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# Testimony of Executive Director Henry Garrido

# District Council 37 – AFSCME

# Joint Legislative Public Hearings on the

# 2016-2017 Executive Budget Proposal

# Health/Medicaid

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# Legislative Office Building

# Hearing Room B

# Albany, New York

District Council 37, AFSCME represents over 18,000 members in the NYC Health and Hospitals system, and another 4,000 in the NYC Department of Health. Our members are involved in every aspect of health care provision. Our clerical members sign up a patient for health insurance or Medicaid, our Hospital Technicians and Institutional Services employees clean, feed and look after patients basic needs, our Respiratory Therapists help them breathe, and our Social Workers safely discharge them back to their homes or next step care. There are numerous other occupational groups as well that work in teams to insure NYC Health and Hospitals patients get the best possible care. We have excellent licensed professional partners among our sister and brothers in NYSNA, Doctor's Council, Committee on Interns and Residents, Local 1180 CWA and more. This year we have engaged in a joint labor and management effort to lobby for more fair funding for our public health system.

The care we provide costs far more than NYC Health and Hospitals receives back in Medicaid revenue or in supplemental payments from the federal and state funds to support care for the uninsured. This must change in the future so that the dollars follow the patients.

A number of corrective actions are in place to address the FY 16 budget, but there are projected gaps in FY 17 of $1.2 billion, and FY 18, $1.1 billion and growing in the out years. This is of great concern to our members. We are already seeing cuts in overtime. The only reason staff are doing overtime is because they are needed for the patient care. We do not want to see any more drastic actions that could affect jobs and patient care. The state must do the right thing and make sure NYC Health and Hospitals is supported fairly.

DC 37 is cautiously encouraged to see that the State has modified its' initial position of shifting additional recurring Medicaid costs to the City of New York but remains concerned about the details involved. The City is doing its part to contribute to the health of NYC Health and Hospitals, and to the health of New Yorkers, by providing resources for additional clinic expansions in high need areas, additional mental health resources, and moving the provision of Correctional Health Services from an ineffective provider to NYC Health and Hospitals and its' affiliate partners. Last week the City of New York announced the provision of an additional $337 million in funds which significantly narrows the projected budget gap for FY 16 but does not address long term funding issues.

Medicaid reimbursement are insufficient to cover costs for Medicaid patients, and the supplemental payments for the indigent care funds are not distributed in a fair and equitable manner that appropriately accounts for the number of uninsured patients H& H sees every year. For example, in Brooklyn alone, of the uninsured population *in Brooklyn NYC Health and Hospitals sees more than 80% of the uninsured patients seeking care.*

*NYC Health and Hospitals is the single largest provider of psychiatric services in Brooklyn, and a very large provider of addiction services. While some* other hospitals are getting out of the labor and delivery business, NYC Health and Hospitals continues to serve labor and delivery, and restored a high quality service at North Central Bronx hospital, with over 1,000 babies born there in the last year. NYC Health and Hospitals is the single largest provider of AIDs services, single largest provider of HIV tests, and successful in getting people into care. 80% of those who get into care stay in care. Our Public Health Advisors, Caseworkers, Social Workers are all a critical part of the care teams to support AIDS patients.

***Indigent Care Funding*** *- NYC Health and Hospitals is the single largest provider but doesn't get the money that is supposed to be dedicated to care for the uninsured* 3.5 B in total, distributed to nearly every hospital, even though many are providing less care to uninsured than NYC Health And Hospitals. 50% federal funds, 50% state funds. $1B to goes to voluntary hospitals with state match. $139 m to public hospital pool, only $96 m to NYC Health and Hospitals. NYC Health and Hospitals can only claim additional funds from this pool after other public hospitals that are not NYC Health and Hospitals, and not providing the same volume of care, draw down on the remaining funds to make up for losses, even though they may not be providing a disproportionate amount of the care.

Due to historical funding formulas, funds that are intended to support the care of the uninsured, are unfairly distributed. Before any NYC Health and Hospitals gets any money, all others get paid. They are the first to give care, and the last to get paid. *Our members, our Social Workers, our Patient Care Associates, our technicians are providing the care and should be the ones getting the fair share of the money. Our jobs should not be at risk since we have dedicated our careers to providing this care. The number of uninsured in NYC is declining thanks to the Affordable Care Act, down to* 450,000 uninsured, from a high of 600,000 in 2009. Those patients who recently got insurance coverage may be lured away to a non NYC Health And Hospitals hospital now that they are more attractive patients to a voluntary hospital. Fortunately the state has implemented the Essential Plan, which will cover even more low income patients, and this will create savings for the state that can be reinvested in Health and Hospitals. Even patients who are eligible for ACA coverage with subsidies are choosing not to get covered because they can not afford the monthly premiums.

The formula must be changed legislatively. If funding was directed to hospitals that had greater than or equal 50% Medicaid and Uninsured expenses as a share of total expenses and greater than or equal to 2% Uninsured expenses as a share of total expenses, it would double the amount of safety net funds to true safety net providers.

**Safety Net Definition and DSH** - A compounded effect of the unfair distribution of indigent care funds also affects the future distribution federal DSH funds. Since the number of uninsured is projected to decline, so are the amounts of DSH funds. Because New York State does not have a

targeted formula to high indigent care providers" more of the funds, more than $600m could be at risk as a result. The current definition must be changed legislatively in order to properly account for providers who are actually providing the most care.

Vital Access Funds, in various versions, including VAP, IAFF and VIP Quick are supposed to be targeted for safety net and hospitals with financial trouble. In the past, NYC Health and Hospitals has been **specifically excluded** from this pool of money. In this budget cycle, this must change. NYC Health And Hospitals should have a fair shot at Vital Access Funds.

**DSRIP** - DC 37 and our sister and brother unions are working to develop a productive relationship around the implementation of DSRIP. We expect to have a dedicated workforce committee working on issues of mutual concern shortly. Nevertheless, the funding that was awarded to NYC Health and Hospitals One City Health was more than $800 million less than what projected costs were and that was before One City Health took on SUNY Downstate as a partner. In order for workforce plans to be addressed and care models to be properly implemented there must be sufficient funding. Workers can not simply take on additional tasks and documentation requirements without the resources to do so properly. We urge NYS to release additional DSRIP funds for One City Health projects.

Proposed language in the state Executive Budget would expand the use of "minute clinics". There must be a balance between the need to provide additional access for non emergency urgent care and the need to provide real continuing primary care access that includes coordination with hospitals if necessary and community services. Otherwise there is a risk that patients will only get surface treatment for conditions that develop into more serious, more costly conditions.