SFY 2018-19 Executive Budget Testimony

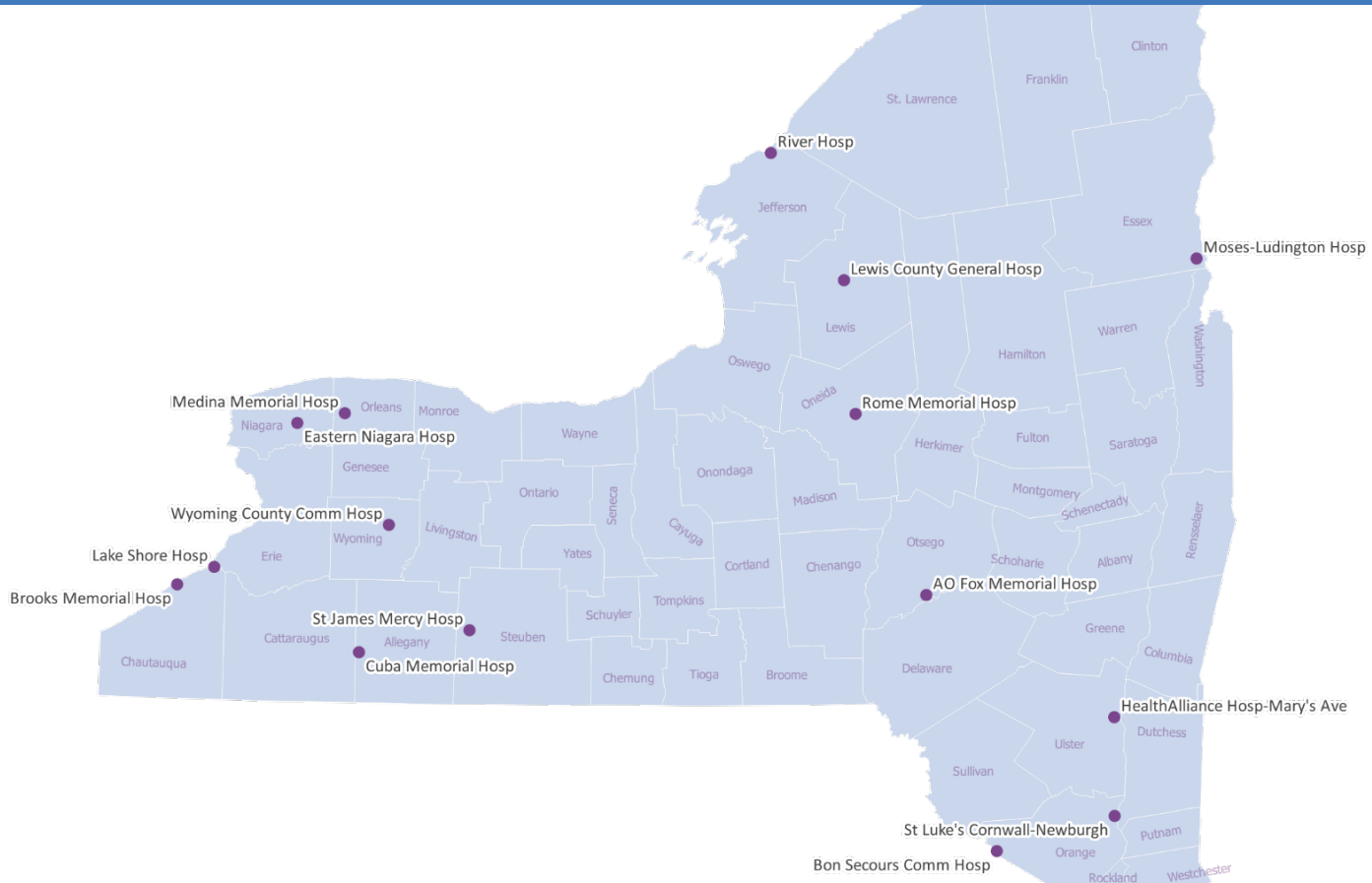
February 12, 2018

Kenneth E. Raske, President

GREATER NEW YORK HOSPITAL ASSOCIATION

Over 100 years of helping hospitals deliver the finest patient care in the most cost-effective way.

