SFY 2025-26 Joint Legislative Budget Hearing—Health

Assembly Ways and Means, Assembly Health, Senate Finance, and Senate Health Committees

February 11, 2025

Kenneth E. Raske, President

GREATER NEW YORK HOSPITAL ASSOCIATION

Committee Chairs and Members, thank you for the opportunity to testify today. I am Kenneth E. Raske, President of the Greater New York Hospital Association (GNYHA). GNYHA represents not-for-profit and public hospitals, health systems, and continuing care providers, including 170 hospitals and health systems and 54 continuing care facilities in New York State.

For the past year, GNYHA and 1199SEIU United Healthcare Workers East, through the Healthcare Education Project, have conducted the "Medicaid Equity Now" campaign to ensure that 1) New York State fully funds the cost of care for Medicaid enrollees in hospitals and 2) health disparities in low-income communities are reduced and ultimately eliminated. This campaign is crucial because New York State's Medicaid program currently pays hospitals 30% less than the actual cost of the care they provide for Medicaid beneficiaries. These chronic underpayments have pushed more and more hospitals across the State—especially safety net hospitals serving our most vulnerable populations—to the financial brink.

New York's hospitals have among the lowest margins of any hospitals in the country. Ending their Medicaid payment rate shortfall is imperative to reducing health care disparities and improving health outcomes for low-income communities.

As we sit here today, Congress is considering hundreds of billions of dollars in Medicare cuts to health care providers, as well as significant Medicaid reductions, in the Federal budget negotiations. Executive actions by the Trump administration threaten to freeze critical funding our institutions depend on for survival. Given these unprecedented threats from Washington, DC, it is more important than ever for New York State to meet its responsibility to fund Medicaid at the cost of care and protect access to care for its most vulnerable citizens.

Last year, the State Legislature took an essential first step toward addressing this problem by providing a $200 million hospital investment and a $150 million nursing home investment. Critically, the budget also directed the Governor to pursue a Managed Care Organization (MCO) tax mechanism to generate additional revenue for investments in the State's health care system. I commend Governor Hochul for pursuing the MCO tax mechanism and working with the Federal government to approve a plan that will generate approximately $3.7 billion in net revenues for New York State over the next two years. The Governor's proposed State Fiscal Year (SFY) 2025-26 budget continues the hospital and nursing home rate increases from last year's budget, with additional investments, including in a new hospital quality pool. I appreciate Governor Hochul and the Legislature's work to advance these first steps towards fixing longstanding Medicaid underpayments.

However, far more needs to be done. The hospital rate increases in last year's budget have yet to be paid, and when they are, they will only match inflation—not close the Medicaid payment gap. The Legislature must therefore strengthen the Governor's budget proposal and provide additional resources to increase Medicaid rates for hospitals and nursing homes. GNYHA and 1199SEIU advocated fiercely in Washington, DC, for Federal approval of the MCO tax to provide revenue

for New York to strengthen the State's health care system. But instead of using $500 million of MCO tax revenue for each of the next two years to provide general fund relief through Medicaid Global Cap offsets (the Governor's current proposal), revenue should be dedicated to support the health care system and bring hospital and nursing home Medicaid rates closer to covering costs. In addition, the State should:

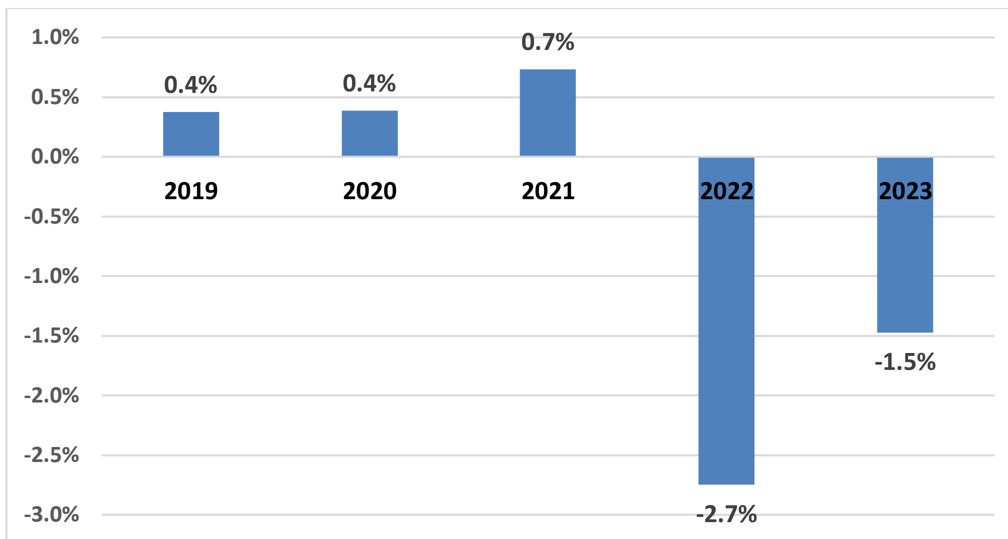
- Restore the proposed $500 million cut to the Vital Access Provider Assurance Program (VAPAP) and boost VAPAP funding. Financially challenged safety net hospitals desperately need this funding.
- Stabilize and keep open the Medical Indemnity Fund (MIF), which funds the health care needs of neurologically impaired individuals.
- Ensure that giant, national, for-profit health insurance companies pay their fair share of health care costs and do not inappropriately deny or delay payment for necessary health care.

