CITY COUNCIL
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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON HOSPITALS

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HELD AT: Committee Room – City Hall

B E F O R E: CARLINA RIVERA
Chairperson

COUNCIL MEMBERS: Diana Ayala
Mathieu Eugene
Mark Levine
Alan N. Maisel
Francisco P. Moya
Antonio Reynoso

A P P E A R A N C E S (CONTINUED)

Mitchell Katz, CEO and President Health & Hospitals

Linda DeHart, Assistant Vice President, Debt Finance, Health & Hospitals

John Alberg (sic) Health and Hospitals

Elizabeth Benjamin, Vice President for Health Initiatives, Community Service Society of New York

Carmen Charles, President, Local 420

Anne Bove, Board of Directors of New York State Nurses Association, NYSNA & HHC Registered Nurse at Bellevue (Retired)

Elisabeth Wynn, Executive Vice President of Health Economics and Finance, Greater New York Hospital Association and Member of Indigent Care Pool Workgroup

Rosa Tekenen, Former Research Associate, CUNY School of Public Health

Anthony Feliciano, Director, Commission on the Public's Health System

[sound check] [pause] [gavel] [background comments]

CHAIRPERSON RIVERA: Good afternoon everyone. I am Council Member Carlina Rivera, Chair of the Committee on Hospitals, and I want to start by acknowledging my colleague and fellow member of the committee Council Member Antonio Reynoso. Today, we'll hear from representatives of Health and Hospitals and other stakeholders about Charity Care Funding for hospitals in New York City. Charity Care Funding is otherwise known as Medicaid Disproportionate Hospital Share Funding or DSH Funding. DSH Funding has been discussed, analyzed and scrutinized for many years, and the conversation surrounding DSH Funding are nuanced and complicated. Our main goal today is to bring these issues to light in a digestible and public way so every New Yorker has the opportunity to understand and weigh in on these discussions as well as to ensure that our hospitals are adequately compensated for the care they provide. Access to adequate healthcare is a fundamental human right, and we must ensure that every New Yorker has access to quality affordable care regardless of their ability to pay or their

insurance carrier. The city safety net hospitals play a lead role in address health disparities and serving our city's marginalized populations including the uninsured. Since safety net hospitals serve many without health insurance as well as those with Medicaid, Charity Care Funding is meant to offset the hospital's uncompensated costs. Although DSH payments are primarily intended to provide support to safety net hospitals, some have argued that both public and voluntary safety net hospitals do not receive adequate levels of DSH Funding while some hospitals receive unexpectedly high amounts of DSH Funding. Today we will discuss the methodology the state uses to distribute DSH Funding. The current process was intended to help transition the state and hospitals from DSH Funding method to another yet the current methodology continues to utilize a problematic structure—structure that arguably doesn't take uncompensated care into account as heavily as it should. While it is important to understand the current process and where we've come from, it is crucial that we also understand where we are going. We know the stated as a result of the 2018 Budget process convenes a work group focused on DSH Funding.

We know that as a result of the work group, there are various proposals to change DSH Funding in the works. Today, I hope to hear more about these potential next steps and proposals and to better understand how the city could get involved to ensure that the DSH Funding process is as equitable as possible. As healthcare continues to change, we must ensure that individuals and communities retain access to care that meets their needs. Today's hearing is a great opportunity to hear about the process by which our hospitals are subsidized for serving New Yorkers who are uninsured or on Medicaid, which has not increased the rate at which it reimburses in roughly a decade. I'd like to thank those who are here to testify today including representatives from Hospitals as well as community members and advocates. It is crucial to have all stakeholders at the table for this discussion including physicians, advocates, patients and hospital representatives, and I look forward to our robust discussion. So with that, I would like to invite the first panel, which is Mitchell Katz, CEO and President of Health and Hospitals; John from HMH.

MITCHELL KATZ: [off mic] That's John from Home Equity. (sic)

CHAIRPERSON RIVERA: John, I know. I'm sorry. It's nice to see you, but I—I'm getting glasses soon, and as well as Linda Dehart from Health and Hospitals. [background comments/pause] Oh, give me, give me one second while the Counsel administers the oath, and we've also been joined by Council Member Diana Ayala.

LEGAL COUNSEL: Can you raise your right hand, please? Can you raise your right hand, please? Do you affirm to tell the truth, the whole truth and nothing but the truth in your testimony before this committee, and to respond honestly to Council Member questions?

MITCHELL KATZ: [off mic] I do.

LINDA DEHART: I do. [pause]

MITCHELL KATZ: So, the--taking your challenge of making sure that people who are listening really understand the program. The way that I think about it is that the disproportionate Share Hospital Program is supposed to reward those hospitals that take care of a disproportionate share of the uninsured and those with Medicaid, and part of the problem from my point of view with how New York State has structured the program historically is it's

more like a pro rata program. So, everyone gets something for the few or many uninsured people they have, and that is not really to my way of thinking consistent with the term disproportionate. The understanding is if you're a hospital and you take care of many patients who have Cadillac insurance and who are able to pay full freight, of course, you are going to be able on the margins to take care of a few people with Medicaid or a few people who are uninsured, but that's not what the disproportionate share program was meant to do. That was—that—it's assumed that you'll just do that because you're a hospital and especially we're blessed by having only non-profit hospitals here that as part of your non-profit mission, of course, you will take care of some people who are uninsured or who are on Medicaid. What the I see the need is to really recognize who are the providers, and it's not just H&H, Health and Hospitals although H&H is the largest provider of indigent services, but that the goal should be to migrated the methodology such that those hospitals that are really doing the lion's share of caring for the uninsured and the Medicaid are the ones who have the dollars because we want to provide the services,

right? Right, we—all of the money goes directly into making the services available for our patients. So, with that, I'm going to—for the specifics, we're incredibly lucky that we have John Alberg who used to be at the state and who is a fund of knowledge and Linda DeHart who's worked for H&H for a long time on these issues, and I have to say as a member of the—the New York State Indigent Care Workshop, it was clear that the two of them knew more than anybody else in the room about the program and how it worked, they have the only-- While there were several excellent community proposals, they had the one with the most people from the community signed onto, and I think that that was because it makes major positive steps for bringing the funding where it's really needed.

JOHN ALBERG: Well, thank you. Yeah, we have a couple of slides here that we're prepared to discuss today. There is also I think some very excellent testimony that was written that includes, you know, a lot of detail and—and I think fully describes, you know, the situation that we're trying to address here. You know, as Dr. Katz mentioned, the Indigent Care Workgroup was convened at the request

of the Governor and the Legislature. This is again a very complicated issue that involves dividing up a source of dollars amongst hospitals, which is—which is always a challenge. You know, when we—when we started to develop our proposal, you know, we started from a framework of, you know, in essence, you know, guiding principles and having some conversation, you know, with Dr. Katz and I-I think what we—the framework that we started from was, you know, fix the issues, right. Don't create new issues, you know, fix the issues at hand, and there are issues that have evolved in Indigent Care because since the last time it's been looked at, you know, we've had, you know, the implementation of the ACA and the landscape has—has changed significantly, you know, as a result of that. You know the second thing that Dr. Katz asked us to keep in mind is, you know, we need to be fair and equitable and—and we tried to take that view here. This proposal doesn't just advantage H&H. It's certainly we think solves problems impaction other, you know, safety net hospitals. So, as we go through the presentation, hopefully, you know, you—you can see that work. The other thing I thought I would do is—is perhaps just as an overview of—of the

conversation is just, you know, first start with a little bit of background on DSH and Indigent Care. Again, it's complicated. It's a federal program. It seems like it's always evolving. Then we can talk about the problems and challenges as we see it that are facing the ICP program today. We discussed our proposal, and when I say "our proposal" it's not just H&H's proposal but, you know, a group of community advocates helped shape this, and then the benefits as we see it and the impacts of our proposal and then- and then the next steps. I would also say right, the reason why we tried to take this format versus just, you know, reading off our testimony is that, you know, we would encourage, you know, to have a dialogue here, and certainly feel free if you have questions along the way to interrupt me, and we—we appreciate that. We like to use this as learning experience. So moving on, you know, to the first slide an overview of the DSH Funding and issues. First important, you know, to mention, as I said, that, you know, this is a federal program. We refer to it as DSH. Some times we refer to it as Indigent Care but it's in our minds and in our parlance it's— it's-it's the same. There's really two, you know,

control points that the federal government has in terms of implementing the DSH. It's what's called the Statewide DSH Cap. Every state gets an allocation of DSH Funding, and that's pursuant, you know, to a federal formula, and then the other control point is facility DSH Caps. So, each facility in—in the state is required to undergo an—an audit in essence and it's part of the federal rules is you cannot receive more DSH Funding than you Medicaid in uninsured losses, and the reason why I refer to that is because over the course of time since the implementation of the ACA, the amount of losses that hospitals are experiencing has shifted from the uninsured to losses not covered by the Medicaid program, and you'll see in our proposal we try to—we try to address both of those issues, but that's the importance of the facility DSH caps. Today New York State receives about 15—14.7% of the nationwide federal DSH allocation, and that's roughly $3.6 billion. H&H is the largest recipient of those funds. So, it's about $1.4 of the $3.6 billion. We are very dependent on these funds. It represents, you know, approximately 14 to 15% of our entire budget. We include other supplemental Medicaid. So,

they're actually a vital source of—of revenue for us. Under the current Federal Law, right, there's this concern is one of the issues that the—that the work group—the reasons why they were convened in Albany is, you know, what do we do in the event of, you know, Federal DSH cuts, that—that would be, you know, catastrophic, you know for New York State and the estimates are—the impacts—our share of the impacts would be $1.3 billion in 2020 growing to $2.6 billion and our estimate today a H&H of that $1.3 billion, $700 million would affect H&H, and that's almost half of the cuts and the reason for that is—and-and many reasons is because of the complexities of the current DSH program and the sequencing of how dollars are funded within the program. H&H is—receives the last dollar of DSH Funding up to the Statewide DSH Cap in the way that when you unwind that and if there's a cut, we receive the first cut up to $700 million. Obviously, it's something that is unsustainable or declare a significant burden on H&H. So, that's- that's the general background of the program. I can shift to kind of what we see as—as the issues facing the program today and the pressures facing the program today. You know, as Dr. Katz said, you know,

