March 3, 2011

Testimony to the Joint Legislative Committees' Public Hearing on the 2011-12 Executive Budget: Recommendations to Combat the Costly Epidemic of Diabetes in New York State

On behalf of Novo Nordisk, a global healthcare company with 87 years of innovation and leadership in diabetes care and commitment to defeating this disease, **I strongly urge the New York Legislature to focus on the drastic economic impact and personal toll that diabetes has on the Medicaid program and population of New York.** While it is a positive step that the Medicaid Redesign Team (MRT) did not omit Recommendation #181 "Coverage for obesity counseling/diabetes prevention services" in its final vote, the MRT did move to make this a long term proposal to review later this year.

Given the magnitude and seriousness of the disease and its disproportionate impact on the elderly and minority populations in New York, a committed strategy and action plan to combat this ravaging chronic disease is critical to the future well being of New York for both the health of state's residents and from an economic policy perspective. Accordingly, combating diabetes is an issue on which the Legislature as well as the MRT must review effective alternatives and take action.. This is an opportunity to reverse the growing financial costs stemming from diabetes across the state and to continue establishing New York as a national leader in health wellness and promotion.

Diabetes is an epidemic in New York State

Statistics confirm that diabetes is already an epidemic in New York. Last year, diabetes affected over 2 million New Yorkers, nearly 1 in 10 of all residents. Of those, over 750,000 people did not even know they had the disease. An additional 3.68 million New Yorkers are estimated to have pre-diabetes.

Along with the human toll of diabetes in New York, diabetes also has an enormous economic impact on the state. Recently commissioned work conducted by the Institute for Alternative Futures (IAF) shows that **diabetes cost New York $18.2 billion in 2010**, including $12.8 billion for medical costs and $5.4 billion for nonmedical costs.

According to the IAF projections, the cost of diabetes in New York will grow by $9.5 billion dollars over the next fifteen years, jumping to $22 billion in 2015 and up to $27.7 billion in 2025. In the same time span, an additional 900,000 people in the state will be living with diabetes or pre-diabetes[1]. Since **over 90% of people with diabetes have at least one additional comorbidity** such as obesity, heart disease, high blood pressure or high cholesterol levels, there will likely be additional costs associated with these other chronic diseases not captured by the IAF projections.[2]

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[1] The Institute for Alternative Futures, *Diabetes 2025.* Estimates are based on national data and population projections. They assume a steady but conservative reduction in cases of undiagnosed diaibetes, due to heightened awareness of the risks, earlier screening and intervention and more effective therapies.

[2] Parekh, Anand, et al. "The Challenge of Multiple Comorbidity for the US Health Care System." *Journal of the American Medical Association.* 7, April 2010.

With data showing that people with diabetes are more likely to come from economically disadvantaged backgrounds and that minority populations have higher prevalence rates of diabetes than their Caucasian counterparts, the state Medicaid program is shouldering a significant portion of the state's overall diabetes burden. Additionally, New York State Medicaid costs are 69% more per beneficiary than the national average with spiralling costs due in part to lack of preventative care for individuals with chronic health conditions, such as diabetes.[3] On average, **the annual cost of health care for a person with diabetes is more than five times the cost for those without diabetes—$13,000 vs. $2,500.**[4]

What Can Be Done

It is encouraging to see that New York State recognizes the need to address the diabetes epidemic by funding new programs such as Diabetes Self-Management Training (DSMT) starting this year. However, still more needs to be done if we are truly to tackle this growing healthcare challenge. More specifically, there needs to be a greater involvement in the healthcare of the quarter-million people with undiagnosed diabetes and the over three million residents at risk for diabetes. Through screening and prevention efforts, the state can curtail costs down the road of undiagnosed and mismanaged diabetes.

New York's involvement must involve reprioritizing its investment in the prevention of diabetes and diabetes complications. We recommend several initiatives that can be implemented and, although there are short-term costs associated with them, they will be outweighed by the long-term savings in reduced hospitalizations and medical care. By taking action today, the State can begin to put itself in the best position for long term savings to combat the epidemic of diabetes.

We hope that the Legislature will consider the following policy imperatives that will address the epidemic of diabetes in New York, reduce the costs of the disease, and improve the overall health and quality of life of New Yorkers:

- Implement a state-wide screening program consistent with current recommendations so that adults and children at increased risk for diabetes can be tested within the health care setting. This would align with Proposal # 181 focusing on diabetes prevention services.

- Utilize Affordable Care Act funds to explore new payment and delivery system models that better coordinate care for patients with diabetes. This may include: Accountable Care Organizations (ACO) and Patient-Centered Medical Homes (PCMH), especially once people at risk for diabetes have been screened and diagnosed. An additional benefit of coordinated care for patients is increased cost savings, higher patient satisfaction and reduced burnout for health care providers.[5] Novo Nordisk supports the MRT's call for increased care coordination.

- Consolidate all diabetes programs and efforts under a **statewide diabetes coordinator**: In order for New York State to effectively tackle the epidemic of diabetes, there must be a position in the new administration that reflects the severity of this crisis. The creation of a state-wide diabetes coordinator to implement and oversee diabetes activities and initiatives across agencies would reduce any duplicative efforts and send a message that New York is serious about combating this disease. The coordinator's charge would also include:

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[3] Kellermann, Carol. "Citizens Budget Commission Recommendations for the Fiscal Year 2009-10 Budget to State Legislators." February 2, 2009.

[4] Hogan P, Dall T, Nikolov P. "Economic Costs of Diabetes in the U.S. in 2002." *Diabetes Care*. 2003. *917-32*

[5] Reid, Robert, et al. "The Group Health Medical Home at Year Two: Cost Savings, Higher Patient Satisfaction, and Less Burnout for Providers." *Health Affairs* May 2010.

- Ensuring that the **Medicaid program biannually identifies its priorities for addressing diabetes in a report to the Legislature and Governor**. A biannual report should identify how best to fight diabetes while directing public health entities on programs that should be implemented to help achieve a goal of controlling and reducing the burden of diabetes in New York. An example of this is the expansion of the **New York City A1c Registry Program** across the state. A1c measures average blood sugar levels over the past 3 months of an individual. The registry in New York receives this measure from laboratories that process blood tests in New York City and the results are used by the Registry and Department of Health and Mental Hygiene to monitor blood sugar control in New York City over time and support providers and their patients in improving diabetes care. An expanded program would be able to monitor the treatment and health of people with diabetes across the state.

- **Biannually reporting on the impact of diabetes on NY and** conducting an assessment of the reach and scope of the state's current work on diabetes prevention and treatment including the **development of a budget blueprint identifying needs, costs and resources** for diabetes and its complications to guide policymakers and elected officials on how best to fight the disease.

Why Diabetes?

Among the many chronic and acute diseases affecting New Yorkers, none has an economic and social impact greater than diabetes. And none is growing at a faster rate. Combating diabetes presents a great opportunity for targeted interventions that are consistent with the focus of the Medicaid Redesign Team, including:

- saving lives and reducing the incidence of co-morbidities;
- reducing health care costs and increasing economic productivity;
- supporting prevention and wellness across the lifespan—from children and adolescents to adults and seniors;
- reducing geographic, racial, and ethnic disparities.

Again, while it is promising to see that the MRT has identified diabetes screening as a proposal to discuss in the long term, I urge Members of the Legislature to remain committed to this chronic disease as a healthier New York and greater savings for the state can be achieved if effective diabetes screening and treatment programs are implemented. Novo Nordisk stands ready to support your work and welcomes the opportunity to work with the New York Legislature to shape these ambitious efforts. Feel free to contact me or our Government Affairs Associate, Manan Shah (609-216-5629; MNXS@novonordisk.com).

Thank you for your time and attention. We would be happy to discuss further with you our recommendations to tackle this epidemic.

Sincerely,

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New York State Senate and Assembly
Joint Session
on the
FY 2011-2012 Executive Budget - Health
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Supportive Housing Network of New York
Ted Houghton, Executive Director

Good afternoon. My name is Ted Houghton, and I am the Executive Director of the Supportive Housing Network of New York. The Network represents more than 200 nonprofit providers and developers who operate over 43,000 supportive housing units throughout New York State, the largest supportive housing membership organization in the country.

Supportive housing – permanent, affordable housing linked to on-site services – is the proven, cost effective and humane way to provide stable homes to individuals and families who have difficulty finding and maintaining housing. The people we house and serve – people with mental illness, HIV/AIDS, substance abuse, and other barriers to independence – are typically frequent users of expensive emergency services like shelters, hospitals, prisons and psychiatric centers. Because placement into supportive housing has been proven to reduce use of these services, supportive housing saves State taxpayers' money, often far more than what was spent building, operating and providing services in the housing. This has been proven, time and time again, by dozens of peer-reviewed academic studies.

With much of the recent public conversation focusing on how we can reduce Medicaid spending while still improving care, I thought it made sense to share some data points on just three of the many studies that have measured the Medicaid savings that supportive housing achieves. For example:

- The Chicago Housing for Health Partnership (CHHP) followed 407 chronically ill homeless persons (many living with HIV/AIDS) over 18 months following discharge from hospitals, with half placed in supportive housing and the other half receiving regular care. Supportive housing reduced hospital days by 46%, emergency department visits by

36%, and nursing home days by 50%. Placing 200 individuals into supportive housing saved $900,000 a year, minus the cost of housing.[1]

- The University of Pennsylvania studied 4,679 homeless people with severe mental illness who were placed into supportive housing in New York City.[2] Looking at pre and post placement data, as well as a matched pair control group, the study found that those placed in supportive housing reduced their use of state psychiatric centers by 50%, and hospitals by 21%. While use of outpatient Medicaid went up as newly-housed people received medical and behavioral health treatment, inpatient Medicaid costs went down enough to produce overall Medicaid savings of $1,200 per person per year.

- In Seattle, supportive housing was provided to 95 homeless people with severe alcoholism, usually accompanied by other chronic illnesses.[3] Compared to a control group, the supportive housing residents reduced their total public costs by 74%, from $4,066 per person/month when homeless, to only $958/month after a year of being housed. Nearly 60% of these savings stemmed from a reduced need for medical services.

Studies confirm these savings, year after year. Yet I still have to come here and recite them every March. I recognize that New York State leads the nation in supportive housing creation. But the fact is, we continue to fall far short of the need. And so we continue to rack up enormous, unnecessary costs providing inadequate emergency care to people who are homeless and ill-housed.

A researcher from Johns Hopkins once said, "If housing was a pill, we wouldn't be arguing about this. We would have long ago prescribed housing as the cost-effective cure that it is." Dr. David Holtgrave was studying people living with AIDS. He found that supportive housing cost just $16,100 per quality-adjusted life year saved. This was more cost-effective for people living with AIDS than *every medical* intervention except one, Enalapril, given for congestive heart failure.

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[1] Sadowski, L., Kee, R., VanderWeele, T., & Buchanan, D. Effect of a Housing and Case Management Program on Emergency Department Visits and Hospitalizations among Chronically Ill Homeless Adults: A Randomized Trial. *JAMA*. 2009;301(17):1771-1778.

[2] Culhane, D., Metraux, S., & Hadley, T. Public service reductions associated with placement of homeless persons with severe mental illness in supportive housing. *Housing Policy Debate*. 2002;13(1):107-163.

[3] Larimer, M., Malone, D., Garner, M., Atkins, D. Burlingham, B., Lonczak, H., Tanzer, K., Ginzler, J., Clifasefi, S., Hobson, W. & Marlatt, A. Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems. *JAMA*. 2009;301(13):1349-1357.

And yet we let tens of thousands of New Yorkers continue to live outside and in shelters, where they get sicker and sicker, and more and more expensive to the public. Already, the average person with schizophrenia lives *twenty years less* than an individual without the disease. We know this fact, just as we know that this lifespan difference is entirely preventable. All we need to do is provide stable housing, adequate services and supports, and evidenced-based interventions like wellness self-management that help people with psychiatric disabilities take control of their personal health.

And yet we still come up short. Why? Without blaming anyone, I believe it's because we now live in a society of specialists. Doctors take care of medical problems, not social ones. Substance abuse programs don't treat mental illnesses. Housing providers don't always look after tenants' physical health as much as they could.

Many practitioners in supportive housing have broken through these silos: they build and operate affordable housing, but they also provide on-site social services that link residents to clinics that now address both behavioral and physical health issues. More often than not, they created these programs on their own, pasting together private and public funding from multiple sources.

It is time now that government agencies themselves break down these silos. It's already starting to happen, but it has to happen faster. I apologize for saying it out loud, but the New York State Department of Health is one of the agencies that lags the most in this regard. For decades, DOH has done little to recognize the role stable, affordable and appropriate housing plays in improving people's health. This is entirely understandable – this is a giant agency that has enough on its hands overseeing hospitals, clinics, doctors and nursing homes and all that goes with these large institutions.

But the end result is that homelessness continues to be addressed as just another poverty issue, rather than the public health emergency that it is. And housing under DOH's purview continues to be substandard. Every decade a scandal occurs in proprietary adult homes licensed by DOH, but little is done to transform or abolish this outdated model. Nursing homes and hospitals must serve homeless people who take additional weeks to discharge because they've got nowhere to go. Finally, they are well enough to return to the shelter, where they get sick again. This cycle costs taxpayers hundreds of

millions of dollars every year, and yet the Department of Health remains ill-equipped to address this most basic of health needs.

This may be starting to change. Six years ago, the Department of Health's AIDS Institute joined OMH, HCR and other State and City agencies as a signatory of the NY/NY III Supportive Housing Agreement, committing to funding services in supportive housing for chronically homeless people living with AIDS. But each year, DOH has consistently been the only one of ten agencies to consistently underfund its share of service funding in the Executive Budget. Each year, I have to come to you to ask for help in restoring this necessary, cost-effective service funding. And, thanks to Assemblyman Gottfried, Senator Duane and many other caring legislators from both sides of the aisle, you have delivered restorations to this critical, life-saving funding.

Once again, this year's DOH AIDS Institute Executive Budget submission underfunded its supportive housing commitment by $2.9 million, 45% short of the need for the more than 500 tenants who depend on these services. But this time, there is a happy ending: the new administration just restored this funding in its 21-day amendment, the first time I've seen this happen after years of requests. We want to recognize this, and express our appreciation for the administration's willingness to correct quickly what would have been a cruel cut to supportive housing tenants living with AIDS that would have ended up costing the public much more in increased emergency intervention costs.

I believe that a major reason that DOH at last recognized the value of supportive housing this year was the Medicaid Redesign Team (MRT). Over and over again, the MRT heard from community-based providers about the importance of housing to individuals' recovery from both psychiatric disabilities and medical illnesses. Certainly, the message of those testimonies came through in the MRT's final recommendations.

I would like to remark on just a handful of them. The proposals were broadly worded and considered very quickly, so it is difficult to know their full effect at this time, but we know it will be profound. The devil will be in the details, and we look to you to ensure that these details make sense for the people of New York. Briefly, here are some of our observations and concerns:

Behavioral Health Services Carve-Out: We strongly support the continued carve-out of behavioral health services from mainstream managed care.

Proposal 93 will establish interim behavioral health organizations to help us move toward a more integrated model of service delivery. Using specialty Behavioral Health Organizations (BHOs) to at first coordinate care, and over two or three years move toward what is likely to be a managed care model, is vastly preferable to just turning over the behavioral health population to mainstream health plans that have little experience with the extensive and complex needs of the behavioral health population.

In some other states, BHOs have had success reducing costs, improving care and establishing innovative new approaches to mental health. But this only happens when states have taken a strong interest in managing them. We are pleased that the MRT proposal charges the OMH with managing this process. We believe that present OMH leadership is highly capable and best suited to manage the transition to managed care. We believe they will ensure that contracts with BHOs will not only restrict profits and administrative costs, but also follow a recovery model of care with a central role for peer initiatives.

