NEW YORK'S PRIMARY CARE REIMBURSEMENT SYSTEM

A ROADMAP TO BETTER OUTCOMES

PRIMARY CARE DEVELOPMENT CORPORATION

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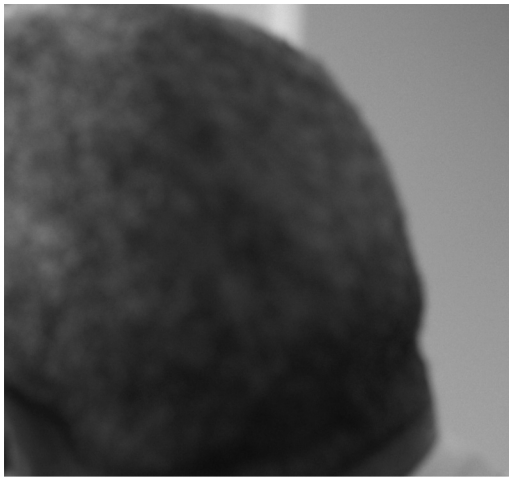
Certified Public Accountants






A REPORT PREPARED BY THE PRIMARY CARE DEVELOPMENT CORPORATION AND RSM MCGLADREY, INC.

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TABLE OF CONTENTS

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EXECUTIVE SUMMARY

This report by the Primary Care Development Corporation in conjunction with RSM McGladrey, Inc. analyzes New York's current reimbursement for the primary care sector, particularly for providers who deliver primary and preventive care in underserved communities, and offers principles and recommendations for reforming the reimbursement system. A thorough understanding of the financial systems is not only crucial to understanding the current primary care system—its shape, size, services, delivery mode, and shortfalls—but to developing a strategy for transforming it into a system capable of producing positive health outcomes while reducing unnecessary costs.

Ambulatory care includes patient services provided on an outpatient basis. This report focuses on a subset of ambulatory care, namely primary care. Primary care to the underserved in New York City (NYC) and New York State (NYS) is provided by three fundamental groups of providers: 1) hospitals in their outpatient departments and community-based satellite centers, 2) freestanding health centers (technically called diagnostic and treatment centers or D&TCs), and 3) private physician practices. Each is organized and reimbursed differently for services provided to the healthcare safety net population and, as a result, each sees a different mix of patients and offers a different model of care.

For this study, we present reimbursement data from New York City. Although the issues presented in the report are applicable to all NYS providers, we recognize that there are some regional variations in cost and rate structures. Additionally, we have segmented the institutional providers (i.e., hospitals and D&TCs) as follows:

We have segmented hospitals into:

- New York City Health and Hospitals Corporation (HHC) Outpatient Departments (OPDs)
- Voluntary Hospital OPDs and their affiliated Federally Qualified Health Centers (FQHCs)

We have segmented free-standing health centers into:

- HHC-affiliated D&TCs
- Federally Qualified Health Centers and Look-A-Likes (FQHCs/LAs)
- Other Comprehensive and Specially-Designated D&TCs

The Primary Care Reimbursement System and Financial Condition

As we analyzed the current primary care reimbursement system and the related financial condition of the sector, key issues emerged:

- Different payers reimburse providers differently for the same service.
- The same payer may pay differently for the same service depending on the setting in which it is delivered.
- Multiple managed care plans use different methods of payment and pay different rates.

These conditions create a reimbursement system that forces primary care providers to access a variety of other sources to fill the gaps where they can. Overall, the dysfunctional components of the current reimbursement system fall largely into three categories:

- The current system is inconsistent and inadequate in how it pays for primary care services and the services for which it pays.
- The current system lacks transparency, particularly with regard to exactly what is being purchased and how efficiently and effectively it is being delivered.
- The reimbursement system and current incentives are not aligned to promote positive health outcomes or to support a high-performing patient-centered primary care delivery system that produces them.

The Patient-Centered Primary Care Model

Recent discussions about healthcare reimbursement reform in NYS have reasonably tried to shift the focus from *who* do we pay to *what* do we want to pay for. In order to achieve positive health outcomes for patients and communities as cost-effectively as possible, the State should pay for a suite of specific services, functions, and operating standards that produce those outcomes at appropriate costs.

A new model of care has been shown to produce positive health outcomes, improve patient experience, and reduce costs. This model of patient-centered primary care—also known as Patient-Centered Medical Home—is more than having a regular source

of care and exceeds FQHC requirements for enabling services. Rather, it has the following enhanced characteristics. It:

- Emphasizes primary and preventive care in achieving better outcomes and using resources more efficiently.
- Creates an ongoing relationship between a patient and a personal provider trained to provide first contact, continuous, and comprehensive care.
- Is organized into provider-directed patient care teams that:
  - Work in partnership with the patient.
  - Collectively take responsibility for the ongoing care of patients and are responsible for the total care of the patient, including coordination across care settings (e.g., specialists, laboratories, x-ray facilities, hospitals, home care agencies, etc.).

Mounting evidence shows that patients who experience patient-centered primary care have better health outcomes. Examples of cost savings associated with Patient-Centered Medical Homes also are emerging. However, the current misaligned reimbursement system discourages these kinds of changes. It also is essential to make investments in the primary care sector to enable primary care practices and centers to offer this type of care.

Recommendations

Several principles should guide reimbursement reform.

- Pay Consistently and Adequately
- Be Transparent
- Align Incentives

Specifically, in order to generate change and design a high-functioning and efficient primary care reimbursement and delivery system, we offer the following recommendations:

Recommendation 1:
Create a Robust Ambulatory Care Data Reporting System

- Redesign Cost Reports for All Provider Settings
- Develop a SPARCS-like Data Reporting System

Recommendation 2:
Pay for Providing a Patient-Centered Primary Care Model

Recommendation 3:
Apply Payment Principles to Managed Care Organizations

- Include Patient-Centered Primary Care Elements in Reimbursement Rates
- Pass Pay-For-Performance Incentives to Providers and Make Consistent

Recommendation 4:
Realign Indigent Care Pool Funding Across Primary Care Sub-Sectors

Recommendation 5:
Revise Licensure Requirements to Allow Mental Health and Other Ancillary Services to Be Integrated into Primary Care

Restructuring the Primary Care Reimbursement System

So long as we adhere to the payment principles, many options are possible. We propose an approach combining several of the existing reimbursement structures to effectively construct a system that incentivizes providers to improve health outcomes while meeting the cost of providing the needed services.

By grouping services with similar cost-drivers and incentives and matching them with appropriate payment forms, a reimbursement model can "bundle" certain services into a capitation model and other services into a fee-for-service model to neutralize the potential incentive to a provider to under- or over-treat a patient based on the form of reimbursement. That type of model would satisfy the payer's concern for improving health outcomes and decreasing overall healthcare spending while at the same time ensuring that providers are reimbursed adequately. In addition, to be eligible for this reimbursement model, a provider must be certified as a patient-centered primary care provider, which would ensure that all elements of the model of care are provided and reported.

Whatever the details of the final blended model of payment, it is critical that both the form and methodology adheres to principles outlined in this report. Application of these principles for primary care reimbursement reform will help realign the NYS healthcare system toward paying for positive health outcomes while reducing overall healthcare spending.

☐ INTRODUCTION

Objective

This report was developed by the Primary Care Development Corporation in conjunction with RSM McGladrey, Inc. and with the support of the New York Community Trust. Founded in 1993, PCDC's mission is to promote effective, accessible, high quality primary and preventive care in underserved communities. For over thirty years, the Healthcare Services Team of RSM McGladrey, Inc. has been committed to supporting the development of strong and successful community health centers nationwide.

This report seeks to illuminate current reimbursement for the primary care sector, particularly for providers who deliver primary and preventive care in underserved communities, and offers principles and recommendations for reforming the reimbursement system. A thorough understanding of the financial systems is not only crucial to understanding the current primary care system—its shape, size, services, delivery mode, and shortfalls—but to developing a strategy for transforming it into a system capable of producing positive health outcomes while reducing unnecessary costs.

Defining Primary Care

The Institute of Medicine (IOM) defines primary care as "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health needs, developing a sustained partnership with patients, and practicing in the context of family and community."[1] General practitioners, family practitioners, internists, obstetricians, and pediatricians as well as mid-level practitioners (e.g., nurse practitioners and physician assistants) render primary care. Optimally, primary care is the first level of contact with the healthcare system, and primary care providers (PCPs) are the means by which patients access routine medical and preventive care and navigate through the healthcare system for needed diagnostic services, referral to specialists, and hospitalization.

Ample evidence illustrates the importance of primary care services at the community level. Multiple studies show that access to primary care lowers healthcare costs by increasing the use of preventive services and decreasing emergency room (ER) utilization and avoidable hospitalizations.[2] More importantly, it improves health outcomes for individuals as well as communities, which is reflected in indicators such as lower rates of infant mortality and complications from chronic conditions, such as asthma and diabetes.[3]

Defining the Safety Net

In New York State (NYS), the underserved or "healthcare safety net" population encompasses all low-income New Yorkers, including residents who are uninsured or underinsured and those who are eligible for or enrolled in NYS-funded insurance programs (i.e., Medicaid, Child Health Plus [CHP], and Family Health Plus [FHP]). The terms "underserved" and "safety net" will be used interchangeably throughout the text.

The IOM defines safety net providers as those who "organize and deliver a significant level of health care and other health-related services to uninsured, Medicaid, and other vulnerable patients."[4] The IOM further defines "core safety net providers" as those:

1. Who, by legal mandate or explicitly adopted mission, maintain an "open door," offering access to services to patients regardless of their ability to pay and
2. Whose patient mix is substantially composed of uninsured, Medicaid, and other vulnerable patients.

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[1] Molla S. Donaldson, Karl D. Yordy, Kathleen N. Lohr, *Primary Care: America's Health in a New Era*, Institute of Medicine Report, 1996.

[2] The statement draws upon several areas of research—particularly the following reports: Barbara Starfield, *Crossing the Quality Chasm: A New Health System for the 21st Century*, Institute Of Medicine, National Academy Press, 2001; Arnold Epstein, *"The role of public clinics in preventable hospitalizations among vulnerable populations,"* Health Services Research, 2001.

[3] Sara Rosenbaum, Peter Shin, Ramona Whittington, *Laying the Foundation, Health System Reform in New York State and the Primary Care Imperative*, June 2006.

[4] RM Weinick, J Billings, *Introduction: Tools for Monitoring the Health Care Safety Net*, Agency for Healthcare Research and Quality, Rockville, MD, November 2003. http://www.ahrq.gov/data/safetynet/intro.htm

Primary Care Providers to the Underserved

Ambulatory care includes patient services provided on an outpatient basis. This report focuses on a subset of ambulatory care, namely primary care. Primary care to the underserved in New York City (NYC) and NYS is provided by three fundamental groups of providers: 1) hospitals in their outpatient departments and community-based satellite centers, 2) freestanding health centers (technically called diagnostic and treatment centers or D&TCs), and 3) private physicians. Each is organized and reimbursed differently for services provided to the healthcare safety net population, and, as a result, each sees a different mix of patients and offers a different model of care.

For this study, we present reimbursement data from New York City. Although the issues presented in the report are applicable to all NYS providers, we recognize that there are some regional variations in cost and rate structures. Additionally, we have segmented the institutional providers (i.e., hospitals and D&TCs) as follows:

We have segmented hospitals into:

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- Other Comprehensive and Specially-Designated D&TCs

It is profoundly difficult to determine the size of the healthcare safety net and the breadth of services it provides. Though we can know the universe of licensed physicians, we have available only incomplete self-reported data as a basis for differentiating primary care from specialty physicians and for identifying the availability of those primary care physicians to safety net populations. No such resource even exists for mid-level practitioners. Moreover, given that there is no comprehensive or uniform reporting of service or visit volumes, we have no information on the universe of primary care visits provided to NYC residents.

Consequently, while we acknowledge the importance of private practitioners to the primary care safety net, in this report we focus primarily on institutional providers who are required to submit annual reports of ambulatory care costs and visit volume to the NYS Department of Health.

☐ CHAPTER 1:

THE PRIMARY CARE REIMBURSEMENT SYSTEM AND FINANCIAL CONDITION

The appendices to this report describe, in detail, the various reimbursement streams for primary care, with in-depth discussions and trends in payment mechanisms for the safety net population (i.e., Medicaid fee-for-service, Medicaid managed care, and Indigent Care Pool funding). This chapter provides an overview of the key issues that emerge.

Overview of the Issues

Different payers reimburse providers differently for the same service.

Healthcare is one of only a handful of industries in which a business enterprise will accept different levels of payment from different customers for the same product/service. For example, two patients present themselves at the front desk of an ambulatory care facility for their annual exam. One is covered by Medicaid, and one is covered by commercial insurance. The facility's fee for the annual exam is $200. The facility may accept the Medicaid rate for the Medicaid beneficiary (e.g., $125) and accept the commercial insurance fee schedule payment for the privately insured patient (e.g., $65) as payment in full for the service provided. Accordingly, healthcare organizations are forced to manage their mix of patients depending on payment sources.

The same payer may pay differently for the same service depending on the setting in which it is delivered.

In NYS, the Medicaid program will reimburse for a primary care visit provided in a hospital's OPD at $67.50 plus capital—a rate that is often lower than

the rate paid for a similar visit provided in a freestanding D&TC ($100 to $150 per visit). Private physicians receive the lowest level of reimbursement at $30 per visit.[5] This practice occurs most frequently among governmental payers (i.e., Medicaid, Medicare) and is often related to the services covered by the rate of payment.

Multiple managed care plans use different methods of payment and pay different rates.

In 1997, the federal government approved New York State's Partnership Plan, a demonstration waiver program authorizing mandatory enrollment of Medicaid beneficiaries into managed care plans, and in 2006 it reauthorized the program as the "Federal-State Health Reform Partnership," or F-SHRP. Over the 10 years this plan has been in place, slightly under half (48% or 3.4 million)[6] of all institutionally-provided Medicaid primary care visits have continued to be covered under Medicaid managed care. Under this arrangement, the NYS Department of Health contracts with managed care organizations (MCOs), who receive a monthly premium to cover the total cost of care received by Medicaid beneficiaries enrolled in their plan. The MCO in turn contracts with healthcare providers, including primary care providers, for the provision of services. Rates of payment are negotiated between MCOs and each provider, resulting in different rates determined by different methods offered by different plans to different providers.