the work group was convened to address some of these issues, advocate, right, develop and advocacy approach to avoid the federal DSH cuts, but then also to make improvements in the program. The work group focused primarily on the Indigent Care Program. There's different elements of the DSH Program, but what they chose to focus on was what we call the ICP portion of the program, and that's DSH Dollars that flow to all hospitals across the state and that's roughly $800 million of the $3.6 billion in DSH. So the conversation is—is—at the work group is primarily around how do we deal with the ICP distribution. So, we see, right, when we look at the current—current program, we see three maybe four issues that—that are of great importance to H&H as well as I think the other safety net hospitals. The first is H&H's total amount of the annual DSH allocation are in constant flux, and this is challenging for us because this—these dollars are so vital. They're really the last dollar that make our financial plan work, and again because of the complexities of the current methodology and how dollars are resourced over the past, you know, five years or so, we've seen fluctuations in DSH Funding ranging from $1.7 billion

to $1.2 billion, right and Linda and I as—as—as the—the Finance side of H&H, you know, we always are striving for a little bit more stability, and having, you know, more known numbers in our plan. So, that's a challenge for us. The other big challenges I mentioned is, you know, H&H is first in line for the Fed DSH cuts. As I explained the way the method works is that we were—we receive dollars up to the Statewide DSH Cap, and when that's cut, we would have to observe the first, you know, $700 million. The—the next one here is what we refer to and this is what I think was discussed in—in great detail amongst the work group members is what we refer to as the transition power. So, in 2012, when the same work group got together, and the task that they were—the challenge that they were tasked with is how to convert the Indigent Care Program and allocation methodology from one that was based on a calculation of bad debts to one today that's based on directly related to the number of uninsured people that our hospital serves. So, as part of when you move, you know, these big sizable amounts of funds within a system, it's common to smooth that out, and the methodology incorporated a transition from the old

method to the new method, and it's in parlance of us rate setters. It's called, you know, the collar, and I think there was—there was consensus amongst all the work group members that the collar should be eliminated and we should fully move towards the uninsured, you know, methodology, which was the intent of the work group. That move was stalled in—in state statute and, you know, some have asked the question well why is that. You know, of the new methodology is—is—is the methodology that people opted for, why not move fully towards it, and what you find when you look into the numbers it's—it's really the impact, and it's the impact on the safety net hospitals, and according to, you know, the—the Health Department, when you eliminate that collar, it's a zero sum game. There's $140 million in facilities the benefit, $140 million in those that have to experience a reduction, but the-the concern quickly, you know, comes to the surface is it's the 60 safety net hospitals that would have to absorb $110 million of the $140 million in cuts. Now for H&H, we actually get a benefit of almost $19 to $20 million, right. So this is not really an issue for us, but again skipping back to our guiding

principles, let's make sure that all the other safety net hospitals aren't at risk of default. Right. This is an issue that need to be addressed, and as we step through our proposal we—we can explain to you how we go about doing that. But I know I've thrown a lot at you. If there's any questions, I can—I can keep plowing ahead here. Is everybody good? Okay. Yeah. [background comments] I'll keep going, right, and—and yeah, we'll piece it out together. Okay.

CHAIRPERSON RIVERA: Keep going. I know that our faces might seem--

JOHN ALBERG: [interposing] Yes.

CHAIRPERSON RIVERA: --like, you know.

JOHN ALBERG: Yeah.

CHAIRPERSON RIVERA: But—[laughter]

JOHN ALBERG: Yes, it's--

CHAIRPERSON RIVERA: And then, you know, it's a—it is a little bit difficult sometimes to have a conversation without like real numbers in front of us--

JOHN ALBERG: Yes.

CHAIRPERSON RIVERA: --but we'll continue.

JOHN ALBERG: Yes. But yeah, let me—let me go through it and—and so it's really I'm trying to, you know, let you—inform you of the problems that we're trying to solve and then this is now the transition to our proposal, right and—and the steps that are included in our proposal. So, the first, right, is eliminate the ICP Transition Collar, right. Fully implement the new methodology, which was, you know, consistent, you know, with the intention of—of the previous working group. The second is, you know, and I'll step you through this and use an example, but—but the first step here is that we reduce ICP funding for all hospitals across the board. So we take a reduction in the DSH right, and I'll use and example of say $100 right. We reduce DSH Dollars, right, out of the ICP pool of $100. That's comprised of $50 federal and $50 state. So that comes from everybody and goes into a pot, right. We then transition those dollars, the federal and state dollars into a Medicaid rate adjustment. So, the DSH Dollars come down by $100 and we transition those dollars into a Medicaid rate adjustment, but the ne element here is that when we transition it to Medicaid rate adjustment, we're targeting those

dollars to the safety net hospitals and the at-risk-hospitals only. So, we're introducing a new concept, which we called Tiered Medicaid Rate Setting, and it—and it makes sense, right if you're a more predominant Medicaid provider, you know, perhaps your base rate should be more, and that's in essence what we're doing there. Now, that—that first trans-that first transaction for the most part eliminates for the hospitals that were going to experience and reduction, it does a lot to cover what would otherwise be a negative hit in the number I said for $110 million. You know, again, these are all dollars that have to be, you know, synchronized, but the idea here is to take the dollars from DSH and move it over into the Medicaid rates, and as I said, the real pressures on the system today are really because the Medicaid rates have not been adjusted in over ten years. So, that's—that's Step No. 2. There's a step here that we're allocating, you know, dollars to the critical access hospitals. These are primarily Upstate Hospitals. It wouldn't affect New York City but they, too, would be impacted by the collar removal, and again we're trying to have a wide scope here in terms of a proposal. So, there's some funds

that would need to be allocated to them. Then, the—the last step here is there's a residual amount of dollars that are not covered as a result of the collar being removed, and the state has program—multiple programs, but it provides supplemental—targeted supplemental payments to certain hospitals that are distressed, and our view of this is that you need to increase those supplemental payments to those hospitals, you know, to protect them from experiencing what we would think could be, you know, significant consequences. And then the last step, if you're following this, is that when we move the DSH, right over to the Medicaid Rate, the federal dollars are still available, and our proposal would allow us, and the other public hospitals, right to draw those federal funds into our system, right. So not only are we helping the safety net hospitals with targeted Medicaid Rate increases, we're using the federal dollars that were going to them as part of the Indigent Care Program and we're absorbing those, and we can do that because we're uniquely positioned because we're a governmental entity that can fund the non-federal share, and so can SUNY and some—and some of the other county hospitals, and we share those

dollars with the other county hospitals, which again have a large role in a system of providing, you know, safety net services. So that is our method, right. There's multiple step, you know, to it. I hope I adequately explained it to you.

CHAIRPERSON RIVERA: You're doing brilliantly.

JOHN ALBERG: Oh, well thank you. I like that. So, I'll keep moving on, and then I'll just talk to you, you know, how we see our proposal in terms of, you know, the final impact and just to go through our list, you know, we eliminate the ICP, you know, collar, without, you know, harming safety net hospitals. We increase Medicaid reimbursement for the safety net and at-risk other needy hospitals introducing this new concept of, you know, tiered rated setting. We established a precedent for—right, for the tiered rate setting, leveraged new federal Medicaid funds into the equation so no longer is it a zero sum equation in terms of how do we divide up Indigent Care dollars. We've managed to appropriately bring in new federal dollars, and then we believe we are attempting to address the disparity between well resourced and-and needier hospitals.

And we do all this, right, without driving a new cost, right to the state. Right, that was important to us. We wanted to present a proposal to them. Their global cap is stressed. We know that. So this proposal does it at no additional cost to the state. Then in terms just to finish up, you know, our next steps is that, you know, first we need to, you know, finalize our model. It's—it's a complicated model. Again, we're trying to be balanced. It's a proposal that we seek everybody's input, right, including yours as well as our other, you know, hospital partners and the state, and that's the way these things tend to work out is everybody if they're willing to work together and share and address the imperfections together, usually you can find yourself in a better place. So, we—we don't feel like we have it all figured out. We figure that we have the good framework, but there's, you know, more work to be done, and we're, you know, partnering with our friends at Greater New York to also, you know, help us with certain elements of data. And then the next is, you know, we want to work with the Legislature and the Governor, you know, to hopefully get our proposal introduced into the final budget, and we've

been, you know, talking to our partners in Albany. We feel, you know, pretty good about our proposal and we look forward to doing that, you know, during the session.

CHAIRPERSON RIVERA: Great. Thank you. So, how much uncompensated care does H&H provide on average every year? [background comment]

JOHN ALBERG: So—

CHAIRPERSON RIVERA: [interposing] I—I saw--

JOHN ALBERG: [interposing] Yeah.

CHAIRPERSON RIVERA: --I saw the—the testimony. I know that 70% of H&H Inpatient Care is through Medicaid and uninsured, and there's about 380,000 patients that are uninsured that you serve and on average you receive about $1.4 billion in DSH Funding?

JOHN ALBERG: Yes.

CHAIRPERSON RIVERA: So, just wondering how much uncompensated care do you provide and how much of that care ends up being covered by DSH Funding?

JOHN ALBERG: So, we receive the full $1.4 billion allocation, and we use those dollars to—

to pay for uncompensated care. You know, those dollars all go in, and in—and in some cases we use those funds to also cover Medicaid losses, but predominantly those funds are fully utilized to provide services to, you know, the uninsured.

CHAIRPERSON RIVERA: But I guess the—the—the—the reason why we're having this hearing besides, you know, awareness, I think many people don't understand the relationship between the city and state and Health and Hospitals and how dependent we are, and I think the disparity between well resourced and needier hospitals are probably our biggest question and concern today. So, you know, that's why there are so many stakeholders in the room, and I wonder with $1.4 billion it's still not enough, though, and I guess that—that's--

JOHN ALBERG: [interposing] Yes, that is correct.