27 “Watch List” Hospitals are Dispersed Across the State



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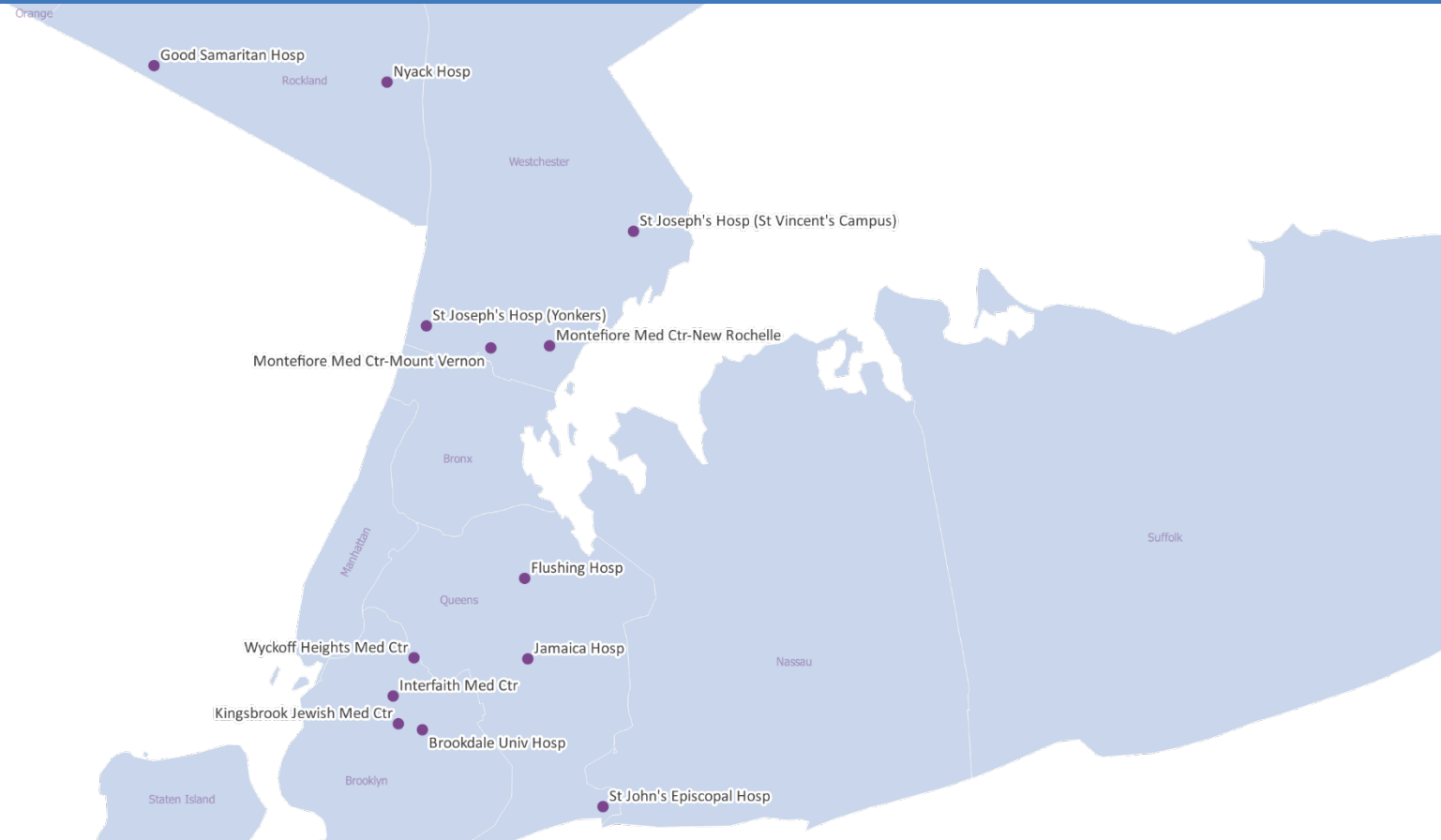


New York's Watch List Hospitals

Criteria

27 voluntary hospitals statewide

- Urban, rural, and suburban
- Fewer than 15 days cash

Receiving direct State subsidies*

- Transform, transition to VBP and improve quality
- Funding has prevented widespread, unplanned closures
- $580M in SFY 2018-19

Hospitals

Aurelia Osborn Fox Memorial Hospital	Medina Memorial Hospital
Bon Secours Community Hospital	Montefiore-Mount Vernon
Brookdale Hospital Medical Center	Montefiore-New Rochelle
Brooks Memorial Hospital	Moses-Ludington Hospital
Cuba Memorial Hospital	Nyack Hospital
Eastern Niagara Hospital	River Hospital
Flushing Hospital Medical Center	Rome Murphy Memorial Hospital
Good Samaritan Hospital of Suffern	St Johns Episcopal South Shore
Health Alliance: Mary's Ave Campus	St Joseph's Medical Center
Interfaith Medical Center	St Luke's Cornwall Hospital
Jamaica Hospital Medical Center	St. James Mercy Hospital
Kingsbrook Jewish Medical Center	TLC Health Network
Lewis County General Hospital	Wyckoff Heights Medical Center
	Wyoming County Community Hospital

Note: Nassau University Medical Center and NYC Health & Hospitals are also participating in the program, but are not receiving State assistance.

