New York State NURSES ASSOCIATION One strong, united voice for nurses and patients

ASSEMBLY STANDING COMMITTEE ON HEALTH

Hearing on Medicaid Program Efficacy and Sustainability

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Testimony of the New York State Nurses Association

My name is Leon Bell, and I am the Director of Public Policy at the New York State Nurses Association (NYSNA). NYSNA represents more than 40,000 registered nurses across New York State for collective bargaining and is a leading proponent of universal, high quality and equal health coverage for all, regardless of race, ethnicity, gender identity, disability, socio-economic status, or ability to pay. On behalf of NYSNA, I thank the Committee for the opportunity to offer our perspective on some key problems in the structure and funding of New York's Medicaid program.

I am going to focus our comments on the issues of inadequate funding for Medicaid and what we consider to be serious structural problems in the way that this funding is distributed, with a focus on inequalities in access to and quality of care. Medicaid provides health care for more than 7 million New Yorkers, or about one third of our population. It is also the predominant form of health coverage for lower income populations, and thus plays an essential role in the state's health care system.

1. **Eliminate the Medicaid Global Cap – Fund Medicaid in accordance with the needs of New Yorkers, not based on artificial budgetary caps**

As noted above, Medicaid is a major component of the health care system and is the primary source of health care for about 35% of New Yorkers, with current enrollment of more than 7.1 million. As a safety-net program, Medicaid plays a vital role in providing coverage to low-income communities that could not otherwise afford to access care. Medicaid funding is also essential to the operation of hospitals and other providers, particularly those that provide services to low-income populations.

In addition to its function as a vital safety net for low-income communities, the program also plays a vital role as an economic stabilizer. When the state economy is doing well, more people are working and can get their health care from employer sponsored health plans. When, on the other hand, the state economy is in recession or crisis, employment levels drop, and people lose

their income and their health care coverage. During the COVID pandemic and the resulting economic crisis, this dynamic was particularly acute – Medicaid enrollment went up from 6.1 million in December 2019 to almost 7.2 million in August of 2021, or about 15%. If the 2020 federal elections had played out differently, the absence of substantial federal aid to state and local governments would have had devastating effects on state Medicaid services. Social and economic "stabilizer" programs (like Medicaid and unemployment insurance) should be expanded during periods of recession or crisis, not artificially capped.

Finally, it should be noted that Medicaid is a federal matching program – for every $1 that the state spends, it gets an additional $1 or more in federal funding. By cutting or limiting the growth of state Medicaid spending, the well-known imbalance between what New York pays into the federal government in taxes and what it receives in federal funding is worsened. Given the importance of health care in the state economy, the limits on state spending adversely effect the broader economy – less economic activity, lower growth, and fewer state tax revenues. The last thing New York should be doing is reducing its share of federal funding and reducing the availability of needed health services.

The Medicaid Global Cap was instituted as a purely budgetary measure to limit the growth of state Medicaid spending and to restrict the program for purely fiscal reasons.

By limiting the growth in annual Medicaid spending to 2%, New York state is arbitrarily pursuing a policy that leads inexorably to restricting access to needed care, impeding enrollment in the program, reducing provider payments to such an extent that safety net providers are faced with perpetual operating deficits, limiting the quality of care and range of services available to Medicaid recipients, and creating a two-tiered and unequal health system in which the wealthy and those with good private insurance receive better care and enjoy better health outcomes than those who rely on Medicaid for their care.

The stated rationale for imposing the Medicaid Global Cap was the need to rein in runaway costs and to make the Medicaid program more efficient and sustainable. The way to accomplish these goals, however, is not with arbitrary spending caps that disregard health care needs of New Yorker. Instead, the Medicaid program should be fully funded, federal matching funds should be maximized, and Medicaid services should be funded based on need rather than fiscal considerations.

To address the fiscal need to pay for the cost of Medicaid services, state policy should jettison the Global Cap and consider the following alternative approaches:

- Maintain and/or increase state Medicaid funding (and federal matching money) through the following revenue enhancements:
    (1) Increase corporate tax rates (which can be fully deducted against federal tax obligations under the 2017Trump tax cuts, unlike the cap on individual payers SALT deductions);
    (2) Further increase income tax rates on the wealthiest New York residents;

(3) Increase taxes or fees targeted at corporate and business entities making windfall profits in health care (private, for-profit health insurers; for-profit health care providers such as pharmacy chains, urgent care chains, imaging and laboratory service providers, large physician practices, pharmacy benefit managers, medical device makers and distributers, and other for-profit entities with high profits in providing health care);
(4) Reinstitute the stock transfer tax (to claw back the huge profits generated in the stock market during the pandemic); and
(5) Impose a pied-a-terre tax or surcharge on luxury second homes.