CHAIRPERSON RIVERA: --that's what I'm trying to get at--

JOHN ALBERG: [interposing] Yeah.

CHAIRPERSON RIVERA: --in terms of I know you're trying to refine at-risk and safety net, but it's just not enough to provide care.

JOHN ALBERG: Yeah, it—go ahead.

LINDA DEHART: But part of the thing to understand with the $1.4 billion that's the amount that the state is paying out to us every year. Those payments are on a lag with respect to the services that they're paying us for. So the state has been able to give money in recent years that fully pays us for uncompensated care at the hospitals through about 2015. There's still hundreds of millions of dollars of uncompensated care for periods after that that we haven't been paid for, and under the current structure we don't have any guarantee that we will be paid for.

CHAIRPERSON RIVERA: And then with every year that the—the—the delay and the forecast that maybe it will be delayed again, and if it's not, some of the numbers that you gave us are incredibly troubling of what you'd be faced with. What is the state relationship like right now? I know that you are looking forward to working with the Legislature to possibly put forward legislation that's going to assist with redefining this formula that so many of us including the people in this room find problematic. How are those conversations going?

Just based on what I saw yesterday in the Governor's announcement, there wasn't anything specific.

JOHN ALBERG: Yeah. No, I think—we think that the conversations are going very well. I mean they called us to the table. They asked Dr. Katz to participate in a work group. We are the biggest, you know, utilizers of these services and providers of these services. So, we feel pretty good about it, right. We—we think we're dealing with multiple issues with our proposal. It takes a little bit as we're doing here to absorb it all, but, you know, we feel as though it's—it's—it's a good proposal, but we welcome other input, and—and—and—and we're optimistic that during the course of this session we—we can take that work up.

CHAIRPERSON RIVERA: And we heard about the proposal, which based on—on what you've listed here, it sounds like, you know, clearly it was thought through, and you had multiple stakeholders in the room. Has the Workgroup presented a proposal to the Governor, to the Executive?

MITCHELL KATZ: Well, we—what I'll just say is so the Workgroup is the advisory. This was the only—John and Linda's proposal was the only one

where multiple people signed on and said yes. I assume they would have liked to have read in the Governor's speech that this was going to be the proposal, but that has not yet happened. So, the—basically it was state sees the committee as their advisory body, and I think John is right, but they take his proposal and Linda's very seriously because they were smart enough to think of a way to grow the pie, which is always a good strategy right to figure our a way to grow the pie so more people can benefit. But there's no—from—from their side what they have said is that the proposals that people have made are being discussed at the highest levels of the state government, but have not committed that one will come out at a specific moment or that a decision will be made. [coughing]

CHAIRPERSON RIVERA: And I saw some of the supporters that—Elizabeth Benjamin from CSS, Sidney Young Bell (sic)from NYSNA and Anthony Feliciano from CPHS, Judy Wessler. Was there a general consent? Was this the majority of the working group that agreed on this? I mean I know that not everyone

MITCHELL KATZ: The—certainly more than any other proposal. So there, you know, there were other people who, right, didn't—didn't sign on that there was no proposal that more people supported, and there were certainly proposals made that less people supported

CHAIRPERSON RIVERA: Okay. Well, I'm glad that you're on board Dr. Katz. I think that that says a lot, and as well as the advocates who have been working on this for years, and as I mentioned in my opening testimony, I mean this really hasn't been revisited in a thoughtful way in nearly a decade, and so hospitals are suffering. I did want to turn it to my colleagues, and not take too long. So, I know first on deck is Council Member Antonio Reynoso. Oh, and we've been joined by Council Member Francisco Moya.

COUNCIL MEMBER REYNOSO: Thank you, Chair. So, thank you for your testimony, and your—I want to call it an attempt to—to inform us on exactly what has—what existed and what has transpired because it is very dense, and like very into the weeds. We don't get a lot of agencies that go into those details with us. A lot of them like to gloss over

things, and I feel like you went deep into it. So, I didn't understand most of it. I want to be honest, but I understand the—the gist of what's happening here. And, what I do understand is that we're trying to be creative on how we can move things around to allow for us to continue support the needier hospitals or the hospitals that are doing the neediest work--

JOHN ALBERG: [interposing] Yes.

COUNCIL MEMBER REYNOSO: --I guess is what I want to call it, not the neediest hospitals.

JOHN ALBERG: Yes.

COUNCIL MEMBER REYNOSO: If you're doing Medicaid work, then you would get support through this alternative program. I wanted to ask federally how—would any of this have to through an approval from the federal government or how—how are they involved, if at all?

JOHN ALBERG: Yes. No, I appreciate that. Obviously they're a stakeholder here and, you know, from the chair that I used to sit in at the start, eight, it would be the responsibility of-of the Department of Health as the state agency, right to submit what we call State Plan Amendments, and

that's the control point, I mean in terms of approving these, you know, sorts of policy changes. There's nothing that we see in our proposal that we think that they would have any—any problem with. Even the—the realignment and the reduction of the DSH Dollars don't see an issue there, and the Tiered Medicaid Rate approach. Right, we—we would see that they would support that as—as well. I had some preliminary, you know, conversations with them about it as we're kind of constructing the idea, but we—we think that we would be in a—in a good position with them.

COUNCIL MEMBER REYNOSO: And then the—I don't think you answered the question that was asked by Chair Rivera when related to how much is the overall uninsured debt that we have. You said $1.4 million is how you get--

JOHN ALBERG: [interposing] Yeah.

COUNCIL MEMBER REYNOSO: --and that it all goes to the uninsured—the uninsured debt against it that you—you assume. So, can we say that it's $1.4 billion or that this covers up to $1.4 billion but there is more?

JOHN ALBERG: It covers--

COUNCIL MEMBER REYNOSO: [interposing] So, we would like to know what the more is as well.

JOHN ALBERG: Yes.

COUNCIL MEMBER REYNOSO: Yeah.

JOHN ALBERG: Yeah, I understand. No, it covers, you know, up to the $1.4 and—and I was trying to explain, you know, this other control point the Facility DSH Cap. Right, the Facility DSH Cap is your Medicaid losses and your uninsured losses, and you cannot receive more than that. What Linda was explaining is that these calculations are on a lag, and we know our costs continue grow, right, just like any other hospital, and the number of people uninsured that we serve continues to grow and it has grown, you know, disproportionately. As a result of the ACA, there's been more pressure on us. More people have insurance. They're seeking care in other places.

COUNCIL MEMBER REYNOSO: Uh-hm.

JOHN ALBERG: So, for all of those reasons, the number is higher than $1.4.

COUNCIL MEMBER REYNOSO: Do we have an estimate at this point for what that number is?

JOHN ALBERG: We—yeah, I think that it would be—again, these are calculations that we're always doing according to the --

COUNCIL MEMBER REYNOSO: [interposing] I guess—I guess we don't want to know your overall debt or like since 2015. Just on a yearly basis, what is the average amount of—of people coming into the—the Health and Hospitals systems that are uninsured, and how much are you spending? What does that bill look like?

JOHN ALBERG: Well, we're-we're 70%, right Medicaid and uninsured, right, and no—nobody in the city takes care of a greater proportion, right of—of that—of those two populations.

COUNCIL MEMBER REYNOSO: But why is it that you can't tell me the number, though? I just don't get why. Is it a concern? Because if it is, I'm a partner. So, if it's a concern, or is it just you don't have the number and you'll get back to us?

JOHN ALBERG: Well, yeah. I think it's—it's—it's always on an evolving basis that we do these calculations according--

COUNCIL MEMBER REYNOSO: [interposing] That's right--

JOHN ALBERG: --to the—the rules of the state, right in terms of calculating the Facility DSH Cap, but we know just kind of doing our pro forma analysis, it could be hundreds of millions higher. I can't give you an exact--

COUNCIL MEMBER REYNOSO: [interposing] So, if you give me a number tomorrow, it could be something that's $200 million more or $200 million less. It's just that--

JOHN ALBERG: We know it's not going the other way.

COUNCIL MEMBER REYNOSO: Okay. [laughs]

JOHN ALBERG: Right.

COUNCIL MEMBER REYNOSO: It will never be less. It will always be more.

JOHN ALBERG: So, let's—let's get back to it, but let's agree for the sake of today's meeting it's hundreds of millions our cost in terms of taking care of uninsured and the Medicaid population difference is hundreds of millions of dollars more than we receive through DSH.

COUNCIL MEMBER REYNOSO: So at least $1.4 million—billion--

JOHN ALBERG: [interposing] Yes.

COUNCIL MEMBER REYNOSO: --let's just say.

JOHN ALBERG: But plus hundreds of millions of dollars.

COUNCIL MEMBER REYNOSO: Right. Okay, so that—and then but the next thing and I'm sorry--I'm almost done with my question—is you get up to $700, you're the first people to get up to $700 million to the cap. You get first dibs on that, and you feel that if a cut happens at the federal level that the first group—the first funding that goes is that?

JOHN ALBERG: [interposing] That's right--

COUNCIL MEMBER REYNOSO: Right that $700 million?

JOHN ALBERG: --and that's the way the state statute is structured.

COUNCIL MEMBER REYNOSO: So, can—can and if that happens, can the state immediately modify the way they—they fund H&H and just the ICB program in general so that that won't be the case because, of course, I get process wise why that would happen. I just don't see that being a reality that we would just cut your $700 million or that would be the first

cut, and then we'll just keep it at that. I really feel like we would be creative in trying to figure out how to be helpful. I just want to make sure that there are systems in place should that happen that we can actually.

JOHN ALBERG: Yes. No, I—that's a question. Certainly, I think there was consensus around this point with the work group that it was unfair and that if there were cuts that should not—the first 700 should not be all absorbed by H&H. Now, again, our advocacy against those cuts is where we want to focus our efforts, but your point is a good one. We need—we need to, you know, plan for the alternative. So, I think there's—there's—this agreement there. As I mentioned, our proposal we're actually drafting up legislation, right that—that we had prepared to submit to the Legislature and the Governor to consider, but within that statute we are proposing a fairer process by which if those cuts do, in fact, go into effect, how they would be distributed amongst all hospitals.

