GREATER NEW YORK HOSPITAL ASSOCIATION

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TESTIMONY OF

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Joint Legislative Public Hearing on the 2015-16 Executive Budget Proposal: Health/Medicaid

FEBRUARY 2, 2015

Chairmen Farrell, DeFrancisco, Gottfried, and Hannon, and other members of the committee, thank you very much for the opportunity to testify today. My name is David Rich, Executive Vice President, Government Affairs, Communications, and Public Policy at the Greater New York Hospital Association (GNYHA). As you know, GNYHA represents all of the hospitals, public and not-for-profit, in New York City, the surrounding areas, and also represents hospitals in Syracuse and Buffalo.

New York's Health Care Environment

New York's health care system is at a crossroads. In conjunction with the State, hospitals statewide are working hard to reform their delivery models and participate in the State's Delivery System Reform Incentive Payment (DSRIP) program, either as lead applicants or members of Performing Provider Systems (PPSs). Many have become accountable care organizations, or are otherwise engaging in activities to provide higher-quality care while reducing costs, such as creating and operating health homes. GNYHA has worked with hospitals across the State on important quality improvement activities, and New York now is a national leader in the reduction of sepsis and central line–associated bloodstream infections.[1] Working in collaborative projects or individually, hospitals are improving safety, reducing mortality rates, reducing hospital readmission rates, and creating patient-centered medical homes. In fact, New York State has more patient-centered medical homes than any other state by far. The health care community can be proud of its accomplishments to date, while striving to become even better in the future.

But even as hospitals transform themselves during this time of change, it is important to remember that hospitals are indispensable and irreplaceable. The recent Ebola outbreak in West Africa, and the need for hospitals to prepare for potential cases here, dramatically illustrated our society's reliance on the hospital

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[1] U.S. Department of Health and Human Services, "New HHS Data Show Major Strides Made in Patient Safety, Leading to Improved Care and Savings," May 7, 2014, p.5.

community to keep them safe and save lives. The State government called upon hospitals to prepare, and they did. All hospitals in the State prepared, because no one can accurately predict which hospital a potential Ebola patient will walk into. 10 hospitals across the State volunteered to be designated Ebola treatment centers, spending millions of dollars to create special isolation units, purchasing supplies, and arduously training their staff. Clearly, there is no substitute for the acute care hospitals provide.

New York hospitals, however, are in critical need of financial support. Numerous hospitals in Brooklyn and across the State are on a "watch list" for closure. The State has provided some critical help through the 1115 Medicaid Redesign Team waiver Interim Access Assurance Fund (IAAF), but that funding will last only through this fiscal year. The reasons for hospitals' financial distress are many and will likely persist. While these include the obvious such as the changing health care environment, the government has also played a large role in the hospital sector's declining financial stability. The Federal government, for example, has cut Medicare reimbursement rates repeatedly since 2010. Last year, Medicare disproportionate share hospital (DSH) payments were cut deeply for many hospitals, and hospitals are losing millions of dollars annually under the Medicare "two-midnight" policy. Sequestration cuts continue, as do other cuts.

At the State level, the previous Administration slashed Medicaid rates for many safety net hospitals. In 2011, Medicaid rates were cut by 2%, until they were restored by the 2014-15 budget. (Unfortunately, providers have not yet felt the benefit of the restoration because the Federal government has not yet approved it.) No inflation "trend factor" update has been provided for seven years. The cumulative effect of these actions is that in 2012, aggregate Medicaid payments covered only 72% of hospital costs—91% for inpatient services and a mere 61% for outpatient services.[2] And while the New York State of Health (NYSOH) marketplace is supported by the hospital community, there is no question that over time the marketplace will place tremendous pressure on commercial reimbursement rates, particularly if employers begin enrolling employees in the marketplace in large numbers. Cost-shifting to the private sector to make up for inadequate Medicare and Medicaid reimbursement rates and uncompensated care will be increasingly difficult for hospitals to achieve, if not impossible, and the rapid growth in high-deductible plans is significantly reducing hospital revenues.[3] And while supportive of the Basic Health Program (BHP) concept, we are concerned that as New Yorkers currently enrolled in commercial NYSOH plans are transitioned into BHP plans, there will be downward pressure on hospital reimbursement rates.