The result of the practices described above is that total net patient revenue per primary care visit differs dramatically by sub-sector, ranging from a low of $92 per visit to a high of $166. These differences are attributable to a variety of factors, including differences in the rate of payment, services covered in the visit, the payer mix of patients served, and the effectiveness of the organization's billing and collection process. Table 1 reports the weighted average total net patient revenue per visit as reported for 2004.

Table 1: Weighted Average Total Net Patient Revenue Per Visit by Sub-Sector, NYC

Subsector	Total Patient Revenue Per Visit
Voluntary Hospital OPDs	115.69
Hospital Affiliated FQHCs	166.07
HHC Hospitals	114.20
FQHCs	143.04
HHC D&TCs	92.33
Other Comprehensives	125.21
Private Physicians	Data Not Available

Data Sources: The above data was extracted from 2004 NYS cost reports and represents gross charges less contractual and charitable allowances and bad debt. "Data Not Available" indicates data elements that could not be obtained from any known public data source.

Care for the uninsured is supported through a variety of federal, state, and local funding streams described more fully in Chapter 2 and Appendices A and B. Many of these replicate the issues that pertain to other payers. For example, NYS has created an Indigent Care Pool that partially offsets the losses incurred by hospitals and D&TCs in serving the uninsured. Similar issues emerge: Indigent Care Pool funding pays all institutional providers for charity care losses but includes non-Medicare bad debt for hospitals only. Different pools and distribution methodologies result in vastly different coverage for institutional providers, while private practices receive no Indigent Care Pool funding at all. Reporting requirements and standards of accountability differ depending on the practice setting. This frequently makes it impossible to determine which patients are covered or which services are purchased by these revenues.

[5] Summary of Medicaid Fee-for-Service Reimbursement Models

[6] 2004 NYS Cost reports

The Result: The Financial Condition of Safety Net Primary Care Providers

To examine the current financial condition of safety net primary care service providers, we examined operating margins on a per visit basis for each sub-sector, comparing operating revenue (i.e., patient revenue and indigent care payments) to operating costs, exclusive of grant and other governmental subsidies. (Lack of comparable revenue and expense data prevents analysis at a provider or more collective level.) Table 2 shows the total net patient service revenue, Indigent Care Pool funding, and total cost per visit for institutional providers.

Table 2: Net Patient Service Revenue and Indigent Care Subsidy Per Primary Care Visit Compared to Cost by Sub-Sector, NYC

	HHC-Hospital	Voluntary Hospital	Hosp Affiliated FQHC	FQHCs	HHC-D&TCs	Other Comprehensive
Net Patient Revenue/Visit	114.20	115.69	166.07	143.04	92.33	125.21
Indigent Care/Visit	13.19	20.21	17.90	3.61	14.49	6.88
Total Patient Service Revenue/Visit	127.39	135.90	183.97	146.65	106.82	132.09
Total Cost/Visit	260.14	362.51	255.92	174.23	218.33	179.02
Net Loss, Prior to Subsidies	**(132.75)**	**(226.61)**	**(71.95)**	**(27.58)**	**(111.51)**	**(46.94)**

Note: The figures represent all visits and are not limited to uninsured visits.
Note: The above revenue amounts exclude additional funding received by hospitals including DSH Cap Payments, UPL Payments, and GME as well as other grants that may be received.

Data Source: 2004 Hospital and D&TC cost reports. Hospital data includes that reported in the pre-defined "clinic" cost center.

Table 2 shows that the cost of providing a primary care visit differs markedly across different sub-sectors, as do patient revenues and indigent care payments. As discussed earlier, revenues vary due to inconsistent rate setting models, varying services covered by reimbursement streams, and payer mix. Costs also vary across sub-sectors, frequently because of inconsistencies in the package of services they are required to provide. The most notable example of the latter is that Hospital OPDs are required by Medicaid to include the full range of ancillary services (e.g., laboratory, radiology, and pharmacy) in the primary care visit while D&TCs are able to contract these to outside parties and often do not incur this expense. However, Medicaid fee-for-service rates to hospitals are capped at the lowest level of payment among the sub-sectors. The constant is that **all providers incur losses on their primary care delivery, ranging from a low of $28 to a high of $226 per visit.**

Lack of consistent information at the provider level prevents any attempt to ascertain varying levels of productivity.

"Plugging the Hole"

No primary care provider could survive with the costs and revenues shown above. To help fill the gaps in the face of inadequate and inconsistent reimbursement streams, healthcare providers access a variety of other sources to cross-subsidize payers who reimburse inadequately. The absence of data on all of these gap sources of funding further confounds the issues of transparency and accountability in the primary care payment system. However, by sub-sector, these sources include:

Hospital OPDs

Hospital OPDs, including HHC hospitals and hospital affiliated FQHCs, have access to additional NYS funding streams that are often used to help fill the gaps in funding. Note, however, that there is no way of distinguishing what may be used for providing primary care vs. other hospital services.

- While NYS has established a statewide Indigent Care Pool of $847 million to assist hospitals in

subsidizing care provided to the uninsured (shown on Table 4), an additional amount is set aside for major public hospitals (called the "Indigent Care Adjustment"), including HHC, which totals $412 million statewide and is not included in Table 4. This is a Disproportionate Share Hospital (DSH) payment available only to major public hospitals. The intent of this payment is to bring these hospitals up to the aggregate share of Indigent Care funds they would receive if they could be paid by the Indigent Care Pool on the same basis as voluntary hospitals.[7]

- Public hospitals also are eligible to receive funding under a second pool of DSH cap payments with a statewide annual amount of $535 million. In addition, HHC receives some $657 million annually under a pool referred to as a "UPL (Upper Payment Limits) Supplement."[8]
- Hospital providers with onsite teaching programs are eligible for Graduate Medical Education funding to pay for resident salaries and physician teaching time. We have no method of quantifying these payments.

FQHCs

FQHCs receive grant funding under Section 330 of the Public Health Service Act, known as the Community Health Center program. This funding source, administered through the Bureau of Primary Health Care under the Health Resources and Services Administration (HRSA), represents a fixed, annual grant—ranging from $650,000 to over $7 million—to assist centers with subsidizing services provided to the uninsured.[9]

Available to All Safety Net Providers

A variety of categorical grants are available that subsidize particular services or programs for the uninsured. These are described more fully in Appendix C and include:

- Ryan White Care Act funding for HIV/AIDS services
- Other HIV funding (e.g., NYS AIDS Institute and federal CDC Prevention funding and COBRA Case Management)
- Title X funding for family planning services
- Maternal and Child Health funding under Title V or Title XIX for mothers and children
- Women, Infants, and Children (WIC) program to over the cost of food and nutrition education and counseling

However, grant funding aimed at filling the gap, particularly for the uninsured, is frequently either flat or being cut back. Juxtaposed with the increasing need to expand primary care, this suggests how difficult the task of reimbursement reform will be.

☐ CHAPTER 2:

THE BROKEN REIMBURSEMENT SYSTEM

A convoluted trail of statutes and regulations, not updated in over 10 years, lies at the bottom of how NYS pays for safety net primary care services. Adding to this complexity is the absence or inconsistency of data, which is due to the lack of comprehensive or uniform ambulatory care reporting systems. The structure is broken. A carefully crafted redesign of the payment system, including a plan for incremental implementation, is urgently needed.

The dysfunctional components of the current reimbursement system fall largely into three categories:

- The current system is inconsistent and inadequate in how it pays for primary care services and the services for which it pays.
- The current system lacks transparency, particularly with regard to exactly what is being purchased and how efficiently and effectively it is being delivered.

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[7] Urban Institute, *Caring for the Uninsured in New York – What Does it Cost, Who Pays, and What Would Full Coverage Add to Health Care Spending?*, October 2006.

[8] id

[9] In 1989, the Federal government determined that the Section 330 Federal grant funding was subsidizing the costs of services provided to Medicaid patients. To insure that Federal grant funds were truly being directed to subsidize care to the uninsured, the Federally Qualified Health Centers (FQHC) program was enacted to insure that the Medicaid and Medicare programs pay FQHCs for the reasonable cost of providing services to their respective beneficiaries (Omnibus Reconciliation Acts of 1989 and 1990).

- The reimbursement system and current incentives are not aligned to promote positive health outcomes or to support a high-performing, patient-centered primary care delivery system that produces them.

Inconsistency and Inadequacy of Payment

Core to a sound reimbursement system is that it must define and adequately pay for the type of primary care services needed to achieve its objectives. (See Chapter 3.) Currently, within NYS's Medicaid program, there are inconsistencies between fee-for-service and managed care programs and, as stated, among sub-sectors. Inadequacies of payment exist throughout.

Medicaid Fee-for-Service Program

New York State's Medicaid fee-for-service program pays for visits. Thus, the fundamental incentive is for providers to produce visits rather than improved health outcomes. Rates for those visits do not cover the current cost of coordination, care management, telephone or e-mail access, patient education and self-management, information technology, or many other services or functions known to be essential to preventing and managing illness, particularly chronic disease. Additionally, services included in the per-visit rates and the corresponding reimbursement models are inconsistent across sub-sectors as shown in Table 3.

Table 3: Services Covered in Medicaid Fee-for-Service Reimbursement, NYS

Subsector	Covered Services	Reimbursement Model
Voluntary Hospital and HHC OPDs	In the clinic-setting, OPDs are required by Medicaid to provide: • General medical services • Ancillary services (e.g., laboratory, radiology, pharmacy)	Operating costs are capped at $67.50 per visit (frozen since 1995) plus capital costs.
FQHCs (including Hospital-Affiliated)	By federal requirement, FQHCs must provide: • General medical services • Preventive services • Enabling services (e.g. health education, nutrition, case management) Ancillary services must be provided but can contract with outside party.	Operating costs are capped based on service mix, averaging $150 per visit (1999/2000 base year cost data), plus capital. Rates are adjusted each year for inflation by federal mandate.
Other Comprehensive D&TCs	Can offer a unique set of comprehensive services available to the general population. Ancillary services are optional.	Operating costs are capped based on service mix, averaging between $100 and $110 per visit, plus capital costs. Rates have been frozen since 1995.
Private Physicians	General medical services. Optional reimbursement for certain procedures and ancillary services.	General medical service set at $30 per visit (fixed since 2000); additional fee billing for other procedures.

Some glaring inconsistencies can be seen in Table 3:

- As mentioned earlier, Hospital OPDs are required to cover ancillary services in the primary care visit yet the operating cost per visit included in its reimbursement rate is the lowest of all institutional providers.
- FQHCs are the only sub-sector that are required (by the federal government) to provide a set of "enabling services" in addition to general medical services. The enhanced Medicaid rates, paid on a cost basis, are mandated by federal statute to ensure that federal FQHC grants do not subsidize underpayment by Medicaid.
- Hospital OPD and D&TC rates have not been adjusted since 1995, even though the cost of providing healthcare has increased dramatically over that period.
- Private physicians are reimbursed for general medical care with a rate that has rarely been changed over the history of the Medicaid program. The last update was in 2000.

Medicaid Managed Care Program

In its Medicaid managed care program, which now encompasses half of all Medicaid beneficiaries, the State developed a standard set of overall covered benefits. The State pays the plans a monthly capitation rate, thus passing down to MCOs the financial risk of managing care for their enrollees as well as monitoring the services provided to their patients/members. Primary care reimbursement is then negotiated between the primary care provider and the MCO, although the large number and small size of providers severely limits their market clout in negotiations. Primary care providers may be paid by monthly capitation or on a fee-for-service basis by MCOs. This rate negotiation, coupled with an overabundance of plans, particularly in NYC, and varying methods of payment, creates a complex and unwieldy reimbursement system for the safety net providers.

Unlike fee-for-service, reimbursement is not clearly tied to providing a particular set of services but rather is a negotiated rate. Data indicate that the average primary care reimbursement across all sub-sectors is relatively consistent. The level, amount, and cost of services, especially enabling services, provided by each sub-sector are inconsistent, however, resulting in payments that are inconsistent and frequently inadequate and inequitable.

Additionally, institutional providers must adhere to enhanced operating protocols and are held to a higher level of administrative review and oversight as a result of their licensure under Article 28 of the Public Health Law. While higher Medicaid fee-for-service rates are intended to pay for these additional costs, these are not recognized by MCOs, creating growing financial hardship for institutional providers as the Medicaid program moves over to managed care. Thus any State commitment to support Article 28 provider requirements disappears as Medicaid managed care is phased in.

The sheer number of plans combined with each paying different reimbursement rates determined by different methods and imposing different administrative protocols creates a hidden but large administrative burden and unreimbursed expense. Furthermore, it results in higher numbers of unreimbursed visits as the complexity of billing and collecting for services increases. That visits are increasingly being provided without reimbursement is substantiated by data on the net revenue per visit reported by the institutional providers.

Indigent Care Pool Funding

Institutional providers are required to serve all patients who present themselves, regardless of their ability to pay.[10] This law does not apply to private physician practices.

To help fund this requirement, NYS has created two Indigent Care Pools: one for hospitals and one for D&TCs. In both cases, pool size is established by a complex process unrelated to need, either among hospitals or D&TCs. Pool payments are then made to providers based on the share of uncompensated care they provide. The award calculations differ for Hospital OPDs as compared to FQHCs and Other Comprehensives licensed under Article 28. An analysis of the funding on a per visit basis between the various sub-sectors is shown in Table 4. *Note that this analysis does not include revenues discussed above under "Plugging the Hole" (the Indigent Care Adjustment, DSH Cap Payments, and UPL Supplements for HHC).*

[10] Public Health Law, Article 28 § 2801

Table 4: Indigent Care Pool Funding per Total Visit, by Sub-Sector, NYC

Subsector	Weighted Average Reimbursement Per Total Visit *	Funding Methodology Reimbursement for the Cost of Providing
Voluntary Hospitals	20.21	Charity care ** plus non-Medicare bad debts
Hospital Affiliated FQHCs	17.90	Charity care ** plus non-Medicare bad debts
HHC Hospitals	13.19	Charity care ** plus non-Medicare bad debts
FQHCs	3.61	Charity care ** only
HHC D&TCs	14.49	Charity care ** only
Other Comprehensives	6.88	Charity care ** only
Private Physicians	None	Indigent Care Pool Funding not available to private physicians per licensure requirements

* These amounts were calculated by dividing the 2004 distributions received from the New York State Department of Health by total 2004 visits. Hospital data was determined using an allocation of the total award to the "clinic" cost center and dividing by total "clinic" visits.

