1199SEIU
United Healthcare Workers East

Testimony on 2020-21 Executive Budget Proposal
Health/Medicaid Joint Budget Hearing
Wednesday, January 29th, 2020

Thank you for the opportunity to comment on Governor Cuomo's 2019-20 Executive Budget Proposal on Health/Medicaid. The 325,000 members of 1199SEIU provide quality care to New Yorkers in every kind of healthcare setting, including hospitals, nursing homes, community-based clinics and consumers' own homes. They are nurses, physician assistants, pharmacists, social workers, dietary aides, environmental services workers, certified nursing assistants and home health aides, among many other titles and duties.

Medicaid is a vital lifeline for 6 million New Yorkers, providing health insurance for almost a third of our neighbors. It is the primary payor for safety net hospitals, which are struggling in both urban and rural areas to keep their doors open and make sure that vulnerable communities have a place to go for desperately needed care. It is particularly important for New Yorkers with disabilities, from those receiving long-term services and supports so that they can live independently in their communities to children with special needs receiving needed therapy at home or in school. It provides the majority of funding for our state's nursing homes, where 1199 members are working hard 24 hours a day to provide quality care to residents.

As you know, the State has reported as much as $4 billion in spending over the Medicaid cap that was put in place nine years ago as part of the first Medicaid Redesign Team's reforms. Governor Cuomo has proposed convening a new team to close a $2.5 billion gap, through savings and healthcare-related revenue. We agree that it makes sense to revisit the work of the MRT, to assess the success or failure of the earlier reforms and address new and continuing challenges.

One key question is whether the Medicaid cap is set at the correct level. When it was created, before the implementation of the Affordable Care Act and Medicaid expansion, just four million New Yorkers were covered by Medicaid. While cutting the rate of uninsured New Yorkers in half is a huge step forward, absorbing two million new beneficiaries with the cap in place has meant that hospital and nursing homes have not had a Medicaid rate increase for 10 years. While some providers could have shifted increased costs to private insurers, safety net providers dependent on Medicaid and Medicare have no such option, leading to greater and greater financial fragility. For example, 28 hospitals around the state have less than 15 days cash on hand and are dependent on extraordinary state support to stay open. 1199 members in nursing homes report reduced staffing levels even as resident acuity increases, with negative impacts on resident care.

That is why we are grateful that the Legislature created the Healthcare Transformation Fund from the Fidelis settlement. The Medicaid rate increases enacted last year began to stem the tide of losses. However, they were not enough for safety nets to be financially solvent. And the progress is threatened by across the board cuts, including the 1% that was imposed beginning

in January. Without adjusting the level of the Medicaid cap, cuts are the only available solution when it is pierced. $2.5 billion in across the board cuts -- $5 billion when the loss of the Federal match is taken into account – would seriously damage access to necessary care for New Yorkers.

The new MRT and the Legislature can take a different approach by focusing on a set of core principles. We believe these should include the following:

- Dedicate new revenues to avoiding cuts.
- Protect access to safety net providers.
- Focus reforms on the drivers of spending growth.
- Reduce excess administrative cost and ban profiteering in publicly-funded programs
- Ensure the availability of a stable and highly-qualified workforce

As it considers the drivers of spending growth, the MRT must look at the managed long-term care (MLTC) program. One of the central themes of original MRT was "care management for all" but some of these reforms – like MLTC -- have failed to live up to their promise of improving quality while controlling costs.

New Yorkers who are dually-eligible for Medicaid and Medicare who need more than 120 days of long -term care are required to enroll in managed care. The original vision of the MRT was that plans would manage both the Medicaid and Medicare resources, and be able to conserve resources by investing in quality long term care and avoiding unnecessary hospitalizations. However, the financial and administrative structures of the state's integrated program, called Fully-Integrated Duals Advantage or FIDA, did not work, and most beneficiaries disenrolled for their Medicare services.

The vast majority of dual-eligibles are now in plans called "partially capitated" that only manage their Medicaid services, primarily home care. For the plans, there are only a couple of pathways to making money within their capitated payment. They can reduce the amount of services or the price of services, but both of those have proven difficult. The other pathway is to seek new enrollees, especially lower-need ones.

We believe it is this financial incentive which has driven the extraordinary plan growth of 13% year over year. The population of New Yorkers over age 85, while growing, is doing so at 3-4% a year. Plans in particular used the explosion of for-profit fiscal intermediaries in the Consumer Directed Personal Assistance Program to find and recruit new enrollees. While plans are barred from marketing, CDPAP FIs were not, and as those of us who live in New York City know, they have plastered neighborhoods and the airwaves with advertising about getting paid to care for your loved ones.

We commend the Legislature for passing reform last year which will require FIs to meet higher standards and have a contract with the state in order to continue to operate. That reform is in the process of being implemented and we are hopeful that it will return control of the CDPAP program to the quality providers – including centers for independent living and others – who

originated the model to ensure that people with disabilities had maximum control over their services. The MRT should build on that progress to reforming the insurance plan financial incentives that have led to extraordinary plan growth.

Other aspects of the long-term care delivery system are also ripe for reform. The first MRT did not think enough about the demographic challenges that we will face. As population ages, cost pressures will certainly increase. We must work to make our delivery system as efficient as possible and avoid the loss of taxpayer dollars to excess administrative cost and profiteering. For example, while the wage parity requirement was a key achievement of the first MRT and has helped stabilize the workforce, some companies are siphoning off reimbursement meant for workers in sophisticated insurance scams. The MRT can recommend reforms to strengthen enforcement of the wage parity law as well as to address administrative duplication and waste, like those caused by excessive insurance company denials.

Finally, we were disturbed to see the cut to the Healthcare Workforce Retraining Initiative in the Executive Budget proposal. Given the amount of change in the healthcare industry – from hospital downsizing to the need for more highly-skilled workers in the home -- now is not the time to eliminate funding for the Healthcare Workforce Retraining Initiative.

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