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NEW YORK STATE LEGISLATURE
2010-2011 JOINT BUDGET HEARINGS

February 9, 2010 9:30 am

Health/Medicaid

HEARING ROOM B

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NYS Catholic Conference	Ron Guglielmo Director of Healthcare
The Group for Scientific Reappraisal of the HIV/AIDS Hypothesis	Frank Stoppenback

**Testimony Presented by
Richard F. Daines, M.D.
New York State Commissioner of Health**

**Joint Legislative Budget Testimony
New York State Department of Health**

**Hearing Room B
Legislative Office Building
Albany, New York**

**February 9, 2010
10 a.m.**

**Joint Legislative Budget Hearing Testimony
February 9, 2010**

Good morning, Chairmen Kruger and Farrell and committee members.

At a time when many New Yorkers are facing difficult financial challenges and the State must close a growing budget deficit – now estimated at \$8.2 billion dollars for the next fiscal year – the Department of Health Executive Budget seeks to do what every New York family is doing: providing for that which is most needed while doing without the extras.

There are several themes that run through all of the Department's budget proposals for the new fiscal year:

- Preserving services that support the Department's core mission of protecting and improving the public's health.
- Achieving reforms that increase efficiency while maintaining quality.
- Accountability and Transparency.
- Elimination of Duplication of Services.
- Consolidation, Streamlining and Simplification;
- Flexibility to target resources where they are needed most;
- And most important, the use of Innovation to reduce the State's greatest public health threats while at the same time helping to reduce the deficit.

Obesity Prevention

We have an opportunity this year – despite the State's fiscal crisis – to have a positive impact in the area of public health and show national leadership specifically on the problem of obesity.

Overweight and obesity are now challenging smoking for the infamous designation as top public health threat in New York State. Currently, about 60 percent of adults and 35 percent of children and adolescents in New York State are obese or overweight.

The increase in overweight and obesity is dramatically increasing New Yorkers' risk for many chronic and debilitating conditions -- including heart disease, diabetes, hypertension, and some cancers. Obesity also shortens life spans, with the severely obese having a life expectancy up to 20 years shorter than those who are not obese.

The obesity crisis threatens the progress we have made in increasing quality and years of healthy life, with the severely obese having a life expectancy up to 20 years shorter than those who are not obese. Not only are the human costs of obesity high, the health care costs related to obesity are equally staggering.

In New York an estimated **\$7.6 billion dollars** a year is spent to treat conditions in adults related to overweight and obesity – with much of that cost paid for by taxpayers through Medicare and Medicaid. The portion of state and federal taxes that goes to pay for treatment of obesity-related diseases is estimated at \$771 dollars per New York household.

Several weeks ago I testified before the State Senate Health Committee hearing on food policy and discussed Governor Paterson's **Obesity Prevention Agenda**.

That agenda includes initiatives to increase exercise among children and improve nutrition, including a calorie posting requirement, a ban on the use of trans fats in certain restaurants and food service establishments, a ban on the sale of high-fat, high-sugar junk foods in schools, and a \$10 million dollar revolving loan fund to increase access to healthy foods in underserved communities.

A key initiative of the Obesity Prevention Agenda is a **proposed excise tax** on beverages containing large amounts of added sugar. There is now a large body of scientific evidence that sugar-sweetened beverages are the single food group most strongly linked with increased rates of obesity and risk for diabetes.

Per capita consumption of sugar-sweetened beverages for American adults now averages 46 gallons a year – the equivalent of 40 pounds of sugar. It requires an excessive amount of exercise to burn off all those calories, which otherwise get stored as body fat. Based on our experience with cigarette taxes, this penny-an-ounce excise tax would reduce consumption of sugary beverages by an estimated 15 percent.

As people replace sugary drinks with diet sodas and other non-sugar beverages, including water and skim milk, we can make a big dent in the obesity problem. At the same time, the sugared beverage tax will raise much-needed revenue for public health programs and health care services.

Based on a September first implementation date, the tax is expected to raise **\$465 million** during the first fiscal year and an estimated **\$1 billion** over a full fiscal year. Like the cigarette tax, the revenue from the excise tax on sugared beverages would go into the Health Care Reform Act (HCRA) pool to support health care and public health services.

I can't think of any other initiatives that provide the opportunity for such a great triple play. We'll get:

- Improved health for New Yorkers,
- Reduced health care costs, and,
- Much needed revenue for health care.