** The methodology for calculating the costs of providing charity care differs between Hospital OPDs and D&TCs.

Three very clear observations emerge from Table 4:

- The Indigent Care Pools pay inconsistently for the losses incurred by institutional providers. The charity care calculation for hospitals is based on discounts provided to the uninsured whereas the calculation for D&TCs is based on a proxy of the cost of services provided to self-pay patients less revenue received. The cost of non-Medicare bad debts is included for Hospitals and excluded for D&TCs.
- The "coverage ratio" (i.e., the ratio of Indigent Care Pool payments to total related losses) is greatly disparate. In 2004 coverage ratios were approximately:
  - 50%: Hospital OPD
  - 29%: HHC D&TCs
  - 22%: Other Comprehensive D&TCs
  - 16%: FQHCs
- Private physician practices do not receive Indigent Care Pool funding nor are they under obligation to see patients regardless of ability to pay.

Other Observations

Aside from the provider specific observations noted above, there are two other general observations that overlay the primary care reimbursement system:

Private Physicians: The lack of funding available to private physicians keeps them from fully opening their doors to the uninsured. Based on self-reported survey data supplied by the State University of New York's Center of Health Workforce Studies, there are just under 6,200 full-time equivalent primary care physicians practicing in NYC; 79% of these are in private practice and the remainder treat patients in institutional settings. Yet, primary care physicians in private practice are much less available to safety net patients than their institution-based counterparts. Half of the full-time equivalent primary care physicians in private practice serve virtually no Medicaid patients and three quarters serve virtually no uninsured patients. Both Medicaid fee-for-service and the Indigent Care Pool appear to provide financial advantage to institutional providers over private practitioners. Higher Medicaid payments are designed to cover the additional expenses of meeting Article 28 administrative protocols, facility requirements, and mandatory services. Similarly, Indigent Care Pool payments are designed to compensate Article 28 providers for the requirement

that they treat all patients, regardless of their ability to pay, thus providing care for the safety net population. Access to private practitioners would be very helpful for the uninsured, however inclusion of private practitioners in these enhanced revenue streams must be accompanied by inclusion in the related obligations.

Service Expansion and Integration: Increasingly it is clear that integration and coordination of services are effective and necessary for prevention, disease management, and prudent use of resources. This need goes beyond medical care to include mental health services as well. Yet licensure requirements are becoming an obstacle. Medical services are governed under Article 28 (administered by the Department of Health) while the majority of mental health services are governed under Article 31 (administered by the Office of Mental Health) of the Public Health Law. The State has increasingly limited the mental health services that can be provided by Article 28 providers who are growing increasingly concerned about the extent to which they can offer those services without acquiring an Article 31 license. Budget neutrality issues, among others, currently make new Article 31 licenses virtually impossible to obtain. The divergence of these licensures and the policies that guide them is becoming an increasing and serious barrier to patient care access and to the effective delivery of care.

Lack of Transparency

Transparency is the foundation for an efficient, effective, and accountable health system. We must know what services we are paying for, if those services are being provided effectively and efficiently, and what outcomes they are producing. Given the current lack of uniform or comprehensive reporting systems, transparency is inconsistent at best and in many respects simply non-existent. Inconsistencies include:

Cost and Service Level Data

Institutional providers are required to submit Medicaid cost reports reflecting financial and statistical data. For example, the D&TC cost report supplies detailed cost and service level data on all services, including primary care (i.e., direct, ancillary, enabling, and other support). The hospital cost report does not supply this information and, with no standardization, allows hospitals to spread their clinic services across multiple cost centers. This does not allow for an understanding of what services are being provided and how efficiently. Private physicians do not file cost reports, and thus we have no consistent information on the volume or type of services they provide to safety net patients. This makes it virtually impossible to link reimbursement to the cost of providing services across sub-sectors.

Efficiency and Effectiveness

Reimbursement rates should generally take into account the "reasonable" cost of providing services, interjecting the concept of efficiency. To ascertain efficiency we need data on provider productivity, support staff ratios, overhead charges, etc. D&TC cost reports require detailed staffing and patient volume data that provide certain measures of efficiency, including provider productivity. The hospital cost report does not provide this information, and, since private physicians are not paid on the basis of costs, they do not provide cost reports. Missing from all data sources is one important measure of efficiency and access: facility utilization. This makes it impossible to know if space is being used effectively.

It also is increasingly important to know the value and effectiveness of what we are purchasing. What outcomes are we getting for our investment? Are we improving the health status and outcomes of patients and communities? Currently, no system exists to tie the services provided and the dollars being paid to health outcomes. Additionally, the inconsistency and inadequacy of information makes it extremely difficult to establish a baseline from which to measure future progress toward building an appropriate and effective primary care system.

Misaligned Incentives

There is a large body of literature that links improved health outcomes to accessible and efficient primary care services. As a result, more and more attention has been given to the primary care delivery system, its performance, and the dollars spent. The goal of many efforts is to improve the overall health outcomes of patients by enhancing their utilization of primary care and preventive services and thereby reducing acute services and improving the management of chronic illnesses.

It is the current belief that to improve health outcomes, we need:

- A reimbursement system that incentivizes providers for positive health outcomes
- Health information technology to improve care delivery, coordination, and safety and enable the exchange of patient information across practice settings (e.g., primary care providers with emergency services and/or hospitals)

Financial Incentives

NYS has a financial incentive program to incentivize MCOs for attaining certain quality measures. If measures are achieved, the MCO will receive an additional premium amount as a financial reward. However, very few plans pass these financial incentives down to the primary care provider—those who can have the greatest impact on many of these outcomes. When incentive programs are offered, they are not communicated well down to the providers and often differ among plans, creating an information strain on an under-developed information technology provider group.

Health Information Technology

The current reimbursement systems for all sub-sectors do not cover the cost of operating, upgrading, and/or enhancing a health information technology system, including electronic health records. The need for health information technology to enable improved quality of care has occurred subsequent to the freezing of the rates and, therefore, is not reflected in rates of payment. Given the rate negotiation process in Medicaid managed care, it is difficult to ascertain whether technology enhancements are included in rates of payment. However, it is highly unlikely since rates paid are generally less than those received under fee-for-service.

□ CHAPTER 3

THE PATIENT-CENTERED PRIMARY CARE MODEL

Recent discussions about healthcare reimbursement reform in NYS have reasonably tried to shift the focus from *who* do we pay to *what* do we want to pay for. If, as the National Academy of Sciences states, "the purpose of the health care system is to reduce continually the burden of illness, injury, and disability and to improve the health status and function of the people…"[11] and to do so as cost-effectively as possible, then the State should pay for a suite of specific services, functions, and operating standards that produce those outcomes at appropriate costs.

The question of what we are paying for has become increasingly urgent as New Yorkers, particularly low-income New Yorkers, continue to suffer under the burden of poor health, experience disparities in health and healthcare, rely too heavily on emergency room care, and experience avoidable hospitalizations. These problems are a direct result of a fragmented, reactive, and episodic healthcare system and a misaligned payment system that shapes it.

A New Model of Care

However, a new model of care has been shown to produce positive health outcomes, improve patient experience, and reduce costs. This model of patient-centered primary care—also known as Patient-Centered Medical Home—is more than having a regular source of care and exceeds FQHC requirements for enabling services. Rather, it has the following enhanced characteristics. It:

- Emphasizes primary and preventive care in achieving better outcomes and using resources more efficiently.
- Creates an ongoing relationship between a patient and a personal provider trained to provide first contact, continuous, and comprehensive care.

[11] Institute of Medicine. "Crossing the Quality Chasm: A New Health System for the 21st Century," Washington, D.C. National Academy Press, 2001.

- Is organized into provider-directed patient care teams that:
  - Work in partnership with the patient
  - Collectively take responsibility for the ongoing care of patients and are responsible for the total care of the patient, including coordination across care settings (e.g., specialists, laboratories, x-ray facilities, hospitals, home care agencies, etc.)

Specifically, patient-centered primary care includes the following set of core services, functions, and operating standards.[12]

Access and Communication

- Provide 24/7 telephone access and other options for access and communication (e.g., e-mail, group visits)
- Ensure the availability of timely and appropriate appointments with patients' personal provider
- Ensure suitable visit cycle times (i.e., total time spent at a visit)
- Ensure the availability of language services for patients with Limited English Proficiency and other communication needs

Care Tracking and Registries

- Use a data system for basic patient information (mostly non-clinical data)
- Use clinical data system(s), including:
  - Charting tools to organize clinical information
  - Data and processes to identify important diagnoses and conditions in practice
  - Processes to generate lists of patients and provide patient and provider reminders
- Track tests and identify abnormal results systematically
- Use electronic systems to order and retrieve tests and flag duplicate tests
- Track referrals to other providers

Care Coordination

- Use evidence-based guidelines for at least three conditions
- Actively support patient self-management
- Manage patient care, including using care plans, assessing progress, and addressing barriers
- Generate reminders about preventive services for clinicians
- Use appropriate staff to coordinate and assist in managing patient care
- Coordinate care and follow-up for patients who receive care in other care settings, including inpatient and outpatient facilities and mental health and substance abuse services

Performance Reporting and Improvement

- Report clinical and/or service performance by physician or across the practice using standardized measures
- Survey patients' care experience and use the information for improvement
- Establish performance improvement goals and implement improvements

Evidence that Patient-Centered Primary Care Improves Health Outcomes and Reduces Costs

Mounting evidence shows that patients who have Patient-Centered Medical Homes experience better health outcomes. Among other examples, a 2007 report by the Commonwealth Fund[13] showed that:

- Seventy-four percent of adults with a medical home always get the care they need, compared with only 52% of those with a regular provider that is not a medical home and 38% of adults without any regular source of care or provider.
- When minorities have a medical home, their access to preventive care improves substantially. Regardless of race or ethnicity, about two-thirds of all adults who have a medical home receive preventive care reminders.

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[12] These components are adapted from unpublished documents by the National Committee for Quality Assurance, American College of Physicians, American Academy of family Practitioners, the American Academy of Pediatrics, and the American Osteopathic Association that define the PCMH.

[13] A.C. Beal, M.M. Doty, S.E. Hernandez, K.K. Shea, and K. Davis, "Closing the Divide: How Medical Homes Promote Equity in Health Care: Results From The Commonwealth Fund 2006 Health Care Quality Survey," the Commonwealth Fund, June 2007.

- Adults who have medical homes are better prepared to manage their chronic conditions. Only 23% of adults with a medical home report their doctor or doctor's office did not give them a plan to manage their care at home compared with 65% of adults who lack a regular source of care.
- Among hypertensive adults, 42% of those with a medical home reported that they regularly check their blood pressure and that it is well controlled, compared to only 25% of hypertensive adults with a regular source of care but not a medical home.
- Two-thirds of both insured and uninsured adults with medical homes receive preventive care reminders, compared with half of insured and uninsured adults without medical homes
- Adults with a medical home reported better coordination between their regular providers and specialists. Among those who saw a specialist, three-fourths said their regular doctor helped them decide whom to see and communicated with the specialist about their medical history, compared with 58% of adults without a medical home.
- When minorities have a medical home, racial and ethnic differences in terms of access to medical care disappear.

Examples of cost savings associated with Patient-Centered Medical Homes also are emerging. Most notably, North Carolina's Medicaid management program, known as Community Care of North Carolina (CCNC), is a group of physician-led networks that rely on the medical home model to save costs and improve healthcare quality. For a capitation of $5.50 per Medicaid patient per month, practices use evidence-based guidelines for at least three conditions, track tests and referrals, and measure and report on clinical and service performance. The program spent $8.1 million between July 2002 and July 2003 but saved more than $60 million over historic expenditures. In the second year of the program, they spent $10.2 million but saved $124 million. In 2005, the savings grew to $231 million.

Existing Reimbursement Barriers

Many providers in NYS are eager to adopt components of this model and these “early adopters” have forged ahead independently even without adequate reimbursement support. However, the current misaligned reimbursement system discourages these kinds of changes. For example:

- Rates do not include the cost of key components of a new model of patient-centered primary care, and historical underpayment has stripped many providers of internal reserves or surpluses that could help to finance such changes. Additionally, they do not pay for the adoption or ongoing costs of health information technology, which is critical to the continuity, decision support, care management, and coordination as well as to reducing errors and wasteful duplication of services.
- Providers lack financial incentives or support to improve their practice or the health outcomes of their patients since current payers pay simply for visit volume. Financial savings from providing better care accrue to the health plan or purchaser and do not benefit the provider making the investment. While the State offers a financial incentive program for MCOs to achieve certain quality measures, few plans pass these incentives down to primary care providers, whose efforts are the most critical to outcomes.
- The current system of reimbursement is primarily driven through payment on an all-inclusive rate per visit (i.e., one rate for all services provided, regardless of the number and intensity of service provided). This system encourages providers, from a financial perspective, to provide as many billable visits as possible to generate dollars. This includes no real connection to the services actually provided during the visit, especially the non-medical type services which are integral to patient-centered primary care.

Investment to Achieve Patient-Center Primary Care

The components above form the framework for reimbursement of on-going operating costs. It is essential to make investments in the primary care sector to enable primary care practices to offer this type of care. For example, achieving the benefits of this new model generally requires changes in practice infrastructure—including the availability of electronic health records and the re-organization of staff into patient care teams. It also is important to construct investments that take into consideration the diverse kinds of support required by different types, sizes, and locations of providers. As examples, rural practices may require investments in telemedicine and other types of “virtual team” support, and solo practices will have to rely on external support for enabling services, such as language services.

CHAPTER 4

RECOMMENDATIONS FOR CHANGE

Reimbursement Reform Principles

As suggested by the earlier discussion, several principles should guide reimbursement reform:

- ***Pay Consistently and Adequately***: A new system must pay consistently and adequately for the reasonable cost of providing outcome-driven, patient-centered primary care across provider settings. Consistency should extend to all payers and payment sources but most especially those under State authority, including Medicaid fee-for-service, MCOs, and Indigent Care Pool funding.
- ***Be Transparent***: A new system must allow us to identify precisely what is being purchased, at what price, and with what outcomes.
- ***Align Incentives***: A new system must align the payment method to support patient-centered primary care by moving from paying for visits to eventually paying for outcomes after investing in improving access and care quality.

