2015 HCRA MODERNIZATION TASK FORCE REPORT

INTRODUCTION

The State Fiscal Year (SFY) 2015-16 Budget enacted the Health Care Reform Act (HCRA) Modernization Task Force under Section 2 of Part W of Chapter 57 of the Laws of 2015. This diverse task force is made up of representatives from the New York State Senate, the New York State Assembly, health care provider and insurance plan associations, health care insurance plans, hospitals, health care attorneys, Department of Health (DOH), Division of the Budget (DOB) and, the Office of Pool Administration. The task force objectives were to evaluate the efficiency and transparency of HCRA and provide recommendations to the Governor and the Legislature on how to update and improve the law, originally enacted in July of 1996. Specifically, the statute required that the workgroup:

- Evaluate the purposes for which the HCRA fund was established and whether such purposes may be continually served by such fund;

- Assess the impact that any reduction or recalculation of indigent care and disproportionate share payments pursuant to federal law may have on the HCRA fund, and the cost that such reductions or recalculations will have to the State;

- Determine the extent to which provisions of law related to HCRA have become obsolete; and

- Review the Federal Balanced Budget Act of 1997, Public Health Law 105-33, and its requirements regarding assessments under HCRA and the impact any proposed change would have on the protections by such law; and

- Consider any other purpose that would contribute to the streamlining and modernization of HCRA and the HCRA fund.

The team members met four times to evaluate HCRA, starting in May of 2015. The highlights of each session are described below. Presentations were created for each session and have been included with this report.

BACKGROUND

HCRA was established in 1996 to help finance a portion of state health care activities. Extensions and modifications to HCRA have financed new health care programs. Specifically, the bill memo drafted in support of the original legislation outlined the initial purpose of the Health Care Reform Act:

"To authorize negotiated rates for inpatient hospital services for all Non-Medicare and Medicaid payors, improve the quality of health care services, establish the New York State Small Business Health Insurance Partnership Program to expand health coverage to the uninsured, expand the Child Health Plus Program to include children through 18 years of age and to enhance the benefit package to include inpatient services, provide a source of revenue for continued funding of health policy initiatives, improve targeting of reimbursement for hospital bad debt and charity care, provide an alternative source of reimbursement for some of the costs of graduate medical education, promote the availability of health care in rural areas, and provide support for restructuring for eligible health care facilities, encourage the expanded and improved delivery of primary care health services and provide support to foster necessary restructuring of our health care infrastructure."

In order to meet its objectives, the Health Care Reform Act established the HCRA Resources Fund (the Fund), providing a source of funding for many public health care goods, like Hospital Indigent Care, Elderly Pharmaceutical Insurance Coverage (EPIC), physicians' excess medical malpractice, and working disabled. Additionally, HCRA provides enhanced funding to programs such as Child Health Plus and rural health care initiatives, health workforce retraining, health facility restructuring, AIDS Drug Assistance Program, and cancer initiatives. Finally, the Fund provides offsetting General Fund spending on the Medicaid program.

Since its establishment, the Fund has relied on a variety of sources of revenue to meet its ever evolving programmatic spending objectives. Currently, $5.5B in state dollars flow through the Special Revenue Fund annually. Major sources of revenue include various surcharge rates assessed on net patient service revenue at facilities licensed under Article 28 of the Public Health Law, (hospitals, diagnostic and treatment centers providing either comprehensive care or ambulatory services), a Covered Lives Assessment per diem imposed on health care payors for each inpatient hospital insured member, a one percent (1%) hospital assessment imposed on hospital's inpatient revenue, and a portion of the State's tobacco tax receipts.

The various revenues and disbursements by HCRA are outlined in the Financial Plan chart below:

HCRA FINANCIAL PLAN FY 2017 THROUGH FY 2021 (millions of dollars)	FY 2017 Current	FY 2018 Projected	FY 2019 Projected	FY 2020 Projected	FY 2021 Projected
Opening Balance	**78**	**0**	**0**	**0**	**0**
Total Receipts	**5,597**	**5,702**	**5,728**	**5,750**	**5,711**
Surcharges	3,146	3,233	3,293	3,353	3,412
Covered Lives Assessment	1,079	1,110	1,110	1,110	1,045
Cigarette Tax Revenue	882	854	823	788	755
Hospital Assessments	404	424	424	424	424
NYC Cigarette Tax Transfer/Other	86	81	78	75	75
Total Disbursements	**5,675**	**5,702**	**5,728**	**5,750**	**5,711**
Medicaid Assistance Account	3,802	3,840	3,811	3,693	3,561
Medicaid Costs	*3,605*	*3,643*	*3,614*	*3,496*	*3,364*
Workforce Recruitment & Retention	*197*	*197*	*197*	*197*	*197*
Hospital Indigent Care	952	892	892	892	892
HCRA Program Account	389	330	330	335	339
Child Health Plus	226	238	253	383	541
Elderly Pharmaceutical Insurance Coverage	144	145	140	140	140
NYSOH Health Benefit Exchange	0	66	84	86	88
SHIN-NY/APD	30	40	40	40	0
All Other	132	151	178	181	150
Annual Operating Surplus/(Deficit)	**(78)**	**0**	**0**	**0**	**0**
Closing Balance	**0**	**0**	**0**	**0**	**0**