In reducing costs, some BHOs have reinvested savings to create new supportive housing opportunities. Appropriate and affordable housing is essential to mental health recovery, and should be a central goal of this effort.

As we move forward, it will be important to have both mental health advocates and providers fully involved in the process. At the present time, we strongly urge you to support Proposal 93 as written.

Prescriber Prevails: We do not support a provision in the MRT proposal that would restrict access to specific medications for people with special needs, including those with psychiatric disabilities and HIV/AIDS. Medications for these groups are excluded from the State's Preferred Drug Program because the State has always recognized that long-term harm can be done when people with serious conditions are denied access to the drug that works best for them and are made to "fail first" on another state-approved drug. Improved care coordination by BHOs will achieve significant reductions in costs this year, making reducing access to certain medications unnecessary. Rather than imposing prior authorization on vulnerable populations who have often had difficulties finding the medication most effective for them, this MRT proposal should be eliminated so that the "prescriber prevails" as to deciding the best course of medication for their patient.

Utilization Controls on Behavioral Health Clinics: The MRT proposes to impose additional limitations on the number of visits one individual can make to clinics. We do not support further reducing payments to clinics as they try to provide an adequate level of services to the most challenging to serve. In our experience, limiting care is not the way to cut costs.

Maximizing Peer Services: The Network's providers have found that expanding peer support and employment opportunities have been central to the success of our housing and programs. Peers are uniquely qualified to help other residents achieve recovery, so we are pleased to see the MRT propose using Medicaid to fund peer supports utilized in new health homes.

Triple New York City's Managed Addiction Treatment Program (MATS): The MATS case management program in New York City has shown promising success in lowering Medicaid costs and improving coordination of care for people with substance abuse issues. We are pleased to see it expanded. Our one note of caution would be to suggest that case managers under MATS not serve supportive housing tenants who already have case managers assigned to them – the two programs play similar roles and we should be doing all we can to use our resources efficiently. Conversely, we should explore how we can strengthen the MATS program by making affordable housing available to participants when that will help to improve outcomes.

Supportive Housing Interagency Workgroup: Lastly, we are pleased to see the MRT propose a workgroup to develop a proposal by July 1st to create between 5,000 and 10,000 housing opportunities for persons at risk of nursing home placements. We strongly support this effort and urge that the workgroup include representatives of nonprofits who are expert in supportive housing development and management. It is important to have at the table people who actually operate this housing and have perfected the effective service models central to supportive housing's success. We further urge that the proposal explicitly give OMH a leadership role in this effort. OMH now has thirty years of experience in this field, and its partnership with the State's housing agency has in particular provided the most integrated and best quality housing for vulnerable populations. It is important that any housing created as an alternative to nursing homes is not just a less expensive nursing home, but is instead is as close as possible to a permanent apartment, well-integrated into the community with all the comforts of home, linked to any essential services that ensure the tenant's independence.

Conclusion

We hope that the workgroup is just the beginning for supportive housing and DOH. But much more needs to be done. As I was writing an email one evening asking the administration to restore the DOH NY/NY III funding, I received a phone call from a woman in California who had found the Supportive Housing Network's website. Her brother, 64 with a history of recent medical hospitalizations, was about to be discharged from a nursing home to the 30th street men's homeless shelter. She was frantic, as he was just seven days removed from having been in a hospital on a respirator for a week. But the nursing home said that it was no longer medically necessary for him to be in the nursing home, and insisted that he had told him he had a place to go. On further questioning, they admitted they knew it wasn't a viable placement, but they had no choice – they couldn't get reimbursed for caring for him anymore, and they knew of no place he could go. I was lucky enough to find a transitional provider who was willing to bend the rules to take him in the next day, and now he is about to be placed in a nonprofit-operated adult home that will be able to fully address both his medical and mental health needs.

As lucky as we were to get him into a more appropriate, less expensive setting in one day, this individual had already cost the taxpayer much more than necessary. He spent 33 extra days in the nursing home when it was no longer medically necessary, plus had experienced several unnecessary hospitalizations that were caused by his moving back and forth from other inappropriate placements.

We must expand supportive housing for this population, and train nursing homes to increase discharges to more appropriate, and less expensive, supportive housing. As the MRT panel continues to develop plans to lower Medicaid costs and improve care, I hope that the Legislature will do all it can to ensure that there is an explicit focus on the expansion of supportive housing opportunities for vulnerable populations.

Extend the Personal Income Tax Surcharge

This year's Executive Budget proposes extensive cuts in just about every area of services and supports that help poor and middle class families and individuals who struggle to maintain a decent quality of life in New York State. Even if we are able to restore the most destructive of these cuts, the consequences of a smaller budget are going to a have a damaging effect on millions of vulnerable New Yorkers.

At the same time, more, ill-advised cuts are being proposed in Washington that are likely to send our economy back into recession. This will further increase the need for low-income housing subsidies, homelessness prevention, community-based services and employment programs, just as these very same programs are being sharply scaled back. It is going to be a very difficult year.
Supportive Housing Network of New York – p. 8

That is why we must take a moment and appeal to you to extend and make permanent the Personal Income Tax Surcharge. I am all for slowing the growth of the State budget, and finding new efficiencies and savings. Some proposals to curb spending are quite promising. But if this budget is truly going to be fair, if it is going to spread the pain evenly, we must ask the very wealthiest New Yorkers to contribute during this time of need. A huge portion of our $10 billion budget deficit is caused by allowing the PIT Surcharge to expire. The least we can do is to ask New Yorkers who continue to earn large incomes to pay a fair tax rate.

There are a number of compelling reasons to support the surcharge:

- People earning over $200,000 a year have, on average, seen their incomes double over the past seven years. The rest of us have seen our incomes barely keep up with inflation.
- At the same time, wealthy taxpayers have been very successful at getting steady decreases in the amount they are taxed. Over the past 25 years, the marginal tax in the top brackets has been reduced from more than 15% to less than 7%.
- The very wealthiest New Yorkers earn most of their income through profits off of investments, for which they pay a capital gains tax of just 15%. The rest of us who earn our pay by working for it must pay rates that approach twice that. With so many low income and middle class families struggling this year, how can we justify this inequity?
- Most of the $5 billion secured by extending the surcharge would otherwise be accumulating in rich people's accounts all over the globe, generating very little economic activity in New York. If it is instead collected by government and spent locally to provide critical safety net supports and preserve teaching, public safety, social service and other essential jobs, it will create the economic multiplier effect we need to pull our state out of recession.

- State income taxes are deducted from federal income taxes, meaning that one-third of the surcharge will be paid for by the federal government, doing a little to correct the structural imbalance that has New York paying far more than it receives from the federal government.
- This is NOT a tax increase. It is a continuation of a current tax.

We urge you to respond to the wishes of 78% of New Yorkers and extend the personal income tax surcharge. To go against the interests of the vast majority of the public in order to aid the very wealthy would just confirm to them that money is all that matters in our legislative process. Remember, this budget proposes to make over ten thousand formerly homeless families and individuals who are now housed homeless again; it will eliminate daycare for women who have got off welfare and are now working, meaning they will go back on public assistance. It will cause localities to close senior centers, lay off teachers, and reduce funding for food pantries that are already overwhelmed by the demand. To give a tax break to the fortunate few, while hundreds of thousands of poor children across New York State are literally going without dinner, is unconscionable. I hope that you will fight for the extension of the surcharge so that we can restore the essential supports and services that help our most vulnerable citizens and make New York State a great place to live.

Thank you for this opportunity to testify.

Respectfully submitted by:

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Testimony
Joint Committee Budget Hearing on Health/Medicaid
New York State Legislature
Thursday, March 3, 2011

Submitted by Ralph Palladino
2nd Vice President AFSCME DC 37 Local 1549, Clerical-Administrative Employees

I represent 17,000 tax paying employees working for the City of New York, 5000 of who work in the public health system, Health and Hospitals Corporation, and the public Metro Plus HMO. I served on Governor Spitzer's Healthcare Transition Team, have been employed for 30 years and am a patient at Bellevue Hospital, and served on the Bellevue Community Advisory Board.

Don't Cut Medicaid

First let me say that I oppose any cuts to the Medicaid Program. Cutting will mean loss of patient services and jobs. It will also mean a reduction of funding from the federal government to the state and the loss of income for local businesses that cater to people who work in health care facilities. It will have a devastating effect on an already fragile economy.

We already do not have enough health care services in communities that need them, especially in communities of color. This has been documented by reports including one from the New York City Council. Disparities in healthcare will not be solved by cuts. Healthcare reform means that more people will be using the program so just how can cuts happen without cutting vital, life saving services?

Inclusive Decision Making Process

Local 1549's membership comes overwhelmingly from communities of color. Decisions made about Medicaid will affect those communities the most. As a result we firmly believe that and decision making or advisory bodies concerning public health and Medicaid should have representation from those communities. Representatives from public health institutions such as the New York City Health and Hospitals' Corporation (HHC) and their unions should be included as well.

The state legislature should continue to have a say in how tax dollars that go into the Medicaid and other public health programs are spent. The legislature is an elected body that reflects and represents constituents on a local level. The is called democracy.

Raise Revenues; Fair Taxation

It is critical that we seek revenues for the state budget. The budget as proposed by the Governor is not fair and is balanced on the back of healthcare workers and the communities they serve.

Wall Street is reporting record profits. The richest individuals and families in this state are paying 7% less in taxes over the past 10-15 years according to the Fiscal Policy Institute. New York ranks number thirty two in collecting corporate taxes according to the Tax Foundation, State Business Tax Climate Index, FY 2011. Wall Street had its second best year ever in 2010.

It is fair that those who were mainly responsible for the crisis the country is in pay their fair share. The revenues would mean that cuts could be partially or totally eliminated. Certainly continuing the temporary surcharge on high incomes is warranted and is not a new tax.

Arguments about how corporations will not create new jobs and the rich will leave the state are unfounded. Corporations currently are sitting on piles of profit but are not hiring as it is. Two Princeton studies do site a small number of people leaving all the northeast states but nowhere does it say it is because of high taxes.

Poll after poll in New York and across the country show that the people want the rich to pay their fair share before any cuts in services occur, the latest being the Sienna Poll. The NY Times/CBS national poll taken this past weekend indicates that public employees should not be blamed for or primarily pays for the current crisis we are in. Voters in Oregon voted for a wealth tax. Voters in Arizona voted for a sales tax in order to stop cuts in services. It is what the people want!

Areas of Concern

1. **Caps on Medicaid spending will hurt public institutions the most.** Public entities should as HHC and its Metro Plus HMO have only 5% overhead while private healthcare institutions and HMO's have a 20% overhead. Public entities service the neediest patients and are the last safety net for communities. When St. Vincent Hospital closed in Manhattan Bellevue Hospital saw a 16% increase in ER use and increases in Ambulatory Care. When two Queens hospitals closed Elmhurst Hospital has ER use has risen 14% and Queens Hospital Center saw anywhere from 13% to 44% increase in ER volume. Yet these institutions had to absorb the extra cost and could not increase badly needed staffing. Public hospitals, clinics and HMO's such as Metro Plus do not receive the funding that private entities do and should not bear the same cuts.
2. **Do not lower Medicaid Rates.** The rates are much too low already and the costs of care cannot be met without cutting in other areas. More institutions could close because of this problem. Services and/or jobs will be lost.
3. **Medicaid dollars should flow to where the Medicaid patients get served**. Medicaid funding should go to where the Medicaid patients go. It is only fair. 70% of HHC's budget revenue comes from Medicaid.
4. **Any funding generated for healthcare should be used for healthcare**. Too often funding designated such as FMAP and other health related "settlement" funds go to the state's general fund and not healthcare. This is unfair.
5. **Bad Debt and Charity Pools should allocate funds based on the percentages of uninsured in an institution.** Reform is need in this area and the proposal by the Commission on Public Health Systems (CPHS) should be instituted.
6. **Do not cut Facilitated Enrollment.** This is especially important now that more people will have to signed up for Medicaid. Our Metro Plus Enrollment Sales Representatives rely on this important outreach mechanism.
7. **Cutting Medicaid hurts the economy.** Federal studies show that every $1 spent on Medicaid translates into $2 more for the local businesses. Local businesses have been suffering in New York's West Village ever since St. Vincent Hospital closed. There also are less healthcare workers working, paying taxes and shopping.
8. **Medicaid cutting does not lead to job growth in the private sector.** No study or proof exists that cutting Medicaid leads to job growth in the private sector. In fact to some companies like Wal Mart and private contractors, Medicaid is the healthcare plan of necessity for their employees.

Finally

Healthcare should not be about dollars and cents. It is a life and death issue. Reform is needed and welcomed but should not be at the expense of programs that are needed, especially in communities that already lack adequate healthcare. These decisions should not be made by a handful of people. They need to be made by people from all communities and backgrounds in the state. This includes advocacy organizations, patients, healthcare workers, and businesses large and small. Soliciting ideas in two minute sound bites is not the way to do it properly.

The discussion about Medicaid should not be about "how much to cut". <u>It should be how we enhance the public's health.</u>

Local 1549 members are angry about budgets that are not fair. They constantly ask "why aren't the rich and powerful being asked to sacrifice?" Anyone who says that "there just is not money" for programs such as Medicaid is not telling the truth. Wall Street is paved with gold!

Thank you.

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March 1, 2011

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Honorable Richard Gottfried
NYS Assembly
Legislative Office Building, Room 822
Albany, New York 12248

Re: Medicaid Redesign Team Proposal #14 - Elimination of Certain Reimbursements for Nursing Homes

Dear Majority Leader Skelos, Speaker Silver, Senator Hannon, and Assemblyman Gottfried:

I am writing to you on behalf of the Greater New York Health Care Facilities Association ("GNYHCFA") and our eighty proprietary nursing home members located throughout downstate New York to express our opposition to including Medicaid Redesign Team ("MRT") Proposal #14 in the budget for State Fiscal Year 2011-2012. GNYHCFA is a not-for-profit trade association serving the needs of the long term care community in the greater New York metropolitan area and beyond. GNYHCFA has a firm commitment to providing quality care and is focused on ensuring successful performance, maintenance, safe practices, equipment operation, and hazard assessment at each facility. It is Greater New York Health Care Facilities Association's mission to address patient care by supporting effective design, construction, inspection, and operation of health care facilities in order to ensure that our State's most vulnerable population -- our senior citizens -- receive the best possible care when residing in nursing homes. Unfortunately, MRT Proposal #14, which would eliminate the "return on" and "return of" equity and residual reimbursement provided in the capital nursing home rate for proprietary nursing homes, runs contrary to this goal. In fact, if enacted, this proposal would punish those who invested in our vulnerable population by providing the capital to improve and enhance the care given at nursing home facilities. Moreover, going forward, this proposal would effectively create a discriminatory system of reimbursement, benefiting voluntary homes to the detriment of our members. In fact, current regulations recognize the importance of capital cost component of rates within the reimbursement system for both voluntary and proprietary homes. This methodology must be preserved.

Department of Health ("DOH") regulations governing the current reimbursement methodology for proprietary nursing homes provide for two key components in capital cost reimbursements: (1) interest payments on the capital investment -- essentially an annual rate of return on the money invested -- and (2) a return of the equity actually invested in the nursing home. *See* 10 NYCRR § 86-2.21. This methodology was established almost two decades ago and has impacted the financing structure and business decision making for the entire proprietary industry. This system was created to inspire and incentivize owners to invest in making capital improvements in nursing homes. Notably, this State policy was accomplished -- many owners made significant improvements to the facilities. These owners, however, made the investments in confidence that Department's obligation to partner in this investment would continue for the useful life of the home, and then at a reduced rate thereafter.