The challenges and risks to New York's hospitals have never been steeper. They cannot continue to incur massive losses from providing care to our most vulnerable citizens. I look forward to continuing to work with the Legislature to secure the funding our hospitals need to provide high-quality care for all New Yorkers.

Financial Condition of Hospitals

New York hospitals continue to experience financial distress as they recover from the COVID-19 pandemic. As I have discussed in past years, the main cost drivers include workforce challenges (both supply and labor costs) and pressures from rising pharmaceutical and supply costs. Hospital revenues simply are not keeping pace with these rising costs. The chart below shows New York hospitals' financial performance trends over the past five years, including significant Federal COVID-19 financial relief (especially in 2020 and 2021) and State financial assistance from the various distressed hospital/safety net programs.

Chart 1. Median Operating Margin, New York Hospitals (2019-2023)



Source: GNYHA analysis of NYS Institutional Cost Reports.

Both the persisting negative margins and the percentage of hospitals in financial distress are deeply concerning. In 2022 and 2023, three out of five New York hospitals experienced losses (63% and 59%, respectively), up from 42% in 2021. Nationally, New York hospitals also continue to be among the lowest-performing financially, ranking from 47th to 51st from 2011-2022. New Yorkers deserve better, and with additional investments in Medicaid reimbursement rates, we can improve our hospitals' financial health.

Chronic financial problems also translate into poor access to capital. It is widely recognized that hospitals require an operating margin of at least 3% to have the resources to reinvest in their infrastructure, including building maintenance/upgrades and information technology. According to the latest survey from "Definitive Healthcare," New York's average plant age is 16.9 years old, compared to 13.3 years nationally.

Despite their challenging financial condition, hospitals make enormous contributions to their communities. We encourage legislators to review a new GNYHA-commissioned report from Ernst & Young LLP (Attachment A), which found that New York City voluntary hospitals provided $9 billion in community benefits in 2022, representing 17.9% of their operating expenses. This is notably higher than the national average of 10.1% in 2021, the most recent year that national data is available. New York hospitals will continue to invest in and care for our communities, not only as employers and engines of their local economies, but as the only provider of 24/7 services 365 days a year for all who walk through our doors, regardless of income.

Addressing Medicaid Underfunding and Ensuring Health Care Equity

The Medicaid program is essential by any measure, but decades of chronic underfunding and inadequate Medicaid payment rates have placed the majority of our health care providers in an increasingly precarious financial state. As previously mentioned, New York's Medicaid program reimburses hospitals at 30% less than the actual cost of delivering care—a direct consequence of years of disinvestment in a program covering almost 40% of New Yorkers. In 2021 alone, New York's disproportionate share hospitals (DSH) reported losing nearly $8 billion from treating Medicaid patients (including dual-eligibles), representing 87% of their reported uncompensated care for Medicaid DSH purposes (i.e., losses from treating Medicaid and uninsured patients).

This is why the GNYHA/1199SEIU Healthcare Education Project's ongoing "Medicaid Equity Now" campaign is so important. We are grateful that the Legislature has stood with us and that many of you took the Medicaid Equity Pledge. Because of this commitment, the SFY 2024-25 budget included new "one-time" Medicaid investments for hospitals ($200 million) and nursing homes ($150 million). (The Governor's proposed SFY 2025-26 budget continues these investments.) We understand that the hospital funding will be invested in a 10% outpatient rate increase, as well as increases in the maternal health quality program, rural hospitals, and the Safety Net Transformation Program. While this funding has yet to be released, we remain optimistic that the New York State Department of Health (DOH) will soon share their distribution plans. Nursing homes have already received the State share of their funding (an across-the-board per day increase), with the release of the Federal share pending Centers for Medicare & Medicaid Services approval.

The MCO tax, which the Biden administration approved in December 2024, was a significant policy achievement in last year's budget. It enables the State to generate an estimated $3.7 billion over the next two years in new revenue to address Medicaid equity gaps and invest in the Medicaid program through the Healthcare Stability Fund. GNYHA members are deeply grateful to the Legislature and Governor Hochul for securing this essential funding.

Building on Last Year's Budget: Healthcare Stability Fund Investments

The MCO tax proceeds will be deposited into the Healthcare Stability Fund to enable additional investments over the next three years to enhance quality and improve Medicaid payment rates. For hospitals, the Governor also proposes a new $125 million quality pool to incentivize high-quality care to Medicaid beneficiaries and the provision of safety net services such as maternity care, trauma care, and psychiatric services. The budget would also add a $50 million nursing home investment. While these proposals are welcome and appreciated, they do not go far enough in closing the Medicaid reimbursement gap for our hospitals and nursing homes. Other proposed investments include additional funding for the Safety Net Transformation Program (discussed below), a Medicaid physician fee schedule increase, and payments to Federally Qualified Health Centers.

GNYHA supports the Consumer Directed Personal Assistance Program (CDPAP) reforms adopted in the SFY 2024-25 budget that would implement a single fiscal intermediary beginning April 1.

This will strengthen the Medicaid program not only for the 250,000 CDPAP recipients and their caregivers, but for the nearly 7 million other New Yorkers who rely on the Medicaid program and its providers for their health care. My op-ed on this program, published in the *Times Union* last week, is attached (Attachment B).