Safety Net Hospitals are Increasingly at Risk of Becoming Watch List Hospitals

In addition to the Watch List, another 30 hospitals are being closely monitored

Can't cost-shift to commercial insurers

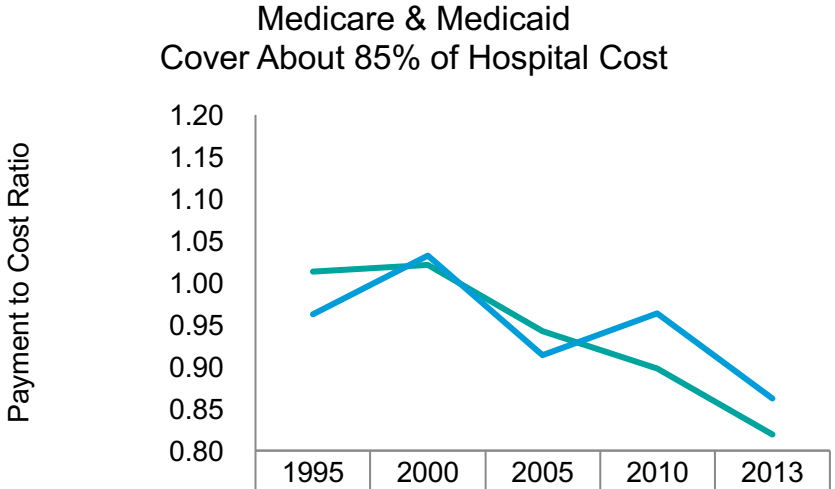
Overall negative operating margins

Gov't revenue covers 85% of patient days

Highly susceptible to gov't funding cuts, especially DSH subsidies

Medicaid rate adequacy is ***critical*** for their sustainability

Hospitals Face Significant Revenue and Cost Pressures



	1995	2000	2005	2010	2013
NY Medicare	1.01	1.02	0.94	0.90	0.82
NY Medicaid	0.96	1.03	0.91	0.96	0.86

Source: American Hospital Association Annual Survey

Revenue pressures

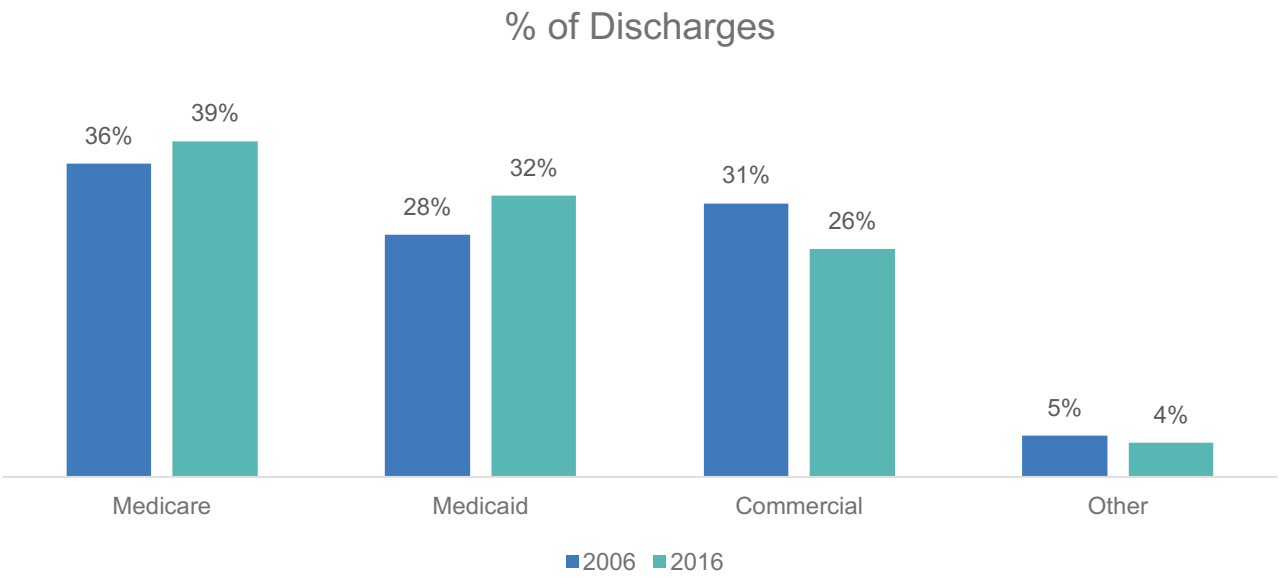
- **Medicaid**—Global Cap, no trend for 10 years
- **Medicare**—ACA cuts, other
- **Private**—quality of insurance is deteriorating
  - **$720M** hospital bad debt*