Comparably, DOH regulations recognize that voluntary and public nursing homes also make capital investments and therefore equally deserve to have capital cost components in their rates. These entities' rates may include allowances for depreciation or debt service, depending on how the investments are financed, as well as mortgage interest. *See* 10 NYCRR § 86-2.19.

These current regulations for capital cost component reimbursement for all residential health care facilities ensure that there is a system for voluntary and proprietary nursing homes that recognizes these expenditures. Enacting MRT Proposal #14 eliminates this equity. Notably, the proposal also mischaracterizes the benefits of the existing regulation, by claiming that there are "no reported costs" associated with the State payment for return on equity. In fact, there are significant long term financial costs to a facility for making the improvements to the home in order to even be eligible for this allowable reimbursement. This proposal is tantamount to the State reneging on its obligation and its partnership with the owner who has invested in the nursing home.

Although the GNYHCFA wishes to continue to be a strong partner with the State in taking steps to reign-in costs of the Medicaid system, this proposal is simply not the manner in which to achieve that end. We are willing to explore other avenues to ameliorate the problem we have highlighted and look forward to a vigorous dialogue.

Sincerely,

Michael Balboni/jlo

Michael Balboni
Executive Director

ALB 040328.010100 1,434,523v1

EMPIRE STATE
PRIDE AGENDA

Testimony for Joint Legislative Hearing of the 2011-2012 Health Budget

From the Empire State Pride Agenda

Prepared by Jonathan Lang
Director of Government Projects and Community Development

In 2009, the Empire State Pride Agenda (Pride Agenda) – New York's statewide LGBT civil rights and advocacy organization – commissioned the first-ever statewide needs assessment of LGBT New Yorkers. By collecting over 3,500 surveys, interviewing dozens of LGBT experts, and by utilizing existing data sets, the Pride Agenda was able to produce a comprehensive, scientifically-driven report that clearly illustrates the state of LGBT Health in New York. Community-based organizations have always known the severity of the health disparities impacting LGBT communities, but they lacked the data to reinforce their stories. The data that we have obtained supports what we have always known anecdotally: LGBT New Yorkers are disproportionately impacted by a staggeringly wide array of health disparities and New York State is not doing enough to address those disparities. Ranging from mental health to substance abuse to lack of adequate primary care, the multiple service needs of LGBT New Yorkers are further compounded by the lack of culturally competent and affirming services available to address the unique needs presented by some of New York's most marginalized residents.

- Forty percent of LGBT people stated there were not enough health professionals who are adequately trained and competent to deliver services to LGBT people.
- LGBT people of color face more barriers to health and experience more depression and loneliness than white people and yet lack access to mental health and support group services.
- Thirty percent of transgender and gender non-conforming people said they were currently or formerly homeless.

The Pride Agenda is the proud coordinator of the New York State LGBT Health and Human Services Network (the Network). Consisting of over 55 service providers, the Network provides cost-efficient, preventative health and human services that address many of the urgent and unmet needs of LGBT New Yorkers. Some of the crucial services that Network organizations provide include:

- Health and wellness programs including primary and preventative care;

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- Mental health treatment and family counseling;
- Domestic violence and sexual assault services;
- Crime victim assistance;
- Homeless youth services; and
- Alcohol and substance abuse prevention.

Many of those served by Network organizations are individuals who have been historically marginalized including youth, seniors, people of color, people of low income and transgender individuals.

With the support of state government, LGBT service providers have been capable of creating a statewide infrastructure that can address the service gaps for LGBT New Yorkers by focusing on collaboration and resource-sharing. The Network also provides a statewide platform to launch the kind of innovative and scalable programming that addresses persistent health disparities and produces healthy outcomes on a community-wide level all across New York State.

Legislative discretionary funding from the Assembly and the Senate remains a critical resource in reducing and eliminating the health disparities affecting LGBT communities. Over half of Network organizations reported that 75% of their operating budgets were made up of State funding. Since 1997, the Assembly has provided support for LGBT service providers and allocated $1.54M in SFY 2009-2010. The Senate recently joined the Assembly in supporting the work of dozens of LGBT-serving organizations by allocating $2.048M in SFY 2009-2010. With the Empire State's small investment in LGBT health and human services, in 2010 the Network delivered over 2,000 trainings, speaking engagements and educational events to various communities and organizations throughout New York State and continues to provide cost-efficient, preventive and supportive services to over 800,000 New Yorkers in all 62 counties of the state.

Even though Network organizations have a proven track record of success, they are faced with potentially devastating decisions. The reduction in funding from New York State has already seriously weakened the capacity of LGBT organizations to provide services to their communities. Organizations that were already stretched thin by the steady erosion of their funding are struggling to meet the rising tide of need. Network organizations continue to be resourceful, resilient and responsive, but eventually doing more with less becomes doing less with less at a time when that is an unacceptable option.

Despite these odds, Network organizations continue to persevere. From cutting program hours to laying off essential employees, LGBT-serving organizations continue to make the necessary sacrifices to provide these much-needed services, but they cannot continue this work alone. LGBT New Yorkers need their Empire State to continue to demonstrate leadership on LGBT health and human services. Both the Governor and the state Legislature share a responsibility

to ensure LGBT New Yorkers and their families receive the healthcare they deserve. New York State cannot afford to ignore its responsibility to some of its most vulnerable citizens.

Only through partnership with the NYS Legislature will LGBT service providers be able to weather this economic storm and continue to provide critically-needed services to LGBT New Yorkers and their families. We urge both the Assembly and the Senate to restore legislative discretionary funding to the budget and continue the same level of support for LGBT health and human services that both chambers demonstrated in SFY 2009-2010. Legislative discretionary funding supports dozens of lifesaving programs across the state and the loss of this funding has severely damaged the safety net of services that LGBT-serving organizations - in partnership with the State of New York - have spent decades to build.

The Pride Agenda shares the same goal as the Legislature - to ensure taxpayer dollars are used effectively and responsibly in order to achieve goals for which they are distributed - and is committed to maintaining transparency and accountability in the use of legislative discretionary funding. We will continue to adhere to those principles when legislative discretionary funding is restored to the budget.

LGBT service providers need no reminder that our state is facing uncertain economic times. They see the effects of the economic downturn every day, as new individuals are engaging them for services and as persistent health and human service disparities continue to impact LGBT communities. With a $10 billion budget deficit, sacrifices will need to be made in order to get our state on sound financial footing. LGBT New Yorkers hope that the New York State Legislature understands that the budget deficit can not be balanced solely on the backs of some of New York's most underserved citizens. As the NYS Legislature weighs the needs of New Yorkers against the fiscal reality that we are all grappling with, the Pride Agenda hopes the state Legislature continues to support LGBT health and human services and provides organizations with the resources they need to provide cost-effective, preventative services to LGBT New Yorkers.

Contact Information: Jonathan Lang, Director of Government Projects and Community Development, jlang@prideagenda.org, 518-472-3330 ext. 301.

TESTIMONY by ACTS
Joint Legislative budget Committee on Health
March 3, 2011
Submitted by Michael Grossfeld, President of ACTS

Good afternoon Chairmen Farrell, DeFrancisco, Gottfried and Hannon and distinguished members of the Committees on Health, Ways and Means, and Finance.

Agencies for Children's Therapy Services, (ACTS), is an umbrella organization which represents nearly two dozen agencies throughout New York State providing Early Intervention, SEIT, and Pre School Special Education Services to children who have special needs.

These programs are intended to identify youngsters with early childhood learning deficits or developmental disabilities and provide services in various community settings to help make these children ready to learn when they reach school age and are entering the public education classrooms.
As such ACTS providers are directly assisting the State in saving millions of dollars each year by helping these children to be ready for the rigors of public education and avoiding far more expensive remediation and/or special education services that otherwise would be needed.

ACTS members are fulfilling the intent of the Early Intervention statute, (EI), that was enacted by the State Legislature 20 years ago by doing exactly what the entitled law said…to provide "early intervention" so as to alleviate problems before they become bigger and more expensive problems for the child, her family and for State and local governments and School Districts.

EI has been one of the State's great success stories by saving the State and local governments millions of dollars each year while improving the lives of thousands of families and their children by applying licensed professional services in education and various learning and cognitive therapies. This is the proverbial "win-win."

Rates for EI providers were set in 1993 and have not been adjusted since in spite of inflation and trend factors and increases in other government programs during the same period of time. In other words even before the current "Great Recession" EI has been doing its part to keep government costs down while providing quality services in spite of ever increasing operating costs.

Last year, in 2010, certain non center based EI programs were assessed a 10% rate reduction, NOT by the Legislature in the enacted budget, but rather by the Paterson Administration's Department of Health

PROFESSIONAL AGENCIES FOR CHILDREN'S THERAPY SERVICES
Michael L. Grossfeld, President
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through a change in regulation. This cut was excessively disproportionate to what other providers were asked to absorb in the areas of Health or Human Services.
This recent history stands as the back drop to Governor Cuomo's 2011-12 legislative budget proposals in the area of EI:

*The Governor has proposed a SECOND cut of 10% in his budget recommendations to the Legislature, estimated to "save" the State $11.1M. This would amount to a devastating cut of 20% in less than one year.
ACTS vigorously opposes this second round of cuts. Such a decrease in rates to EI providers currently operating at the margins would inevitably impact service capacity to thousands of the youngest and most vulnerable children in the State. It must be REJECTED.

*The Governor has also recommended, (as his predecessor did last year), to require Early Intervention providers that receive more than $500,000 in annual Medicaid revenue to first bill Medicaid or private insurance carriers prior to seeking reimbursement from municipalities. The savings to the State is estimated to be $0.5M. This proposal must be REJECTED this year… as it was last year.
This proposal would shift the burden of processing reimbursement from large municipalities on to the shoulders of the providers who can ill afford to take on this new mandate. Moreover the inevitable delays in being reimbursed for legitimate services and costs already incurred will strain to the breaking point the cash flow of these EI agencies

*The Governor is also recommending that EI companies bill services in fifteen minute increments replacing the current basic visits of up to 59 minutes of contact time with a child and an extended visit for 60 minutes or more. It is still unclear as to the intent or the impact of this proposal. However if this new computation results in further short changing EI companies of legitimate reimbursements, weakening the financial viability of EI companies and drastically compromising its services, ACTS would be VEHEMENTLY OPPOSED.

Perhaps these proposals by Governor Cuomo and his Division of the Budget were not intended to destroy the fragile structure of Early Intervention services in this State. But its adoption would surely do just that. For 20 Years the State Legislature has stood behind the importance and essential work of Early Intervention providers for our young citizens and their families. Especially in today's difficult economy where families are struggling to keep their heads above water we ought not sever this important life line to so many thousands of families whose children face special challenges just to get off to a decent and hopeful start in life.

We, Providers of essential EI services, are mindful of the difficult decisions facing the Legislature to adopt a fiscally sound budget without eviscerating vital health and human services. We stand prepared to assist the Legislature in identifying alternative savings within the EI service world that would more equitable and less destructive of this very important resource to the tens of thousands of families across this State who rely on Early Intervention for their young and vulnerable children.

Thank you for your past support of EI and for your present efforts to maintain desperately needed EI services around the State.

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New York State Academy of Trial Lawyers

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Good morning, my name is Anthony S. Bottar, and I am the President of the New York State Academy of Trial Lawyers. I want to thank Chairman DeFrancisco and Chairman Farrell for allowing me to testify at today's budget hearing, and I would also like to thank Chairmen Gottfried and Hannon for their work on the Medicaid Redesign Team. I come before you today with both an appreciation of the difficult task inherent in any attempt to make changes to the Medicaid program and grave concerns about both the process and outcome of the recently concluded Medicaid Redesign Team. Because there are more proposals than I could hope to address in my short testimony, I am going to direct my remarks to one proposal in particular, Proposal 131, the proposal to establish a neurologically impaired infant fund and to cap the recoveries that victims are entitled to recover. This proposal will create a financial windfall for negligent hospitals, incompetent health care providers and their insurance companies, and will drastically limit their responsibility to injured patients, especially brain-damaged babies, all while failing to provide the savings to Medicaid that supposedly supported their inclusion.

Before I address the merits of the proposal, I would like to first speak to the process. The Medicaid Redesign Team process has been rife with self-dealing and conflicts of interest. The Medicaid Redesign Team was dominated by hospital and industry lobbyists, and excluded consumer and patient advocates. Although the team agreed to open its meetings to the public after initially planning for a closed process, the role of the public was limited at best, as the public submitted thousands of proposals, staff culled these proposals down to less than 300, and then without any additional input, culled the list again to fewer than 50 proposals. Even more troubling, the proposals contain so little detail that the public and the legislature have been unable to fully analyze let alone understand the implications of many of the proposals. Despite this lack of detail, the hospitals were permitted to "score" the proposals as they saw fit, allowing them to come up with an absurdly-high "savings" number and leading to the proposals that most affected those groups not on the panel to be scored highest and proposals that most affected the members of the team to be scored lowest. This is not the democratic process that we expected, and that we hope that the Governor expected, when this process began.

Based on the sketchy details released so far, Proposal 131 would drastically limit patients' legal rights, including brutal "caps" on non-economic damages and a birth injury fund that limits the rights of brain-damaged babies and their families. The Neurologically Impaired Infant Fund would force newborns and moms into a new liability system that denies them the same kind of rights and recourse that adult men have in this state. Even if the baby's family were able to bring a lawsuit, the limited details available suggest that they would be condemned to a lifetime of additional suffering, forced to deal with a burdensome and humiliating struggle to get bills paid from an unaccountable insurance-funded entity.

Caps on non-economic damages arbitrarily limit compensation and promote a kind of caste system by branding entire classes of low- or non-earners in our society as worth less than their wealthier counterparts. This is because precluding non-economic damages limits damages to lost income and costs incurred, and if the lost income is low or nonexistent, as is often the case with seniors, children, women who do not work outside the home, and the poor, then the damages are too low to support a suit even being brought. This is not just my view, President Clinton made the same point in 1996 when he vetoed products liability legislation on the grounds that any limit on a victim's ability to recover non-economic damages would unfairly impact women, children, the elderly and the poor. This has been the experience in other states that have chosen to enact caps like those proposed: many cases involving those categories of plaintiffs are no longer brought at all. While it is not outright class warfare, creating a system in which consequences only exist for injuring the rich while the poor have no practical recourse, is bad public policy.

This leads me to the unfortunate fact that not only is this proposal bad public policy, but Medicaid costs would increase, not decrease, under the proposal. The reasons are simple and easy to understand. Under the current system, victims of medical malpractice use their settlements or verdicts to pay for their needs. Although they are injured and might be unable to work, they are not a burden on the Medicaid system because they have been compensated for their loss and have the funds available to address their care. Purporting to limit only non-economic damages might sound workable in theory, but as was just discussed, it often leads to no suit being brought at all, meaning there is no recovery of either non-economic or economic loss. This leaves an injured person without any resources and more dependent on public monies rather than less dependent, shifting costs that were borne by the negligent hospital directly onto Medicaid.

In addition to the fact that this proposal simply does not and cannot achieve the purported savings for Medicaid, this proposal most definitely increases costs to consumers. The NII Fund is capitalized by an insurance surcharge or tax, presumably to be passed onto all individuals and small businesses, on all property and casualty insurance. For example, this means that all car insurance consumers would be forced to subsidize medical negligence with each payment.

