State of Upstate New York Conference: Resiliency, Partnerships and Innovation
June 8-9, 2011
State of Upstate: Health Care

- A major economic and social engine
- Subject to compressive economic forces of state and federal issues
- Medicaid is the state’s determinant of investment
- Expense and revenue trend lines are diverging
- Restructuring and consolidation ahead
- Cost and access issues will increase
Health Reform: The Need to “Bend the Cost Curve”

Exhibit ES-1. Total National Health Expenditures (NHE), 2009–2020
Current Projection and Alternative Scenarios

NHE in trillions

- Current projection (6.7% annual growth)
- Path proposals (5.5% annual growth)
- Constant (2009) proportion of GDP (4.7% annual growth)

Cumulative reduction in NHE through 2020: $3 trillion

Note: GDP = Gross Domestic Product.
Data: Estimates by The Lewin Group for The Commonwealth Fund.
Themes for Today

I. The Federal Squeeze - Medicare
II. The State Medicaid “Redesign”
III. Physician Trends
IV. What happens next?
V. Adaptive responses
The Federal Squeeze
Not Much Room to Maneuver

Program Areas in the Remaining Fifth of the Budget

- Benefits for Federal Retirees and Veterans: 6%
- Scientific and Medical Research: 3%
- Transportation Infrastructure: 3%
- Education: 2%
- Non-security International: 1%
- All Other: 5%

Source: Congressional Budget Office
Note: Percentages may not total 100 due to rounding.
Medicare and Medicaid Spending as a Share of the 2011 Federal Budget

Baseline Federal Budgets for FY 2007 -- $2.7 Trillion
Baseline Federal Budget for FY 2011 -- $3.7 Trillion
Baseline Federal Receipts for FY 2011 -- $2.6 Trillion

Source: Office of Management and Budget, 2010

Interest on the federal debt will quadruple in the next decade
The key longer-term challenge for not-for-profit hospitals is the reform’s reliance on extracting long-term cost efficiencies from hospitals, probably resulting in diminished hospital revenues.

The reform squeezes savings out of Medicare and Medicaid and places private health insurers under stronger regulatory oversight, potentially straining negotiations with commercial and managed care payers.

Consequently, many not-for-profit hospitals will struggle with these challenges and we expect reform will contribute to already existing market forces favoring larger health systems.”

Mark Pascaris, Analyst
Moody’s
ACA's Medicare Payment Reductions to Hospitals

New York State

ACA's Effect on New York Hospitals' Medicare Margins* (Forecast includes effect of ACA and CMS' Coding Offset to Inpatient Payments)

ACA's Medicare Payment Reductions to NY Hospitals' (2010-2019) (Chart also shows CMS' Coding Offset to Inpatient Payments)

Key Data-Driven Points and Questions about Medicare Payment to New York Hospitals*

**[10,619,148,000]**  ACA's net impact on hospital Medicare payments over ten years.

**[$556,118,000]**  CMS' "coding offset" cut to Medicare inpatient payments (2011 and 2012 for most hospitals, ten year value for rural hospitals with special payment status).

34%  Medicare patient percent of total hospital days.

With Medicare being such an important payer to hospitals, will health reform implementation efforts be undermined by a weakened health care delivery system?

Will revenue increases associated with providing care to newly insured individuals beginning in 2014 make up for the magnitude of Medicare payment cuts to hospitals legislated in the ACA?

Will CMS continue to ignore real increases in patient severity and persist in applying these additional unnecessary and methodologically flawed regulatory Medicare payment cuts to hospitals?

Timeline of ACA's Medicare Payment Cuts to Hospitals (Includes CMS' coding offset to inpatient payments in 2011 and 2012)

2010  Medicare update factor cuts (Regulated pre-determined values) begin and continue through 2020 for all Medicare payment Systems [ACA].

2011  Medicaid update factor cuts (Regulated "productivity offset" values) begin and continue in perpetuity for all Medicare payment Systems [ACA].

2012  Medicare update factor cuts (Regulated "productivity offset" values) begin and continue in perpetuity for all Medicare payment Systems [ACA].

2013  Medicare readmission payment policy cuts inpatient payments to most hospitals and the Medicare hospital VBP program redistributes inpatient payments between all hospitals. These programs continue in perpetuity [ACA].

2014  Medicare and Medicaid DSH cuts and Medicare cuts to home health providers through payment rebasing begin and continue in perpetuity [ACA].