Tobacco Prevention & Control

Tobacco use continues to be New York's number one cause of preventable disease and death. Health care costs related to treating smoking-caused diseases total approximately **\$8 billion** annually for New York alone.

Evidence indicates that cigarette tax increases are one of the most effective ways to reduce youth smoking and encourage adult cessation. New York's \$1.25 increase in the cigarette tax in 2008 was associated with increased enrollment in the New York State Smokers Quitline program, increased quit attempts, reduced consumption of cigarettes, and reductions in adult and youth smoking prevalence.

Between 2007 and 2008, the adult smoking rate in New York State declined from 18.9 percent to 16.8 percent, resulting in 310,000 fewer smokers in only one year. Governor Paterson's Executive Budget proposes an additional \$1 per pack tax on cigarettes, which would increase the State cigarette tax to \$3.75 per pack.

The \$1 per pack tax increase is expected to:

- Result in more than **50,000** adults in the State **quitting** smoking;
- Prevent more than **100,000** youth under 18 from **becoming** smokers;
- **Decrease** youth smoking by almost 10 percent; and,
- **Save** an estimated **48,300** New Yorkers from premature death.

Over the next five years, the State also would save an estimated **\$40 million** in costs related to health problems caused by smoking. The cigarette tax increase would produce an estimated \$200 million in annual revenues, which would go into the Health Care Reform Act – or HCRA Pool – to support health care services, tobacco prevention and control, and other public health initiatives. For example, the proposed cigarette tax would allow for such measures as the restoration of the anti-tobacco media funding of \$10 million.

Lead Poisoning

Over the past two years Governor Paterson has made a commitment to end childhood lead poisoning in New York State once and for all. We're making progress toward that end. Childhood lead poisoning has fallen by 17 percent in upstate New York since 2005.

But there's more work we must do to eliminate the threat of lead for thousands of children living in older housing with lead-based paint. To further efforts to eliminate lead poisoning as a public health threat to New York's children, the Governor's Executive Budget maintains support for the Childhood Lead Poisoning Primary Prevention Program.

HIV/AIDS

Despite the very challenging fiscal crisis, the Governor's Budget sustains the State's commitment to fighting the HIV/AIDS epidemic by providing statewide spending of \$3.2 billion dollars for HIV/AIDS programs, including \$104 million for the Department's AIDS Institute.

More than 25 years since inception of the AIDS Institute it is important to restructure appropriation lines to mirror today's epidemic and maximize programmatic effectiveness through continued effective prevention and access to quality health and supportive services.

To achieve these goals, the budget proposes the consolidation of multiple appropriations lines into the following comprehensive programmatic categories:

- Regional and targeted HIV, STD, and Hepatitis C Programs;
- HIV, STD, and Hepatitis C Prevention;
- HIV Health Care and Support Services;
- Clinical Education; and
- Hepatitis C programs.

This measure would give us the flexibility to easily and quickly prioritize emergent needs and would generate \$3.8 million in savings. The measure also gives administrative efficiencies to both the State Health Department and community-based organizations because there would be fewer contracts and request for proposals to manage.

Cancer Services

The budget also focuses on making our **Cancer Services Program** more flexible, efficient, and responsive to current need. Specifically, the budget proposes to consolidate 15 unique appropriation lines that would generate \$1.1 million in savings.

The consolidation places emphasis on screening, registry operations, and survivor support. In doing so, priority would be placed on evidence-based interventions.

General Public Health Work

General Public Health Work is our legislative mandate in Public Health Law, Article 6, under which the State reimburses counties for a defined set of public health services and other activities. This budget would eliminate reimbursement for certain optional services that we have determined are not core public health activities.

The budget would transfer funding of the county Medical Examiner Program to the Division of Criminal Justice Services, as much of the work done by MEs, coroners, and coroners physicians is criminal/forensic in nature and in alignment with DCJS's mission.

Early Intervention Program

The budget would strengthen our Early Intervention Program, which helps preserve essential services for New York's infants and toddlers and their families. The budget proposes reforms to the program that would make it more efficient so we can continue providing early intervention services to more New York families.

These changes include a variety of administrative actions that would require preferred assessment tools, modify speech eligibility standards, and revise reimbursement rates. In addition, the budget proposes legislative actions that require providers to bill Medicaid, maximize commercial insurance reimbursement, and establish an early intervention parent fee.

Health Care Reform

Turning to health care, the Governor's Budget continues the historic health care reforms achieved over the last two years. The Governor's budget recognizes the critical need to protect the most vulnerable New Yorkers and the safety-net institutions that serve them.