The typical supporter of this proposal will tell you that doctors are subjected to increasing numbers of lawsuits, that no doctor is immune, and that we must do *something*. I am here to tell you that this is simply not true. Medical Malpractice claims are stable and dropping. According to Public Citizen's analysis of the National Practitioner Data Bank, the number of medical malpractice payouts has remained stable for years, despite a rapidly increasing supply of doctors and growth in the general population. Since the creation of the National Practitioner Data Bank in 1990, the large majority of doctors – 82% – never made a single malpractice payment. Far from malpractice being common among doctors, from 1991 to 2005, only 5.9 percent of doctors were responsible for 57.8 percent of malpractice payments. Each of those doctors made at least two payments. The unfortunate fact is that there are some dangerous doctors practicing medicine, but the state has failed miserably in weeding these doctors out of the system. If the state's desire is a reduction of medical malpractice insurance costs, we support that goal. However, rather than proposing to eliminate the rights of injured people, the state should do a better job of policing the medical profession, and the medical profession should do a better job of preventing medical errors.

Thank you for your time.

North Country Behavioral Healthcare Network

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1997 ♦ Celebrating Our 10th Year ♦ 2007

Written Testimony of

Northern New York Rural Behavioral Health Institute, Inc.
(dba: North Country Behavioral Healthcare Network)

Joint Legislative Public Hearing on 2011-2012 Executive Budget Health / Medicaid

Thursday, March 3rd, 2011,
10:00 am - 3:00 pm

Legislative Office Building
181 State Street, Hearing Room B
Albany, NY 12247

Chairs:
Senator Kemp Hannon
Assemblyman Richard Gottfried

Submitted by:

Bud Ziolkowski, Sr. Project Specialist for System Redesign
Barry Brogan, Executive Director

Testimony to the Joint Legislative Budget Hearing: Health and Medicaid

North Country Behavioral Healthcare Network (NCBHN) is a 19-member network of non-profit agencies that provide both mental health and substance use disorder services in New York's six northernmost counties. NCBHN is a New York State Department of Health designated Rural Health Network, and its service area includes the Fort Drum Region near Watertown, NY. The Network has a track record of seeking more closely coordinated integration between primary and behavioral healthcare and welcomes this opportunity to provide written testimony to the joint committee on the Governor's 2011-2012 Budget proposal.

While some constituencies who say that achieving the Governor's budget goals creates an impossible task, NCBHN stands with other behavioral health provider groups who embrace the opportunity to participate in system redesign. We have submitted our system redesign ideas to the Medicaid Redesign Team through oral testimony and in writing via the public hearing format. We have also joined with other behavioral healthcare provider organizations in an effort to move the system toward greater efficiency and cost reduction while also improving outcomes. We believe the Governor's goals are achievable as long as all three of the following critical components are put in place. In every case, the three components are consistent with reducing Medicaid expenditure by successfully providing effective treatment at the lowest level of intensity and expense, including a significant reduction in recurrent episodes of hospital-based detoxification and unnecessary emergency room visits and hospitalizations.

Component 1: Person-Centered Care across the Spectrum (Clinical Integration)

The integration of behavioral healthcare with primary healthcare is central to this thinking. We believe that the field must move to a Health Home/Recovery Home model that includes case management for the state's most vulnerable citizens. We recommend the application of models, such as the New York Coordinated Care Program, that have shown success in several areas. We however believe that it is imperative that both mental health and substance use disorder services are incorporated into this model, and that representatives from the two disciplines are at the table during the decision-making process. Further, we advocate that this planning can best be accomplished on a regional level. This is especially true as behavioral health, in order to maximize efficiency and reduce cost, moves to a managed care reimbursement model for behavioral healthcare.

Component 2: Managed Care utilizing Pay for Performance

NCBHN recognizes the importance of the implementation of the Ambulatory Patient Group (APG) model for mental health and substance use disorder services as an interim step. During the transitional period of current fee for service to managed care, the State can expect the most positive outcomes for the lowest cost to result from the well-designed APG model. It is important to implement that model as planned. Longer term, we strongly advocate for **a carve out of behavioral healthcare** management by the experts in the field as opposed to a takeover

by traditional healthcare HMOs. Healthcare integration can better be accomplished when the management of behavioral services is done by those who have the knowledge necessary to collaborate with providers to maintain services at the least intensive effective level of care. Without a behavioral healthcare voice in the discussion, a far less efficient and less effective model would likely be adopted. Our networking efforts indicate that New York State's behavioral healthcare providers speak to this point with one voice, as indicated by the attached position paper signed onto by over 40 provider organizations and consumer advocate groups statewide.

Component 3: Mandate Relief & OMIG Reform

Further, we are in agreement with the Governor's initiative for the relief from mandates, and see this as applicable to the development of uniform OMH/OASAS regulations with a reduction in the regulatory mandates that currently keep clinicians busy in recording and reporting efforts and away from direct care with the people they serve. Standardized regulatory and billing documentation requirements across OMH, OASAS and Medicaid would also serve to remove complexity and confusion for providers as they attempt to adhere to all such requirements. It would further allow OMIG to apply its resources toward the elimination of fraud, waste and abuse, rather than examining administrative errors and differences in the interpretation of OMH and OASAS regulations, and could bring consistency across audits by all of these oversight agencies.

NCBHN's 19 members provide services in New York State's most rural counties. Our experience informs us that diseconomies of scale and significant transportation issues create challenges that are unique to very rural areas. Service delivery will be most efficient and effective if provided under a comprehensive rural healthcare policy that takes these challenges into consideration. The long-time service providers are in a position to contribute important knowledge and ideas to this discussion.

We at NCBHN thank you for your hard work and dedication. We thank you as well for the opportunity to contribute to this critical decision-making process. Obviously, there are no easy answers, and we appreciate the difficult decisions that you are in the process of addressing. Please feel free to utilize NCBHN as a resource for issues regarding behavioral healthcare system redesign specifically as it relates to services in uniquely rural communities.

Advocates for New Yorkers with Behavioral Health Conditions Support Regional Managed Behavioral Health Carve Out

February 15, 2011

A comprehensive group of advocates for New Yorkers with psychiatric disabilities and substance use disorders, their families and behavioral health safety net providers agree that the best way to administer mental health care funding that will lower costs, protect and promote best practices in health and behavioral care services, improve outcomes, protect public dollars, and comport with Federal and State law is through the implementation of a regional behavioral care coordination model that relies on specialty managed behavioral health organizations (MBHOs).

We are equally united in firmly rejecting proposals to turn the behavioral care of Medicaid beneficiaries with disabling mental health conditions over to generic Medicaid Managed Care Plans, which do not have positive track records in other states or here in NY.

Specialty MBHOs would be charged with coordinating outpatient and inpatient behavioral health treatment and with linkage to appropriate medical care and non-Medicaid supports and housing. We support this approach because it will:

1. ***Lower Costs: Regional Managed Behavioral Health Initiatives have demonstrated impressive performance improvements and health and behavioral healthcare savings, for example,***
    a. Pennsylvania's Behavioral Health Choices program has generated $4 billion in savings from 1997-2007, while expanding service access, quality, innovation and integration between mental health and substance abuse treatment services and medical care and which has made critical investments in expanding housing and supports;
    b. The New York Care Coordination Project (NYCCP) has joined the efforts of county governments, providers and consumers in Erie, Monroe, Onondaga, Wyoming, Genesee, Chautauqua and Westchester counties with Beacon Health Strategies to implement a very successful "Complex Care Management program" that has shown 41% less in services' spending compared to comparable counties while substantially reducing avoidable costly inpatient, homeless shelter and criminal justice stays. One version of this program in Westchester County saved over $1.2 million in reduced Medicaid, criminal justice and state hospital costs in 2009.
    c. Missouri CMHC Case Management Program (APS Health) has realized a savings of $311 per person per month for a total savings of over $25 million or 17%.
2. ***Protect and promote best practices in health and behavioral care services:*** Regional Behavioral Health Managed Networks will operate under the oversight of the appropriate NYS mental health and substance abuse treatment agencies (OMH and OASAS), but should be dually authorized to become the medical home for children, youth, and adults with psychiatric disabilities and substance use needs. By allowing licensed OMH and OASAS outpatient programs to be included in the implementation of the Affordable Care Act's Medical Home provisions, these at-risk individuals can access the health care they need while attending to their intensive, ongoing behavioral health care needs.
3. ***Improve Outcomes:*** Individuals with complex mental health, substance abuse and medical conditions require specialized methods of outreach, engagement, and recovery and crisis support. They access the care system far more regularly through the more engaging and familiar "behavioral health door," not through traditional health care systems. Recent state data showed 40% of unengaged "at risk" individuals in Brooklyn and the Bronx were already followed by health plans but no evidence of care coordination or

follow-up could be found leaving them at risk for more serious problems, which lead to higher costs. Health plans have no experience or successful data with engaging and serving this group, certainly not on a level comparable to New York State and City.

4. ***Protect Public Dollars:*** State budget cuts will hit the Medicaid system hard this year. After the cuts, Health Plans will take an average of 16% in administration and overhead and profits and likely subcontract with behavioral health organizations who will take an additional cut as well. The result: huge funding holes in New York's safety net as dollars intended by taxpayers for patient care turn into profits for plan stockholders. Foremost the state's investment must flow for direct services; administrative fees should be capped and surpluses should be mandated to be reinvested. For example, Pennsylvania's Health Choices program kept 90% of the state's investment in direct services and reinvested $60 million for critically needed housing.
5. ***Comply with Federal and New York State Law:*** When Tennessee moved to a Medicaid managed care Model, 350,000 people were lost to the system. NY State has had its share of scandals related to lack of treatment and uncoordinated care, e.g. Adult Homes. NY is legally mandated to care for the most disabled among us: it is they who will fall through the cracks, not being able to negotiate the office and illness based health plan systems.

Conclusion: New York State can best improve care and reduce runaway costs for Medicaid beneficiaries with chronic behavioral and physical health conditions through the implementation of regionally managed behavioral health care coordination systems. These systems can provide the most effective outreach, engagement and linkages to medical care, housing and local support and social services that will produce savings immediately through reductions in avoidable high cost inpatient stays and emergency room visits.

Addiction Treatment Providers Association (ATPA)
Association for Community Living
Association of Addiction Recovery Care Homes of NYS (AARCH)
Association of NYC Addiction Programs (ANYCAP)
Central New York Alcohol and Drug Association (CNYADA)
Citizens Committee for Children of NYC
Coalition for Community Services
Coalition of Alcoholism and Substance Abuse Programs of NENY
Coalition of Behavioral Health Agencies
Committee of Methadone Program Administrators, Inc. (COMPA)
Consortium of Alcohol & Substance Abuse Services
Council on Addictions of New York State
FOR-NY
Families Together
Hudson Valley Catskill Coalition
Long Island Coalition of Behavioral Health Providers
Mental Health Association of NYC
Mental Health Association of NYS
Mental Health Empowerment Project
Nassau Coalition of Chemical Dependency Providers
National Alliance on Mental Illness - NYC Metro
National Alliance on Mental Illness - NYS
New York Association of Alcoholism and Substance Abuse Prov
New York Association of Psychiatric Rehabilitation Services
New York State Case Management Coalition
New York State Coalition for Children's Mental Health Services
New York State Council for Community Behavioral Healthcare
New York State Psychiatric Association
New York State Rehabilitation Association
Northern Tier Providers Coalition
North Country Behavioral Healthcare Network
NYS Coalition of Addiction Crisis Centers
Quality Consortium of Suffolk County
Recovery Net
Statewide Black and Puerto Rican/Latino Substance Abuse Tasl
Supportive Housing Network of New York
Therapeutic Communities Association of New York (TCA)
UJA Federation of New York
Veterans Health Alliance of Long Island
Westchester/Putnam Coalition of Alcoholism & Substance Abu
Western New York Chemical Dependency Consortium

2011
NEW YORK STATE BUDGET HEARINGS on Health/Medicaid

Written Submitted Testimony of
Ellen G. Hollander
Executive Director
New York Alliance for Donation, Inc.
99 Troy Road, Suite 200
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DONATE LIFE New York State

MARCH 3, 2011

It has been the privilege of the Alliance for Donation, Inc. (Alliance) to submit testimony to the Joint Legislative Fiscal Committee for the past seven years. The aim has been to provide you with information about a very important public health issue and to communicate the impact that the budget process has on this issue. We would like to first thank you for your past fiscal and programmatic support. Since 2002, the Legislature and Governor have provided funding support to the New York Alliance for Donation, Inc. This funding has been invested in:

- creating a Donor Medal of Honor that is provided to every organ, tissue, eye and bone marrow donor or donor family;
- education programs for health professionals who are critical to improving donation rates in New York; and
- developing and implementing public education efforts to increase donor designations and awareness in New York.

In addition, from 2006 through 2010, both Chambers passed, and the Governor signed, a number of significant pieces of legislation, currently being implemented, that will have long-lasting impact on donation and transplantation in New York. On behalf of my Board, all the individuals needing an organ transplant, those who would benefit from the gift of sight, firefighters in need of burn treatment, cancer patients needing bone replacement, and all the generous donors and their families, thank you. While policy changes will continue to be needed, the unanimous support of legislation with the aim to improve donation and transplantation was historic and greatly appreciated.

The New York Alliance for Donation, Inc. is a not-for-profit organization whose mission is to increase organ, eye and tissue donation throughout the State. The Corporate member organizations are: the Center for Donation and Transplant, the Eye-Bank for Sight Restoration, the Finger Lakes Donor Recovery Network, the Finger Lakes Eye and Tissue Bank, the Musculoskeletal Transplant Foundation, the New York Organ Donor Network, the Sight Society of Northeastern New York and the Upstate New York Transplant Services. Individuals serving on the Board as the Donation Advisory Council include transplant recipients, dedicated donation and transplant professionals, donors and other professionals with interest in donation. Among our Affiliate members are: Allosource, Astellas, Lions Eye Bank of Long Island at North Shore University Hospital, the New York Firefighters Skin Bank, New York Presbyterian Hospital – Transplant Division, and the University of Rochester Medical Center. All members are dedicated to developing strategies to increase public awareness, improve professional education, recognize donors and donor families and improve donation and transplantation in New York.

Organ and tissue donation is a public health imperative. Today, there are over 110,000 people on waiting lists across the country for a donated organ. Almost 10,000 people are on waiting lists in New York; the only state with more individuals waiting is California. Nineteen people a day die waiting for a transplant. Life-saving donations are critical to improving lives in New York. These numbers reflect the significant need to increase awareness about organ, eye and tissue donation.

I encourage the Committee members to think about the people represented by these numbers. People need transplants because of end stage organ failure; they are dependent on dialysis, medications, ventricular assist devices and other extraordinary medical treatments that

hopefully will extend their lives until an organ becomes available. All of us are aware of people who need the gift of sight, healing from burns, restoration of physical function, and treatment of cancer. These are men, women and children of all ages, ethnicity and religious beliefs; these people are our family members, neighbors, colleagues and friends. These same descriptions apply to the altruistic donors and their families who have made a gift of life through the donation of organs, tissues, or corneas after death. This is an issue that affects all of us. It is likely that few of us will need a transplant; but all of us can choose to be organ donors. There is a significant opportunity to increase the number of New Yorkers who choose to be donors.

The Alliance is collaborating with the national Donate Life America which has launched a Donor Designation Collaborative to increase the number of lives saved and enhanced through organ, eye and tissue donation in the United States. *The aim of the Donor Designation Collaborative is to increase the number of Actionable Donor Designations in the United States to 100 million.* Achieving this aim means that 100 million Americans will have taken the appropriate steps in their home state to ensure that their personal decision to become a donor is recognized and honored. This will approximately double the current number, estimated to be about 65 million people. Please continue to support the efforts of the Alliance so that we can help America achieve this goal.