MITCHELL KATZ: To—to the Council Member's question, if—in terms of timing, if the feds said yes this cut is happening—

JOHN ALBERG: Right.

MITCHELL KATZ: --that we're all going to fight against, the chair has really helped us in fighting against DSH cuts as-of other members of the Council, which we have been very appreciative of. Would we have then enough time in the state process to change how the money distributed. So, all of the first cut wouldn't be us.

JOHN ALBERG: Yeah, and I—I think that's certainly something that we would, you know, why we would like to have some sort of statute in place prior to October, right, when the Federal DSH cuts are scheduled to into effect. We—we think it's—it's reasonable, right to have an alternative, you know, method on—in state law, and one that we will push for and would appreciate your help on.

COUNCIL MEMBER REYNOSO: So, please. After your—after this is done, and the state makes the decision, I think we should have another hearing because I would love to know how your advice to the Governor at what—what fruits that has—the results in the—in the labor of—of your work. I'm just concerned that you'll make a great proposal and won't get everything you want, and will make it so that we have

to do some work. So, I would love to hear how that goes. Every single working group that the Governor has spun is advisory. I just want to be very clear with that firs and foremost.

JOHN ALBERG: Correct.

COUNCIL MEMBER REYNOSO: So, be careful—be careful who your friends are, and the last thing is I love this—this committee is one of my favorite committees because what you learn through the work that you do in Health and Hospitals is like second to none. It's just a learning process every single time, and I'm so grateful to be here to be able to advocate to make sure that we do our best to—to—to help our hospitals, and it's like going to—I feel like I'm in college every time I come to this committee. So, I really appreciate the thoughtful work that the committee is doing in finding these hearings that are meaningful and—and important and the work that you did to make sure you inform us on those issues. So thank you again.

JOHN ALBERG: I appreciate your support.

COUNCIL MEMBER REYNOSO: Thank you, Chair. Always.

CHAIRPERSON RIVERA: Thank you Council Member. I'm very susceptible to flattery.

COUNCIL MEMBER REYNOSO: That—that was my goal.

CHAIRPERSON RIVERA: So, you know, we—we harp on the numbers a little bit because of our relationship, and I would say that we're—we're new and Dr. Katz you and I are kind of on the same timeline--

MITCHELL KATZ: [interposing] Right.

CHAIRPERSON RIVERA: --I mean in terms of joining the city with a capital C, but does—I want to ask you about NYC Care because we were asking about numbers and there was a recent big announcement, and I want to know does the Mayor's proposed NYC Care Plan affect your advocacy around DSH Funding?

MITCHELL KATZ: I don't see that it—it affects--

CHAIRPERSON RIVERA: [interposing] Well, let me—let me add one thing--

MITCHELL KATZ: Oh, I'm sorry.

CHAIRPERSON RIVERA: --if you don't mind. No, no, that's my fault. Because when—when they announced NYC Care [coughing] de Blasio said and I

quote: "H&H is running a surplus and has turned its financial situation around." Alluding-and that was the quote: Alluding that the city would be able to pay for the new program using savings generated from Health and Hospitals system. So, can you just clarify that and explain how--

JOHN ALBERG: [interposing] Sure.

CHAIRPERSON RIVERA --and explain how it ties to the proposal?

JOHN ALBERG: Sure. So, and, you know, I—I think there is a way to explain it so that-that we're clear to all our stakeholders. So, in terms of, you know, surplus, and we brought in in our first year together $150 million more of pure patient revenue by billing insurance, not by billing patients, but by billing their insurance correctly and that's above and beyond the budget, and it really represents H&H. That's going to snowball over time learning how to bill accurately for people who are insured, which is a big portion of what—what we talked about at our initial budget hearing is that that—that—that's the way to avoid the closure scenario of having to shrink. Instead, let's grow and do revenue. When I—when I talk to people, what

I—what I always say because of this—this Council, this committee is that New York City has done its part to take care of the uninsured. I need the state and the feds to do their part. So, I don't—I don't see the fact that New York is willing to do the right thing in any way, you know, saying therefore the state or the feds don't have to do their part. The way that we have estimated, and it's just an estimate, and we're happy to keep working with—with the Council and with other stakeholders, the cost of—of the NYC Care is we assume that the cost of hospitalization is already covered by the state and by the federal government. Because people pretty much if you get so sick these days that you need to be in the hospital, you don't have any choice. The people I really want to get into NYC Care is the 25-year-old woman who hasn't had a pap smear, right, and she's not going to get one by going to the Emergency Department either. I want to get the people who are exhibiting the signs of Diabetes or hypertension, and I want to, you know, start treating them before they have manifestations of serious disease, and while I'm so proud of Health and Hospitals, it has been historically a hospital based system, a system where

if you go into the Emergency Room, you will get amazing care. What has not been so amazing is the customer service if you're an outpatient. Can I get an appointment? Does somebody answer the phone? Is it convenient to get an appointment at your center? What is the wait times, and often those have lagged, and that's why in crafting the proposal I feel so strongly that what—what the money needs to do is to really focus on getting people the care that they need in the outpatient area.

CHAIRPERSON RIVERA: So, I'll ask about kind of the state's role and reimbursement rates in a second, but I know that my colleague Council Member Moya had a question. [coughing]

COUNCIL MEMBER MOYA: Thank you, Madam Chair. I thank the doctor for being here as always. I was just going back to talk a little bit about sort of the conversations you had at the state level when knowing that the state has two pools of ICP funding one for volunteer and one for the public hospitals. Is the fact that there are these two pools, pose and issue to the public hospital system getting funding?

JOHN ALBORG: No, I don't think so. I mean I—I think, you know, we're in our proposal we're

not necessarily, you know, disturbing the relationship, you know, between the—the current—the current structure. We—we think, you know, the allocation based on uninsured units and eliminating the collar, right all those things we think were kind of the intent of the—the previous workgroup, and I think even, you know, supported by everybody involved. So I don't think that—that-that's the issue. I think the issues that we're trying to grapple with win our proposal is-is really the Medicaid rates that have not been--

COUNCIL MEMBER MOYA: [interposing] Right.

JOHN ALBERG: --adjusted in 10 years.

COUNCIL MEMBER MOYA: Right in terms of that.

JOHN ALBERG: And if you do the fast math on medical CPI, right over a 10-year period, that—that results in—in over a billion dollars for H&H, right. So the real issue, right, one of the many issues that we're trying to address here is the lack of a Medicaid Rate adjustment for many, many years.

COUNCIL MEMBER MOYA: Right, and—and—and that's the conversations that you've had with the

Administration in Albany in regards to—to this and this is part of the ongoing dialogue with the—with the group that's being proposed?

JOHN ALBERG: Yes.

COUNCIL MEMBER MOYA: And-and just back to the Medicaid reimbursement. So, and I came late, and I'm really sorry if you might have addressed this, but there are the reimbursement rates the same across the board for all hospitals?

JOHN ALBERG: In—in our proposal, right, we're introducing this concept of tiered rates where—whereby the rates would be adjusted and there would be higher rates for those safety net hospitals that serve a greater number—a proportional number of Medicaid and uninsured individuals. So, that's the new concept here that we're introducing.

MITCHELL KATZ: I—I would—I would like to add that the rates are the same for everyone, but then the result is that, for example, in Behavioral Health where the rate is very low, only Health and Hospitals is willing

JOHN ALBERG: [interposing] right.

MITCHELL KATZ: --to do a large amount of it.

JOHN ALBERG: Right.

MITCHELL KATZ: So, some of the rates are okay and so hospitals will participate, but then there are other services like Behavioral Health where, you know, we do it out of a sense of mission, but most providers are not interested in doing it.

COUNCIL MEMBER MOYA: Right. Well, that was it. Thank you very much and thank you, Madam Chair for the opportunity.

CHAIRPERSON RIVERA: Sure, so why—why haven't Medicaid rates increased in the last decade?

JOHN ALBERG: Well, what I—I would say is—is because there's just ongoing, you know, pressure on the state budget or the state's global cap. It used to be a feature of the methodology that there would be an annual increase kind of built into the—the methodology, and built into the state law, and that that we not longer enjoy that. So, I—I think it's just, you know, the pressure is on the global cap, the pressure is on state budgets, trying to find—use those resources in other—in other places, but after 10 years, right, it becomes significant stress and—and certainly more of a stress on those

hospital systems that are most depending on Medicaid obviously.

CHAIRPERSON RIVERA: And I know that you said—and we've been joined by Council Member Maisel—I know that you said the conversations are going well, but what if there aren't any changes to the DSH Funding methodologies? How is that—how is that going to affect you and—and even if the proposal were implemented, you know, we have a lot of questions about money and the operating deficit for Fiscal Year 2020 and beyond, and the reason why we asked about NYC Care is because that's—is that additional city funding? So, this is where we—we have a lot of questions. Besides that, a lot of this information again is nuanced and it's complicated. We know that you're in a deficit and you're trying to figure out a way to bill and to do things a little bit more efficiently and then they announce NYC Care, which is additional money that should hopefully help the system. So, we're trying to compare what seemingly are two different things, but in the end of the day, the money is going into H&H.

JOHN ALBERG: Right.

CHAIRPERSON RIVERA: So, I know that I asked a couple of things, but I guess it's like worst case and best cases scenarios where do you foresee the deficit? Should things go your way, and if not and then with the additional city funding for NYC Care where is that coming from?

