Testimony of the

**Upstate New York Healthcare Coalition**

Submitted to the

**New York State Senate Finance Committee**

**and**

**New York State Assembly Ways & Means Committee**

regarding

# 2020-2021 Executive Budget Proposal on Health

by Gary J. Fitzgerald
President & CEO, Iroquois Healthcare Alliance

*www.upstatenyhealthcarecoalition.org*

**January 29, 2020**

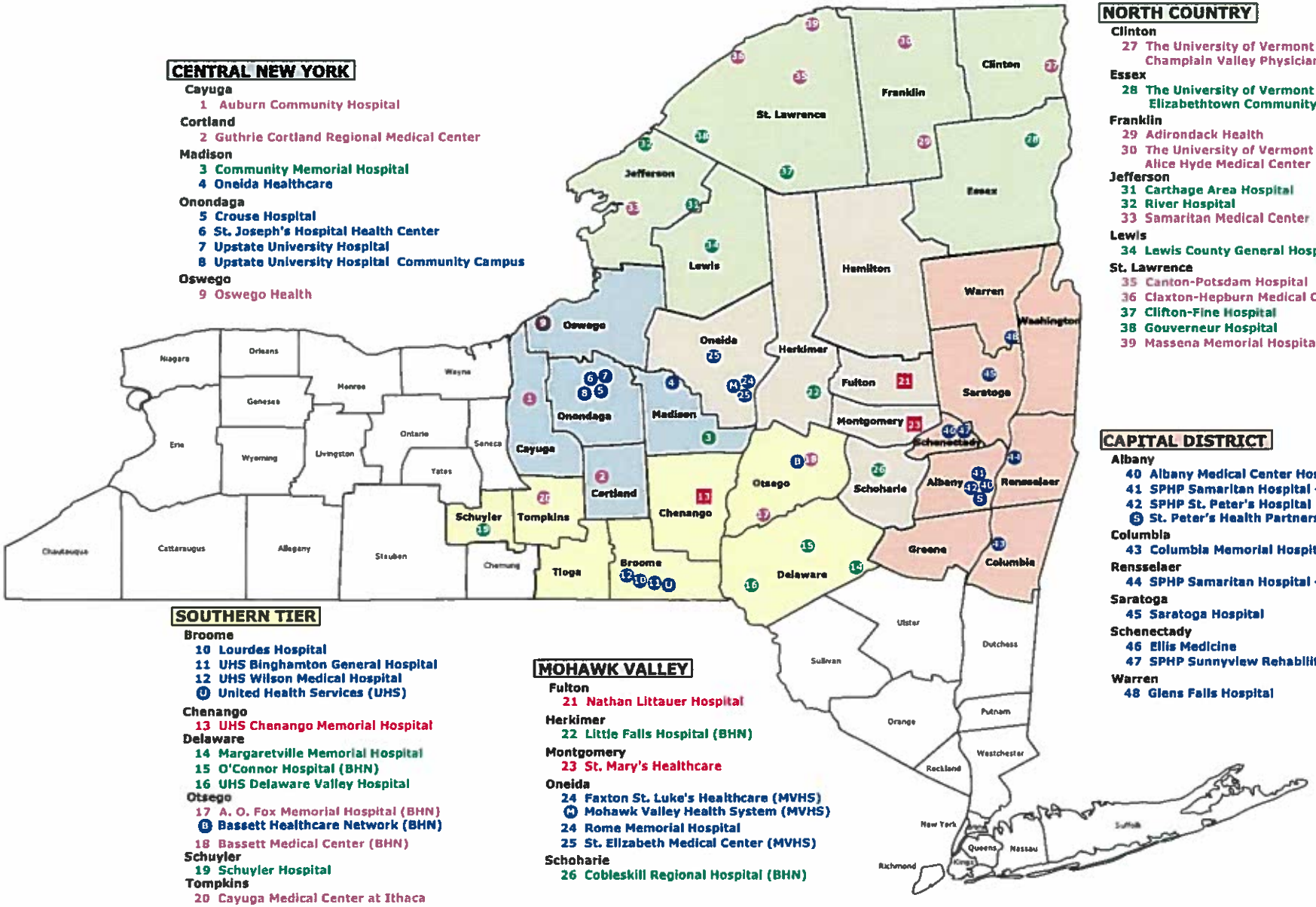
www.iroquois.org

# IROQUOIS HEALTHCARE

*Representing healthcare providers in Upstate New York*

## Iroquois Healthcare Alliance Members

- Critical Access Hospitals (13)
- Sole Commuity Hospitals (13)
- Medicare Dependent Hospitals (3)
- Inpatient Prospective Payment Hospitals & Other (24)




### CENTRAL NEW YORK

**Cayuga**
1 Auburn Community Hospital

**Cortland**
2 Guthrie Cortland Regional Medical Center

**Madison**
3 Community Memorial Hospital
4 Oneida Healthcare

**Onondaga**
5 Crouse Hospital
6 St. Joseph's Hospital Health Center
7 Upstate University Hospital
8 Upstate University Hospital Community Campus

**Oswego**
9 Oswego Health

### NORTH COUNTRY

**Clinton**
27 The University of Vermont Health Network Champlain Valley Physicians Hospital

**Essex**
28 The University of Vermont Health Network Elizabethtown Community Hospital

**Franklin**
29 Adirondack Health
30 The University of Vermont Health Network Alice Hyde Medical Center

**Jefferson**
31 Carthage Area Hospital
32 River Hospital
33 Samaritan Medical Center

**Lewis**
34 Lewis County General Hospital

**St. Lawrence**
35 Canton-Potsdam Hospital
36 Claxton-Hepburn Medical Center
37 Clifton-Fine Hospital
38 Gouverneur Hospital
39 Massena Memorial Hospital

### CAPITAL DISTRICT

**Albany**
40 Albany Medical Center Hospital
