TESTIMONY OF

New York Coalition of Essential/Safety Net Hospitals

On the Governor's Proposed SFY 2023 Health and Medicaid Budget

Submitted for the

Joint Legislative Budget Hearing on Health

Senate Finance Committee Chair Liz Krueger and Assembly Ways and Means Chair Helene E. Weinstein Presiding

February 8, 2022

Introduction

Any objective, knowledgeable observer of New York's health care system would conclude that the current system is broken and has created unconscionable disparities and inequities. The failure of the current system is especially apparent in how we support our community safety net hospitals, which predominantly serve low-income, communities of color. Consider the facts:

- **In New York City, community safety net hospitals serve the City's most historically marginalized neighborhoods where health and economic disparities are most stark.**
    - The neighborhoods served by community safety net hospitals are home to more than 4.7 million New Yorkers where up to 76 percent of the residents are people of color, including Black and Latinx residents.
    - These neighborhoods have experienced significantly higher rates of COVID hospitalizations and deaths, and have long suffered from higher poverty rates, higher rates of uninsurance, and significantly worse health outcomes compared to wealthier neighborhoods.[1,2]
- **While the need for care and support in marginalized communities is greater, the community safety net hospitals that serve them are vastly underfunded.**
    - Today in New York, Medicaid pays only 67 cents on the dollar for care provided by hospitals and even less for some services such as inpatient psychiatric care. Since Medicaid is the single largest payer for community safety net hospitals, we are chronically underfunded, live hand to mouth, and are forced to make tough choices about services and capacity for the low-income neighborhoods and communities of color we serve.[3]
    - New York's community safety net hospitals see relatively few commercially-insured patients (typically less than 20 percent of the patient mix) and receive comparably lower rates due to our poor negotiating power with commercial payers. In fact, the average commercial rates in Manhattan and the City as a whole are up to seven times higher than the average commercial and Medicaid managed care rates received by our hospitals.[4]
    - As a result of the inequities in how we are paid, we often run negative operating margins and are not able to demonstrate creditworthiness to buy supplies and invest in our infrastructure.

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[1] Monthly Hospitalization and Death Rates by Zip Code and Total Case, Hospitalization, and Death Rates, NYC Health, March 2021.

[2] "Today's Health Inequities in New York City Driven by Historic Redlining Practices," Primary Care Development Corporation. September 2020. Available at: https://www.pcdc.org/wp-content/uploads/Points-on-Care-_-Issue-5-_-FINAL.pdf

[3] "Statewide Report: New York's Hospitals and Health Systems Improve the Economy & Community," Healthcare Association of New York State, December 2021. Available at: https://www.hanys.org/government_affairs/community_benefit/docs/statewide/statewide.pdf

[4] Manatt Health analysis of Coalition hospital reimbursement rates and Citywide and Manhattan estimated commercial allowed amounts based on data compiled and maintained by FAIR Health, Inc. FAIR Health is not responsible for any of the opinions or conclusions expressed herein. Data (c) 2021 FAIR Health, Inc.

- Over the years, chronic underfunding has led to bed reductions and hospital closures throughout New York, including the loss of 18 hospitals and 21,000 beds in New York City alone.[5]

- **The result of the current financing approach is a two tier health care system has exacerbated disparities and forces the State to provide funding to make up for the failures of the reimbursement system, but at levels that continue to remain inadequate.**
  - A recent op-ed piece in The Washington Post highlighted this disparity: "Poor neighborhoods have proportionately more people who are uninsured or insured by Medicaid, which has payment rates that are often too low to cover the costs of care. People tend to seek health care near home. As a result, hospitals that are located in poorer neighborhoods have less to work with, and often lack the resources needed to provide optimal health care. *In effect, doctors and hospitals in the United States are paid less to take care of Black patients than they are paid to take care of White patients.* When we talk about structural racism in health care, this is part of what we mean."[6]

"Insanity is doing the same thing over and over and expecting a different result." While this quote is often attributed to Albert Einstein, it is also a fitting assessment of New York's approach to supporting community safety net hospitals. The State currently provides near-term cash support for our hospitals, which is primarily intended to keep us from missing payroll or closing and perpetuates a subsistence existence. **While the proposed Executive Budget does provide for more funding, it is not enough to address the structural issue of inadequate Medicaid rates, which have not increased for more than a decade and have been far outpaced by rising medical costs.** In effect, the proposed Executive Budget perpetuates the inequities of the current financing system for community safety net hospitals, which chronically underfunds community safety net hospitals and the marginalized communities we serve.

