Testimony

Before the Joint Legislative Hearing

of the

Assembly Ways and Means and Senate Finance Committees

on the

2009-2010 Executive Budget Proposal

Presented by

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Introduction

Chairpersons Farrell, Kruger, Gottfried, and Duane; honorable members of the Assembly and Senate, thank you for this opportunity to testify on behalf of the more than 550 hospitals, nursing homes and home health care organizations that comprise the Healthcare Association of New York State (HANYS) membership.

Today I will discuss a number of critically important issues that collectively underscore four key messages that we believe the Legislature must fully understand before enacting any final budget proposal:

- The dangerously fragile financial condition and immeasurable human and economic value of our state's health care providers.

- The tremendous harm that will come to these providers and the New Yorkers they serve and employ if the Governor's cuts and taxes are enacted.

- The truth about our Medicaid program, including what really drives spending.

- The critical importance of the Legislature acting affirmatively to ensure that any federal Medicaid funding New York receives from the stimulus package be used only for the Medicaid program. This funding must be used to offset the cuts proposed in the Governor's Executive Budget. The Legislature should take no action on the budget until these forthcoming funding sources are identified and fully understood.

Our Message to the Legislature

The cuts and taxes on health care providers contained in Governor Paterson's state fiscal year (SFY) 2009-2010 Executive Budget proposal must be rejected. In total, we face $2.3 billion in cuts and taxes, and hundreds of millions more in redistributions. The magnitude of the cuts, taxes,

and redistributions contained in his proposal will without doubt lead to hospital, nursing home, and home health care agency service and job reductions and, in some cases, closures across the state.

These actions will affect every community in the state. In fact, as I will explain in detail later in this testimony, service reductions and layoffs are already occurring in many communities.

Ironically, the Governor's proposals would undercut his own goal of expanding outpatient care. That is because hospitals provide a significant portion of outpatient care, but do so by subsidizing these money-losing services with inpatient revenue.

I am here on behalf of the 19 million New Yorkers served by our membership to communicate serious concerns and to request redress for several critical budgetary issues.

At the top of our list of priorities for your consideration are these two:

1) Take no action on the Governor's health care provider proposals until the federal government finalizes the forthcoming stimulus package, which Senator Schumer and other congressional leaders have indicated is likely to include billions in federal Medicaid funds, and billions more in other funds. The recently passed House bill would provide an estimated $6.5 billion to New York in SFY 2009-2010. Two-thirds of that funding ($4.4 billion) would be available to the state; the remaining one-third ($2.1 billion) would benefit local counties. The stimulus legislation is expected to be delivered to the President for signature mid-February. It would be unconscionable to pass a draconian state budget that will lead to wholesale services reductions, closures, and massive layoffs, without first factoring in these anticipated revenues.

Given that the proposed health care provisions of the Governor's deficit reduction plan have largely no cash savings in the current fiscal year, there is no compelling reason to rush such a plan through at this time.

2) Ensure that every dollar of federal Medicaid stimulus funding New York receives is spent on the Medicaid program to first offset the Governor's proposed cuts. These are

Medicaid dollars; they should first be used to restore the proposed cuts and taxes in the Executive Budget proposal, and facilitate the reform and access to care initiatives promoted by the Governor.

Health care providers are deeply affected by the state and national economic crisis, and we are well aware of our responsibility to be a part of the solution. We have already made a tremendous sacrifice in the current state fiscal year by enduring nearly $1 billion in cuts resulting from the April and August 2008 budget actions. No other sector of state spending was hit as hard. In fact, other major budget sectors saw spending increases.

In addition, coming during a severe economic downturn and the intense economic strain that health care providers already face, the cuts and taxes would be especially damaging because of the increased number of uninsured New Yorkers seeking care in emergency rooms or hospital outpatient clinics.

The grossly disproportionate nature of the Governor's plan compels us to seek your intervention and mitigation.

The Governor's Budget Proposal

The health care cuts, taxes, and redistributions of funds in Governor Paterson's proposed state budget would profoundly affect hospitals, nursing homes, home health providers, and—most importantly—the communities they serve. Every area of health care is being pummeled, even though more and more patients and residents will need care as the economy continues to weaken and our state's population continues to age. The proposed health care cuts contained in the Executive Budget, in most instances, represent only the state share of Medicaid. The provider impact is much greater after including the loss of federal Medicaid funds and the effect on Medicaid managed care rates linked to hospital Medicaid fee-for-service payments.

When combined with the loss of federal funds and the ripple effect on Medicaid managed care payments, the proposed cuts and taxes on hospitals, nursing homes, and home health providers grow to more than $2.3 billion. These are on top of the $1 billion in cuts enacted in 2008.

There are two general categories of actions contained in the budget proposal:

- deficit reduction actions (across-the-board cuts and taxes); and
- redistributions/restructuring of reimbursement.

Estimated Budget Impact Over Two Years

(millions)

	Previously Enacted 2008 Reductions	Current Proposals	Totals
Hospitals	$320	$1,037*	$1,357
Nursing Homes	$405	$890	$1,295
Home Care	$205	$396	$601
Total	$930	$2,323	$3,253

*Includes the impact on Medicaid managed care.

However, the budget **does not**:

- include any potential revenue from the likely passage of a federal stimulus package that would include a substantial increase in the Federal Medical Assistance Percentage (FMAP);
- include any broad-based personal income tax increase;
- utilize the state's "rainy day" reserve funds; or
- address needed reform in the areas of managed care, medical liability, regulatory relief, or clinical integration.

Deficit Reduction Actions ($1.8 Billion Impact on Hospitals, Nursing Homes, and Home Health)

The Governor has proposed cuts and taxes on every hospital, nursing home, and home health provider in the state as part of what is called a "deficit reduction" plan.

Deficit Reduction Impacts by Provider Type (millions)

	Trend Factor Cuts	Across-the--Board Reduction in Medicaid Rates	Gross Receipts Tax	Other Deficit Reduction Provisions	Impact on Medicaid Managed Care	Total Deficit Reduction
Total	($711.2)	($359.4)	($335.2)	($245.1)	($152.0)	($1,802.8)
Hospitals	**($217.5)**	**($132.2)**	**($316.1)**	**($49.4)**	**($152.0)**	**($867.1)**
Nursing Homes	**($309.2)**	**($188.4)**		**($98.3)**		**($595.9)**
Home Care	**($184.5)**	**($38.8)**	**($19.1)**	**($97.4)**		**($339.8)**

Specifically, the proposed budget would eliminate the 2008 and 2009 trend factors for hospitals, nursing homes, and home health providers, effective for payment rates starting January 2009.

In addition, across-the-board payment reductions would be imposed for hospitals, nursing homes, and home health agencies. For hospitals and nursing homes, an 8% reduction has been proposed for the period January through March 2009, and 2% in SFY 2009-2010. For home health agencies, a 1% across-the-board reduction would be imposed.

Taken together, the trend factor cuts and across-the-board reductions mean that hospitals and nursing homes would be paid 2% below what they were paid in 2007—a catastrophic cut when you realize that the 0.9% operating margin hospitals experienced in 2007 was their best financial performance in more than a decade.

Additionally, the proposed budget includes other proposals that would reduce home care payments, grants, Health Care Reform Act (HCRA) funds, and other funding.

On top of all that, a 0.7% gross receipts tax would be reinstated on hospitals and home health agencies. As we have stated in prior years, the imposition of the gross receipts tax on health care essentially represents a "sick tax"—a concept we believe the Legislature should reject. For many providers, the gross receipts tax alone would eliminate their entire margin.