Reimbursement Reform Recommendations

In order to generate change and design a highly functioning and efficient primary care reimbursement and delivery system, we offer the following recommendations:

Recommendation 1: Create a Robust Ambulatory Care Data Reporting System

Obtaining basic and meaningful data on primary care delivery ranges from difficult to impossible (with the exception of Medicaid data and data from institutional providers). Yet data is critical for the State to analyze, plan, monitor, or reform healthcare delivery. Therefore, the State should:

Redesign Cost Reports for All Provider Settings

Cost reports should be modified to capture the level of services and costs entailed in providing patient-centered primary care. Improved cost reports should enable consistency in reporting from both hospitals and D&TCs and provide the baseline information needed for an initial assessment of the amount, kind, and efficiency of services provided. They also should provide NYS with the information to monitor the new primary care model; provide a basis for future, local, and State planning, research, evaluation, and market assessments; and allow a better understanding of the wide variation in costs and services by practice settings.

Develop a SPARCS-like Data Reporting System

A SPARCS-like data reporting system should be developed for all ambulatory care, regardless of the payer or setting, and linked to inpatient and ER data in order to capture health outcomes. This is essential for tracking utilization for chronic diseases. Additionally, because it is patient-specific and has diagnostic and procedures codes, it will enable the monitoring and examination of case mixes.

Recommendation 2: Pay for Providing a Patient-Centered Primary Care Model

NYS must move from purely paying for visits to a system that structures payment based on services and standards that produce positive health outcomes. Medicaid and Indigent Care Pool payment methodologies supporting the new model of care should be consistent across settings (i.e., hospital, D&TC, and private practice), take into account variations in infrastructure, and be available only to those who provide the patient-centered primary care services. While decisions about the specific services and infrastructure that the reimbursement package must cover are yet to be made, it is clear that costs related to patient-centered services, functions, and operating standards known to be most effective in achieving positive health outcomes must be invested in and reimbursed. These include access and communication, care tracking and registries, care coordination, and performance reporting and improvement. Additionally, health information technology, especially electronic health records, requires both an initial investment and reimbursement to cover ongoing costs.

Recommendation 3: Apply Payment Principles to Managed Care Organizations

NYS must exert oversight on what and how managed care organizations pay primary care providers in terms of reimbursement rates and incentives.

Include Patient-Centered Primary Care Elements in Reimbursement Rates

Rates that MCOs pay primary care providers should similarly include all of the elements required for a patient-centered primary care model. To the extent that plans already provide care coordination and management services, a division of both services and related costs must be clear and coordinated.

Pass Pay-For-Performance Incentives to Providers and Make Consistent

Incentives must pass down from plans to the provider level and should be consistent across the Medicaid managed care plans to ease the administrative burden on primary care providers of managing multiple incentive programs.

Recommendation 4: Realign Indigent Care Pool Funding Across Primary Care Sub-Sectors

NYS must design consistency and, to the full extent possible, alignment of incentives into the methodology and coverage ratios it uses for Indigent Care Pool funding across sub-sectors in the primary care delivery system. The methodology utilized to define the unreimbursed cost of indigent care provided that is eligible for funding should be the same for hospitals and D&TCs. Additionally, the percentage of unreimbursed cost of indigent care actually funded by NYS should be the same across practice settings. This will allow for improved access and effectiveness of care for the uninsured. This may take several years to phase in.

Recommendation 5: Revise Licensure Requirements to Allow Mental Health and Other Ancillary Services to Be Integrated into Primary Care

New York State must review the Article 28 and 31 licensure requirements—as well as others not addressed in this report (e.g., Article 32 for substance abuse services and Article 16 services for the MRDD population)—and revise them to allow for the integration of mental health and other ancillary services into the primary care setting. It has been widely publicized that the most medically high-need and complicated populations (e.g., mentally ill, substance abusers) represent a significant amount of the healthcare expenditures in NYS. One of the necessary avenues to address this situation is to better integrate mental health and substance abuse services into the primary care setting. The first step to this integration is to breakdown the licensure barrier.

Restructuring the Primary Care Reimbursement System

Form of Payment

There are essentially three options for paying for patient-centered primary care:

- Fee-For-Service
- Capitation
- Incentive Payments

Each of these options comes with particular advantages and disadvantages. Payers believe that the “fee-for-service” model—regardless of whether it is intensity-weighted or all-inclusive—inevitably encourages providers to perform more services whether they are needed or not. Intensity-weighted rates encourage “up-coding” by providers in an effort to increase revenue. While the “all-inclusive rate” model discourages up-coding, it pays for all visits at the same level, regardless of the actual service delivered. The alternative, paying capitation to primary care providers, poses the opposite problem. It discourages them from providing primary and preventive services since they receive payment regardless of the care rendered and since they generally do not share in any savings that may result.

To balance the divergent fee-for-service and capitation incentives, many reimbursement experts considering the patient-centered primary care model believe that a blend is appropriate, with capitation covering care management and the structural costs of providing care (those incurred incident to the provision of medical services) and fee-for-service for the delivery of preventive and primary care services.

Rate Setting Methodologies

In addition to the form of payment, there are differing methods by which rates are determined:

- Price-Fixed Reimbursement
- Cost-Based Reimbursement with Retrospective Settlement
- Prospective Payment Reimbursement

Payers prefer price-fixed reimbursement because it is predictable and easy to administer, but providers are concerned that this rate-setting process can easily under-represent the true cost of providing services. For cost-based reimbursement, payers generally build in standards to ensure that costs are reasonable and efficient, however, cost-based payment is inevitably associated with paying for, and therefore encouraging, inefficiencies. Most payers using a cost-based rate do a retrospective reconciliation and settlement so as to control and pay reasonable costs. Third party payers dislike this method both because of its administrative burden and because they have difficulty predicting or controlling overall health expenditures under this model. Technically, NYS has a cost-based, prospective payment ambulatory care system in regulation, but, because rates have been frozen for many years, it has effectively become a flat, fixed rate payment system, except for FQHCs. (For more detail on the payment form and rate setting methodology options, see Appendix D.)

Recommendation

So long as we adhere to the payment principles, many options are possible. We propose an approach combining several of the existing reimbursement structures to effectively construct a system that incentivizes providers to improve health outcomes while meeting the cost of providing the needed services.

Each form of payment contains incentives dependent on the amount and type of services included in the rate. The central problem with stand-alone forms of payment is that "each variable that is included within a single payment amount creates a risk that the provider receiving the payment will under-treat or exclude patients that have high values on that variable (e.g., patients who need an above average number of services per episode of care) in order to reduce their costs in comparison to payment. Each variable that is excluded from a single payment amount creates the risk of over-treatment (i.e., providers will seek additional patients, episodes of care, etc. beyond what otherwise might be necessary in order to increase the total amount of revenue they receive.)"[14]

The factors that drive cost and provider behaviors differ based on the specific service provided. By grouping services with similar cost-drivers and incentives and matching them with appropriate payment forms, a reimbursement model can "bundle" certain services into a capitation model and other services into a fee-for-service model to neutralize the potential incentive to a provider to under- or over-treat a patient based on the form of reimbursement. That type of model would satisfy the payer's concern for improving health outcomes and decreasing overall healthcare spending while at the same time ensuring that providers are reimbursed adequately.

In addition, one important element of this proposed primary care reimbursement model is provider eligibility. To be eligible for this reimbursement model, a provider must be certified as a patient-centered primary care provider, which would ensure that all elements of the model of care are provided and reported.

Whatever the details of the final blended model of payment, it is critical that both the form and methodology adheres to principles outlined in this report. Application of these principles for primary care reimbursement reform will help realign the NYS healthcare system toward paying for positive health outcomes while reducing overall healthcare spending.

The Conceptual Framework for a Restructured Patient-Centered Primary Care Reimbursement System

The following table builds upon existing payment methods and sets forth a conceptual framework for a new patient-centered primary care reimbursement model. (For additional details on the conceptual framework, see Appendix E.)

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[14] Harold D. Miller, *Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Policy Reform*, The Commonwealth Fund, September 2007.

What's Being Paid For	How to Pay
Preventive and primary care services, including after-care treatment from acute episodes of care	***Fee-For-Service*** - Price-fixed rate determined for each procedure (or visit) to be used across all practice settings with adjustment for regional variations. Rates will vary by procedure based on a measure of intensity of service provided (e.g., RBRVS, APCs). The rates established must take into account the increased administrative/operational requirements of Article 28 regulation.
Patient-Centered Primary Care Model Services, including access and communication, care tracking and registries, care coordination, and performance reporting and improvement. Also includes the management of patients with chronic conditions.	***Monthly Capitation Payment*** - Patients would select a provider as their care manager. Provider receives a case-mix adjusted PMPM rate for each patient based on the patient's health status (pre-defined categories established based on factors such as age, sex, current health condition, and other risk factors).
Technology and Capital (Physical Plant)	***"Facility-Specific" Add-On*** – This is in addition to the rate to reflect level of technology implementation and interoperability as well as capital cost infrastructure, which will differ by individual providers.
Positive Health Outcomes	***Incentive Payment*** - Upon satisfying pre-determined, standard, state-wide quality measures/health outcomes, providers will be paid an incentive payment to recognize performance and positive health outcomes for patients who have selected the providers as their care manager.

☐ SUMMARY

From a national perspective, moving reimbursement away from unit of service or procedure driven systems to ones based on quality outcomes and performance fits hand-in-hand with the evolution of the healthcare system. Healthcare delivery is moving away from provider-driven to patient-centered, and the reimbursement or reward system must follow suit. Given the numerous licensure requirements and reimbursement methodologies employed in NYS by the various payers of healthcare services, it is not surprising that the State's Governor and the new administration in the Department of Health are taking a fresh look at New York's healthcare financing system. Rationally reforming the reimbursement system according to the principles and recommendations set forth in this report will take us far in ensuring that we are getting what we need out of our healthcare system: healthy patients who receive cost-effective, high quality care.

Appendix A

Methodology and Caveats

Methodology

Determining the financial condition of the primary care sector and the relative levels of reimbursements received by each sub-sector is a challenge given the varying corporate structures and reporting requirements. Accordingly, in attempting to assess comparable performance, we measured operational revenue and expenses on a per visit basis.

RSM McGladrey, Inc. utilized cost report data for Hospitals and Diagnostic and Treatment Centers (HHC, FQHCs, and Other Comprehensives) to obtain certain operational measures. Cost report filings for Article 28 providers was utilized as it crossed all sub-sectors, excluding private physician practices, and we believed it would give us the best aggregate level information for the primary care system across all payer categories. In defining the sub-sectors and safety net providers, identifying the providers who serve special populations or provide specific services was a challenge. For instance, providers who serve the homeless or patients affected with HIV/AIDS may be standalone facilities and easily identified, or they may be part of a larger, more comprehensive provider. As such, specifically identifying special needs providers was not possible. Accordingly, the Diagnostic and Treatment Centers that were not HHC facilities or FQHCs were grouped together to represent those stand-alone, specially designated providers, as well as other community-based organizations who provide healthcare services to the general populations.

At the time of the study, the only available, certified cost report information and reimbursement data across all sub-sectors from the NYS Department of Health (NYSDOH) was for 2004 and this became the base year for the analysis. From the cost reports, we were able to determine the following:

- Number of visits provided
- Patient services revenue
- Allowable operating and capital costs

Due to difficulties obtaining credible data regarding reimbursement by payer source, alternative sources were utilized to assess reimbursement from government payers. Approved Medicaid rates and Indigent Care Pool funding amounts were obtained from the NYSDOH through the Freedom of Information Act. In those cases where fixed fee schedules were used for reimbursing primary care providers, standard coding schemes were applied to the fee schedules to determine average levels of reimbursement.

Caveats

2004 Hospital Cost Reports (ICRs)

- Given the inconsistencies in reporting at the cost center level on the ICR, it was difficult to identify the gross amounts of visits, revenue, and costs for primary care services. Therefore, we obtained cost, revenue, and visit data for the “standard clinic cost center” and calculated per visit amounts for the purposes of our analysis using the “standard clinic cost center” only.
- In developing comparable operating revenues between Hospitals and D&TCs, only revenues which both are eligible to receive were included in the analysis. As such, DSH cap payment, UPL amounts, and GME were excluded from the Hospital operating performance analysis as were other grants and contracts.
- Hospitals receive funding from the Indigent Care Pool covering both inpatient and outpatient services. To arrive at a funding amount for comparison to D&TCs, we used detailed calculations of the Hospital Indigent Care Pool awards. Using the underlying formula for the calculation of the Uncompensated Care Amount, a calculation was performed to determine the Uncompensated Care Amount for the “standard clinic cost center” using data reported on the ICR. The Uncompensated Care Amount for the “standard clinic cost center” was compared to the Total Uncompensated Care Amount for each hospital to arrive at a percentage of the Total that was attributed to the “standard clinic cost center.” This percentage was applied to the Indigent Care Pool award to approximate the amount of the award pertaining to clinic operations, which was

then divided by total visits across all payers to arrive at the Indigent Care Pool award per visit.

- During 2004, there were three (3) Hospital-Affiliated FQHCs in New York City. This report includes only two (2) of the facilities due to difficulties gathering credible data on the third.

2004 D&TC Cost Reports (AHCFs)

- Total cost, revenue, and visit data from the 2004 AHCFs were used to calculate per visit amounts utilized in the financial performance analysis.
- In developing comparable operating revenues between Hospitals and D&TCs, only revenues which both are eligible to receive were included in the analysis. As such, federal Section 330 funding and other grants and contracts were excluded from the D&TC operating performance analysis.

Private Physician Practices

- Information on visits, patient revenue, and expenses were difficult to obtain through publicly available resources. As such, this report includes limited financial and statistical information pertaining to the relative performance of Private Physician Practices.

Appendix B

Detailed Analysis of Reimbursement, by Payer, in the Primary Care Sub-Sector

Primary care providers in NYC receive varying levels of reimbursement from different payers, often driven by their practice setting (i.e., Hospital outpatient department, Federally Qualified Health Centers, other Diagnostic and Treatment Centers, and Private Physician Practices). The analyses that follow include detailed descriptions of the reimbursement methodologies and experiences that primary care providers are experiencing, by sub-sector, for the numerous payer types they encounter. Current trends in each payer category will also be discussed.

