**Testimony of Bill Hammond**
*Senior Fellow for Health Policy, Empire Center for Public Policy*
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In writing this year's budget, the Legislature should resist the clamor for another big increase in Medicaid spending – first, because the state can't afford it, and second, because more spending won't fix the most important problems.

If money were the answer, New York's health-care system would already be the envy of the world. New York spends more per capita on Medicaid,[1] and on medical care generally,[2] than any other state in the U.S., and the U.S. spends more than any other country.

Yet New York's hospitals consistently rank near the bottom of quality report cards.[3] Its emergency room wait times are among the longest in the country. Lawsuits by the attorney general have exposed widespread neglect and profiteering in its nursing homes. And when a new virus arrived, its major population center suffered a deadlier first wave than virtually any other place on the planet.[4]

Given the fiscal crunch, New York should focus on spending smarter, not bigger. Legislators should seek to eliminate waste, improve efficiency and choose targeted investments rather than across-the-board increases.

One urgent but low-cost priority should be reviewing and strengthening the state's pandemic defenses. Four years after the worst natural disaster of modern times – which revealed New York to be both acutely vulnerable and painfully unprepared – the state has not yet properly analyzed what happened, let alone repaired the many systems that failed.

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[1] Financial management reports from the Center for Medicare & Medicaid Services, available at https://www.medicaid.gov/medicaid/financial-management/state-expenditure-reporting-for-medicaid-chip/expenditure-reports-mbescbes/index.html.

[2] CMS National Health Expenditure data by state of residents, available at https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/state-residence.

[3] See, for example: https://www.empirecenter.org/publications/new-yorks-hospital-industry-ranks-near-the-bottom/

[4] Bill Hammond, "Behind the Curve: The Extreme Severity of New York City's First Pandemic Wave," Empire Center, Aug. 30, 2023. https://www.empirecenter.org/publications/behind-the-curve/

To cite a small but telling example: A March 2022 comptroller's audit found that the Health Department's system for monitoring nursing home outbreaks, known as NORA, had been dysfunctional for years, rendering it useless when COVID hit.[5] When the comptroller followed up 18 months later, it found the department had done nothing to repair NORA's flaws but was still using it anyway.[6]

How many known issues like this has the department failed to address? And how many *unknown* issues remain to be found – because the state has yet to conduct the after-action review that should be routine after disasters of any size?

Governor Hochul belatedly ordered a consultant's study last year, but the firm has no power to subpoena documents or witnesses and no mechanism for public hearings. A catastrophe of this scale demands a more robust and transparent reckoning.

A bill introduced by Assembly Member Gonzalez-Rojas and Senator Salazar would establish a pandemic investigation commission, made up of outside experts, with full investigatory powers and a requirement to hold multiple public hearings.[7] Its mission would be to document what happened, analyze where things went wrong and recommend the changes necessary to safeguard the state against future threats. In the spirit of the National Transportation Safety Board and the 9/11 Commission, its mandate would be to improve systems, not point fingers.

Lawmakers should approve the study without delay – and make sure that this year's budget allocates the modest funding necessary for this crucial task.

With respect to Medicaid, lawmakers should be aware that spending on the program has been escalating at unprecedented rates – at a time when enrollment is flat or declining. Last week, the governor confirmed that the state share is running $1.5 billion over budget, putting it on track to jump by 15 percent in this year alone and 62 percent over the past three. Again, that rapid growth comes on top of what was already the highest per-capita Medicaid spending of any state.

The drivers of this surge include big fee increases for providers, bonuses granted to a range of workers, hikes in the minimum wage, higher operating subsidies for money-losing hospitals and seemingly bottomless demand for home-based long-term care, especially for the non-medical supports known as personal care.[8]

New York's Medicaid program spends almost as much on personal care as the other 49 states combined. Enrollment for this benefit, after a pause during the pandemic, has resumed its relentless upward climb. This cannot be explained by demographics alone: From 2015 to 2020, personal care spending grew more than five times faster than the over-65 population.

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[5] Office of the New York State Comptroller audit, "Department of Health: Use, Collection and Reporting of Infection Control Data," March 2022. https://www.osc.ny.gov/files/state-agencies/audits/pdf/sga-2022-20s55.pdf

[6] Office of the New York State Comptroller follow-up letter to the Health Department, Dec. 20, 2023. https://www.osc.ny.gov/files/state-agencies/audits/pdf/sga-2024-23f13.pdf

[7] Assembly Bill No. 8053, Senate Bill No. 8168. https://nyassembly.gov/leg/?bn=A08053&leg_video=

[8] See, for example, Bill Hammond, "Long Term Crisis: The Case for Reforming Medicaid 'Personal Care' in New York," Nov. 14, 2022. https://www.empirecenter.org/publications/long-term-crisis/

While the specific of the governor's cost-cutting proposals are debatable, she is right to say that Medicaid's recent growth rates are not sustainable – and to advocate a slowdown this year.

