Statement about NY State Budget FY 2022-2023: Joint legislative budget hearing on Health/Medicaid--Tuesday, February 8th, 2022

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Considered the king of all beasts, this year's zodiac animal during this Chinese New Year, is a sign of new beginnings. We hope that is true as the state deliberates around the budget priorities. The Governor's Executive Budget for FY 2022-2023 has directions we support, directions we need more clarity, and places of critical concern that continue a direction of repeating the offenses to people of color, which has been our experience in other past governor administrations.

CPHS based its summary from a perspective informed by our coalition work with health care advocates, promoters and designers of equity, health care providers, and those with an anti-racist lens throughout the state of New York. We are providing a detailed summary on the key campaigns we work impacted by the state budget. We ground our summary in the experiences of the uninsured, people on Medicaid and Low-income, immigrant communities of color and all other groups they would identify with (person w disability; LGBTQ+ person, all gender identities, a youth, a senior, and of any certain beliefs, faith, and religions). While we have had concerns with lack of selection of community and faith-based organizations to testify, we are submitting testimony to ensure our voices are on record.

Here are the three advocacy areas:

Indigent Care Pool & Health Care Safety-net Advocacy

The executive budget does not propose a corrective measure for the unfair distribution of NY State Indigent Care Pool (ICP) Funds, which provide support to hospitals to offset their losses by providing care to financially needy patients. The Assembly and Senate Health Committees Chairs and some of the members have supported changes and the recent "Peoples Budget" from the Black, Puerto Rican, Hispanic & Asian Legislative Caucus supports in concept reforms to ICP.

ICP is part of the Hospital Uncompensated Care Funding: Federal financing mechanism to provide funding to hospitals that provide large volumes of care to Medicaid beneficiaries and uninsured patients. The formula to allocate ICP Funds in NYS benefits large academic medical centers instead of benefiting true safety hospitals and neighborhoods served. The sequencing

of NYS DSH funds allocations means the hospitals which provide the most care to Medicaid and uninsured people get paid last, not first.

New York receives about $1.8 billion in federal DSH funds and is required to match that amount, to increase the total fund for hospitals to $3.6 billion. New York's hospital Medicaid reimbursement covers only about 68% of the actual cost of providing the care. The mismatch of the current distribution of funds does not address the gap in covering the cost. It does contribute to the heightening of racial and ethnic disparities that were apparent before the virus but became more evident when people got sick from COVID.

The Affordable Care Act expanded Medicaid to increase access to public insurance options for low-income individuals and families, as well as improve access to specialty medical care services. However, the expansion did not lead patients receiving care at safety net hospitals to transfer their care to non-safety-net hospitals. Poor people who are uninsured, are of marginalized groups and immigrant status, live in geographically or economically disadvantaged communities, or have a broad range of social, demographic, and poverty-related health problems must rely disproportionately on the core safety net (public hospitals, rural and small number of private hospitals serving disproportionate numbers) for their health care. All this undermining of our public hospital and other safety-net provider is making the pandemic and health care crisis more painful and reconstruction more challenging. The state continues a racist and classist budget determination by not fixing ICP. It sends the message that people who are uninsured and on Medicaid, who are predominantly people of color, immigrants, and low-income New Yorkers are less important. We have fix with legislation without diminishing the federal share of DSH funding and would not add to state Medicaid costs because it just redistributes existing spending from wealthy hospitals to safety-net hospitals that are barely making ends meet.

CPHS Calls for:

Passing legislation A6883/S5954. The ICP funding must target public and private enhanced safety net providers as defined in NYS PHL Article 2807-c (34). $275 million of ICP funding would be converted to increased reimbursement rates for "enhanced safety-net hospitals" and to "qualified safety-net hospitals", meaning that more money would be available for true safety-net hospitals.

Effective Date: April 1, 2022

Executive Budget proposes a Medicaid Global Cap Metric Modification and Extension so attempts to revise the nature and look-back period for reviewing competence from ten to seven years. Any change of ownership transaction that is subject to Public Health and Health Planning Committee review shall be effective ninety days after the applicant has fully responded to the DOH's final request for additional information. According to Budget documents, this will result in an increase in the Global Cap of $366 million in additional Medicaid spending authority in FY23 and an additional $899 million in spending authority in FY24.

The cap limits the amount of state funds that can be spent in any year. In more impactful terms creates a pre-determine the amount of money spent per person enrolled in Medicaid,

which is about seven million New Yorkers. This is not likely to assist in promoting the objectives of Medicaid and has been predictably harmful to both beneficiaries and to state economic interests. The cap has a similar effect of a block-grant program. And while increasing the cap seems promising, it does not guarantee that the state will spend up to the cap – it could spend less if it wants to or if it must reduce state spending.

