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

Health and Mental Health 2020-2021 Executive Budget

Testimony to the Joint Committee on Health

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New York State Nurses Association

Cecilia Jordan, *DNP, MS, GNP, ANP-BC, RN-BC, CLNC*
NYSNA Area Director-NYC H+H/Mayorals

The New York State Nurses Association represents over 42,000 registered nurses and is the largest union representing registered nurses in New York State.

As a union representing registered nurses, we advocate universal, equal, high quality health care for all New Yorkers regardless of ability to pay.

We strongly support legislation and regulations that will allow nurses and other direct care health workers to provide care for our patients and communities in accordance with professional standards, with guaranteed minimum staffing levels, and under safe and fair working conditions.

The Executive Budget for FY2021 is primarily focused on addressing an estimated gap of $6.1 billion, of which more than $4 billion is identified as a Medicaid deficit or "structural gap" that exceeds the state's self-imposed "Medicaid Global Cap" limiting year-to-year increases in state Medicaid spending.

The Executive Budget proposal calls for the appointment of a new Medicaid Redesign Team (MRT II) to develop specific proposals to reduce the Medicaid gap by $2.5 billion, but does not provide much in the way of specific details as to how the gap is to be addressed. The cost saving proposals to be developed by the MRT II, however, are supposed to avoid negatively impacting the availability or quality of health services.

The state has already reduced Medicaid funding through executive action in the form of a 1% across the board reduction in Medicaid provider reimbursement rates implemented on January 1st as part of a mid-year savings plan. This action will reduce Medicaid funding by $559 million in FY2020 and an additional $851 million thereafter.

NYSNA is generally opposed to any cuts to Medicaid spending, which provides health coverage to about 6.2 million New Yorkers, or about 30% of the population. The Affordable Care Act (ACA) substantially increased Medicaid enrollment by raising the income eligibility levels for Medicaid and increasing the Federal matching rate on Medicaid costs for this expanded coverage to 90%. The ACA thus played a decisive role in the dramatic reduction in uninsured rates in New York and other states that implemented the ACA Medicaid expansion. We need to maintain the gains resulting from the passage of Obamacare.

We further note that (a) the people receiving Medicaid services are the poorest and most vulnerable New Yorkers and (b) that adequate Medicaid funding and reimbursement rates are critical to keeping vital safety-net providers open and caring for our communities.

Medicaid Redesign Team should be include strong representation of direct care workers and health care advocates and consumers

The Governor has announced the convening of a Medicaid Redesign Team (MRT II), to be chaired by Northwell President and CEO Michael Dowling and former 1199SEIU President Dennis Rivera. The composition of the full MRT II has yet to be announced.

The MRT II will, according to the Governor, be assigned the task of identifying $2.5 billion in Medicaid savings or cuts to help balance the projected $4 billion gap in the Medicaid budget.

The Governor further announced that in carrying out this role, the MRT II would protect access to care and have "no impact on beneficiaries."

NYSNA believes that the MRT II, if it is to fulfill its mandate to do no harm to the availability and quality of health care services for Medicaid beneficiaries, must include a wide range of representatives of front line health care workers, advocates for quality patient care, and consumers of health care services. In addition, the MRT II cannot be stacked in favor of providers, but must have an evenly balanced composition that gives more than representation to the health care users and the direct care workers (including nurses, physicians, and other care practitioners) that actually provide the care.

Cutting Medicaid to meet arbitrary spending caps will negatively impact health care

NYSNA is concerned that the mid-year adjustments already enacted, which include a 1% across the board reduction in Medicaid reimbursement rates, coupled with the directive to generate an additional $2.5 billion in budget cuts through the MRT II, will adversely affect the overall health care delivery system and will be particularly devastating to the safety net hospitals and other providers of care for the 6.2 million New Yorkers receiving Medicaid coverage.

The state cannot cut $4 billion in Medicaid spending, or about 5.3% of the FY2020 total Medicaid budget of $74.8 billion, without significantly affecting patient care.

