Actors Fund ☙ African Service Committee ☙ Children's Defense Fund-New York
Coalition for Asian American Children and Families ☙ Community Service Society of New York
Consumers Union ☙ Empire Justice Center ☙ Hispanic Federation ☙ The Legal Aid Society
Make the Road New York ☙ Medicare Rights Center ☙ Metro New York Health Care for All Campaign
New Yorkers for Accessible Health Coverage ☙ New York Immigration Coalition ☙ Project CHARGE
Public Policy and Education Fund of New York/Citizen Action of New York
Raising Women's Voices-New York ☙ Schuyler Center for Analysis and Advocacy
South Asian Council for Social Services ☙ Young Invincibles

Testimony to the Assembly Standing Committee on Health Hearing on Medicaid Program Efficiency and Sustainability

November 1, 2021

Health Care for All New York (HCFANY) would like to thank the chairs and members of the Assembly Health Committee for this opportunity to provide our comments on issues affecting Medicaid. HCFANY is a statewide coalition of over 170 organizations dedicated to achieving quality, affordable health coverage for all New Yorkers. My name is Elisabeth Benjamin, and I am Vice President for Health Initiatives at the Community Service Society of New York and a co-founder of HCFANY.

For over a decade, HCFANY has staunchly advocated for coverage expansions, from expanding the Child Health Plus program to all New York children to robustly implementing the Affordable Care Act by establishing a state-based Marketplace and adopting a Basic Health Plan (known as the Essential Plan). Our primary goal is to expand quality, affordable health coverage to as many New Yorkers as possible, and—from the patient's perspective—the best way to achieve that goal is through the New York Health Act.

Today's hearing, however, is devoted to the efficiency and sustainability of New York's Medicaid program. For the past decade, discussions about Medicaid often emphasize its costs without acknowledging its benefits. The "costs" discussion is often fearmongers by focusing on the portion of the state budget that is dedicated to Medicaid. But this misses a two key factors about Medicaid: first, it leverages billions of federal dollars to pay for the health care of our state's residents; and second, no other insurance program provides comprehensive coverage with little or no consumer cost-sharing at a more efficient price (roughly $450 per member per month). By contrast, the cheapest "Silver" level individual market health plan with a $1,300 deductible costs well over $600 per member per month.

In New York, the evidence indicates that the benefits of Medicaid for millions of New Yorkers are enormous:

- In states like New York that have expanded Medicaid to all low-income adults, fewer people forgo necessary medical care and as a result, fewer die prematurely.[1] This includes significant reductions in infant mortality.[2]

- Numerous studies demonstrate the impact Medicaid has on health: fewer people suffering from depression, earlier cancer diagnoses, and better controlled diabetes and hypertension.[3]
- Medicaid provides greater financial security for both individuals and health care providers. Fewer people go into debt, are evicted, or ruin their credit paying for medical care.[4] Hospitals spend drastically less on uncompensated care and have better margins, which means fewer close.[5] This is especially apparent in rural areas.
- Medicaid also provides a critical lifeline at times of crisis, as it did for over 700,000 New Yorkers who lost work during the economic collapse sparked by Covid-19.[6]
- Medicaid narrows racial and ethnic disparities in the number of people with insurance and the number of people who report avoiding care due to costs.[7]

HCFANY would like to offer the following recommendations to improve and enhance our state's Medicaid program, including: expanding the number of people that have quality, affordable coverage; reducing health disparities; and improving the quality of care accessible to people enrolled in Medicaid.

New York Should Enroll More People in Public Health Insurance.

Thanks to the Affordable Care Act, the percent of New Yorkers without health insurance has plummeted from over 10 percent to just over five percent. But this success has been uneven from a health equity perspective. As the chart below reveals, racial and ethnic minorities are still far more likely to be uninsured compared to their white counterparts.