41 SPHP Samaritan Hospital - Albany
42 SPHP St. Peter's Hospital
(S) St. Peter's Health Partners (SPHP)

**Columbia**
43 Columbia Memorial Hospital

**Rensselaer**
44 SPHP Samaritan Hospital - Troy

**Saratoga**
45 Saratoga Hospital

**Schenectady**
46 Ellis Medicine
47 SPHP Sunnyview Rehabilitation Hospital

**Warren**
48 Glens Falls Hospital

### SOUTHERN TIER

**Broome**
10 Lourdes Hospital
11 UHS Binghamton General Hospital
12 UHS Wilson Medical Hospital
(U) United Health Services (UHS)

**Chenango**
13 UHS Chenango Memorial Hospital

**Delaware**
14 Margaretville Memorial Hospital
15 O'Connor Hospital (BHN)
16 UHS Delaware Valley Hospital

**Otsego**
17 A. O. Fox Memorial Hospital (BHN)
(B) Bassett Healthcare Network (BHN)
18 Bassett Medical Center (BHN)

**Schuyler**
19 Schuyler Hospital

**Tompkins**
20 Cayuga Medical Center at Ithaca

### MOHAWK VALLEY

**Fulton**
21 Nathan Littauer Hospital

**Herkimer**
22 Little Falls Hospital (BHN)

**Montgomery**
23 St. Mary's Healthcare

**Oneida**
24 Faxton St. Luke's Healthcare (MVHS)
(M) Mohawk Valley Health System (MVHS)
24 Rome Memorial Hospital
25 St. Elizabeth Medical Center (MVHS)

**Schoharie**
26 Cobleskill Regional Hospital (BHN)

January 2020

**FOR IMMEDIATE RELEASE**
January 21, 2020

IROQUOIS Healthcare Alliance

Pandion OPTIMIZATION ALLIANCE

## Statement from the Upstate New York Healthcare Coalition in Response to Governor Cuomo's Executive Budget Proposal

ALBANY, NY – The Upstate New York Healthcare Coalition acknowledges Governor Andrew M. Cuomo for his support of New York's healthcare delivery system, made evident by several provisions outlined in his 2020-21 Executive Budget Proposal.