In the area of labor, legislators should be wary of claims about severe or widespread shortages. According to federal employment data, New York's overall health-care workforce is bigger and better paid than ever. It now employs more health workers per capita than any other state, having surpassed Minnesota and Massachusetts over the past four years.[9]

That said, there are wide disparities among provider types and regions of the state. Home health care employment is 21 percent higher than it was before the pandemic, while nursing home employment is 18 percent lower. Upstate payrolls have generally bounced back slower than those in New York City and its surrounding suburbs.[10]

In this context, across-the-board rate increases would be counterproductive. They would send a disproportionate share of money to the New York City area, where Medicaid enrollment is concentrated, and relatively less to parts of the state where hiring remains most difficult.

Also dubious is the claim that Medicaid is underpaying hospitals by 30 percent. The TV ads making this assertion do not provide a source for this figure or define how it is calculated, making the figure hard to dispute. However, a federal study of Medicaid hospital fees in 2010 found that New York's rates were higher than the national average – and, when supplemental payments were factored in, higher than the fees paid by Medicare.[11] Other more recent federal figures show that New York's per capita hospital spending from all payers, public and private, is the highest in the U.S., and that gap with the national average has been getting wider.[12]

In their own financial reports, hospitals across the country say that Medicaid pays them less than the cost of care. But this self-reported gap is generally lower among safety-net hospitals and higher among hospitals serving wealthier patients. If Medicaid were to move toward paying 100 percent of costs – as the hospitals propose – it would be paying the highest fees to the least needy institutions. It would also incentivize hospitals of all kinds to inflate their expenses, a recipe for soaring costs.

Such a change would also be enormously expensive. Eliminating a putative 30 percent shortfall for hospitals alone would cost Medicaid about $7 billion per year, $3.2 billion of which would come from state coffers. If a similar adjustment were to be made for all Medicaid providers – nursing homes, clinics, home health care organizations, physicians, etc. – the price tag would balloon to approximately $43 billion, including $19 billion from the state. The latter amount is the equivalent of a roughly 33 percent increase in the state's personal income tax.

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[9] Employment data from the U.S. Bureau of Labor Statistics. https://data.bls.gov/cgi-bin/dsrv?sm

[10] Ibid.

[11] Medicaid and CHIP Payment and Access Commission, "Medicaid Hospital Payment: A Comparison Across State and to Medicare," April 2017. https://www.macpac.gov/wp-content/uploads/2017/04/Medicaid-Hospital-Payment-A-Comparison-across-States-and-to-Medicare.pdf

[12] Op cit., CMS National Health Expenditure data by state of residence.

One sector of the health system that's facing a genuine crisis is nursing homes.

Both their patient populations and employment levels remain well below what they were before the pandemic – and show no clear sign of bouncing back. Most are out of compliance with new state-imposed minimum staffing requirements, putting them at risk of financial penalties and deterring them from accepting new residents. The attorney general has filed a series of lawsuits accusing some of the most prominent operators in the state of neglect, abuse, profiteering and fraud.

Yet even in this case the Legislature should be cautious about broadly increasing support from Medicaid. The attorney general's suits have also documented that owners are drawing hefty profits from seemingly money-losing institutions thanks to the widespread use of so-called related-company transactions. In the absence of a smarter reimbursement system from the Health Department, any infusion of Medicaid money would be at risk of going to waste.

If legislators are truly committed to making New York more affordable, they need to find ways of truly bringing down high health-care costs, not simply shifting the burden onto taxpayers.

The governor has pointed to one promising approach – reforming professional licensing, scope of practice rules and certificate-of-need regulations.

These regimes limit competition and restrict choice – a combination guaranteed to drive up costs and drive down quality.

Legislators who care about affordability should want it to be as easy as possible for professionals licensed in other states and countries to bring their skills to New York. They should be empowering nurse-practitioners, pharmacists and other non-M.D.s to make full use of their training – and to fill gaps in the delivery of primary care. And given the generally low quality and high cost of the state's hospital and nursing home systems, they should welcome healthy competition from new players.