The State has begun to reinvest in its Medicaid program through temporary funding such as the vital access provider (VAP) program, through DSRIP, and through capital funding. We have considerable concern, however, about the long-term viability of safety net providers whose Medicaid reimbursement rates have eroded in value so significantly over the years. Safety net providers who rely on Medicaid and Medicare for the vast majority of their funding cannot continue to lose money on each and every Medicaid and Medicare patient and expect to survive, much less reinvest surpluses into their operations. The State's current-year surplus, the enhanced Federal matching rate the State will begin to enjoy next year, and savings associated with BHP implementation give the State an excellent opportunity to make

[2] GNYHA analysis of DOH data. Statewide Medicaid payment-to-cost ratios reflect the average of hospital-specific ratios weighted by each hospital's proportion of uninsured units of service. This was a dataset restriction.

[3] See Moody's Investor Services, "Not-for-Profit Hospitals Revenue Growth Reaches an All-Time Low," August 28, 2014.

long-term investments in the Medicaid program that will ensure payment adequacy for those caring for the Medicaid population.

The Executive Budget

For all of these reasons, GNYHA is very pleased that Governor Cuomo's budget proposal included critical financial relief for hospitals. The Governor clearly understands that hospitals need to be strengthened and has proposed a number of steps to help safety net institutions in particular.

As mentioned, hospitals have not seen a Medicaid rate increase or inflation update since 2007, and have experienced a 2% payment cut since 2011. While this budget does not propose an inflation update, it does—through a combination of allowing past Medicaid cuts to expire, providing quality incentives, and reducing taxes—provide for the first increase in eight years.

Specific actions include:

- **Quality:** The Executive budget proposes creating a $91 million Medicaid quality pool for hospitals ($45 million State share), bringing hospital quality efforts in line with State strategies for health plans and nursing homes, which already have quality pools under State law. The pool's purpose is to incentivize hospitals to report on selected quality measures and reward them for performance. The budget language is flexible enough to allow for changes over time, which is important given health care's ever-changing nature. GNYHA strongly supports providing quality incentives and the overall movement to performance-based payment, as long as the measures are evidence-based, aligned with other initiatives, and implemented by consensus. Thus, GNYHA supports this provision in the Executive budget.

  The Executive budget also proposes eliminating two antiquated Medicaid quality-related reimbursement rate cuts. The first, a cut to penalize hospitals for so-called Potentially Preventable Negative Outcomes (PPNOs), reduces Medicaid rates for hospitals for readmissions (based on 2007 performance) and complication rates (based on 2009 performance). Continuing to penalize hospitals based on past PPNO rates makes no sense. Allowing this cut to expire will increase hospital Medicaid rates by $51 million in 2015-16 ($26 million State share). GNYHA strongly supports allowing this cut to expire. It is important to note that the New York State Medicaid program will continue to deny hospitals reimbursement for hospital-acquired conditions through its "code suppression" policy in alignment with the Medicare program.

  The second cut, which was implemented administratively, is a Medicaid reimbursement rate cut to hospitals that was originally envisioned as a disincentive for hospitals to schedule and perform early elective deliveries, given the clear health benefits of carrying babies to full term. In practice, however, the cut is merely a $19 million across-the-board cut to hospitals, even those that provide no maternity services. The cut has no policy justification or quality improvement impact. In the meantime, hospitals have worked very hard to reduce elective pre-term deliveries, with fantastic results. The State Department of Health (DOH) announced last month that the 97 birthing hospitals participating in the New York State Perinatal Quality Collaborative have reduced scheduled deliveries (without a justifiable medical reason) by 92%, including an 86% reduction in

inductions and a 94% reduction in caesarean sections[4]. This is a remarkable improvement, providing better health care and outcomes for babies and mothers across New York State. For these reasons, GNYHA strongly supports eliminating this arbitrary across-the-board cut.

- **Obstetrical Services Tax:** Current law imposes a tax on inpatient obstetrical care services revenue, known as the "quality contribution," set at a rate designed to raise approximately $38 million in the coming State fiscal year. The Executive budget reduces the revenue target by $15 million, providing significant tax relief for hospitals providing obstetrical services. Given the high costs of providing obstetrical services, the low Medicaid reimbursement rates associated with them, and the above-mentioned extraordinary efforts to improve the quality of obstetrics care, GNYHA strongly supports this tax cut.

