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Living Expenses

How a Hospital Stumbled Across An Rx for Medicaid

**Mt. Sinai Helps Patients Avoid
The ER, Paring State Costs
And Aiding Its Bottom Line**

Dr. Chassin Goes After Salt

By **JOHN CARREYROU**

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After being diagnosed with congestive heart failure three years ago, Norma Soto became a regular at the emergency room of New York's Mount Sinai hospital. Each visit was lucrative for Mount Sinai because Medicaid covered Ms. Soto's expensive treatment.

"I'd end up spending hours there," recalls the unemployed 54-year-old, who lives alone in public housing in East Harlem. On one visit she could barely breathe and was kept overnight, a service Sinai typically bills at about \$7,000.


FIXING FINANCES

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These days, when Ms. Soto doesn't feel well, she calls a nurse who checks her weight, gives her advice and adjusts her medicine. Mount Sinai pays the nurse's salary and misses out on the big fees Ms. Soto used to generate. More importantly, New York state, which helps fund Medicaid, avoids having to pay a hefty hospital bill.

The unusual program is the result of a deal between Mount Sinai and the state, and it could offer a way to help ease the U.S.'s seemingly intractable health-care crisis. The hospital provides free preventive care to poor East Harlem residents in exchange for higher Medicaid reimbursement rates at its outpatient clinic. It also expects to fill the beds that become free with better-paying patients. Combined, that will more than make up for the hospital's lost revenue. The state, for its part, hopes the program will help reduce its ballooning Medicaid expenditures by cutting down on expensive trips to the ER.

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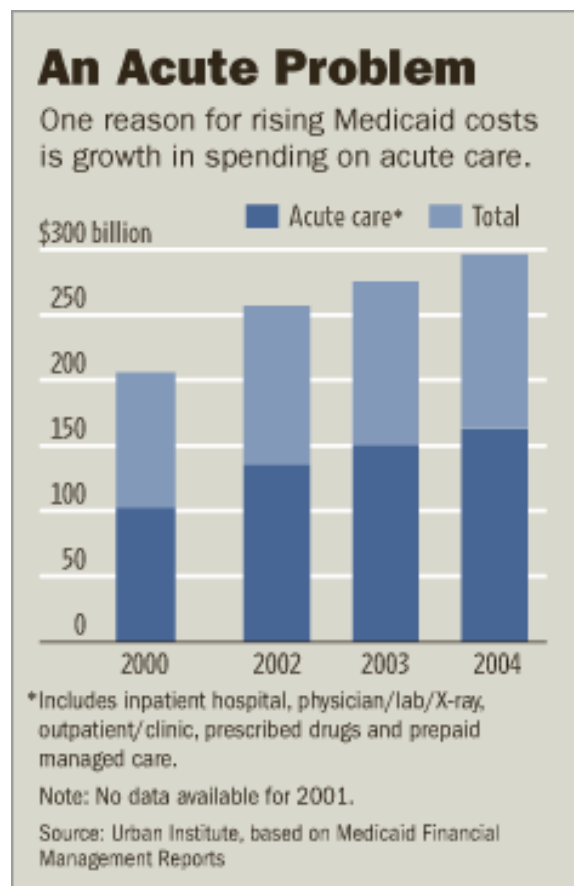
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As health care grows ever more costly, Medicaid is becoming a growing financial burden for the states. The program, which provides health insurance to 52 million low-income Americans, saw costs rise 44% between 2000 and 2004 to \$296 billion. States share the expense with the federal government, and Medicaid now consumes almost 17% of their budgets.

The lion's share of these costs is generated by a minority of recipients, typically patients with chronic diseases such as heart failure. According to the nonprofit Center for Health Care Strategies, adults with chronic illnesses represent 40% of Medicaid recipients but 80% of its expenditures. Hospital fees for these patients make up a major chunk of the costs.

Some states have tried limiting the expenses they cover. Others have dropped thousands of people from the rolls by changing eligibility criteria. Neither approach tackles the core problem. Reducing hospitalization rates for chronically ill people is "the Holy Grail of Medicaid cost savings," says James Tallon, president of the United Hospital Fund, a philanthropic organization that tries to improve New York's health-care system. Mount Sinai's program, he says, could provide an answer.



