



## **HANYS' Board of Trustees Health Reform Policy Priorities**

September 2009

### **Health System Savings Proposals**

#### Annual Medicare Marketbasket Updates

In both the U.S. House of Representatives and the Senate, a major policy aimed at discounting Medicare reimbursement to inpatient hospitals and continuing care providers is through the long-term reduction of Medicare reimbursement inflationary increases, called marketbasket updates. Proposals in each chamber to cut payments in this manner would reduce Medicare payments by approximately \$12.9 billion to New York's hospitals and continuing care providers over ten years. However, the reductions would not stop after ten years, as neither the House nor the Senate provisions would sunset at the end of the ten-year budget window.

The majority of the marketbasket cuts are tied to offsetting projected increases in productivity. Currently, there is no health care measure of productivity and we are concerned about congressional use of a Bureau of Labor Statistics economy-wide productivity measure as a proxy for health care productivity.

We believe it prudent for Congress to establish a trigger mechanism to implement the marketbasket reductions linked to offsetting productivity gains. The trigger should require that cuts go into effect only if benchmarks for projected coverage increases and health insurance administrative simplification reform are successfully achieved.

Annual Medicare marketbasket updates to hospitals and continuing care providers are designed to capture the rate of cost increase for certain categories of goods and services efficient providers must purchase for the provision of care. These goods and services include wages, pharmaceuticals, medical devices, blood, and energy. Providers rely on marketbasket updates to increase Medicare payments that often do not cover the cost of providing care, even when a full update is provided. For example, approximately half of all New York hospitals experienced negative overall Medicare margins in 2007, the last year for which complete data are available.

The importance of Medicare as a payer to New York State hospitals and the negative ripple effect of cuts cannot be understated. In 2006, 45% of all inpatient hospital days were for care provided to Medicare patients.

While the marketbasket update is intended to reflect cost increases, it has taken on more complex functions. Per legislated changes, receipt of a full update now also functions as a financial incentive related to quality reporting and will soon be linked to hospital adoption and use of health information technology (HIT). Hospitals and home health agencies that fail to successfully submit quality data to the Centers for Medicare and Medicaid Services are subject to a two percentage point reduction in their marketbasket update. In 2015, hospitals that have not yet achieved the status of a "meaningful user" of HIT will have their marketbasket all but eliminated.

In short, the marketbasket update functions no longer as an independent variable that can be altered to achieve budget savings—it is also a financial incentive to achieve quality and HIT goals.

*We urge the Delegation to limit the magnitude of Medicare marketbasket cuts to hospitals and continuing care providers over the ten-year budget window, ensuring that the provision reducing payments explicitly sunsets at the close of that window. Any marketbasket cuts tied to productivity increases should go into effect only if benchmarks for projected coverage increases and health insurance administrative simplification reform are reached.*

### **Disproportionate Share Hospital Payments**

The House and Senate health reform bills propose significant reductions to both Medicare and Medicaid Disproportionate Share Hospital (DSH) programs. DSH payments are a lifeline for hospitals that provide significant levels of care to Medicare, Medicaid, uninsured, and underinsured patients.

We believe that even if health care reform achieves significant coverage expansions, hospitals will continue to bear the burden of providing health care and essential community services to populations that will remain uncovered or underinsured, including significant numbers of undocumented individuals.

DSH provides financial support to hospitals throughout New York State, enabling them to care for our state's most vulnerable while supporting specialty services that would otherwise be significantly less accessible to all. DSH payments help cover not only losses due to uncompensated care, but also the additional costs incurred in serving poor and disadvantaged populations, including recognizing the value of Medicaid payment shortfalls.

The Medicare DSH program furnishes support for rural and urban institutions for the provision of care to many low-income people. The Medicaid DSH program supports a broad array of services for Medicaid, uninsured, and underinsured children and adults, such as chronic disease management, preventive care, dental care, and child abuse screening.

Low-income and disadvantaged populations are more likely to have chronic conditions or other complicating factors that increase the cost of care. DSH payments help cover the costs of providing that care. Further, Medicaid DSH funds help support essential community services such as trauma and burn care, pediatric intensive care, high-risk neonatal care, and emergency psychiatric services.