Cost pressures

- Pharmaceutical prices
- Technology
- Labor

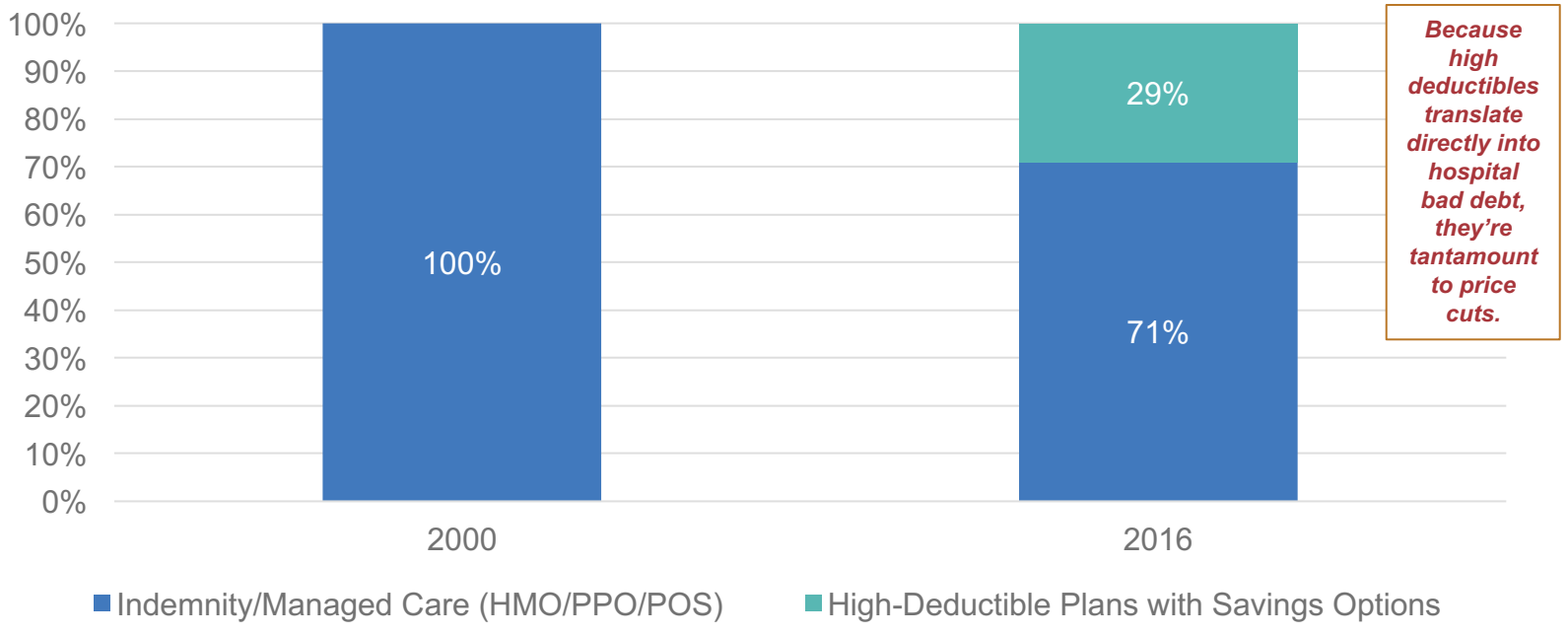
Source: NYS Institutional Cost Reports.

NY Hospitals are More Reliant on Public Payers Than a Decade Ago



Source: NYS Institutional Cost Reports.

Employers are Shifting to High-Deductible Health Plans



Because high deductibles translate directly into hospital bad debt, they're tantamount to price cuts.

Source: The Kaiser Foundation and Health Research & Educational Trust (HRET).

Proposal to Reduce Hospital Bad Debt

Require private insurers to reimburse hospitals for bad debt incurred on behalf of their enrollees

Precedent: Medicare reimburses hospitals for a portion of the bad debt incurred on behalf of their beneficiaries

Our *future* economic situation is defined by two factors:

Ongoing threats from DC

No Medicaid trend for the past decade

- Global Cap trend absorbed by enrollment growth

Ongoing DC Threats Create Continued Instability

CHIP Reauthorization
- 10 years

Medicaid DSH
- Two-year reprieve
- FY 2020 cut =$658M (doubles to $1.3B in FY 2021)

Medicare DSH ($600M)

340B Program
- Medicare cut ($50M)
- Pharma efforts to curtail program

Loss of CSRs for the Essential Plan ($975M)