The Governor's latest round of cuts and taxes follows two previous rounds of enacted health care cuts from April and August that reduced funding for hospitals, nursing homes, and home health services by nearly $1 billion.

For hospitals, the Medicaid cuts and "sick tax" are projected to result in an average statewide operating deficit of more than 2.0%. The Department of Health (DOH) has repeatedly pointed to positive industry operating margins in 2006 (+0.7%) and 2007 (+0.9%) as an indication of the capacity of hospital providers to absorb the proposed cuts and reforms. Our margins have always meant that New York hospitals ranked at or near the bottom compared with hospitals across the country—and these margins are grossly inadequate for not-for-profit providers to have the wherewithal to invest properly in their operations. But the results at the end of 2007 are rosy compared to the negative margins and balance sheet deterioration that has occurred at the end of 2008 as a result of the national recession and Wall Street collapse—as we elaborate on later.

Based on a HANYS survey conducted in October 2008, hospital operating margins were minus 0.3% through the end of September—and the worst was yet to come. If the margins stay at minus 0.3% for 2008, the proposed Medicaid cuts and taxes would result in a projected deficit for 2009 of -2.2%. We believe the situation will actually be worse in 2009—even without the cuts and taxes—because of deteriorating balance sheets and the legal obligations of providers to make up for losses in defined benefit pension funds, captive malpractice funds, and similar reserves for long-term liabilities.

51,000 Jobs at Stake

Moreover, the Medicaid cuts and taxes on all three sectors—hospitals, nursing homes, and home care providers—represent 35,000 jobs. These are jobs and services that the state can ill afford to lose at a time when the state and nation are looking to stimulate employment—especially when there is more than adequate new federal funding (through the FMAP increase) to avoid it. Additionally, the loss of these health care sector jobs will have a ripple effect through the economy of the state. A direct loss of 35,000 health care jobs results in at least 51,000 jobs lost in total throughout the state. Clearly, further cuts of this magnitude will only contribute to the economic downturn and make it that much harder for the state's economy to recover.

Redistribution and Restructuring Payments; Shifting to Outpatient Care

The Governor has called for a significant restructuring of how Medicaid pays for hospital, nursing home, and home health services. These new reimbursement systems are in addition to the proposed deficit reduction cuts and taxes and would result in considerable redistribution of funding between providers.

Hospital Rebasing: $300 million cut to hospitals (In addition to the $867 million in Deficit Reduction Plan cuts and taxes)

The Governor proposes to reinvent how Medicaid pays for hospital inpatient services through a series of highly technical and redistributive changes, cutting $300 million in Medicaid payments in the process, and then reinvesting a portion of the amount into outpatient care. Additionally, the Governor proposes to eliminate the HCRA private payer commitment to Graduate Medical Education (GME) and to redistribute those funds as indigent care payments for teaching hospitals.

Changes of the magnitude proposed have not been made since 1988. The proposal makes highly complex technical changes that would cut hospital inpatient payments by $300 million, in the aggregate, but the redistributional impact would be much greater—$425 million. Specifically, the budget would:

- rebase hospital inpatient rates to 2005;
- replace the current Medicaid methodology with a "Medicare-like" methodology;
- eliminate hospital supplemental payments for workforce recruitment and retention, GME enhancement, rural workforce funds, and various priority restoration and transition pools;
- implement a severity-adjusted Diagnosis Related Group methodology; and
- accelerate the phase-in for inpatient detoxification reform.

Clearly, the payment system needs updating and simplification. But HANYS does not believe that inpatient reimbursement should be cut further.

Moreover, this proposal would result in significant redistribution of funding. The majority of hospitals would experience significant payment cuts under this proposal, notwithstanding a temporary and small transition funding pool. Based on the state's numbers, 25% of hospitals would have their Medicaid rates cut by 20% or more, not including the transition pool or ambulatory payments. Relying only on the state's analysis, there are categories of hospitals (e.g., major public and safety net) and regions that appear to be disproportionately hurt. For

example, nearly all hospitals in the Western New York and Rochester regions would lose—even after the reinvestment in outpatient care and transition payments. Major public hospitals are the most adversely impacted group.

The payment system needs reform, but it must be done responsibly, disparities must be addressed, and the transition must be adequate. While HANYS conceptually supports rebasing, we oppose the unaltered passage of the array of redistribution proposals in the Executive Budget. Rebasing also requires reliable impact estimates, the ability to test the impacts via full disclosure of the data and models applied, adequate reasonable/manageable impacts on providers, transition funding, and realistic implementation timeframes. None of these exist.

For the minority of hospitals that appear to benefit from rebasing, experience has shown that new funding—if it happens at all—comes slowly and often falls victim to proposed policy changes. Moreover, the Administration has only just provided the information necessary to validate and replicate the impact of the methodology changes proposed. Adequate time must be provided to fully analyze and understand the state proposals, and modifications must be incorporated as necessary to address unsustainable disparities.

These proposals follow numerous cuts and reforms that have been enacted over the past two years, including payment cuts, a new ambulatory payment system, revisions to the distribution of bad debt and charity care funding, updated service intensity weights, and reform of inpatient detoxification reimbursement.

Detoxification Services

Last year's budget reduced inpatient detoxification payments as a means to encourage more outpatient care. That action included a four-year phase-in period necessary for providers to adjust to the loss of inpatient revenue and, more importantly, for community-based programs to be developed to ensure services remains available for those in need.

The 2009-2010 budget, (which provides a mere $4 million for outpatient detoxification services) reduces that phase-in period to just four months, virtually assuring a crisis both for patients, who will not be able to find services, and for providers, who will have not been afforded the time necessary to adapt to the changing revenue streams.

In addition, HANYS believes that state's published preliminary rates implementing the provisions of the 2008-2009 budget include an incorrect calculation of the phase-in rate.

When the inpatient detoxification system was restructured last year to reduce inpatient payments and encourage more outpatient care; not one dime of the savings was reinvested in outpatient and therefore no new outpatient programs were opened.

Graduate Medical Education (GME): $283 Million Redistributional Impact on Hospitals

The budget also redirects the remaining GME pool payments for teaching hospitals ($283 million) to indigent care payments. New York State is home to many of the country's most prestigious academic medical centers and community teaching hospitals. These facilities provide an invaluable service by training the next generation of physicians, and medical resident programs in New York receive federal matching funds, bringing much-needed federal funding into our health care system.

Yet, even as physician shortages propagate in most regions of the state, the Governor has proposed extraordinarily deep cuts to physician training funds. His proposal effectively eliminates the private payer funding pool for GME by discontinuing the Professional Education Pool, transferring those funds ($283 million) to the indigent care pool, and distributing the funds as Disproportionate Share Hospital payments to teaching hospitals based upon the value of services provided to uninsured patients. The state would save $141 million through this change. The Governor also proposes to reduce "unspent" GME funding by 20% ($23.4 million).

Although the state would still dedicate funding to teaching hospitals, the new methodology would substantially redistribute funds among those hospitals. HANYS believes that one of the

reasons the state proposed this change was to help some major public hospitals significantly hurt by the Administration's rebasing scheme. Major public hospitals are indeed the most adversely impacted by the Administration's rebasing proposal. However, that proposal needs to be modified to avoid such a disparate impact on public hospitals and others, and not by "robbing Peter to pay Paul."