The focus of the discussion is centered around NYC's "safety net" providers. Revenues generated by primary care providers from third party payers (i.e., Medicaid, Medicare, self-pay, and commercial insurance) are considered in detail. In addition, we have analyzed the funding mechanisms underlying NYS's Indigent Care Pool funding, which is intended to help subsidize services provided to the uninsured. ***These analyses do not include other revenue streams that help to "Plug The Hole" in the provision of primary care services, including DSH Cap Payments and UPL Supplements received by public hospitals and grants/contracts received from governmental agencies.***

Table 5 highlights the average rates of payment for clinic services by government payer source and sub-sector for 2004. ***The variances are significant in some instances and are sometimes driven by covered or reimbursable services provided.*** However, the variances among sub-sectors often affect specific strategies employed by organizations to address the payer mix of patients served.

Table 5: Weighted Average Reimbursement Rates by Government Payer and Sub-Sector, NYC

Subsector	Medicaid Fee-for-Service	Medicaid Managed Care	Indigent Care Pool Funding	Medicare
Voluntary Hospital OPDs	$90.30	$105.08	$20.21	$65.10
Hospital Affiliated FQHCs	$172.53	$105.08	$17.90	$65.10
HHC Hospitals	$82.15	$105.08	$13.19	$65.10
FQHCs	$164.73	$119.32	$3.61	$115.33
HHC D&TCs	$150.35	$119.32	$14.49	$80.11
Other Comprehensives	$141.53	$119.32	$6.88	$80.11
Private Physicians	$30.00	$116.39	None	$80.11

Data Sources: We extracted the above data from Medicaid clinic rate and Indigent Care Pool funding data supplied by the NYS Department of Health and Medicaid/Medicare fee schedules, which are analyzed in-depth in the following sections. For Hospital clinics, these rates ***do not*** *include those hospitals that are paid enhanced rates under the Products of Ambulatory Care, or PAC, methodology. We extracted Medicaid managed care data from the Medicaid Managed Care Operating Reports filed by participating plans for the NYC Metropolitan area. "None" indicates that this reimbursement stream is not applicable for the particular sub-sector.*

Given certain inconsistencies in the reporting of patient revenue information by payer in the Hospital and D&TC cost reports, we analyzed data included in this reimbursement section on a per visit basis. We obtained provider-specific rates of payment from government payers through the Freedom of Information Act. We calculated total patient service revenue per visit for Hospital OPDs based on information reported in the clinic cost center of the 2004 Institutional Cost Reports (ICR). For FQHCs and Other Comprehensives, we based total revenue per visit on the 2004 Ambulatory Healthcare Facility reports (AHCF-1).

Medicaid Fee-For-Service

Article 28 of NYS's Public Health Law sets forth the authority of the NYS Department of Health (NYSDOH) to develop and administer NYS's policy with respect to hospital and related services.[15] Included within the Article 28 law are the provisions governing the establishment or incorporation of hospitals, approval of hospitals, and the issuance of operating certificates that authorize the types of services to be provided as well as locations and reimbursement provisions.[16] For the purposes of this analysis, the two main reimbursement streams included under Article 28 are Medicaid and Indigent Care Pool funding.

Article 28 further defines "hospitals" to include "a general hospital, public health centers, and diagnostic centers and treatment centers,"[17] among other provider types. As such, the provisions of Article 28 establish the Medicaid and Indigent Care Pool funding methodologies for Hospital OPDs and freestanding D&TCs, which include FQHCs and Other Comprehensive Service Providers. Since private physician offices are not considered hospitals under the terms of Article 28, they are not reimbursed under the Article 28 methodologies for Medicaid and Indigent Care Pool funding and instead are reimbursed for services under the NYS Medicaid fee schedule.

The regulations implementing the provisions of Article 28 are contained in Title 10 of NYS's Codes, Rules, and Regulations, commonly referred to as 10 NYCRR. In general, 10 NYCRR require Article 28 providers to comply with requirements concerning governance, administration, medical staff, quality assurance, patients' rights, incident reporting, minimum protocols for the provision of numerous healthcare services, and requirements of the physical plant.[18] NYSDOH requires formal policies and procedures and conducts periodic reviews to ensure compliance with the regulations. For those primary care providers willing to operate within the requirements of Article 28, they are entitled to enhanced Medicaid reimbursement as well as subsidies for uncompensated care through the Indigent Care Pool.

[15] Public Health Law – Article 28 § 2800
[16] Public Health Law – Article 28 § various
[17] Public Health Law – Article 28 § 2801
[18] 10 NYCRR Part 405

In 1997, the federal government approved NYS's Partnership Plan, which authorized the mandatory enrollment of Medicaid beneficiaries into a managed care environment. In 2006, this demonstration waiver program was re-authorized as the Federal-State Health Reform Partnership (F-SHRP). Although this plan has been in place for over 10 years, in 2004, just over 50% (3.5 million) of the primary care visits provided by Article 28 providers to Medicaid beneficiaries were covered under the Medicaid fee-for-service program. Based on revenue reported in the clinic cost centers of the 2004 ICRs and revenue reported in the AHCF-1s, Medicaid fee-for-service revenue represented approximately $586 million of revenue, or 63% of the Medicaid reimbursement received. Therefore, although NYS's Medicaid program is converting to managed care, a large percentage of patients seen in the primary care setting are still covered under the traditional fee-for-service reimbursement model.

Table 6 delineates the average fee-for-service reimbursement rates received from Medicaid for primary care services by sub-sector:

Table 6: Weighted Average Medicaid Fee-For-Service Rates by Sub-Sectors, NYC

Subsector	Weighted Average Reimbursement Rate *	Covered Services
Voluntary Hospital OPD	$90.30	In the clinic-setting, required to provide general medical services as well as ancillary services (e.g. laboratory, radiology, pharmacy)
Hospital Affiliated FQHCs	$172.53	Required set of Federal primary and preventive services, including enabling services (e.g. health education, nutrition, case management) ancillary services must be provided directly
HHC Hospitals	$82.15	In the clinic-setting, required to provide general medical services as well as ancillary services (e.g. laboratory, radiology, pharmacy)
FQHCs	$164.73	Required set of Federal primary and preventive services, including enabling services (e.g. health education, nutrition, case management) ancillary services must be provided but can contract with outside party
HHC D&TCs	$150.35	Can design a unique set of comprehensive services open to the general population (ancillary services being optional)
Other Comprehensives	$141.53	Can design a unique set of comprehensive services open to the general population (ancillary services being optional)
Private Physicians	$30.00	General medical services optional reimbursement for certain procedures and ancillary services

** We based rates for the Article 28 providers on the average of actual rates promulgated by the NYS Department of Health for clinic settings in 2004. For Hospital clinics, these rates represent the "clinic" rate only and **do not** include those hospitals that are paid enhanced rates under the Products of Ambulatory Care, or PAC, methodology. We based the rate for private physicians on the Medicaid fee schedule for an office visit, applying standard weightings across all Evaluation and Management codes.*

Hospital Outpatient Departments

Primary care services provided in Hospital OPDs or extension clinics[19] are generally reimbursed at the hospital's clinic rate. The clinic rate is calculated each year based on the annual filing of the ICR, which contains cost, revenue, and statistical data. The clinic rate is an all-inclusive rate. That means that one rate is billed for each visit provided at the OPD/extension clinic regardless of the service provided. Initially, the rate is cost-based, arrived at by dividing total allowable costs by total visits. In determining the clinic rate for

[19] Also called satellite sites

the rate period April 1, 2004, through March 31, 2005, NYSDOH uses the 2002 ICR and allocates allowable costs between operating costs and capital costs. A ceiling is then applied to the actual operating cost per visit, thereby imposing a maximum limit on the operating cost per visit that will be reimbursed through the clinic rate. This ceiling is $67.50, which has been frozen at that level since 1995. The hospital clinic's actual capital cost per visit is included in the rate calculation with no imposition of a ceiling or cap[20] except for depreciation on major movable equipment, which is limited.

Actual allowable operating costs for hospital clinics significantly exceed the $67.50 ceiling, which is set in the statute. The costs included relate to administration, medical care, laboratory, radiology, and pharmaceutical services among others.

The definition of a billable visit also is set in regulation.[21] By definition, only one visit can be billed per day each time a patient crosses the threshold of the facility. As such, if a patient sees their primary care provider for an exam and the primary care provider refers the patient to a specialist, only one visit can be billed for that day if the specialist sees the patient on the same day as the primary care provider. The second visit is non-billable to Medicaid.

Some Hospital OPDs were eligible to receive Medicaid reimbursement under a demonstration project known as Products of Ambulatory Care, or PACs. This rate system reimburses hospitals for services provided in the clinic setting using 71 different prices, or PAC rates, based on resources utilized and patient characteristics. The PAC system generally reimburses hospital clinics at amounts greater than their standard clinic rates. However, there has been a moratorium on this program since 1995 and only a handful of hospitals currently participate in the program.

FQHCs

FQHCs also are reimbursed on an all-inclusive rate basis. However, there are some significant differences in the rate-setting methodology as compared to Hospital OPDs. Due to the federal government's recognition of FQHCs as a critical safety net provider, the federal government requires states to reimburse FQHCs under a prospective payment system generally outlined in federal statute. Each FQHC's Medicaid fee-for-service rate for 2001 was established based on the average of the reasonable cost per visit for 1999 and 2000 for providing covered services. Similar to the hospital clinic rate-setting model, the base year costs for 1999 and 2000 were segregated between operating and capital costs, and a ceiling was applied to the operating costs. Unlike the hospital model, however, the operating costs and ceilings were further broken down between six cost centers (i.e., administration, patient transportation, medical, dental, therapies, and ancillaries), and the ceilings were calculated based on the average costs by cost center of all comprehensive primary care providers by geographic area. As a result, each FQHCs operating cost ceiling differs based on the case mix of visits provided between medical, dental, and therapies and, on average, is significantly higher than the hospital clinic's operating cost ceiling. Capital costs similarly are not held to a cap or ceiling. Effective October 1, 2001, and each year thereafter, the operating component of the Medicaid rate is trended up by an inflationary factor, tied into the Medicare Economic Index, which has averaged approximately 3% per year. The operating component of the rate also may be adjusted if the FQHC experiences a change in scope of services as defined in both federal and state law. Capital costs are fixed at the base year level but are subject to appeal given a change in scope as well.22

The threshold visit concept that applies to Hospital OPDs also applies to FQHCs.

FQHCs, by definition, are required to provide a certain set of services as defined in the federal statute. A critical set of services FQHCs are required to provide are commonly referred to as enabling services, which include items such as health education, case management, nutrition, translation services, outreach services, and eligibility services, to name a few. These services and costs do not generate billable visits and add to the cost of an FQHC. As such, these costs are included in the rate calculation and contribute to a higher operating cost per visit. Quantifying the cost of providing these enabling services is a difficult task as they are reported throughout the underlying Medicaid cost reports.

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[20] Public Health Law – Article 28 § 2807
[21] 10 NYCRR Part 86-4
[22] Public Health Law – Article 28 § 2807

Other Comprehensives (Other D&TCs)

Other Comprehensives that are being reimbursed for Medicaid services through an Article 28 license also receive an all-inclusive Medicaid rate. The rate-setting process, as set forth in regulation,[23] is similar to the Hospital OPDs' except that the ceiling on operating costs is broken down between six cost centers (i.e., administration, patient transportation, medical, dental, therapies, and ancillaries), and the ceilings are calculated based on the average of costs by cost center of all comprehensive primary care providers by geographic area, including FQHCs. (The ceiling calculation is similar to that utilized for FQHCs.) The Other Comprehensives' actual capital cost per visit is included in the rate calculation with no imposition of a ceiling or cap.

Similar to the hospital clinic rate-setting methodology, 2002 theoretically is the base year used to calculate the Medicaid rate for the rate period October 1, 2004, through September 30, 2005, with the operating component held to the peer group ceilings and the capital component based on actual costs with no cap. However, the Medicaid rates for freestanding D&TCs, including Other Comprehensives, have been frozen since 1995.[24] Accordingly, the Medicaid rates paid to Other Comprehensives have not changed for 12 years, from both an operating and capital component perspective.

Similar to Hospital OPDs, a handful of D&TCs are able to access an enhanced Medicaid reimbursement system: PACs. This system has been subject to a moratorium, and NYS's intent is to eliminate this system over time.

Private Physicians

Private physicians organized as either sole practitioners or group practices receive reimbursement from Medicaid based on the Medicaid Physician Fee Schedule. The Physician Fee Schedule assigns a different fee or rate of payment based on the procedures performed using Common Procedural Terminology (CPT) codes. There are five CPT codes assigned to office visits for new patients and another five CPT codes assigned for established patients. CPT codes often carry different weights, or relative value units, to reflect the amount of time and resources used during a particular procedure. Those that require a more significant amount of time and resources would be assigned a higher weight and are often paid at higher rates. The Medicaid Physician Fee Schedule was last updated in 2000, and the fee for all 10 CPT codes mentioned above is $30. This $30 payment will reimburse the private physician for the medical services provided during the exam as well as administration and facility costs. If the physician provides additional procedures during a visit (e.g., EKG, laboratory test), additional billing may be performed. The Physician Fee Schedule does not provide for reimbursement of enabling services.

Other Services Provided in the Primary Care Setting—Mental Health and Dental Services

Mental health and dental services often are considered integral to primary care, and many Article 28 providers include them in the suite of services offered to their patients. Private physicians rarely practice in a multi-specialty care setting in New York City and thus are not addressed in this analysis.

Dental

Given the rate-setting models in place for Hospital OPDs, FQHCs, and Other Comprehensives, the methodologies and payment systems noted above for primary care services are the same for dental services. Accordingly, the same rates of payment received for primary care services are received for dental services, and the underlying issues are the same.

Mental Health

The provision of outpatient mental health services and their reimbursement differ among the three Article 28 provider types. One of the underlying issues with Medicaid reimbursement for mental health services is which branch of NYS government is responsible for the oversight of these services: the Department of Health or the Office of Mental Hygiene (OMH). Mental health services are generally provided under the oversight of OMH and governed by Article 31 of the Mental Hygiene Law. Healthcare organizations providing mental health services are therefore required to obtain

[23] 10 NYCRR Part 86-4

[24] Public Health Law – Article 28 § 2807

licensure under Article 31, which differs from Article 28. However, over the years, Article 28 providers have been providing certain mental healthcare services and the reimbursement systems, in some cases, pay for it.