In New York and many other states, most poor people get their care at hospitals. That's because Medicaid doesn't reimburse office-based doctors enough to cover the costs of treating poor patients. At the same time, few hospitals run preventive-care programs because Medicaid pays them only for specific procedures, reducing their incentive to intervene before a patient's health deteriorates.

Like other states, New York created Medicaid managed-care plans in the early 1990s in an attempt to tamp down costs. The plans pay premiums to private health insurers to cost-effectively manage the care of Medicaid patients. But New York excluded Medicaid patients with disabilities and chronic illnesses such as

heart failure, worrying that private insurers would skimp on their care.

Huge Costs

As a result, those patients, who now number 630,000, continue to generate huge costs for the state. In 2005, they accounted for 45% of New York's \$46 billion Medicaid budget even though they represented only 15% of New York's Medicaid recipients. New York's Medicaid program is the most expensive in the country, says Dennis Whalen, executive deputy commissioner of the New York Department of Health.

Mr. Whalen says the health department can't yet expand the Mount Sinai program to the entire state, but "this is where we want to see health care move." (More than half of New York's Medicaid budget is covered by the federal government. The state picks up about a third and local governments, including New York City, are responsible for the rest.)

Mount Sinai is located at the intersection of East Harlem, one of New York's poorest neighborhoods, and the Upper East Side, one of its most affluent. The two neighborhoods have very different mortality rates. In 2001, the latest year for which the state provided data, there were 1,064 deaths per 100,000 people in East Harlem, 311 of which were heart-related. That same year, there were 551 deaths per hundred thousand on the Upper East Side, including 205 from heart-related illnesses.

Mount Sinai is on "the San Andreas fault line of health disparities," says Mark Chassin, the hospital's chairman of health policy.

Dr. Chassin wanted to bridge the health-care gap between Harlem's poor residents and their wealthy white neighbors. One area he decided to focus on was heart failure, an illness that has been taking a worsening toll among Harlem's blacks and Hispanics.

A chronic disease in which the heart muscle weakens and atrophies, heart failure has a terrible mortality rate: 75% of the men and 62% of the women diagnosed with it die within five years. Yet, new drugs, a low-sodium diet and careful monitoring can dramatically improve a patient's health and life expectancy.

Biggest Enemies

One of the biggest enemies for a weakening heart is salt, which causes the body to retain water, making it harder to breathe. To keep the disease under control, patients must limit their salt intake and monitor their weight regularly for any sign of water retention.





Mark Chassin

Dr. Chassin and a Mount Sinai colleague, Carol Horowitz, conducted interviews with 19 heart-failure patients treated at the hospital. The interviews showed few understood their illness and some didn't even know they had been diagnosed with it. A second round of interviews confirmed the findings.

Using a \$2.3 million grant from the Agency for Healthcare Research and Quality, a federal agency that works to improve the U.S. health-care system, Drs. Chassin and Horowitz devised a 12-month trial to see if they could contain the disease with preventive care.

They enrolled 405 heart-failure patients from Mount Sinai and three other Harlem hospitals, including nearby North General Hospital, with which Mount Sinai has developed a close relationship. Of these patients, 60% had annual incomes of less than \$15,000. Half were placed in a control group. The other half met with Mount Sinai nurses who taught the patients basic facts about their illness and followed up with regular phone calls to their homes.

Reducing salt consumption is no easy task in East Harlem. Hispanic immigrants in New York, who make up 55% of the local population, eat a lot of salty dishes and condiments. East Harlem has few supermarkets. Many residents shop at corner bodegas, which carry few fresh foods and are stocked with salty canned goods and soups.

Accompanied by a nutritionist, Dr. Horowitz canvassed the neighborhood and collected dozens of common foods, such as Pathmark Chicken Noodle Soup and Goya Yellow Rice. She put the labels into a binder, which the nurses used to teach patients how to decipher nutritional information. Dr. Horowitz says she called the binder the "Oh-my-God book" because patients often blurted out "Oh my God!" when they found out about the salt levels in their food.

Impressive Results

The results of the trial, which has been accepted for publication in the *Annals of Internal Medicine*, were impressive. The mobility of the patients monitored by the nurses -- a good gauge of a heart-failure patient's health -- stabilized during the trial's first nine months and improved between the ninth and 12th months. Patients in the control group, by contrast, became increasingly less mobile over the 12 months of the trial.

