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Member Hospitals

Brookhaven Memorial Hospital Medical
Center, *Patchogue*

Catholic Health Services of Long Island

- Good Samaritan Hospital Medical
Center, *West Islip*
- New Island Hospital, *Bethpage*
- Mercy Medical Center, *Rockville
Centre*
- St. Catherine of Siena Medical
Center, *Smithtown*
- St. Charles Hospital, *Port Jefferson*
- St. Francis Hospital – The Heart
Center, *Roslyn*

East End Health Alliance

- Eastern Long Island Hospital,
Greenport
- Peconic Bay Medical Center,
Riverhead
- Southampton Hospital,
Southampton

Long Beach Medical Center, *Long Beach*

John T. Mather Memorial Hospital, *Port
Jefferson*

Nassau University Medical Center, *East
Meadow*

North Shore-Long Island Jewish Health
System

- Franklin Hospital, *Valley Stream*
- Glen Cove Hospital, *Glen Cove*
- Huntington Hospital, *Huntington*
- North Shore University Hospital,
Manhasset
- Plainview Hospital, *Plainview*
- Southside Hospital, *Bay Shore*
- Syosset Hospital, *Syosset*

Stony Brook University Hospital, *Stony
Brook*

Veterans Affairs Medical Center,
Northport

Winthrop South Nassau University
Health System

- South Nassau Communities Hospital,
Oceanside
- Winthrop-University Hospital,
Mineola

Testimony of
The Nassau-Suffolk Hospital Council
Regarding the 2011-2012 Budget
Prepared for
The Long Island Regional Budget Hearing
Of
The New York State Assembly Minority

March 11, 2011

Good morning. Thank you for the opportunity to address this panel on behalf of the 24 public and not-for-profit hospitals that make up the membership of the Nassau-Suffolk Hospital Council. I am Wendy Darwell, chief operating officer of the Hospital Council.

Given the combination of an unprecedented budget deficit and new leadership in Albany committed to addressing not just to the deficit itself but to fundamental changes in the budgeting process, the hospital community expected that this would be an extraordinary year. That has certainly proven to be the case, at least as the process relates to the Medicaid portion of the budget.

The governor's decision to appoint the Medicaid Redesign Team (MRT) and delegate most of the responsibility for achieving \$2.85 billion in savings from the state's share of Medicaid was in itself unprecedented. The Hospital Council and its members were represented on the MRT by way of their state association, the Healthcare Association of New York State (HANYYS). The CEO of a member health system, Michael Dowling of the North Shore-LIJ Health System, is a co-chair.

Our representatives to the Team took on this challenge knowing that the state's fiscal circumstances – with a \$10 billion deficit for the coming fiscal year and cumulative deficits reaching \$40 billion over the next several years – demanded the health care cuts be part of the budget. We knew that these cuts would be painful to a sector that had already withstood \$5.3 billion in cuts and new taxes in eight separate budget action over the past two years. It also behooves me to mention that Stony Brook University Hospital, which has faced some of the deepest cuts in the region in the previous rounds of budget cuts, is particularly jeopardized by the Executive Budget. In addition to the potential for \$15 million in Medicaid cuts, Stony Brook is at risk of losing \$50 million in state support for essential programs provided to the community.

These eight separate budget actions were a sign unto themselves of a fundamentally broken system. Serious structural reforms were needed to make the program financially sustainable and ensure that the essential safety net of care – and access to it – was preserved throughout the state.

The hospital community made a substantial commitment to this effort, agreeing to the elimination of the annual trend factor adjustment, a two percent across-the-board cut in Medicaid rates, and a global cap on Medicaid expenditures that is tied to rate of medical inflation as determined by the Consumer Price Index.

Hospital associations also contributed dozens of policy recommendations that will result in state savings, including streamlined regulatory processes, care management initiatives for the disabled, behavioral health and substance abuse populations, better management of spending on optional services and, of particular importance to Long Island institutions, important malpractice reforms. Many of these recommendations were among the 79 ultimately endorsed by the MRT.

The MRT package of recommendations is broad and historic, and we support the decision of our industry representatives to vote for it. However, we strongly discourage the Legislature from considering the health care chapter of the budget to be closed. Many of the 79 MRT proposals, though broad, are short on detail. There are large swaths of health care policy still to be defined,

some through the budget process and others through future regulations and in future budget years. The MRT recommendations are not a fait accompli – the Legislature must remain every bit as engaged in the coming weeks as in any other budget year. I ask you to give your specific attention to the following:

1. Many of these reforms are experimental. Some will work and some won't. The Legislature must be continually engaged in monitoring the reforms and be prepared to make modifications. The global cap, which places all health care providers at risk if Medicaid expenditures rise above the rate of medical inflation, is one such area. Even though enrollment growth and increased utilization have been by far the biggest drivers of rising expenditures in the past decade, providers will be the ones penalized if that trend continues.
2. The MRT recommendations do not determine a method for monitoring whether the total Medicaid expenditure cap has been pierced, instead granting sole authority to the Commissioner of Health to reconcile data, attribute the increases to each health care sector and determine how to take back funds from providers. The Legislature should not cede its authority here.
3. Malpractice reform is a key element of this reform for providers. The two key provisions included in the MRT, a cap on non-economic damages at \$250,000 and the establishment of a medical indemnity fund for neurologically-impaired infants, are estimated to reduce premiums between 20 and 40 percent. The state would recoup some of that provider savings by way of an assessment to pay for the medical indemnity fund. If the malpractice elements fall apart in negotiations, we fear that the assessment will remain.
4. Such a tax that is not specifically tied to malpractice reforms would be no different than the gross receipts tax (GRT) we have fought so hard in previous budget years and which we fear will reappear this year. The Team already considered and rejected a proposal to triple the GRT, which is assessed on all hospital inpatient revenue. The gross receipts tax disproportionately impacts Long Island hospitals.

Hospitals are the only sector – in health care or outside of it – to voluntarily commit to substantial cuts and true reforms. Although we are concerned about some aspects of the MRT package, particularly with regard to their success in implementation, we have stepped up to the plate. We need for the Legislature to ensure that our sacrifices are not deepened in the ensuing budget negotiations, whether through an increase in the gross receipts tax or malpractice assessment, or by ceding control to the Health Commissioner to make unilateral decisions on Medicaid rates or programs. We ask for your support and ongoing engagement in decision-making.