Percent Uninsured in New York State by Race or Ethnicity, 2019[8]	
New York State	5.2%
American Indian/Alaska Native	13.9%
Hispanic or Latino (any race)	10.1%
Native Hawaiian and Other Pacific Islander	7.7%
Asian	6.7%
Black or African American	5.6%
White	3.2%

New York has frequently worked with the federal government to expand Medicaid (and other public coverage) to populations that not covered in the original program. It has also used state funds to provide Medicaid benefits and access to its provider networks for people who are ineligible for federal funding. New York should continue this tradition by:

- **Use state funding to enroll people ineligible for public coverage due to their immigration status in a state-funded Essential Plan**. New Yorkers without citizenship are much more likely than others to be uninsured (21.0% compared to 3.5% for native-born Americans).[9] This is in part because federal rules bar some people from enrolling in Medicaid based on their immigration status. Undocumented immigrants contribute over $1 billion in state and local taxes and worked tirelessly throughout the COVID-19

pandemic. While these immigrants are eligible for "emergency" Medicaid, this coverage does not cover primary care and non-emergency services.

The current Essential Plan covers over 900,000 people who earn up to 200% of the federal poverty level, including some whose income would make them eligible for Medicaid if not for their immigration status.[10] It is currently fully funded by the federal government. New York can address the immigrant coverage gap by developing a "look-alike" Essential Plan to all income-eligible immigrants. The state-funded Essential Plan would leverage $482 million in federal Emergency Medicaid funds to lower the cost of the overall program. The state's portion would be $462 million and cover over 110,000 immigrant New Yorkers.[11]

HCFANY urges the adoption of A0880/S1572, which would authorize state funding to support an Essential Plan for immigrants.

- **Extending Medicaid coverage from 60 days after the end of pregnancy to one year**. Medicaid coverage reduces maternal mortality.[12] Medicaid provides health insurance during pregnancy and for 60 days postpartum for those who meet income requirements during pregnancy. On the 61st day, New York pays the premium for women who enroll into a Marketplace plan that has a $1,300 deductible and other cost-sharing.

  HCFANY believes that this change in coverage occurs at a vulnerable time. Deaths related to pregnancy and childbirth are a public health crisis that affects three times as many Black as White New Yorkers. Many of these deaths are preventable and many occur more than 60 days postpartum.[13] Marketplace plans include cost-sharing that can be difficult for low-income patients to manage.[14] The Centers for Disease Control and Prevention recommends ensuring access to care for at least a year after pregnancy to avoid disruptions that lead to preventable deaths.[15] New York should ensure stable Medicaid coverage for one year after the last day of pregnancy by filing a State Plan Amendment with CMS. Enacting A307A/S1411A would authorize the Department of Health to do this and would also provide state-only funds so that people ineligible for federal funding can enroll.

- **Adopt the same eligibility rules for the Medicaid Aged and Disabled Program as are in place for the general Medicaid program**. People who are over 65 years old or who have disabilities qualify for Medicaid if they make 84% of the federal poverty level (around $10,800 a year) or less and must also pass an asset test by reducing any savings to below $15,900. Many New Yorkers rely on savings to pay bills when they do not have an income or as a buffer against emergencies. It is unfair that some should be penalized for having savings by losing access to health insurance.

  It is even less fair because younger people without disabilities qualify for Medicaid at higher incomes (up to 138% of the federal poverty level, around $17,700) with no asset test. New York should increase the Medicaid eligibility limit to 138% of the federal

poverty level and eliminate the asset for everyone so that all New Yorkers can access Medicaid when they need it.

New York should use a pay-for-performance system to hold Medicaid plans accountable for reducing racial and ethnic health disparities.

New York has successfully used pay-for-performance to improve quality within the Medicaid program before. Managed care plans are required to participate in the Quality Assurance Reporting Requirement (QARR) system, and New York began providing bonuses to the highest performing plans in 2002.[16] This effort worked: by 2007, New York's performance increased on measures like immunizations, well-child visits, and diabetes control. However, these improvements were not experienced by all New Yorkers. Black and African Americans had worse outcomes than other New Yorkers than others on many quality measures. This could be because quality improvement rewards were based on the entire population regardless of disparities between sub-populations. Further, this data was not –and still is not–stratified by race or ethnicity in public reports. It is only available through requests to the Department of Health.

New York should publicly report these quality measures by race and ethnicity so that the public can understand whether or not overall performance applies to everyone, and which plans achieve greater equality. The state should also structure its reimbursement rates to incentivize health plans that reduce health disparities.