Proposals under consideration that would reduce DSH payments are generally tied to reductions in the number of uninsured individuals. These proposals should ensure that any determination of the number of uninsured individuals include all people residing in the United States, regardless of citizenship status. Excluding uninsured, undocumented immigrants from the count of uninsured people overall would inappropriately penalize states and providers serving a disproportionate number of people ineligible for new coverage. Federal law and the mission of all hospitals require that any individual needing care must be provided that care, regardless of citizenship status or ability to pay.

We believe it prudent for Congress to establish an additional trigger mechanism to implement the reductions. The trigger should require that cuts go into effect only if benchmarks for health insurance administrative simplification reform are successfully achieved.

***We urge the Delegation to ensure that Medicare or Medicaid DSH payments are fully protected until real coverage expansion takes hold and health insurance administrative simplification benchmarks are reached. The level of the reductions must preserve DSH payments in a manner consistent with the continuing responsibility of hospitals, including safety net hospitals, to serve ALL uninsured and underinsured patients in their communities, including continuing to recognize the cost of Medicaid payment shortfalls.***

### **Medicare Delivery System Reform**

New York hospitals, health systems, and continuing care providers support thoughtfully designed Medicare quality-related reimbursement reform proposals that align incentives to improve care quality and reward provider performance excellence. Well designed, value-based purchasing, hospital readmissions, bundling, accountable care organization, and medical home model proposals have the promise of improving the quality and coordination of care, while creating efficiencies that should generate savings over time.

It is crucial that delivery system reform ensures that providers facing the greatest challenges to improving care, and those continually striving to achieve excellence, are afforded the opportunities and resources to do so. The true long-term savings that can be achieved with these policies should be generated from improvements in performance and quality outcomes, not from discounting reimbursement.

HANYS and physician members of HANYS' Statewide Steering Committee on Quality Initiatives have discussed in detail these proposals with authorizing committees in both congressional chambers and have submitted detailed comments in writing. Below we indicate some key points that must be considered in the development of delivery system reform proposals.

#### Hospital Value-Based Purchasing

We are pleased that the House and Senate have rejected earlier proposals that would significantly reduce spending for value-based purchasing (VBP) and are instead advancing budget-neutral, VBP provisions that include incentives for both attaining specific quality goals and for achieving a certain rate of quality improvement.

VBP systems should ensure that payment penalties do not result in increases in the inequality of health care delivery—with poor performers' resources reduced, preventing them from investing in the steps necessary to improve quality. Further, payment incentives to top performers should be a true incentive and not just a recoupment of funds contributed to the VBP incentive pool.

In addition, we believe the VBP pool should be limited to 1% of total Medicare Inpatient Prospective Payment System (IPPS) payments for only Medicare severity-diagnosis related groups (MS-DRGs) associated with quality measures in use, as opposed to all MS-DRGs in the IPPS system. It is excessive to reduce payments to all MS-DRGs when a hospital will be rewarded or penalized based on its performance on only a subset of MS-DRGs.

***We support including in health reform a well designed and budget-neutral VBP provision that would reward providers for both attainment of a quality goal and improvements made to achieve that goal.***

### Hospital Readmissions

Researchers are beginning to uncover the multitude of variables that may influence whether a patient is readmitted to a hospital; yet, we remain far from understanding how, when, and to what degree these variables matter and how to diminish their impact. Hospital readmissions are complex, system-wide problems that involve the whole continuum of care, including hospitals, physicians, post-acute providers, patients, and their families.

While some readmissions could potentially be avoided if patients received appropriate and timely care, many readmissions may be unavoidable due to a multitude of factors, including the natural progression of the underlying disease, the complex nature of the patient's condition, lack of patient compliance with discharge instructions, and a lack of appropriate resources in the community.