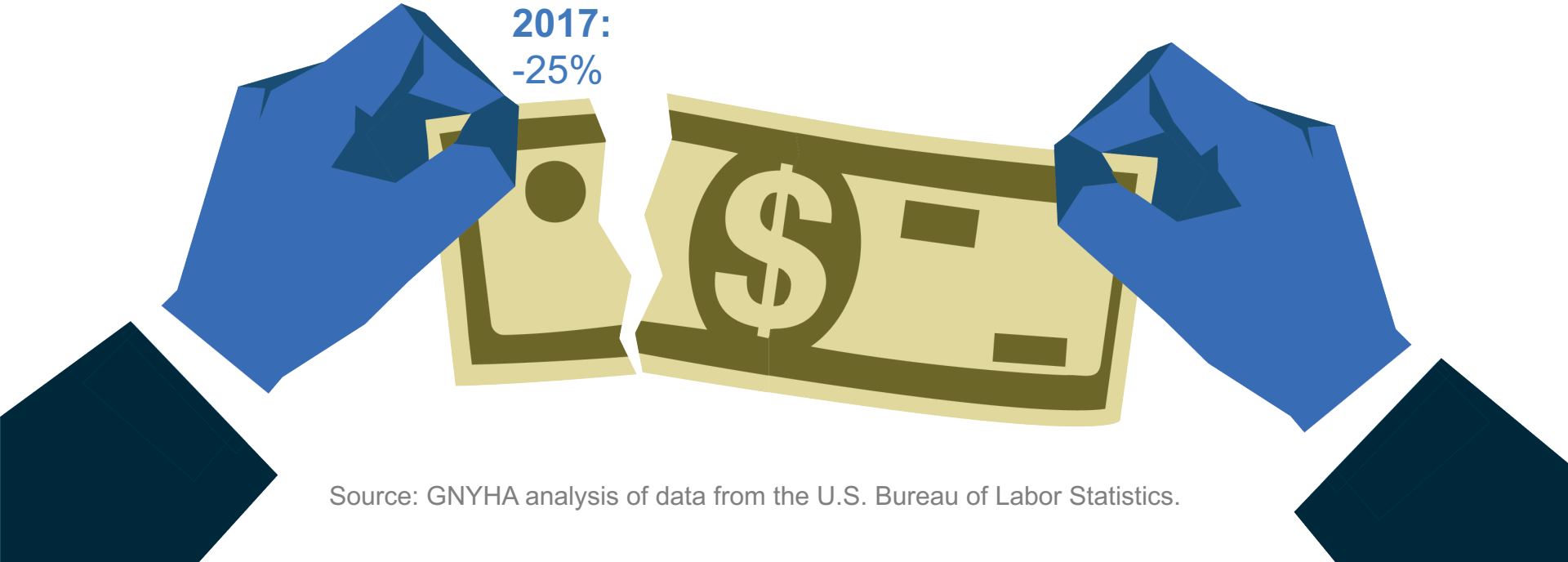
Tax Reform
- Transit tax
- Other

Entitlement/ Medicare Reform

ACA Repeal Efforts
- Medicaid reforms
- Exchange instability

CSRs= Cost-sharing reductions.

Decline in the Medicaid Dollar's Purchasing Power Over the Past 10 Years



Source: GNYHA analysis of data from the U.S. Bureau of Labor Statistics.

Healthcare Shortfall Fund: $1B Over 4 Years

Purposes

- Address shortfalls from DC cuts
- Provide funding to improve health care delivery

Fund of at least $1.5B is needed to address 1) DC cuts and 2) Medicaid payment adequacy

Support New Capital Investments in Executive Budget

$425M in Capital Funding

Purposes

- Transformation
- VBP participation
- Information technology/ telehealth
- Improve quality

Other Considerations: Support Maintenance of Funding for Financially Fragile Hospitals

1. Executive Budget fully funds Watch List hospital programs
   - *27 hospitals with less than 15 days cash on hand*
2. Extends Indigent Care Pool allocation method for one year
3. Continues the safety net pool

Other Considerations: Support Reducing Medical Liability Costs

Executive Budget repeals the requirement that hospitals pay exorbitant interest on judgments (currently 9% annually)

This will help mitigate the cost of Lavern's Law

GNYHA supports additional measures, such as the ability to depose expert witnesses

- Would reduce costs, increase transparency, and lead to quicker settlements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NEW YORK
HEALTHCARE
FUNDING!

Appendix

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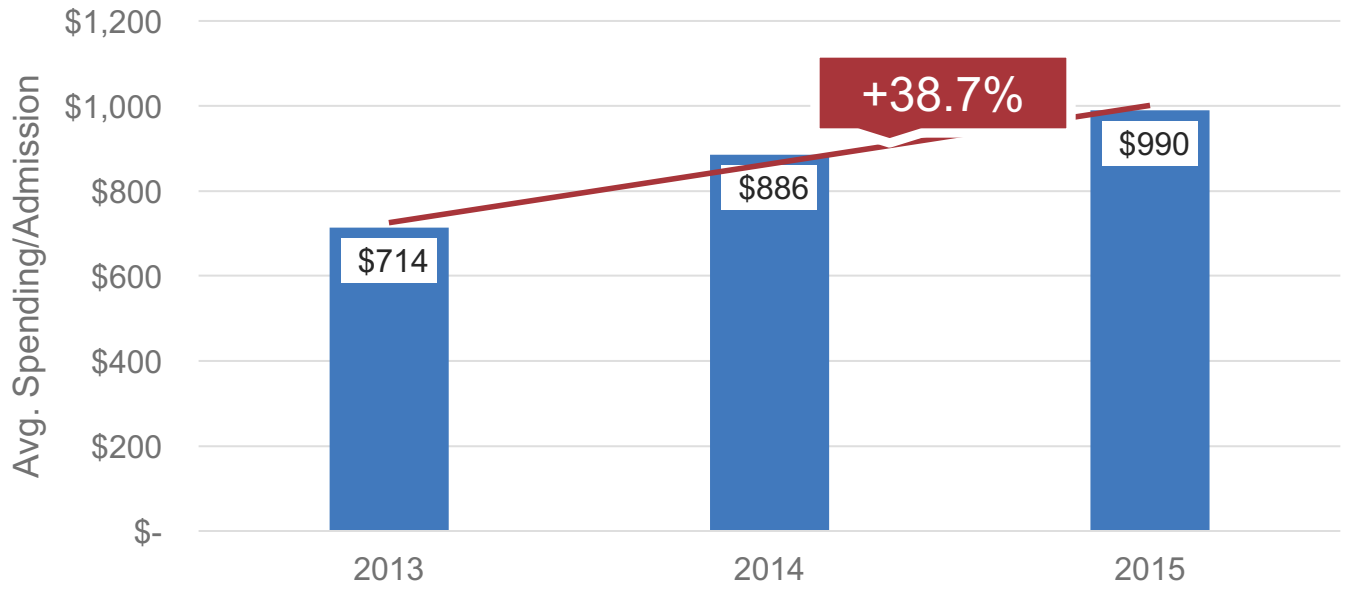
Hospital Drug Costs are Growing Substantially