When the trial ended in 2003, Dr. Chassin decided to turn it into a permanent program. "Communities have come to feel like they're guinea pigs because these research programs end and are never institutionalized," he says. Patients who had been helped by the nurses relapsed after the trial ended.

But Dr. Chassin was out of money. Mount Sinai, meanwhile, was in bad financial shape. The hospital had lost a total of \$50 million in the last quarter of 2002 and the first quarter of 2003.

Early in 2003, the hospital tapped a psychiatrist, Kenneth Davis, as its new chief executive. As part of his effort to turn the hospital around, Dr. Davis approached the New York Department of Health in search of a deal that would reduce losses at Mount Sinai's outpatient clinic. The clinic loses tens of millions of dollars a

year because Medicaid reimbursements aren't enough to cover the costs of treating low-income patients.

New York's Medicaid rules allow certain types of clinics, known as Diagnostic and Treatment Centers, to enjoy higher Medicaid reimbursement rates. Mount Sinai and North General asked the state to grant their outpatient clinics DTC status. But the state wanted something in return: The hospitals had to find a way to help it reduce its Medicaid spending.

At a strategy meeting with hospital administrators, Dr. Chassin proposed using the heart-failure program as a bargaining chip. By turning it into a permanent program, Mount Sinai would reduce hospitalization rates of heart-failure patients, saving the state money. At the same time, the higher Medicaid reimbursements Mount Sinai's clinic would enjoy as a DTC would cut its annual losses by several million dollars a year. Part of those savings would fund the heart-failure program and the rest would flow to Mount Sinai's bottom line.

One Unknown

One unknown in the financial equation was how much revenue Mount Sinai would lose by improving its patients' health. Dr. Davis says he didn't worry; with Mount Sinai's occupancy rate around 95%, he figured the hospital could replace heart-failure admissions with more lucrative, non-Medicaid patients, such as those getting hip replacements. "Having fewer heart-failure hospitalizations is actually very good for Mount Sinai," he says.

The state agreed, hoping that the increase in reimbursements would be outweighed by the reduction in hospital bills. The heart-failure program resumed as a permanent program in September 2005 and so far about 40 East Harlem residents have been enrolled. One of them is Rafael Mulero, a 43-year-old father of six who was diagnosed with the disease in his late 30s after suffering a heart attack while lifting crates at his warehouse job.

Mr. Mulero was a talented baseball player in his youth. As a teenager, he played third base for a high school in San Antonio. But he says he blew out his knee on the day Texas Rangers scouts came to see him play. "They were going to draft me," he recalls wistfully.

These days, Mr. Mulero is too weak to play baseball or work. He spends his days at home in a Harlem high rise minding his 2-year-old twins. Mr. Mulero's wife works at a pharmacy and brings home his medicine. Like many heart-failure patients, Mr. Mulero also suffers from diabetes, requiring three daily injections of insulin.

The Mount Sinai program has changed the way he eats. Before enrolling last fall, he says he doused his food in Adobo and Sofrito, two salty seasonings, and ate a lot of fast and fried food. He now uses Mrs. Dash salt-free seasoning and bakes dishes, instead of frying them, eats a lot of rice and beans, and tries to limit pizza to once a month.

Two years ago, Mr. Mulero weighed 260 pounds. Today, his weight is 197 pounds. Since December, his sodium consumption readings have come in below 2,000 mg a day -- the threshold Mount Sinai doctors recommend heart-failure patients not cross.

On a recent afternoon, Mr. Mulero was sitting in his living room watching a Mets game. He said he had

regained his motivation to stay healthy. Glancing toward his young twins, he said: "I want to see these two graduate from college."

Ms. Soto, the frequent ER visitor, joined the program in January. She was born in Puerto Rico and came to the mainland U.S. as a child. Heart disease runs in her family. Her mother died of heart failure, and her father wears a pacemaker.

She used to mind her grandchildren while her daughter was at work, but she had to stop because she could no longer keep up with them. On some days, just walking across her living room leaves her out of breath.

Her first sodium reading came in at 4,007 mg a day, double the maximum recommended dose. She says the program has been helpful by providing her with a support network. "You have somebody to call when you have questions," she says. Ms. Soto now avoids the neighborhood bodegas and lingers in the supermarket aisles reading food labels. After she followed the program, her sodium reading dropped to 1,707.

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