For every dollar a state spends on Medicaid, it receives a matching amount of federal funds—without limit—making Medicaid a statutory entitlement for states participating in the program. Loses are about $1.30 or more in matching federal money (known as enhanced Federal Medical Assistance Percentage- eFMAP) – costing providers and our local economy billions in lost revenues and economic activity. The cap on Medicaid spending hinders public health measures and patient care in the context of the ongoing pandemic and recovery, especially for Black, Latinx/Latine, and Asian-American and Pacific Islander communities. It weakens the safety-net Infrastructure. It limits the long-term capacity and resources of critical providers of care and community-based organizations to succeed in meeting the needs of patients and people accessing services in underserved areas. It weakens the safety-net Infrastructure. It limits the long-term capacity and resources of critical providers of care and community-based organizations to succeed in meeting the needs of patients and people accessing services in underserved areas.

CPHS Calls for:

- **Elimination of the Medicaid "global cap"**

- **A planning process with health advocates, labor, and safety-net providers to maximize the implementation and growth of a Medicaid program with a transparent and accountable global budgeting process that appropriately accounts for the demographic changes and increased health care needs of New Yorkers that are the real drivers of the budget gap.**

Effective Date: April 1, 2022

The executive budget proposes a uniform 1 percent rate increase for all DOH Medicaid Fee for Service payments for services provided. This was in part to recognize provider labor cost increases and delays changes to the base period for determining the operating cost components of hospital reimbursement rates, including the DRG weights.

Certain Medicaid rates will be excluded. Those exclusions are including increases that would violate federal law, increases that would violate the Disproportionate Share Hospital facility cap, payments made from other agencies not covered by Medicaid, payments which do not include state Medicaid share. The increased rates projects adding $3.7 billion in spending over 5 years.

A DRG, or diagnostic related group, is how Medicare and health insurance companies categorize hospitalization costs and determine how much to pay for your hospital stay. The updated base period for calculating base rates after July 1, 2018, is delayed to an indeterminate time on or after 1/1/2024. The budget pointed out that this will not cost the state

any additional money. While it may be cost neutral, it could keep current rates locked in for all hospitals.

CPHS supports the increase but strongly believe the increase is not enough. Other factors are important for when discerning an increase. They are staffing and healthcare needs, particularly for safety-net hospitals. We must continue demands for shifting funding from wealthier hospital networks that have historically delivered less care or steered care away people on Medicaid and who are uninsured.

The budget language is not too clear about the new methodology will mean for reimbursement rates. It has high potential to prevent any shift of funding to provide enhanced funding for safety net hospitals. We need clarity on what it means for different hospitals with distinct and overlapping services and communities served.

CPHS Calls for:

- **Supporting the increase but calling on the Assembly and Senate to negotiate a higher increase.**

- **Targeting any of the Medicaid reimbursement increase to underfunded and at-risk services (psych, labor and deliver, pediatrics, trauma)**

Article VI Advocacy

Effective Date: April 1, 2022

The executive budget proposes General Public Health Work County Support (also known as Article Vi funds) with the following provisions:

- **Retaining the 20% cut to New York City while Increasing base grants by $6.7 million in FY23 and $13.4 million in FY24 for the rest of the state.**

- **Authorizing the DOH to increase the annual base grant full-service local health departments to $750,000 or $1.30 per capital and increase the grant to partial-service local health departments to $577,500.**

- **Authorizing local health departments to claim up to 50% of personnel service costs (Fringe expenses like health and pensions)**

The General Public Health Works Program more commonly known to advocates as the Article VI funds is the statutory mechanism for state matching dollars to reimburse localities like NYC for local specified public health programs and services conducted by the NYC Department of Health & Mental Hygiene. Article VI provides a level of supportive funding for NYCDOHMH to contract community-based organizations and health providers with the expertise and capacity to provide preventive services that meet the cultural and language needs of low-income and

immigrant New Yorkers, communities of color and women, children, youth, seniors, people formerly incarcerated, people with disabilities, and homeless New Yorkers. Communities rely on Article VI for services impacting maternal and child, HIV, Viral Hepatitis, TB, STi, substance use, chronic disease management, and many more vital public health services.

Unfortunately, over the past five years in New York State, the number of staff at the fifty-eight local health departments delivering Article 6 core services has declined. According to data from the New York State Department of Health, the number of FTEs working on Article 6 services declined by 7% between 2015 and 2020. We believe that the community-based organizations receiving Article Vi, have assisted in relieving the DOH pressures of addressing health disparities and inequities. But a cut only to New York City has made it harder to address the public health challenges facing our communities, including responding to the COVID-19 pandemic. While federal pandemic funding support has been vital, those funds are not permanent, but Article VI is part of the public health law and is a consistent source of funding support for both local health departments and CBOs alike.