Future Physicians: An Important Legacy

New York's teaching hospitals are a critical resource for developing the state's future supply of physicians, as well as disproportionately treating the state's indigent populations. Preservation of this Graduate Medical Education asset is important for both reasons. The state benefits, moreover, because the federal government still provides the bulk of the support. The federal government—through Medicare payments and its 50% (or greater) share of Medicaid payments—supports roughly 55% of the costs of GME within academic medical centers and other teaching hospitals.

New York also paved the way in ensuring that third-party payers contribute to the cost of educating physicians—first through linking payments such that insurers are paid the same as Medicaid in the state, then by establishing the Professional Education Pool and requiring third-party payers to contribute to a portion of those costs.

The state is proposing to eliminate an important public policy commitment to ensure private payer contributions to GME and to the training of future physicians in New York. When the Professional Education Pool was first created in 1996, it represented only half of what had been previously paid by private payers in GME-related payments. It has since been subject to several cuts that have reduced GME funding by another 40%.

Our teaching hospitals also serve as the backbone of a health care system that provides high quality care for all New Yorkers, including a significant amount of indigent care. In fact, 82% of the uncompensated care delivered in New York annually is provided by teaching hospitals.

The 116 teaching hospitals, including 11 academic medical centers located in New York, are responsible for the training of over 15,000 medical residents each year—representing roughly 15% of the nation's future physician workforce.

In fact, the care provided by these physician trainees is at a relatively low cost, and permits our clinics, emergency rooms and other ambulatory services to function under the inadequate Medicaid reimbursement that hospitals receive. If New York hospitals had to replace all physician trainees with doctors, nurses, and other personnel, and continue providing the same level of coverage, the Medicaid share alone would be $500 million, an increase of $200 million compared to current compensation of residents.

Health care in New York and, more specifically, the training of physicians, is also an important component of the economy. Many of these prestigious institutions are among the top employers in their regions and serve as centers for biomedical research that attract billions of dollars in federal grant funding and support thousands of New York jobs. In fact, according to an analysis of the Association of American Medical Colleges, the economic contributions of New York teaching hospitals and academic medical centers in 2005 totaled more than $66 billion.

Physician training has come under scrutiny in recent years as an increasing number of residents trained in New York chose to leave upon completion of their training. A recent survey by the Centers for Health Workforce Studies, however, suggests that the problem lies not in the Graduate Medical Education system. Survey results revealed that a plurality of new physicians who trained in New York left the state for reasons related to better jobs at higher salaries and locations with a lower cost of living.

As the need for physicians continues to rise and the pressure on our national and state economies continues to increase, the need to support New York's academic medical centers and community teaching hospitals will become increasingly critical.

In sum, given their unparalleled value as trainers of needed physicians, economic engines for our state and local economies, and global centers of advanced medical and technological research,

our teaching hospitals and academic medical centers are invaluable resources that must be fully supported, especially in times such as these.

Outpatient Investment

The Administration's proposal also includes reinvesting of a portion of the amount cut from acute care services into outpatient care. Primary care and other outpatient care certainly need investment, but taking money from hospital inpatient care and providing a reduced amount of that taken to outpatient care is not investing in primary care, as the Administration contends. It is a net reduction, not an increase in funding.

For the acute care sector, the Administration contends that its "transformational reimbursement" actions seek to better promote outpatient, preventive care as a means to improve public health and generate inpatient hospital savings.

Although the plan assumes that today's investment in outpatient care will reduce the demand for inpatient care today, the reality is that this takes time.

But let me be clear: when we talk about providing outpatient care, we are still talking about hospitals. Hospitals have been leaders in the evolution to provide outpatient care.

The numbers tell the story. Each year, New York's hospitals handle 54 million outpatient and emergency room visits, compared to 2.6 million inpatient stays. This is a 20-to-1 outpatient to inpatient ratio. Yet, hospitals continue to experience $2 billion each year in outpatient losses. Clearly, primary care and outpatient care need investment.

It does not make sense to promote primary care delivery by reducing inpatient reimbursement by more than $250 million and reinvesting half of its back in ambulatory care. That loss will result in fewer, not more services.

Nursing Home Rebasing Changes: $294 Million Cuts to Nursing Homes (In addition to $596 million in Deficit Reduction Plan cuts)

The Executive Budget would renege on the nursing home rebasing plan enacted by the Legislature in 2006 and implemented just this year. Instead, the Governor seeks to replace it with a new regional pricing-based methodology, effective March 1, 2009. The 2006 legislative action was the result of a comprehensive, multi-year effort by HANYS, New York Association of Homes and Services for the Aging, New York State Health Facilities Association, DOH, and other stakeholders, to achieve consensus on reform that was considered by all to be necessary and equitable. The Governor's proposal effectively breaks the commitment, which was reaffirmed in the 2008-2009 state budget agreement, even as nursing homes have begun to implement the rebasing plan.

The Governor's proposed nursing home reimbursement scheme would provide substantially less funding overall than under the plan previously approved by the Legislature and, by implementing a regional, pricing-based methodology, would create substantial redistributions, disproportionately affecting certain categories of nursing homes (e.g., major public hospitals, safety net homes, hospital-based, and those with more than 300 beds) and regions.

The Legislature should reaffirm its commitment to the already enacted and implemented nursing home rebasing plan.

Specifically, the budget proposes to:

- move to a 2005 base year with nearly $300 million in reductions;
- adopt a 100% regional price, with eight regions and no wage equalization factor;
- eliminate adjustments for hospital-based and large nursing homes and other safety net adjustments;
- not include hold-harmless provisions or appeals, which would ensure fairness; and

- build in a Medicaid-only case mix and a 25% reduction for Physical A and Physical B residents.

The proposed budget would also eliminate up to 6,000 nursing home beds in exchange for the addition of up to 6,000 assisted living beds, establish a nursing home quality of care incentive pool, and make changes to the financially disadvantaged nursing home pool.

Home Care Reimbursement Methodology Changes: $56 Million Cut to Home Care (In addition to $340 million in Deficit Reduction Plan cuts and taxes)

The budget proposes a new, per-episode pricing methodology based on patient condition under Medicaid, similar to the Medicare prospective pricing system. Under the new system, per-episode payments would be established for 60 days, and base payments would be based on claims paid in the 2007 base year. To determine case mix, each patient would be measured based on factors in the Outcome and Assessment Information Set (OASIS). A 3.5% across-the-board rate reduction would be imposed until the proposed, new payment system is implemented.

Other major home care provisions include a prohibition on subcontracting with another entity for home health aides, elimination of the moratorium on the establishment of new Certified Home Health Agencies (CHHAs), and the creation of a quality of care incentive pool for home care.

The Governor proposes the most sweeping changes in decades to home care. These changes carry significant unknowns, and have not been fully evaluated or even discussed. Plus, there is a general lack of information on the structure of these changes.

Moreover, the consequences of home care cuts of the magnitude proposed cannot be overstated. These cuts could not come at a worse time. Home care services are critical for transitioning patients from the hospital to home, and in some models, providing an alternative to traditional nursing home care. As a proven, cost-effective alternative to institutional settings, home care targets Medicaid resources efficiently and fulfills a critical role in enabling patients to stay in their own homes. HANYS agrees with the Home Care Association of New York State that the

proposed cuts are contrary to public policy objectives to expand home- and community-based services.

The Fragile Financial Condition of Health Care Providers

The Wall Street crisis of 2008 came as a surprise to most Americans, who are now acutely feeling its consequences. For many years, however, yellow and red warning lights flashed that should have alerted Wall Street insiders, federal regulators, and lawmakers that the meltdown was coming. Yet, no significant precautions were taken to stop the crisis in our financial system.