Upstate New York's hospitals and health systems are the safety-net of their communities. They are not like their Downstate counterparts where access to care is a short walk down the block or quick subway ride away. Upstate hospitals are often the only source of emergency and primary care for many miles, yet nearly 85% of hospitals throughout Upstate New York are operating with negative margins.

The Executive Budget Proposal reconvenes the Medicaid Redesign Team (MRT) to reform the State's Medicaid program and identify billions in Medicaid savings by April 1, 2020. The Upstate New York Healthcare Coalition remains concerned that any additional cuts to our hospitals will impair the ability to provide high-quality care, causing devastating effects on our communities. We request the MRT consider the unique qualities of Upstate New York that affect access to care including healthcare workforce shortages, geography, and transportation services.

We appreciate the Governor's investments in public health initiatives including lowering prescription drug costs and protecting Upstate New York's youth by banning flavored e-cigarettes.

We will continue to advocate diligently for our hospitals and health systems to support an innovative and progressive healthcare delivery system throughout our Upstate New York communities. We look forward to working closely with the Administration, Legislature and MRT to ensure every Upstate New Yorker receives the access, quality and level of care they deserve.

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*The Upstate New York Healthcare Coalition is a partnership between Iroquois Healthcare Alliance and Pandion Optimization Alliance. The Coalition represents over 60 hospitals and healthcare systems in approximately 45 counties and 40,000 square miles across Upstate New York. Gary J. Fitzgerald is the President & CEO of Iroquois Healthcare Alliance and Travis Heider is the President & CEO of Pandion Optimization Alliance. To learn more, please visit www.iroquois.org/upstate-healthcare-coalition.*

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Good afternoon Chairwoman Krueger, Chairwoman Weinstein, Health Committee Chairs Gottfried and Rivera, legislators, and staff. Thank you for the opportunity to comment on the Executive Budget Proposal for state fiscal year 2020-2021. We appreciate your support of healthcare throughout the good state of New York and look forward to continuing our dialogue with you during this critically important legislative session.

I am Gary Fitzgerald, President and CEO of the Iroquois Healthcare Alliance, a membership organization representing over 50 hospitals and health systems in 32 counties of Upstate New York, spanning nearly 28,000 square miles. Our membership is diverse, comprising of 32 rural hospitals including 13 Critical Access Hospitals and 13 Sole Community Hospitals. We represent the smallest hospital in the state, as well as some of the largest teaching hospitals in Upstate New York.

I am presenting to you today on behalf of the Upstate New York Healthcare Coalition, a group of diverse health care organizations working together to obtain statewide equity and ensure access to quality health care services for the people of Upstate New York. The Coalition is a partnership between Iroquois Healthcare Alliance and Pandion Optimizations Alliance (Rochester hospitals). Collectively the Upstate New York Healthcare Coalition represents over 60 hospitals and healthcare systems in approximately 45 counties and 40,000 square miles across Upstate New York.

Last week, Governor Andrew M. Cuomo released his Fiscal Year 2021 Executive Budget proposal. Hospitals across Upstate New York were pleased to see several proposals included that we have championed for many years, including the provisional credentialing of physicians, as well as prohibiting administrative claims denials; codifying the requirement that plans identify an insured's plan or product; requiring health plans to use nationally accepted coding standards; and

requiring plans to report to Department of Financial Services the number and value of healthcare claims received, paid, pended and denied. Additionally we are highly supportive of the public health policies regarding including lowering prescription drug costs and protecting Upstate New York's youth by banning flavored e-cigarettes.