In addition to these extremely important changes to help reduce day-to-day expenses and increase operating revenue, the Executive budget contains two very important proposals to help improve and sustain the financial health of the many financially distressed hospitals across the State:

- **VAP:** The Executive budget contains a $580 million increase in VAP funding ($290 million State share). This funding is extremely important. Under the Federal 1115 Medicaid waiver, IAAFs were provided for 27 not-for-profit hospitals across the State, as well as to the State's public hospitals, to ensure that severely financially distressed hospitals could continue to provide vital services until DSRIP funding starts to flow. Financial distress was defined very strictly as having available resources of less than 15 days cash and equivalents, and included only safety net providers who have exhausted all efforts to monetize unneeded assets and obtain maximum supportive resources from corporate parents and affiliated entities. However, this funding will expire on March 31, and many of these providers remain in severe fiscal distress. Increased VAP funding also recognizes that DSRIP funds need to be prioritized for investments in delivery system changes, not in sustaining financially struggling providers. GNYHA therefore strongly supports the Executive budget proposal to provide increased VAP funding to ensure that safety net providers can sustain the health care services their communities need.

- **Capital Access Funds:** The 2014-15 budget included $1.2 billion over seven years in capital funding, primarily to support DSRIP-related capital needs (though other non-DSRIP-related funding is available as well). The health care community's capital needs are extraordinary, and given the pressures on hospital revenues mentioned earlier, it is increasingly difficult for hospitals to realize positive margins that can then be reinvested into capital and physical plant improvements. Recognizing this, the Executive budget provides $1.4 billion in additional capital funds, with $700 million intended primarily for Brooklyn and $1.4 billion primarily for community and rural hospitals upstate. GNYHA strongly supports the increased funding, and is very grateful for the proposal, while recognizing that capital needs go far beyond even this extraordinary level of State support. We would like to work with the Executive and the Legislature to better understand the intended uses of the increased funds and determine even further capital creation opportunities.

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[4] New York State Department of Health, "New York State Department of Health Honors Birthing Hospitals for Reversing the Trend of Scheduling Early Deliveries," January 13, 2015, http://www.health.ny.gov/press/releases/2015/2015-01-13_scheduling_early_deliveries.htm

A separate provision would, like past Executive budgets, create a demonstration project under which five business corporations would be authorized, in affiliation with academic medical centers or major teaching hospitals, to invest in and operate hospitals. Publicly traded corporations would be prohibited from participating, and new language was added to this proposal under which DOH, when reviewing applications, would have to take into account such issues as continued community access, community input, whether or not a not-for-profit maintains control over the hospital, and other considerations. GNYHA is reviewing the new provisions with our members and will report back to you on our position as soon as possible.

Other provisions of importance to hospitals in the Executive budget include:

- **Indigent Care Pool (ICP) Reauthorization:** The ICP provides critical support for hospitals by covering a portion of the charity care they provide for uninsured patients. The current ICP allocation methodology expires on December 31, 2015. The Executive budget proposes extending the methodology through December 31, 2018, and continues to provide a cap on losses, though losses for individual hospitals would be allowed to grow substantially. Under the current methodology, which was implemented in 2013, individual hospital losses due to the methodology were capped at 2.5% in 2013, 5% in 2014, and 7.5% in 2015, compared to what hospitals would have otherwise received under the methodology in place prior to 2013. Under the Executive budget, the caps on losses would be increased to 10% in 2016, 12.5% in 2017, and 15% in 2018. GNYHA strongly supports extending the methodology and a continued cap on losses. It should be pointed out that these caps represent very large losses in funding for many hospitals, so they are critically important to ensure that hospitals are not destabilized during the transition. The Executive budget also provides flexibility for DOH to alter the methodology if Federal Medicaid DSH cuts are implemented during the period of the ICP extension.

- **Copayments for Qualified Medicare Beneficiaries (QMBs):** To ensure access for low-income Medicare beneficiaries to physician and other outpatient services, the Medicaid program pays the Medicare copayments and other cost-sharing amounts on behalf of many low-income Medicare beneficiaries, also known as "QMBs." This arrangement benefits the State Medicaid program, since many QMBs are also eligible for Medicaid, but Medicare picks up the vast majority of this population's health care costs—with Medicaid responsible only for the cost-sharing amounts. Under current State law, the copayments Medicaid pays on behalf of QMBs is based on Medicare rates. The Executive budget proposes to instead base the copayments Medicaid rates, which would greatly reduce payments to physicians and other outpatient providers since Medicaid rates are almost always much lower than Medicare rates. In some cases, the provision would mean that no copayment would be made at all, reducing the amounts providers receive by as much as 20%. The Division of the Budget projects that this would reduce payments to providers by $92 million in the coming State fiscal year. GNYHA strongly opposes this provision, and urges the Legislature to reject it.