- *Hospital OPDs*: The ICR filed by the hospital segregates the costs and visits of services provided in their OMH-licensed mental health clinics in a separate cost center. The actual outpatient reimbursement rates, however, are not calculated on an all-inclusive rate per visit but rather are set in regulation. The outpatient reimbursement rates per regulation are the same whether the clinic is hospital-sponsored or freestanding. Services provided by psychiatrists, psychologists, and social workers are billable under the Article 31 licensure in both an individual and group setting.
- *FQHCs*: Aside from the four FQHCs that also have Article 31 licenses, most FQHCs provide mental healthcare services under their Article 28 license. As such, mental healthcare services provided by psychiatrists, psychologists, and licensed clinical social workers are reimbursed at the all-inclusive rate noted above, with a few caveats:[25]
  - No more than 15% of the total visit volume can be for mental health services.
  - Mental health services provided should be ancillary to primary medical care, and, if a chronic mental illness is diagnosed, the patient should be referred to a licensed Article 31 facility.
  - Reimbursement for group counseling services was approved for FQHCs, retroactive to 2006. However, a reimbursement methodology and rates have recently been promulgated. The reimbursement rates are set in regulation at $35.16 per visit for New York City providers.

    The billing for group counseling services, however, is restricted to psychotherapy services; other forms of group counseling or therapy are not currently billable under Medicaid fee-for-service.
- *Other Comprehensives*: Other Comprehensives that have Article 31 licenses are being reimbursed under the rates established in OMH regulation for outpatient services. However, if the Other Comprehensive providers do not possess an Article 31 license and are providing mental healthcare services under its Article 28 license, the services and billable providers are very limited. Non-FQHC Article 28 providers can only bill for individual services provided by psychiatrists and psychologists, and, unlike FQHCs, they cannot currently bill for clinical social work or group counseling services. There also is an informal cap on the percentage of visits that the Other Comprehensives can provide for mental healthcare (15-20%), although it is not set in regulation. Once this threshold is passed, concern is raised as to whether the services should be provided under the auspice of OMH and Article 31.

Walking this tightrope between Article 28 and 31 licensure is a dilemma for FQHCs and Other Comprehensives who do not have an Article 31 license. If an Article 28 is considering pursuing an Article 31 license since its patients and the community it services require increased mental healthcare services, OMH licensure is virtually impossible given the budget neutrality requirements in obtaining an Article 31 license.

Trends

Based on the analysis of the current state of the Medicaid fee-for-service reimbursement system in NYS and changes occurring nation-wide, reimbursement for primary care services is poised for change.

New York State's New Administration

In November 2006, Elliot Spitzer was elected as the new Governor of NYS. Governor Spitzer has made it clear that reimbursement reform is one of his top priorities, with primary care as one of the main areas of focus. New leadership has been appointed to NYSDOH, and the ideals of the new primary care reimbursement system are starting to take shape. An internal NYSDOH task force is being assembled to review the current reimbursement system and is focused on ambulatory care reform. The disparities in

[25] 10 NYCRR Part 86-4

reimbursement rates among provider types and barriers to care created by licensure requirements (e.g., Article 28 versus 31) are high on their priority list. One of the goals of this task force is creating a new, equitable reimbursement system across all provider types based on services provided. The new system also will cross all NYS Medicaid programs and licenses, including those administered by NYSDOH, OMH, the Office of Mental Retardation and Developmental Disabilities (OMRDD), and the Office of Alcoholism and Substance Abuse Services (OASAS). The intended result of this effort will be to prevent licensure and reimbursement from being a barrier to care.[26]

Pay-for-Performance (P4P)

Many payers of healthcare services are attempting to link their reimbursement to quality measures. CMS and Medicare have recently completed a demonstration project and have implemented a voluntary program, which will be a key driver of future reimbursement systems into the future. CMS defines P4P as the "use of payment methods and other incentives to encourage quality improvement and patient-focused high value care."[27] As of July 1, 2006, more than half of all state Medicaid programs were operating one or more P4P programs. Within the next five years, if all current plans to start new programs are realized, nearly 85% of states will be operating Medicaid P4P programs.[28] Of the existing programs, there are 28 states with 36 programs in place, characterized as follows:[29]

- *Provider Type*: The existing programs differ by what provider type is engaged in the program. Of the 36 programs, 24 are geared towards managed care type organizations with the balance spread across various direct provider types; only two programs are engaged with the primary care providers. The number of P4P programs directed at physicians is increasing from two to nine with the anticipated new programs.[30]
- *Type of Measure*: Measures are selected based on the data available and what their intended goal is. As such, they vary by state. The most predominant measures are as follows:
  - HEDIS and HEDIS-type measures are included in 24 of the programs and represent standardized, universally-recognized performance measures. Of particular note, more than 85% of all states with existing programs incorporate measures that relate to the provision of primary care services; with the addition of the new programs, the proportion of states will increase to 90%.[31]
  - Structural-type measures are included in 21 of the programs and are related to a specific status or activity, such as accreditation. These measures are often used as a proxy of care.[32]
  - Cost/Efficiency are included in 13 of the programs. Measures in this category include gauging, for example, the use of generic drugs, utilization rates, and overall spending levels.[33]

New NYSDOH leadership is focused on adjusting the current reimbursement system such that reimbursement will be tied to quality outcomes and performance.[34] New York has had a P4P system in place with managed care organizations for years but not for primary care providers reimbursed under fee-for-service. In 2006, NYSDOH issued a Request for Applications for a Pay-for-Performance Demonstration Project. Applicants included regional coalitions of healthcare payers and providers with the intent to promote the development of P4P programs involving multiple payers that achieve increased quality and cost effectiveness. The statute authorizes up to five regional demonstration projects, totaling only $9.5 million. In March 2007, four demonstration projects were announced.[35]

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[26] Pursuant to meetings/discussions with NYSDOH Office of Health Insurance Programs
[27] CMS State Medicaid Director Letter #06-003, dated April 6, 2006
[28] The Commonwealth Fund, Pay-For-Performance in State Medicaid Programs: A Survey of State Medicaid Directors and Programs, April 2007.
[29] id
[30] id
[31] id
[32] id
[33] id
[34] Pursuant to meetings/discussions with NYSDOH Office of Health Insurance Programs
[35] The State awarded demonstration grants to the Independent Health Association, Inc., the Taconic Health Information Network and Community Regional Health Information Organization, Montefiore Medical Center, and the New York Health Plan Association.

Aside from the obvious positive intentions of P4P programs, there are concerns as well. There may be unintended consequences resulting from P4P programs that are primarily focused on quality and access. For example, providers may steer complicated or potentially noncompliant patients away, and the wrong kinds of incentives or mandatory participation could result in providers leaving the Medicaid program.[36] Additionally, HIT adoption is critical to success in a P4P environment. As such, the fact that the primary care providers lag behind the rest of healthcare sector in adoption and use puts the primary care sector at a disadvantage relative to P4P initiatives.

Medicaid Managed Care

Under NYS's 1115 Waiver, Medicaid beneficiaries are mandated to enroll in a Medicaid managed care plan unless they are specifically excluded or exempt. Exempted populations have the option to enroll in managed care organizations but will not be required to join. Those exempted include people with HIV/AIDS, people who are seriously and persistently mentally ill, people for whom a managed care provider is not geographically accessible, pregnant women already receiving prenatal care from a primary care provider, and Native Americans. Because some patients need specialized care and/or live in institutions, they will not be given the option to enroll in managed care organizations (MCO). Some examples of excluded populations are residents of nursing facilities, residents of NYS-operated psychiatric facilities, and Medicaid-eligible infants living with incarcerated mothers. Patients who are dually eligible for Medicaid and Medicare may be excluded or exempt depending on certain eligibility requirements.

Under Medicaid managed care, NYSDOH contracts with the MCOs, which receive a monthly premium for Medicaid covered services provided to Medicaid beneficiaries who are enrollees of their plan. MCOs then contract with healthcare providers for the provision of services. Rates of payment are negotiated between the plans and each provider. Some plans offer standard reimbursement rates for the same service regardless of the practice setting, whereas others may vary by practice setting. Some MCOs may be provider-sponsored (i.e., healthcare providers also are the owners of the plan), which may result in different negotiated rates than those paid to non-owner providers.

The types of reimbursement rates also differ by plan and provider. One of the more common reimbursement arrangements for the primary care setting is to receive a monthly, fixed payment from the plan, per member, regardless of whether or not the member received primary care services during that month. This is referred to as capitation and shifts the financial risk of primary care services to the provider. Additional reimbursement may be received for services provided over and above the covered primary care services included in the capitation, such as laboratory services and immunizations. These arrangements all differ by plan. Other plans may reimburse for primary care services under a fee-for-service model. Specialty care services are commonly reimbursed on a fee-for-service basis, often at some percentage of the Medicare fee schedule.

There has been much debate over what reimbursement method is appropriate for primary care—capitation versus fee-for-service. Payers believe that capitation will encourage providers to provide preventive services thereby improving the health status of patients. The logic is that healthier patients will be seen less frequently and thereby create a "surplus" for the provider as fixed income continues to be received. Some consumer advocates believe capitation encourages providers to keep patients out of their offices since the provider is incentivized to reduce utilization, thereby creating a barrier to care.

Given the number of plans and their differing contract terms, payment rates, and covered services, primary care providers encounter significant complexity when serving the Medicaid managed care population. This complexity creates additional burden on the professional staff to ensure that the provider will be reimbursed appropriately for services by abiding by each contract's administrative requirements.

Medicaid managed care plans are eligible for additional increases in their premiums received from NYSDOH if certain quality measures are attained. This form of P4P program incentivizes the plans to improve the quality of services provided to their members. A number of the measures are primary care related and based on data supplied to the plan by its contracted providers. Only a handful of plans share the quality measures and scores with their primary care providers, and a few plans might actually incentivize the primary care providers for meeting or exceeding the targeted

[36] The Commonwealth Fund, *Pay-For-Performance in State Medicaid Programs: A Survey of State Medicaid Directors and Programs*, April 2007.

quality measures by providing additional reimbursement. For those plans that are incentivizing providers, they each have different measures that they are monitoring—often poorly defined in the provider's eyes—and information is not shared. The lack of communication and consistency are barriers to success.

One of the barriers cited by Managed Care plans regarding attainment of certain performance measures has been the lack of encounter data being received from the providers. This is more common with arrangements in which primary care is reimbursed on a capitated basis as payment is not tied to submitting claims. Some plans have changed to reimbursing primary care at a fee-for-service payment to force providers to submit claims and hopefully improve performance measures.

Given the above, the reimbursement rates by sub-sector are not necessarily driven by the practice setting but more by the relative size and bargaining position of the provider relative to the MCO. Due to the competition between plans in New York City for membership, larger primary care provider organizations that control a larger portion of a plan's members, or potential members, are often in a better position to negotiate better reimbursement rates. When Medicaid managed care was first introduced in the late 1980s, primary care providers had more flexibility in negotiating rates. But, as the industry has matured, negotiating rates has become less frequent and more difficult. These negotiations are very plan-specific, and NYSDOH has allowed the plans flexibility in these negotiations. However, risk-sharing arrangements, in which a provider and/or plan share in the surplus or deficit, requires NYSDOH review.

Attempting to analyze the Medicaid managed care rates paid, by sub-sector, is a challenge due to the flexibility in rate negotiations and concerns over reporting. Patient revenue reporting by payer type in the NYS cost reports is irregular due to system issues with the transfer of visits between payer categories as a result of the collection process. Median rates reported ranged from $54 to $109 per visit using 2004 data. Managed care organizations are required to file operating reports with NYSDOH, which include a schedule identifying claims and visits paid for primary and specialty care services broken down by provider type (e.g. free-standing clinics, other hospital outpatient departments, other large medical groups). Table 7 summarizes data from the 2005 Medicaid Managed Care Operating Reports (MMCORs).

Table 7: Weighted Average Medicaid Managed Care Net Revenue Per Visit Received, by Sub-Sector, NYC

Subsector	Weighted Average Net Revenue Per Visit *
Voluntary Hospital OPD	$105.08
Hospital Affiliated FQHCs	$105.08
HHC Hospitals	$105.08
FQHCs	$119.32
HHC D&TCs	$119.32
Other Comprehensives	$119.32
Private Physicians	$116.39

** Data Source: We based net revenue per visit on claims expense per visit reported in the 2004 Medicaid Managed Care Operating Reports filed by participating plans.*

Two noteworthy observations are evident from these two sets of data. ***First, from a plan perspective, rates of payment do not fluctuate significantly by sub-sector.*** This is consistent with the maturing of the industry and lessening flexibility in rate negotiations. Plans have generally established uniform rates of payment across sub-sectors, although rates vary between plans. ***Second, the median rates as reported by managed care plans are significantly greater than those reported on the provider Medicaid cost reports.*** Part of this is driven by the specialty care services that are included in the plan data. Another factor is that plans report on a "paid claims" basis, whereas providers are reporting on an "accrual" basis, which reflects bad debt as well as other administrative adjustments resulting in non-payment.

Although there are some data integrity issues with the Medicaid managed care data addressed in the respective section of this analysis, the implementation of Medicaid managed care has spawned an interesting dynamic within New York City's safety net. Medicaid managed care reimbursement has created increased competition amongst providers for members of Medicaid managed care plans. Private physician practices receive the lowest rate of reimbursement under the Medicaid Physician Fee Schedule. With the advent of Medicaid managed care, the level of reimbursement received by physician practices for serving the Medicaid population has increased and, in some situations, risen to a level commensurate with commercial insurance rates. As such, many physician

practices have opened their doors to Medicaid managed care patients causing increased competition among providers for these patients.

FQHC providers receive a supplemental Medicaid managed care shortfall payment from NYSDOH for the difference between the Medicaid fee-for-service rate and the average revenue per visit received from the Medicaid managed care plans.[37] As such, FQHCs are theoretically reimbursed at the same level for both Medicaid and Medicaid managed care patients. This supplemental payment is required as the result of federal statute.[38] Based on data reported on the 2004 AHCF-1s, FQHCs received an additional $50.00 per Medicaid managed care visit as a result of this program.

Trends

NYSDOH continues to promote the expansion of Medicaid managed care in NYS. The new administration continues to look at the excluded and exempt populations and identify opportunities for enrolling them into a managed care environment. In 2005, NYSDOH implemented the Medicaid Advantage program with the goal of transferring dually-eligible Medicaid and Medicare patients into a managed care setting. NYSDOH is currently working with OMH on developing special needs plans and transferring seriously and persistently mentally ill patients into managed care.

The new budget will streamline the enrollment and certification processes for Medicaid and Family Health Plus in an effort to keep patients enrolled in managed care. Proposals include eliminating certain documentation requirements at recertification and providing twelve months guaranteed continuous coverage.