Source: NORC analysis of AHA-FAH Drug Survey.

Insurance Companies will Experience a Windfall From Federal Tax Reform

Estimated Increase in 2018 Earnings Per Share	% Increase
Molina Healthcare	62.1%
Humana	34.4%
WellCare	32.5%
Centene	31.6%
Aetna	30.4%
Anthem	25.2%
UnitedHealth Group	24.3%
Cigna	21.6%

Source: "How Health Insurers Would Benefit from Tax Reform," *Axios*, December 11, 2017.

2018-19 NYS EXECUTIVE BUDGET HEALTH CARE PROPOSALS, GNYHA POSITIONS

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ISSUE	EXECUTIVE BUDGET PROVISION	GNYHA POSITION
Healthcare Shortfall Fund	Provides $1 billion over four years ($2 billion if matched by the Federal government through Medicaid) to mitigate the impact of Federal provider reimbursement cuts and to enhance Medicaid rate adequacy. Financed from the proceeds of not-for-profit insurer conversions to for-profit entities.	GNYHA **strongly supports** the Healthcare Shortfall Fund and respectfully requests that the Legislature increase its funding. New York's health care community is facing multi-billion cuts from Washington. This is exacerbated by the fact that *Medicaid providers have not seen a payment rate increase in a decade.* This is the primary source of much of the financial distress suffered by safety net hospitals and nursing homes.
Capital Funding	Provides $425 million for the Health Care Facility Transformation Program, Part III. Provides funding for health care providers to enable them to transform to meet the needs of the 21st century, including enhancing and preserving essential services and system development. $60 million is set aside for community-based providers, and $45 million is reserved for residential health care providers. $300 million of the funding would be bondable, with the other $125 million provided for "soft" capital needs.	GNYHA **strongly supports** the capital provision in the Executive budget.
Funding for Financially Distressed Providers	Provides full funding of existing commitments to voluntary safety net hospitals that are on the State's "watch list" through the VBP-QIP and VAPAP programs. Increases funding by $69 million ($45 million in State funds). Creates a combined $40 million allocation (gross) for safety net, critical access, and sole community hospitals, pursuant to criteria determined by the New York State Department of Health (DOH) Commissioner.	GNYHA **strongly supports** full funding of existing commitments through VBP-QIP and VAPAP to hospitals. GNYHA also **strongly supports** the funding allocation for safety net and rural hospitals with flexibility for the DOH Commissioner to determine eligibility.

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Indigent Care Pool	Extends the Indigent Care Pool allocation methodology for one year, through December 31, 2019. The stop-loss transition floor is increased to 17.5%.	GNYHA **strongly supports** extension of the Indigent Care Pool.
Medicaid – DOH Global Cap; Minimum Wage; Essential Plan	Extends the Global Cap on DOH Medicaid spending through 2019-20. Funds minimum wage costs primarily for home health care agencies outside of the Global Cap. Funds the Healthcare Shortfall Fund outside of the Global Cap as well. Deals with the Federal cut to the Essential Plan by rearranging funding without cutting eligibility or benefits.	GNYHA **strongly supports** funding the minimum wage increase and the Healthcare Shortfall Fund outside of the Global Cap. GNYHA also **supports** continuing the Essential Plan without benefit or eligibility cuts.
Medicaid – Hospitals	Reduces payments to hospitals (and nursing homes) by mandating 1% savings in Medicaid capital payments ($13 million impact). Also creates a penalty pool by setting performance targets for hospitals to reduce potentially preventable emergency department visits, increase value-based contracting, and by setting targets for other inpatient quality and safety measures in the existing Hospital Quality Pool program ($34 million impact). Reinvests up to $24 million of the penalty pool into preventive services (to include revising the physical therapy [PT] cap, expanding social worker coverage in hospitals, etc.) and provides $10 million in Global Cap savings. Also reduces payments to emergency departments and outpatient setttings for IV infusion of saline bags ($10 million impact).	GNYHA **opposes** these Executive budget proposals that reduce hospital payments. However, we support raising the cap on PT visits from 20 to 40. We do not believe this requires a funding source, as raising the cap is likely to result in offsetting savings due to avoided surgical interventions and reduced use of opioids.
Medicaid – Nursing Homes	Reduces payments to nursing homes (and hospitals) by mandating 1% savings in Medicaid capital payments ($13 million impact). Further reduces payments to nursing homes by 1) imposing a 2% penalty on poor-performing nursing homes ($20 million impact), and 2) administratively reducing case mix increases ($15 million impact). The plan would also slow down the restoration of the 1% across-the-board cuts from the SFY 2011-12 budget.	GNYHA **opposes** the nursing home cuts.