We continue to review the proposed budget language and its effect on our Upstate New York hospitals. We have several areas of concern, including the proposal that eliminates state funding for the Hospital Excess Liability Pool. This pool purchases medical malpractice policies for physicians and dentists to cover liabilities in excess of their usual policy limits. It is used as a component to recruit and retain physicians throughout Upstate New York. Under the Executive Budget proposal, program support would end on June 30, 2020, which is also the end of the current program year. This could further exacerbate the physician shortage throughout Upstate New York.

We also have concerns about the proposal to expand the Independent Dispute Resolution (IDR) process to include inpatient services which follow an emergency room visit. This bill does not provide additional consumer protections. In fact, some plans may be motivated to underpay hospitals – especially smaller, rural, Upstate hospitals, by relying on the dispute resolution process and have less robust networks. Additionally, this bill adds an unneeded administrative step for hospitals and may cause a further backlog of cases that are awaiting consideration by the dispute resolution entity. It is important to note that Upstate New York's hospitals should not be penalized for the actions of bad actors in other regions of the state. Our hospitals and health systems simply cannot be compared to massive downstate entities.

As widely reported, the proposal also calls for the Medicaid Redesign Team, aka the MRT II, to convene to address the State's structural imbalance in Medicaid spending. This

group of industry stakeholders and experts is tasked with identifying $2.5 billion in Medicaid savings in order to ensure a balanced budget. If these savings cannot be reached, unilateral cuts will be implemented. Having already taken an unplanned 1% across-the board-cut revealed on New Year's Eve 2019, further cuts would be unsustainable and devastating for Upstate New York hospitals. We anticipate working collaboratively with the MRT II to identify cost-saving approaches that secure the fiscal sustainability of the Medicaid program while ensuring patients continue to have access to essential Medicaid services throughout Upstate New York. We request the MRT consider the unique qualities and challenges of Upstate New York that affect access to care. Qualities and challenges that we have outlined, in detail, in the following testimony.

***PAYMENT ADEQUACY & PAYER MIX***

Upstate New York's hospitals and health systems are the safety-net of their communities. They are not like their Downstate counterparts where access to care is a short walk down the block or quick subway ride away. Upstate hospitals are often the only source of emergency, primary and long-term care services for miles, yet nearly 85% of hospitals throughout Upstate New York are operating with negative margins. In fact, Upstate New York hospitals have an average margin of -4.3%.

Upstate's rural hospitals face multiple instabilities due to the unique circumstances of providing care in rural areas, including remote geographic location, low-patient volumes, workforce shortages, and a population that is often older, sicker, and more dependent upon government programs like Medicaid and Medicare. While these two programs are widely utilized by patients, unfortunately, both programs reimburse providers far below the cost of

providing care. Medicaid, in particular, reimburses hospitals in Upstate New York only 69% of the total cost of providing care.

There are 18 hospitals throughout New York State designated as Critical Access Hospitals and 17 hospitals designated as Sole Community Hospitals. These are federal designations with program requirements such as bed size, location, local topography, and distance from other hospitals. These designations are designed to reduce the financial vulnerability of rural hospitals and improve access to healthcare by keeping essential services in rural communities.

Thanks to all of you, the New York State Legislature, and Governor Cuomo, legislation was passed in 2017 statutorily recognizing Critical Access Hospitals and Sole Community Hospitals as "Safety Net" institutions, allowing them to receive higher Medicaid rates in order to support critically needed health care services. While these designations might seem technical in nature, I can assure you they have tremendous significance and must be protected.

***HEALTHCARE WORKFORCE SHORTAGES: PHYSICIANS***

New reimbursement models rely upon our ability to attract and retain a high-quality and dedicated healthcare workforce. While New York State trains the most doctors in the country, the reality is, we continue to export physicians. Almost half of newly trained physicians leave New York after completing residency training and only 6% of new physicians plan to practice in rural areas. Of the vast majority who are staying in New York State, 88%, are remaining in the same region where they trained. However, most training and educational opportunities exist in urban areas.