Additionally, NYSDOH is changing the premium rate calculation used to determine the premiums paid to Medicaid MCOs. The new premium model will move to a risk-adjusted model, thereby reimbursing plans based on the utilization and claims data relative to providing services to their patients. NYSDOH plans to implement the new form of premium reimbursement in April 2008, and preliminary premium rate setting discussions are underway. If history were to repeat itself, as the premium reimbursement to the plans changes, a change to the reimbursement paid to the providers themselves is soon to follow. Due to the infancy of this new model, it is difficult to determine what impact, if any, it will have on the reimbursement for primary care services.

Indigent Care Pool Funding

Article 28 providers are required to serve all patients that present themselves, regardless of their ability to pay.[39] This law does not apply to private physician practices. As such, Hospital OPDs, FQHCs, and Other Comprehensives licensed under Article 28 provide a majority of the services to New York City's uninsured. These uninsured or self-pay patients often cannot pay for the full charges related to services provided, thus Article 28 providers are not fully compensated by the patients for services provided. In recognition of the need to supply subsidy to Article 28 providers for uncompensated care, NYS has created the Indigent Care Pool, which is used to provide funding to Hospital OPDs, FQHCs, and Other Comprehensives licensed under Article 28.

Awards from the Indigent Care Pool are defined based on specific methodologies set forth in regulation. The award calculations differ between those used for Hospital OPDs and those used for FQHCs and Other Comprehensives licensed under Article 28. An analysis of the funding on a per visit basis between the various sub-sectors is contained in Table 8.

Table 8: Indigent Care Pool Funding Per Total Visit, by Sub-Sector, NYC

Subsector	Weighted Average Reimbursement Per Total Visit *
Voluntary Hospital OPDs	$20.21
Hospital Affiliated FQHCs	$17.90
HHC Hospitals	$13.19
FQHCs	$3.61
HHC D&TCs	$14.49
Other Comprehensives	$6.88
Private Physicians	None

* *We calculated these amounts by dividing the 2004 distributions received from NYSDOH by total visits. We determined hospital data using an allocation of the total award to the "clinic" cost center divided by total "clinic" visits.*

[37] New York State's Operational Protocol for the Partnership Plan, Chapter Two
[38] The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act, as enacted at 42 U.S.C 1396a
[39] Public Health Law, Article 28 § 2801

Hospital OPDs

General hospitals receive reimbursement from NYSDOH through the Indigent Care Pool for both inpatient and outpatient services. For both practice settings, Indigent Care Pool funding covers charity care measured by the level of discounts offered to uninsured patients (adjusted to cost) as well as bad debts for all payers excluding Medicare. In a given year, the Indigent Care Pool award is based on data supplied to NYSDOH in the ICR from two years previous (e.g., 2007 award is based on the 2005 ICR). Hospitals are not paid for 100% of their charity care and non-Medicare bad debt as the hospital Indigent Care Pool is capped ($847 million, statewide, for 2004). Therefore, in determining the final award amounts, the levels of charity care and non-Medicare bad debt are adjusted and weighted such that hospitals with high need and those who serve a higher percentage of uninsured patients receive a larger percentage of their losses versus those with a lower need. After this weighting of the losses, the total statewide loss is compared to the total amount available. Each hospital then receives a percentage of their overall, weighted loss.[40]

A separate funding pool exists for major public hospitals, including HHC, known as the Indigent Care Adjustment ($412 million, statewide). This represents a DSH payment given only to major public hospitals in an attempt to bring these hospitals up to the aggregate share of funds they would receive if they were paid by the Indigent Care Pool on the same basis as voluntary hospitals.[41] This funding is not included in the above calculations. In addition, major public hospitals are entitled to additional funding streams, known as "DSH Cap Payments" and "UPL Supplements", which are not included in this analysis.

FQHCs and Other Comprehensives Licensed Under Article 28

Article 28 also provides for Indigent Care Pool funding for certain D&TCs. Entities within the D&TC provider type that are eligible for Indigent Care Pool funding are not-for-profit, comprehensive primary care providers.[42]

Unlike the hospital Pool, the D&TC Pool only funds the charity care provided via services to uninsured/self-pay patients and does not include the reimbursement for non-Medicare bad debt. The calculation of charity care also differs. The loss is calculated by multiplying the number of self-pay/uninsured visits by the Medicaid rate, arriving at a proxy for the cost of providing services. This cost is then reduced by the amount of revenues collected from these patients, arriving at the loss eligible for reimbursement. Similar to the hospital setting, centers are not paid for 100% of their charity care since there is a limited amount of funding appropriated for this purpose ($48 million for 2004). An added complexity is that this pool is further segregated into three sub-pools: one for HHC facilities, one for county health departments, and one for voluntary, not-for-profit health centers. As with the hospital award methodology, the levels of charity care are weighted such that those that serve a higher percentage of self-pay/uninsured visits receive a larger percentage of their losses. After the charity care is weighted, the total statewide loss is compared to the total amount available in each sub-pool, and the provider then receives a percentage of their overall, weighted loss.

The award calculations in both the hospital and D&TC pools do not cover 100% of a provider's losses, therefore the awards are often compared against the actual losses to determine what "coverage" of the loss is provided. For New York City providers, the 2004 coverage ratio for Hospital OPDs is approximately 50%, whereas the 2004 coverage ratios for D&TCs are: 29% for HHC, 22% for Other Comprehensives licensed under Article 28, and 16% for FQHCs. Although the Other Comprehensives and FQHCs draw from the same sub-pool, the coverage ratio for the Other Comprehensives is greater as 4 out of the 11 Other Comprehensives provide significant levels of service for free, varying from 25% to 95% of total patient volume. Since services are provided free of charge, and a large percentage of their total volume is self-pay or free, they are entitled to a larger coverage of their losses.[43]

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[40] Public Health Law, Article 28 § 2807-k and w

[41] Urban Institute, *Caring for the Uninsured in New York – What Does it Cost, Who Pays, and What Would Full Coverage Add to Health Care Spending?*, October 2006.

[42] Public Health Law, Article 28 § 2807-p

[43] id

Trends

In NYS's 2007/2008 Budget, NYSDOH has been charged with reviewing the methodology behind the calculations of the Indigent Care Pool awards. Two initial steps were established to begin this effort:

- A task force has been established to review the hospital Indigent Care Pool methodology
- Over a two-year period, the three sub-pools included within the D&TC Indigent Care Pool will be consolidated into one, thereby creating a uniform coverage ratio for all D&TCs. This consolidation is anticipated to increase the coverage ratio for voluntary, not-for-profit centers and reduce the coverage ratio for county health departments. The coverage ratio for HHC facilities should remain approximately the same.

Self-Pay/Uninsured

As noted above, Article 28 providers are required to provide services to patients that present themselves, regardless of their ability to pay, and are partially subsidized for uncompensated care through Indigent Care Pool funding. Certain safety net providers receive additional funding from federal, state, and local governments to serve the uninsured. HHC receives subsidies from NYC to assist this crucial safety net provider in meeting the unmet needs of serving New York City's uninsured. FQHCs receive federal grant funding from the U.S. Department of Health and Human services under the Community Health Center program (Section 330 of the Public Health Services Act) to help subsidize the uncompensated care provided to the communities they serve. As a condition of these funding streams, the providers are required to offer a sliding fee scale discount program to uninsured patients. In essence, a percentage of the patient's charge for services provided is charged-off to charity care, and the patient is requested to pay the reduced fee remaining after the discount.

Credible data currently is not available to analyze the patient revenue generated from self-pay/uninsured patients by sub-sector. Given the subsides received by HHC and the FQHCs, coupled with the Indigent Care Pool funding, it is not surprising that these providers serve a greater percentage of self-pay patients than their counterparts. Based on 2004 Medicaid Cost Report data, self-pay payer mixes are as follows:

- HHC Facilities: 25-28%
- FQHC Facilities: 12-16%
- Other Comprehensives: 7-8%

Trends

NYS has been a leader in expanding healthcare coverage to the uninsured through innovative public programs. NYS expanded the Medicaid managed care program with the creation of Family Health Plus, which covers NYS residents between the ages of 19 through 64 who are not otherwise eligible for Medicaid and meet certain resource/income tests. The other health coverage program is Child Health Plus where children under the age of 19 who are not Medicaid eligible may be eligible depending on gross family income. In an effort to expand healthcare services to NYS's children, the recently passed NYS Budget expands the eligibility requirements from 250% of the Federal Poverty Level to 400%. Historically, as NYS has expanded these programs, primary care providers have seen a shift in their patient mix, with uninsured volumes decreasing as patients are newly covered by expanded public programs. Accordingly, with the impending expansion of these programs, primary care providers could see a shift of these patients out of the uninsured population.

Rates charged to self-pay patients are often tied to government funding that assists in subsidizing the care provided to the uninsured. As these funding streams remain relatively fixed over time, and the costs of providing services increase, the fees charged to the uninsured patients would be expected to increase as well. This trend may be exacerbated as other sources of revenue that may have historically been used to cross-subsidize the uninsured disappear, which puts an added strain on the safety net providers as resources get stretched thin and providers begin to evaluate options to stay financially solvent. Providers may be forced to increase amounts charged to the uninsured or determine the breaking point as to how many uninsured can be seen given their limited subsidies. This could result in a barrier of care to the uninsured in the coming years.

Medicare

Medicare is a national health insurance program covering the elderly, those under the age of 65 with certain disabilities, and individuals with End Stage Renal Disease. Medicare, administered by the Center for Medicaid and Medicare Services (CMS) also has different reimbursement methodologies depending on the practice setting.

Table 9 delineates the average reimbursement rates paid by Medicare for primary care services, by sub-sector. This table includes the 20% coinsurance amount that would be collected from the patient or secondary insurers.

Table 9: Average Medicare Fee-For-Service Rates, by Sub-Sector, NYC

Subsector	Weighted Average Reimbursement Rate *	Covered Services
Hospital OPDs	$65.10	General medical services
FQHCs	$115.33	Federal pre-defined set of services, including medical and enabling services
Other Comprehensives	$80.11	General medical services
Private Physicians	$80.11	General medical services

** Rates for Hospital OPDs, Other Comprehensives, and Private Physician practices are based on the respective Medicare fee schedule for an office visit, applying standard weightings across all Evaluation and Management codes. The rate for FQHCs is based on the 2007 Medicaid payment ceiling.*

Hospital OPDs

Hospital OPDs are reimbursed by Medicare under a prospective payment system in which specific rates are established for services that are grouped according to Ambulatory Payment Classifications (APCs). Services in each APC are similar clinically and in terms of the resources they require. Depending on the services provided, a Hospital OPD may be paid for more than one APC per visit. The bases for APCs are the CPT codes traditionally used in outpatient settings to identify the procedures performed. The pricing of these services generally reflect the medical care and resources provided during such services. There is a 20% coinsurance provision and a patient deductible for which the patient is responsible. Additional billing can be processed to Medicare for ancillary services.

FQHCs

FQHCs also have a separate reimbursement methodology with CMS, and are one of the few provider types that remain on a cost-based reimbursement system. Each year, FQHCs submit a cost report to CMS reporting costs and billable visits. Based on the cost report, CMS calculates a reasonable cost per visit based on certain reimbursement formulae. This reasonable cost per visit is then compared to a national ceiling, and the Medicare rate is established at the lower of the actual reasonable cost per visit and the ceiling. For 2007, the ceiling that applies to FQHCs in New York City is $115.33. Unlike APCs and the Medicare physician fee schedule, the basis for these ceilings include the costs related to the enabling services FQHCs provide to the patients they serve. There is also a 20% coinsurance provision for FQHC services. However, there is no patient deductible for services provided at an FQHC, and the coinsurance amount can be reduced based on the FQHC's sliding fee scale. The ceiling is trended each calendar year based on the Medicare Economic Index. Additional billing can also be submitted to the Medicare intermediary for ancillary services.

Other Comprehensives and Private Physicians

Other Comprehensives and private physicians are generally reimbursed according to the same reimbursement system, that is, under a Medicare fee schedule organized around the Medicare Resource-Based Relative Value Scale (RBRVS). As with

Medicaid, reimbursement is received based on the procedures performed during a visit using CPT codes. This payment rate will reimburse the Other Comprehensives or private physician for the medical services provided during the exam as well as administration and facility costs. There is a 20% coinsurance provision and a patient deductible for which the patient is responsible. If the physician provides additional procedures during a visit (e.g., EKG, laboratory test), additional billing may be performed. The Physician Fee Schedule does not include reimbursement for enabling services.

Trends

CMS has been reviewing the reimbursement system for outpatient services, including primary care, for the past several years. The APC system, currently in use in Hospital OPDs, was implemented in 2000. The other two initiatives that will impact primary care reimbursement in the future is the implementation of the Medicare Advantage program and the Medicare Physician Quality Reporting Initiative.

- A large majority of Medicare beneficiaries receive their health insurance through Medicare's traditional fee-for-service program. Medicare managed care plans have been in existence but with limited success due to low premiums paid to the plans and beneficiaries' concerns over the providers they can see. In an effort to expand the Medicare managed care program, the Medicare Modernization Act of 2003 was enacted. As a result, premiums paid to managed care plans (i.e., Medicare Advantage plans) were increased, and new types of managed care plans are now available. This has resulted in Medicare managed care becoming more enticing to the beneficiaries as covered services will expand, coinsurance payments may reduce, and flexibility in provider choice has improved. As a result, many Medicare beneficiaries are considering shifting to a Medicare Advantage plan for health coverage. In addition, due to improved premiums received, Medicare Advantage plans are pushing for enrollment. As a result, the future may bring a significant shift in Medicare beneficiaries moving from the fee-for-service model to managed care. From a primary care provider perspective, managed care implementation often has been equated with reduced reimbursement rates, there providers are very concerned about the ramifications such a conversion would have on their revenues and ultimately their practices.