2015  Medicare NAC payment policy cuts inpatient payments to one-quarter of all hospitals begin and continue in perpetuity [ACA].
Upstate Dollars at Risk

- Upstate population of 5.9 million is 30% of total state 19.5 million
- Upstate annual Medicare payments of $2.8 billion are 22% of total state payments of $12.5 billion (2009 numbers)
- So, 22% of $10 billion over ten years from the ACA approximates $2.0 billion less to upstate from ACA over next 10 years or $200 million per year less
II. Medicaid
"Medicaid is hugely wasteful and inefficient. Don't trim Medicaid. Redesign Medicaid, overhaul Medicaid."

"Bring the stakeholders in the room...you tell me now to make the program work better, how to redesign the program. We can adjust the reimbursement rate, or we can redesign."

"Where do you cut the money? You're going to cut funds where you spend them. You have no economic future if New York is the tax capital of the nation. To raise taxes to raise more revenue is not the answer."
The Gamer

Using stealth, seduction, and the threat of a government shutdown, Andrew Cuomo is on the verge of winning round one in the perennial battle of the governor versus Albany.

By Chris Smith  Published Mar 27, 2011

Governor Andrew Cuomo is performing what he calls his Toto act. He’s played the part all over New York State, relentlessly, since January, traveling from Amherst to Binghamton to Watertown. Today he is on Long Island, in Patchogue, at St. Joseph’s College. The audience on a winter Wednesday morning is roughly 200 professors, students, and local retirees. Cuomo opens with a joke about arriving late this morning and being confronted by a nun—triggering pangs of nostalgic guilt from his own years in parochial school. Then it’s on to his beloved slideshow of budget horrors: a $10 billion state deficit! Medicaid spending scheduled to increase by an unsustainable 13 percent! Public-school bureaucrats making $300,000 salaries—even more than New York pays its governor!
January 2011: NYS Budget Deficit
$43 Billion Over Next Three Years

Source: Division of Budget, February 2011
Overview –

Historical Medicaid Spending ($ in Billions)

State share will increase markedly in 2011-12 due to local cap and phase-out of enhanced Federal financial participation.
Governor Cuomo’s Proposed Cuts

Largest Medicaid Cuts in History

• First year impact of $5.9 billion represented a 13% cut for 2011-2012

• Second year cut of $9.1 billion represented a 15% cut for 2012-2013
• 20% of beneficiaries drive 75% of spending
• Multiple co-morbidities, medically complex
NYS DOH Medicaid Reform Team Recommendations

Save $2.3 billion for the state:

- Provider Rate Reductions
- Cap on Future Medicaid Spending with an Enforcement Mechanism
- Patient-Centered Medical Homes
- Care Management for Medicaid Population
NYS DOH Medicaid Reform Team Recommendations

- Controls on Personal Care and Home Health
- Controls on Utilization of Certain Optional Benefits
- Regulatory Streamlining and Reform
- Medical Malpractice Reform
Enacted State Budget Reduces Projected State Deficits

Combined Four-Year Gap Reduced From $63 Billion to Less Than $10 Billion
## Summary of MRT

### Savings By Sector (State Share)

<table>
<thead>
<tr>
<th>Sector Proposals</th>
<th>Number of Proposals</th>
<th>MRT Reform Savings</th>
<th>1.7% Trend Reductions</th>
<th>Across the Board Cuts</th>
<th>Total Reductions</th>
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<td>All Sector Crossover</td>
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<td>Eligibility</td>
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<td>Fraud and Abuse</td>
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<td>FS Clinic &amp; Practitioner</td>
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<td>Hospital</td>
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<td>$ (28)</td>
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<td>$ (84)</td>
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<td>Non-Inst. LTC</td>
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<td>Nursing Homes</td>
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<td>$ (48)</td>
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<td>Pharmacy</td>
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<td>$ (41)</td>
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<td>Transportation</td>
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<td>Sector Sub-Total</td>
<td>79</td>
<td>$ (1,138)</td>
<td>$ (186)</td>
<td>$ (345)</td>
<td>$ (1,669)</td>
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Global Cap

Traditional Payment Cuts
- Trend factor
- 2 percent reduction
- Premium reduction
- Various other

Utilization Changes/Limits
- Personal care
- Behavioral health
- Benefit limits
- Enrollment (relationship to economy)

Redesign
- ACOs, health homes, dual eligibles, medical homes
- Medical Indemnity Fund
- Managed care, MLTC, SNPs, BHOs

Payment Methodology Changes
- Hospital payment and quality linkages
- Nursing home pricing
- Home care payments

Medicaid Savings Allocation Plan (if necessary)
Overview: Historical Enrollment

Medicaid Caseload (Including FHP)