In response to the urgent need for structural financing reform, nine community safety net hospitals formed the New York Coalition of Essential/Safety Net Hospitals ("Safety Net Hospital Coalition" or "Coalition").[7] Our hospitals are independent and separate from other public safety net hospitals, such as NYC Health + Hospitals, which also play an indispensable role in serving low-income neighborhoods and communities of color. Our community safety net hospitals predominantly serve low-income Medicaid and uninsured patients, who represent 45 percent or more of our patient

[5] Dunker, A. and Benjamin, E., "How Structural Inequalities in New York's Health Care System Exacerbate Health Disparities During the COVID-19 Pandemic: A Call for Equitable Reform," Community Service Society of New York. June 2020. Available at: https://www.cssny.org/news/entry/structural-inequalities-in-new-yorks-health-care-system

[6] Asch, D. and Werner, R., "Opinion: Segregated hospitals are killing Black people. Data from the pandemic proves it," The Washington Post. June 18, 2021. Available at: https://www.washingtonpost.com/opinions/2021/06/18/segregated-hospitals-are-killing-black-people-data-pandemic-proves-it/

[7] The nine Coalition member hospitals include: Brooklyn Hospital Center, Brookdale Hospital Medical Center, Interfaith Medical Center, Maimonides Medical Center, Jamaica Hospital Medical Center, Flushing Hospital Medical Center, St. Barnabas Hospital, St. John's Episcopal, and Wyckoff Heights Medical Center. These hospitals are independent and do not have access to the same sources of financial support as public hospitals and academic medical centers.

mix.[8] After a careful review and analysis of the proposed Executive Budget, **we have concluded that $635m in additional State/Federal funds is needed to provide adequate support to our hospitals to ensure our sustainability and enable us to invest in our programs and services**. Some of this increase in funds could potentially be supported through Federal Financial Participation (FFP) by enhancing the State's Directed Payments Program to target the additional funding to Coalition hospitals (which serve higher volumes of Medicaid patients compared to some of the other hospitals in the current budget proposal). **Addressing this gap would require an increase of up to $400m in State matching fund support, subject to the level of FFP that is approved, and in many ways represents a reinvestment of the savings that our hospitals have generated through the Delivery System Reform Incentive Program (DSRIP) and related transformation efforts.**

Our request for this increase in funding for SFY 23 represents the beginning of a fundamental shift in state health policy, which transitions us away from keeping community safety net hospitals on life support and toward a more equitable financing approach that corrects for decades of disinvestment in our facilities and the communities we serve. **By providing sufficient support for community safety net hospitals, we can address the inequities of the current financing system and truly invest in our communities.**

The New York Coalition of Essential/Safety Net Hospitals

The New York Coalition of Essential/Safety Net Hospitals formed in 2021 in response to the urgent need for significant, structural payment reforms for community safety net hospitals in New York. **The nine members of the Coalition predominantly care for low income communities, with at least 45 percent of inpatient and outpatient patients served being covered by Medicaid or uninsured.** Few of our patients are commercially-insured, representing less than 20 percent of the patient mix. We serve historically marginalized neighborhoods which are home to more than 4.7 million New Yorkers where up to 76 percent of the residents are people of color, including Black and Latinx residents. The neighborhoods served by our hospitals have also experienced disproportionately higher rates of COVID-related hospitalizations and deaths compared to other areas in New York City.