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Medicaid – Managed Care	Reduces managed care spending through administrative actions, including 1) reducing premiums to reduce "excess" reserves; 2) increasing value-based payment (VBP) target penalties; 3) establishing a fee-for-service and managed care benchmark for providers with insufficient VBP arrangements; 4) encouraging enrollment in health homes; and 5) penalties for failing to submit a Partnership Plan with Performing Provider Systems.	GNYHA **opposes** increasing VBP target penalties and establishing benchmark Medicaid rates for providers with insufficient VBP arrangements. GNYHA believes hospitals and plans are moving steadily to VBP arrangements and existing penalties are sufficient to continue that movement. GNYHA does not believe that establishing reduced managed care benchmark rates is workable, as it will enable managed care plans to arbitrarily reduce hospital payments when in fact the plan may be to blame for insufficient VBP arrangements.
Medicaid – Managed Long Term Care (MLTC)	Reduces MLTC spending by 1) limiting eligibility for nursing home residents to those who are in nursing homes for less than six months; 2) requiring 120 continuous days of community-based LTC services to maintain eligibility; 3) limiting the number of licensed home care agencies (LHCSAs) an MLTC can contract with to 10; 4) allowing MLTCs to better manage social adult day care services; 5) reducing administrative payments; 6) carving transportation out of MLTC premiums; and other proposals.	GNYHA **supports** pursuing MLTC eligibility changes and programmatic reforms, including the MLTC transportation carveout and the LHCSA contract limitation. However, GNYHA is concerned that reducing MLTC administrative funds will negatively impact the plans' ability to effectively manage this patient population.
Medicaid – Opioid Prescribing	Reduces opioid dispensing by 20% by modifying formularies and clinical editing to encourage access to non-opioid alternatives, and requiring treatment plans as a condition for opioid prescribing. Also eliminates prescriber prevails for opioids.	GNYHA members are committed to the safe use of opioids. GNYHA is studying this proposal.
Patient-Centered Medical Homes (PCMHs)	Caps at $180 million the amount of Medicaid incentive payment funding that would be provided for recognized PCMHs.	GNYHA **opposes** the Executive budget provision.
Medicaid Integrity	Imposes fines in the amount of $5,000 per violation per day for noncompliance with "any statute, rule, regulation, or directive of the medical assistance program" by any entity participating in the program or who is a subcontractor or provider of an Article 44 of the Public Health Law or 43 of the Insurance Law.	GNYHA **opposes** the Executive Budget provisions as written. They are very broadly worded and do not expressly empower the Medicaid inspector general to take into account whether a provider has an effective compliance program. We are also concerned about the impact on distressed hospitals.

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Health Republic Fund; Health Insurance Guaranty Fund	No provision.	GNYHA **supports** setting aside settlement funds, as envisioned in the SFY 2016-17 budget, to pay provider claims once the Health Republic liquidation process is complete. Providers are owed hundreds of millions of dollars for care rendered to Health Republic enrollees. GNYHA also **strongly supports** enactment of a **health insurance guaranty fund** for future insolvencies.
Public Health and Workforce Funding	Consolidates 28 public health and workforce programs into four pools (disease prevention and control, maternal and child health, public health workforce, and health outcomes and advocacy) and cuts overall funding by 20%. Notable programs are worker retraining, Doctors Across New York, and poison control. Does not restore last year's cut to the Health Workforce Retraining Initiative (HWRI).	GNYHA **opposes** the Executive budget provision, and urges the Legislature to restore the HWRI cut contained in last year's budget.
School-Based Health Centers (SBHCs)	SBHCs provide critical primary care services to underserved public school children across New York State. The Executive kept SBHC funding at the same level as last year: $17 million. While the final FY 2017-18 budget reduced SBHC funding by 20%, a subsequent administrative decision disproportionately cut many hospital-sponsored SBHCs by much more—individual centers were cut by 44%, 66%, and 70%, for example–putting New York's health care safety net at risk.	While we understand the difficult fiscal environment, GNYHA is disappointed the budget does not restore the previous administrative funding reductions. We urge the Legislature to reverse these damaging cuts—which would cost $4 million—and support schoolchildren across New York State. Of the 234,000 students served by SBHCs statewide, more than 100,000 are served by SBHCs that GNYHA member hospitals operate in the Bronx, Brooklyn, Queens, Manhattan, Staten Island, Buffalo, Yonkers, and Rochester.
Rate of Interest on Judgments	Ties the rate of interest on judgments and accrued claims to market rates, rather than the current statutory provision of 9%.	GNYHA **strongly supports** the Executive budget proposal. Current law requires defendants to pay exorbitant interest rates that bear no relationship to market interest rates, driving up malpractice and other liability costs.