  Due to the relative infancy of this initiative, it is hard to predict the eventual impact on provider reimbursement. Medicare Advantage plans are focusing on enrollment and are approaching primary care providers to join their plan and expand their provider network, some offering flexibility in the reimbursement methods. This may provide an opportunity for providers to negotiate rates with the plans. Primary care providers also may consider negotiating incentive reimbursement opportunities for satisfying certain quality measures, however, providers need to ensure that their HIT capabilities are in a position to capitalize on this opportunity. At the same time, premiums paid to Medicare Advantage plans currently are not driven by a quality scoring or P4P method, so plans may not be interested in such an option. Primary care providers may want to look back at the lessons learned during the implementation of Medicaid managed care in NYS as many of the same dynamics may play themselves out. Managed care plans build their provider networks and actively market to the Medicare population. As new members are enrolled into the Medicare Advantage product, their primary care provider may change to those who are members of the plan's provider network. Those providers who do not actively embrace the Medicare Advantage program may experience a deteriorization of their Medicare patient base. In addition, the rates of payment from the Medicare Advantage plans as well as the administrative requirements may differ significantly from the traditional fee-for-service program, potentially resulting in a further reduction in revenue.
- FQHCs have been granted protection of their reimbursement in the Medicare Advantage program. As with Medicaid managed care, FQHCs are entitled to a supplemental payment from CMS to cover the difference between the Medicare FQHC rate and the average revenue per visit received from the Medicare Advantage program.
- CMS has implemented a voluntary P4P program for private physicians, linking Medicare payments to quality.[44] This system, titled Physician Quality

[44] Tax Relief and Health Care Act of 2006, Title 1, Section 101

Reporting Initiative (PQRI), is a voluntary program that will provide a financial incentive (i.e., a bonus) to private physicians who successfully report quality data on 74 measures related to services provided between July 1 and December 31, 2007. The bonus is subject to a cap of 1.5% of total allowed charges for covered Medicare physician fee schedule services. In order to satisfactorily meet the requirements of the program and receive the bonus payment, certain reporting thresholds must be met. When no more than three quality measures are applicable to services provided by an eligible professional, each such measure must be reported in at least 80% of the cases in which the measure is reportable. When four or more measures are applicable to the services provided by an eligible professional, the 80% threshold must be met on at least three of the measures reported. As this program is in its infancy stage, its impact cannot yet be ascertained. It is safe to say that HIT is integral for successful participation in this program.

- In 2008, Medicare payment rates paid for hospital outpatient services will be impacted by the reporting of certain quality measures. On August 2, 2007, a proposed ruling was published in the Federal Register setting forth the initial quality measures under consideration and requesting comment.

Commercial Insurance

As with Medicaid managed care, commercial insurance rates for primary care services, by sub-sector, are not clearly defined in law or regulation. Rates of payment are negotiated between the commercial insurers and each provider. Some plans offer standard reimbursement rates for the same service, regardless of the practice setting, whereas others may vary by practice setting. Reimbursement arrangements also may differ by plan and provider, that is, capitation versus fee-for-service. As for services covered by rates paid by commercial insurers, they generally cover the medical services provided during the exam as well as administration and facility costs. Additional fees are available for ancillary services provided. Enabling services often are not included in the determination of the reimbursement rates or included as covered services in the contracts.

Some commercial insurers are providing financial incentives to providers for satisfying certain quality measures. However, each insurer often will request different quality measures, creating a very complex process for the primary care providers to monitor and actually generate change. This—combined with minimal financial rewards and an often incomplete understanding of the incentive program and the measures to be monitored—has minimized the impact of the incentives on the quality of care delivered and the reimbursement received by the provider.

Trends

Pay-for-performance is a national phenomenon in the private sector, being lead by both payers as well as healthcare purchasers. In some instances, employers and other purchases of healthcare services are banding together to improve quality of care and reward providers for satisfying certain standards. Such organizations include Bridges to Excellence and The Leapfrog Group. In other instances, healthcare purchasers and providers are joining forces and implementing P4P programs, such as Integrated Healthcare Association in California. As mentioned earlier in this report, New York is in the process of initiating a two-year demonstration project to explore P4P programs in a joint effort among multiple payers and providers in five geographic regions. The trend in the commercial insurance world is clearly to link reimbursement and rewards to quality and outcomes. Again, the successful adoption and use of HIT among primary care providers is critical to the success of these programs.

Appendix C

Detailed Description of Available Grant Subsidies

A variety of government grants and subsidies are available to all institutional providers to assist with providing services to the uninsured. Many of these often target specific health conditions.

- Ryan White Care Act funding for services to HIV/AIDs patients: This program is administered by the HIV/AIDS Bureau (HAB), which is also part of HRSA. Ryan White funding includes the following programs:
  - Title I - Administered by the Medical Health and Research Association of New York City (MHRA) and covers 300 contracts over 130 organizations with approximately $130 million

annual expenditures. New York City is the largest Emergency Metropolitan Area (EMA) for Title I funding.

  - Title II – Administered through NYS and includes funding for the AIDS Drug Assistance Program (ADAP), which is administered by the NYS Department of Health AIDS Institute
  - Title III – Funds early intervention services for community health centers. Many health centers in New York City are direct Title III grantees.
  - Title IV – Provides funding for organizations serving women and families. Some of the Title IV funding in New York City goes through consortia of providers.
  - Part F – Includes Special Projects of National Significance (SPNS), AIDS Education and Training Centers (AETC), and the Dental Reimbursement program. Safety net providers can potentially receive funding directly, or receive services to help build infrastructure and deliver care.

- Other HIV funding: Safety net providers may have other contracts directly with the NYS AIDS Institute to provide services. Some safety net providers also receive federal CDC Prevention funding. This funding also is administered through MHRA and covers 70 contracts totaling over $14 million. Some safety net providers also may have licenses to provide COBRA Case Management, which is billable in 15-minute increments.
- Title X funding: This covers family planning services, which are billed in 15-minute increments. Even when patients enroll in managed care, family planning providers may bill and be paid by NYS directly; these funds are subsequently charged back to the managed care plans.
- Maternal and Child Health: Safety net providers may be funded under Title V or Title XIX for serving mothers and children.
- WIC: Some safety net providers receive funding through the Women, Infants, and Children program. This funding covers the pass-through costs of food and also may cover nutrition education and counseling as well as certain administrative costs.

Appendix D

Options for Payment Form and Rate Setting Methodology

Form of Payment

Healthcare providers are generally reimbursed by third party payers utilizing four forms of payment:

1. *Fee-for-service* –
   - *Intensity-weighted*: Under this form of reimbursement, providers are paid for each encounter or procedure performed during the patient visit; multiple procedures may be performed during a given patient visit. The fee for each procedure differs to reflect the general intensity of service provided as measured by the resources utilized to provide the typical service. Under Medicare, this form of reimbursement is known as the Resource-Based Relative Value Scale, or RBRVS, system for physician practices and ambulatory payment classifications (APCs) in the hospital outpatient setting. Each service is assigned a code, which is linked to a relative value. The medical industry generally uses the Common Procedural Terminology (CPT) coding scheme for this purpose.
   - *All-Inclusive Threshold Rate*: This payment rate is the currently used form of Medicaid payment for primary care services in New York State. Using this model, the healthcare provider is paid one pre-defined rate for each patient visit, regardless of the nature or amount of services provided during the visit. One rate is paid whether it entails a brief visit or a comprehensive exam. The rate typically is calculated as an average and encompasses all services provided to the patient during the visit.
2. *Capitation* – This form of reimbursement is popular in managed care arrangements in which the healthcare provider is paid a fixed monthly amount (capitation payment) for each patient that has selected the provider as his/her primary care provider, regardless of whether or not the patient receives services. Capitation payments differ based on patient actuarial class. (Each actuarial class is defined based on demographic and expected utilization factors; these utilization factors are then used to determine the expected

healthcare expenditures in a given year. These expected annual healthcare expenditures are then divided by twelve to arrive at the monthly capitation payment for each actuarial class.)

3. *Episode of Care* – The Institute of Medicine has defined an episode of care as a health problem from its first encounter with a healthcare provider through the completion of the last encounter. This form of payment covers all services required to treat an episode of care, which may include multiple provider types. The DRG payment received by hospitals for inpatient services is a form of an Episode of Care payment.
4. *Incentive Payments* – Under this model, providers are paid an additional amount for attaining certain quality measures or health outcomes for patients. The underlying theory suggests that if primary care providers improve the health status of their patients there will be savings to the entire healthcare delivery system, which would then be shared with the providers. Incentive, or pay-for-performance, payments are often used to supplement other forms of reimbursement.

Payment Rate Setting Methodologies

In addition to the form of payment, there are differing methods by which rates are determined:

- *Price-Fixed Reimbursement* – Under this method, the payer performs an analysis and determines the amount of reimbursement that is appropriate for a particular unit of service. Those amounts are usually updated regularly based on inflation and/or changes in the practice of medicine. The payer may use historical cost and utilization data as well as actuarial assumptions to determine the cost and level of required resources to be used for a typical service; rates are then set based on the analysis. This method is used by Medicare in its RBRVS-based physician reimbursement as well as by NYS Medicaid in its physician rates. Payers prefer this form of reimbursement as it reflects the intensity of services provided, but providers are concerned about the extent to which this rate-setting process reflects the true cost of providing services.
- *Prospective Payment* – Prospective payment methods essentially establish rates at the beginning of the specific rate period, which are then used to pay for services during the course of the year. The PPS rate is determined using data available from a specific base year. The rate is often based on the costs of each provider, which are then trended forward year-by-year to take into account inflation. Technically, New York State has an ambulatory care cost-based, prospective payment system in regulation, which uses a rolling base year (i.e., changes each year to a base of two-years prior). Because it has been frozen since 1995, however, it has effectively become a flat, fixed rate of payment. Payers prefer this model, since the payment amount is fixed at the beginning of the rate period and is therefore predictable.
- *Cost-Based Reimbursement with Retrospective Settlement* – Under this method of rate determination, initial rates are prospectively determined, usually based on a prior year's cost per unit of service, and paid during the year on an interim basis. After the specific rate period (year) is completed, the provider submits a cost report and the payer determines the actual cost of providing services. Interim payments made during the year are then subtracted from the cost determined per the cost report, and the payer imposes a settlement to adjust total payments for the year to actual costs. Although payers generally build in standards to assure that costs are reasonable and efficient, cost-based payment is inevitably associated with paying for, and therefore encouraging, inefficiencies. Third party payers dislike this method both because of its administrative requirements and because they have difficulty predicting or controlling overall health expenditures under this model.

Appendix E

The Conceptual Framework for a Restructured Patient-Centered Primary Care Reimbursement System

This framework combines four reimbursement approaches:

Preventive and Primary Care Services

The provider would be paid a fee-for-service, intensity-adjusted rate for preventive and primary care services provided to the patient in the exam room (with the exception of the annual physical exam, which is included in the capitation payment below) plus incidental services,

thus encouraging the provision of primary and preventive care services. Rates would vary by procedure, or visit, with adjustment for regional variations, and should be consistent across all practice settings (e.g., RBRVS, APCs). The rates established must take into account the increased administrative/operational requirements of Article 28 regulation. (Rates would be determined by NYS based on expected practice patterns, resource utilization, historical cost data, and generally accepted intensity measures. Rates would be updated annually.)

Patient-Centered Primary Care Model Services

Those providers who meet the standards of providing patient-centered primary care would be paid for these services on a case-mix adjusted, capitation basis (PMPM). Patient-centered primary care elements include access and communication requirements, care tracking and the use of registries, care management, and performance reporting and improvement.[45] Patients would select a provider as their care manager, who would then be responsible for performing the relevant services to the patient. If a patient has been diagnosed with a chronic condition (e.g. asthma, diabetes), the provider would also be responsible for managing the treatment plan of the specific condition. The provider is required to provide an annual exam to develop an annual care plan and appropriately assess the patient's health condition/status, which would set the PMPM payment for the year. The case-mix adjusted PMPM rate would be based on the patient's health status (pre-defined categories established based on factors such as age, sex, current health condition, etc.). A new claim submission protocol would be required to provide NYS with evidence of the patient-centered services provided. (The capitation payment needs to be developed as the new primary care model evolves and matures. Initially, the rate would be based on budgeted cost and expected utilization data for care management and other patient-centered services. As actual data is collected through the revised cost report and claims data, the payment rate would be adjusted to reflect actual experience. Over time, expected patient-centered service cost and utilization data, by patient health status categories, can be analyzed, eventually evolving into a more refined model reflecting the reasonable cost of the efficient provision of care management and patient-centered services.)

Technology and Capital

The provider would receive a facility-specific add-on for the costs of technology and capital. These differ by individual provider, accommodating the different regulatory requirements that pertain to different settings as well as varying levels of technology implementation and capital cost. (The facility specific add-on can also be used as a vehicle to fund the introduction of graduate medical education in the primary care setting. [Facility specific add-ons would be based on data collected through the filing of cost reports, eventually adjusted to actual and taking into account efficiency measures.])

Positive Health Outcomes

Each year, the overall health outcomes of a provider's patients, who have selected the provider as their care manager (mandated patient-centered services), would be evaluated. If predefined performance measures and/or health outcomes are achieved, the provider would be eligible for an incentive payment. Payments would be made out of overall healthcare savings. (Incentive payments would be set by the State, based on the sharing of overall healthcare savings, and need to be sizable enough to incentivize providers to achieve desired performance and outcomes.)

Developing such a reimbursement approach will require certain data analysis. The current cost report format for D&TCs captures much of the information required to construct the proposed model. It would need modification to capture the patient-centered primary care services (both cost and utilization) as well as technology and need more clearly defined instructions for the proper completion. This cost report would be required for all participating primary care providers (D&TCs, hospitals, and private practices) on an ongoing basis to provide the State with the information necessary to update rates according to changes at the facility as well as to monitor the effects of the new primary care model.

The properly designed report, coupled with analysis of Medicaid paid claims data, including new claim submission requirements for patient-centered services, will provide the information necessary to construct this

[45] Standards and measures of these elements, as well as methods for patient-centered primary care designation, are being developed at a national level by the National Committee on Quality Assurance in conjunction with the major primary care specialty associations and can be adapted for use in New York State.

model. This data can also be used to monitor and evaluate providers to ensure that all required services are being performed and to monitor utilization of services, including patient-centered primary care services, by patients.

Improved health outcomes can first be measured by reductions in emergency room and inpatient utilization available in the Medicaid claims files and can form a rudimentary basis for constructing incentive payments for primary care providers. Enhanced performance and outcome tracking and reporting is an integral part of the patient-centered primary care model and to designing proper incentives. Reporting systems making this data available to the State will need to be designed.

This reporting and rate-setting model creates transparency and accountability while at the same time supporting a patient-centered primary care model that, if successful, will produce savings to the State's overall healthcare spending and incentives to the providers. By segregating services between fee-for-service and capitation, it ensures providers are paid appropriately and unintended provider practice incentives that exist in the current reimbursement system are disentangled.

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