The Coalition's mission is to advocate for reforms to better support local communities and address long standing health disparities through advancing state and federal policy initiatives supporting sustainable reimbursement and access to capital for our institutions and communities. Through these efforts, the Coalition seeks to begin to address the failures of the current financing system and reverse decades disinvestment that have resulted in an inequitable health system of racially segregated haves and have nots, and promote investment in an equitable health care system in our communities and facilities. These investments are critical because our hospitals are more than just essential healthcare providers, we are also large economic drivers and employers in these communities.

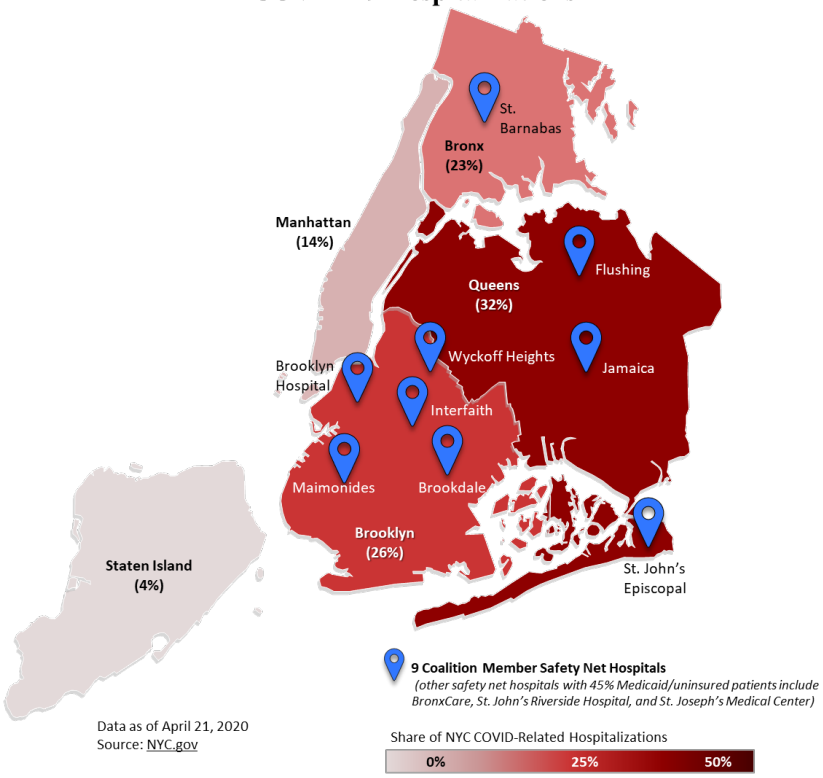
[8] Other hospitals in New York that meet this threshold include BronxCare, St. John's Riverside Hospital, and St. Joseph's Medical Center.

The COVID-19 pandemic exacerbated the financial challenges faced by community safety net hospitals and laid bare significant inequalities that persist across communities of color and low-income neighborhoods, which are an extension of decades of redlining and historical community disinvestment. In New York City, formerly redlined neighborhoods have experienced significantly higher rates of COVID both hospitalizations and deaths. In these neighborhoods:

- The proportion of Black residents is more than nine times higher compared to wealthier neighborhoods (these neighbors also include Latinx and other communities of color),
- Poverty rates are more than three times higher, with approximately 23 percent of residents living below the poverty line; and,
- Rates of uninsurance and poor health outcomes (e.g., obesity) are significantly higher.

As a result of these crises and the structural failures of the current financing system, Coalition members must rely on significant State support to simply remain open to care for their communities, and to keep their healthcare staff employed. It has become clear, however, that these State supports have not provided adequate investment to stabilize these hospitals, let alone enough to fund sustainable transformations for them. As a result, community safety net hospitals are chronically underfunded and often unable to invest in vital infrastructure and new services to better serve their communities. Many facilities are routinely forced to balance the prospects of either reducing services to their communities or closing their doors entirely, either of which would exacerbate disparities and further reduce the availability of quality of care in the very communities where access to care is already strained. The imperative for investment in our hospitals is critical not only for the delivery of healthcare services in communities of color and low-income neighborhoods, but also to the role of these hospitals as anchor institutions that fuel our communities and support economic development.