We are troubled by the Governor's proposal to use $500 million of MCO tax proceeds in SFY 2025-26 and SFY 2026-27 to address the State's Medicaid Global Cap deficit. That would siphon away substantial MCO tax proceeds over the next two years that could instead be used to increase Medicaid reimbursement rates for hospitals and nursing homes—a far more pressing need given that 59% of New York hospitals are in financial distress. We are also concerned that the proposed Healthcare Stability Fund investments are contingent on MCO tax revenues. The State continues to be in a historically strong financial position, with more than $45 billion in cash reserves. Healthcare Stability Fund investments should be made regardless of MCO tax revenues.

Safety Net & Distressed Hospital Funding

The Governor's proposed budget continues the State's $3 billion "base" investment in financially distressed hospitals, critical access hospitals, and facilities receiving VAPAP funding. This crucial funding supports 75 hospitals in rural and underserved areas, ensuring that access to care is preserved in communities with scarce health care resources. In addition, the budget supports the 1115 Medicaid waiver's global budget demonstration program for downstate safety net hospitals that serve high volumes of Medicaid patients.

Alarmingly, as mentioned above, the Governor's proposed SFY 2025-26 budget eliminates $500 million in supplemental VAPAP funding. VAPAP funds are critical to hospitals struggling to meet essential financial obligations. Without these funds, many hospitals will be forced into impossible decisions about which bills to pay, further hindering their ability to invest in expanded services, staff, or capital infrastructure improvements. We urge the Legislature to restore this funding to ensure that patient care is not impacted.

Safety Net Transformation Program

The Safety Net Transformation Program seeks to improve safety net hospitals' financial sustainability by supporting collaborations between safety net hospitals and a partner (either a health system or other provider partner). DOH has already received about 30 Letters of Interest this year, and the Governor recently awarded seven projects across the State based on SFY 2024-25 investments. The State proposes to increase its investment by $300 million in operating support (annual investment over the next three years from the Healthcare Stability Fund) and $1 billion in dedicated capital funding. GNYHA strongly supports these investments and believes the program can improve the financial sustainability of safety net hospitals while also improving health care quality and access for New Yorkers.

Troubling Headwinds from Washington, DC

The State budget process is challenging enough in the best of circumstances. Unfortunately, this year's State budget deliberations coincide with a period of tremendous uncertainty and upheaval in Washington, DC. In just the first three weeks of the Trump Administration, we have seen a

wave of executive orders and policy reversals that seriously threaten vital Federal funding for our member hospitals and not-for-profit nursing homes.

Equally troubling, congressional Republicans appear poised to advance sweeping legislation that could result in huge Medicaid reductions and Medicare provider cuts to offset the cost of tax, budget, immigration, and other non-health care priorities that could total trillions of dollars. Proposals being discussed include establishing Medicaid per capita caps that cap payments to states at a fixed cost per enrollee, reducing the Federal Medicaid assistance percentage (or FMAP) either for the "expansion" population or for the entire program, and limiting provider taxes. Other proposed Medicaid reforms could include restricting beneficiary eligibility or imposing work requirements. These proposals threaten not only Federal support for New York's Medicaid program, but also health insurance coverage for the 7 million New Yorkers enrolled in Medicaid.

Congress is also considering a series of Medicare cuts that would directly impact New York's hospitals. These include Medicare "site-neutral" cuts that would slash hospital reimbursement for outpatient services to match the lower rates paid to physician offices. GNYHA strongly opposes site-neutral cuts because hospitals and doctors' offices are not the same. Hospitals provide 24/7 care, accept all patients regardless of their ability to pay, and are equipped to handle major disasters, while adhering to stringent regulatory requirements—factors that both necessitate and justify their higher reimbursement rates.

Large-scale reforms to Medicare support for graduate medical education—payments that New York's hospitals depend on to train the next generation of physicians—are also on the table, as are cuts to Medicare funding for hospital uncompensated care. Washington may also modify the 340B Drug Pricing Program, a critical program for safety net providers that enables them to purchase prescription drugs at discounted prices. We have already seen disturbing advertisements that criticize the 340B program for subsidizing health care for immigrants and gender-affirming surgery for children, likely in hopes of securing Republican support for gutting the program.

If these Federal threats become reality, New Yorkers will lose access to quality health care services and the State will face huge deficits. Hospitals, nursing homes, and clinics will be forced to cut staff, eliminate or reduce services, or even close. In response, the GNYHA/1199SEIU Healthcare Education Project has launched a statewide campaign highlighting the importance of Federal Medicaid funding and the severe harm these proposals would inflict on New Yorkers.

Other Issues of Importance in the Executive Budget

Medical Indemnity Fund (MIF)

The MIF was established in 2011 to cover future medical costs for individuals with birth-related neurological injuries while reducing medical malpractice premiums for providers. New York must continue investing in this State-run program to ensure its sustainability and protect the interests of affected families and health care providers. However, the Executive budget proposal does not include additional funding for the MIF, despite the program briefly closing to new enrollees last year due to financial strain. This abrupt closure created instability and threatened the benefits on which many hospitals and families rely.