NYSNA has no objection to reducing Medicaid costs by rooting out fraud or waste in the system or by reducing administrative or overhead expenses.

NYSNA, however, is opposed to broad spending cuts that reduce access to needed health care services and dilute the quality of care.

Cutting Medicaid spending is financially short sighted

The Executive budget presentation recognizes the punitive fiscal effects of the 2017 Federal "Tax Cuts and Jobs Act", which not only gave huge benefits to corporations and to the wealthiest Americans, but also directly attacked New York's state and local finances by limiting the deductibility of state and local taxes (SALT).

According to the Executive budget, it is estimated that the 2017 tax law has cost NY taxpayers as much as $15 billion a year in increased tax payments. This is in addition to the existing structural imbalance under which New York pays $22 billion a year more to the federal government than it receives in federal funding for education, social services, health care and other services.

In this context, the enactment of across the board reductions and MRT II targeted cuts in the amount of $4 billion will only exacerbate this imbalance in revenue flows to the detriment of New York.

Medicaid is a program under which New York receives matching funds from the Federal government. Under the normal FMAP formula, the Federal match is 50%, but under the Medicaid expansion provided by the ACA, the matching rate reaches 90%. In total, New York's federal match is about 60% of total spending.

This means that for every dollar that New York proposes to cut Medicaid spending, the state saves 40 cents in state and local spending but loses 60 cents in federal aid. Put another way, every 40 cents in state and local spending results in a $1 decrease in funding for New York's health care delivery system and the broader New York economy.

Given the existing unfair and punitive imbalance in money flows between New York and the federal government, any cuts to Medicaid will only increase the net amount that New York loses to the federal government.

The impact of the proposed reductions in Medicaid spending are reflected in the Financial Plan, which estimates that federal operating aid to New York will shrink by about $2 billion in FY2021. Given the federal FMAP matching rates, it is readily apparent that the projected reductions in federal funding for the entire state budget are largely attributable to the proposal to reduce the Medicaid budget by $4 billion in FY2021.

NYSNA is against any budget cuts that will increase the rate of revenue outflow to the federal government, particularly when those lost revenues are being used by the Trump administration to finance unprecedented tax cuts for corporations, billionaires and hedge fund managers.

The State should search for revenue enhancements to close the Medicaid budget gap and maximize federal funding

As noted above, 6.2 million New Yorkers rely on Medicaid for their health care services and New York has a net loss or outflow of at least $22 billion and as much as $37 billion a year to the federal government. Cutting Medicaid funding will significantly increase this gap, with negative consequences for the health care system and the broader economy.

Rather than focusing on across the board and more targeted cuts to Medicaid, which will only exacerbate this fiscal imbalance, the State should focus its efforts on maintaining or increasing Medicaid funding and closing the budget gap through increased taxes, surcharges and fees on economic actors that have profited from the changes in federal tax laws and/or from state health spending.

NYSNA urges the state to consider the following measures to address the Medicaid budget gap:

- **Increase corporate tax rates**
  The FY2021 budget projects total personal income tax receipts to total about $57 billion. Business revenues, including corporate franchise, corporation and utilities, insurance and bank taxes, however, are projected to total $9.9 billion.

  As noted above, the Trump tax cuts of 2017 sharply reduced the tax rates on corporations, pass through entities like hedge funds and other financial entities, and on the wealthiest tax payers. In addition, while the ability of individual tax payers to deduct state and local taxes was severely limited in a targeted attack against New York and other states with generous government social service programs and high costs of living, the federal tax law continues to allow corporations and other business entities to fully deduct their state and local taxes from their federal tax bills.

  Given this dynamic, we believe that the state should increase tax rates on corporations and other financial or business entities as a primary means of closing its budget gap.
  These institutions have greatly benefited from the federal tax law changes and are in a position to pay more to support vital social programs. In addition, they will be insulated from any increases in their state tax obligations because they will be able to fully deduct these increased levies from their federal tax obligations.

