Testimony of the

Iroquois Healthcare Alliance

presented to the

New York State Senate Finance Committee
and
New York State Assembly Ways & Means Committee

regarding

2013-2014 Executive Budget Proposal on Health

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Good afternoon Chairman DeFrancisco and Chairman Farrell, legislators, and staff. I am Gary Fitzgerald, President and CEO of the Iroquois Healthcare Alliance, a membership organization representing 53 hospitals and their affiliated organizations in 31 upstate counties. IHA's membership is diverse in that it comprises 32 rural hospitals including 5 Critical Access Hospitals, and represents the smallest hospitals in the state as well as some of the largest teaching hospitals in Upstate New York. I want to thank you for conducting this public hearing regarding the Executive's proposed healthcare budget.

My colleagues from HANYS and GNYHA have given you extensive testimony as to the challenges of the New York State Medicaid system. The Iroquois Healthcare Alliance supports many of the recommendations made by HANYS and GNYHA, and will work with them, and with you, to see that these efforts become reality. I will not repeat their testimony, but would like to speak briefly on the concerns of Upstate hospitals, nursing homes, and physicians.

The Cap

The creation of the "Voluntary Health Care Cost Containment Initiative," to enforce the global spending cap, was a two year experiment. Continuation of the "Medicaid cap" is of concern for our members. We would request an analysis and evaluation of the global cap experiment before it is continued.

Under the initiative, DOH was given the authority to implement utilization controls and rate reductions if Medicaid expenditures exceed the cap agreed to by the MRT. IHA believes that the Legislature should be actively involved in monitoring Medicaid utilization and expenditures. The Legislature should provide input into any implementation of controls or rate reductions.

The cap provided an "incentive" for providers to find efficiencies. The MRT required reporting of Medicaid expenses by sector and this is good. The cap has not been pierced, but if it is, the reason for the spending growth should be examined for regional and sector impact, and there should not be across-the-board responsibility for additional cuts or taxes.

There are many variables that can impact the cap, including enrollment. Enrollment in Medicaid is expected to continue to increase. From January 2011 through November 2012, enrollment in Medicaid has increased by 388,285. According to the New York State Department of Health Medicaid Enrollment Database, Medicaid enrollment is 5.2 million. The number of Medicaid recipients including Family Health Plus, is expected to exceed 5.6 million at the end of fiscal year 2014, an increase of 7.3 percent from fiscal year 2013, a result mainly attributable to expanded eligibility pursuant to the ACA and the economy. Given New York State's population today is 19,570,261, which means 29% of the population will be enrolled in Medicaid. New York State's healthcare providers have no control over increases in enrollment yet are subject to increased cuts if enrollment is a cause or reason for piercing the cap.

The IHA region's hospital inpatient, outpatient, and emergency department Medicaid expenditures *decreased* 22 percent comparing the period April 2011-2012 to April 2012-2013. There are a number of reasons for this decrease in expenditures, and it is good news. However, despite these numbers the Governor has proposed a 0% trend factor increase and a 2% across-the-board cut for hospitals, nursing homes and home care. Hospitals cannot sustain cuts to Medicaid while the patient population and request for services increases. Despite the U.S> health care inflation rate of 3.2% in December 2012, the Governor proposes to eliminate the trend factor.

And, in the context of national reform and the ACA, hospitals have already been cut significantly. Due to sequestration, hospitals may see additional cuts to Medicare rates in a month. This is significant because Upstate hospitals have a very high number of Medicare patients compared to other areas of the state and nation. In the first six months of 2012, the majority of Upstate hospitals (67%) had from 50% to 87% of their total inpatient overnight stays paid for by Medicare. With the recent fiscal cliff agreement, hospitals in the U.S. will be paid less for each service they provide to Medicare patients.

With the federal and state governments cutting the rates and eliminating the trend factor for Medicaid, a significant amount of the care provided to New Yorkers is not being paid for adequately. This has real consequences. During the last half of 2012, our members have eliminated more than 350 positions.

Workforce and Economic Development

Hospitals contribute to their local and regional economies through the purchase of goods and services from local establishments and through employment of large numbers of workers. Retaining hospitals as fixed assets in a community is particularly important in distressed cities or regions as hospitals stabilize the economy and contribute to revitalization.

The economic importance of hospitals extends beyond their purchasing power and employment-generating impact. Strong healthcare institutions are a necessity for attracting new workers and companies, and thereby jobs to a region.

IHA applauds Governor Cuomo's focus on economic development, and specifically the economic development of Upstate New York. The essential role that hospitals play in regional economies, should urge economic development councils to view hospitals as a focal point for attention. It is important from an economic development perspective to understand the impact of Medicare and Medicaid cuts to hospitals. These cuts result in limiting access, services, and jobs – and therefore, economic development. In the past 6 months, hospitals large and small across Upstate have been laying off employees and eliminating positions. As hospitals continue to operate under the financial restraints imposed through rate reductions and cuts, more of the workforce will be impacted, and economic development will be hindered.

Physician Shortage

Related to economic development and the workforce, communities in Upstate New York desperately need to recruit new physicians. IHA members are struggling with recruitment of physicians – primary and specialty. Physicians of all types are needed and in short supply, and

in some cases non-existent in many Upstate communities. Ina recent HANYS survey, thirty-two percent of hospitals had to either reduce or eliminate hospital services due to the physician shortage. A study from the SUNY Center for Health Workforce Studies shows that the average age of a physician in New York State is 52, and slightly older in rural counties, with 15% over the age of 65 in rural counties. The aging physician population and the need for additional health care services in Upstate due to its aging general population, creates a challenging environment. IHA requests that additional funding be included to continue the Doctors Across New York program.

Vital Access Providers

IHA commends the $182 million funding for "Vital Access Providers." This funding is essential to assist hospitals with the transitions necessary to meet the demands of the ACA. As the terms "safety net" and "vital access provider" are defined and needs are evaluated, it is imperative that Sole Community Providers and Critical Access Hospitals are by their definitions vital to the communities they serve. It is necessary for transition assistance for vital access to acknowledge geography and outpatient volume, not just Medicaid inpatient volume.

Access to Capital

The Executive Budget proposal also includes a provision to allow hospitals access to for-profit private equity capital as a demonstration. In this current financial environment, hospitals in the Iroquois region overwhelming support allowing private equity investment in NYS facilities.

Financially Fragile Upstate Nursing Homes

There is statutory language in the Executive proposal which mandates that the commissioners of health and labor shall establish "standard rates of compensation" to employees of nursing homes. Currently, 26 of Iroquois' members operate hospital-based nursing homes. IHA is opposed to the commissioners setting wages; allow the nursing homes' management to negotiate compensation for their workforce.

Excess Medical Malpractice

A provision has been added in the Executive Budget on "excess medical malpractice funding" on the basis that the program has been over-subscribed. The provision grants the superintendent of financial services and the Commissioner the discretion to determine the number of physicians and dentists who will receive policies, and priority is given to high-risk physicians in high-risk territories. High-risk specialties could exclude internal medicine and anesthesiology, and high-risk territories could be limited to New York City and Long Island. Internal medicine physicians from Upstate could find themselves excluded from the program including physicians who have participated in the program for many years. IHA opposes this exclusionary provision.

Thank you again for your time and the opportunity to comment. I hope that during your deliberations you will consider the issues that I have discussed with you today. The members of the Iroquois Healthcare Alliance look forward to working with you in making sure that quality, affordable health care is accessible to all of the citizens of New York State. I am happy to respond to any questions.