NY Safety Net Hospital Coalition Members and COVID-19 Hospitalizations



The Inequities in New York's Financing System for Community Safety Net Hospitals Must be Addressed

While we are essential providers of services and anchors in communities throughout New York, our community safety net hospitals are on the verge of reducing services or closing as

a result of longstanding structural inequities in how we are reimbursed and supported. Any reduction in service or loss of our hospitals would exacerbate existing health disparities and further impair access in the very communities where access to care is already constrained. Over time, this flawed system of supports and reimbursement has somehow slowly become "normal" or "acceptable" for these communities. *It is not*.

Key to the structural inequity in the current payment system is the low rates that community safety net hospitals receive from Medicaid. In New York, **Medicaid covers only 67 percent of costs for hospitals**, and pays even less for some services such as inpatient psychiatric care. Rates in Medicaid fall well below those in Medicare fee-for-service, which already does not cover the cost of care. [9,10] Since Medicaid is the single largest payer for community safety net hospitals, these low rates translate into chronic underfunding of our facilities, resulting in low to negative operating margins and few days cash on hand to respond to emergencies and public health crises. While other facilities can cross-subsidize low rates in Medicaid with commercial business, community safety net hospitals see relatively few commercially-insured patients (typically less than 20 percent of the patient mix) and receive comparably lower rates due to their poor negotiating power with commercial payers. In fact, the average commercial rates in Manhattan and the City as a whole are up to seven times higher than the average commercial and Medicaid managed care rates received by our hospitals.[11] This two tier system has exacerbated disparities and forces our hospitals to rely on state financial supports to remain open.

Similarly, due to our chronic underfunding, we lack the creditworthiness to access capital to support needed investments in infrastructure, services and programs, quality improvement, and transformation. This has perpetuated a cycle of disinvestment in our facilities and the low-income communities we serve, resulting in a modern day redlining in communities of color**.** Without access to capital, we are forced to rely on public grant programs that often are insufficient to meet our needs and have resulted in deteriorating infrastructure that does not meet current standards of medical care. Together, our nine hospitals have more than $3 billion in outstanding infrastructure investment needs, including deferred facility upgrades (e.g., Electrical Systems, HVAC, working elevators) and investments in programs (e.g., primary care).

This problem with our current reimbursement system is structural and has resulted in a two-tier health care system that disinvests in low-income neighborhoods and communities of color. This structural problem requires a bold solution that moves beyond incremental near-term fixes that have failed to resolve the root causes. Providing the resources and support for our Coalition members is critical to all for equitable care to be provided to all New Yorker's, including the most underserved, and to begin to reverse the current racial and social inequality in the distribution and availability of health care services in the communities served by these hospitals. Many of New York's most vulnerable residents rely on community safety net hospitals for their healthcare, and it is now critical that the State's healthcare resources be directed to the community

[9] "Statewide Report: New York's Hospitals and Health Systems Improve the Economy & Community," Healthcare Association of New York State, December 2021. Available at: https://www.hanys.org/government_affairs/community_benefit/docs/statewide/statewide.pdf

[10] For example, at two Coalition hospitals Medicaid managed care pays 61 to 71 percent of Medicare fee-for-service.

[11] Manatt Health analysis of Coalition hospital reimbursement rates and Citywide and Manhattan estimated commercial allowed amounts based on data compiled and maintained by FAIR Health, Inc. FAIR Health is not responsible for any of the opinions or conclusions expressed herein. Data (c) 2021 FAIR Health, Inc.

safety net hospitals that serve low-income, immigrants, communities of color, other historically marginalized people.