Meeting Summaries

This first meeting was held in Albany on May 20, 2015 and provided the group with an overview of HCRA's history since its inception on January 1, 1997, detailing legislative surcharge and Covered Lives Assessment changes, as well as monetary changes in support to programs. Additionally, a summary of HCRA's Financial Plan for SFY 2015 through 2019 was presented detailing projected receipts and disbursements. This included historical HCRA revenues for SFY 2008 through SFY 2015, broken down by Covered Lives Assessment (including the top 25 payors), surcharges (including the top 25 payors), tobacco tax transfer, and all other revenue sources. Finally, the Federal Balanced Budget Act of 1997 (Public Health Law 105-33) was reviewed, along with the potential impact any proposed change would have on the protections provided by such law.

The second meeting was convened in Albany on June 24, 2015 to discuss the HCRA revenue reports and audit process. State contractors from the Office of the Pool Administrator (OPA) and KPMG, LLC were in attendance to present on both subjects, respectively. OPA provided the group with a copy of the quarterly report it prepares for the Legislature that shows collections for HCRA surcharge and Covered Lives Assessments and 1% assessment. The report also shows distributions for Hospital Indigent Care, Empire Clinical Research Investigator Program (ECRIP), Poison Control Network, School Based Health Center Grants, and Financial Assistance Compliance Pool. It was decided the report is too voluminous to work with and the team discussed ways to make the report more succinct and useful. The second half of the meeting entailed an overview of the HCRA audit process, presented by the current contracted auditing firm, KPMG, LLC. Audit staff presented payor and provider audit milestones and timelines, common audit issues seen in previous audits and recommended improvements to existing audit services. Finally, consistent with the direction the State is moving with its MRT Waiver and value based payment (VBP), the group discussed the need to increase KPMG outreach and training regarding how payors and providers should handle reporting VBP arrangements for audit purposes.

The purpose of the third meeting, held in New York City on Tuesday, August 11, 2015, was to present preliminary recommendations to the group based on prior meetings. Based on the feedback received from the group, the final recommendations have been outlined below.

A fourth meeting was convened based on a request from select Workgroup members to take a deeper look into quarterly revenue and disbursement reports developed by OPA. Similar to the outcome noted in the second meeting above, the group concluded that while the reports contain large amounts of information regarding OPA transactions, they were difficult to follow and lengthy. A revised report was proposed, which was shorter and would ideally match as closely as possible to the DOB HCRA Financial Plan information available online. This would be done for the items that OPA is responsible for reporting on, which are noted above.

All of the documents provided during the meetings have been attached to this report.

RECOMMENDATIONS

Based on the Workgroup meetings summarized above, the following list of final recommendations were developed:

- **Recommendations #1:** "Clean up" HCRA statute to produce greater public transparency and to eliminate irrelevant or outdated language.

- **Recommendation #2:** Improve HCRA quarterly reporting in order to make revenue and expense information more transparent and understandable to stakeholders. Additionally, ensure that OPA reporting ties as closely as possible to DOB Financial Plan reporting.

- **Recommendation #3:** Expand payor and provider training programs to more frequently address areas in which potential vulnerabilities have been identified. Current contracted auditing firm of KPMG, LLC, will derive specialized targeted education programs when systemic audit issues are identified. Refine auditing procedures to improve efficiency, reduce delays and detect issues earlier. Additionally, KPMG will incorporate VBP (i.e. subcapitation arrangements) in their education forums to prepare for the shift under the federal waiver. These training programs will be conducted within current vendor contract resources.

- **Recommendation #4:** In the event the federal government makes reductions to New York's indigent care and disproportionate share (DSH) allotment, the Department of Health will reconvene the Medicaid Redesign Team Indigent Care Technical Advisory Committee, a subgroup of the Payment Reform and Quality Measurement Workgroup. The group will evaluate the impact of the funding decrease and make recommendations to the Commissioner of Health and Legislative Chairs regarding the most appropriate way to implement the federal reductions. This letter has been attached to the report.