HANYS strongly urges Congress to focus exclusively on including cases of unplanned and preventable readmissions for which the reason is related to the initial admission (e.g., a patient is admitted for an emergency appendectomy, discharged, and then readmitted the following week for a surgical site infection). Readmissions provisions should exclude certain conditions considered unpreventable, such as those associated with chronic conditions and specific diseases, like cancer, as well as planned readmissions like scheduled surgeries. Behavioral health complications or comorbidities also add to the unpredictability of readmissions and should be a basis for exclusion.

Risk adjustment is a necessary part of any reasoned and productive readmissions proposal. We encourage Congress to ensure that any readmission policy option has a strong clinical risk adjuster, ensuring hospitals that treat sicker patients are not unjustly penalized. We urge Congress to direct the Secretary of Health and Human Services (HHS) to conduct research into variables beyond the reach of the hospital such as patient socio-economic status, patient compliance, access in the community to timely primary/ambulatory follow-up care, and others that likely influence readmission rates. From this research, a non-clinical risk adjuster should be developed and applied.

To date, the House has embraced an aggressive readmissions provision using an inappropriately long 30-day readmissions window that would cut payments by \$16 billion nationwide over ten years through across-the-board payment reductions, as opposed to reducing payments only for the conditions subject to the readmissions policy. The Senate Finance Committee, through seven- and 15-day readmission window policies, would seek more modest savings by focusing on related and preventable conditions. Each proposal would reduce payments to hospitals deemed to have readmissions rates considered "high." No regard is given for hospitals that make gains in reducing readmission rates. We encourage Congress to maintain full reimbursement for hospitals that improve performance and reduce readmissions rates, as well as those that have rates below a target level.

***We support including in health reform a well designed and narrow readmissions policy focused on generally recognized preventable and related readmissions, appropriately modified by both a clinical and a socio-economic risk adjuster. We urge that readmissions provisions refrain from reducing hospital payments when hospitals show either improvement in reducing readmission rates or in achieving readmission rates below any targeted level.***

### Payment Bundling, Accountable Care Organizations, Medical Home Models

We commend the House and Senate for seeking to establish pilot programs as a solid first stage in developing policies associated with bundling, accountable care organizations, and medical home models. Analyzing the results of the pilot programs to ensure the best methods of moving forward with any nationwide policy on these concepts makes sense, given the tremendous variety of health

care delivery systems across the country and numerous laws and regulations that must be modified before nationwide payment reform can be developed and implemented. Further, pilots would test and define payment mechanisms and allow providers to develop provider coordination arrangements.

*We support the concept of payment bundling, accountable care organizations, and medical home models and the goal behind each to incentivize providers to act in concert to coordinate patient care, creating efficiencies, and improved care delivery for patients. We believe strongly that Congress should ensure that any acute/post-acute care bundle be broadened to include physicians—without which the goal of the policy cannot be met. Congress should also incorporate anti-trust protections for providers seeking to work together to better align payment incentives.*

### **Medicare Graduate Medical Education**

We commend the House and Senate for supporting the nation's teaching hospitals and academic medical centers by preserving in health reform legislation current funding levels of Medicare and Graduate Medical Education (GME).

New York teaching hospitals and academic medical centers rely on support from the Medicare and Medicaid GME programs for the pursuit of the public good of training physicians and other health care providers, furthering and disseminating research, and furnishing highly specialized care to the most medically complex patients. The teaching hospital mission further encompasses delivery of the preponderance of critical services such as trauma and burn care, along with the vast majority of uncompensated care.

Projections show the physician shortage experienced by communities across the nation will worsen over time. As coverage increases through comprehensive health reform, a greater need for physician services will take hold. Supporting the training mission of teaching hospitals and academic medical centers is more important than ever.

### Redistribution of Unused Graduate Medical Education Slots

We appreciate both the House and Senate provisions to increase the number of Medicare-funded GME medical resident slots through the redistribution of currently unused slots. In the reallocation of these slots, preference should be given to institutions currently training physicians in excess of their Medicare GME cap. As communities across the state and nation experience shortages of physicians and other health professionals, a further federal commitment to training doctors and other health professionals will be necessary, including raising the cap Medicare places on the number of medical residency slots the Medicare program will support at a particular institution.