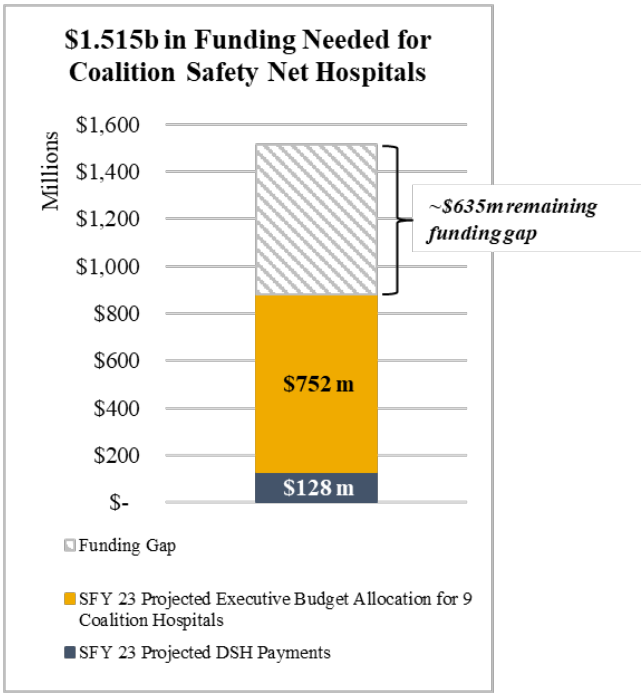
Comment on the SFY 23 Executive Budget

After careful review of the Executive Budget, the Coalition concludes that, while the proposal begins to lay the groundwork for reform, the level of funding provided only serves to perpetuate the inequities in the current financing system for community safety net hospitals. As further described in this testimony, based on a Coalition analysis of the Executive Budget we have concluded that an additional investment of $635m is needed for the nine Coalition hospitals for SFY 23. We believe this investment can be made through an enhanced Directed Payment Program, which would allow the State to maximize FFP, requiring the State to invest up to $400m in additional funding to support our hospitals.

We believe that the State estimates of the funding needed by our hospitals is rooted in the State's current approach of providing funding at levels that only allow our hospitals to remain open, rather than addressing decades of disinvestment and supporting sustainability. Specifically, we believe that the funding estimates that support the Executive Budget proposal fail to address the inequities in the current financing system for the following reasons:

1) **The State and Coalition's goals vary significantly for determining the funding need for each hospital.** The State is focused on the near-term cash need across hospitals with an aim toward controlling on an annual basis the funding necessary for each hospital to achieve breakeven year-end cash balances based on austerity budgets. The Coalition's funding need estimates focus on forecasting the hospitals' need on an accrual basis and targets a 1.7% operating margin – the average in New York State – with an aim toward stabilizing these facilities and providing a modest margin to allow management to support accounts payable and routine maintenance.
2) **The underlying assumptions for the State's funding estimates drive lower funding need estimates for community safety net hospitals compared to the Coalition's estimates.** For example, the State does not factor in cost inflation, while the Coalition's approach does account for it. In addition, while the Coalition's model includes hospital-provided assumptions for revenues and expenses, the State has modified the hospitals' assumptions in its model (e.g., accounting for savings driven by management initiatives, adjusting volume and associated revenues upward, reducing expenses). The State's approach also appears to be inconsistent in accounting for operating and capital investment needs in the models for select hospitals. The State's cash basis methodology recognizes revenues from capital reimbursement, included in the rates intended to allow funding of depreciation, but excludes depreciation expenses, and so provides no funding for community safety net hospitals to maintain and make on-going improvements in their physical plants and thus, improve patient experience.

3) **Most importantly, the divergence of goals and approaches between the State and the Coalition's funding need estimates drive significant differences in the projected level of funding needed for community safety net hospitals.** The Coalition's model estimates that $1.515b in funding is needed across the nine Coalition hospitals in SFY 2023. While the State has not released information on the specific hospital allocations in the Executive Budget, the Budget summary indicates a gross investment of $700m in directed payments per year for four years across a broader class of 18 hospitals with a patient mix of at least 36% Medicaid for IP/OP services. Our understanding is that the State has allocated additional funding for Coalition safety net hospitals through a combination of the new directed payment program and existing programs, totaling $752m in State and Federal funds for SFY 23. However, as shown in the graph, even with $128m in projected Disproportionate Share Hospital payments and the $752m allocation for Coalition hospitals, the level of support for the nine Coalition safety net hospitals still falls short of the need by $635m in State/Federal funding. The State has an opportunity to close this gap by leveraging Federal funding to target enhanced directed payments to Coalition hospitals, which would require up to a $400m investment in State funding depending on the Federal matching rate.