Today, New York's health care system ominously moves toward a similar systemic calamity—but only if we continue to ignore the key structural problems that threaten the health care services of 19 million New Yorkers. If the breaking point comes, access to emergency and routine health care will be compromised in many communities across the state.

Impact of the Wall Street Collapse

This year, the nation watched as, one by one, financial houses began to crumble. A stunning domino effect devastated our financial sector and some of its most recognized investment banks. Bear Stearns, Morgan Stanley, Goldman Sachs, Lehman Brothers, and Merrill Lynch all succumbed in one way or another, either falling into bankruptcy, being acquired under financial pressures, or completely overhauling their business model.

This collapse and the ongoing national and state fiscal crises have only weakened the already fragile state of most health care facilities across the state. Provider balance sheets have been hit particularly hard, making it almost impossible for health care providers to access the capital needed to invest in the latest technologies and improve facility infrastructure. The credit and equity crisis further limits access to bonds, and uncertainty exists as to if and when the market will return to functional levels.

Credit agencies have begun downgrading not-for-profit hospitals across the country, and predict rating downgrades will exceed rating upgrades for up to the next 36 months. A recent report published by Fitch Ratings downgraded the U.S. not-for-profit hospital sector from "Stable" to "Negative." Moody's Investors Service recently provided further evidence of hospitals' struggles, issuing a report showing a dramatic spike in bond rating downgrades for not-for-profit hospitals during the fourth quarter of 2008. Moody's cited a number of factors that led to the downgrades, including the softening of revenue as patients defer elective procedures and increased bad debt and charity care as unemployment rises. On January 21, Standard & Poor's Ratings Services issued negative outlook for hospitals and health care systems because of "operating, financial, and economic conditions that are more severe than in 2008 and certainly worse than the preceding years."

With the economic downturn expected to continue—or likely worsen—into the foreseeable future, hospitals and other providers across the country can expect reduced revenue, continued cost increases, potential for declines or shifts in utilization, and increased uncompensated care—all trends adversely affecting hospitals' credit profiles and balance sheets.

These effects are magnified in hospitals and other providers in New York State, as they are already operating with margins well below the national average. Moving forward, providers must now contend with daunting challenges, including:

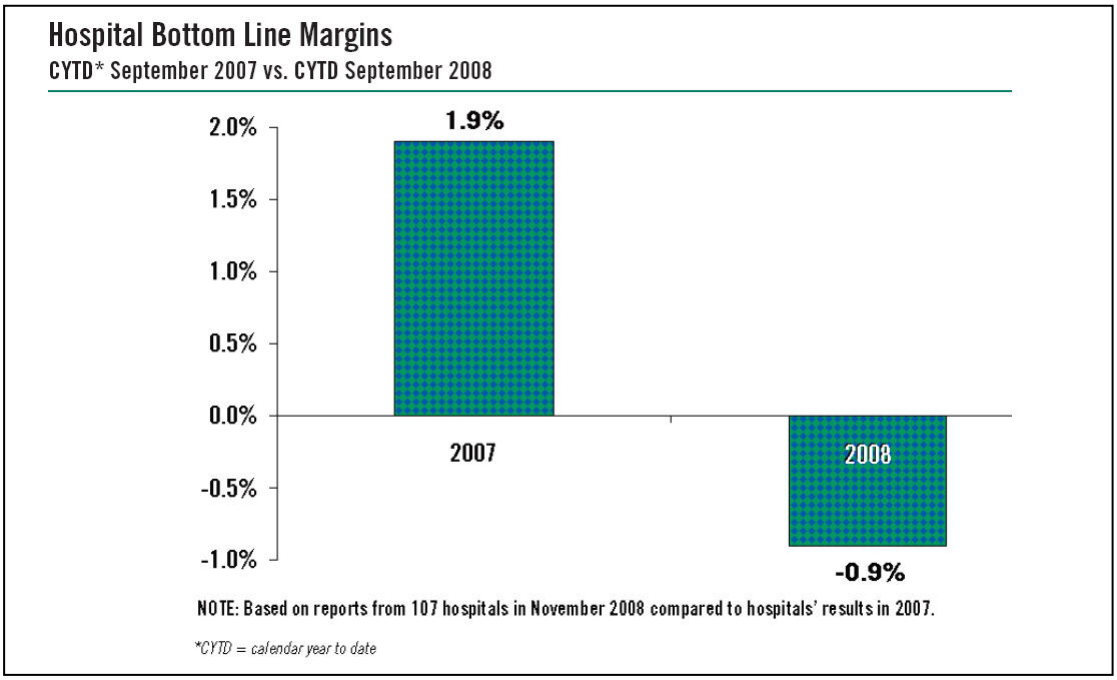
- the tightening of credit for both daily operations and desperately needed capital improvements;
- reduced philanthropy;
- a growing number of uninsured and the associated loss of market-based insurance revenue;
- the loss of business as health care treatments are deferred;
- exploding pension obligations as a result of shrinking asset valuation and the need to divert operating income to meet statutory requirements; and
- serious threats to meeting bond covenants on existing financing due to balance sheet reductions.

Anemic Hospital Margins: The First Dominoes Begin to Fall

For nearly a decade, New York's hospitals had average operating margins that were negative. After eight years of consecutive losses totaling more than $2 billion, hospitals began to turn a corner in 2006-2007, posting a meager operating margin in 2007 of just 0.9%.

Similarly, the 2007 statewide hospital bottom-line margin (which includes philanthropy and investment income) was just 1.9%, less than one-third of the national average of 6.8%. Since then, through September 2008, according to a recent HANYS' survey, that margin has fallen even further to negative 0.9%, further starving providers of essential operating cash and capital funds. When one takes into account that the economic picture has become even more bleak since September, it is certain that hospitals' current balance sheets are even more dismal today than reflected in the survey data.

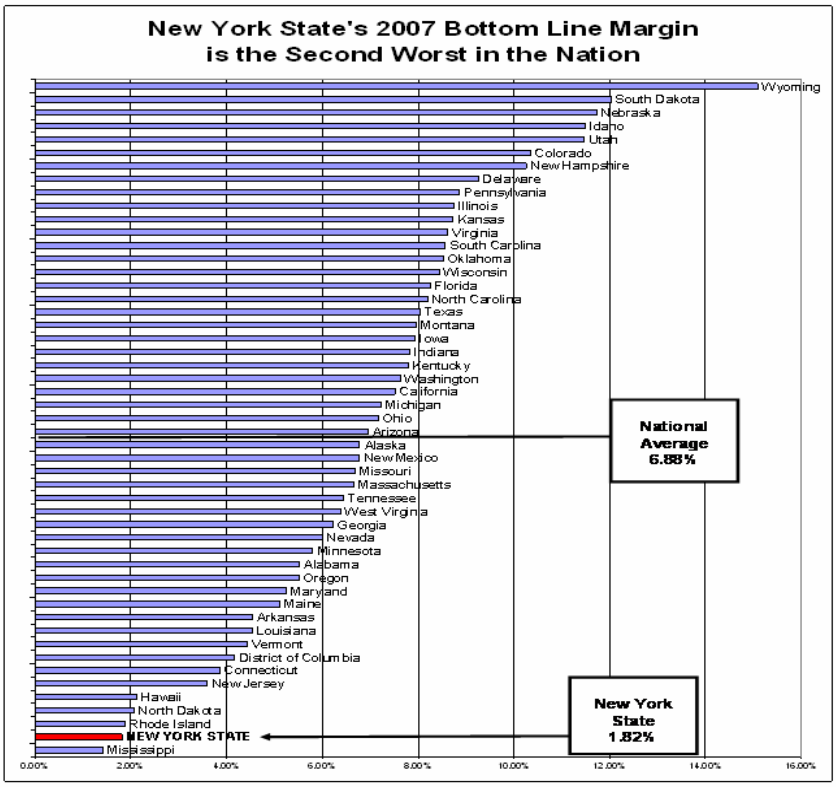
The impact has already become manifest. In 2009, two hospitals teeter on closure and several others in various areas of the state have announced service cutbacks and hundreds of layoffs. Since 2000 alone, 21 hospitals and 48 nursing homes have closed. In addition, 12 acute inpatient adult or adolescent psychiatric units have closed since 2002.