  This approach is not only fair, but helps to address the imbalance in money flows between the state and the federal government.

- **Increase the millionaire surcharge**
  The state should consider further increasing the tax rates on the highest income individual payers. Numerous studies have documented that wealthiest individuals have received a disproportionate share of the growth in income generated by the broader economy, while the income of the majority of individuals and households has remained largely static.

Accordingly, NYSNA would support a restructuring of the personal income tax code to reduce tax rates for working people and an increase in rates for those with annual incomes in excess of $1 million.

- **Target taxes and fees at corporate and business entities that make windfall profits in health care**

  Total health care spending in New York is more than $10,000 per person, or more than $200 billion a year.

  Within this broader health care economy, there are numerous market participants that generate high rates of profit from health care services.

  Rather than cutting spending and services for recipients of Medicaid, NYSNA believes that the state should generate new revenues to close the Medicaid budget gap by targeting health care entities that are profiting from the system.

  Accordingly, we recommend that the state should increase taxes, fees and surcharges on the following health care market business entities:

  - Private for-profit health insurers;
  - For-profit corporate providers, including pharmacy chains, urgent care companies, imaging and laboratory companies, large physician practices, medical device manufacturers and distributors, pharmacy benefit managers, and other for-profit entities that generate high profits in health care;
  - Pharmaceutical manufacturers and distributors;
  - Highly profitable hospital systems with low rates of Medicaid and uninsured/charity care services.

- **Reinstitute the stock transfer tax**

  The state of New York currently has a tax on stock transfers (based on the levy of a small tax on the purchase and sale of stock market shares). The New York stock transfer tax was enacted early in the 20th century and remains on the books, but since 1981 the taxes paid on stock transfers have been subject to a 100% refund. In practice, the tax is filed annually, but the state refunds it in full, meaning that no money is actually collected.

  The stock transfer generates in excess of $20 billion per year on paper, but the levied amount is fully refunded or rebated.

  Given the current speculative binge and run-up in equity markets, which has generated huge profits for traders, the state should consider at least a partial restoration of the stock transfer tax to address the Medicaid budget gap.

  The restoration of the stock transfer tax could be initially targeted at “high speed trading” in which large trading companies buy and sell stocks in extremely short time frames, often holding

the stocks for only a fraction of a second. This type of trading is highly exploitative in that it allows sophisticated traders employ high tech methods and computer programs to essentially game the market to the disadvantage of institutional and individual investors. These high speed trades are also highly destabilizing of the normal operation of equity markets, and pose a systemic risk by increasing market volatility and contributing to market price gyrations.

Imposing a tax on these or other abusive stock market practices would not only generate revenue to preserve needed health care services, but would also discourage such behavior and allow fairer and smoother stock market operations.

Reduce Medicaid costs by setting price controls on drugs/pharmaceuticals

The Executive Budget proposes to strengthen the ability of the State to rein in the explosive growth of drug costs, which impact both Medicaid and the broader health care system.

NYSNA supports the proposal to enhance the power of the Dept. of Financial Services to investigate and enforce restrictions on abusive drug pricing practices.

We would argue, however, that the state should consider stricter regulation of drug prices, including wider price controls and increased penalties for abusive practices. A more robust approach to drug pricing would reduce costs and increase revenues.

Medicaid funding flows should be restructured to direct funding more equitably to safety-net providers

The Executive Budget proposes to convene an MRT II to identify $2.5 billion in Medicaid cuts to address the budget gap. NYSNA is not opposed to efforts to root out fraud, waste and abusive practices that seek to generate windfall profits at the expense of Medicaid recipients and taxpayers.

We believe, however, that across the board or targeted cuts to Medicaid should not be the sole or main method of addressing the budget gap.

In addition, any restructuring of Medicaid must also consider the distribution of Medicaid funding to providers based on health care needs.