The State Donate Life donor registry is the focal point for awareness and action for donor designations in New York. Currently, 2.2 million New Yorkers are enrolled on the New York State Donate Life Registry. Despite the growth of the Registry since its inception in 2000, New York lags behind many other states in the total number of people on the registry. Florida, Ohio, Pennsylvania, Georgia, Virginia and North Carolina had over three million people on their respective donor registries. As of September of 2010, a total of 19 other states had more donor enrollees than New York. Clearly, more needs to be done to increase the level of awareness of donation in New York.

The Alliance is extraordinarily grateful for the funding support from the Legislature in previous years. The funding has been used for projects such as:

- ✓ radio campaigns developed with the New York State Broadcasters Association reaching every major market in New York from 2002 to 2008;
- ✓ a college awareness project;
- ✓ a cable television campaign focused on organ, eye and tissue donation and awareness;
- ✓ the creation of a unique Donate Life New York State logo and website, www.donatelifenys.net , to facilitate on-line donor registration;
- ✓ the creation of an ongoing continuing medical education project for physicians with the Medical Society of the State of New York;
- ✓ the education materials for funeral directors; and
- ✓ the education of registered nurses in collaboration with the New York State Nurses Association.
- ✓ collaboration with the Hospital Trustees of New York State and the Healthcare Association of New York State
- ✓ initiatives with the New York State Association of County Clerks to promote donation in county-run DMVs

The Alliance has efficiently utilized the funding provided by the State. The college project piloted with State funding was the focus of a grant proposal to the Department of Health and Human Services (DHHS) which resulted in a three-year grant of over $850,000. This grant has helped us better inform our initiatives to increase enrollment in the Donor Registry. In 2005, the Alliance was awarded another $652,000 DHHS grant related to evaluating the impact of educating medical students and residents about organ and tissue donation. Currently Albany Medical College, University of Buffalo Medical School and Mount Sinai Medical School are participating in this project which was developed from the success of the physician education project supported with New York State funds. The seed funding for highly productive projects allows the Alliance to seek additional funding and to bring funds back to New York.

In September 2008, the Alliance began work on a new federal Human Resources and Services Administration grant. This project will develop and implement an internet-based viral marketing campaign to promote organ, eye and tissue donation to college students and to have them sign up to the Donate Life Registry.

We were pleased to find that the consistent commitment for funding by the Legislature over the last several years has translated into appropriations in the Governor's Budget proposal last year, and now again in SFY 2011-2012. The Alliance does have concerns, however, about this appropriation. The line item of $372,000 that was originally divided between the Alliance and the New York Center for Liver Transplantation will now be divided among three organizations. With the addition of a Cardiothoracic Consortium, the Alliance's appropriation will be cut in half. Since most of the Alliance funding is directed toward educational outreach and registry promotion, this should be of great concern to the State of New York. Donation and transplantation saves money by, for example, getting people off dialysis, in addition to saving lives.

We ask that funds of at least these levels be supported by the Legislature as it reviews the Executive Budget proposal.

Thank you for your consideration.

TESTIMONY

SANTOS CRESPO

PRESIDENT, LOCAL 372

NEW YORK CITY BOARD OF EDUCATION EMPLOYEES

PUBLIC HEARING

NEW YORK STATE SENATE FINANCE COMMITTEE & ASSEMBLY WAYS AND MEANS COMMITTEE

EXECUTIVE BUDGET HEARING

HUMAN SERVICES

MARCH 2, 2011

Chairman DeFrancisco, Chairman Farrell, and Committee Members:

Thank you for the opportunity to express our concerns regarding the 2011-2012 Executive Budget.

As President of Local 372, I represent close to 25,000 Department of Education employees who perform essential services for the children of New York City. Most Local 372 members work in the communities in which they live, spend money, pay taxes, and vote. They not only take their jobs seriously, they take them personally, with a very strong sense of accountability. Our members provide the support services that are essential to making our 1.1 million school children learning-ready. Yet when budget cuts occur, the children's immediate needs come last and support services are cut first.

Let me preface my comments with the recognition that both New York State and New York City are financially hurting. We recognize that in tough times, tough decisions need to be made. There is no easy fix in this economic climate; not in the State, and not in the City. ***However, we cannot balance the budget on the backs of New York City's school children.***

SUBSTANCE ABUSE PREVENTION/ INTERVENTION SPECIALISTS (SAPIS)

Today, I would like to address the devastating cuts impacting our Substance Abuse Prevention/Invention Specialist (SAPIS) workforce. SAPIS professionals have been recognized as a critical part of a functioning school system. These professionals provide counseling services to children in grades kindergarten through high school with respect to substance use and abuse; antisocial behavior; poor academic achievement; personal and emotional problems; family problems; truancy and attendance problems; and crisis intervention.

The Local 372 professionals providing these services are stakeholders in New York City's schools; living, raising their families, and contributing to the community. However, these valued professionals have repeatedly been the target of layoffs to the point where the student to specialist ratio is currently the highest in program history – seriously threatening the 1.1 million public school children served. With SAPIS workers serving the entire school population, the continually increasing SAPIS-to-student ratio negatively impacts the effectiveness of their prevention and intervention services.

At its inception, the SAPIS Program received sufficient funding to allow for one SAPIS professional to be assigned per school. Over time the once 1500-member group of SAPIS professionals has dwindled to a fraction of that. The SAPIS program now consists of approximately two hundred eighty six (286) professionals.

At a time when there are noticeable and documented increases in the use of alcohol and drugs among adolescents, funding of school-based substance abuse prevention services should be increased—not cut further.

Of the funds that are available for substance abuse prevention services, a sizeable portion is spent on so-called "community-based organizations." These community-based organizations, however, are not located within the schools (as are SAPIS professionals), making them much less able to successfully intervene early-on in the lives of students and prevent development of substance abuse problems. These community-based organizations are often primarily in the business of providing substance abuse treatment services, whereas SAPIS professionals devote themselves to counteracting the need for such treatment by stopping substance abuse before it begins.

The 2011-2012 Executive Budget appears to alter the funding of New York City's SAPIS program. In previous years, SAPIS funding (although continually reduced) had a specific line item in the Office of Substance Abuse Services budget. According to Senate Finance, this year the Executive proposes, through administrative action, to use quality assessments in determining funding for OASAS programs. Programs that fail to attain performance indicators, established by OASAS, will experience a reduction in funding.

Local 372 recognizes the State's critical fiscal situation and strongly advocates the funding of quality, progressive programs. SAPIS professionals are successful in part because they have received proper training through the New York State Office of Alcohol and Substance Abuse Services to implement science-based counseling methods and Local 372 has put forth proposals to expand the role of the SAPIS employee to address the requirements of recent legislative initiatives.

Specifically, New York's recently enacted "Dignity for All Students Act," that goes into effect in 2012, requires DOE to create policies to develop school environments that are free from harassment. It also requires that at least one staff member at every school be trained to handle "human relations in the areas of race, color weight, national origin, ethnic group, religion, religious practice, disability, sexual orientation, gender, and sex." Local 372 asserts that these services could be delivered by SAPIS employees. We welcome the opportunity to work with the State and the City to provide quality programs to New York's school children.

When the Federal Government passed the Education Jobs Fund this year, it recognized the importance of school support services. The Feds allotted $190 million dollars to New York City for education jobs and specifically stipulated that this funding must go towards retaining school support staff, as well as teachers. It further stated that funds be available towards rehiring laid off staff. ***Local 372 asks New York to similarly recognize the importance of the SAPIS professional and dedicate funding specifically for this program. Removal of the line item (as suggested in the Executive budget) creates great uncertainty for the school-based programs.***

Taking a solely monetary perspective, NYC DOE asserts that the greatest share of its allocation goes to personnel, and therefore, layoffs will be necessary to balance the budget. However, layoffs of more Local 372 school-based support service workers will cost the taxpayers much more than the DOE claims it will save.

Attached is a chart prepared by the DC 37 Office of Research and Negotiations, demonstrating the actual monetary costs of Local 372 layoffs to New York taxpayers. (See attachment 1.)

As the chart reveals, there are other contributing factors that determine the financial outcome of laying off one Local 372 employee, or any City employee, for that matter. While the DOE cuts the cost of salary plus fringe benefits, the New York taxpayers must assume the burden of the loss of the worker's economic activity which includes income tax payments and vital support to local businesses. Since the job market is bare, the taxpayers must also pick up the tab for unemployment insurance, Food Stamps, and Medicaid.

Many of our members are parents and grandparents of the children in our schools. Many live and work in our communities, providing the services that our children critically need. Many reside in and are actively involved in the communities in which they work. Our members are a force for stability and continuity in our communities. In hard times, the axe often falls on support services. If more support service jobs are cut, the education of 1.1 million New York City school children will suffer the most.

Our children are our life's work and they deserve more support, not less.

On behalf of Local 372 and its almost 25,000 members, thank you for the opportunity to present this information and I welcome addressing any questions you may have.

Don't trade Local 372 jobs for outside contracts!

The Mayor and the Chancellor have stated publicly that since personnel is the largest cost component in the DOE budget, layoffs are necessary to cut costs.

The DOE also claims that it is more cost-effective to invite outside contractors to perform the same tasks as Local 372 employees. Let's do the Math.

Estimated Direct Costs of Layoffs: An average Local 372 Employee (Head of Household/4)		
	Annual Cost	**Comment**
Wage	($25,000)	Estimated salary of a Local 372 School Aide
Pension Cost	($2,500)	This amount assumes a 10% entry rate.
Lost Taxes to the City	($2,400)	Estimates provided by DC 37 accounting Dept., including income tax & FICA
Unemployment Insurance	($240) per week ($6,240) (26 weeks)	Based upon NYS Unemployment Insurance Guidelines. Source: www.labor.ny.gov
"One Shot Deals"	($1,200)	Back rent, utilities - estimate
Food Stamps - Cost to Federal Gov't.	($8,016)	$668 per month per NYS eligibility guidelines for a family of four. Source: USDA
Health Insurance Premium	($12,219)	Premium paid for employee
Medicaid Payments per Enrollee	($9,974)	Based upon FY2006 Medicaid Payments per Enrollee (1 adult, 3 children) Source: www.statehealthfacts.org
Total Savings to City (salary + pension + health insurance) ($25,000 + 2,500 + $12,219)	$39,719	Savings to DOE budget when one employee is laid-off
Total Cost to City/State/Federal Gov't Medicaid + "One Shot Deal") ($2,400 + $6,240 + $8,016 + $9,974 + $1,200)	($27,830)	Costs to taxpayers when One Employee is laid-off and relies upon government assistance
Net Savings of 1 Job Not Retained	$11,889	Savings to DOE budget
Lost Economic Activity of a single job	($62,500)	Multiplier of 2.5 times salary (DC 37 Research & Negotiations)
Net Cost to City: 1 Job (Savings - Economic Activity)	($50,611)	= Lost Economic Activity minus Net Savings of 1 Job Not Retained

FEDERATION OF PROTESTANT WELFARE AGENCIES

Statement Prepared for the March 3, 2011 Hearing of the

Assembly Ways And Means Committee
&
Senate Finance Committee

on the
2011 - 2012 Executive Budget Proposal for Health and Medicaid

Prepared by:
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Fatima Goldman

Executive Director/CEO

About FPWA

The Federation of Protestant Welfare Agencies (FPWA) has been working since 1922 to improve the lives and conditions of disadvantaged and low-income New Yorkers. We are unique in New York City in that we are the only membership organization for Protestant and non-sectarian health and human services organizations. Our work with almost 300 member agencies and church-based human service programs puts us in direct contact with every level of the social service system. This gives us a comprehensive view of the complex social problems that face human service organizations today, and allows us to identify common ground among our members so that we can have a greater impact as we advocate for them.

Though we understand the challenges faced by the state in these difficult economic times, these are also the times when people are without jobs, have lost or are on the verge of losing their homes, and must turn to essential human services to feed and clothe their families, pay for heat, medicine and other needs.

This written testimony will address the Governor's budget proposals for the Department of Health AIDS Institute, State Office for the Aging and the Medicaid program, with emphasis on programs that will particularly impact the elderly and individuals living with HIV/AIDS.

I. Department of Health AIDS Institute

FPWA is pleased to know that the Governor has kept his promise by allocating adequate funds back to the AIDS Drug Assistance Program. However, FPWA continues to be deeply concerned about the consolidation of the AIDS Institute budget from roughly 60 budget lines to 5 large categories. We believe this action has severely undermined state agency transparency, thus making it difficult for legislators, as well as the general public, to learn about the budget allocations. It also eliminates statutory protections for safety providers including those funded by Community Development Initiatives/Multi Service Agency lines and the Community Service Provider lines. This adds incredible uncertainty to service providers to leverage private and government funds in a difficult economic environment.

If this proposal is adopted, it will set an unprecedented example that the AIDS Institute will no longer be required to disclose budget allocations for each program. Instead, only the lump sum of each of the five large categories will be listed on the budget document.

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FPWA urges the Legislature to re-insert the language listed below in the budget bill that would allow safety net providers to be exempted from the competitive bidding process and re-line out funding allocations for each program to preserve transparency.

> *To ensure organizational viability, agency administration may be supported subject to review and approval of the commissioner of health. Notwithstanding any provision of law to the contrary, the commissioner of health shall be authorized to continue contracts with community service programs, multiservice agencies and community development initiatives for all such contracts which were executed on or before March 31, 2009, without any additional requirements that such contracts be subject to competitive bidding or a request for proposals process.*

II. Medicaid

FPWA is deeply concerned that some proposals the Medicaid Redesign Team recommended to the Governor may have a negative impact on low-income New Yorkers, particularly persons living with HIV/AIDS, the elderly as well as their service providers. The NYS Department of Health reported that in 2007, there were approximately 66,000 to 68,000 persons living with HIV/AIDS who received Medicaid. Within this population, about 11,000 are Medicaid and Medicare dual eligible.

As a member of Medicaid Matters New York, FPWA strongly believes that a meaningful Medicaid Redesign effort should embrace the principle to protect the safety-net providers that serve Medicaid consumers and the uninsured. In the process of identifying savings for the state's Medicaid programs, it is equally important to ensure there is an emphasis on community-based primary and preventive care and long term services and supports while improving quality and performance of services to eliminate health disparities.

One way to reduce spending of Medicaid is to address health care cost that is currently concentrated among a minority of "high utilizers" of health services. Among this group are those who are homeless and have complex health conditions. FPWA recommends the Governor and the Legislature to consider including a 30 percent rent cap affordable housing protection for clients of the HIV/AIDS Services Administration (HASA). This would not only fix New York State's policy by aligning with long-term standard for affordable housing used by the federal Department of Housing and Urban Development (HUD), it would also generate approximately $22 million in Medicaid

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savings through reduction of emergency and inpatient health care uses due to increase in housing stability.

FPWA strongly oppose the following recommendations submitted by the Medicaid Redesign Team:

- **Oppose the proposal to reduce personal care services.**
  FPWA is very concerned about this Medicaid Redesign proposal which would reduce and control utilization of personal care services. In particular, we are concerned that this proposal includes important personal care services such as housekeeping, shopping, and meal preparation. If vulnerable, frail seniors do not have this assistance available to them, they could be at much higher risk of falling or of sustaining other injuries which would require them to have much more expensive emergency medical care or long-term care assistance. Personal care services are essential for many seniors in that they are assisted with these more strenuous household 2 duties. This type of assistance is critical to helping seniors remain in their homes and communities as long as possible.

