



State of the State Address Fact Sheet: **Medicaid Reimbursement Reform – Shift funding to primary and preventive care**

“As we move toward universal health care, we must also take steps to make health care more affordable for every family and every business in New York...Our best tool for this is to change reimbursement rates, encouraging prevention and primary care. Outdated reimbursement systems pay too much for some hospital-based procedures that technology has now made routine, and too little for primary and preventive care that should be routine... We must start paying for the right care in the right setting at the right price”

-Governor Eliot Spitzer (January 9, 2008)

The Challenge

- Medicaid covers 4.5 million New Yorkers and spends over \$45 billion annually –nearly one third of all health care spending in the State, making it the single largest health insurer in New York State.
- We must use our market position to buy value (high quality/cost effective care) for Medicaid beneficiaries and thereby influence the delivery of care for all New Yorkers.
- Medicaid’s payment policies are outdated, paying too much for inpatient care and too little for ambulatory care and using payment methods that are not sensitive to the intensity or quality of the care provided.
- Medicaid payment rates for primary care are too low. For hospitals and free-standing clinics, the rates have been frozen for more than a decade. Physician fees in New York are the second lowest in the country.
- As we enroll the 1.3 million uninsured children and adults who are eligible for Medicaid, CHPlus and Family Health Plus insurance programs, we must make certain we have the physicians available to care for them.

Our Approach

- Medicaid will provide additional support to outpatient services in hospital clinics, community clinics and doctors offices and pay added amounts to physicians practicing in underserved areas of the State. Details will be provided in the Executive Budget.
- Effective January 2008, the Department of Health will begin to phase-in new “service intensity weights” (SIWs) which are used by the Medicaid Program to determine payments for inpatient services at hospitals based on diagnosis. These new SIWs will more accurately reflect the resources required to provide hospital care.

- SIWs need to be updated because over the last 15 years there have been many improvements and efficiencies for certain procedures that have reduced costs. When we update the weights we should be reimbursing less for those procedures. Weights of certain services could be going down because of shorter lengths of stay, advanced clinical treatment protocols and modern technology, and less intensive nursing care. For those going up, longer lengths of stay and shifting of easy cases to the outpatient setting means that those requiring hospital care are more severe and therefore more intensive and costly. For example, weights and related reimbursement for care for premature babies and chemotherapy are going up and the weights for cardiac defibrillators and lung transplants are going down.
- We will update the 1982 inpatient base year which is currently used to establish inpatient rates so that inpatient Medicaid rates more closely track inpatient costs. Today, we are overpaying, in part because our payment system has not accounted for medical advances which have helped lower costs for some treatments.
- Medicaid will pay for care that has been proven effective, such as diabetes and asthma educators, and pay less for care that is not effective.
- The Department of Health will begin to collect the data and develop standards to enable Medicaid to stop paying for events that should never happen and pay reduced amounts for events that could have and should have been prevented.
- DOH will review and monitor the care received by Medicaid beneficiaries to ensure that it conforms with clinically sound and well established quality and safety criteria.