According to a *Center for Health Workforce Studies* report, Upstate New York has less than 300 physicians per 100,000 population, which is approximately 35.7% less than the Downstate average of 417. This includes all physicians regardless of their care setting.

At present, and almost exclusively, in order to recruit a physician to serve an Upstate community, the physician must be offered an employment arrangement by the hospital or health care system. In most cases the total cost to a hospital – including compensation, benefits, insurance, equipment, supplies, practice site etc. – for employing a physician far exceeds the revenue generated by the physician, creating an unsustainable recruitment model. On average, Upstate hospitals pay 22% more for their employed physicians than their Downstate counterparts. More than 60% of primary care physicians working in Upstate communities are hospital-employed. In rural communities, a small hospital may employ anywhere from 1 to 5 primary care physicians. While this might not seem like a significant number, the hospital-employed physicians are often the only primary care physicians working in those communities.

While the statewide supply of primary care physicians appears to be sufficient, it is widely recognized that these providers are unevenly distributed across the state. New York City has the highest rate of primary care physicians while some regions across Upstate New York have the lowest. The maldistribution of providers limits access to care for underserved populations.

New York has an opportunity to grow our own physicians by promoting opportunities throughout the education pipeline from high school to medical school to residency to practice. We believe that collaboration with medical schools and residency programs to promote these opportunities will help with addressing the physician misdistribution. In efforts to increase the number of primary care doctors, we need to develop a more focused Graduate Medical

Education (GME) system. GME residency training programs can do things that would increase the likelihood of residents choosing primary care and underserved areas. The location of these residency programs, mentor opportunities, faculty development, and exposure to positive experiences in rural and underserved areas would make a compelling difference.

## *HEALTHCARE WORKFORCE SHORTAGES: NURSES, BEHAVIORAL HEALTH SPECIALISTS AND HOME CARE WORKERS*

Workforce vacancies do not only exist for physicians, but all practice levels, including nurses, nurse practitioners, behavioral health specialists and home care workers.

**There are currently over 2,000 registered nurse vacancies across Upstate New York in hospital inpatient settings alone.** Yet our hospitals and nursing homes are faced with the threat of mandated nurse to patient ratios. This rigid, one-size-fits all approach to patient care would be devastating to our local healthcare system, especially our rural providers by removing local control over staffing decisions. Government-mandated ratios would have the unintended consequence of eliminating jobs for other healthcare professionals who assist nurses in patient care – including technicians, respiratory therapists, physical therapists, occupational therapists, and other members of the healthcare team – and would significantly increase costs for healthcare providers that are already facing significant financial challenges. There are simply not enough nurses in Upstate New York to comply with such a regulation.

Rural communities across the state are also suffering from shortages of home care workers. Because of low wages and competition from other sectors, 17% of home health aide jobs across the state are unfilled, according to a *Home Care Association of New York* report released last year. Even as the number of home health aides has declined, the elderly population

in Upstate New York has continued to grow. While Medicaid and Medicare pay for in-home care, their rates do not cover cost.

New York State must make a concerted effort to recruit and retain a qualified and engaged healthcare workforce. This can and should be done in conjunction with education and economic development initiatives. 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 to their communities, and thereby jobs to a region. Across Upstate New York, the health care infrastructure is often a mainstay of the region's economy. The economic growth and stability of communities requires the presence of a strong health care system to attract and keep residents, and to attract businesses to employ local residents.

***GEOGRAPHIC ISOLATION & TELEMEDICINE***

Rural hospitals exist in communities that are often located away from population centers and other health care facilities making coordination of care extremely difficult. Public transportation is rare and even if it does exist, it is often sporadic. For many rural residents, these challenges mean that preventative and post-acute care, pharmaceutical needs, and other services are delayed, or abandoned entirely, which can increase the overall cost of care once services are delivered.