JOHN ALBERG: So, to answer them in your order. So, worst case scenario if the DSH cut happens in happens in October and the state does not change methodology and so Health and Hospitals bears the entire first part of the cut, right and nobody else does. So that's—that's absolutely the—the worst case scenario for us. Then there's the DSH Cut does not happen but the state does not change the methodology, in which case our costs will not be met while other hospitals that are much better resourced will continue to, in my opinion, benefit from a program that wasn't meant for them. It was meant for Health and Hospitals and other hospitals that take care of a disproportionate degree of uninsured and Medicaid, which is other public hospitals and some of the non-profit hospitals. So that's the—the I think next worst scenario for us. In terms of-of the money and, you know, I still consider myself new to New

York City and how the process works. We are—we've been working with the city, with OMB. I know that the City Council has an important role in approving budgets, and that the budget process is in front of us. I would say that the—the—it would have been impossible to consider doing NYC Care were it not for the Council and the Mayor's support of the transformation of Health and Hospitals. So, we've already brought down the wait times for primary care physicians. We've already decreased the wait time for specialty although now we have a lot more to go. So, a lot of very positive things have happened, and those are the things that would enable this to work as a system, but my understanding is that the dollars or they aren't what has been promised or proposed, what—whatever the right word is. It requires your—the Council's approval would be new money to Health and Hospitals to allow us to provide the kinds of customer service and capacity in the outpatient environment where we've never been able to do that before.

CHAIRPERSON RIVERA: Did you mention NYC Care whether that's—I'm sorry, new-new money?

JOHN ALBERG: The new money to NYC Care is—yes.

CHAIRPERSON RIVERA: Okay, what-what can the Council do to support your efforts?

JOHN ALBERG: I think this hearing and all of the hearings that I've been to, this Council has been incredibly supportive and—and you, yourself Char and other people around this table, you know, have really helped us. I think continuing to advocate with the state for why this proposal should happen, why it's their proposal, why it rose the pie. I think making clear why they need a [coughs] to put into statute that it would be unfair for Health and Hospitals to take the entire cut, and in these are, you know, hundreds of millions of dollars at stake, and so your advocacy means so much to us.

CHAIRPERSON RIVERA: So, besides pushing for the proposal and lobbying, and I know that budget season is upon us, and we'll be having hearings. The one thing I would ask I guess in preparation for the budget is, you know, when you asked you the questions about where is the money coming from, new money, old money, your deficit, the state, it's—it's because we want to continue to increase the transparency between

Health and Hospitals and the City Council because I think that's been a little lacking over the past years, which I'm very vocal about. Is—so pushing forward the proposal I think also what I wanted to ask was that in terms of your capital budget, that's really, really important to us that we have a better understanding of your kind of capital needs and your capital plan. I don't—I don't really feel that well versed on that, and I know that I have a lot to learn, but my crash course the first was that there are a number of capital needs at Health and Hospitals that we would be able to potentially support you with. We just don't have the information.

JOHN ALBERG: I—I—I totally agree with that, and I was so happy with Council Member Ayala was at Metropolitan, and we were able to address some to Metropolitan's needs, and I appreciate her advocacy for that hospital and he importance of it in the community, but you're absolutely right. We have a set of 11 acute care and 5 skilled nursing facilities, and some of them are, you know, brand new and beautiful, and some of theme really need quite a lot of infrastructure improvements not just have

fancy wallpaper, but to be able, you know, to meet our mission of taking care of people.

CHAIRPERSON RIVERA: Well, I don't think my Council Member Colleagues have any additional questions. I just want to thank you first for your testimony. I know we have a lot of questions as time goes on, on how NYC Care will assist you all in doing your job but also, you know, making sure that we call on the Governor to be a little bit more explicit in details on hos H&H is funded when it comes to the Indigent Care Program and DSH Dollars and the future of the largest public health system in the country. So, I just want to thank you for your testimony. I look forward to working with you, and with that, I don't have any further questions.

MITCHELL KATZ: And thank you so much. John and Linda are able to stay. I'm going to go see patients at Governeur for the rest of my afternoon. So, I'm sorry I'll miss the other testimony, but the two of them will be hear, and will tell me what people say.

CHAIRPERSON RIVERA: Alright. Thank you, Dr. Katz. So, we're going to call the next panel. Elizabeth Benjamin from Community Service Society;

Carmen Charles, President, Local 420, DC37; and Anne Bove, NYSNA. [background comments/pause]

CHAIRPERSON RIVERA: Hi and Good afternoon. [background comments]

ELIZABETH BENJAMIN: [off mic]

CHAIRPERSON RIVERA: Yes.

ELIZABETH BENJAMIN: [off mic] My name is Elizabeth Benjamin, and I'm Vice President for Health Services—for Health Issues at the Julia Kirk Society. I want to thank this Council for having this meeting.

CHAIRPERSON RIVERA: Is the button pressed?

ELIZABETH BENJAMIN: [on mic] No.

CHAIRPERSON RIVERA: Okay.

ELIZABETH BENJAMIN: Oh, read means go for this thing. Okay. [laughs]

CHAIRPERSON RIVERA: It does.

ELIZABETH BENJAMIN: Okay. [laughs]

CHAIRPERSON RIVERA: Yeah.

ELIZABETH BENJAMIN: So my name is Elizabeth Benjamin. I'm Vice President for Health Initiatives at the Community Service Society of New York. Was the Co-Chair of the State Indigent Care Panel our most recent Indigent Care Advisory Group?

I also served on the Indigent Care Advisory Group in 2012. I also served on the Indigent Care Technical Advisory Committee in 2008. I've written four reports on this subject starting in 2001 when I was the Supervising Attorney at the Legal Aid Society Health Law, and I'd like to say we've made some progress on this issues, but not all the progress we'd to make and the good news is in our-as a result of our early efforts, we were able to make a lot more progress. I think this past year it's been a little discouraging that we've sort of flattened and made almost no progress at all I'd say in the past year. So, why is this important? And I think the reason why this is important is that there are still 1.1 million people uninsured in New York State. That kind of falls in three clumps. One are people that just can't afford insurance even with the financial assistance that's offered, and that's around 300,000 people. There's another vital group that really matters down in New York City which are immigrants who are ineligible under the Affordable Care Act, and that's around 400,000 people, and then there's a final group of around 300 plus thousand people who are actually eligible for Medicaid or public programs and just

aren't signing up, and that's the sort of trickiest last group to deal with. But there are real proposals that could resolve the problems for the first two. But regardless, since the Governor has not proposed any coverage expansions, and has only proposed a clinician to study the idea of dealing with this last 1.1 million people. It's clear that the problem of a large number of folks around 600,000 in New York City who are uninsured and don't have health insurance, you know, and aren't able to access care are going to be coming to facilities like Health and Hospitals and the other true safety net in securing uncompensated care. So, we would-we are blessed in New York State because we are one of the few states that actually has resources that the state goes out and gets federal matching funds for to help, you know, offset hospitals, you know, expenditures for providing care to the uninsured. The problem is that the way we allocate $1.1 billion of that set of funding is inappropriate, and the reason why it's inappropriate is it—because it's-it's kind of 85% appropriate and about 15% inappropriate. You would think oh, 15%, you know, why are you—why are you still complaining about this all these decades later?

And I would say, it's, you know, around $130 million a year, and that's really money. You know, it just is and that $138 million a year is being inappropriately spent so that there are winders and losers, and the losers guess what? Are the ones that are doing two times more care to the uninsured than the winners? One of the biggest winners is Memorial Sloan Kettering, who, you know, if I get cancer I want to go to Memorial Sloan Kettering, but the thing is if you're uninsured, you can't go to Memorial Sloan Kettering because they are not going to give you a financial assistance application, and that's problem and it's not me just saying that, it's the data that Memorial Sloan Kettering reports to the State Department of Health that we, you know, got under the Freedom of Information Act that reveals it. So, that's the problem. Similarly, not, you know, these winners and losers: New York Presbyterian over three years the win is $9 million, more than they actually spend on charity care. NYU $5 million. Who is losing? Elmhurst Hospital, $22 million. They're losing over three years. Lutheran, $16 million, they're losing over three years. That's a problem and that's why this last 15% we're fighting over and

we care about it. So, I think, you know, we publish a report. I won't bore you on it. You know, it's on our website. I think it's why I ended up becoming one of the co-chairs of the Workgroup this year. We call it Unintended Consequences, and we show how not resolving that last 15% improperly funds hospitals that really aren't doing the work. So, the next—so the at was sort of my first point. You know, I think there's real things that this committee could do around that. I think one of your questions is what can we do, and I think, you know, writing a letter to the Governor and to the second floor of the Administration saying hey, you all never issued—that workgroup never issued a report. It was supposed to issue a report last December. You have nothing in your budget on this topic. There should be something on this budget. Right now, this transition collar that's allowing this last 15% of $185 million or $138 million to be spent and it kind of was inappropriately allocated. It's just going to keep rolling over and rolling over and rolling over. It will only become 100% accountable in the Year 2050. Honestly, I don't even know if I'll be alive in 2050 to write another report on this topic. So, you know,

like let's really. Maybe we could speed it up a little. I don't know. Just think. So, the second issue that I think is really important is one that I think Health and Hospitals did an excellent job of discussing, which is, you know, the way that DSH funding is sequenced in New York State is kind of backwards especially—I mean it's fine under the current system where DSH Dollars are flowing freely. It DSH Dollars—if DSH cuts—if federal DSH cuts to into effect, then it's really problematic having Health and Hospitals pull last from the—the staging, and so that needs to be right sized. So, we—the Community Service Society, as you all noted, signed onto the Health and Hospitals Community Coalition for a proposal. We think that's the way to deal with the DSH sequencing as well as right sizing the Indigent Care Pool. And then, the final thing I would say is, you know, why is that Memorial Sloan Kettering and some of these hospitals are getting more money than actually care they're providing, and it's because we have law at the state level called the Hospital Financial Assistance Law. It has never been adequately enforced. In the 2012 Workgroup, we were able to get 85% accountable. We talked about that

already, but we also got an auditing regime set up so KPMG, the accountants for the State Department of Health would go in and audit how hospitals were providing financial assistance and they had to follow all these rules. Well, guess what? Even if you—and if you pass the audit, you were supposed to get a reward like a special little bonus pool. Well, guess what, even the hospitals that passed, I mean event the hospitals that didn't pass the audit that had many, many questions, you know, wrong, passed. So, it's a regime that everybody, you know, what is it the millennial regime of auditing? I've never seen auditors like pass everybody. You know, usually auditors, you know, have enforcement mechanisms, but we have this: Everybody gets a medal regime set up in how we allocate the—the, you know, how we pass all the hospitals on the Financial Assistance Law, and that's a problem, too. Again, it would be great if you all could get involved with that. So, that's all I have to say. I'm sorry. I decided it wasn't great to read my testimony. So, if I was a little scattered, I apologize for that.