  This provision is actually made even worse by the fact that the State is greatly reducing Medicaid primary care reimbursement rates this year. Under the Affordable Care Act (ACA) the Federal government mandated that states increase Medicaid rates for primary care services to the usually

higher Medicare reimbursement rates for the same services. The mandate was in effect for two years, and the Federal government paid 100% of the cost. Unfortunately, this provision expired on December 31, 2014, and unlike many other states, New York State has not exercised its option to continue to pay Medicare rates for these services at the usual 50% Federal Medicaid matching rate. Thus, reimbursement rates are plummeting for primary care services, and on top of that, due to the Executive Budget provision described above, reimbursement rates for Medicare outpatient services provided to low-income Medicare beneficiaries, including primary care services, will plummet as well. Consequently, in addition to opposing this Executive budget provision, GNYHA also supports adding a provision to keep primary care reimbursement rates at Medicare levels.

- **BHP:** The 2013-14 State budget authorized the State to create a BHP. Under the ACA, a state may create a public insurance plan for individuals with incomes between 138% and 200% of the Federal poverty level and receive 95% of the subsidies these individuals would have received if they enrolled in commercial plans through an ACA marketplace, such as NYSOH. The Executive budget would begin BHP coverage for Medicaid immigrants currently funded with State-only Medicaid dollars on April 1, 2015, for savings of $644 million. BHP coverage would begin on January 1, 2016 for other eligible BHP individuals. DOH would establish premium rates for BHP plans in consultation with an actuary, similar to the way DOH establishes Medicaid managed care premium rates.

  While GNYHA supports the BHP because of its potential to provide better benefits than may be provided through NYSOH plans, we are concerned that the State may set premiums for BHP plans very low, which would put downward pressure on provider reimbursement rates. We also believe that the State should be prohibited from setting provider reimbursement rates under the BHP, through a Medicaid default rate or otherwise. Because many potential BHP enrollees are currently enrolled in commercial plans through the NYSOH, hospitals have been able to negotiate payment rates that, while generally discounted from commercial rates, are higher than inadequate Medicaid rates. Any State action that would reduce BHP reimbursement rates to providers to Medicaid reimbursement rates would have a negative impact on hospitals and their financial health. We look forward to working with the Administration and the Legislature to ensure that this potentially negative outcome is avoided.

- **Public Health and Workforce Funding:** The Executive budget, as in past years, proposes consolidating 41 public health and workforce programs into five broad categories and then cutting the overall funding by 15%, for a State savings of $21.3 million. GNYHA opposes consolidating and cutting the funding for many of these programs, including school-based health center programs and health care workforce programs. The majority of school-based health centers in the State are operated by hospitals at a financial loss, and Medicaid managed care for the populations served by the centers has created a great deal of financial uncertainty. As for workforce programs, many have State contracts with specific dollar amounts attached to the contracts. We believe current contracts must be honored and, given the great need for retraining health care workers for a transformed health care environment, current levels of funding should continue.

- **Certificate of Need (CON) Reform:** GNYHA strongly supports the Executive budget's CON reform provisions, which were also included in the 2013–14 and 2014-15 Executive budget proposals. These provisions had been recommended by the Public Health and Health Planning Council (PHHPC) in its June 2012 and December 2012 reports on streamlining the State's CON program. In particular, the provisions would amend State law to eliminate CON review of construction projects, regardless of cost, except to the extent that a project may involve certain specified "cost drivers" or may curtail access to care. Examples of construction projects that would no longer be subject to CON review are physical plant modernization and reconfiguration projects (e.g., renovations to convert double rooms to single rooms or consolidate programs in a single building). In addition, PHHPC had recommended eliminating primary care facilities, such as diagnostic and treatment centers and extension clinics, from CON review. Although GNYHA supports additional streamlining of the State's CON program, we urge passage of the foregoing proposed reforms in particular.

- **Rationalizing Character and Competence Reviews:** GNYHA also strongly supports the Executive budget's character and competence provisions, which were also included in the 2013–14 and 2014–15 Executive budget proposals. In June 2012 and December 2012, PHHPC approved recommendations to "rationalize" the way in which the State undertakes character and competence reviews as part of the process for "establishing" a new health care facility or certain new services. In particular, Section 2801-a of the State Public Health Law requires the State to affirmatively find by substantial evidence that "a substantially consistent high level of care is being or was rendered in each such hospital…or institution" with which each proposed incorporator, board member, or operator was affiliated over the prior 10 years. As applied today, the State takes the position that if a facility experiences two enforcement actions for events that the State may call "recurrent" over the last 10 years, all board members or operators who were involved with the facility at the times the events occurred are "tainted" and cannot serve with respect to any new facilities. GNYHA supports the State's recommendations to reduce the "look back" period from 10 years to seven years and to permit examination of the individual's role in the organization, actions to address problems, and recent performance.