In 2016, New York State amended the New York Public Health, Social Services and Insurance Laws to require commercial insurers and the Medicaid program to provide coverage for telehealth services to the same extent those services would have been covered had they been rendered in person. However, the legislation <u>does not</u> require insurers to reimburse providers for

telehealth services *at the same rate* for the same services rendered in person. There are also strict requirements on when and where telehealth services may be rendered to qualify for reimbursement. As a result, many providers are often not aware of when and how they may render telehealth services to receive reimbursement.

This issue is only compounded by a second challenge, which many providers consider to be the single largest impediment in advancing of use telemedicine in New York State. Though legislation has been proposed to require public and private insurers to reimburse telehealth services at the same rate as if the services were rendered in-person, currently, the reimbursement rates are being set by the insurers may be less than the reimbursement rates for in-person services. This lack of parity in payment rates creates a disincentive for providers' use of telehealth.

There are also technological challenges related to implementing telehealth across New York State including inconsistency in the availability of high-speed broadband. The fact that high speed broadband is still not available throughout many parts of Upstate New York has made it extremely challenging to implement telehealth programs. Implementing and maintaining telehealth technology also requires dedicated IT staff. Telehealth also adds a new layer of risks and vulnerabilities to handling electronic health data as determinations must be made whether the data is subject to HIPAA and, if so, conduct a thorough assessment of potential security risks and vulnerabilities in order to be HIPPA compliant. Despite these challenges, telehealth is the future of healthcare, especially for many with limited transportation options or who lack nearby health services.

## *MERGERS AND AFFILIATIONS*

Many hospitals throughout Upstate New York have created mergers and affiliations with larger health systems across the state and beyond. The nature of these agreements vary widely; however, they present one common theme - regional borders are no longer relevant. There are hospitals in Upstate New York who are now affiliated with other hospitals in New York State that are not geographically close to one another. There are also hospitals that have affiliations with out-of-state hospitals and health systems that border New York State while some hospitals have out of state, national affiliations.

Many Upstate hospitals affiliate and merge due to the fact they generally experience lower patient volumes compared to their urban counterparts, making it difficult for these organizations to manage the high fixed costs of operating a hospital. This, in turn, makes them particularly vulnerable to policy and market changes, as well as Medicaid payment cuts.

Additionally, competition with freestanding outpatient entities remains both a serious challenge and concern for Upstate hospitals. These competitors are not required to serve the poor or indigent, nor do they have any obligation to help address the population health needs of the community, creating a local market that is simply not a level-competitive market. Pulling limited resources away from the hospital in order to provide profits to the competing physician-owned, limited-service facility only undermines a hospital's ability to influence other aspects of health in that community.

## *SOCIAL DETERMINANTS OF HEALTH*

Because Upstate New York's residents are typically older individuals, they are more likely to have one or more chronic diseases such as heart disease, diabetes, substance abuse

disorder, and mental illness. Therefore, rural and underserved communities across Upstate New York often face poorer health outcomes that are directly tied to quality and value-based care reimbursement. While New York's urban communities typically have the depth and abundance of specialties necessary to address social determinants of health in their communities and the research strength to obtain the funding required to study these issues, rural areas simply cannot sufficiently compete and participate.

For reference, social determinants of health-influencing factors outside the hospital setting - like diet, education, and income - account for 80% of patient health outcomes. The lack of payment mechanisms is currently cited as the top barrier to social health programs. Given that there is no standardized reimbursement process does not encourage directing patients to social programs.

Through the Delivery System Reform Incentive Payment Program (DSRIP), New York State has committed to reaching 80% value based payments (VBP) by the end of the waiver period. This is a lofty but admirable goal, and presents significant challenges for Upstate's rural and smaller hospitals. While every hospital is attempting to achieve this milestone, value-based reimbursement models require large initial investments, such as making electronic health records systems interoperable and accepting downside financial risk. Many Upstate hospitals do not have access to financial resources to invest in value-based reimbursement models. In addition, some small and rural hospitals have difficulties with provider buy-in for both value-based reimbursement and population health management models. Since many rural practices serve larger proportions of Medicare fee-for-service beneficiaries compared to other providers who treat more Medicare Advantage patients, they have more incentive to remain under fee-for-service arrangements.