A fundamental principle of the MIF is that not all birth-related injuries result from negligence. Before the MIF was created, hospitals that provided birthing services ended up bearing the full

cost of lifetime health care for these individuals despite the complicated nature of the causality of these injuries. This created extreme and unpredictable financial exposure for these facilities, many of which are safety net hospitals serving low-income communities. These costs contributed to the challenges of maintaining access to maternity services in all communities throughout the State. The MIF has been critical to mitigating the extreme financial cost associated with providing maternity services.

Despite rising costs, the State's financial commitment to the MIF has remained stagnant. The initial appropriation in 2011 was $30 million, with anticipated appropriations of $100 million annually by year three. However, apart from this year's additional $58 million deposit, the State has never allocated more than $52 million in a year. The State's tax on inpatient obstetrical revenue (OB tax) has sometimes been erroneously described as a funding source for the MIF. However, the statutory purpose and the original intent of the OB tax is to fund quality improvement programs to improve birth outcomes. This tax was never meant to be the source of funding for the MIF, nor would it be sufficient. Due to delays in actuarial reports, it is unknown how much funding is required this year. GNYHA stands ready to work with the Governor and Legislature on a permanent solution to ensure the MIF remains solvent and enrollment is not suspended again.

Health Insurance Company Abuses

In addition to the budgetary issues, I urge the Legislature to adopt comprehensive reforms this year to curb health insurance company abuses that harm both patients and providers (see Attachment C). Unfortunately, insurance companies often have the final say on whether a procedure is covered. According to the Kaiser Family Foundation, 16% of insured adults reported prior authorization delays. In addition, New York State Division of Financial Services data reveals that New York's commercial health insurance plans denied approximately 23% of all inpatient hospital claims in 2022 and 25% in 2023.

These denials—rejecting coverage for care deemed medically necessary by trusted providers—boost insurers' already massive profits while shifting costs onto consumers and hospitals. Governor Hochul announced in her State of the State proposals that she would direct DOH to review network adequacy standards and increase enforcement of plan compliance. GNYHA supports this proposal, but Albany must do more to curb health insurers' abusive behavior. The State should implement common-sense insurance reforms to protect both patients and health care providers. Together, we can advance consumer protections and improve transparency into the insurance industry's influence over health care pricing, coverage decisions, and claim denials.

Workforce

The Governor proposes several workforce initiatives, including:

- Allowing New York State to join the Interstate Nurse Licensure Compact.
- Allowing PAs to practice more independently and allowing supervised medical assistants to administer immunizations in an outpatient office.
- Allowing supervised, certified medication aides in residential health care facilities to administer routine medications.
- Allowing paramedics to administer buprenorphine and COVID-19 vaccines to adult patients.

GNYHA strongly supports these measures, which will help hospitals hire and retain qualified health care workers as they confront a historic workforce shortage. GNYHA also urges the Legislature to pass legislation authorizing New York to join the Interstate Medical Licensure Compact, which would streamline the licensure process for physicians and enable qualified professionals from 42 states and jurisdictions to practice in New York.

A detailed table outlining all budget provisions of interest to hospitals and nursing homes is attached to this testimony. Thank you for the opportunity to share this testimony with you. I am happy to answer any questions you may have.

Attachment A

2022 New York City not-for-profit hospitals' community benefits analysis

January 2025

Building a better working world

This page left intentionally blank.

Executive Summary

The New York City not-for-profit hospital sector is organized as 16 acute care hospitals and systems[1], excluding public hospitals, which are not required to file an Internal Revenue Service (IRS) Form 990. These not-for-profit entities conduct research, educate current and future medical professionals, improve their communities' health and well-being, and provide healthcare services regardless of patients' ability to pay. As part of their not-for-profit mission, in 2022 New York City hospitals provided $9 billion in community benefits, including absorbing a $4.1 billion cost in financial assistance and other care to means-tested populations and $4.9 billion in other benefits, such as community health improvement, health professions education, research, and subsidized health services. On average, this accounted for 17.9% of their total hospital expense, which is higher than the national average of 10.1%[2]. In addition, New York City hospitals provided an additional $1.6 billion to the community through community building activities, by forgoing collection on bad debt attributable to financial assistance, and Medicare shortfalls. This represents an additional 3.1% of their total expenses.

Hospitals' Benefits to the Community

Many of the benefits that hospitals provide to their communities are captured by Internal Revenue Service (IRS) Form 990 Schedule H. The Schedule H contains community benefits programs recognized by both government and industry health professionals. Hospitals provide financial assistance and absorb underpayments from means-tested government programs such as Medicaid. In addition, they offer programs and activities to:

- Improve community and population health
- Underwrite medical research and health professions education
- Subsidize high-cost essential health services

At the request of Greater New York Hospital Association (GNYHA), Ernst & Young LLP (EY) reviewed GNYHA's member hospitals' Form 990 Schedule Hs for tax year 2022. Schedule Hs were provided for all New York City member not-for-profit hospitals.

This summary of 2022 Schedule Hs reports the financial costs and forgone revenue incurred by acute care hospitals and systems in providing these community benefits, but does not measure the overall tangible and intangible benefits of improving their communities' health and economic well-being. Hospitals provided the IRS with detailed descriptions of their community benefit programs as part of their filing. These descriptions often provide additional information beyond the financial information presented on the form.