- **Hospital Resident Working Hours and Conditions:** GNYHA strongly supports the Executive budget proposal to eliminate third-party audits of resident working hours and conditions. The State contracts with a third-party organization to conduct annual reviews of teaching hospitals' compliance with specific regulations on resident working hours and conditions included within the State Hospital Code. These reviews are administratively burdensome and duplicative of reviews conducted by accrediting organizations, and should be eliminated. Since the inception of this enhanced State oversight, the graduate medical education (GME) accrediting organizations have added extensive requirements and review functions to their accreditation procedures, and these enhanced procedures obviate the need for New York State to separately review compliance in this area. GNYHA strongly urges the State to eliminate the mandate that DOH perform this review, and also eliminate the review's associated appropriation. At a minimum, the State should eliminate the requirement that teaching hospitals be subject to onsite visits to gather this information. These visits distract from important hospital and GME operations, cost taxpayers money, waste DOH resources, and serve no useful purpose for the State or its citizens.

- **Health Information Technology (HIT):** The Executive budget provides $63 million to fund the Statewide Health Information Network for New York ($45 million), fund the All-Payer Claims Database ($10 million), and for other HIT projects. GNYHA member hospitals are deeply involved in implementing HIT and in health information exchange (HIE) efforts. GNYHA looks forward to working with the Administration and the Legislature to ensure that funds are used in the most efficient way to help providers implement HIT and HIE expeditiously, meet Federal meaningful use requirements, and support DSRIP's goals.

- **Electronic Prescribing Deadline:** Under the I-STOP law, prescription drug prescribers are required to begin e-prescribing on March 27, 2015. While hospitals are strongly committed to e-prescribing, and many have been e-prescribing for several years, e-prescribing for controlled substances presents a challenge given the need to comply with Federal Food and Drug Administration (FDA) requirements. HIT vendors are developing systems to integrate both FDA and New York State requirements, but our hospitals have been informed that very few of these systems will be ready to be fully implemented on March 27. GNYHA and the Healthcare Association of New York State (HANYS) have been working closely with the State's Bureau of Narcotics Enforcement on a waiver process that can enable hospitals to apply for waivers on behalf of their prescribers. While we are extremely grateful for this collaborative effort and for the waiver process the State is developing within the confines of the current law, the waiver process is, by necessity, cumbersome and burdensome for all involved. Therefore, we agree with many physician societies across the State that have called for a yearlong delay in the e-prescribing deadline. We support Senator Hannon's bill, S.2486, either as a freestanding bill or to be included as part of the budget.

- **Liability Insurance Issues:** The Executive budget extends the excess medical malpractice insurance fund provisions enacted last year for another year, through June 30, 2016, although it adds a requirement that physicians and dentists applying for coverage must receive a tax clearance from the State's Department of Taxation and Finance. GNYHA supports the extension, but is trying to better understand the process for receiving a tax clearance and its potential impact on the timing of coverage decisions. We would also like to work with the Administration and the Legislature over time to not just preserve the pool, but expand it to maximize the number of physicians eligible for coverage. To maximize the number of physicians covered by the pool, GNYHA recommends that the State consider ways to ensure that the premiums charged reflect only carriers' actual costs.

  GNYHA also strongly supports expanding the definition of those eligible for coverage under the Medical Indemnity Fund (MIF). GNYHA is extremely grateful to Governor Cuomo and the Legislature for enacting the MIF in the 2011-12 State budget. We understand that the MIF is serving its covered population, consisting solely of neurologically impaired newborns, extremely well and that it has consistently performed under budget. GNYHA therefore supports amending the MIF statute to cover all neurologically impaired persons, regardless of age, as a way of further reducing hospital medical malpractice insurance costs and expediting settlements of cases. Having said that, we would continue to strongly oppose any provisions that would increase medical malpractice insurance costs for hospitals and physicians in exchange for a MIF expansion, including a lengthening of the statute of limitations; an increase in attorney

contingency fees; a prohibition on informal discovery (by overturning the Court of Appeals' decision in *Arons v. Jutkowitz*); and a requirement to make uninformed, pre-trial decisions on the amount of liability paid by a non-settling defendant.