- **Oppose the proposal to eliminate trend factors for nursing homes, home care and personal care services.**
  FPWA disagrees with the Medicaid Redesign proposal that the 1.7% 2011 trend factor for nursing home, home care and personal care services should be eliminated as of 4/1/11. In the current Long Term Home Health Care Program, the highest rate of reimbursement to one program is $45 per day while the actual cost for a social adult care day is $70 or more. If this proposal is enacted it will be the fourth consecutive year that these health care sectors have not received an increase. With the projected growth of the elderly in the coming years, sufficient financial resources need to be in place for providers of these critical services in the communities. Home health care and personal care services are very beneficial to caregivers who need a respite from caring for their loved ones. We urge you to vote "nay" on this proposal.

- **Oppose the proposal to eliminate spousal refusal.**
  FPWA is concerned about the Medicaid Redesign proposal to eliminate spousal refusal because it will force spouses to impoverish themselves in order for the elderly client to be approved for Medicaid covered community-based care. Currently, when couples reside in the community and only one spouse requires Medicaid, the sick spouse can apply for Medicaid

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as a single individual and the other spouse can exercise "spousal refusal," declining to make his or her income and resources available to the sick spouse. We urge that this proposal, which would be detrimental to so many couples, be rejected.

FPWA urges the Governor and Legislature to follow principles mentioned in this testimony when making budgetary and program restructuring decisions on the New York State Medicaid programs.

III. State Office for the Aging (SOFA)

In the 2011-2012 Executive Budget, the Governor has proposed to direct $36 million in **Title XX-Social Service Block Grant** discretionary funds to be used for Child Welfare Services. Currently, $102 million in Title XX funds is allocated throughout New York State by the Office of Children and Family Services (OCFS). Of the total $102 million, $66 million is directed to Adult Protective/Domestic Violence services and $36 million is distributed to counties to fund programs at their discretion. Nearly $25 million in local discretionary funding is currently allocated for aging services in New York City for senior centers, meal programs, transportation, educational and recreational programs. FPWA is very concerned that this shift in funding could result in the closure of 110 New York City senior centers. We ask the legislature to work to prevent this dramatic change from occurring.

FPWA strongly supports additional funding for **Social Adult Day Service (SADS) model**. SADS programs are designed to provide a variety of long term care services to older New Yorkers with functional impairments in a congregate setting and according to an individualized service plan. Funding for SADS has been eliminated by New York City, making this request that much more imperative.

Cost-Effectiveness: SADS are a cost effective way to care for frail elders and enables them to live in their homes and communities, averting premature nursing home placement. For example, the cost of a year in a SADS program is $18,500 and is significantly less than the cost for a year in a nursing home at $123,420.

Transportation remains a high need for SADS programs and transportation allocations should include funds to support social adult day service programs on a consistent basis. If new funding becomes available we support the use of new EISEP funding for SADS programs where feasible, so

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long as this does not reduce funding for EISEP home care programs. We support SADS programs receiving reimbursement for services for assisting caregivers in need of respite.

In addition, FPWA is concerned that funding for **enriched social adult day services** has been recommended for significant reductions in the Governor's Executive Budget Proposal and is one of the programs that will be included in the newly proposed local competitive performance grant program. The enriched model of social adult day services affords program providers the opportunity to expand the range of services offered, allows the elderly to remain in the community longer and deters or delays nursing home placement. These programs give caregivers peace of mind and they are able to work, maintain their households, and keep their loved ones home with them longer. Facilities need the flexibility to adjust to the range of services needed by the clients they serve. Examples of services provided under this program include assistance with toileting, mobility, transferring, eating, and medication dispensing by a Registered Nurse. We urge the legislature to restore funding for this important program.

FPWA is concerned that funding for some other key aging programs will be greatly reduced and possibly eliminated as a part of the Governor's **proposed local competitive grant program**. Funding is proposed to be cut by a total $2.17 million for 2011-2012 and $3.1 million for 2012-13. Some examples of programs that will be impacted, in addition to the enriched social adult day centers, include the Community Empowerment Initiative and the Congregate Services Initiative among others. We urge the legislature to restore funds for these critical programs.

Thank you for the opportunity to present this testimony.

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GMHC

FIGHT AIDS. LOVE LIFE.

Gay Men's Health Crisis Testimony
Legislative Public Hearing Health/ Medicaid
2011-2012 Executive Budget Proposal

March 3, 2011

Gay Men's Health Crisis (GMHC) appreciates this opportunity to submit testimony on Governor Cuomo's 2011-2012 Executive budget. While we feel that this budget does a good job of preserving funding for HIV services, proposed cuts and changes to Medicaid are concerning.

GMHC provides services to in excess of 11,000 individuals in New York City each year. Founded in 1981, GMHC has empowered thousands of HIV positive and high-risk negative individuals through targeted and highly effective HIV prevention, education, outreach and advocacy services.

This year marks the 30th year of the HIV/AIDS epidemic. Despite some progress, the number of people living with HIV, particularly in New York, continues to increase. African Americans, Latinos and young gay and bisexual men continue to be disproportionately affected. In New York State, almost 90% of new HIV diagnoses among women occur among black and Latina women. African American men comprise 45% of all new diagnoses among men, and African American women comprise 67% of all new diagnoses among women in New York City. In addition from 2003 to 2008, the proportion of men who have sex with men (MSM) among all newly diagnosed males grew from 47% to 56%. Also very troubling is the 27% increase in new HIV diagnoses among MSM aged 13-29 in New York City between 2003 and 2009.

GMHC commends the budget proposal to fully fund New York State Department of Health's AIDS Institute and the AIDS Drugs Assistance Program at 2010 levels. In addition, budget proposals to reduce wasteful spending such as eliminating excess prison capacity are laudable. At the same time we urge the legislature to ensure thoughtful redesign of Medicaid to guarantee efficient access to quality care by the people who depend on the program.

Our clients represent the City's most marginalized populations and 78% of them live at or below the poverty level. Medicaid provides a crucial safety net service to these clients, because without it they would be unable to afford medical care or navigate the benefits system.

GMHC is particularly concerned that, as a final budget is negotiated, proposals that jeopardize beneficiaries' access to case management, medications and wrap around services may be considered. We urge the legislature to reject these harmful and short sighted proposals. The proposals that came before the Medicaid Redesign Team, which we opposed, and will continue to oppose as the budget process moves forward are:

1. Any effort to reduce access to needed medications. For example, GMHC opposed an expansion of the Medicaid Preferred Drug List to include HIV and psychotropic drugs.
2. Any effort to impose limits on brand named drugs that a beneficiary can access. GMHC opposed a limit of 5 brand named drugs per month.
3. Any effort to eliminate targeted case management for Medicaid enrollees. GMHC opposed two proposals, one to move all Medicaid beneficiaries into mandatory Managed Care and the other to eliminate Targeted Case Management for all Managed Care enrollees.

One of the crucial services provided by Medicaid is COBRA case management. This service provides intensive targeted case management services that help beneficiaries who have difficulty or challenges accessing medical care and other needed services to stay in care. GMHC believes that for cost-savings to be realized while maintaining quality care, Medicaid must be reformed to promote efficient and coordinated delivery of care. Intensive case management is a critical component of such an approach, since it helps remove barriers and increase access to care.

Existing managed care programs do not adequately provide case management for people with disabilities. COBRA case management fills this void for Medicaid beneficiaries and provides access to intensive targeted case management regardless of whether or not they are in managed care. Targeted case management services such as COBRA ***enable patients to effectively access medical care, and are not duplicative of medical management of medical care.***

GMHC would oppose a budget which would remove community-based coordinated care from Medicaid. Our strategy for closing the budget gap must consider long-term financial savings and detrimental impacts on patients. We simply cannot support any proposals which create barriers to care, reduce access to care and increase inefficiencies that lead to wasteful spending when beneficiaries are not appropriately linked to care. Cost increases will result from repeat and inappropriate referrals, delayed care and a lack of adherence to treatment producing poor health outcomes.

Access to social services must also be key components of any Medicaid redesign. Coordination of care needs to be emphasized and services should be delivered in an integrated way. Beneficiaries need to be closely followed when they transition between care settings so that they do not fall out of care. Intensive targeted case management does this. To remove this service would be ill-advised. Targeted Case Management programs provide care coordination services for special groups of Medicaid enrollees who have developmental disabilities, chronic medical conditions, such as HIV, and/or chronic mental illness. These programs save money and improve health by:

- Assuring access and retention in medical care
- Reducing disease transmission
- Addressing needs of persons with multiple co-morbidities
- Alleviating barriers to care
- Linking individuals with housing, mental health, substance abuse treatment, legal, nutrition, entitlements, child care, domestic violence, and transportation services
- Stabilizing individuals so that they remain in medical care

Secondly, GMHC opposes budget measures that would limit sick New Yorkers from accessing needed medications. The State's Medicaid Preferred Drug List is a valuable cost savings tool. However, some classes of drugs, such as HIV and psychotropic medications, have remained exempt for good reason. After consulting with a number of providers and experts in this field GMHC strongly believes that HIV medications should remain exempt. While we agree that the cost of these medications is way too high, we strongly oppose listing HIV drugs on a preferred drug list (PDL). We must find other ways to bring down the cost of these drugs.

Our main concern is that placing HIV drugs on the PDL would severely limit options available to doctors to treat their patients. Treatment for HIV is different from treatment for most other illnesses because each patient's drug regiment is unique and often difficult to calibrate. Small changes have great effects on individual patients and doctors must carefully match treatments to patients to minimize side effects and increase adherence.

The PDL emphasizes the use of generics, but in the case of HIV, the most effective drugs are relatively new and still under patent. Emphasizing generics would limit a doctor's ability to prescribe the most effective drugs. Further, generics may have more side effects than brand name drugs making adherence harder for patients, which in turn would increase community viral loads.

We also oppose the elimination of the prescriber prevails provision for drug coverage under the Medicaid Program. GMHC believes that these provisions must be maintained, removing them would result in delayed treatment as prescribers would need to provide clinical justification for a non-preferred drug and wait for prior authorization. We urge the legislature to find other ways to realize cost savings.

Finally, limiting brand named prescriptions to 5 a month could result in beneficiaries not obtaining necessary treatment and jeopardize treatment adherence. Beneficiaries may decide not to fill prescriptions to stay within the limit. Again, instead of removing barriers to care, this will make it harder for beneficiaries to access treatment.

In conclusion, GMHC urges the New York State Legislature to enact the AIDS Institute and ADAP budget as proposed by Governor Andrew Cuomo. We also urge the Legislature to exercise its authority with regard to Medicaid reform by ensuring that decisions are made in the best interest of beneficiaries and the long term financial health of New York State. It is incumbent on our elected officials to ensure long term, and not just immediate cost savings, while improving the care of all New Yorks.

We appreciate this opportunity to testify. For questions or additional information please contact Lyndel Urbano, Manager of Government Relations in the Public Policy Department at GMHC. lyndelu@gmhc.org or 212-367-1456.

TESTIMONY

OF

JOAN SIEGEL
SENIOR POLICY ASSOCIATE,
HEALTH AND MENTAL HEALTH

SUBMITTED TO THE
NEW YORK STATE SENATE FINANCE COMMITTEE
AND
NEW YORK STATE ASSEMBLY COMMITTEE ON WAYS AND MEANS

REGARDING THE
NEW YORK STATE EXECUTIVE BUDGET PROPOSALS FOR
MENTAL HEALTH
STATE FISCAL YEAR 2011-2012

MARCH 2, 2011

Good Morning. My name is Joan Siegel and I am the Senior Policy Associate for Health and Mental Health at Citizens' Committee for Children of New York (CCC). CCC is a 67- year old privately supported, independent, multi-issue child advocacy organization, dedicated to ensuring every New York child is healthy, housed, educated and safe. CCC does not accept or receive public resources, provide direct services, or represent a sector or workforce. For 67 years CCC has undertaken public policy research, community education and advocacy efforts to draw attention to children and their needs so that we can advance budget, legislative, and policy priorities that are cost-effective and produce better outcomes for New York's youngest residents. I would like to thank Chairman Farrell and Chairman DeFrancisco and members of the Assembly Ways and Means and Senate Finance Committees for this opportunity to testify on the Governor's Executive Budget for State Fiscal Year 2011-2012.

It is clear that New York's troubled economy and staggering budget deficit demand long-term structural budget changes and not short-term fixes. To this end, Governor Cuomo's first Executive Budget looks to redesign state government to help address the fiscal challenges facing our state. While addressing the state's spending is critical and all New Yorkers are reeling from the economic downturn, few are being hit harder than poor children and their families. It is CCC's belief that we must not allow this year's budget to eliminate the safety net needed to ensure that the next generation of New Yorkers can reach their full potential.

Governor Cuomo's $132.9 billion Executive Budget proposes to close a $10 billion gap, almost entirely through spending reductions and cost-shifts to counties. While shifting costs of mandated programs to counties saves the state government money, it does not reduce the need for funds for these programs, leaving struggling counties burdened with paying for these programs and faced with tremendous service reductions. In addition to the proposed $2.85 billion reduction to Education and $2.3 billion reduction to Medicaid, the Executive Budget proposes to reduce its commitment to Human Services by over $300 million, $114.2 million of which is Human Services cost shifts to localities.

For New York City, Mayor Bloomberg has estimated that the reduction in aid totals $2.1 billion, including a $1.4 billion in aid to public schools; $361 million in cuts and cost shifts in social services; and $300 million due to the elimination of the AIM for New York City.

While there are some areas where the Executive Budget proposals protect essential programs for children and families, and Governor Cuomo has made laudable efforts to address the State's broken juvenile justice system, CCC is extremely concerned that the adoption of this budget, as it is proposed, would place the State of New York's most vulnerable children at even greater risk.

Notably, the Executive Budget includes numerous cuts and cost shifts for programs and services that have been cost-effective and producing good outcomes for children. This Budget decreases state support and commitment to children adopted from foster care, special needs school children being educated in special schools to meet their needs, homeless families in New York City, new mothers seeking to raise their children safely and healthy by participating in home visiting programs, and youth trying to engage in positive activities and grow into successful adults through participating in after school programs and the Summer Youth Employment Program.

These cost shifts can be seen in the elimination of the AIM to New York City, the changed formula for adoption subsidies, the elimination of state support for CSE placements, the new proposed requirement to use Title XX for child welfare, the changed formula for adult homeless shelter costs, and the changed financing structure for TANF Family Assistance and Safety Net. In addition, cuts and service reductions can be seen not only in Education and Medicaid support, but also for critical services previously funded with TANF dollars, such as Nurse-Family Partnership, post-adoption services, supportive housing, homelessness prevention programs and the Summer Youth Employment program, as well as to the budget's proposed cuts to the Runaway and Homeless Youth Program, Healthy Families New York Home Visiting, Early Intervention Services, and family treatment beds for children needing mental health treatment.

We urge you to negotiate a budget that uses fairness as a guiding principle. Fairness includes making deliberative choices about where the expense side of the budget needs to be reduced

without jeopardizing cost-effective programs, resisting the urge to merely shift costs to counties to bear, and ensuring there is shared sacrifice for all New Yorkers. We urge you to negotiate an Adopted Budget that ensures that the state remains committed to the programs that produce positive outcomes for children, and ultimately saves the state money on more expensive interventions such as foster care, medical care, homeless shelters, and the juvenile justice system. Fairness also requires an acknowledgement that it is unfair and disingenuous for the State to balance its budget by shifting costs for essential and mandated services to the counties, including New York City, which is hit particularly hard by the Executive Budget.