Currently, approximately 40% of teaching hospitals and academic medical centers in New York State train a number of physicians that exceeds their allotted Medicare-supported residency slots. These institutions provide a public good by training new physicians above the Medicare cap, but do not receive support from the federal government for doing so.

Health reform should include provisions of the Resident Physician Shortage Reduction Act of 2009, recently introduced in the Senate by Finance Committee members Charles Schumer (D-NY) and Bill Nelson (D-FL) and in the House by Representatives Joseph Crowley (D-NY), Kathy Castor (D-FL), and Kendrick Meek (D-FL). The bill would increase the total number of Medicare-supported medical resident training slots (frozen since 1996) by 15%, or about 15,000 slots. This increase would be achieved through a combination of reducing medical resident caps at hospitals with unused

positions and supplementing those positions by creating additional new medical residency slots. The bill places a preference on increasing primary care and general surgery residencies.

***Increased Medicare support for training medical residents is critical, as the physician shortage in New York and throughout the nation persists and is projected to worsen. We support the redistribution of currently unused medical resident slots along with increasing the number of slots Medicare supports by 15%.***

#### Greater Flexibility for Residency Training Programs

We support both the House and Senate proposals to increase Medicare support for hospitals that train residents in non-hospital settings such as physician offices or other outpatient care settings, and for counting medical resident time spent on certain non-patient care activities, such as didactic and scholarly activities. Current policies are extremely restrictive and often result in the disallowance of Medicare GME payments to providers for these types of training activities. The Resident Physician Shortage Reduction Act of 2009 also contains HANYS-supported provisions to achieve these goals.

***We support modernization of GME training language to allow Medicare support for the training of residents in non-hospital settings.***

#### **Geographic Variation**

Two provisions in the House legislation relate to payment adjustments among regions to address perceived differences in the value of services provided and the Medicare price paid. Regional variation in per capita health expenditures is a legitimate area of inquiry. Currently, the causality of this variation can be explained only in part through the available literature, most of which approaches this complex issue with simplistic analytical framework.

Questions regarding the cause of geographic variation in spending as well as any links between quality of care or associated patient outcomes and spending levels should be examined thoroughly. We believe that such a rigorous analysis must consider key variables including:

- input prices, such as labor costs;
- socio-economic issues—income levels, race, education, and cultural variations result in differences in patient needs and treatment patterns;
- patient compliance;
- practice patterns;
- payment policies related to GME and DSH;
- health care outcomes, and
- provider organizational models—variation in care delivery systems from one community to the next, including the availability of post-acute services.

#### IOM Value Index Study

The House has developed a set of provisions that would direct the Institute of Medicine (IOM) to rigorously analyze geographic variation and develop recommendations for the HHS Secretary for the establishment and application of a “value index” to adjust for unwarranted variation in Medicare spending. From there, the Secretary would present Congress a plan to implement the recommendations. The provisions would not allow Congress to modify the proposal in any way; only to approve or reject it.

Without a proper charge to IOM and the ability to influence the nature of any payment reform plans, Congress cannot make certain payment reform proposals are adequately and reliably tailored to account for the significant dissimilarity in the availability of health care services in different communities.

***We support a comprehensive and thorough analysis by IOM of the causes of geographic variation with an appropriate charge by Congress, including cost influencing factors that should be considered. We strongly urge Congress to retain its full authority to determine the nature of Medicare spending, and whether to adopt in whole or in part recommendations for addressing any inappropriate variations.***

#### The Medicare Wage Index for Hospitals

Of all of the adjustments that go into determining the reimbursement rate for hospitals and continuing care providers that care for Medicare patients, none is more controversial or in need of reform than the Medicare wage index. The wage index, Medicare’s “geographic adjuster” is flawed in many regards, including the use of a budget-neutrality adjustment, perpetuating inequitable Medicare payments to many providers across New York and the country.

