage of its uncompensated care costs that are covered by State payments. There are three steps in the process:

- Calculation of each hospital's "targeted need." Targeted need is the relationship of its uncompensated care costs to its reported costs (inpatient and outpatient) expressed as a percent. In order to be eligible for distributions from the indigent care pool, a general hospital's targeted need must exceed one-half of one percent.
- Calculation of each hospital's "nominal payment amount" -- The nominal payment amount is calculated according to a scale which progressively recognizes more of a hospital's need the more such need figures as a percentage of overall costs. This is the amount of the hospital's uncompensated care need eligible for reimbursement out of the indigent care pool.
- Utilization of the nominal payment amounts to calculate the amount of each hospital's share of the indigent care pool funds. Voluntary hospitals draw from the \$572M based on the relationship between their nominal payment amount and that of all other participating hospitals.

Voluntary hospitals are typically reimbursed between 50 – 60 percent of their compensated care costs from the HCRA pools. The exact coverage ratios rise and fall as the hospitals' percentage of uninsured patients rises and falls. High need hospitals can draw from the additional \$82M in proportion to the excess of their respective nominal payment amounts above the 4% threshold.

## Issues

- Outdated Cost and Statistical Data

Since 1996, there has been no change to the methodology.

- Costs of Safety Net Hospitals not Adequately Captured

It has been suggested that the current distribution methodology does not adequately recognize the added costs of safety net hospitals.

- Lack of Discrimination Between Need and High Need Hospitals

Under the current method, it is possible for two hospitals with the same reported costs yet with uncompensated care needs differing by 100% to have nominal payment amounts that differ only slightly.<sup>22</sup>

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<sup>22</sup> "Medicaid and Indigent Care Pool Reimbursement for Safety Net Services and Safety Net Hospitals," Manatt Phelps, Phillips.

- Bad Debt vs. Charity Care

For practical and policy reasons, New York State does not require hospitals to distinguish between bad debt and charity care when classifying uncompensated care. From a policy perspective, the state requires hospitals to engage in reasonable collection efforts prior to requesting funds from the Indigent Care Pools. From a practical perspective, the designations are influenced by the point in time when a hospital determines that a patient is eligible for discounted or free care due to inability to pay. If the determination is made up front because it is clear that the patient cannot pay, then a hospital could classify that account as “charity care.” However, as a practical matter, in many situations, the patient cannot provide adequate information or documentation up front to verify inability to pay, so the account is registered as one for which payment is expected. At the point in time when the hospital is able to determine that the patient is unable to pay, the unpaid amount is reclassified as a bad debt simply because the account was originally registered as one for which a bill should be generated with an expectation of payment.<sup>23</sup>

### Options

The Work Group on Health Care Reform made a number of suggestions regarding changes to the HCRA Pools. Conceptually, these included the following initiatives:

- Update methodology for the Public Indigent Care Adjustment distribution based upon 2002 cost and statistical data. Since 1996, there has been no change to methodology or adjustments.
- Adjust the Indigent Care Pool Allocation in order to drive more of the funds to facilities with the highest need.

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<sup>23</sup> “Q&A on The New York Health Care Reform Act, GNYHA.