- **Nurse Staffing Issues:** GNYHA has a long history of working with nurses and their representative unions on issues of mutual concern and on legislation to improve their working conditions. Several years ago, GNYHA took the lead on negotiating with the unions on a statutory ban on mandatory overtime. In 2010, the Legislature passed a law requiring hospitals to make nurse staffing information available to the public upon request. Last year, GNYHA, working with HANYS, negotiated the safe patient handling provisions that were included in the State budget. We are grateful that the Legislature was so willing to work with us and the unions to make sure that these consensus proposals were enacted to ensure that they can be implemented practically, effectively, and cost-efficiently. This year, the Executive budget contains a provision to create an advanced home health aide certification under State law, under the supervision of a registered nurse, which GNYHA supports. GNYHA also supports legislation, strongly supported by nurse executives and unions alike, to require registered nurses to obtain a bachelor's degree within 10 years of receiving their initial license.

  GNYHA will strongly oppose, however, any legislation that would mandate uniform, inflexible nurse-to-patient ratios on every unit of every hospital in the State. Such legislation has only passed in one state, California, 16 years ago, and has caused a host of problems there, including significant strife between nurses unions and unions representing other health care workers, including the SEIU. Governor Jerry Brown has twice vetoed legislation to create a more robust enforcement mechanism amid nurse union complaints that hospitals have not adhered to the ratios. Hospitals have been reported to be out of compliance with the ratios the vast majority of the time because of the sheer inability to comply. National experts, including the nurse President Obama appointed to head his national committee on the workforce, as well as the American Nurses Association, strongly oppose staffing ratio legislation due to the lack of evidence that it improves patient outcomes and its adverse impact on teams of professionals and workers to provide quality patient care in flexible environments tailored to meet the needs of individual patients. For all of these reasons and more, GNYHA strongly opposes nurse staffing legislation beyond the significant legislation that has already been enacted to improve nurses' work environment.

Conclusion

Thank you again for allowing me to testify today. Attached to this testimony is a table briefly describing the Executive budget's hospital-related provisions and GNYHA's positions. We hope you find this useful as we work together on a budget that can improve the health care of all New Yorkers. I am happy to answer any questions you may have at this time or in the future.

SFY 2015–16 EXECUTIVE BUDGET

IMPORTANT HOSPITAL-RELATED HEALTH CARE PROVISIONS

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PROVISION	EXECUTIVE BUDGET	GNYHA POSITION
Global Cap	The State-share Medicaid spending global cap is tied to the 10-year rolling average of the medical component of the U.S. consumer price index (CPI), which is currently 3.6%. State-share Medicaid spending is projected to increase to $17.6 billion in SFY 2015-16 and $17.9 billion in SFY 2016-17. Extends the global cap permanently. Also extends shared savings provisions.	GNYHA **supports** the 3.6% global cap increase for the upcoming State fiscal year and the shared savings provisions. GNYHA **opposes** making the global cap permanent.
Expiration of Past Medicaid Cuts	Allows two hospital Medicaid cuts to expire: 1) a statutory cut related to past rates of potentially preventable negative outcomes (PPNOs) (e.g., readmissions, complications), and 2) an across-the-board cut to the reimbursement rate for hospitals, ostensibly related to obstetrical quality (this cut was implemented administratively). The Medicaid program continues to provide no reimbursement for hospital-acquired conditions through its "code suppression" policy.	GNYHA strongly **supports** allowing these cuts to expire. There are powerful incentives for hospitals to reduce PPNOs as part of DSRIP and the Medicare program, so the Medicaid cut ($51 million impact on hospitals—40% more than the amount that the PPNOs actually cost the Medicaid program) is unnecessary. In addition, the penalties relate to 2007 readmission rates and 2009 complication rates, which makes no sense given the many changes and improvements hospitals have implemented since then. Hospitals have also greatly improved quality in obstetrics, and are struggling with inadequate Medicaid rates for obstetrical services, so the obstetrical services cut ($19 million impact on hospitals) should be eliminated.
Medicaid Quality Pool	Aligns State hospital quality policy with policies for Medicaid managed care plans and nursing homes by creating a quality pool to provide Medicaid rate adjustments for hospitals that achieve quality goals set by DOH. $91 million benefit to hospitals and patients ($45 million State share).	GNYHA strongly **supports** the creation of a quality pool for hospitals.
Vital Access Providers (VAP)	Increases State-share VAP funding for financially distressed safety net providers by $290 million in SFY 2015–16.	GNYHA strongly **supports** the increase in VAP funding, particularly given the expiration of IAAF funding on March 31.
Obstetrical Services Quality Contribution	Reduces by $15 million the targeted amount raised by the tax, or "quality contribution," related to inpatient obstetrical care services revenue.	GNYHA strongly **supports** this tax cut to provide financial relief for hospitals providing obstetrical services.
Capital Access Pool	Provides $700 million for health care transformation in Brooklyn and $700 million primarily for hospitals in other areas of the State, over and above the $1.2 billion over seven years included in the SFY 2014-15 budget.	GNYHA strongly **supports** capital investment to help many of New York's financially struggling institutions transform into financially viable providers.