A set of provisions in the House would direct IOM to report to the Secretary and Congress on the validity and effects of the Medicare wage index for hospitals and the geographic practice cost index (GPCI) for physicians, and make recommendations for improving both. Based on the analysis, the Secretary may propose policies to modify the Medicare wage index adjustment for hospitals and the GPCI for physicians to increase Medicare payment levels by up to \$4 billion per year for two years (\$2 billion per year to hospitals, \$2 billion per year to physicians).

During year three of implementation, the new money/hold harmless provision expires. Any changes the Secretary wants to continue making to the wage index would be budget-neutral and therefore redistributive within New York State and in the aggregate, from the state to elsewhere in the country.

***We support allowing hospitals in areas with low wage indexes the opportunity to receive higher wage index adjustments, while holding all other hospitals harmless through the permanent infusion of funding into the Medicare wage index system.***

#### **New Federal Medicare Payment Commission**

We are disappointed that both the House and Senate have indicated interest in establishing a new federal entity, or expanding the current authority of the Medicare Payment Advisory Commission (MedPAC) with unprecedented and extraordinary powers to determine levels of reimbursement and related Medicare policies for hospitals, physicians, and other providers of health care services.

Creating a new federal entity with the authority to set Medicare payment levels takes critical decisions about the level of funding for health services out of the purview of Congress and places it the hands of unelected individuals who serve at the pleasure of the Executive. We are convinced this would lead to significant funding cuts and redistributions, and would expose us to other potential unilateral “reform” proposals. Funding decisions from the level of annual inflationary increase (marketbasket adjustment), to the level of Indirect Medical Education (IME) funding, to payment policies as far-reaching as broad-based bundling, could be made by such an entity.

MedPAC, which currently serves in an advisory capacity to Congress on Medicare issues, provides ample evidence of the potential risk of such a provision. Repeatedly, MedPAC has made

recommendations to reduce critical provider funding such as cutting IME in half, despite the growing physician shortage, and suggesting major changes to Critical Access Hospitals (CAHs) that would have decreased the number of CAHs serving rural America. These recommendations are made based on national “average” measures, without fully appreciating the consequences for New York or any other state that is not “average.” More often than not, Congress has understood the consequences and rejected these recommendations.

***We unequivocally oppose proposals under consideration that would create a new federal entity with the authority to set Medicare payment levels. It is imperative that Congress maintain its role in determining overall funding for health services and in framing conditions for reform. Congress cannot allow an entity that is largely unaccountable to the American people to have virtually unlimited authority in determining how the health care system is funded.***

### **Coverage Expansion**

#### Options of a Public Plan or Consumer-owned and Consumer-oriented Plans (Cooperatives)

In addition to Medicaid expansion and the creation of a Health Insurance Exchange, we believe robust health insurance market reform and administrative simplification would yield significant increases in the accessibility and affordability of health insurance, reducing the number of uninsured and underinsured Americans. These proposals would improve the condition of hospitals and health systems and the patients they serve. Implementation of these proposals should be closely monitored, with mechanisms to correct for unintended consequences or policy failures to secure increased coverage and reduce insurance product costs.

We believe that any public plan option or cooperative should ensure that provider reimbursement is rational and covers the cost of providing care and fulfilling the mission of health care providers to furnish the care their communities deserve. We strongly urge Congress to ensure that any public plan or cooperative allow providers to negotiate reimbursement rates in a meaningful manner with the administrator of the plan.

***We urge Congress to ensure that any public plan or cooperative option allows providers to negotiate reimbursement rates with the plan administrator. If Congress establishes a public plan option, we urge it be implemented in targeted geographic areas only if insurance market reform and administrative simplification fail to achieve coverage increase benchmarks.***

#### Medicaid Expansion

We support the expansion of Medicaid as one mechanism to increase insurance coverage. Provisions in the House and the Senate would require that all state Medicaid programs raise income eligibility for pregnant women, children, and parents beyond the current minimum levels. Under these proposals, the federal government would cover the entire cost of the expansion for a period before states would assume that responsibility in a phased-in manner. New York State’s Medicaid program already covers individuals beyond the thresholds currently under discussion in health reform and, as such, would not benefit from the infusion of federal funding as would other states that have less generous programs. Indeed, the inclusion of an individual mandate would clearly result in an increase in state Medicaid costs for those low-income individuals currently eligible but not enrolled.