- Reduce unnecessary Medicaid costs without affecting patient care by taking the following measures:
    (1) Set direct price schedules and regulate price levels for all drugs (applicable to the Medicaid program, as well as to private insurers, retailers, and pharmacy benefit managers);
    (2) Crack down on fraudulent billing and other abuses by providers, with increased penalties (e.g., triple damages for civil and criminal fraud or billing abuse), enhanced civil enforcement procedures and penalties (which entail a lower standard of proof than criminal cases); increased power to freeze and/or seize financial or tangible property assets during enforcement actions; increase the length of the statute of limitations for civil and criminal fraud/abuse; increase criminal penalties (targeted at providers, and with lower dollar thresholds); and make it easier to find corporate officers and principals personally liable civilly and criminally).

2. Restructure Medicaid funding and reimbursement to address inequalities in care

New York Medicaid policy has been characterized by an increased emphasis and reliance on competitive market approaches to reining in costs and improving quality.

Our health care system has traditionally relied heavily on private entities, most of whom operate on a for-profit basis, to provide health care services. Pharmacies (large corporate chains and smaller independent operators), insurance companies, large physician groups and small individual practices, medical equipment manufacturers and distributors, imaging and laboratory service providers, urgent care centers, insurance companies, nursing homes, home care services, adult care program operators, pharmacy benefits managers, and a wide range of other health services are mostly provided by for-profit companies that are primarily motivated by the desire to make money rather than respond to the actual health care needs of the populations.

In addition, many non-profit providers increasingly act like for-profit entities in their business practices and approach to health care. This is particularly true of the hospital system, which is more and more concentrated in large networks led by academic medical centers. These hospital

systems focus on increasing their market share through acquisitions, consolidations, and aggressive advertising campaigns and marketing strategies aimed at increasing revenues and net profits.

The increasingly profit-driven nature of the hospital industry is also expressed in an accelerating tendency to shed less profitable service lines and shift their focus to patient populations and services that generate higher reimbursements and add to their net income.

The drive to maximize profits has negatively affected the Medicaid program and Medicaid recipients in a range of ways.

First, as we have already noted, state policy fosters the creation of a two-tiered health care system in which low-income Medicaid patients receive inferior services and suffer from worse health outcomes. Because Medicaid reimbursement rates are below the cost of care, hospitals and other providers seek to avoid providing services to Medicaid patients entirely. A glaring example of this tendency is the continued closure or reduction in inpatient and outpatient psychiatric services and their replacement with more lucrative specialty services that are paid at higher rates by Medicaid and by private insurers. As private providers pursuing higher revenues focus on more profitable services, the financial burden of providing care to psychiatric and other "undesirable" patients is increasingly shifted to public and private safety net providers.

Second, even when hospitals continue to provide services that are under-reimbursed, the drive to maximize revenues fosters the creation of two-tiered health services *within* hospital systems, with Medicaid patients being segregated from other patients and receiving unequal levels of care. Hospital systems direct privately insured patients to better equipped and furnished units or sites, with better staffing, newer furnishings and facilities, shorter wait times for care, and more amenities and services.

State Medicaid policy reinforces the inherent emphasis on revenue maximization by continuing to underpay for Medicaid services in general and by failing to address structural price distortions that pay more for certain services (e.g., coronary procedures, cancer care, surgical procedures) and underpay for others (psychiatric, obstetrics, etc.).

The prevalence of for-profit and private providers in the health care system in general and in Medicaid has been accelerated by the state policy expressed in the MRT and MRT II process to increasingly shift Medicaid patient into private, and largely for-profit managed care plans.

The state's reliance on private for-profit providers and market incentive to provide care for Medicaid patients is misguided and is worsening racial and socio-economic inequality in our health care system in general and Medicaid in particular.

To address these problems, New York should change direction and move to wring market incentives and private profit maximizing activity out of the Medicaid system, including the following measures:

- Increase Medicaid reimbursement rates to cover the actual costs of care;
- Increase reimbursement rates for underpaid services and remove the incentive to replace those services with others that pay more;
- Require all Medicaid participating providers, particularly hospitals, to provide equal and unsegregated care to Medicaid patients; and,
- Remove private Medicaid managed care providers and replace them with direct state and local mechanisms to oversee and manage Medicaid services in a uniform system.