At the same time, the budget will slow the growth of Medicaid spending, as we continue to work toward achieving efficient delivery of high-quality, cost-effective care. Our efforts focus on achieving greater efficiency without creating barriers to enrollment for those eligible for Medicaid services.

New York continues to rank first in the nation in Medicaid spending per capita – twice the national average. Unchecked Medicaid spending will grow to more than **\$53 billion** in the 2010-2011 Fiscal Year.

It is important to note that the Governor also proposes to continue the State cap on the local Medicaid share. Recently I attended a meeting of local social services officials, and one made a point of saying how the Governor's cap on local share had, in his words, "saved his county last year."

In New York, Medicaid is the largest single payer of health care, so if we can reform Medicaid then we have an opportunity to leverage changes in the health care system. That's why over the last two years, and in the proposed budget, we are making important reforms to the Medicaid system, because our Medicaid reimbursement system helps to shape the health care system in New York.

The new budget continues important reforms begun two years ago to make Medicaid reimbursement rates more transparent and straightforward and to serve patients in the right setting, at the right price. The budget also continues to emphasize improved quality of care. While New York has a number of world-class health care providers, overall our rankings on quality are mediocre. We should be getting better quality for the money we are spending.

Hospital Reimbursement Reform

New York leads the nation in Medicaid inpatient hospital spending. The State **rank**s 4th on per enrollee inpatient hospital spending and spends almost twice the national average. To roll back that spending and to better serve patients in the right setting at the right price, New York has invested more than \$600 million in outpatient care in the last two years. The investments include:

- \$270 million in hospital programs, including outpatient clinics, ambulatory surgery, and emergency room;
- \$188 million in physicians' fees;
- \$128 million in primary care;
- \$50 million in freestanding programs; and
- \$2.7 million in mental hygiene enhancements.

Another critical component of our historic health care reforms of the last two years has been the updating of the decade-old hospital **reimbursement system**. The Executive Budget also begins to address the issue of **potentially preventable hospital readmissions**. Potentially preventable readmissions occur because the patient is discharged too soon or too sick or because of a lack of follow-up care in the community following the discharge.

In 2007, we found that more than 70,000 readmissions were potentially preventable and cost \$813 million. These readmissions are tremendously costly – to patient well-being and in terms of Medicaid dollars that would be far better spent on services to keep the patient well and out of the hospital.

The 2010-11 Executive Budget proposes to begin reducing funding for preventable admissions and in 2012 begins to reinvest a portion of the savings in rewarding hospitals that reduce readmissions and in post discharge linkages.

The budget also funds an additional 100 slots for **Doctors Across New York** – 50 for physician loan repayment and 50 for physician practice support – to improve access in medically underserved areas of the state.

Long-term care

The challenge of long-term care in New York is that spending is increasing while the number of recipients is decreasing. Long-term care includes nursing homes, home care, and personal care services.

New York's spending on home care and personal care exceeds all other states. Currently, 28 percent of Medicaid spending is on long-term care services – 54 percent of that goes to nursing facilities.

Nursing homes

The proposed budget maintains the commitment to extend rebasing for nursing homes, which is the planned update of cost-based rates from 1983 to 2002, through February 28, 2011. The \$210 million included in the budget for rebasing includes \$50 million for a quality pool to reward high-performing nursing homes.

It is critical that we implement the regional pricing model because nursing home costs and rates vary dramatically from region to region – *and within the same region*. The current practice is irrational, inefficient, and drives up costs overall.

Similar to the reimbursement method just implemented for inpatient hospital services, a value-based regional pricing model sets a fair base-price, recognizes legitimate cost differences among providers, and takes into account the acuity of the patient the facility is serving. We will continue to work with the industry, workers, and consumers – through the Nursing Home Reimbursement Workgroup – to refine the value-based regional pricing model.

Home Care

Home care is the area of long-term care for which the pattern of spending is clearly unsustainable. From 2003 to 2008, spending on home care increased by 55 percent while the number of individuals served decreased by 12 percent.

Better management of the reimbursement process is critical to bringing spending under control. The Budget will implement the Certified Home Health Agency Episodic Pricing/Quality Model on January 1, 2012. This measure will help to ensure that appropriate payment for each patient is based on his or her needs. As with nursing homes, we will continue to work with stakeholders as we further develop this model.

Personal Care

The Budget also proposes better management and utilization of personal care, which provides Medicaid-eligible individuals with assistance with activities of daily living, including bathing, toileting, grooming, eating, laundry, meal preparation, and housekeeping. These services are ordered by a physician and based on services needed by a patient. The hours are determined by local social services districts following an assessment of the recipients' needs in their homes.