Additionally, national studies indicate that many rural and small hospitals feel pressure to merge with larger healthcare organizations in order to manage value-based reimbursement models and regulations. Surveys have shown that with limited staff, some hospitals reported that their providers and employees struggled to manage more administrative duties, such as quality reporting, while still providing care delivery. As a result, many administrative tasks were not completed. Merging with a larger organization presents a potential solution to limited healthcare employment and value-based reimbursement capabilities.

***SOLUTIONS/RECOMMENDATIONS***

Collectively, we need to contribute to finding solutions that support Upstate's healthcare delivery system. We also need to focus on the economic development and sustainability of our Upstate communities. We urge state lawmakers to reframe the way we think about Upstate hospitals and their role in the community – providing the proper financial incentives for these hospitals in order to help solve ongoing population health problems and access to care challenges. The Upstate New York Healthcare Coalition is fearful that by not addressing these concerns, the rural health care delivery system will face difficulties in meeting the milestones and objectives of transformation. Specifically, we would ask for your consideration of the following solutions:

- **Minimize Impact of any Further Cuts to Upstate New York Hospitals and Health Systems**
    - On New Year's Eve 2019, Upstate New York's hospitals and health systems received an across-the-board Medicaid cut of 1%. This cut was for the last quarter of 2019. The Executive Budget makes this cut permanent, totaling nearly $500 million annually. This cut is in addition to the $2.5 billion in savings that the MRT II must find. We respectfully request that any further cuts to Upstate New

York's hospitals are as minimal as possible. A cut to an Upstate small, rural and suburban hospital could translate into the downfall of an entire community.
    - We also urge the MRT II to protect and continue funding for Safety-Net hospitals across Upstate. These institutions serve as the backbone of their communities and rely on fiscal support in order to ensure access to quality care.
    - The Upstate New York Healthcare Coalition encourages state lawmakers and the MRT II to utilize revenue from other sources to close the Medicaid cap including, but not limited to, the State's opioid lawsuit settlement, recreational marijuana, Medicaid waste, fraud and abuse claims and mobile sports betting.

- **Utilize the Regional Economic Development Councils for Recruitment of Healthcare Workforce in Rural Areas**
    - The Upstate New York Healthcare Coalition applauds Governor Cuomo's focus on economic development, specifically the economic development of Upstate New York. The essential role that hospitals play in regional economies should urge New York's Regional Economic Development Councils to view hospitals as a focal point. Healthcare, however, has generally not been viewed by the Councils as an economic development issue. We would suggest utilizing the Councils to address healthcare workforce shortages in Upstate communities.

- **Convene the Rural Health Council**
    - Chapter 419 of 2017 statutorily establishes the Rural Health Council, comprised of health care providers and representatives that represent the health care delivery system in the state's rural areas. The Rural Health Council advises the Health Commissioner on all aspects of rural health care and rural health care delivery. However, to date, the Council has not been officially reestablished nor has it convened. We urge the Legislature and Governor to convene the Rural Health Council at the earliest opportunity to ensure a rural voice is included in state-level health care decisions.

I would like to leave you with one last statistic. According to a recent *New York Times* article, over 100 rural hospitals have closed across the country over the last 10 years including several in Upstate New York. Let's not allow this trend to continue.

Thank you again for your time and the opportunity to comment. The members of the Upstate New York Healthcare Coalition look forward to working with you, as well as the MRT II, to ensure that quality, affordable health care is accessible to all Upstate New Yorkers, particularly our most vulnerable populations. I am happy to respond to any questions.