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Rape Kit Maintenance	Extends the time period that hospitals must maintain sexual offense evidence from the current statutory 30 days to "the longer of five years or the date the alleged sexual offense victim reaches the age of nineteen." Existing law permits the victim to sign a statement directing the hospital "to not collect and keep such … evidence."	GNYHA **supports** the intent of this provision, but wants to make sure that it does not place a burden on safety net institutions, especially public hospitals.
Integrated Primary Care and Behavioral Health	Permits providers licensed or certified by DOH, Office of Mental Health (OMH), or Office of Alcoholissm and Substance Abuse Services (OASAS) to provide integrated primary care, mental health and/or substance use disorder services when authorized to do so by one of the three agencies pursuant to regulation without needing a second or third license or certification.	GNYHA **strongly supports** the Executive budget provision.
Community Paramedicine	Allows EMS providers to engage in community paramedicine collaboratives to reduce unnecessary ER visits.	GNYHA **strongly supports** the Executive budget provision.
Comprehensive Medication Managment	Allows pharmacists, through agreements with physicians, to provide medication management services to ensure proper use of medications.	GNYHA **strongly supports** the Executive budget provision.
Telehealth	Expands "originating site" definition to include patient's residence as well as any other location where the patient may be temporarily located; adds practitioners permitted to provide telehealth.	GNYHA **strongly supports** the Executive budget provision.
Statewide Health Information Network for New York (SHIN-NY)	Provides $30 million for the SHIN-NY.	GNYHA **strongly supports** the Executive budget provision.
Empire Clinical Research Investigator Program (ECRIP)	Discontinues funding for ECRIP, on the theory that it is duplicative of the funding provided under the State's Life Sciences Initiative.	GNYHA **opposes** the Executive budget provision.
Resident Work Hour Audits	Repeals the provision requiring the State to contract with a third-party organization to conduct resident work hour audits. The State would instead require hospitals to submit an attestation wherein hospitals state that they are in compliance with resident work hour limitations.	GNYHA **strongly supports** the Executive budget provision, as we believe the current requirement is disruptive and duplicative of accreditation organization requirements.

ISSUE	EXECUTIVE BUDGET PROVISION	GNYHA POSITION
Certified Registered Nurse Anesthetists (CRNAs)	Codifies the practice of nurse anesthesia and allows CRNAs to practice to the full extent of their license.	GNYHA **strongly supports** the Executive budget provision.
Retail Clinics	Authorizes the provision of certain health services in retail settings such as pharmacies, grocery stores, or shopping malls. The retail clinics would be permitted to provide basic primary and preventive care and refer patients for specified health conditions and concerns. Permissible sponsors of such clinics may include "business corporations, and general hospitals, nursing homes, and diagnostic and treatment centers licensed pursuant to" Article 28 of the Public Health Law. The practices would be required to enter at least one "collaborative" relationship with a hospital, physician's practice, accountable care organization or Performing Provider System under DSRIP that supports coordinated care, among other requirements.	GNYHA is discussing this proposal with its members to determine a position.
Food Recycling	Beginning January 1, 2021, requires that generators of large quantities of "food scraps," including hospitals or other health care facilities, separate excess food for donation for human consumption to the extent practicable. In addition, covered food scraps generators located within a 40-mile radius of an organics recycler regulated by the Department of Environmental Conservation and that has the capacity to accept a substantial portion of the generator's waste must either transport the remaining food scraps to an organics recycler or provide for recycling on-site. This provision would presumably not apply to food scraps generators in New York City, which already has a food scraps diversion requirement.	While GNYHA members are already undertaking food recycling programs, this proposed food scraps program would present significant challenges and costs for GNYHA members. GNYHA will work to limit the extent to which the program applies to hospitals and other health care faciliites.
For-Profit Insurance Windfall Profit Fee	Imposes a fee on for-profit health insurers who will reap windfall profits due to the enactment of the Federal Tax Cuts and Jobs Act.	GNYHA **strongly supports** the fee and would support imposing it on all for-profit insurers, not just health insurers.