Under the Governor's proposed budget, individuals receiving personal care services will be eligible for up to 12 hours a day for their authorized period. The proposal would improve care while reducing costs. Currently, there are approximately 73,000 individuals statewide who receive **12 hours or less** of personal care services per day.

This budget proposal would affect the fewer than **5,000** individuals statewide who require **more than 12 hours** a day of personal care services. Under this measure, these individuals would be eligible to move to certain programs or alternative service providers where their care can be **managed and coordinated**.

Up to three not-for-profit organizations would be selected to assist those who need to transition to other programs. Better coordination of care benefits the individuals receiving services. They would be assigned a care manager, receive a comprehensive assessment of needs, and obtain assistance with medical appointments, transportation, home care services, and Medicaid re-certification, among other services. The State would realize **\$30 million** in savings with the better managed personal care program.

Eligibility

This year's budget proposes modest changes to continue to streamline the eligibility process for health insurance programs to ensure that eligible persons are able to get and keep coverage. Three years ago, we began the process of tearing down the barriers that were keeping eligible people from enrolling in public health insurance programs. The proposed new budget continues to help eligible people get and keep coverage.

Since 2008, we have permitted self-attestation of income and residency at renewal for non-SSI related Medicaid beneficiaries and Family Health Plus members. The proposed budget permits Medicaid enrollees receiving community-based long-term care to attest to their income and residency at renewal.

And the budget proposes to allow the Department of Health to pursue a federal option called **Express Lane** eligibility for children in Medicaid and Child Health Plus. As the name suggests, Express Lane will allow children to transfer between Medicaid and Child Health Plus more easily, and it will allow for easier enrollment of children already in receipt of food stamps.

The implementation of the **Statewide Enrollment Center** is on track. A contractor has been selected and as soon as the State Comptroller approves the contract implementation will begin. The Enrollment Center will consolidate the Medicaid, Family Health Plus, and Child Health Plus toll-free numbers to provide one-stop shopping for persons already enrolled in public health insurance and for those seeking information about applying, and it will augment the local social services districts by processing telephone and mail-in renewals.

Program Integrity

The Budget also includes a number of proposals to strengthen the **integrity of the eligibility process**. These include the use of tax data to verify eligibility, selection of a vendor to perform independent verification of assets, and proposals to close certain loopholes related to recovery.

The budget also includes initiatives to help ensure that Medicaid pays only for the appropriate use of services that are needed by the patient. These initiatives include measures to provide better management of physical and occupational therapy services, non-emergency transportation services in counties that are not already doing so, and personal care services.

These actions will ensure that people get the care they need while, at the same time, ensuring that Medicaid dollars are wisely spent.

Pharmacy

State Medicaid spending on pharmacy services will reach \$1.7 billion in the next fiscal year if we do not make efforts to control growth. This budget includes a number of recommendations to control the growth of pharmacy costs.

These include measures that will increase rebate revenue without affecting patient access to needed medications. The budget proposes to collect supplemental rebates on anti-depressants, atypical antipsychotics, anti-retrovirals, and anti-rejection drugs. This proposal will not require prior authorization of non-preferred drugs in these classes and it will not restrict access.

Another action is the elimination of the Medicare Part D Drug Wrap. This would discontinue Medicaid coverage for anti-depressants, atypical anti-psychotics, anti-retroviral, and anti-rejection drugs for **dual-eligible enrollees** – those individuals eligible for both Medicaid and Medicare. Medicaid currently pays for these drugs with “state only” dollars, even though they already are covered through Medicare Part D. Since the inception of the Medicare Part D program four years ago, significant improvements have been made to that program to assure access to critical drugs.

The Medicare Part D program has now matured and has caught up to New York State benefits, so there is no need for the State to maintain the Part D Drug Wrap. This budget action would improve care management by creating a complete record of a patient’s drug in Medicare Part D. The elimination of the Part D Wrap would affect less than 1 percent of the total dual-eligible population.

Because Medicare Part D provides comprehensive access to drugs in all classes, the budget also proposes eliminating the EPIC Part D Drug Wrap. Currently, 17 of the 19 states with State Pharmacy Assistance Programs do not include a Part D wrap. That means EPIC would no longer cover drugs in classes covered by Medicare Part D.