GREATER NEW YORK HOSPITAL ASSOCIATION GNYHA

GNYHA is a dynamic, constantly evolving center for health care advocacy and expertise, but our core mission—helping hospitals deliver the finest patient care in the most cost-effective way—never changes.

PROVISION	EXECUTIVE BUDGET	GNYHA POSITION
Private Equity Demonstration Projects	Allows up to five demonstration projects to enable private equity investors, partnered with academic medical centers or teaching hospitals, to invest in restructuring of hospitals. Prohibits publicly traded corporations and requires DOH to take into account, when reviewing applications, whether a proposal would allow not-for-profit operators to maintain majority control; the impact on patients and communities; and requires the applicant to identify the length of time it expects to invest in the hospital.	Under review with GNYHA members.
Indigent Care Pool (ICP)	Under current law, the ICP methodology expires on December 31, 2015. The Executive budget proposes extending the methodology through December 31, 2018, with annual losses capped at 10%, 12.5%, and 15% in 2016, 2017, and 2018, respectively.	GNYHA strongly **supports** the extension of the ICP and the caps on losses to ensure that hospitals are not destabilized financially during this time of transition and reform.
Qualified Medicare Beneficiaries (QMBs)	Reduces the Medicare Part B and Part C cost-sharing amounts Medicaid pays providers on behalf of low-income or "qualified" Medicare beneficiaries by basing the cost-sharing on rates Medicaid would have paid for a service rather than the amount Medicare is paying for a service. ($46 million in State-share savings.)	GNYHA strongly **opposes** this $92 million cut to providers, which would have a negative impact on providers serving low-income beneficiaries and a negative impact on access to care.
Primary Care Reimbursement Rates	The ACA provided 100% Federal financing for states to increase Medicaid primary care reimbursement rates to Medicare reimbursement levels for two years. The 100% Federal financing expired on December 31, 2014. The Executive budget ***does not*** keep the rates at Medicare levels.	GNYHA **supports adding a provision** to the budget to keep primary care rates at Medicare reimbursement rate levels; otherwise Medicaid physician rates will be cut substantially, providing a further disincentive for physicians to treat Medicaid patients.
OPWDD Potential Disallowance	Sets aside $850 million in settlement funds to cover a potential Medicaid take-back from the Federal government associated with OPWDD audits.	GNYHA **supports** reserving these funds so Medicaid providers would not be cut in the future to pay for the potential take-back.
Basic Health Program (BHP)	Begins BHP coverage on April 1, 2015 for the Medicaid immigrant population (currently funded with State-only dollars) for savings of $644 million. Begins BHP coverage on January 1, 2016 for individuals earning between 138% and 200% of the Federal Poverty Level who are currently enrolled in, or eligible for, New York State of Health (NYSOH) coverage. DOH would establish premium rates in consultation with an actuary, similar to the way DOH establishes Medicaid managed care premium rates.	While GNYHA **supports** the BHP, many individuals who will be enrolled in January 2016 currently have commercial coverage through NYSOH. Hospitals have often negotiated discounted commercial rates with plans, not Medicaid rates, for this population. GNYHA believes that artificially low premiums for BHP or setting Medicaid as a default rate for such individuals could potentially result in hospital reimbursement rate cuts. GNYHA supports prohibiting DOH from setting provider default rates.
New York State of Health (NYSOH)	Requires a modest contribution from insurers to finance ongoing NYSOH operations.	GNYHA **supports** this method of financing for NYSOH.