Methodology

Data was collected and tabulated for the following sections of the Schedule H form:[3]

- Part I line 7a-k on financial assistance and certain other community benefits (these are the traditional community benefit items)
- Part II line 10
- Part III lines 3 and 7 on bad debt and Medicare

Data reported on New York City not-for-profit hospital Schedule Hs are reported at the hospital or hospital system level. Part I, II, and III responses are reported to the IRS as a percentage of hospitals' or systems' total annual expenses. Overall net expense for community benefit programs was calculated and compared to aggregate total hospital expense.

Community Benefits

In 2022, hospitals and systems reported an average of 17.9% of their total annual expense as providing benefits to the community. Benefits to the community include financial assistance, Medicaid and other means-tested government program underpayments, community health improvement services, research, health professions education, cash and in-kind contributions for community benefits, and subsidized health services. These are the financial costs or foregone revenue incurred by hospitals in providing these community benefits, but they do not necessarily reflect the value of these services to communities.

Table 1 shows the average percentage of total expense disaggregated to correspond to Part I the Schedule H form:

Table 1. Hospitals' benefit to the community, by type of benefit
Net expense in millions of dollars

	Percent of Total Hospital Expense		Net Expense ($M)
Part 1 Line 7 Community Benefit Percentages			
7a. Financial Assistance at cost	1.06%	$	532.7
7b. Medicaid	7.08%	$	3,549.9
7c. Costs of other means-tested government programs	0.01%	$	4.8
7d. Total Financial Assistance and Means-Tested Government Programs (categories a-c above)	8.15%	$	4,087.3
7e. Community health improvement services and community benefit operations	0.65%	$	323.7
7f. Health professions education	4.84%	$	2,427.5
7g. Subsidized health services	2.55%	$	1,279.7
7h. Research	1.34%	$	671.5
7i. Cash and in-kind contributions for community benefit	0.36%	$	179.5
7j. Total "other benefits" (categories e-i above)	9.73%	$	4,881.9
7k. Total (Lines 7d and 7j)	17.88%	$	8,969.3

Note: Figures may not appear to sum due to rounding.
Source: EY tabulations of New York City hospitals' Form 990, Schedule Hs, 2022.

New York City not-for-profit hospitals provided $4.1 billion in assistance to means-tested populations (line 7d in Table 1), accounting for 8.1% of total hospital expense. They provided an additional $4.9 billion in other community benefits (line 7j in Table 1), including health professional education, subsidized health services, research, community health improvement, and cash and in-kind contributions for community benefits, which together accounted for an additional 9.7% of total hospital expense. The total financial assistance, means tested, and other community benefits was $9 billion (line 7k in Table 1), accounting for over 17% of total hospital expenses.

Non-traditional Community Benefits

Although not typically included in analyses of community benefits, the bad debt expense attributable to financial assistance and the losses from Medicare shortfalls represent the cost of services for which the hospitals are not compensated. As such, they are similar to the list of items in the traditional set of community benefits. In addition, community building activities address community unmet health needs. New York City hospitals provided an additional $1.6 billion to the community through these non-traditional community benefits.

Bad Debt Expense Attributable to Financial Assistance

In 2022, New York City hospitals reported $46.2 million in bad debt expense attributable to financial assistance, accounting for 0.1% of their total expenses. This category represents amounts owed by patients who qualified for financial assistance under the hospital's charity care policy. Most hospitals report that this portion of bad debt expense should be included as community benefits.

Medicare Shortfall

Medicare reimbursement shortfalls occur when the Federal government reimburses hospitals less than their costs for treating Medicare patients. The net shortfall[4] in 2022 accounted for an average 3% of total hospital expense, with a total net shortfall of $1.5 billion across all the hospitals studied.

On their Schedule Hs, most hospitals described why their Medicare shortfall should be treated as community benefit:

- Non-negotiable Medicare rates are sometimes out of line with the true costs of treating Medicare patients.
- By continuing to treat patients eligible for Medicare, hospitals reduce the public-sector burden related to funding medical care. The IRS has acknowledged that lessening the government burden associated with providing Medicare benefits is a charitable purpose.[5]
- Additionally, hospitals pointed to IRS Rev. Rul. 69-545 in their explanation of Medicare shortfall as a community benefit. IRS Rev. Rul. 69-545 states that if a hospital serves patients with government health benefits, including Medicare, then this is an indication that the hospital operates to promote the health of the community.

Community-Building Activities

In 2022, hospital systems and individual hospitals spent 0.02% of their total expenses on community-building activities, for a total of $11.1 million. Community-building activities take many forms, including:

- Hospital employees report participating on the state Board of Health, in regional health departments and neighborhood community relations committees, and with university and other school partnerships;
- Environmental improvements such as alleviation of water or air pollution, safe removal or treatment of garbage or other waste products, and other activities to protect the community from environmental hazards;
- Workforce development programs such as recruitment of health professionals.

These activities often promote regional health by offering direct and indirect support to communities with unmet health needs. These include patients who are indigent, uninsured, underprovided for, or geographically isolated from health care facilities.