EPIC would continue to cover Medicare Part D copayments, claims that fall in the Medicare Part D “doughnut hole” and drugs in classes not covered by Part D (*barbiturates and benzodiazepines*). Today, more than 80 percent of seniors in New York’s EPIC program are enrolled in Medicare Part D. This Budget proposes measures that would require about 26,000 more seniors to enroll in Part D.

Most of these are seniors who have chosen a Medicare managed care option that does not provide prescription drug coverage, even though an option with Part D is available to them. Their prescription drug costs under EPIC are almost twice those of a senior who has enrolled in a Part D plan. The budget includes \$1.5 million to educate seniors about these changes and assist them in selecting the best Medicare Part D program to meet their needs.

Conclusion

The ongoing economic crisis challenges New York as never before to maintain our commitment to historic health care reforms as we serve a growing population of unemployed individuals in need of health care and health care insurance coverage. Currently, more than 2.7 million New Yorkers lack health insurance coverage.

Governor Paterson has made coverage a priority, and the State has made great strides in extending coverage to the most vulnerable New Yorkers through Medicaid, Child Health Plus, and Family Health Plus. This year's budget will streamline the eligibility process to ensure all eligible residents can obtain coverage.

The budget maintains our investments in primary and preventive care through reimbursement reform and refocusing on our core mission in public health.

The budget proposals for long-term care will help rein in spending while better managing patient care and services.

Finally, the Governor has made bold public health proposals to institute an excise tax on sugar-sweetened beverages and increase the tax on cigarettes – measures that would help us achieve a healthier New York while generating much-needed revenue.

The health care proposals in this budget continue New York on the path to a world-class health care system that is accessible and affordable – and of the highest quality.

Thank you.

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**Testimony Presented by
James G. Sheehan
New York State Medicaid Inspector General**

**Joint Legislative Budget Testimony
New York State Office of the Medicaid Inspector General**

**Hearing Room B
Legislative Office Building
Albany, New York**

**February 9, 2010
11:30 a.m.**

Committee Chairs Kruger, Farrell, Duane and Gottfried, and all committee members present, I want to thank you for the opportunity to discuss Governor Paterson's budget and goals for the Office of the Medicaid Inspector General (OMIG) this year.

As Governor Paterson said in the State of the State, "This is a winter of reckoning" for the government and people of New York. This message is especially important when we look at our State's Medicaid program. New York's Medicaid program is the nation's largest with anticipated expenditures of over \$50 billion in the next fiscal year. New Yorkers must trust that we as a State are doing everything possible to assure that Medicaid dollars are well-spent, and that the providers who receive those dollars are appropriately accountable. The Governor has called upon OMIG to continue and increase our efforts to assure the integrity of the Medicaid program, and the Governor's budget provides the resources necessary to achieve that goal. The Executive budget proposes a series of actions that would improve the coordination and administration of public benefits, and prevent and uncover public benefits fraud, including increased civil penalties for first-time and repeat offenders who commit Medicaid fraud; shared services between the OMIG and the Office of the Welfare Inspector General (OWIG) to provide greater efficiency and strengthen collaborative efforts to detect and control public benefits fraud; and the ability to match individuals and providers who are disqualified from the Medicaid program and thus prohibited from billing for Medicaid services to the records of the Department of Taxation and Finance and the Workers Compensation Board to ensure that Medicaid is not billed. In addition, the Budget also proposes additional measures to ensure the integrity of public benefits programs such as closing loopholes that allow for the transfer of assets; implementing an asset verification system to identify resources not captured today; and collaboration between the OWIG and the Department of Labor (DOL) to target those who illegally shift the cost of employees' medical care to Medicaid by paying people under the table to lower their own insurance costs and/or enable employees who receive public benefits to earn income in excess of established eligibility levels.

Assuring the good stewardship of the over \$50 billion in Medicaid expenditures is the mission of OMIG. The agency's statutory authority directs it to preserve the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds. The state's efforts to prevent and detect fraud, waste and abuse have taken us from a national symbol of Medicaid fraud, waste and abuse in 2005 to the nation's leader in recovery dollars and program integrity today.