Fairness also requires supporting revenue-generating proposals, to ensure shared sacrifice. CCC urges you to extend the personal income tax increase; impose an excise tax on sugar-sweetened beverages as a means to take a critical step towards addressing childhood obesity and the associated illnesses such as diabetes and heart disease while increasing revenue; and to work with the Governor and Mayor Bloomberg on pension reform.

Turning to the topic of Mental Health specifically, while New York State has made incredible progress in bringing screening and assessment to child serving settings and expanding access to treatment, children's mental health services continue to be in short supply and the rate of reimbursement for treatment has generally not kept up with the actual cost of care. Studies also show that when earlier identification occurs and treatment is secured for children, children are better off academically, socially, and within their family. In New York City, there are over 1.3 million children between the ages of 5 and 17 and of those, more than 67,000 have a severe mental health need. Furthermore, there are approximately 570,000 children ages 0 to 4 and over 21,000 of them require a mental health interventions.[1]

Keeping in mind the benefits of early detection and treatment and the desire to avoid costlier interventions, CCC believes that New York State has the obligation to enact a State Budget that

[1] Census data: U.S. Bureau of the Census. 2006-2008 3-year American Community Survey. Prevalence Data for 0-4: Lavigne JV, Gibbons RD, Chirstofeel KK, et al (1996). *Prevalence Rates and Correlates of Psychiatric Disorder among Preschool Children.* J Am Acad Child Adolesc Psychiatry, 35:2, 204-214. Prevalence data for 5-17: Shaffer D, Fisher P, Dulcan MK, et al (1996). *The NIMH Diagnostic Interview Schedule for Children Version 2.3 (DISC-2.3): Description, Acceptability, Prevalence Rates and Performance in the MECA Study.*, J Am Acad Adolesc Psychiatry, 35:7, 865-877.

includes budget, policy as well as Medicaid Redesign proposals that protect and address the specific health and mental health care needs of children.

With respect to specific Medical Redesign Proposals, CCC recommends that health care coverage options must protect and address the specific health and mental health care needs of all children, including children currently covered by Medicaid, Child Health Plus, and Family Health Plus; children served by waiver programs due to fragile health, behavioral health, mental retardation and disability; as well as children in foster care. It is within this larger frame that our support and opposition to specific Medicaid Redesign proposals has been determined.

We urge the Governor and the State Legislature to support the Medicaid Redesign proposal #1021 to co-locate physical health, behavioral health and developmental disability services. Current regulations, each promulgated by the different state agencies, are sometimes an obstacle to co-locating these services, as the regulations are often duplicative or in conflict with each other. Enabling the co-location of services is a positive step in coordinating service delivery for some of the highest need patients who utilize more than one system.

In addition we support Medicaid Redesign proposals #150 and #1029, which automate eligibility determinations and verifications, and simplify enrollment and retention. The State has received a grant from the federal government to automate Medicaid determinations sand verifications. Automating these functions under proposal #150 will expedite determinations, which in turn means children will receive benefits sooner. The proposal to simplify enrollment will allow the State to outreach to consumers who indicate, on a tax return, interest in finding out about Medicaid, CHP or FHP. Proposal # 1029 to simplify retention would set up Medicaid in New York State to renew every two years, as opposed to annually. This proposal requires federal approval. Actions that make it easier for eligible children to enroll in and stay in Medicaid, CHP or FHP are positive for the health of children.

With respect to ensuring that the mental health needs of New Yorkers, and in particular children are adequately addressed, we support Medicaid Redesign proposal #93, which develops regional behavioral health organizations and creates a behavioral health carve out. In the area of

pediatrics in particular, it is clear that greater attention should be paid and investments made to improve the detection and treatment of children's behavioral health care needs. Yet, because managed health care plans have historically done a very poor job with respect to behavioral health care in general and children's mental health care in particular, we urge the Governor and Legislature to enact a statewide regionalized carve out using a specialty behavioral health organization. In states where this approach has been implemented, findings of the Health Care Reform Tracking Project[2] suggest that behavioral health care carve outs allow for more discrete planning for special populations, improve education and training for service providers, increase access to a broader array of needed services, and improve care coordination with mainstream health care plans as well as across non-Medicaid services. Furthermore, significant savings have been achieved under these models. In addition, because early identification and treatment are vital to improvements in child well being, we oppose the Medicaid Redesign proposal to develop utilization controls on behavioral health clinics for children.

Finally, we support the wide array of workgroups proposed under the Medicaid Redesign proposals (i.e., Payment Reform, Basic Benefit review, Program streamlining, Supportive housing, Assisted Living Program redesign, Workforce flexibility, Long Term Care waiver redesign, Managed Long Term Care implementation), but urge the Governor and the Legislature to ensure that child specific workgroups are created as well, in order to pay particular attention to the complex needs of special populations of children including children who are mentally ill, children that currently participate in waiver programs, and children who are in foster care. The Medicaid Redesign Team proposes to bring everyone into a managed care plan over the next three years (#1458); however, many of these children are currently carved out of Medicaid due to their complex needs. While folding them into a managed care plan may appear to make fiscal sense, the State may end up expending more money and producing poorer health and mental health outcomes, if the benefits packages are not carefully crafted to ensure that the children's needs are met.

With respect to specific Mental Health proposals included in the Executive Budget, several proposals would realign, restructure or reduce services, but negatively impact children with

[2] *See e.g.*, http://rtckids.fmhi.usf.edu/rtcpubs/hctrking/pubs/promising_approaches/issues/issue_06/issue06_full.pdf

behavioral health issues. As we noted earlier in our testimony, it is well established that the earlier a child's mental health concerns are addressed, the better the outcome for the child. With that in mind, we urge the Legislature and the Governor to consider the following recommendations.

We urge the Governor and the Legislature to reinvest savings achieved through Child and Family Clinic-Plus restructuring into pediatric screening programs and children's mental health treatment. Child and Family Clinic-Plus expanded treatment options for children, but to date, the take-up rate for screening in child serving settings has not been as high as anticipated. The Clinic-Plus data show that in 2010, only 5,916 children were screened in New York City[3]. It would be a disservice to children to reduce efforts to screen effectively and then secure treatment for children with mental health needs. An analysis of mental health prevalence performed by CCC with regard to children in New York City, showed that there are more than 67,000 children in New York City between the ages of 5 to 17 who have a mental health disorder that is considered a severe impairment and over 21,000 children between the age 0 to 4 would benefit from mental health intervention. Yet, service delivery data shows that in any single week only 14,663 children are served by a licensed mental health program in the city overall.[4] In sum, the gap between need and the availability of children's mental health services is profound.

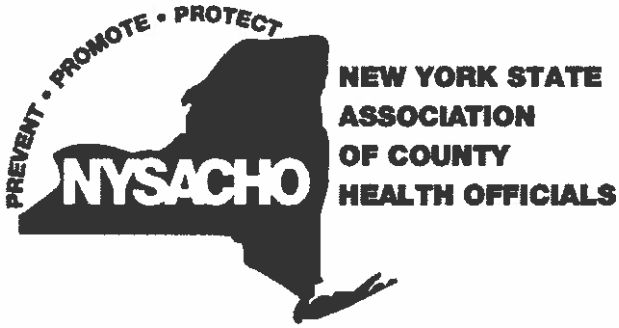
We also urge the Legislature to oppose eliminating funding for children's family based treatment beds over the next two years. Family-Based Treatment is the least restrictive of the State Office of Mental Health's out-of-own-home programs. This time limited (2 year maximum) program allows a child to be in a therapeutic, home environment. While treating the child, the family based treatment parent educates the child's legal parent(s) on viable behavioral interventions so that the child can go home. Unlike a foster care therapeutic home, the child's parents do not lose legal custody of their children while treatment is being provided. Lastly, this reduction would be harmful because it pits the needs of children with mental illness against those of adults with mental illness. The reduction was triggered by State's need to cover costs associated with the federal court mandate to provide increased supportive housing for adults with mental illness. We

[3] http://bi.omh.state.ny.us/clinicplus/region?goal=screen&show_all_regions=true&p_year=2010 (accessed 2/22/11)
[4] New York State Department of Mental Health. Patient Characteristics Surveys. 2007

believe resources should be found elsewhere to meet the needs of adults and that children's services should not be sacrificed.

In closing, we ask the Assembly and the Senate to negotiate a budget with the Governor that protects our youngest New Yorkers from paying for this economic downturn for the rest of their lives. While we appreciate that very difficult choices about revenue increases and expense reductions need to be made, we urge you to protect the services that will ultimately be less costly to the children of today and the taxpayers of tomorrow.

Thank you for the opportunity to testify.



"The Voice of Local Public Health in New York State"

March 3, 2011
Testimony before the Joint Legislative Committees on Health and Finance/Ways and Means
Regarding the 2011-12 Executive Budget Proposal

NYSACHO's MISSION:

To support local health departments
in their work to prevent disease, disability and injury
and promote health and wellness
throughout New York State.

NYSACHO is incorporated as a not-for-profit, non-partisan
charitable organization with 501(c)(3) tax exempt status.

Paula Calkins Lacombe, BSN, MPA
President of the New York State Association of County Health Officials (NYSACHO):

Good afternoon Senator DeFrancisco, Assemblyman Farrell, Senator Hannon, Assemblyman Gottfried and distinguished committee members of both houses. My name is Paula Calkins Lacombe. I serve as the Public Health Director for Clinton County and as the current President of the New York State Association of County Health Officials (NYSACHO). Thank you for the opportunity to present this testimony on behalf of my colleagues at all 58 local health departments in New York State.

Today I will present a brief overview of the current status of local public health in New York State and then review specific requests for consideration by this legislature.

Local health departments provide essential, population-based health services that protect all New Yorkers. Examples include but are not limited to control of communicable disease, immunizations, identification and abatement of lead hazards, maternal child health services, tobacco control efforts, restaurant and camp inspections and chronic disease prevention.

Primary prevention through core public health services can be cost-effective. As an example, a 2009 report by the Pew Charitable Trust found that for every dollar invested in lead poisoning prevention, 17 dollars are saved by preventing costs related to medical care, special education, behavioral problems, crime, loss in IQ and reduced lifetime earnings for the child exposed. Or consider annual influenza vaccination. The cost for an office visit to provide an influenza vaccination averages one hundred fifty-five dollars nationally; the cost for a hospitalization due to influenza illness averages eleven thousand dollars nationally.

Public health is critical to efforts to control the rising costs of medical care and to improve the quality of life in our communities, both of which are cornerstones for economic and job development. But I'm sorry to report that the local public health infrastructure in New York State is becoming increasingly fragile. Combined state and local funding reductions due to the fiscal crisis of recent years have required significant reductions in programs, services and staff.

The current federal budget proposals for public health are likely to result in additional reductions of funding for New York State and its localities. These shrinking resources put our state at risk for serious public health problems, as the public health infrastructure and essential services are curtailed or disappear. What will these problems look like? They could emerge as outbreaks of preventable childhood illnesses that have been under control for decades, or as an increased incidence of foodborne illnesses in communities across the state. One of our state's greatest assets – a plentiful supply of safe, fresh water – may be threatened. These are the types of widespread public health catastrophes that our local health departments strive to prevent.

We fully recognize the challenges before you and respectfully request that, as you consider the many hard choices you must make in this year's state budget, you keep in mind:

- **Stable and timely funding to support core public health services is essential for the protection of our communities.** NYSACHO applauds Governor Cuomo's recognition of this in his executive budget proposals. It is critical that the state maintains core public health services through general public health work appropriations and specific categorical funding for programs such as lead poisoning prevention and immunizations.
- **The State must explore and consider all opportunities to maximize revenue sources.** NYSACHO strongly supports the Governor's proposal to close loopholes that allow commercial insurers to shirk their responsibility for coverage of early intervention

services for children with special needs. This proposal will close loopholes in existing law that have permitted private insurers to shift costs to taxpayers since 1993. To better realign fiscal responsibility for this program so that services are appropriately covered and the program remains fiscally viable, we urge that an additional provision be included that would redefine time of loss for the purposes of Early Intervention insurance claiming to be the date the municipality pays the provider. Although we support many of the additional Early Intervention reforms proposed, we oppose the provision that would require large providers to directly bill insurers prior to submitting claims to municipalities: this provision would increase the administrative burden to municipalities to ensure due diligence on the part of providers in maximizing insurance reimbursement for services. NYSACHO understands the need for the proposed 10% rate reduction, given the importance of reducing state and local expenditures overall. However, we recommend that the implementation of any rate reduction be managed in such a way as to help ensure sufficient provider capacity.

- **Article Six support for the statutorily required administration of local Early Intervention programs must continue.** The elimination of state financial support for this service affects all local health departments. It is not an "optional" service since municipalities are mandated by public health law to administer this program.
- **Local flexibility in meeting the unique public health needs of each community must be maintained and supported.** As noted previously, we are pleased that the Governor's budget proposal preserves public health funding for services that are defined under the law as "core" mandated services. But we are concerned that the governor proposed to eliminate the section of the statute that currently provides 36% reimbursement for

additional public health services, funding that gives individual localities the flexibility to meet the unique public health priorities of their communities. At some point in the development of regulations for this section of the statute, the misnomer "optional" replaced the term "additional." Despite this misnomer, the law is clearly intended to provide local health departments with the flexibility and fiscal support necessary to address public health priorities that are particular and essential to different communities. Included in this additional services category that would be cut under the executive budget are Medical Examiners who are instrumental in identifying important public health trends as they investigate unattended deaths, and home health services in counties where the health department is the sole provider of these essential services.

- **The recommendations of the 2007 gubernatorial task force on the pre-K special education program need to be implemented.** In particular, the recommendation that fiscal, administrative and programmatic responsibility for the pre-K program be transferred to school districts should be adopted to ensure fiscal responsibility and greater accountability.

In closing, NYSACHO and its members in local health departments are eager and willing to work with the governor, the legislature, and our local governments to prevent and reduce harm to New York's citizens through disease control, injury prevention, protection of our food, water and air, and promotion of healthy behaviors. We urge you to keep in mind that by preserving public health, you are meeting one of the central functions of government – that is, providing the infrastructure to keep our citizens healthy and safe. Your local health departments help you meet this obligation through proven, cost-effective methods.

NYAPT
NEW YORK ASSOCIATION FOR PUPIL TRANSPORTATION
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Our future is riding with us!

March 2, 2011

Hon. Herman D. Farrell, Chair
Assembly Ways and Means Committee
Legislative Office Bldg.—Room 926
Albany, New York 12248

Hon. James Hayes, Ranking
Assembly Ways and Means Committee
Legislative Office Bldg.—Room 924
Albany, New York 12248

Hon. John DeFrancisco, Chair
Senate Finance Committee
Legislative Office Bldg.—Room 915
Albany, New York 12247

Hon. Carl Kruger, Ranking
Senate Finance Committee
Legislative Office Bldg.—Room 915
Albany, New York 12247

Dear Senators and Assembly Members:

On behalf of the members of the New York Association for Pupil Transportation, I write to expand upon the statement we made at the February 15, 2011, hearing of the committees regarding the 2011-12 Executive Budget Proposal.

We appreciate greatly the opportunity to have come before your committees on that day and to be among those expressing their honest and constructive concerns and recommendations on the Governor's budget proposal.

We wish to take this opportunity to underscore several of the positions we stated in our testimony and to offer further detail and explanation of each of those positions in the attached talking points. In short, we request that the Legislature:

- Reject the Governor's proposal to restrict transportation aid to replacements for school buses (ten or more passengers) that have at least 10 years and 120,000 miles accumulated, and for school buses (fewer than ten passengers) that have at least 6 years and 75,000 miles accumulated;
- Reject the Governor's proposal to impose penalties on school districts that do not complete certain cost efficiency and shared services models and efforts;
- Reject the Governor's proposal to place unnecessary restrictions on the leasing of school buses as an alternative to purchasing school buses.