PROVISION	EXECUTIVE BUDGET	GNYHA POSITION
Certificate of Need (CON)	Eliminates a hospital or diagnostic and treatment center (D&TC) application for construction from "need review," unless it expands or limits services. The DOH Commissioner may also waive the financial feasibility review of these projects. The Executive budget also eliminates "need review" for construction of primary care facilities by D&TCs. The DOH Commissioner may also waive the financial feasibility review of these projects.	GNYHA strongly **supports** these CON streamlining provisions.
Character and Competence Reviews	Reduces the "look-back" period from the current 10 years to 7 years for character and competence review of a board member or operator during an establishment review. Permits individuals to demonstrate that past violations are not attributable to them.	GNYHA strongly **supports** these provisions.
Resident Work Hour Audits	Repeals Section 2803 (9) of the Public Health Law, which authorizes DOH to contract with a third party to survey hospitals on resident work hours. State savings of $1.1 million.	GNYHA strongly **supports** this provision. The third-party audits are duplicative of the more robust surveys conducted by the Accreditation Council for Graduate Medical Education (ACGME). Current law wastes taxpayer dollars and scarce DOH resources.
Health Information Technology (HIT) and Health Information Exchange (HIE)	Provides $63 million to fund the Statewide Health Information Network for New York ($45 million), the All-Payer Claims Database ($10 million), and for other HIT projects.	GNYHA **supports** funding for HIT and HIE initiatives, and looks forward to working with the Administration and State Legislature to ensure that funding is spent efficiently and effectively to enable providers to achieve practical HIE goals, meet Federal meaningful use requirements, and support DSRIP's goals.
Electronic Prescribing	Current law requires prescription drug prescribers to implement e-prescribing on March 27, 2015, including for controlled substances. The Bureau of Narcotics Enforcement (BNE) is working on a waiver process for prescribers who cannot meet the deadline.	GNYHA **supports** Senator Hannon's proposal (S.2486) for a yearlong delay in the e-prescribing requirement. Hospitals are committed to e-prescribing, and GNYHA is grateful for BNE's waiver development work, but a waiver process is by definition cumbersome and burdensome to implement, so a delay is preferable.
Medical Malpractice	Extends the physician excess medical malpractice pool through June 30, 2016. Eligibility limited to physicians and dentists covered in current policy year. Additional individuals can be covered if total number covered in current year exceeds those eligible for 2014-15. Allocated on basis of hospital's share of current year's covered individuals. Maintains the current funding level of $127.4 million. Adds requirement that physicians and dentists applying for coverage must receive a tax clearance from the State Department of Taxation and Finance.	GNYHA **supports** the extension of the excess medical malpractice pool, but seeks more information on the new tax clearance policy and its impact on timely coverage decisions. GNYHA supports adding a provision to expand eligibility for the Medical Indemnity Fund to all neurologically impaired individuals. GNYHA opposes adding provisions to increase medical liability insurance costs.

PROVISION	EXECUTIVE BUDGET	GNYHA POSITION
Public Health/ Workforce Appropriations	Consolidates 41 specific public health appropriations into five funding pools. Reduces overall funding by 15% for savings of $21.3 million.	GNYHA **opposes** consolidating many of these programs, including school-based health centers and workforce programs that are currently under contract with the State for specific dollar amounts. Existing contracts should be honored and the programs should continue to be funded separately.
Ebola Health Professionals Bill of Rights	Creates a bill of rights for health care professionals who travel overseas to fight Ebola, including job and benefits protection and covering the costs of lost wages if placed in 21-day quarantine when returning home.	GNYHA **supports** the Ebola bill of rights.
Certification of Advanced Home Health Aide	Under the supervision of a registered nurse, an advanced home health aide with at least one year of experience and additional training could administer medications, as ordered by a practitioner, that are routine and premeasured, or otherwise packaged in a manner that promotes safety, to a self-directing individual. The DOH Commissioner and Education Commissioner will work with industry experts to develop guidance on the certification of an advanced home health aide and to determine if there are other "advanced tasks" they may be permitted to perform.	GNYHA **supports** the advanced home health aide provisions.
Limited Service Clinics, Urgent Care, Office-Based Surgery, Anesthesia	Creates a new licensure category for limited service clinics (commonly known as "retail clinics"). Creates a definition for "urgent care" and requires accreditation for urgent care providers. Creates new registration, patient safety, and reporting requirements for office-based surgery and office-based anesthesia.	Under review with GNYHA members.
Spinal Cord Injury Research Program (SCIRP)	Continues to provide $7 million in annual funding for the SCIRP to support peer-reviewed efforts to develop, test, and validate therapies for spinal cord injury treatment.	GNYHA **supports** SCIRP funding.