Our Request for the SFY 23 Budget

It is critical that the investments directed to the community safety net hospitals in the **SFY23 Budget** lead to their stability, rather than an extension of providing temporary support that has failed to address the structural failures of the current reimbursement system. ***To this end, the Coalition urges the Legislature to advocate for adequate funding and a sustainable supplemental payment structure that transitions away from focusing on supporting the near-term cash needs across hospitals.*** This demonstrably broken methodology perpetuates disparities by keeping the hospitals and their communities in a subsistence condition and does not aim to provide sufficient margin for the hospitals to move beyond crisis cash management planning and enable them to invest in their services and transformation.

The Coalition urges the Legislature to advocate for a support structure that is reliable and provides an appropriate operating margin to allow these hospitals to meet the needs of the communities that they serve every day. This fundamental transformation is vital for community safety net hospitals to stabilize and build a sustainable future. Without adequate funding, the

Coalition hospitals are unable to reliably plan, prevent service reductions and closures, and invest in their services, programs, and transformation.

***In order to achieve these goals, the Coalition calls on our partners in the Legislature to*:**

- **Increase SFY23 Dedicated Operating Support for Coalition safety net hospitals**. Ensure that the One House and Enacted SFY23 Budgets close the gap in necessary operating funding for Coalition safety net hospitals in SFY23 by dedicating an additional $400 million in state funds to community safety net hospitals serving high volumes of Medicaid patients. This level of additional funding requested in the Enacted SFY23 Budget will provide sufficient margin for the hospitals – 1.7 percent, the average in New York – to stabilize and build a sustainable future focused on meeting the needs of the communities they serve.

- **Commitment to Structural Reimbursement Reform**. The Coalition urges the Legislature to work with the Executive to adopt a set of sustainable, long-term solutions adequate to meet the needs of the Coalition members and the communities they care for.

Safety Net Hospital Funding

The Coalition sought **$1.5 billion** in operating funding (state and federal) in the SFY23 Executive Budget to allow our nine Coalition hospitals to begin to move away from crisis cash-management starvation diets, to a more stable and equitable provision of healthcare. The Coalition supports, and is greatly appreciative of, the Executive's allocation of $2.8 billion (gross) over four years in payments directed to safety net hospitals, including the $250 million Distressed Provider Assistance Account, a $100 million distressed hospital pool, and a three-year $1 billion (state share, over three years) "transformation and sustainability" health care reserve fund. However, the Executive's allocation of $2.8 billion (gross) over four years in payments directed to community safety net hospitals,[12] falls short of this request, and continues to provide just enough money for our hospitals to barely get by, perpetuating a broken payment system, and failing to provide any real opportunity for necessary transformation.

This funding amounts to only **$700 million per year** gross (state and federal) in operating support for a broader class of broader class of 18 hospitals with a patient mix of at least 36 percent Medicaid for IP/OP services (compared to our 45 percent threshold). As a result, there is a significant funding gap for Coalition safety net hospitals, which serve an even more significant share of Medicaid and uninsured patients (45 percent and higher of their patient mix).

After accounting for Disproportionate Share Hospital payments and the projected Executive Budget allocation for the Coalition hospitals, **the remaining funding need totals $635m (state and federal).** Due to the opportunity to utilize federal match through the proposed Directed Payment Program, the net increase in State funding needed for operating support for Coalition hospitals totals **approximately $400m for the nine Coalition hospitals**.

[12] Inclusive of the $250 million Distressed Provider Assistance Account and $100 million investment in distressed hospital pool.

This year, this gap can be addressed by allocating funds included in the $1 billion "Transformation and Sustainability" Health Care Reserve Fund[13] to Coalition hospitals to stabilize and fund their transformation initiatives. Specifically, the State has an opportunity to close the gap in required operating support for Coalition safety net hospitals by dedicating ***$400 million of state funds*** this year from the "Reserve Fund" for safety net hospitals serving 45 percent or more of Medicaid patients. State funds used for this purpose can leverage Federal funding to target enhanced directed payments to Coalition hospitals. Since the Coalition hospitals have in the past supported efforts to drive savings in the Medicaid program through the DSRIP program and other restructuring and transformation actions, in many ways our request for additional support is also an ask for the State to reinvest those savings back into our facilities.