We are concerned over other elements of the Executive Budget proposal and those are outlined later in this letter. The three items listed above present the most serious potential for harm to school transportation efficiency as well as safety for our children.

Our concern is that the proposals contained in the Governor's budget reflected a desire to change the way school districts conduct their affairs with regard to school transportation. The assumption in those proposals is that school district leaders, including transportation managers, are making poor or inefficient decisions. The assumption extends to suggest that those decisions are costly and placing a burden on the state and local taxpayers, and that they can be modified through arbitrary conditions and restrictions on the provision of school aid for transportation services.

Our members --- and anyone familiar with transportation of people, most especially the transportation of children --- understand that the transportation of children to and from school and a host of other activities each day is logistically complex and not an inexpensive proposition.

The costs that are incurred for these transportation services are those that are deemed to be in the interests of child passenger safety. School transportation programs offer efficient routing of school buses to make the ride as efficient as possible for the districts and as short as possible for the students. We acquire through purchase or lease the most appropriate school buses to meet the needs and travel conditions of our communities and students. We retain and diligently prepare qualified school bus drivers, mechanics and support personnel to ensure that our children are safe on the road at all times.

We do all we can to ensure that the "first classroom" of the day is a safe and secure ride for our children and is a well-managed, cost-efficient ride for our taxpayers and the overall well-being of our school districts.

We offer the following general commentary on several provisions of the proposed budget and expand further in the accompanying talking points:

- §34 of A.4008/S. 2808 on School Bus Replacements: We do not replace school buses in a random fashion or because we like some new feature being built into a school bus. Rather, we work with our school boards and school business leaders to craft replacement plans that address our road conditions, student travel patterns, weather and road conditions, road treatment systems, and the diversity of our students' needs.

  Accordingly, we want to be able to continue to make such decisions and judgments with our school boards and our taxpayers (who vote on our purchases each year). We want to ensure that children are riding on the safest and environmentally cleanest school buses possible within our financial means, and therefore we oppose the Governor's proposed 'time and mileage' limitations on school bus replacement. *(see our talking points for further discussion)*

- §33 of A.4008/S. 2808 on Cost Efficiencies and Penalties: School transportation managers, in collaboration with their school boards and school superintendents, have instituted numerous changes in the delivery of transportation services to children in districts all across the state. This was done because it was right and timely to do, not because someone at the state level mandated the changes or threatened to reduce aid in the absence of their action.

  The Governor's proposal to penalize through aid reductions school districts that do not implement a pre-determined set of cost efficiencies suggests that school districts have done little or nothing and are waiting for the state to lead the way. We are leading the way on cost reductions through our actions over the past several years. Moreover, we are leading the way in recommending very specific and costly mandates that, if addressed, could save local and state taxpayers several millions of dollars each year. *(see our talking points for further discussion)*

- §8, 9 and 71 of A.4008/S. 2808 on School Bus Leasing: School districts do not lease school buses when it would be more appropriate and more cost-efficient to purchase the bus outright. Many of our districts have found that leasing one or more school buses can be as efficient or more efficient that purchasing school buses under certain circumstances. Moreover, school districts and municipalities have the option and are often encouraged to consider leasing of all forms of equipment and vehicles through the Office of General Services. This has become a standard cost-savings practice. We are concerned that leasing of school buses is being unreasonably and inappropriately singled out in this budget proposal.

  Accordingly, we want to be able to make that decision based on need and prudent cost analysis and therefore oppose the Governor's proposed restrictions on school bus leasing. *(see our talking points for further discussion)*

- §48 of A.4008/S. 2808 on School Bus Equipment Purchases: The purchase of school bus parts and equipment is also singled out in the Governor's budget by establishing a requirement that equipment

purchases pass the test of being related to cost efficiency and savings in the transportation operation.

School bus parts and equipment are purchased in accordance with laws and regulations adopted by the Department of Motor Vehicles and in accordance with options made available through the state contract officiated by the Office of General Services. State transportation aid is only allowed for those items included on a school bus that the State Education Department determines contribute to safety, health and efficiency. In fact, the Education Department, we believe, has been inordinately restrictive in allowing aid to support the purchase of certain technological advances like GPS and school bus tracking systems that are used for managing over-the-road cost factors like fuel usage, variances from specified routes, speeding and other factors. This proposal ignores all the hurdles put in place for equipment and parts purchases and assumes that school districts are purchasing unnecessary items (bells and whistles) for their school buses.

NYAPT supports allowing for negotiations with the Education Department on aidable equipment and parts and also supports the need to re-assess the equipment that is mandated by law to be installed on school buses at significant cost to school districts and all operators.

- §82 of A.4008/S. 2808 on School Bus Driver Training: We have offered as well our support for the appropriation of $400,000 for the Comprehensive School Bus Driver Safety Training program in this proposed budget. It is important that we continue and sustain our efforts to ensure that school bus drivers are receiving the most current knowledge and best practices to enable them to keep our children safe.

  On a related note, we urge the Governor and the Legislature to appoint all the members to the Advisory Council established pursuant to Section 3650 of the Education Law to oversee this program and other matters. It has been dormant for more than ten years and this is undesirable given the great needs we have for more and better school bus driver training and preparation.

Thank you again for this opportunity to explain further our positions and the rationale behind those positions. School transportation services enjoy the support of millions of parents and children across the state. While we recognize the need to ensure efficiency in the delivery of transportation and other services in our schools, we also believe it is important to focus our energies on ways that will more readily and directly benefit both our student riders and our taxpayers.

Please contact me directly to discuss any of these considerations and recommendations further.

Sincerely,

Peter F. Mannella
Executive Director

TALKING POINTS: SCHOOL BUS REPLACEMENT

First, we want to reiterate recommendation that you reject section 34 of the budget bill [A4008/S2808] which would put new constraints on the ability of school districts to purchase school buses to replenish and modernize their fleets. Fleet maintenance and cost effective vehicle replacement are vital elements of operating a school bus fleet efficiently and prudently. The Governor's budget seems to adopt the premise that allowing buses to run for certain and extended periods of time and distance is prudent management. We respectfully suggest that that is not always acceptable.

Our reasons for taking this position include the following:

School bus replacement policies and practices have been honed over the years by school transportation and school business officials in consultation with local school boards. These policies take into consideration the following at a minimum:

- the number of years in service but also the miles that have accumulated on each vehicle;
- the kinds of roads traveled in terms of quality and geography;
- weather conditions and winter road treatments used in their locale;
- the fact that the trade-in value of the school buses is significantly reduced by increased years in service and miles driven;
- the fact that the annual maintenance costs for buses over five years old are nearly double the costs of maintenance on newer buses;
- other factors related to costs, safety, operations and maintenance.

School districts have also taken steps to embrace policies of the state and federal government to replace older, less efficient and more polluting school buses with school buses that meet the 2007 EPA-sanctioned emissions standards. This budget proposal will hamper their efforts to update and upgrade fleets to ensure the cleanest, least polluting school buses available are in use for our children. This is consistent with the 2010 policy framework issued by then-candidate Cuomo which endorsed clean-air vehicles of all kinds.

Currently, nearly 40,000 of the 51,000 school buses in New York State are equipped with pre-2007 diesel engines. Those school buses are nearly 10% less efficient and "clean" than school buses manufactured after 2007. This budget proposal is inconsistent with the state's efforts to clean up our fleet. In the past ten years, school bus emission standards have reduced Nitrous Oxides discharged from school buses by 95% and reduced Particulate Matters discharged from school buses by 90%.

Our investment in these newer cleaner buses is a sound policy for the health of our children. Clearly, the best and most efficient way to reduce emissions from school buses in New York State is through the replacement of pre 2007 EPA Emission Standard compliant buses, not by mandating the continued use of older, inefficient and "dirtier" buses.

To further underscore the point, NYS Department of Transportation data show that as of August 2010, of the 51,246 inspected school buses, approximately 73% were equipped with pre-2007 EPA Diesel Emission Compliant and were discharging approximately 8,250,000 pounds of NOx [Nitrous Oxide] and 150,000 pounds of Particulate Matter each year of service more than a fleet of school buses equipped with 2010 EPA Emission Compliant diesel engine school buses. This kind of data argues for a more aggressive replacement policy than one which is constrained for the purpose of dubious savings.

We urge the Legislature to reject this proposal to help ensure consistency with EPA and state-level clean air efforts and to ensure that our children are riding on modern school buses that are equipped with the best available emissions reduction and clean-air technology.

Again, we OPPOSE the proposed provisions of this section and urge the Legislature to reject it in the adopted budget. However, if the Legislature should see fit to include the same or similar provisions, we call your attention to the following considerations and alternatives:

1. Allowing school buses with a seating capacity of more than 10 individuals (including the driver) to be replaced upon either attaining ten years of operation from the date of service OR accumulating over 120,000 miles of operation. The Governor's proposal requires that BOTH thresholds be met. This is completely impractical given the variations in duty requirements among school districts. For instance, one district reports that it has buses that are 6-7 years old but already have more than 150,000 miles of operation. These buses, which by all standards should be retired and replaced, would be ineligible under the Governor's proposal.
2. Allowing school buses with a seating capacity of fewer than 10 individuals (including the driver) to be replaced upon either attaining FIVE YEARS of operation from the date of service OR after accumulating over 75,000 miles of operation. The Governor's proposal requires that BOTH thresholds be met for these buses as well as for large buses. This is impractical given that such buses are manufactured differently than the larger buses and have more aggressive duty cycles. By all standards to our knowledge, such vehicles should be retired and replaced after 5-7 years.
3. Any replacement conditions must also be based on the "in service" date of the bus.
4. In any case, deferring implementation of this requirement in any form to the 2012-2013 fiscal year or later. School districts are already in negotiation for the purchase of school buses utilizing the current provisions of law. The timing of state budget adoption would mean that some of those bus purchases would have to be withdrawn at the last minute to comply with these provisions.
5. Including provisions which would allow for the purchase of new school buses as part of an increase in the district fleet to accommodate increased student populations and shifts in population centers. The current language does not apparently allow for this type of purchase.

NOTE: In Governor Cuomo's 2011 State of the State address, he outlined initiatives for his Cleaner, Greener NY" agenda including emissions control and energy efficiency.

NOTE: On October 30, 2010, then-candidate Cuomo issued this statement: "New York has historically been at the forefront of environmental protection efforts. As Secretary of HUD and as Attorney General environmental protection has been one of my central concerns. As Governor, I look forward to expanding New York's commitment to environmental justice and building on other government partnerships with local advocates. Those alliances have achieved great work in the past, and I will ensure that my Administration places these issues at the forefront once again so that New York returns to its place as a national environmental leader."

TALKING POINTS: LEASING

First, Leasing a school bus for five years (the current limits) is at least as cost efficient as the costs associated with purchasing a bus and keeping it in operation for five years. The Governor's proposal would require that the lease meet the test of being MORE cost efficient. It should only have to be no less cost efficient and that efficiency should measure consistent factors. In examples we have seen comparing five-year lease costs with five-year purchase and maintenance costs, the differences were insignificant, thereby having little or no budgetary impact.

Second, as schools potentially near or reach their indebtedness limitations, leasing of school buses provides a mechanism for a school to maintain their planned fleet rotation for safety purposes, acquire buses that are safer, more cost efficient and environmentally greener without further increasing balance sheet indebtedness.

One-year to five-year leasing programs have allowed school districts the flexibility they have needed to maintain safe and efficient bus fleets in a variety of economic and political climates. It would be unfortunate for this strategy to be discontinued given the anticipated fiscal challenges facing New York for the foreseeable future. Such an approach could make the difference in a school district's ability to present its children with safer, cleaner school buses.

Third, in such a challenging financial environment as we face today, it is not prudent to limit school boards and school leaders to fewer management options. This applies to their decisions and strategies related to sustaining and maintaining a safe, efficient, and greener school bus fleet. School Districts are being asked to be reflective and creative during this budget crisis; we urge the State to enable that flexibility by restoring and continuing a strategy that exists today in the form of leasing.

Fourth: School Districts and municipalities have and utilize frequently the ability to lease other equipment such as copiers, computers, and telephone systems for the same reasons a district leases buses – financial viability and flexibility. There is no effort being put forth in this budget proposal to limit or restrict or reduce leasing of these other commodities. We would argue that school buses should be treated no differently than these other goods and products.

TALKING POINTS: EFFICIENCIES AND PENALTIES

With regard to the provisions of Section 33 of the budget bill (A4008/S2808) that would impose penalties on school districts that fail to satisfy cost efficiency measures defined in the bill but also subject to definition by the Education Commissioner:

We remain concerned that the budget proposal lays out cost efficiencies that are not clearly defined. Moreover, school districts have already instituted numerous cost savings strategies in response to the budget struggles they faced over the past several years. Efficiency and cost reduction are not new in the education community and are well-practiced in the school transportation industry.

In the past two years and longer, transportation services have been modified in many ways. School districts have taken steps to:

- reduce the number of school buses involved
- increased utilization of computorized routing and scheduling software
- instituting performance measures and benchmarks for efficiency purposes
- increasing the use of technologies that allow monitoring of school bus functions and operations
- require students to walk longer distances up to the state minimum
- eliminate or reduce late bus runs
- eliminate or reduce the transportation for athletic events and extra-curricular activities
- reduce the costs of maintenance of the vehicles
- allow for increased sharing of services and cooperation in routes
- negotiate bell time and arrival changes to increase the efficiency of routes
- to limit the equipment and technology included in purchased buses.....among other steps

These efforts cannot be minimized but they would be ignored under this proposal which approaches change and efficiency measures *de novo* and gives no credit to school district for major improvements and efficiencies already instituted.

Moreover, we are greatly concerned that the Education Department, which has suffered staffing reductions over the past several years and retains no significant staff in its Pupil Transportation Services office, will be unable to perform the due diligence that would be needed to execute the provisions of this section's provisions. If they cannot fairly and adequately monitor and document district efforts, it is totally unreasonable to allow penalties of any size to be levied against school districts by the Department.

TALKING POINTS: MANDATE RELIEF

NYAPT has consistently pointed out that the proposals being considered in the Executive Budget Proposal will neither yield immediate savings nor the levels of savings envisioned by their proponents. In the alternative, NYAPT has surveyed our members about some sixteen mandates or operational requirements that (1) could be eliminated or (2) could be modified with the result of immediate and substantial cost savings to state and local taxpayers. These changes could be implemented with little or no effect on the overall safety of the children who ride on our school buses. That factor, above all else, needs to be taken into consideration as we proceed.

That list of cost efficiency measures and mandates that could be relieved or modified includes:

- Standardizing school calendars at least within BOCES areas
- Coordination of bell times among schools and special programs
- Eliminating seat belts on large school buses
- Eliminating requirement for 2nd set of fingerprints for drivers to serve as attendants
- Consulting with transportation managers relating to special needs transportation during IEP process
- Allow reassessment of homeless student school location for transportation purposes
- Reducing non-public transportation radius from 15 miles to 10 miles
- Eliminating idling reporting paperwork requirement
- Eliminating private school transportation prior to the first day of public school sessions
- Flexibility in schedule for delivering driver refresher courses
- Eliminating paperwork requirement to submit all original bid documents
- Moving to the Federal DOT biennial driver physical from the current annual physical
- Reducing to 25 miles from 50 miles the radius for transporting special needs children
- Allow reflective SCHOOL BUS sign in lieu of backlit equipment
- Provide aid for Pre-K transportation that is currently a district expense

We believe that these changes could yield savings in excess of $200 million each year and urge that they be considered and explored by the Legislature, the Executive and the Education Department.