Appendix 1 – Details by EIN

Below are the community benefit details provided on an EIN basis.[6]

EIN	Hospital Name	Total Financial Assistance and Means-Tested Government Programs Line 7d		Total Other Benefits Line 7j		Total Community Benefits Line 7k		Total Non-traditional Community Benefits Part II, Part III, Line 3, 7	
	(net expenses in $M, % total hospital expense)	*Expense*	*%*	*Expense*	*%*	*Expense*	*%*	*Expense*	*%*
131974191	BronxCare Health System	$ 17.2	1.96%	$ 114.1	13.01%	$ 131.3	14.97%	$ 18.7	2.14%
111665825	Episcopal Health Services	$ 23.3	7.03%	$ 37.5	11.33%	$ 60.9	18.36%	$ 10.5	3.15%
111631781	Flushing Hospital Medical Center	$ 34.0	10.19%	$ 55.8	16.71%	$ 89.9	26.90%	$ 7.0	2.05%
131624135	Hospital for Special Surgery	$ 46.1	3.12%	$ 100.4	6.81%	$ 146.5	9.93%	$ 78.4	5.46%
111631788	Jamaica Hospital Medical Center	$ 57.4	8.07%	$ 133.2	18.73%	$ 190.6	26.80%	$ -	0.00%
131624070	Lenox Hill Hospital	$ 123.6	7.08%	$ 131.7	7.54%	$ 255.4	14.62%	$ 88.6	5.06%
112241326	Long Island Jewish Medical Center	$ 381.9	9.90%	$ 267.7	6.93%	$ 649.5	16.83%	$ 61.9	1.64%
111635081	Maimonides Medical Center	$ 105.7	6.97%	$ 120.0	7.91%	$ 225.7	14.88%	$ 0.5	0.03%
111986351	Maimonides Midwood Community Hospital	$ 22.7	17.40%	$ 1.7	1.30%	$ 24.4	18.70%	$ 12.9	9.93%
912154267	Memorial Sloan Kettering Cancer Center	$ 252.3	3.69%	$ 559.0	8.15%	$ 811.4	11.84%	$ 609.8	8.90%
131740114	Montefiore Medical Center	$ 557.6	11.70%	$ 425.6	8.93%	$ 983.2	20.63%	$ 3.0	0.06%
135564934	Mount Sinai Beth Israel / Brooklyn	$ 102.6	9.40%	$ 111.2	9.89%	$ 213.8	19.29%	$ 43.7	3.72%
131624096	Mount Sinai Hospital	$ 425.2	11.79%	$ 341.4	9.47%	$ 766.6	21.26%	$ 42.0	1.16%
132997301	Mount Sinai Morningside / West	$ 160.0	10.16%	$ 133.8	8.78%	$ 293.8	18.94%	$ 64.6	3.98%
135562304	New York Eye and Ear Infirmary of Mount Sinai	$ 15.3	10.60%	$ 6.8	4.73%	$ 22.2	15.33%	$ 3.9	2.72%
111631796	NewYork-Presbyterian Brooklyn Methodist Hospital	$ 96.8	12.24%	$ 111.1	14.04%	$ 207.9	26.27%	$ 0.0	0.00%
133957095	NewYork-Presbyterian Hospital	$ 836.2	9.79%	$ 940.3	11.00%	$ 1,776.6	20.79%	$ 159.3	1.86%
111839362	NewYork-Presbyterian Queens	$ 71.5	7.37%	$ 178.9	18.44%	$ 250.5	25.82%	$ 0.2	0.02%
133971298	NYU Langone Hospitals	$ 437.4	6.55%	$ 675.7	10.11%	$ 1,113.1	16.66%	$ 318.7	4.77%
111631746	One Brooklyn Health System	$ 168.1	14.60%	$ 164.5	14.30%	$ 332.6	28.90%	$ 5.7	0.50%
743177454	Richmond University Medical Center	$ 14.8	3.72%	$ 38.0	9.53%	$ 52.8	13.25%	$ 1.4	0.36%
131740122	St. Barnabas Hospital	$ 3.5	0.70%	$ 65.9	13.16%	$ 69.4	13.87%	$ -	0.00%
112868878	Staten Island University Hospital	$ 103.4	7.75%	$ 83.8	6.30%	$ 187.2	14.05%	$ 24.0	1.80%
111630755	The Brooklyn Hospital Center	$ 1.2	0.26%	$ 42.1	9.43%	$ 43.2	9.69%	$ 1.7	0.38%
111631837	Wyckoff Heights Medical Center	$ 29.3	7.55%	$ 41.7	10.77%	$ 71.0	18.32%	$ 3.7	0.96%

Appendix 2 – Community Benefit Descriptions

On the IRS Form 990, Schedule H, all net benefit expenses are calculated on a cost basis, rather than a charge basis. For details on the calculations, please see the instructions for the Schedule H. Below are short descriptions of each of the community benefit items:

1. Financial Assistance at cost: Free or reduced-price care provided to individuals who qualify for the hospital's financial assistance policy. Expense is net of any offsetting revenue (e.g., payments received from an uncompensated care pool or disproportionate share hospital [DSH] program in the organization's home state are intended primarily to offset the cost of financial assistance).
2. Medicaid: This is the uncompensated cost of providing care to Medicaid patients. This is on a cost basis, so if a hospital charges $1,000 for a procedure that costs the hospital $500 to perform and Medicaid only pays $300 for the procedure, the shortfall is $200, meaning the hospital loses $200 for performing the procedure rather than the loss of revenue.
3. Costs of other means-tested government programs: This is similar to Medicaid but is for other government-sponsored programs provided at the state and local levels; "means-tested government program" is a government health program for which eligibility depends on the recipient's income or asset level.
4. Community health improvement services and community benefit operations: Activities or programs, subsidized by the health care organization, carried out or supported for the express purpose of improving community health. Such services don't generate inpatient or outpatient revenue, although there may be a nominal patient fee or sliding scale fee for these services. Marketing activities are not included.
5. Health professions education: Educational programs that result in a degree, a certificate, or training necessary to be licensed to practice as a health professional, as required by state law, or continuing education necessary to retain state license or certification by a board in the individual's health profession specialty. It doesn't include education or training programs available exclusively to the organization's employees and medical staff or scholarships provided to those individuals. However, it does include education programs if the primary purpose of such programs is to educate health professionals in the broader community.
6. Subsidized health services: Clinical services provided despite a financial loss to the organization. To qualify as a subsidized health service, the organization must provide the service because it meets an identified community need.
7. Research: Research means any study or investigation the goal of which is to generate increased generalizable knowledge made available to the public. The organization cannot include direct or indirect costs of research funded by an individual or an organization that isn't a tax-exempt or government entity.
8. Cash and in-kind contributions: Contributions made by the organization to health care organizations and other community groups restricted, in writing, to one or more of the community benefit activities noted above.
9. Community building activities: Includes community building activities that promote the health of communities served, including physical improvements and housing, economic development, community support, environmental improvements, leadership development/training of community members, coalition building, community health improvement advocacy, and workforce development.
10. Bad debt attributable to financial assistance: The estimated amount of the organization's bad debt expense that can be attributed to patients eligible under the organization's financial assistance policy. Requires an explanation of the methodology used to estimate and the rationale, if any, for including this as a community benefit.
11. Medicare shortfall: This is the uncompensated cost of providing care to Medicare patients. This is on a cost basis, so if a hospital charges $1,000 for a procedure that costs the hospital $500 to perform and Medicare only

pays $300 for the procedure, the shortfall is $200, meaning the hospital loses $200 for performing the procedure rather than the loss of revenue.

---

[1] Analysis included 25 Form 990 Schedule Hs filed by New York City hospitals and hospital systems for Tax Year 2022, except for NYU Langone, which, due to their fiscal year end of August 30 puts most of their 2022 year in Tax Year 2021. Some systems consolidated all or a portion of their facilities into one or more group returns.

[2] EY estimate based on dollar-weighted average of 2263 Schedule Hs from Tax Year 2021.

[3] The detail of each of these Parts is available on the Form 990 Schedule H 2022 located: http://www.irs.gov/pub/irs-prior/f990sh--2022.pdf

[4] Some hospitals have a Medicare surplus. Similar to other community benefits, the negative net expense and negative percentage numbers are zeroed out. Overall, there is a net shortfall for hospitals located in New York City.

[5] IRS Notice 2011-20.

[6] Financial assistance and means-tested government programs includes: financial assistance at cost, unreimbursed Medicaid, and costs of other means-tested government programs.

Total other benefits includes: community health improvement services and community benefit operations, health professions education, subsidized health services research, and cash and in-kind contributions for community benefit.

Net community benefit expense includes all community benefit expenses in Schedule H, Part I, Line 7a-k.

Non-traditional community benefits includes: bad debt expense attributable to patients eligible under the organization's financial assistance policy, Medicare shortfall, and community building activities. Similar to other community benefits, the negative net expense and negative percentage numbers are zeroed out by organization.

Attachment B

CDPAP changes are needed to get runaway costs under control

The amount of Medicaid money going to home care programs is hurting New York's ability to make crucial health care investments in other areas.

By Kenneth E. Raske
Feb 7, 2025

New York's Consumer-Directed Personal Assistance Program has experienced rapid growth over the past decade. Originally developed to allow consumer choice, the program provides home-based personal care for chronically ill and disabled individuals who qualify for Medicaid. It now serves more than 250,000 individuals at a cost of more than $9 billion annually.

From 2017 to 2023, CDPAP spending grew 500%, according to the state Division of Budget, while per the state comptroller overall Medicaid spending growth was 46%.

CDPAP's growth has been fueled, in large part, by the more than 650 mostly for-profit companies called "fiscal intermediaries" that act as middlemen between the recipient's health plan and the CDPAP recipient. The fiscal intermediaries have no role in the direct caregiving for the CDPAP recipient but rather perform administrative functions to ensure timely payment.

Under CDPAP's current structure, it is in the financial interest of the fiscal intermediaries to stimulate program growth. This has manifested itself in widespread advertising campaigns promoting the program. With the proliferation of these fiscal intermediaries, the program is ripe for abuse.

Gov. Kathy Hochul is taking needed action to curb CDPAP's explosive growth. The Greater New York Hospital Association supports these reforms for a simple reason: The runaway cost of CDPAP is crowding out the limited financial resources available for New York to make critically needed health care investments in other areas.

For example, hospitals currently receive 30% less than the cost of treating Medicaid patients and nursing homes receive 25% less — the direct result of a 15-year freeze on Medicaid payment rates.

These reforms will have no impact on CDPAP eligibility or the ability of recipients to choose their own caregiver. Instead, the state has contracted with a single fiscal intermediary, which will help reduce the administrative waste in the program and diminish the current incentive to increase enrollment.