Funding cuts mean decreasing or completely cutting services, staff and destabilizing marginalized communities who depend on community-based organization and their services. Those impacted will be New Yorkers who are people of color, low-income, and highly susceptible to chronic disease. According to a report from Comptroller Stringer, nonprofits make up 18% of the private workforce-- predominantly female, foreign-born or people of color -- in New York City, and account for over 9% of the City's GDP. During this critical time, the city must invest, not divest, from organizations who have been a trusted resource to communities in need.

CBOs already struggle to piece funding together to provide essential services. Paying for CBO Staff and programs are times cobbled together through many sources and deliverables and public-private partnerships often established. Maintaining the cut could have a ripple effect of much greater magnitude than the amount of the funds themselves.

CPHS calls for:

- **Restoring Article VI to 36% reimbursement rate for New York City. The total cost NYC restoration=$60 million annually.**

- **Allowing claims of fringe benefits as part of Article VI and any increase to the base rate dollar amount because it adds $19 million in FY23 and $38 million in FY24. Total estimated cost of fringe reimbursement at 36% results in $56 million.**

- **Increasing the annual base grant full-service local health departments to $1.5 per capital.**

Effective Date: Varies based on provisions

Pandemic Equity & Recovery Advocacy

Executive budget proposes through the creation of innovative programs, as well as the expansion of existing programs, the FY 2023 Executive Budget will work to support a strong and equitable recovery for New York State, particularly for those communities that have been historically disadvantaged.

There is plenty to state around the various stressors and harm caused by this virus. This includes the disrupted education system for children, youth, and young adults to the protection of essential workers and excluded workers. Our fellow advocates have done the advocacy and we will try to share their assessments. They are working with those directly impacted by those inequities and have a strong voice on those matters that we support.

We represent a New York City coalition named Communities Driving Recovery. As community-based organizations and faith-based organizations serving predominantly low-income neighborhoods and communities most impacted by COVID, we know that only by partnering with communities, respecting, and incorporating their knowledge, skills, and dedication to rebuild health, can we succeed with an equitable recovery from this pandemic.

New York State received and continues to receive billions of federal COVID Relief Funds. Most current has been the announcement from the Federal Health and Humans Service (HHS) agency, that it is providing more than $2 billion in Provider Relief Fund phased into four payments. Total payments to providers in New York State sums up to $299.6 million. The number of providers receiving payments are 559.

All this money only exists because of the trauma and illness that struck the underserved neighborhoods we represent; yet, while the city has done better, the state is inconsistent in how these communities' needs should be addressed. The challenges in marginalized communities are NOT always represented in recovery planning and programming done by the state. We can do better to address our community's pleas for real, evidence-based information to reduce many of the chronic diseases which impacted and fueled Covid.

Throughout this pandemic, we experienced many differences of opinion and concerns about how the state is re-opening and when we can we stressed the times when we supported policies.

We are informed by the voices from our communities and our experiences, that while other monied interests influenced policies, coordinated multiple spaces for their commercial benefit, and made decisions, that many of our marginalized community members are often excluded, lacking clarity, transparency, and accountability about where the decisions are taking place, who are the people making those decisions, and what are their singular interests. CBO's often function without governmental support or when it is present, their bureaucracy leads to a glacial response.

CPHS Calls for:

- **Transparency reporting of the use of he covid funds that the state has distributed to hospitals and local health departments**

- **Community and City Resourcing— inclusively and equitably providing more funding in fairer proportions to local and distinct community and geographically needs. These need to in the millions for CBOs/FBOs, targeted toward an array of potential projects in hardest hit communities. Work with CBO/FBOs to explore the shifting of funds that address capacity and collaboration with local health departments.**

- **The passage of the Public Health Reinvestment and Emergency Pandemic, Adaptability, Readiness and Efficiency (PREPARE) Act. We need an adequately funded public health infrastructure that ensure local health departments are well equipped to provide core public health services, continue to respond to the COVID-19 pandemic and address future public health emergencies. The act contains budget provisions totaling $216.5M that will help to achieve a base level of preparedness through funding the state's fifty-eight local health departments that have been chronically underfunded for over a decade.**

- **A universal single payer health coverage through passage of the New York Health Act. In response to the COVID-19 induced economic and healthcare crisis, New Yorkers elected a Democratic supermajority in November 2021 which includes several vocal supporters of the New York Health Act. In March 2021, for the first time in New York legislative history, state lawmakers introduced the New York Health Act with majority support in both houses of the state legislature. Now its time for the bill that would assist the state for a just recovery.**