The MRT II should, accordingly, consider measures to more fairly allocate Medicaid funding, including reimbursement rates to hospitals and other providers, allocation of Federal Disproportionate Share Hospital (DSH) funding and the distribution of Indigent Care Pool funding.

Current policies distribute these Medicaid funding pools in a manner that does not fairly account for the needs of the most financially vulnerable safety-net providers and which unjustly enriches providers that provide fewer services for Medicaid and indigent patients.

To this end, the MRT II and the final budget must consider and address the following issues:

- **Incorporate the terms of A6677B/S5546A into the budget**
  Under the provisions of the federal DSH program, funds are made available to states to distribute to hospitals to compensate for the unreimbursed costs of care for Medicaid and uninsured patients. The reimbursement rates for Medicaid patients are estimated at roughly 70%-90% of actual costs, depending on the kind of health service. With respect to indigent uninsured patients, the reimbursement is generally zero. The federal DSH program is designed to provide additional funding to hospitals with high rates of Medicaid and uninsured patients and allow them to continue to provide vital services to their vulnerable patient populations.

  In New York, the DSH program provides a total of about $3.6 billion in funding, of which $1.8 billion is federal money. New York is required to provide an equal, 50/50 local share of about $1.8 billion.

  The state local share of $1.8 billion comes from two main sources – $1.135 billion in state share funding generated from HCRA fees and $700-800 million in "inter-governmental transfers" (IGTs) most of which are paid by the City of New York to fund the local share in support of DSH allocations to the Health + Hospitals system.

  New York distributes the DSH funding in a generally broad manner that allows many profitable hospitals with high percentages of privately insured patients to receive significant DSH allocations. Even though their favorable payer mix allows them to operate at a profit and they serve lower percentages of indigent patients, they continue to be eligible for and receive DSH and ICP funds that they neither need nor deserve.

  This problem is further distorted by the state's continued inclusion of "bad debt" in the formulas for allocating DSH and ICP funds. Bad debt includes unpaid patient co-pays or charges for privately insured patients, for whom the hospital may have received payment from the insurer that exceeded patient care costs and actually generated a profit. By classifying this bad debt as "charity care," these hospitals were then able to lay claim to charity care funds on top of the direct payments received from private insurers.

  Under the terms of Affordable Care Act, bad debt could no longer be counted as charity care for DSH purposes. In 2013, NY implemented a two year phase out of bad debt in its DSH/ICP formulas, but that phase out was subsequently capped or subject to a "transition collar" of no more than 2.5% reduction per year, which means that the elimination of bad debt from the allocation formulas will stretch out indefinitely.

  The Executive Budget proposes to abruptly end the "transition collar" on December 31, 2020, but it is unclear how this would affect safety net hospitals.

  This legislation addresses the distortions in the distribution of federal Medicaid DSH funding, protects safety-net hospitals from financial harm, increases the distribution of Medicaid funds to

those hospitals with the highest rates of Medicaid and uninsured patients, increases matching Federal Medicaid funding, and increases reimbursement rates for true safety-net providers.

NYSNA strongly supports the inclusion of the provisions of this proposed legislation in the final budget more fairly distribute ICP/DSH funding and protect vital safety-net providers.

- **Maintain Enhanced Safety Net (ESN) Hospital funding**

  Pursuant to Public Health Law Section 2807-c(34), Enhanced Safety Net Hospitals, including public hospitals, sole community hospitals, critical access hospitals and private hospitals with defined patient mixes that include high Medicaid and uninsured and low commercially insured patient rates are to be provided with supplemental funding to offset their uncompensated care costs.

  The Executive Budget proposes to eliminate the entire $82 million in funding for ESN Hospitals that was previously appropriated.

  NYSNA strongly objects to the proposed zeroing out of ESN Hospital funding in the budget. Funding for these true safety net hospitals must be maintained or expanded.

- **Apply means testing for determining Medicaid reimbursement rates**
  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.