The Coalition supports the investments in safety net hospitals proposed in the SFY23 Executive Budget; however, it is evident that more is needed in order to address decades of divestment that has resulted in clear health disparities in the communities served by Coalition members and further exacerbated by the impacts of the COVID-19 pandemic. Specifically, the Budget proposal does not adequately address the operating needs of our Coalition hospitals serving communities with a significant share of Medicaid and uninsured patients (45 percent and higher of their patient mix), ***and leaves a state funding gap of approximately $400 million in necessary operating support in SFY23 for our hospitals.***

Medicaid Rate Increases

The Coalition supports the Executive's proposal to eliminate the 1.5 percent Medicaid across-the-board cut for all providers and increase the Medicaid rate for all providers by 1 percent; and to eliminate the 1.5% Medicaid cut implemented in 2020. As providers that primarily serve the Medicaid population, the Coalition supports efforts to increase Medicaid rates to more appropriately reflect to the cost of care and adequately reimburse providers. However, it is important to recognize that that Medicaid rates have remained stagnant for the last 14 years, the increased rate applies to all providers, regardless of financial position or payer source, and continues to fail to come close to covering the cost of care even as medical cost inflation continues to rise. As Medicaid serves as the payer for over 40 percent of New York's population, with over 7 million enrollees, the need for Medicaid reimbursement rates to reflect the cost of care is more critical than ever.

The Coalition supports the Executive's proposal to restore and increase Medicaid rates, and supports the continued investment in Medicaid through increased Medicaid rates.

Healthcare Capital Funding

The Coalition supports the Executive's proposal to provide $1.6 billion in capital funding for healthcare providers, which includes an increase in the amount for funding in the Statewide Transformation Program and capital to ensure provider financial sustainability. As safety net providers who operate without any profit margin, Coalition members are unable to demonstrate

[13] The Budget creates a three-year $1 billion (state share, over three years) "transformation and sustainability" health care reserve fund.

creditworthiness and access capital from financial markets for necessary capital expenditures. Facing aging physical plans, with deteriorating infrastructure and inadequate facilities, our members rely on State capital support as the only source of funding available to undertake critical infrastructure projects (e.g., HVAC, equipment, elevators) to provide equitable quality care and patient experience. A dedicated program for safety net hospitals that provides regular access to critical capital is essential to reverse the current two-tier health system.

The Coalition supports the Executive's healthcare capital investment and encourages the Legislature to consider establishing capital support mechanisms for providers with limited access to capital from the financial markets and other sources.

Health Care Worker Bonuses

The Coalition supports the Executive's proposal to provide $1.2 billion in bonuses of up to $3,000 for health and mental hygiene workers earning less than $100,000 per year. The Coalition supports improving the pay of our health care workers and believes that this proposal will improve the recruitment and retention of healthcare workers at our Coalition member hospitals. As all hospitals face the increased costs to for staffing, the proposal assists our Coalition members to compensate staff in a manner that our reimbursement rates could not support.

The Coalition supports the Executive's focus and investment on our hard-working healthcare workforce.

Conclusion

The New York Coalition of Essential/Safety Net Hospitals urges the Legislature to seize the opportunity to correct for decades of disinvestment in our community safety net hospitals and the marginalized New Yorkers we serve. As described in this testimony, providing adequate funding and a sustainable payment structure will stabilize our facilities and enable us to shift from crisis cash management to investment in our services and innovative programs. Most importantly, this investment will make a real difference in the lives of our patients and communities by ensuring that we are able to not only just remain open, but to invest in new programs/services responsive to communities' health needs with the levels of staffing and in environments that all patients deserve. Given that most of our patients are low-income and from communities of color, this level of investment will also help New York make significant progress toward addressing health equity. We appreciate your support and look forward to working together on this important cause.