The current House provisions would recognize that New York and a dozen other states have expanded their Medicaid programs in advance of federal reform—and provide enhanced federal

matching for some existing enrollees or eligibles. The current Senate bill only provides enhanced federal funding for newly eligible populations—in New York, single adults between 100% and 133% of federal poverty levels. The Senate provisions are estimated to cost New York State between \$900 million and \$1.6 billion in increased state spending, depending on whether New York reduces Medicaid eligibility levels to the minimum (e.g., 133% of the federal poverty level for single adults) in 2014. It is unfair for states that have endeavored to do the right thing to be penalized for their positive social policies. Moreover, New York and other states are ill-equipped in the current fiscal environment to absorb this cost of expanded coverage.

*We support health reform provisions to expand Medicaid coverage. However, the increased federal funding should take into account states that have already increased their eligibility standards to the specified levels so that additional federal Medicaid funding should be available to all states that meet the specified levels, no matter when the expansion was implemented.*

### **Insurance Market Reform**

We fully support several health insurance reform provisions under consideration in both the House and Senate. These provisions include important marketplace improvements for patients, such as prohibiting insurance companies from refusing coverage due to the presence of a pre-existing condition, and guaranteed issue and renewal of coverage.

A set of provisions address some of the challenges and the costs hospitals and other health care providers face through duplicative regulations, compliance burdens, and myriad different claims processing and recordkeeping requirements that vary with each insurance plan. These administrative simplification provisions would make major advances in rationalizing and standardizing insurance administrative requirements.

For example, one provision would require insurers and providers to use common standards for transactions such as claims payment, eligibility, and enrollment, building on the Health Insurance Portability and Accountability Act of 1996.

The efficiencies that would be gained by the implementation of the administrative simplification provisions in the House and Senate bills would enable health care professionals to spend more time at the bedside and less on paperwork. Further, these provisions would reduce provider administrative costs—costs not associated with the delivery of patient care—that currently comprise between \$145 billion and \$294 billion of our nation’s annual health care spending.

*We support the insurance market reform aimed at instilling fairness for patients in the health insurance marketplace while reducing costs and relieving the vast administrative burden currently facing providers. We urge Congress to include additional provisions that would standardize the collection and reporting of quality data for both public and private payers.*

### **Tax-exempt Hospital Status**

All acute care hospitals in New York State are either public hospitals or not-for-profit. Organized under Section 501(c)(3) of the tax code, not-for-profit hospitals are generally exempt from federal income tax, are eligible to receive tax-deductible contributions, have access to tax-exempt financing through state and local governments, and generally are exempt from state and local taxes. Since

1969, the Internal Revenue Service has applied a “community benefit” standard for determining whether a hospital meets its charitable, not-for-profit mission.

The current community benefit standard allows hospitals the flexibility necessary to determine the specific needs of their communities and address those needs with a creative mix of solutions. What a community in Manhattan needs may not be the same as a community in the Adirondack Mountains.

New York hospitals and health systems accept the responsibility to demonstrate value and accountability to their communities. They provide a multitude of inpatient, outpatient, emergency, and other health care services; uncompensated care; and financial aid. They also provide a vast array of health education, prevention, and outreach initiatives such as diabetes and asthma care, breast health screenings, obesity prevention and nutrition programs, healthy heart programs, child and adolescent programs, dental health programs, and assistance for helping uninsured people find health care coverage, all of which make immeasurable contributions to communities across the state.

New York hospitals demonstrated their commitment to treating all patients with compassion from the bedside to the billing office, regardless of ability to pay in 2004 when HANYS’ Board of Trustees developed and adopted financial aid/charity care voluntary guidelines that were universally adopted by hospitals across the state. The guidelines were embraced by the New York State Legislature and became law in 2006, requiring hospitals to provide free or discounted care to patients up to 300% of FPL, according to a sliding scale.

In addition, all New York hospitals are required under state statute to annually submit a Community Service Plan (CSP) to the New York State Department of Health. These plans require hospitals to detail how they have assessed the health care needs of their communities and describe the hospital’s plans to address those needs.

