46

New York State Legislature

Joint Legislative Budget Hearing – Health/Medicaid

Hearing Testimony: January 29, 2020

David Rich, Executive Vice President, Government Affairs, Communications, and Public Policy

GREATER NEW YORK HOSPITAL ASSOCIATION

Chairs Weinstein, Krueger, Gottfried, Rivera, and distinguished legislators, thank you for allowing me to testify today on behalf of not-for-profit and public hospitals across New York State.

My name is David Rich, Executive Vice President, Government Affairs, Communications, and Public Policy at the Greater New York Hospital Association (GNYHA). Our members include urban, suburban, and exurban hospitals across New York State, from Buffalo to Long Island. Our members include public hospitals, voluntary safety net hospitals, academic medical centers, major teaching hospitals, and suburban community hospitals. All are committed to providing the highest quality care to all, regardless of ability to pay, 24 hours per day, 365 days per year. And all serve Medicaid patients.

First, I would like to commend Governor Cuomo for once again empaneling a Medicaid Redesign Team (MRT) of experts to aid in the challenging task of finding savings and recommending structural reforms to New York's Medicaid program. Prior governors all too often proposed budgets designed behind closed doors that included major Medicaid cuts with little input from experts, advocates, and stakeholders. From the start of his governorship, Governor Cuomo made clear that he values collaboration over confrontation, and that if we are to make hard decisions, they should be made together, with expert input and, most importantly, with Medicaid beneficiaries and communities utmost in our minds. We look forward to working with the Legislature, the MRT, and the Executive on a budget that can help strengthen the Medicaid program for future beneficiaries.

But make no mistake: we all confront a major, unprecedented, and daunting challenge. The MRT has been charged with finding, in just over two months, $2.5 billion in Medicaid savings for State fiscal year 2021. To give you a sense of the magnitude of this number, if there were an across-the-board cut to all Medicaid payments to achieve $2.5 billion in savings, it would require a 10% cut in Medicaid payments to every hospital, nursing home, home care agency, clinic, physician, and managed care plan in the State. And, of course, the actual *impact* on providers, and, thus, the beneficiaries they serve, would be a $5 billion cut, since providers would lose the Federal matching dollars as well. A $5 billion across-the-board cut to all providers would be unsustainable, forcing financially struggling hospitals, nursing homes, clinics, and other providers to close their doors.

As I said, the MRT—and the Legislature and the Executive—are facing a huge challenge. But clearly it is a challenge that must be met.

Since it became clear several months ago that the State is facing a Medicaid spending problem, we have taken the position that we will judge the outcome of the budget process according to the following principles:

1) **Any new revenues must be dedicated to Medicaid.** If revenues become available from settlements (such as anticipated opioid settlement funds and others not otherwise encumbered), tobacco taxes, revenue re-estimates, higher-than-expected rainy day funds, or other sources, they must be dedicated to the Medicaid program. Hospitals and other safety net providers should not be unnecessarily cut if other revenues can lessen the impact.
2) **The Medicaid Global Cap must be reformed.** The Global Cap is a construct that came out of the first MRT in 2011. At the time, we had approximately 4 million Medicaid enrollees in the State.

We now have more than 6 million, and yet the formula that determines the Global Cap—the 10-year rolling average of the medical consumer price index—has actually *decreased* allowable, annual growth from 4% in 2011 to 2.9% in 2020. And there have been unintended consequences. Because there was no adjustment for enrollment, hospitals and other providers went a decade without a Medicaid rate increase. As a result, Medicaid rates covered only 72% of hospital cost in 2017, contributing to the financial distress of many safety net institutions. Finally, in 2019, there was a one-time 2% increase in hospital inpatient rates—which has been totally obliterated by the 1% across the board cut to *all* hospital payments that began on January 1, as well as other anticipated current year budget actions. The Global Cap should be reformed so that legitimate growth due to enrollment, aging of the Medicaid population, utilization changes, and other factors are taken into account.

3) **The true drivers of growth must be reformed.** The Executive and other experts have pointed to unbridled growth in the managed long-term care program as the major driver of unanticipated Medicaid spending growth. According to the Executive, the program has grown 301% since 2013 and now accounts for one-third of State Medicaid spending. Any serious solution to the problem must address this program, and all aspects of it should be on the table, from administration of the program to oversight to eligibility. It is important to do so, not just to avoid unnecessary cuts for other sectors, but to ensure that disabled New Yorkers who truly need services do not have to worry that inappropriate, unsustainable growth will threaten services they desperately need.
4) **If there are hospital cuts, safety net providers must be protected.** Safety net providers with high volumes of Medicaid patients would, by definition, be disproportionately harmed by Medicaid reimbursement rate cuts. An "across-the-board cut" has a very different impact on a public or voluntary hospital with a high percentage of its revenue coming from Medicaid. In addition, there are already some 30 hospitals on a State "watch list" for closure who rely upon regular, significant support just to make payroll and keep the lights on. Another cohort of struggling hospitals, which do not meet the technical criteria to be on the watch list (because, for example, they have more than 15 days cash on hand!), tend also to be safety net hospitals with large volumes of Medicaid patients. It makes no sense to cut Medicaid rates for these hospitals, just to have to bail them out through special, ad hoc payments from other parts of the budget. They need to be protected so they can continue to serve their communities.
5) **If there are hospital cuts, the State should find ways to help hospitals weather them.** In this vein, we strongly support the provisions of the Executive budget that would put an end to insurance companies' outrageous behavior. Insurers have taken to denying huge numbers of claims for medically necessary services that should be covered, forcing hospitals and other providers into lengthy appeals that require significant staff resources and can last many months or even years. Hospitals must spend ever-increasing amounts just to collect payments from insurers for patient care they already provided while the insurer holds onto the money. And often they never get paid at all. The Executive budget provisions that would prohibit administrative denials, ensure more timely payment, speed authorization for hospital patients for rehabilitation services, set parameters for down-coding, and other reforms will appropriately reduce hospital operating costs and reform insurance company policies that inappropriately deny or delay claims payments. We have attached to this testimony a more detailed description of these critical reforms.