CHAIRPERSON RIVERA: It's okay and we have your testimony for the record, and I think

you're absolutely right in terms of contacting the Governor because of yesterday's underwhelming announcement or lack thereof. So, thank you, thank you, Ms. Benjamin.

CARMEN CHARLES: I'll go in order. Good afternoon Chairperson Rivera and members of the committee Than you for the opportunity of allowing Local 420 to lend its voice to this very important issue. My name is Carmen Charles. I'm the President of Local 420. I represent more than 8,000 men and women that work within the Health and Hospitals hospital system. Many of our members live in the communities where they work. They treat everyone who comes through the hospital doors with compassion, dignity and respect, which is not always afforded to them. Our members play a critical role in system, which has been structured to serve those most in need who area also without the resources to pay. According to current estimates, there are some 600,00 New York City residents without federal coverage as well a another half a million undocumented immigrants who live in fear of coming out in the shadows. For those hundreds of thousands of New Yorkers, it falls upon H+H to provide the healthcare safety net. In

fact, according to a 2017 report, H+H provided more than 50% of the states uncompensated healthcare yet received only 15% of its charity care dollars. At the same time, private hospitals, which provide 42% of that charity care receives 85% of those state dollars. The disparity—the disparity is as disheartening as it is indefensible and now Mayor de Blasio has unveiled a new plan to provide universal healthcare for all New Yorkers. We admire the effort. As the saying goes, every little bit helps. Unfortunately, we live in an era where a plan which will provide an additional $100 million to H+H Hospital does little to reduce the projected $6 billion shortfall. Local 420 has consistently held the position that the funding formula is flawed and has a disproportionate bias against public hospital. Let me just repeat that. Local 420 has consistently held the position that the funding formula is flawed and has a disproportionate bias against public hospital, particularly H+H hospitals. The state's refusal to revive the formula in a manner that brings equity to the distribution of the Charity Care Fund is putting an undue strain on the city's finances. We believe that the formula should be changed so that

safety net hospitals serving the larger number of charity care patients be reimbursed at the rate reflective of its—of the service. I want to commend Dr. Katz for his input on the committee, but I believe the committee needs to be more aggressive in dealing with this issue. Nevertheless, if we continue to serve the healthcare needs of all New Yorkers, this Council, the Administration and all elected officials are going to have to work together to bridge the chasm facing our public healthcare system. This issue has been going on for far too long, and the disparities must end. Thank you very much.

ANNE BOVE: Thank you. Thank you Councilperson Rivera for having this hearing, and your—and your colleagues on the committee on hospitals. I'm Anne Bove, and I'm representing New York State Nurses Association. I'm part of the Board of Directors of NYSNA and I'm also—last year retired after about 40 years of service as a HHC employee registered nurse at Bellevue. I'm just going to cut to the chase in terms of the solution. We know what the problem is. The problem is that money isn't going following the patient. Just like with schools,

you just got to follow the student. It's just not following the patient, and in terms of looking at recommendations regarding that, what NYSNA has recommended is to fix the current edition, you know, Indigent Care Pool structure is that it says please support the H&H community proposal, and that works to eliminate bad debt from both DSH and ICP distributions targeting more funds to two safety net hospitals. And, I guess the other thing that I'm very concerned about is that you have these networks, the five big networks and like for example NYU has taken over Lutheran, but is the money that they're getting going to Lutheran Hospital, which is really managing those patients, or is it somehow getting dissolved into the greater system for that--the non-utilization to who that money was intended for. So, you know, the idea is to make sure that truly it goes to that safety net hospital. NYSNA also supports laws to direct more funding to real safety net hospitals and reduce tax base subsidies to profitable hospital systems that don't need and don't deserve subsidies that they're actually getting. NYSNA also supports increased Medicaid reimbursement rates for all hospitals meeting the definition of enhanced

safety net under the PHL Section of 2807. NYSNA supports immediate change in the priority order for distribution of DSH and ICP fund pools to remove Health and Hospitals from the residual and/or leftover pool that will bear full and sole brunt of any future reductions in federal DSH money. So, it's not an also ran. It's upfront in terms of first getting the money. NYSNA supports treating tiers of hospitals with the ICP voluntary pool based on safety net status to redirect $1. [coughs] Excuse me--$1 billion in that pool to two safety net hospitals and to eliminated funding for hospitals with low levels of Medicaid and uninsured patients or high profits. NYSNA supports changing the technical formula for distribution of ICP funds to target ICP allocations, as I mentioned before to hospitals within the pool with the highest level of Medicaid and uninsured patients. So, the actual provision of care is being supported financially accordingly. NYSNA supports applying means—means testing to totally eliminated DSH and ICP funding for hospitals that are highly profitable and do not serve significant numbers of uninsured and Medicaid patients. So, in essence, you know, looking to what the solutions are and in

essence looking to see that the money truly follows the patient, and it's not just, you know, given to a network that has huge profits bearing and that is—is not—is not following that money directly to who those patients need to receive.

CHAIRPERSON RIVERA: So, for—for those that participated in the—in the—the work group, do you think it needs to be reconvened and—and what were your experiences like?

ELIZABETH BENJAMIN: You know, I thought the work--

ANNE BOVE: No, you go.

ELIZABETH BENJAMIN: Is that okay?

ANNE BOVE: Yeah, I'm fine. No, it's—you're the one it didn't work with. [laugher] Don't worry. We just watched.

ELIZABETH BENJAMIN: So, I mean I think it would be nice to get the report out. We're—we thought the report was going to come. We though that the workgroup members would see a draft of the report in early December, and we're not sur about the status of it, and it would be, you know, it was promised to the Legislature in December and so the—I think as a first step, it would be great to get the report

issued, and I think it would be helpful to, you know, have I think the Workgroup members be on the record about which workgroup members were supportive of which proposal.

ANNE BAVE: Right.

ELIZABETH BENJAMIN: There were several proposals and I think that would be helpful information to have as part of the report, but since we haven't had an opportunity to comment on the draft and the draft hasn't come out—a published report, it's sort of hard to know if it would be helpful to reconvene per se. But I felt like we had four meetings and we all understood it would just be four meetings. I think the thing that's completely concerning is the idea that those transitions collars keeps rolling over, and so if the workgroup does nothing and the Legislature does nothing, and the Governor does nothing it will sunset in March of 2020, but my big concern—at the end of March 2020 my big concern is that they will be continued to—just continue it, and as we know it has, you know, unintended consequences where there are winners and losers, and some of the winners really shouldn't be winners. In fact, you know, New York Presbyterian

has gone on the record in Crain's Magazine a year ago saying we don't even need this money. That's right. They don't really need this money, and yet they get tens of millions of dollars a year. So, you know, maybe they could send a nice check to Health and Hospitals or other safety net facilities. You know most—most states in the country take—and then Institute of Medicine and AHRQ so the big—the big entities, the big sort of intellectual powerhouses recommend that DSH funding is only spent on the top 25% of those true safety net hospitals in the state that provide healthcare to the uninsured and Medicaid beneficiaries. We're one of the few stats that spreads DSH money around like it's peanut butter.

CHAIRPERSON RIVERA: Right.

ELIZABETH BENJAMIN: It's a very unusual practice, and it's really got to stop.

CHAIRPERSON RIVERA: Do you think that the H&H Proposal is going to sufficiently protect the safety net hospitals including the voluntary ones.

ANNE BOVE: Yes.

CHAIRPERSON RIVERA: In the proposal?

ANNE BOVE: Yeah, no-no. Just in addition to that, though, the means testing I think

can augment what that H&H Proposal has to offer. Not just me, but in terms of what we discussed at NYSNA. So that would further secure the funding to follow where it needs to go. I do believe, you know, when you hear advisory, I'm always very suspect to that because even if you come up with a good report, that means somebody has to listen to you, but that way—I—I do believe there needs—there has to be stronger lobbying and maybe even a whole move regarding how this funding needs to be addressed and—and send to the State Legislature, which may have, you know, a more sympathetic—I don't like that word, but a more appropriate ear to the needs of the community. You, now, and, you know, I always find it amazing that, you know, when people say oh, you know, you have so many hospitals, there's eight million people. There's no other city in this country or in even in the world that matches the population that we have here. So, we need to be able to take care of those people.

ELIZABETH BENJAMIN: What the H&H Proposal does it's still-it's still a spreading of the money. It's just pushing the peanut butter onto the part of the sandwich that actually serves more uninsured and Medicaid patients, you know, instead of

now it's people, you know, hospitals that don't do any uninsured patients at all really get—get peanut butter. They shouldn't be getting peanut butter, you know. It's like they shouldn't be getting any of these funds.

ANNE BOVE: Well, when you brought up about Sloan Kettering, you know, the incidents of cancer in people of color is—is lower than the general population but when it comes to the actual treatment and morbidity, mortality rates, they far surpass what that—that general population. So, it's obviously access to care issues and Sloan Kettering can be used. Even when Medicaid first happened back in the '60s, they were suspect. So was Columbia Presbyterian. So, was NYU in terms of not meeting the requirements for Medicare, Medicaid to-to be reimbursable accordingly. So, it's like for 50 or 60 years they haven't been doing what they're supposed to do unless they really are pressed to the limit to do that. So, you know, your support in lobbying accordingly is greatly needed and appreciated. Thank you.

CHAIRPERSON RIVERA: Thank you.

ANNE BOVE: Can I also—Judy Wessler couldn't be here so I submitted her testimony as well, a hard copy. Thank you.