- **Require minimum levels of Medicaid and indigent care services private providers**
  If there are to be cuts to Medicaid spending, the state should institute requirements that profitable providers shoulder a minimum burden of providing care to Medicaid and uninsured patients. These requirements should include minimum thresholds of Medicaid/uninsured patients with financial penalties for failure to meet the target.

- **Reduce support for mergers/consolidations for hospital systems with large surpluses**
  Executive budget provides approximately $725 million in funding to foster "health care restructuring." Almost all of this funding is directed at supporting mergers, acquisitions, consolidations and other hospital corporate restructuring operations.

  Much of this funding is targeted to supporting and maintaining vital safety-net provider hospitals, including support for the One Brooklyn Health System, which NYSNA supports.

We are concerned, however, that these funds should not be used to support merger, acquisition, consolidation and restructuring activity that is being undertaken or led by large hospital systems that generate excessive surpluses and that expend considerable resources in competing with each other for market share and the most profitable service lines.

The state should not be subsidizing wasteful market concentration trends and practices by hospital systems that are extremely profitable and do not need public funding to carry out these activities. This funding should be narrowly targeted to support true safety net hospitals.

The State should not implement a shift in Medicaid costs to localities or introduce automatic claw-backs of funding for exceeding the 2% property tax cap or the 3% Medicaid growth cap

Executive Budget proposes two measures to penalize counties or cities that fail to abide by the property tax and Medicaid caps.

To that end, the state would eliminate the State payment of the local share of Medicaid costs in any amount that exceeds (a) the 2% property tax cap or (b) the 3% Medicaid cap.

This approach is predicated on the argument that the localities have no incentive to contain Medicaid costs and that this is a major factor in the rise in Medicaid spending and the Medicaid budget gap.

NYSNA is concerned that this approach will have destabilizing and potentially devastating effects on Medicaid services and local finances when the Trump recession hits (and it will hit sooner or later).

By creating automatic penalties or claw-backs for exceeding hard limits on local tax levies and Medicaid spending, this proposed structure would cause localities to limit Medicaid and other social service spending at precisely the moment when the demand for such services would spike.

During a recession or economic crisis, unemployment rates would spike and many New Yorkers would lose their employer health coverage and would need to shift to Medicaid to meet their health care needs. The proposed claw-back mechanism would thus operate to penalize localities that respond to this spike in need at precisely the moment that increased spending becomes necessary.

This would not only harm the people needing medical services, but would also have serious fiscal and economic ripple effects that would make the economic crisis worse. It would cause spending to drop at a time when spending should be increased or maintained to provide an economic stimulus.

Safe Staffing – Nurse to Patient Ratios

The 2019-2020 Executive Budget included a proposal directing the Department of Health to conduct a study that will examine ways to implement staffing enhancements to improve patient safety and the quality of care in our hospitals and nursing homes.

The study was conducted and the results are expected to be released soon.

NYSNA and a range of other labor and community advocates strongly support expanding mandatory safe staffing ratios to ensure that hospital and nursing home patients have enough registered nurses, licensed practical nurses, nurse's aides, patient care technicians, and other direct patient care workers and professionals who are part of an inter-disciplinary team to deliver safe high quality patient care.

We believe that minimum staffing ratios covering registered nurses, licensed practical nurses, nursing aides, patient care technicians and other members of the inter-disciplinary team of direct care staff is the most effective approach to improving patient safety and the working conditions of direct care workers.

Setting a floor on the number of patients that registered nurses, licensed practical nurses, nursing aides, patient care technicians and other direct care staff can be assigned to care for is safer for patients and for direct care workers. We also believe it is a cost effective way to improve patient care.

Research shows that the more patients assigned to a nurse and other direct care staff, the worse the quality of care that is received by those patients. Poor staffing increases patient mortality rates, reduces patient health outcomes, increases the incidence of co-morbidities, complications and length of stay, reduces patient ratings of their care experience, lengthens patient recovery times, and leads to higher rates of readmission and unnecessary health care utilization.