- **Support of the executive budget amendments in the Vital Access Provider Assurance Program to include distressed nursing homes, adult care facilities, independent practice associations and accountable care organizations as eligible providers. The funding must not exclude the New York City Health + Hospitals long term care facilities. The funding subjected to an evaluation process must incorporates metrics that are equitable and transparent around the approval by the Commissioner.**

- **Support for the expansion of Medicaid eligibility for low-income New Yorkers who are over the age of sixty-five as well as those with disabilities. Eliminating the resource test and raise the income level to 138% of the Federal Poverty Level for seniors and individuals with disabilities is extremely critical.** COVID-19 pandemic has triggered unprecedented economic turmoil, these tests—which require applicants and beneficiaries to have resources below a certain threshold to qualify for benefits—trap people in a state of economic instability and insecurity. This has been particularly harmful for people with disabilities, whose economic condition has generally declined since the 1970s

- **Supporting the Essential Plan Reforms expansion of Medicaid and Essential Plan coverage to include the uninsured. The following are the right steps for policy changes.**

  - ✓ Raising the Federal Poverty Cap for essential plan from 200% to 250% of the Federal Poverty Level.
  - ✓ Extending coverage for pregnant women and their children for one year after birth, regardless of any change in household income.
  - ✓ Expanding coverage of essential plan to include options that comply with Olmstead rules to live in home/community settings.

- **Supporting the Child Health Plus Reforms. The following moves towards the right direction:**

✓ Aligns Child Health Plus benefits with Medicaid benefits and transitions Child Health Plus rate setting authority from the Department of Financial Services to the Department of Health.
✓ Expands covered healthcare services to include Children's Family Treatment and Support Services, Children's Home and Community Based Services, Assertive Community Treatment Services, residential rehabilitation for youth services, and health related services provided by voluntary foster care agency health facilities.
✓ Seeks to eliminate the $9.00 per month premium payment for eligible children whose family income is 223% of the federal poverty limit.

The elimination of premium would take effect April 1, 2022. The other provisions would take effect on January 1, 2023. And authorizes DOH to review reimbursement rates for providers and consider increases in 2023.

- **Amendments and protections for patients around the reimbursement parity for telehealth services** by requiring Medicaid and commercial insurers and health plans to reimburse practitioners delivering services through telehealth on the same basis and at the same rate as delivered in person. The reimbursing of telehealth on parity is not objectionable but must be technologically appropriate for the social, cultural, environmental, and economic conditions of the setting where they will apply to. The state must:

✓ **Stop any evasion or neglect towards language access rights and laws.**

✓ **Establish safeguards connected to the incentives so not to create a routine substitute for in-person care. Telehealth visits tend to be shorter and include fewer diagnostic services than in-person visits.**

✓ **Improve the monitoring of the requirement that commercial health plans maintain an adequate network of professionals to provide access to telehealth for all services covered under the plan. Network adequacy is critical because of the trend of insurance companies to narrow their networks.**

✓ **Direct that the payment rates reflect the cost of the service, avoiding overpayment if clinicians can use telehealth to deliver more visits per session. Mechanism to avoid perversely incentivizing the use of telehealth encounters is necessary.**

✓ **Make certain the parity requirement ensures the access to audio-only telehealth services**

✓ **Impose barring of out-of-state, unlicensed providers to supplant local health care providers or shirk state regulations, particularly with respect to for-profit providers operating across state lines.**

✓ **Build in a quality evaluation into the telehealth process. In year one of the implementation of the parity, an evaluation report must be in collaboration with health, civil rights groups, and other stakeholders. Must be available for public comment. This includes**

- The impact to access to specialty care capacity, such as in rural areas where many specialties may not be available. While telehealth may be important modality for future care needs—this view varies widely depending on the type of care.
- Concerns around safety and privacy compromised by rapid deregulation of telehealth.
- Cultural Humility
- Application for mental health treatment and counseling and harm reduction.

- **Supporting the renaming the Office of Minority Health to the Office of Health Equity and redefining the scope and mission of the office**. Key changes would be
  - Amending the Mental Hygiene Law to change the name Alcohol Awareness Program to the Substance Use Awareness Program.
  - Expanding the program to include raising awareness of the health and social costs of cannabis use.
  - Appropriating $750,000 for the development of evidence-based best practices to address addiction by expanding program and making it available to more individuals.

Affected stakeholders must set the priorities and this cannot be advisory for the development and implementation of intervention aimed at achieving health equity among poor and communities of color. Changing the name could create a reconstructed charge for the state office, but it will only be meaningful if there is an elimination of the internal biases and power imbalances faced by community-based organizations and impacted stakeholders to define and co-create with government agencies.

Thank You