3. Target DSH/ICP and other supplemental payments to safety net hospitals with the highest levels of Medicaid and uninsured patients

The current methodology for distributing the total pool of $3.6 billion in Disproportionate Share Hospital (DSH) funds (including the roughly $1 billion in the state's Indigent Care Pool (ICP)), inappropriately disperses these funds very widely to nearly every hospital in the state.

These funds are supposed to provide support to safety net hospitals that have the highest proportional shares of Medicaid and uninsured patients. We have already noted that Medicaid reimbursement rates are substantially below the costs of providing care and that this creates incentives for private hospitals to avoid Medicaid patients and focus on more profitable patient populations. We have also noted that uneven reimbursement rates *within* Medicaid encourage hospitals to stop providing certain underpaid services and to shift the financial burden of providing psychiatric and other services to public and private safety net providers.

This dynamic is putting increasing financial strains on safety net providers, and there are increasing signs that safety net providers will be under enormous financial strains as federal emergency COVID funding and enhanced reimbursements begin to dry up. These safety net hospitals will find it increasingly difficult to continue to operate and will face looming closures or reductions in services.

The current DSH/ICP distribution methodologies for voluntary safety net hospitals distribute a significant portion of these funds to hospitals that (a) do not provide services to a large relative share of Medicaid and uninsured patients and (b) generate high net profits because they have a higher percentage of privately insured patients.

DSH/ICP funds should be targeted to public and private safety net hospitals and should not be distributed to profitable hospitals that neither need nor deserve this supplemental funding.

To address the looming crisis faced by safety net hospitals, DSH/ICP funding should be modified as follows:

- **Assess provider fees to claw back excessive executive compensation**
  Excessive executive compensation is endemic throughout the health care system and is particularly egregious in the hospital system. The state Medicaid program should assess

a penalty or fee to reduce Medicaid and DSH/ICP payments to any hospital that pays executives more than a reasonable salary (e.g., $500,000/year). The sum of the total excess executive pay packages paid by the hospital would be deducted from the reimbursement, with the excess fund redistributed to safety net hospitals.

- **Assess provider fees on excessive administrative and/or non-patient care costs**
  In addition to paying exorbitant salaries to top executives, many hospitals also spend inordinate amounts on administrative costs, advertising, marketing, and other non-patient care costs. The state should set a threshold (i.e., a medical loss ratio or similar concept) to claw back any non-patient care expenditures above a determined threshold (say, 20%), with the funding that is clawed back to be distributed to safety net providers.
- **Enact A6883/S5954 to address unfair DSH/ICP funding allocations**
  This legislation would start the process of more fairly targeting DSH/ICP funds to those hospitals that are designated as "enhanced safety net hospitals" under PHL Section 2897-c(34) and as "qualified safety net hospitals" with high levels of Medicaid and uninsured patients. It would convert $275 million in ICP funds into higher reimbursement rates for safety net hospitals, leverage $150 million in federal funds for public hospitals, and leave less money for distribution to hospitals that do not need or deserve DSH funding. This bill would maintain existing federal DSH funding and would not add to state Medicaid expenditures. It would merely redistribute existing funds more fairly to support safety net hospitals.
- **Use "means testing" to restructure DSH/ICP funding and Medicaid reimbursements**
  New York currently provides Medicaid reimbursement rates to hospitals based on generic formulas that do not account for hospital profitability. As a result, many large hospitals systems that generate hundreds of millions in operating profits continue to receive Medicaid funding that they neither need nor deserve. Medicaid reimbursement rates should be higher for providers with the highest rates of Medicaid and uninsured patients and should be substantially reduced for providers with the lowest rates of such patients.

4. Implement a Single Payer System – Enact the NY Health Act or similar legislation

NYSNA is a strong supporter of universal, single payer health care. The NY Health Act would create a single payer system in New York that would not only provide universal health care to all New Yorkers, but would also address many of the unequal and unfair aspects of New York's Medicaid program by combining all Medicaid and Medicare funding in a single health plan administered by the State of New York. The New York Health Act would address the racial and socio-economic disparities in care for Medicaid patients be creating a single health system. The NY Heath Act would also address the issues of unfair Medicaid reimbursements and the incentives to shed Medicaid services and patients by directly setting reimbursement rates for all patients and services.