New York's Hospitals Compared to the Nation

The strains of the Wall Street collapse and economic downturn were especially hard for New York health care providers—because the industry as a whole was already struggling, without margins to draw from, when 2008's harsh fiscal realities surfaced. New York's hospitals are non-profit organizations that reinvest all earnings back into improving patient care. In 2007, the collective bottom line margin of hospitals in New York State ranked second-worst in the nation, second only to Mississippi. That means our hospitals lack resources to hire staff, build new service capacity, invest in new buildings, and purchase the latest technology.

What this means for tomorrow is far more disconcerting. New York's hospitals constantly seek out and implement new efficiencies to lower costs and improve patient care, but hospitals have reached the point where they have no other option than to eliminate valuable health care and community services. If hospital margins continue to shrink, communities across the state will lose access to essential services.

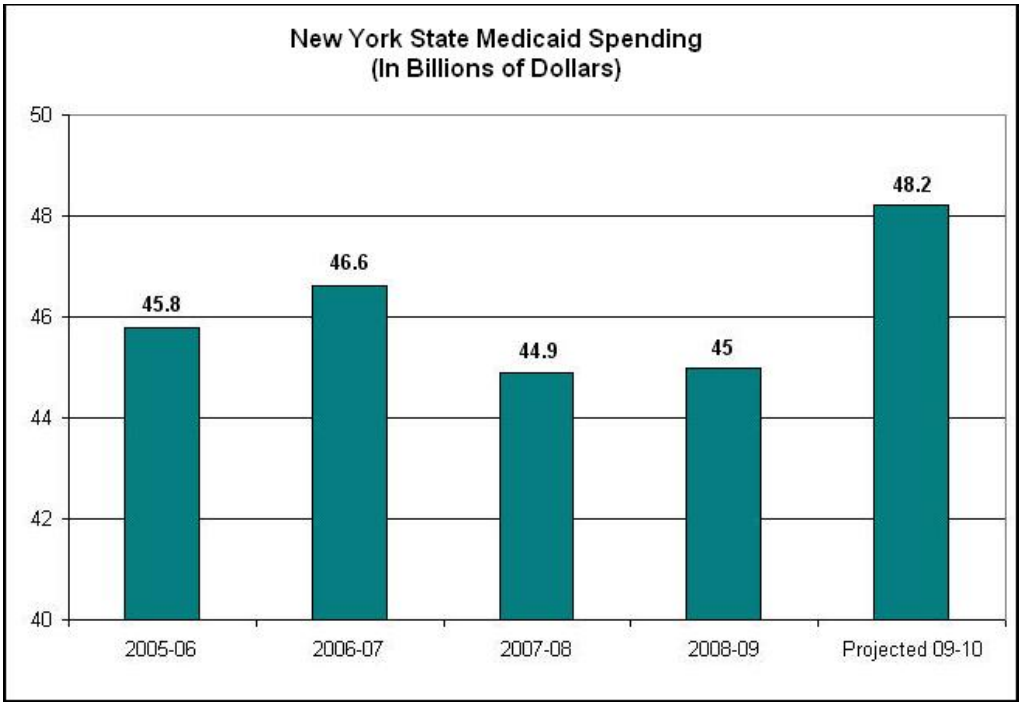


Source: American Hospital Association - "Hospital Statistics 2009"

The Truth About Medicaid Spending

Government Policy, Not Provider Costs, Drive Spending Growth

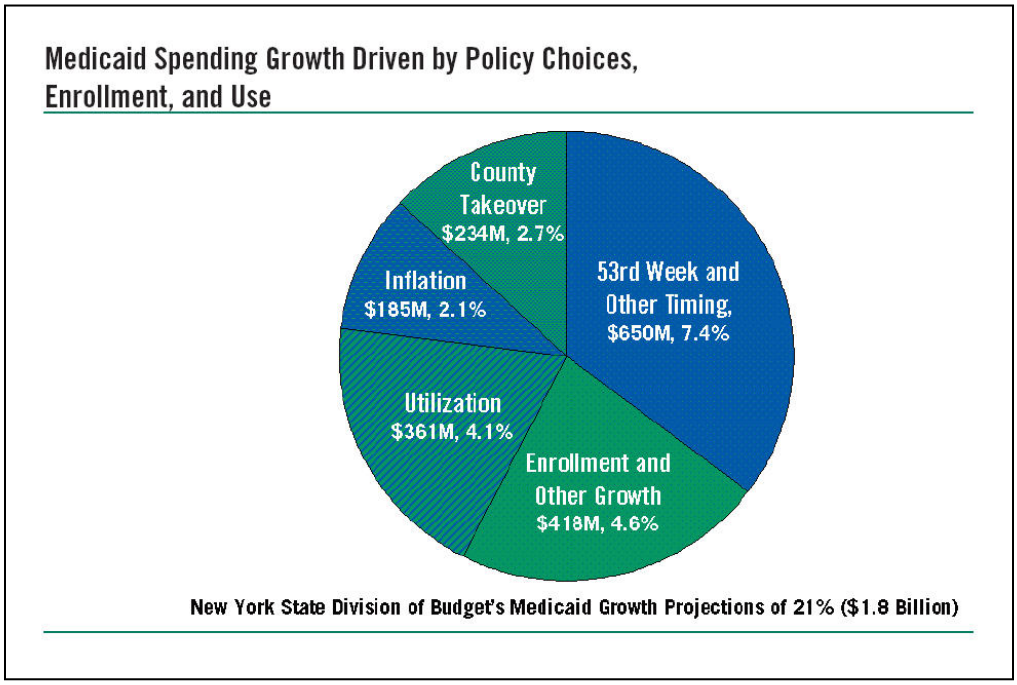
Contrary to the common misconception that Medicaid spending spirals out of control, the facts demonstrate something different. According to Division of the Budget (DOB) projections, spending for the current 2008-2009 state fiscal year will total $45 billion, representing an increase of less than 1% over the previous state fiscal year.



Notwithstanding this experience, the state predicts Medicaid state-share spending will increase by 21% next year. However, a careful review of the state DOB projections shows that provider cost increases account for just a small fraction of that total. In fact, the true drivers of Medicaid spending growth become quite clear:

- 2.7% is due to the state takeover of county Medicaid expenditures;
- 4.6% is due to Medicaid enrollment increases, driven in large part by the state's laudably aggressive Medicaid enrollment activities;

- 7.4% is due to a simple timing issue created by a calendar fluke, and other timing related issues, and does not represent an actual increase in spending—Medicaid pays providers on the same day each week and that day occurs 53 times instead of 52 times in 2009;
- 4.1% is attributed to utilization—the increase in the amount of health services the average individual Medicaid recipient is expected to receive (utilization actually decreased each of the last few years); and
- just 2.1% is due to the cost-of-living adjustment to provider payment—far below the rate of inflation.