Ensure Community Priorities Are Included in the "Health Equity" 1115 Waiver.

New York State will soon apply for a new 1115 waiver. In preparation, it released a concept paper in August describing a five-year plan costing $17 billion. The concept paper discusses the need for achieving greater equity in the wake of the disproportionate mortality and morbidity experienced by people of color during the COVID-19 pandemic. New York has a history of drafting and implementing these waivers without prioritizing patient- or community-level needs. It should not make that mistake again. It is critically important that consumer and community interests are included in the new waiver design. That means:

- Process and outcome metrics developed with community members to ensure that metrics directly address disparities and will lead to results that are meaningful to community members;
- Support, technical assistance, and funding that will allow meaningful participation of community-based organizations in drafting and implementing the waiver;
- Fiscal transparency with respect to decisions about who receives Medicaid dollars and what their funding is used for; and
- Meaningful involvement of consumers and community members in governance structures and decision-making roles.

Decommission the Medicaid Redesign Team

The Medicaid Redesign Team (MRT) process is the wrong way for New York to make decisions about the Medicaid program. In 2020, it was used to make decisions about the Medicaid budget behind closed doors and with no input from the public. The MRT provided a public "suggestion box" but there is no evidence that any of these proposals were seriously considered. As of March 2, 2020, when the Health Budget Committees were held one month before the budget was due, the MRT had released no public recommendations. When its recommendations finally appeared, legislators were asked to approve them wholesale or allow the Executive Branch to make across the board cuts to Medicaid providers. Serious health policy decisions should not be made into a game of legislative "chicken."

The most important stakeholders, the people who have health insurance through Medicaid, had no say on the MRT. Nor did the public or the legislators they elect. A fully public MRT process that includes all stakeholders, especially those who have health insurance through Medicaid, could produce meaningful recommendations for improving the program. This process would take substantial time to succeed, not the few weeks it was given in 2020. The recommendations created by a MRT process should then be incorporated into the Medicaid budget using the legislative process which allows New Yorkers to hold their elected officials accountable for their decisions.

Repeal the Medicaid Global Spending Cap

The Medicaid global spending cap has been in place since 2011. The global cap imposes automatic cuts when Medicaid spending hits a pre-determined threshold. These budget cuts are made by the Executive Branch alone with no input from the Legislature or the public and with no regard for public health needs. Year after year, the global spending cap has allowed a "crisis" narrative for Medicaid, even when the State has ample tax revenue to fund its budget.

The global cap contributes to racial and ethnic health disparities because it takes resources away from low-income communities without regard for the effect it will have on their access to care. Some hospitals in New York serve far more uninsured and Medicaid patients than others. For example, public hospitals are a subset of New York's safety-net hospitals. In the most recent year for which there is data, 55 percent of patients discharged by public hospitals in New York were uninsured or covered by Medicaid while only 29 percent of patients discharged from private hospitals were. Because of the differences in payer mix, Medicaid cuts automatically fall on the hospitals that serve low-income communities and have lost access to hospital care over the years. Concentrating our efforts to "discipline" Medicaid on safety-net providers is one of the reasons New Yorkers lived or died according to their wealth during the pandemic.[17]

The spending cap does not allow for planning based on public health data or economic conditions. The failure of this approach was readily apparent last year when the Executive Budget proposed across-the-board cuts to Medicaid providers. These were proposed in the middle of a pandemic that has killed tens of thousands of New Yorkers and pushed safety-net hospitals that serve the most Medicaid patients to their limits. If the rules of the global cap are

followed this year, Medicaid will again face across-the-board cuts to adjust for increased spending resulting from more enrollment. This will be framed as a way of "disciplining" the program, but increased Medicaid enrollment during an economic crisis is not a failure.

New York should allow its Medicaid program to work as it is meant to work. Its budget should be determined through the same budget process as any other program. Those processes are transparent and responsive to the public. That means repealing the global spending cap.

If the health policy goal is to efficiently control costs, New York should seriously consider an all-payor solution, such as: restoring the New York Prospective Hospital Reimbursement Methodology; adopting a global payment model, like Maryland; or establishing cost-containment/benchmarking commissions along the lines of Massachusetts, Washington, New Jersey, Connecticut.

Thank for your attention.

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