*We support flexibility in how not-for-profit hospitals and health systems report community benefit to best suit the realities and disparities of need within varying communities. We oppose the establishment of an arbitrary percentage of revenue as the level of charitable patient care that must be delivered to allow a hospital to retain its tax-exempt status.*

### **Medical Liability Insurance**

The explosive growth in medical malpractice insurance premiums is exerting great fiscal pressure on hospital finances. Virtually every year, malpractice rates skyrocket (up 14% in 2007 alone), driving physicians to other states and out of high-risk practices such as obstetrics/gynecology and neurosurgery. It is not unusual to see annual premiums as high as \$200,000 or more for a single physician—a level that is simply unsustainable.

Moreover, malpractice costs are compounded, since both physicians and hospitals are compelled to obtain costly coverage. The high cost of malpractice has exacerbated physician shortages in many areas of the state and discouraged countless practitioners from establishing practices in New York State. Moreover, exorbitant premiums paid by hospitals have a profoundly negative impact on the availability of resources necessary to meet basic operational demands.

Millions of dollars wasted on an irrational and grossly ineffective malpractice system would be better spent on core hospital functions, such as adding or augmenting essential services, addressing staffing shortages, and investing in health information technology.

The President has announced his Administration will make available limited funding—\$25 million nationwide over three years—to be used to establish modest demonstration programs to address liability reform. The Senate Finance Committee has suggested a “Sense of the Senate,” stating support for demonstration projects to test alternatives to the current civil litigation system as a means to reducing the financial burden to providers of medical liability insurance.

*We encourage Congress to move beyond these actions and take a more aggressive stance to address the burdens associated with the current medical liability system. We urge the adoption of a medical indemnity fund, which would provide an alternative financing mechanism for specific, high-cost cases involving neurological impairment, and a mechanism to reduce the cost of insurance for physicians. In addition, administrative compensation systems, medical courts, and the promotion of a “sorry works” program to encourage physicians to be candid with patients without fear of reprisals, should be actively pursued. Finally, we urge Congress consider the establishment of caps on non-economic (pain and suffering) damages.*

### **Health Information Technology (HIT)**

Congress and the Obama Administration have shown tremendous leadership in developing the HIT provisions of the American Recovery and Reinvestment Act, known as Health Information Technology for Economic and Clinical Health (HITECH). HITECH represents an unprecedented commitment by the federal government to promote the widespread adoption and use of HIT with the goal of ensuring every American has an electronic health record (EHR).

Inpatient acute care hospitals and non hospital-based physicians will qualify for the temporary Medicare and Medicaid incentive payments authorized by HITECH only after they have in place a “certified” EHR and are “meaningful users” of HIT, soon to be defined by the Centers for Medicare and Medicaid Services. Inpatient rehabilitation, psychiatric, cancer, and long-term care hospitals, along with skilled nursing facilities, home health agencies, and hospices are not eligible for the incentive payments. HIT adoption is needed among all providers because of its benefits in the coordination of care and improved quality across the continuum of care.

While hospitals across New York State are committed to making investments in HIT to improve the quality of care delivered and reduce medical errors, adoption rates are low. Cost is the most significant barrier institutions face in the procurement, maintenance, and upgrading of HIT systems. During the current economic downturn, capital markets are severely restricted, making the prospects of borrowing for HIT projects bleak.

HITECH has allocated less than \$1 billion nationwide to state governments to establish HIT loan and grant programs to assist providers in making the initial HIT purchase of an EHR, to enable them to become meaningful users and thus draw down the incentive payments. This funding to states should be significantly increased to effectively enable hospitals to purchase EHRs.

*We urge Congress to include in health reform provisions to increase funding to states for grant and loan pools, enabling hospitals to access up-front capital to procure HIT systems that will be considered “certified” and used in a meaningful way. We also urge that Congress make providers throughout the continuum of care eligible for HIT incentive payments, to better serve the goal of widespread HIT adoption and use, and facilitate care coordination and quality improvement.*