Chronically Ill and Aged Represent Bulk of Total Medicaid Costs

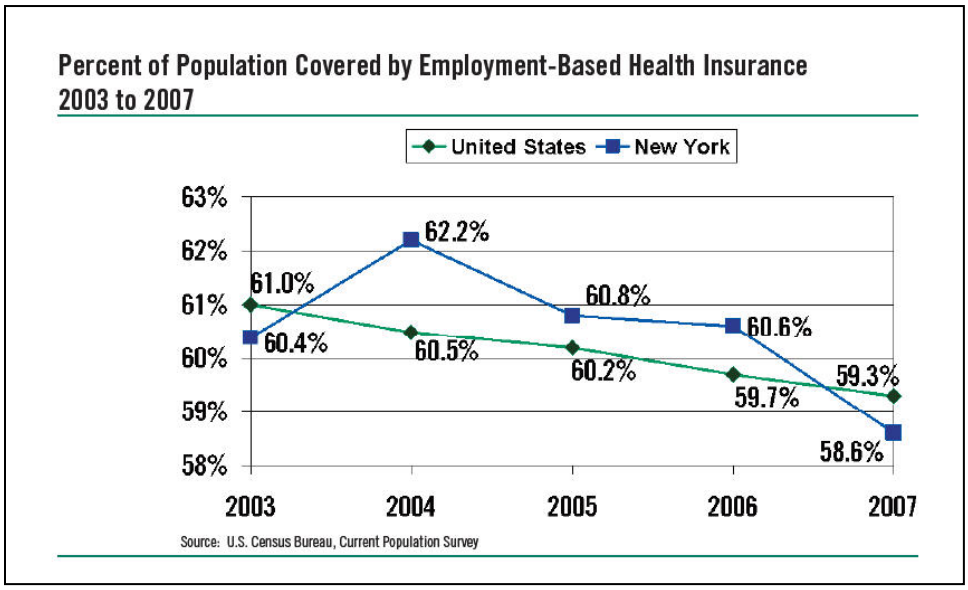
Data show that the chronically ill (who present multiple diagnoses, often including mental health and/or substance abuse diagnoses) and the aged account for nearly 75% of all Medicaid spending. Yet, these two groups combined represent just 21% of all Medicaid enrollees, according to DOH.

Currently, there is no rational payment system that supports, promotes or rewards any activity that identifies and replicates basic efficiencies in providing better coordination and management of the care delivered to these individuals. Think of it as building a house without a general contractor. You end up with the framers and plumbers and electricians showing up at the same time or the wrong time, or not at all. The result is a poorly built home that costs far more than need be.

Given that significant Medicaid costs accrue to treating the chronically ill and aged, were we to identify just a 10% savings in care provided to them, we could significantly reduce overall Medicaid costs.

The Uninsured and Underinsured

Despite the success of Child Health Plus and Family Health Plus in achieving sizeable enrollment increases, the number of uninsured New Yorkers has been resistant to major reduction. In 2007, 13.2% of New York's population (2.5 million) were uninsured, down from a high of 15.3% (or 2.9 million) in 2002. While the growth in public sector coverage has been impressive, it has been partly offset by reductions in employer-sponsored coverage—and that trend is troubling.



The problems associated with the uninsured include the preventable advancement of illness due to lack of timely access to primary and preventive care, and the high costs associated with treating these illnesses that were identified too late. In total, New York's health care facilities provide more than $1.6 billion in free care each year, only a portion of which is reimbursed.

The uninsured are a societal problem that affects everyone. The uninsured themselves are most affected; they often deny themselves care, especially preventive care, or spend inordinately high percentages of their household income to access needed services. When care is finally received, it is often delivered in the most expensive setting at a time when the disease process has advanced. A recent Commonwealth Fund study found that a staggering 68% of uninsured people went without needed care.

To its credit, DOH has committed to making investments in primary and preventive care. However, while doing so, DOH has created a false choice: to make necessary investments in primary care, we must take resources away from hospitals and acute care services.

The truth is that we must find a way to properly finance primary and preventive care, but not at the expense of hospital acute services. If done properly, investment in primary care will translate into significant savings to the state and to other payers. But if the state's "false choice" is not successful, we weaken the acute care system even further.

The uninsured disproportionately rely on hospital emergency departments (EDs), and to a lesser degree neighborhood health centers, for their care. Hospital EDs are not the right place to receive primary and preventive care, with patients competing for time and attention of an already overtaxed system. Those who gain access to care through EDs represent a significant resource drain on hospitals, since the care received by uninsured patients is provided at a significant loss to the facility.

Hospitals understand and embrace their responsibility to provide access to services without regard to a patient's ability to pay. However, that mission comes at a price. It limits providers' ability to make investments in patient care that are necessary to keep pace with the evolution of

health care services. As a result, we are all impacted by a health system that, from a physical plant, technological, and efficiency standpoint, is falling behind the rest of the nation.

The growth of the underinsured population similarly taxes the health care system. The same Commonwealth Fund study found that 14% of adults in America were underinsured. Like the uninsured, the underinsured are less likely to seek care, and if they do, providers are vulnerable to reimbursement gaps when an underinsured person cannot pay their share of the cost for services provided.

Payers Dominate Care Decisions

The promise of the managed care approach to medicine has yet to be realized. In theory, managed care promised to improve patient care and make the health care delivery system efficient. However, the central emphasis of most private insurance payers has been to manage costs, not care. Instead of efficiencies, managed care has added a web of administrative burdens requiring an army of staff to process, detracting from actual patient care.

Managed care has required patients and providers to navigate an often incomprehensible maze of rules and process requirements. Those complex processing rules frequently result in the denial of payment for medically necessary, covered services because a technical or administrative rule was not followed. Patients are left frustrated by delays or a lack of access to care and unexpected medical bills. Providers are left to explain rules that are not of their making and scrambling to collect payment for medical services they have provided.

The bureaucracy and misdirected focus of managed care, i.e., on profits and not care, has required hospitals to devote scarce resources to the payment process—resources that could have been devoted to providing essential medical care to patients and other community-wide benefits.

In addition, there has been strong evidence of systematic corruption in the form of the Ingenix database, which is owned by UnitedHealth Group and is used to calculate “usual, customary, and reasonable” charges that insurers pay when a patient is treated at an out-of-network hospital.

The Ingenix database will be replaced under recent settlements by UnitedHealth Group and Aetna with the New York State Attorney General. HANYS was instrumental in surfacing this issue and is pleased that an above-board database will be created with no ties to the insurance industry.

Costly, Duplicative, and Misaligned Reporting Requirements

A multitude of governmental and non-governmental organizations have linked payment to numerous quality and patient satisfaction measures. Providers support the federal government's quality reporting system because it provides useful, standardized information to the public and to providers, which assists with quality improvement. Providers accept reasonable approaches to increase linkages between quality and reimbursement, if fairly constructed.

However, these requirements, coupled with often duplicative and misaligned requirements from other quality reporting organizations and government agencies, cost providers hundreds of million of dollars in administrative capacity to maintain records and meet filing requirements.

Whether governmental or private sector, these payments and quality requirements have been proposed in isolation, with few attempts to coordinate efforts or avoid duplication. Providers are left to shoulder the cost of growing administrative staffs to meet these ever-growing payment and quality requirements.

Fraud and Abuse

The state government has ramped up its Medicaid anti-fraud operations. Health care providers support responsible anti-fraud efforts because every dollar fraudulently taken from government health care programs is one less dollar available for patient care.