CHAIRPERSON RIVERA: And thank you and—and please count on us to—to lobby. This is an impressive—I think the people that were included and that have endorsed the plan and I think that says a lot about collaboration considering. So, thank you all.

ANNE BOVE: Thank you.

CHAIRPERSON RIVERA: I'm going to ask that Elizabeth Wynn from Great New York Hospitals Association come up. [background comments/pause]

ELISABETH WYNN: Hi. Good afternoon, Chairperson Rivera and other members of the Committee. I'm Elizabeth Wynn, the Executive Vice President of Health Economics and Finance at the Greater New York Hospital Association and I was privileged to be a member of the Indigent Care Pool Workgroup that is the discussion of the topic this afternoon. The Medicaid DSH Program provided $3.5 billion in funding to New York State Hospitals including about $2 billion to New York City Hospitals in recognition of their uncompensated care losses

that they incur from treating uninsured and Medicaid patients. This funding is really critical to ensuring the access to care for low-income, uninsured and other vulnerable populations in New York City and throughout the state. John Alberg and Dr. Katz did an excellent job of describing some of the intricacies [bell] and technical details associated with the calculations. I've outlined some of this in my testimony as well, but I just wanted to briefly touch on two topics this afternoon. First is the real threat of Federal Medicaid DSH cuts beginning on October 1st. This is really the most critical issues facing our member institutions in 2019. New York's share of these cuts are estimated just in terms of the federal share and about $600 million in 2020 and $1.2 billion over the next five years or $6.6 billion if implemented these cuts would really severely jeopardize the ability of safety net hospitals to continue their patient care missions. This is our top advocacy priority this year, and we'll be working closely with the Congressional Delegation, our member hospitals and we'd really urge that you support our advocacy efforts on this. Second, I wanted to touch on the implications of ending the transition collar

that ends—that expires at the end of 2019 under current law. Well, it's easy to conjecture that a transition is no longer necessary. It's important to understand the implications of this transition on certain safety net hospitals including many in New York City and the challenge is really how to balance and address these issues. In my written testimony I've provided a table depicting the impact of eliminating a collar on different groups of hospital including the SUNY's what we call watch list hospitals or those that are in severe financial distress, and receiving extraordinary financial support from the state, and also it's essential safety net hospitals. Straight elimination of the transition collar would mean that the watch list hospitals would incur losses of about $22 million and the essential safety net hospitals would incur losses of over $45 million. Five of the city's essential safety net hospitals would lose more than $5 million each. These include Brookdale, Jamaica, Montefiore, Saint Barnabas and SUNY Downstate. Given their already extremely financial fragile condition, these hospitals simply can't sustain these losses and maintain access to services for their communities.

So the issue of eliminating the collar is really complicate d and needs to recognize the unintended consequences or any solution needs to recognize these unintended consequences. Greater New York is the process of evaluating the proposals brought before the Workgroup including the H&H Consensus—Community Consensus proposal as well as the NYSA and other proposals with our Governance Committees to determine our advocacy position. This exercise, however, is really complicated by the uncertainty of the federal DSH cuts that I mentioned earlier, and again, restoration of these cuts is really our top priority in Washington and the success on this effort really will require the energy of all impacted. I'm happy to take any questions that you may have.

CHAIRPERSON RIVERA: Thank you so much for being here. You're currently still evaluating all three plans? You haven't endorsed any proposal including the one put forward. Is that correct?

ELISABETH WYNN: That's correct. We have a Board of Governors and we will be—we started discussions with them, but we'll continue those discussions in our meetings over the next few months.

CHAIRPERSON RIVERA: When do you think you'll have—I mean, you know, there's a number of—the working group is clearly very diverse and they have put forward a proposal—some of them and I think that Dr. Katz said there was more of a concensus on this than a consensus on anything else or something like. So, when—when do you think you'll have some sort of—some sort of answer or a little bit more details on what you're supporting because clearly you all agree that there is a problem? That there are as—as Ms. Benjamin so I think concisely put there are winners and losers.

ELISABETH WYNN: Yeah, so we will, you know we'll continue to work through our governance process. We have a couple of meetings scheduled over the next month, and so we'll, you know, we'll see where we are in about a month.

CHAIRPERSON RIVERA: How are you looking to expand what hospitals are considered safety net hospitals?

ELISABETH WYNN: I'm sorry. Can you repeat that?

CHAIRPERSON RIVERA: How are you looking to expand what hospitals are considered safety nets.

There's a lot of discussion on how to redefine safety net and at-risk and who gets the dollars. So, how are you working on that?

ELISABETH WYNN: So, one of the things that we always look at is the pair mix or the organization. So, what is the percentage of Medicaid and uninsured as well as Medicare patients, hospitals that treat a large proportion of government pair patients tend to be the most financially distressed. Medicaid given the right phrase that was alluded to earlier only pays about 75 cents of every hospital dollar and Medicare is covering like roughly 85 cents for New York hospitals. So, therefore, there's hospitals with a larger proportion of Medicaid and Medicare patients tend to be the most financially challenged. So that's one factor that we've been looking at. One of the concerns with the existing definition that's that in state law around essential safety net is that there are essentially cliffs that get created because you have to meet kind of hard dollar or hard percentages in order to qualify. Sometimes we look at approaches of kind of doing kind of a gradual tiering. So, it's a—kind of a—more of

the bell curve as opposed to either you're in or you're out.

CHAIRPERSON RIVERA: So, you pointed to a table that was in your testimony that I—I find very helpful regarding the impact of elimination the collar. Do you—do you have figures for what this would look like under each of the proposals?

ELISABETH WYNN: You mean each of the committee—the ICP Workgroup Proposals. I don't but not with me today, but I believe those were provided to the committee, each of the five proponents or the supporter—the sponsors of each of the proposals did provide those to the Workgroup. So, that's something that we could give you.

CHAIRPERSON RIVERA: Yeah, can—can you send that to us? We'd—we'd love—I'd love to see that. You know we—we-again, this is all about in the end it's just addressing the disparities between well resourced and needier hospitals and I know you have a very diverse I guess membership or—or group. So, I am looking forward to kind of what your final outcomes are in terms of what you decide, and if you could give me those numbers, I would really, really

appreciate it, and thank you. Thank you for your testimony.

ELISABETH WYNN: Thank you.

CHAIRPERSON RIVERA: So with that, I'm going to call—there's two more, the last panel. Roos Tekenen from the CUNY School of Public Health. I know, you're independent, and Anthony Feliciano from the Commission of Public Health Systems. [background comments/pause]

ROSA TEKENEN: Alright, good afternoon. I will jump right in. My name Rosa Tekenen. I'm a former research associate at the CUNY School of Public Health and I'm delighted to join you at this hearing this afternoon, and thank you very much for the opportunity to testify. Today I will be sharing with research findings on recommendations regarding charity care payments made from the State Indigent Care Pool to New York City Hospitals from a report that I co-wrote in 2017 for the New York State Health Foundation. I'll start with some background, and then I'll step into the actual report findings. So, as you know, the Indigent Care Pool Workgroup was established in 1996 as the Bad Debts and Charity Care Pool with a goal to compensate hospitals for care

provided to uninsured and Medicaid patients according to the level of need due providing charity care. The pool is funded through federal Medicaid Disproportionate Share Hospital or DSH Fund and state taxes collected by the Healthcare Reform Assessment of HCRA, and as noted earlier, HCRA redistributes approximately one-third of State Medicaid DSH dollars. Prior to 2012, several investigations including those from Elizabeth Benjamin and colleagues and the Commission for the Public Health System had conclude that payments from this pool were not adequately channeled to safety net hospitals and recommended that the state revise the payment formula. In 2012 the state did exactly that in part to comply with new federal requirements. The Affordable Care Act prohibits using federal DSH dollars for hospital bad debt. That is uncompensated care provided insured individuals. Instead, DSH funds can only be used to pay for charity care, i.e., uninsured care. The state thus renamed the pool as the Indigent Care Pool and removed bad debt from the calculation formula. However, as we've heard today, the state decided to save in this new methodology very gradually. We've heard referrals to this as the

Transition Collar in the interest of protection individual hospitals from large revenue fluctuations. So, now I'll jump into findings from my report that as submitted to the New York State Health Foundation. So, in 2017, me and my colleagues at the CUNY School of Public Health published this report that investigated whether the 2012 reforms to the Indigent Care Pool Workgroup payment methodology had resulted in one that more fairly compensated safety net hospitals, and for this report I analyzed data from the New York State Health Department examining charity care payments made to New York City Acute Care Hospitals. My report found that New York City private hospitals were more generously rewarded despite providing less uninsured care. The 12 public hospital in New York including Health and Hospitals and SUNY Downstate provided more than half of all uninsured services in the city or 58% but received one-seventh of total Indigent Care Pool dollars paid to New York City hospitals. To further illustrate this disparity, I will share an example. Jamaica Hospital, a private non-profit hospital and North Central Bronx a public city hospital both provided approximately 45,000 uninsured services in 2013.