Recession 12-01 to 08-02
Mid Peak of 1.265.824
April 2001

Recession 09-08 to 12-08
April 2008
Mid Peak of 2.725.456
April 2009

FHP expanded to 100% Effective April 08

Projected Enrollment
Actual Enrollment
Margins on Medicare and Medicaid Less in Upstate

2009 Estimated Medicare and Medicaid Margins
Data Sources: 2009 SPARCS, 2008 ICR’s, 3M Grouper Pricer

<table>
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<tr>
<th></th>
<th>Upstate</th>
<th>Downstate</th>
<th>NYS</th>
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<tr>
<td>Medicare Margin</td>
<td>-3.7%</td>
<td>3.1%</td>
<td>1.6%</td>
</tr>
<tr>
<td>Medicaid Margin</td>
<td>-3.8%</td>
<td>-5.0%</td>
<td>-4.8%</td>
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<tr>
<td>Combined Medicare &amp; Medicaid Margin</td>
<td>-3.7%</td>
<td>0.4%</td>
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Insurance Premiums Less in Upstate
III. Physicians in Health Reform
Physicians per 100,000 and Regional Increases (%), 2005 – 2009
Center for Workforce Studies – 2010 - Albany, NY

Figure 1. Map of CHWS New York Health Workforce Regions

- North Country: 198/15
- Mohawk Valley: 172/5
- Central NY: 264/7
- Western NY: 252/11
- Finger Lakes: 284/11
- Southern Tier: 256/12
- New York City: 393/5
- Hudson Valley
- Capital: 278/12
- Long Island
Most Physicians Are Not in GEMS
Hospitals’ Race to Employ Physicians — The Logic Behind a Money-Losing Proposition

NEJM | March 30, 2011
Hospitals’ Race to Employ Physicians — The Logic Behind a Money-Losing Proposition
NEJM | March 30, 2011
Group Employed Models

- Mayo, Cleveland, Geisinger, Guthrie, Bassett
- Physician led
- Collaborative
- Information system support
- Salaried with incentive or variation – blunted fee for service incentive
- Linked to hospitals
- Collective accountability
- Lower costs and better outcomes, no sense of rationing
Emerging Thinking

- Physicians exert control over 65% of expenditures
- Accountability of physicians for overall resource utilization is not inherent in the fee for service system
- New models emerging – bundling, global payments for episodes of care
- Accountable Care Organizations
- Emphasis on group employed models which have lower costs and utilization and good outcomes
What Happens Next?
Number of Workers Per Social Security Beneficiary 1950-2075

Source: Social Security Administration, 1998 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds.
Fischer 2006; Shortell and Casalino 2007

“local entity and related set of providers…. primary care, specialists and hospitals…. held accountable for the cost and quality of care delivered to….. a defined subset of Medicare beneficiaries or health plan subscribers…."

Accountability through changes in Medicare payment based on quality and spending measures
Accountable Care Organizations
Specific Entitlement Reform / Deficit Reduction Proposals Being Considered on the Hill

Block Granting the Medicaid Program:

House-passed GOP budget resolution would reduce federal support for the Medicaid program by $771 billion nationwide, $90 billion to New York, over 10 years by changing the financing mechanism of the program to a block grant.

- HANYS opposes proposals to reduce federal support for the Medicaid program.
- Divesting the federal government of its role as a fair financial partner with states and protector of a minimum benefit package would undercut New York’s finances and further weaken the finances of its hospitals and health systems, while undermining health coverage for millions of New Yorkers.
V. Adaptive Responses

And if You Don’t Come In from the Cold…

“Then, I thought, Hey, hold on a minute—maybe failure is an option.”

The New Yorker, 2007
“It is not the strongest who survive, or the fastest. It is the ones who can change the quickest.”

Charles Darwin
“On The Origin of Species”
“Transforming Not-for-Profit Healthcare in the Era of Reform”
Moody’s Investor Services May 2010

- **Growth strategies to drive revenues and achieve critical mass**
- **Physician alignment to prepare for global reimbursement**
- **Investment in more information technology to further cost and quality initiatives**
- **Effective management and governance, driving long-term financial sustainability.”**
Hospital Leadership Opportunities

- Reframing the future of organizations—need to consider integration, mergers, consolidations to survive
- Exploring new arrangements with physicians
- Attention to operational efficiencies and quality improvement
- Strong link with communities to enable communication about change
Adaptive Responses

- Not just hospitals (Margie Keith, Moderator)
- Local government (Don Barber)
- Human Service Organizations (Pat Rogers)
- Public health, prevention, access (Will White)
Politics is a strife of interests disguised as a conflict of principles.

Ambrose Bierce, The Devil’s Dictionary