However, the state has taken an aggressive "guilty until proven innocent" approach in many of its recent provider audit initiatives. Provider claims processing errors and care decisions have been caught in the wide net the state has cast, resulting in millions of dollars of threatened

payment recoupments and denials. Moreover, providers are afforded very little opportunity or time to respond to these allegations, placing an enormous administrative burden on providers to dig through thousands of medical records to produce "proof" that their claims are legitimate.

Real fraud should be rooted out and punished, but honest mistakes and legitimate care decisions are not fraud.

Explosion of Additional Administrative Burdens

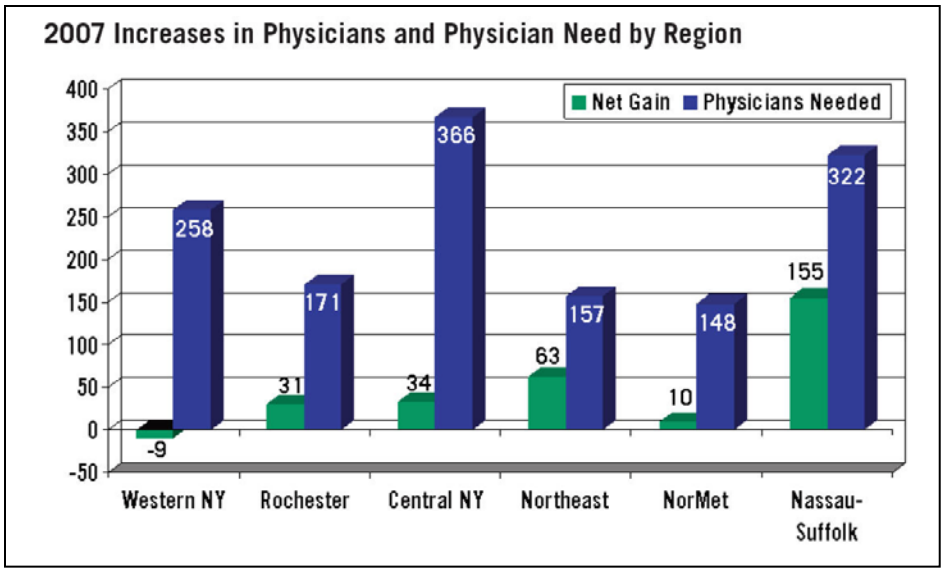
Pressures providers face from inadequate reimbursement and increasing utilization demands are exacerbated further by the explosion of administrative demands placed on providers by government and private sector payers. The administrative costs of private insurance and government programs were estimated last year by the U.S. Congressional Research Service to be $465 billion per year—which does not include billions more in administrative costs borne by health care providers to comply with those requirements.

Before medical care is rendered or a claim for medical services is even submitted, providers check a patient's eligibility, benefits, and copayment or deductible liability, and seek a managed care plan's authorization to provide the care. Once a claim is submitted, health insurers' payment rules are numerous and complex, often not fully disclosed, and constantly revised without sufficient notice to providers. When providers receive less payment than the amount claimed, they are again forced to spend time and resources researching the discrepancy, appealing the error, simply trying to get paid for the medically necessary covered services that already have been rendered.

Physician Shortages

It is well documented that the health care workforce is aging and replacements for retirees are increasingly hard to find. The challenge of recruiting health care professionals to New York is complicated further by the increasingly fragile financial condition of providers.

Hospitals across New York State report increasing challenges with the recruitment and retention of physicians. In many rural and inner city areas, severe shortages are widespread. Respondents to *HANYS' 2008 Physician Workforce Survey* reported a current need for more than 1,400 physicians outside of New York City alone.



The survey also revealed that:

- 25% of reporting hospitals had to eliminate or reduce services;
- 55% reported a lack of coverage in the emergency department for certain specialties, forcing patients to be transferred elsewhere; and
- 75% reported having to hire costly temporary staff.

Providers simply cannot offer health care services without trained physicians. Entire communities will increasingly face the loss of services, requiring patients to travel farther to receive necessary care, even in emergencies. Because of these shortages, many facility administrators must spend excessive amounts of time and energy on physician recruitment—often with little success—leaving even less time, energy, and staff resources to attend to a host of other pressing matters.

HANYS applauds the state's Doctors Across New York program as a first step in addressing the physician shortage, particularly in under-served areas, and is pleased to see that the Governor did

not propose to reduce program spending from the levels of the current fiscal year. Doctors Across New York is being lauded nationwide as a model program. More than 100 physicians should be placed in under-served areas of New York State by the program during 2009. It is unfortunate, however, that the Governor's budget proposal does not explicitly specify funding for inclusion of a second round of physicians that could be placed in under-served areas during 2010. The funding commitment to the program should be increased so that we can continue our progress in addressing a need that greatly outweighs our first year's response.

Explosive Growth in Malpractice Insurance Costs

Exerting even greater fiscal pressure on hospital finances is the ongoing explosive growth in medical malpractice insurance premiums. Virtually every year, malpractice rates skyrocket (up 14% in 2007 alone), driving physicians to other states and out of high-risk practices such as obstetrics/gynecology and neurosurgery. It is not unusual to see annual premiums as high as $200,000 or more for a single physician—levels that are simply unsustainable.

Moreover, malpractice costs are compounded, since both physicians and hospitals are compelled to obtain costly coverage. The high cost of malpractice has exacerbated physician shortages in many areas of the state and discouraged countless practitioners from establishing practices here. Moreover, exorbitant premiums paid by hospitals have had a profoundly negative impact on the availability of resources necessary to meet basic operational demands.

Millions of dollars wasted on an irrational and grossly ineffective malpractice system would be better spent on core hospital functions, such as adding or augmenting essential services, addressing staffing shortages, and investing in health information technology.

HANYS urges the adoption of a medical indemnity fund, which would provide an alternative financing mechanism for specific, high-cost cases involving neurological impairment, medical tribunals, and a "sorry works" program to encourage physicians to be candid with patients without fear of reprisals. While HANYS supports a cap on non-economic damages in malpractice lawsuits, the likelihood of its passage is remote.

Nursing and Allied Professional Shortages

Registered nurses represent the largest single health profession in the state and nation. New York State hospitals report a vacancy rate of 8.8%, which is slightly higher than the national rate of 8.5%. However, according to the Bureau of Health Professions of Health Resources and Services Administration (HRSA), there is a projected widening gap between national nurse supply and demand of approximately 750,000 nurses by 2020. In New York State, this projected shortfall is 37,000 registered nurses (RNs) by 2015. The average age of an RN in New York is 47.

Nursing shortages are exacerbated by a lack of capacity at schools of nursing, which must turn away thousands of qualified applicants each year. HANYS advocates for legislation that would authorize funding to schools of nursing, other educational institutions, and health care providers to ensure adequate faculty, administrative, and capital resources to prepare the future generation of nurses. HANYS also supports mentoring programs, financial assistance to nursing students, and incentives to keep nurses in the workforce.

While the nursing and physician shortages have attracted the most attention, shortages of other allied health professionals including pharmacists, coders, various medical technicians and therapists, and other clinical workers are beginning to reach crisis levels. According to the Department of Labor, the total number of jobs needed in health care is expected to grow 18% by 2012—more than twice the rate of growth of all other occupations. In 2006, 11.4% of jobs in New York State were in health care, compared to 8.7% nationally.

These shortages further tax providers' ability to offer comprehensive, and often, basic health care services.