We are looking at other measures as well, including input costs affecting our hospitals.

There are several Executive budget proposals that we would like the MRT and the Legislature to address:

- **Indigent Care Pool (ICP):** The budget maintains the hospital ICP but allows the $25 million transition "collar" to sunset on December 31, 2020. The collar caps hospital losses at 20% in 2020 compared to base year distributions under the old ICP methodology. This was the topic of an ICP Workgroup last year, but no consensus recommendations were reached, in part due to the fiscal impact on certain critical safety net providers. GNYHA strongly urges you to protect safety net hospitals that are affected by the elimination of the transition collar.
- **Enhanced Safety Net Pool:** The Executive proposes discontinuing this pool due to lack of approval by the Federal government. GNYHA would like to better understand the reasons for the Federal government's concerns, as this pool could go a long way to helping safety net hospitals' finances.
- **Prevailing Wage:** We are studying the Executive budget's prevailing wage proposal and its potential impact on hospitals. Particularly given the potential loss of revenue through Medicaid, we want to make sure that this proposal does not increase costs for hospitals.

In community after community and legislative district after legislative district, New York's hospitals deliver compassionate, quality care 24/7 to all who walk through their doors. They are also their communities' largest employers. Members of the Senate and Assembly have stood up time and again over the years to defend their hospitals. We thank them from the bottom of our heart for that support.

The future requires all hands on deck, and we look forward to working with you.

Thank you.

Attachment

PLEASE SUPPORT GOVERNOR CUOMO'S INSURANCE REFORMS

PRESIDENT, KENNETH E. RASKE • 555 WEST 57TH STREET, NEW YORK, NY 10019 • T (212) 246-7100 • F (212) 262-6350 • WWW.GNYHA.ORG

New York Governor Andrew Cuomo's proposed budget for State Fiscal Year (SFY) 2021 includes much-needed provisions that would protect New Yorkers from abusive insurance companies that wrongly refuse to pay for medically necessary care and emergency care.

We urge the New York State Legislature to support the following insurance reforms:

Prohibition on Administrative Denials. This budget provision would prohibit insurers from refusing to pay for critically needed services simply because one of the plan's administrative rules wasn't followed. For example, some plans require a hospital to submit patient medical records within 48 hours of an emergency admission, and deny the claim if the records are submitted within 49. Insurance companies should not be able to refuse to pay for hospital services that they agree are medically necessary just because some paperwork is submitted late.

Balance Billing. The State's current dispute resolution law requires insurance companies to pay hospitals directly for out-of-network emergency services. The proposed budget would also prohibit hospitals and physicians from billing patients for such services beyond any applicable copayment or deductible that would have been paid in an in-network situation. This will ensure that patients do not receive bills they are not responsible for.

Down-coding. This budget provision would require that insurers use national coding guidelines when processing claims, and limit the ability of insurers to reduce payments to hospitals by ignoring diagnostic codes if the coding is consistent with these guidelines.

Authorizations for Rehabilitation Services. This budget provision would help consumers by reducing the timeframe for insurers to approve a request for rehabilitation services provided by a hospital or a skilled nursing facility from three business days to one. This will help ensure that patients receive the rehab care they need in a timely manner instead of remaining in a hospital bed longer than necessary.

Appeals/Payment Timeframes and Interest Payment. This budget provision would reduce the time insurance companies have to act on appeals from 60 days after they have the information they need to 30 days. It would also require insurers to pay after an appeal is approved within 15 days and to include interest on the payment. Currently, lengthy appeal processes allow insurers to delay payments for medically necessary care for months or even years.

Provisional Credentialing. This budget provision would require insurers to grant provisional credentialing status to newly licensed physicians who are employed by hospitals, Article 28 diagnostic and treatment centers, and Office of Mental Health-licensed facilities. Insurers would be required to reimburse for services provided by physicians in this provisional status once the physician's credentials are approved by the plan. Insurance companies often delay credentialing so they can deny payment for medically necessary care.

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.

Plan Product Information. This budget provision would require insurers to notify hospitals in writing and electronically of the specific plan or product the patient is covered by. Right now only the insurance companies have this information, and hospitals need it to ensure they are correctly following State and/or Federal rules in terms of billing, reporting, and disclosure of information. This will also help consumers and providers more quickly understand what the ultimate consumer bill should be.

Administrative Simplification Workgroup. This budget provision would require the establishment of an administrative simplification workgroup comprising insurers, health care providers, and consumers to make recommendations to the Department of Financial Services, the Department of Health, and the Legislature on how to reduce health care administrative costs through standardization, simplification, and technology.

Reporting on Insurer Claims Payment/Denials. This budget provision would require insurers to report quarterly and annually on claims payment activity, including claims received, paid, and denied. This information is important for plan monitoring and to identify outlier performance.

These reforms are found in Part J of the Executive Budget Health and Mental Hygiene Article VII Bill (A.9507/S.7507).