Poor staffing also negatively affects the working conditions of direct care workers and the experience of patients. Inadequate staffing increases wait times for care, is a trigger for workplace violence and assaults on patient care staff, leads to increased workplace injuries and illness, depresses workplace morale and leads to higher rates of staff burnout and turnover.

The adverse effects of poor staffing also have serious costs and financial consequences for bottom lines of hospitals, nursing home and other health care providers. High rates of turnover of direct care staff pose a huge and increasing cost for employers in the form of direct recruitment and training costs and indirectly in the form of lost experience and productivity. Unnecessary patient admissions and readmissions impose significant costs on the health care system and result in reduced provider reimbursement and other monetary penalties under current federal and state policy. Poor staffing is a major contributing factor in assaults and work-related injuries, leading to increased labor back-fill and employee health care costs to employers. Poor staffing also increases liability costs for malpractice and patient harm lawsuits. Poor patient care outcomes also impose a macro-economic cost in the form of lost work time, decreased quality of life and higher total health costs in the broader economy.

NYSNA strongly supports the expansion and establishment of enforceable staffing ratios and urges their inclusion in the budget.

NYSNA opposes proposals to dilute professional practice standards that jeopardize patient care

The Executive Budget proposes to amend the Education law relating to pharmacist practice to (a) increase the number of unlicensed persons who may be supervised by a pharmacist from 4 to 6; (b) increase the range of vaccinations that may be administered by a licensed pharmacist to include all CDC recommended vaccines for persons older than 18; (c) to allow physician assistants and nurse practitioners (as well as physicians) to enter into collaborative drug therapy agreements with pharmacists and (d) to give nurse practitioners and physician assistants the right to supervise pharmacists in the administration of vaccines.

NYSNA has no objections to allowing nurse practitioners and physician assistants to enter into collaborative drug therapy agreements with pharmacists or to supervise pharmacists in the written agreements and protocols.

NYSNA is concerned however, that the expansion of the number of unlicensed personnel that can be supervised by a pharmacist from 4 to 6 and the expanded list of vaccinations that may be administered by pharmacists under the proposal raises serious questions about patient safety.

Currently, pharmacists are entitled to administer influenza, pneumococcal, acute herpes zoster, meningococcal, tetanus, diphtheria and pertussis vaccinations.

The proposed budget legislations would appear to add the following CDC recommended vaccinations: Anthrax, BCG, Cholera, DTaP/Tdap/Td, Hepatitis A, Hepatitis B, Hib, HPV, Japanese Encephalitis, Measles, Mumps and Rubella, MMRV, Polio, Rabies, Rotavirus, Smallpox (Vaccinia), Typhoid, Varicella (Chickenpox), Yellow Fever and Zoster (Shingles).

NYSNA is opposed to the expanded list of vaccinations that may be administered by pharmacists, as many of these vaccinations have complex contraindications and may require a patient assessment prior to administration can be provided only by a registered nurse.

NYSNA will provide a more detailed analysis of the propose language and the health and safety concerns related to allowing pharmacists to administer these vaccines.

Other budget provisions

NYSNA is currently reviewing other components of the proposed Executive Budget but generally supports the following proposals:

- Extension or approval of a new DSRIP Waiver;
- Continued robust support of the Essential Plan;
- Protecting women's health through the creation of a Maternal Mortality program and support for reproductive rights;
- Expanded tobacco and vaping controls;
- Cannabis regulation and taxation measures;

- Regulation of pharmacy benefits managers;
- Increased consumer health cost transparency, but NYSNA would further urge that transparency should include public information related not only to pricing, but also to providing information about nurse to patient staffing ratios and excessive executive salaries;
- Increased opioid treatment funding;
- Restrictions on the ability of private insurers to delay payments or down-code diagnoses submitted by hospitals;
- Expanded “pay and pursue” policies to prevent insurer abuses; and,
- Continuation of CPEP programs.

As more concrete information emerges and we continue our review of these and other Executive Budget proposals related to health care, including the proposed HCRA revisions, we will provide more detailed analysis and position statement.