Despite providing similar levels of uninsured care, Jamaica received an ICP payment o f $34 million, which I s eight times greater than that received by North Central Bronx received, which is $4 million. Further, we show that Indigent Care Pool payments are not related to need measured as uncompensated care costs, i.e. the hospital financial losses from uninsured services. We found that the average private hospital in New York City incurred between 46 and $8 million in uninsured losses yet received Indigent Care Pool payments that exceeded these losses by 50 to 80% on average. Some hospitals such as Lenox Hill and Brooklyn Hospital received Indigent Care Pool Payments that exceeded their uninsured losses by more than ten fold. In contrast, uninsured losses for the city's public hospitals averaged at $42 million i.e. four to five times greater than for the average private hospital yet their Indigent Care Pool payments compensated only a fraction or 18% of these losses. We found that there are two key provisions in the Indigent Care Pool distribution methodology that prevents these funds from going to true safety net hospitals. One is the transition payment formula that we have heard being referred to

as the transition collar earlier today that was introduced as part of the 2012 reforms. It sets a floor and a ceiling for Indigent Care Pool payments relative to previous years as allocation. In 2019, the floor is set up 17%. This means that no hospital can lose more than 17% relative to what they received in the previous three years. This floor increases by 2.5% each year and as Elizabeth Benjamin pointed out earlier, this means that the Indigent Care Pool will be fully implemented in terms of this new methodology by 2050. The fact—the second provision in the distribution methodology is the statutory caps on public and private hospitals. These are currently set at $139 million for public hospitals across the state and $994 million for private hospitals. Because private hospitals provider fewer uninsured services than the public's overall, this higher gap essentially guarantees that these facilities continue to receive Indigent Care Pool payments that exceed their need. I will now move onto the recommendations that we made in the report to more thoroughly reward safety net hospitals. (1) We recommended that the transition payment formula or collar be abolished or accelerated because it continues to link Indigent

Care Pool payments to historical allocations. So, although the new methodology in 2012 is more equitable than previously, it is being phased in s gradually, which means that the majority of Indigent Care Pool payments continue to be tied to hospital bad debt, which is now disallowed under the ACA. (2) we recommended that ICP payments be better targeted to a smaller group of hospitals with the greatest needs. This is because the majority of hospitals in New York City are eligible for Indigent Care Pool payments. However, this means that these crucial funds should be better targeted to a smaller number of true safety net hospitals as they are in other states. (3) We recommended that the pools available for public hospitals from the Indigent Care Pool be increased to more closely align with actual provision. The city's public hospitals are unfairly disadvantaged by the $139 million cap imposed on public hospitals especially seeing that they provide the vast majority of charity care. Or, we recommended that the state impose a facility level ceiling for maximum Indigent Care Pool payments that cannot exceed their need, i.e., uncompensated care costs, and this is because some hospitals in the city

receive millions of dollars in ICP payments without incurring any uncompensated care costs while others receive payments that far exceed their actual loses by several fold. (5) We recommend that the state monitor non-profit hospitals as charity care provisions. This is because in New York State the state law mandates that private hospitals operate as non-profits, i.e. charities. While some private hospitals in the city are true safety net hospitals, other institutions do not provide much charity care. Yet, they continue to receive tax exemptions worth millions of dollars each year because of their charitable status, and I will note that there are some states such as Illinois and Pennsylvania that require a non-profit hospital to meet minimum charity care requirements in order to keep their tax exemptions. To close, I would like to make a note on urgency. The way in which New York allocates its charity care payments to hospitals is not only a matter of complying with federal regulations, but also social justice. New York City has a highly segregated hospital system whereby black and minority patients as well as uninsured and Medicaid insured individuals are disproportionately served by the

city's public hospitals and safety net institutions. In the past two decades, the city has seen several safety net hospitals shut down in low-income areas while public hospitals have been financially struggling alongside, and when the charity care funds fail to reach these institutions, their patient populations also suffer as a consequence. I thereby urge the City Council to work together with the State Department Indigent care Workgroup as they revise the payment methodology. Thank you. I'm happy to take questions now.

ANTHONY FELICIANO: Good afternoon. My name is Anthony Feliciano. I'm the Director of the Commission on the Public Health's System. So, it's good to have Lisa and our other colleagues say the right things because then that means I don't have to always repeat myself here. So, I'm just going to go and shorten my—my testimony and to say why I'm here. Some hospitals reap the benefits of getting state charity care funds, but continue to not provide sufficient care to immigrants and low-income communities of color, people of color. Access to healthcare has been seriously reduced and will continue to be if more hospitals continue to be

financially bleeding especially public hospitals. I'm sure that in yesterday Governor's State of the State Address that the increase of funding in healthcare will fix that partially because we have not learned all the details, but I will that we mapped out so many closings over the years, and even when they close they don't—they don't benefit the community they're tending to or the real estate value issues. But I also want to say that charity care funding is determined—must be changed so that it more closely matches with uninsured and people on Medicaid that are treated. I'm going to skip some of the historic on the history piece as some of the political gaming that's happened in the past and go to page 3 and say that we have to be aware of several critical issues regarding both federal DSH and ICP funds. (1) Powerful political and monetary influences have been used to tilt charity care policies toward the protection of our academic (sic) medical centers and possible hospitals. Often to the detriment of community hospitals, public hospitals and the communities that they serve. Several private hospital networks operate with huge surpluses and serve a very low percentage of uninsured and people

on Medicaid. The large private hospitals have grown into multi-site healthcare networks and have positioned themselves to benefit from changes in the healthcare sector. The combined net revenue of the five major private hospital networks were $877 million in 2016 up and over one-third from $650 million for all five in 2014 and 2015. We now have some legal definition in the State Hospital Code that defines public hospitals urban and rural voluntary hospitals that provide critical services. Although this is separate from the ICP funding, it provides some guidance around the ICP method for change. The other one is HHC remains exposed to the brunt of looming federal DSH cuts. Allocation of DSH funding is unfair, the sequencing as well, as you heard before, and then you also have the Affordable Care Act that actually reduce DSH payments nationally because uninsured will be more eligible, but we know in New York State we're still serving many uninsured and people that are still not eligible as you heard before. So, basically the—the position with that needs to be equalized and fair, and so we support all the stuff that Health and Hospitals proposes and is apart of, and also NYSNA. So, I'm not going to go

through all the pieces of that, but I will say and I will reiterate what Elizabeth said. When Manny's (sic) law in 2--was put together around financial systems, we still have hospitals now providing the information around financial assistance and it needs to be more closely monitored and protected particularly as we know that medical debt and other issues and quality of care and also access to care is so important. So, thank you, Council Member Carlina Rivera and staff. Thank you.

CHAIRPERSON RIVERA: Thank you so much. I wanted to ask to—you know based on your-on your I guess you studies, Ms. Tekenen, you know, you heard some of the proposal that was put forward I guess that was endorsed by—including Anthony is one of the people that have support the proposal. I know you don't have a lot of details about the proposal besides maybe what you saw if you saw the slide show, but do you feel it's in the right direction? I mean based on what you've said I mean I see a lot of—this is probably the one—one hearing that I would say we're very, very all kind of aligned, and we all share a lot of the same ideals. Do you see the proposal going in the right direction based on your

research? Because some of the-some this—I don't want to call it anecdotal because you're giving us actual hospitals and what they received compared and the Jamaica example was to me very I guess enlightening. Do you see it going in the right direction? .

ROSA TEKENEN: Yes, I actually have the details of two proposals in front of me including the Health and Hospitals Committee Coalition Proposal, and the one thing that we've heard today is the alignment seems to be in the area of the transition collar, which I recommended either accelerating or eliminating entirely. However, I have not analyzed the impact of them. The other area that I didn't touch upon in my report was the Medicaid rates. . Obviously the reason we have Indigent Care Pools at all is uninsured and the fact that Medicaid rates are low and it should be noted that the Indigent Care Pool was founded in 1996 when NYSNA (sic), which is hospital rate setting was abolished in New York State. Maryland is the only hospital that continues to have that system and, you know, if I got to rebuild a system from scratch that is one thing I would introduce is all payments to all hospitals regardless of which insurance you have. So, that's

obviously and important piece of this puzzle is to increase Medicaid rates, and then at the other area where my recommendations align with these proposals from New York Health and Hospitals and NYSNA is the fact that like I pointed out, a lot of non-profit hospitals do not clearly have a charitable mission, and there is an attempt to make a distinction between those voluntary hospitals that are, too, safety nets versus those that are not and that I definitely endorse.

CHAIRPERSON RIVERA: And—and Mr. Feliciano, what—what would you say your experience is like. You're part of the Working Group?

ANTHONY FELICIANO: No, I wasn't part of the Working Group. I participated by going there, and part of the actual collation so--

CHAIRPERSON RIVERA: So, what was-what was the experience like in terms of-because there's a number of stakeholders right that were included that I know you work really closely with, and you have an amazing relationship with over the years. Do you—do you feel like they got to in the four meetings and—and through some of the work that you've seen

addressed enough of—of the issues that we find so troubling?

ANTHONY FELICIANO: I don't think they fully addressed it. I think we should have met more times, but when there was consensus around the transition collar removal somewhat, and some of the other stuff, it's not the question of the consensus that I have an issue, it's a question of how you're going to do it, and that's where you see the differences across the board with the folks that were there. The majority of folks who were there supported some of the H&H Proposal, the TS System design and all that, which I think would address a lot of the issues, but there's also this issue of political gaming going on, and it always goes on, and so I think we need the Council to step up even if it's not in your purview in terms of your powers, is to really get to your state colleagues, and tell them why it's important to make the change and all that. The other piece of it I think is going back to what Elizabeth said, one thing is to get the report out, it's another thing to also get it implementable and think through, and so those are some of the issues. I mean the work group has folks that there was a lot of good

on there. I don't think it was diverse enough but that's not the issue we have to deal with. Now we have an issue of there's nothing the State that we know of in terms of details that really addresses the core type of charity care funding and the fixes that needs to happen.

CHAIRPERSON RIVERA: So, I just want to say that I know that there was a recommendation for us to, of course, to lobby the Legislature, which we'll certainly do and whether it's in Albany or it's in DC or it's here in New York City, you all have my commitment and—and we will be contacting the Governor. So I hope that I can call on the people in this room to-to support me and assist me—assist me with making sure that that messaging is direct and on point and comprehensive. So, I just want to thank you all for being here, for giving us your time, for continuing to work on this for years and decades, and I really do appreciate all the work you've done around healthcare because I think we all agree that is a human right, and right now in one of the most progressive cities in the world, not everyone has access. So, I don't have any further question, but I just want to again thank every and I want to thank

H&H also for staying and-and listening to—to the testimony today and with seeing no one else to testify, we are going to adjourn the hearing. Thank you so much everyone.

C E R T I F I C A T E

World Wide Dictation certifies that the foregoing transcript is a true and accurate record of the proceedings. We further certify that there is no relation to any of the parties to this action by blood or marriage, and that there is interest in the outcome of this matter.

Date February 1, 2019