Medicaid resources must be used judiciously for the sake of all recipients, providers and, of course, taxpayers. This is the driving imperative behind the governor's CDPAP initiative. As our population ages, we must ensure that the full range of necessary services are available to New Yorkers. That requires our programs to be as transparent and efficient as possible.

Kenneth E. Raske is president of the Greater New York Hospital Association.

GREATER NEW YORK HOSPITAL ASSOCIATION

PRESIDENT, KENNETH E. RASKE • 555 WEST 57TH STREET, NEW YORK, NY 10019 • T (212) 246-7100 • F (212) 262-6350 • WWW.GNYHA.ORG

Stop Insurance Industry Abuses that Harm New Yorkers

National, for-profit insurance companies with a track record of abusive practices dominate the New York health insurance market. They charge consumers high premiums and deny coverage for patient care at alarming rates. State data shows New York State commercial plans denied approximately 23% of all inpatient hospital claims in 2022 and 25% in 2023.

Those denials of care— care that New Yorkers' trusted providers deemed medically necessary—pad insurance companies' bottom lines while leaving consumers and providers to cover the costs. In addition, national for-profit insurers transfer significant profits out-of-state—$1.5 billion in dividends were transferred to shareholders in 2023.

Albany can protect New Yorkers and the hospitals that serve them by enacting these common-sense, pro-consumer insurance reforms:

- ***Ensure insurance company transparency.*** While State law requires insurers to disclose information on the claims they deny, the data they provide to the Department of Financial Services (DFS) is often disorganized and hard to interpret. DFS should be required to analyze and report on the data annually to inform policy and ensure that insurance companies disclose accurate, complete data on the claims they deny and downgrade. We also support establishing an independent review process for claims denied for medical necessity. Results of these independent reviews and information on excessive and erroneous denials should be disclosed to insureds and prospective insureds
- ***Protect patient access to care and coverage.***
    - *Improve claim review standards*. GNYHA urges the Legislature to **shorten the deadlines for insurers to decide on requests for care**. Standard requests should be decided within 72 hours, not the current three business days. (A.7268/S.3400, Weprin/Breslin). **Post-hospital care decisions (including rehab, nursing home, and home health services) should be made within 24 hours** to help mitigate patients needlessly languishing in hospital beds when that level of care is no longer clinically appropriate. And **when insurers fail to make a decision in the timeframes required by law, the requested service should be automatically approved**. Today, the law creates perverse incentives by deeming service requests denied when payers fail to act within statutory timeframes.
    - *Require insurance companies to make clinically supported coverage decisions.* Albany should **require insurers to use evidence-based, peer-reviewed criteria when deciding if care is medically necessary**. The Medicare program requires this of Medicare Advantage (MA) plans.
    - *Pass continuity of care protections*. **Authorizations should be valid for as long as medically necessary to avoid care disruption**. MA plans are required to meet this standard. In addition, the **patient/provider relationship deserves greater protection** in a system where insured individuals regularly change health plans and networks due to employment, income, and other factors. Today, some New Yorkers who are enrolled in managed care plans can continue seeing their providers for 60 days when switching plans. Continuity of care protections should extend to all plan types and for a longer period. MA plans, for example, must provide a minimum 90 day transition period for new enrollees in an active course of treatment.
    - *Create AI safeguards*. We must **prevent insurance companies from abusing AI in the claims review process**. News outlets have documented how insurance companies use technology to deny claims without a human being even reading them. New York law should be clear that insurers cannot rely on AI to deny care. All care requests must be carefully reviewed by appropriately licensed clinicians and comply with all utilization review laws. To foster transparency and ensure compliance, all denial letters should include a statement explaining

how AI was used in the review process. Further, individual physicians should be required to sign every denial letter and attest that they reviewed the case and medical record.

- ***Tax insurance company profits.*** For-profit insurance companies make billions and then transfer those profits to their out-of-state investors. In 2023, Empire, Oxford and United collectively reported $1.5B in dividends to stockholders. We should tax these profits and invest the proceeds in safety net hospitals (A.3885, Dilan).

Protect 340B Providers The 340B Drug Pricing program allows hospitals and community health centers serving the most vulnerable communities to buy prescription drugs at significant discounts. Congress established the program in 1992 to help not-for-profit and public health providers stretch scare resources, serve more patients, and improve services.

But the pharmaceutical industry hates 340B because it cuts into their massive profits. They have long sought to destroy the program, spending millions on a campaign to undermine it at the Federal level. House Republicans have proposed legislation that would gut the 340B program. And pharma and pharmacy benefit managers (PBMs) are instituting onerous requirements on 340B providers to prevent them from realizing the program's benefits, including restricting the ability of hospitals and health centers to work with local and chain pharmacies, imposing unnecessary administrative burdens, and demanding copious data. Several manufacturers are currently suing to stop providing safety net providers with 340B discounts at the time of purchase and instead impose conditions on the payment of "back-end rebates"

The Legislature can curb pharmaceutical industry abuses by passing A.7789/S.8992 (Paulin/Rivera), which would ban abusive industry practices and increase access to care for New Yorkers. Other states have enacted such laws, and while the status of pharmaceutical industry legal challenges to these laws is very fluid, the US Court of Appeals for the 8th Circuit upheld Arkansas's first-in-nation law banning limitations on covered entities' use of contract pharmacies, and the US Supreme Court declined to review that decision. Arkansas has begun enforcing the law.