The Economic Impact of Health Care Providers

In the midst of a national economic calamity, one sector of employment—health care—continues to buoy countless communities throughout the state. In fact, in a great many communities in

upstate New York in particular, the local hospital anchors the economy and serves as an economic engine. Consider:

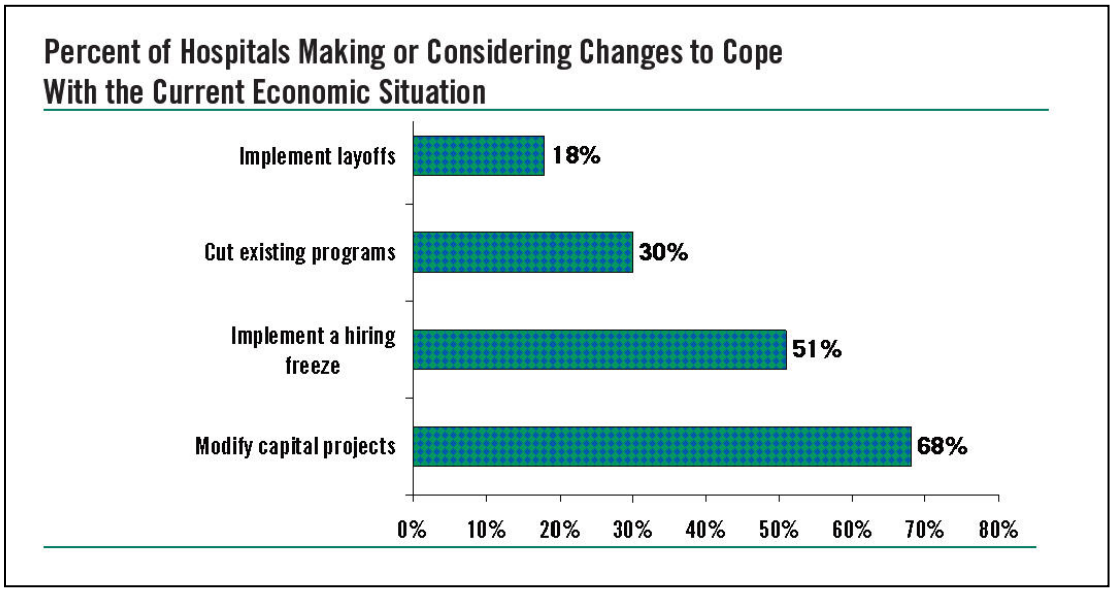
- New York's hospitals employ more than 357,780 full-time equivalent (FTE) workers, with a total payroll of $26.8 billion.
- Dollars earned by hospital employees and spent on groceries, clothing, mortgage payments, rent, etc., generate approximately $57.9 billion in economic activity for the local economy.
- Hospital employees and those jobs supported indirectly by the hospital paid more than $2.6 billion in state and local personal income taxes.
- Hospital employees and those jobs supported indirectly by the hospital paid another $919.3 million in local sales taxes and $901.2 million in state sales tax.
- New York hospitals spend about $17.1 billion per year on the goods and services they need to provide health care—for example, medical supplies, electricity for buildings, and food for patients. Funds spent to buy goods and services flow from the hospital to vendors and businesses and then ripple throughout the economy.
- This spending on goods and services generates $36.9 billion in the economy each year.
- New York hospitals spend about $2.9 billion per year on buildings and equipment.
- This capital spending generates almost $6.4 billion in the economy each year.
- All together, the dollars spent by hospitals in New York generate approximately $101.1 billion throughout New York's economy and $4.5 billion in state and local personal income and sales taxes.

How Providers Struggle to Adapt and Cope

The challenging environment is by no means a recent occurrence. In fact, for decades, health care providers have increasingly been compelled to provide more services and care for more patients and residents, with proportionately less funding.

Few other sectors of our economy have responded as aggressively and effectively as the health care provider sector in finding the efficiencies necessary to survive revenue shortfalls.

Providers have created thousands of joint agreements and mergers among and between cooperative and even competitive entities, and are looking to creative solutions such as partnering in non-traditional ways to best care for their communities. Tertiary hospitals have linked with their rural counterparts via telemedicine to provide state-of-the-art stroke care to residents in the most remote areas of the state. Rural hospitals increasingly are employing primary care practitioners and offering practice support to secure a stable health care system for their communities, where reimbursement often fails to cover the costs of preventive and primary care.



Other providers focusing on the continuum of care have worked with private entities to develop low-cost housing, supported by nearby health care services, for seniors and others with limited incomes and resources. In some cases, providers have fought efforts by state policymakers to force cuts in programs, reaching out to neighboring facilities for support in maintaining important services, such as obstetrics, especially when patients would face transportation obstacles and other challenges if forced to travel too far for their care. Even in the most competitive markets, hospitals have joined forces to support community health activities, such as mobile dental vans, geared specifically toward treating under-served communities.

These efforts have not been undertaken by hospitals to sustain a profitable business model (New York hospitals are not-for-profit organizations)—they have done these things to protect core health care services, including emergency and primary care, obstetrics/gynecology, inpatient care, diagnostic care and treatment, surgery, nursing home and home health care, and many others.

However, not all of the coping strategies have been successful. When all other options have been exhausted, providers have been compelled to make very painful decisions—chief among them is the outright closure of a facility. Since 2000 alone, 21 hospitals and 48 nursing homes have closed across New York, leaving many communities burdened with greater travel distances to obtain care, and more vulnerable to having insufficient capacity to manage natural disasters, mass casualty accidents, and severe illness outbreaks.

And, as recent media reports confirm, several hospitals and nursing homes are at or near insolvency and near closure, while others have announced significant layoffs—some in anticipation of the Governor's cuts. Added together, about 3,000 health care workers have been laid off since the economic crisis began. Additionally, as government payers (Medicaid and Medicare) have continually failed to adequately reimburse the true cost of care, providers have been compelled to shift costs to other payers, primarily the business community, through their employee health insurance premiums, even as health insurance companies record billions in annual profits.

It is not just health care providers that are shorted by both the government's failure to adequately reimburse and by the tremendous excess revenue appetites of the health maintenance organizations. The business and health care communities would be wise to recognize their shared interest and join together to demand a realistic and equitable reimbursement system.

Summation

When reflecting upon all these concerns, suggestions and challenges, one thing becomes perfectly clear: New York's sick, injured, elderly, disabled, under-served, mentally ill, and chronically ill now, more than ever, need your intervention to continue receiving the health care they need.

The Governor's proposed health care cuts and taxes would mean the closure of health care units, services, or facilities in every region of the state. If enacted, these proposals also would mean the loss of health care jobs, which would worsen the already poor economic outlook in communities across the state.

Our members are non-profit organizations whose mission is to provide medical care to everyone, regardless of ability to pay. We ask for responsible reimbursement so we have sufficient resources to fulfill that mission. I urge you to reject the proposed cuts and taxes and use the expected federal Medicaid stimulus funds to support our health care system. And, by "support" I mean use the FMAP Medicaid funds to restore the Governor's cuts, reject the "sick tax," and truly invest in health care reform.

While we may disagree with some of the Governor's specific strategies and timetables, HANYS strongly supports many of the Governor's health care reform objectives and we stand ready to work with the Governor and Legislature to work in partnership to enhance New York's health care delivery system.

In these difficult economic times, when uncertainty exists about the stability of many of our most important institutions, we should not undermine our hospitals, nursing homes, and home health providers. With the help of the federal government, now is the time to invest in health care, to rebuild its aging infrastructure and ensure that the highest quality of care will be available to all New Yorkers for generations to come.

I would be pleased to answer any questions you might have.