Testimony of

The Healthcare Association of New York State

Concerning the 2011-2012 State Budget

Presented to the Joint Hearing of the

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

March 3, 2011

Thank you, Chairman DeFrancisco, Chairman Farrell, Chairman Hannon, Chairman Gottfried, and members of the Legislature, for the opportunity to speak to you today. I am Daniel Sisto, President of the Healthcare Association of New York State (HANYS).

As you know, the dynamics associated with the 2011-2012 state budget process are like no others in recent memory, especially regarding the Medicaid program. New York faces an historic $10 billion deficit, presenting challenges of equally historic magnitudes, and requiring sacrifices from every sector. In response to this crisis, Governor Cuomo engaged an unconventional strategy by creating the Medicaid Redesign Team (MRT), turning the normal process on its head and requiring all of us to think differently and more collaboratively than ever before.

The MRT was an entirely new approach for New York, empowering stakeholders to assume responsibility for meeting the state's savings target, while at the same time recommending and facilitating systemic reforms desperately needed to stabilize and sustain the Medicaid program.

Most would agree that a new approach was necessary. In just the last three years, the Legislature has been compelled to take eight distinct budget actions, including numerous deficit reduction actions, which, combined, cut more than $5.3 billion from hospitals, nursing homes, and home health care providers. The magnitude and unpredictability of these actions wreaked chaos for health care providers as they tried to continually adjust to these seasonal reimbursement reductions, pushing fragile organizations nearer and nearer to the brink.

During this same time, numerous reforms to the hospital reimbursement system were imposed, creating more challenges and unpredictability for providers. All the while, the unsustainability and looming potential collapse of the Medicaid program remained largely unaddressed.

The Governor's charge to the MRT was to simultaneously redesign the Medicaid system and achieve historic savings. We therefore needed to try something different.

As you weigh the Governor's budget proposal, specifically the elements recommended by the MRT, I would ask you to view them as I do: as a groundbreaking two-year experiment.

The Legislature's role is central in this experiment, not only in terms of your consideration of the proposal before you, but also your vigilance and supervision throughout its two-year life-cycle. Equally critical will be your role at the conclusion of this experiment, when we will collectively determine which elements to continue, which require modification, and which should potentially be abandoned.

I would also ask you to consider the tremendous cost hospitals and other providers have agreed to pay to secure the MRT agreement. These costs are substantial:

- Loss of the annual trend factor cost of living increase. The Governor's proposal permanently eliminates the trend factor. This is one of several elements that will need reconsideration at the end of this two-year period.
- A 2% across-the-board Medicaid rate cut.
- A global cap on the state's Medicaid expenditures.
- Potential recoupment of expenditures that pierce the cap.

The known cuts to hospitals alone in this agreement amount to more than $400 million, without including any cuts that may accrue if the cap is pierced. Clearly, no sectors have been spared.

Moreover, consider this proposal within the context of the last three years, during which time:

- Eight distinct budget actions imposed hospital cuts of more than $2.4 billion.
- Hospitals have been subjected to numerous significant state reforms, some of which are now being applied to other sectors of care.

Rationale for Supporting the MRT Recommendations

The MRT by its nature realistically was fraught with potential for disagreement, disparity, and tension. Notwithstanding these perils, the group worked earnestly to meet the seemingly insurmountable challenge the Governor presented. This process resulted in a product that, while not perfect, was extraordinarily successful in achieving consensus for meaningful reform and hitting the Governor's savings target.

As you know, I supported the MRT recommendations. I did so for two global reasons:

1) The recommendations contain options preferable to additional major across-the-board taxes and cuts that threatened us if we failed. These preferred elements include:

- A reduction of the state's savings target from $2.85 billion to $2.35 billion.
- A number of fundamental redesign elements that incentivize savings through better care coordination and other reforms.
- Long-needed reform to the medical malpractice system. The termination of insurance coverage for obstetrics at a major New York City hospital just this week illustrates how access to care is threatened because of inaction on meaningful reform. Capping non-economic damages and establishing an indemnity fund for neurologically impaired infants would help ensure access to care and reduce costs throughout the entire health care system.
- A global cap on state Medicaid expenditures and the concept of a two-year Medicaid budget. This core element is very daring, ambitious, creative, and experimental. As such, it will require the vigilance of the Administration and the Legislature to ensure that its implementation, progression, and ultimate disposition are sound public advocacy. In the budget amendments, the cap and the elimination of the trend factor are presented as permanent changes. As an MRT member, I viewed them as a major challenge for two years and accepted that challenge for HANYS. Whether this approach, and the permanent elimination of the trend factor in state fiscal year 2013-2014, should be

maintained beyond two years should be reassessed by the Administration and Legislature as key federal reforms accelerate in October 2013, the start of federal fiscal year 2014.

    - If state Medicaid expenditures fail to stay within the designated cap, then any amount over the cap would be recouped. However, the MRT did not specify a mechanism to monitor this evolution or prescribe a proposed formula or policy that defines how these potential "take-backs" would be implemented, which is one of several elements we ask the Legislature to watch closely over the course of this two-year experiment.

- Reform to the state's outdated regulatory structure.
- Better managed spending on optional services.
- Other proposals.

2) Many harmful proposals were eliminated in the MRT process, including:

- Increasing the gross receipts tax on hospitals.
- Deep cuts to indigent care funding.
- A flawed pay-for-performance proposal that penalized providers yet afforded no discernable value.
- The Health Care Reform Act streamlining proposal.
- And others.

The MRT vote was a simple up or down on the entire package of recommendations, compelling HANYS in some instances to appear to support items that we would not normally support individually. We did not have that option. We therefore approached our role on the MRT as an opportunity to first, if possible, realistically reduce the state's savings target (which we successfully accomplished in concert with others), and second, to mitigate the damage and chaos that would result from far larger across-the-board cuts and taxes (as high as 10% to 15%) that could have been imposed if the MRT failed. A far better alternative was agreeing to a 2% reduction and an experimental cap that can be modified by the Administration and Legislature in the future.

Moreover, the MRT agreement gives providers far more control over how a large percentage of the savings will be generated, granting our members much more flexibility than would be possible under a rubric of all state-defined cuts.

In the end, given the powers afforded to the Governor through popular support and the threat of budget extenders, it seemed likely that the state's savings target would be met, one way or another. To us, the final MRT package, which we were compelled to generate within an extraordinarily tight timeframe, provided the most rational, equitable, and responsible plan to adjust and achieve that target.

As you weigh this proposal, I also ask that hospitals operating in areas where access to care is limited be given special consideration to ensure the viability of the health care safety net in every region. It is also critical that appropriate safeguards are built into the home health care system as it transitions to an episodic-based payment model.

Importantly, the issue of nursing home reimbursement and the intersection between rebasing and pricing urgently needs to be addressed. The MRT process did <u>not</u> address this critical issue, which must be resolved, with so many nursing homes having relied on rebasing funds after years of underpayments.

Notwithstanding these considerations and the imperfect elements contained within this proposal, I ask the Legislature to adopt the MRT plan as soon as practicable.

Thank you.