While much more remains to be done, the State's progress to date reflects three things: first, Legislative and Executive leadership in creating an effective fraud control program; second, improvements undertaken by the provider community; and third, good work on the part of all the entities responsible for program oversight and enforcement. In addition to OMIG, these include the Department of Health-responsible for program design and regulation of other state agencies involved in oversight; the Attorney General's Medicaid Fraud Control Unit (MFCU)-responsible for criminal prosecutions; the county social services agencies-handling the primary responsibility for enrollment integrity; the Office of State Comptroller-providing information and policy recommendations for decision makers;

and various government contractors. We are on FBI led task forces in NYC, Albany, Rochester and Buffalo. We are also on the DOJ led Strike Force in Brooklyn. In addition, we are on a DEA task force in Albany. In each case, we are members with federal law enforcement agencies, as well as other state and local agencies and private insurers. At the county level, we have a network of counties including the City of New York doing work through the county demonstration project to perform audits and/or investigations of Medicaid providers in selected ambulatory care areas.

These improvements stand in stark contrast with where we were five years ago. In July of 2005, a series of articles in the New York Times painted a painful picture of New York State's Medicaid program. "Medicaid has . . . morphed into an economic engine that fuels one of the state's biggest industries, leaving fraud and unnecessary spending to grow in its wake." "The lax regulation of the program did not come about by chance. Doctors, hospitals, health care unions and drug companies have long resisted attempts to increase the policing of Medicaid." These articles and later reviews by the Federal Center for Medicare and Medicaid Services, Federal Office of the Inspector General, and State Senate Finance Committee addressed the reduction in state staff responsible for audit and investigations, and the approach of audit reviews as "provider education" rather than recovery of improper payments.

Within a year after the New York Times series, the legislature created the independent Office of the Medicaid Inspector General.

As the state's first Senate confirmed Medicaid Inspector General, I came to a new agency tasked with overseeing the largest Medicaid program of any State, and a recovery commitment, Federal State Health Reform Partnership (FSHRP), requiring that New York alone exceed the total 2006 national Medicaid fraud and abuse recovery.

New York has met its FSHRP obligations to the federal government. We have improved the controls on the Medicaid system to keep bad providers out. We have met aggressive budget targets for recoveries and avoided costs set by the Governor and the Legislature (which, as shown in chart 1, have gone from \$300 million in 2006 to \$1.2 billion in this year's budget).

As part of our budget message, I want to give you a progress report on where the Office of the Medicaid Inspector General is today and where we are going. I hope we will leave you with an understanding of how the Governor's commitment, and the Legislature's commitment to rooting out fraud, waste and abuse in the Medicaid system has resulted in lower costs and greater accountability.

The 2010-11 Executive Budget includes a total of \$88 million, including \$50 million in federal funds for the OMIG. We are projecting that OMIG will have a workforce of 659 by the end of SFY 09-10 and anticipate filling another 69 positions in SFY 10-11 to reach our funded target of 728.

OMIG has used a four step approach to meeting its statutory and budget obligations:

First, we have conducted an examination of every major component of Medicaid expenditures to determine the amount paid in that area, the audit and investigative activity committed to it, and the risks of fraud and abuse. This includes use of significant new data mining techniques and technologies. As a result of this effort, OMIG has expanded its efforts to look more closely at the fast growing areas of managed care, home health care, and personal care.

Second, we conducted together with CMS an examination of the Medicaid program through a random sample to determine the extent of improper payments of claims based upon the patient records submitted by providers. For 2008, our review showed that improper payments of claims were less than 1.5 percent of Medicaid expenditures. There is no question that this is a significant amount of money, but it is substantially better than the performance of the Medicare and Medicaid programs of most other states, and reflects our audit efforts, the improvements by DOH to its payment and edit systems, and providers' compliance efforts.

Third, State law now requires that every provider billing over \$500,000 have an effective compliance program, including auditing of its billings and disclosure of overpayments. In 2009, we received over 85 disclosures by New York providers.

The overpayment disclosures reflect a significant provider commitment to the compliance process, and have educated OMIG about potential weaknesses in billing and claims to look for in other providers. Where a provider has an effective compliance program, including reliable auditing of areas OMIG would audit, we want to refocus our audit activity toward other providers who have not demonstrated an effective program, and reduce the burdens on the compliant providers.

Fourth, OMIG has begun a series of initiatives designed to address significant gaps between the requirements of law, proper medical and billing practices, and the practices of some providers. These initiatives involve significant data analysis, and focus on encouraging entities to change their practices, identifying system weaknesses, and identifying providers who are "frequent flyers" (that is providers who keep appearing in our data mining and audit efforts) for more intense audit and investigative attention.

One example of our new initiatives is our deceased patients project, which began with an open letter to providers that we would be targeting claims for patients at the time the service was allegedly performed. We selected the month of October 2009, and identified 290 claims for services to patients who were, according to our records, deceased. On December 1, we sent letters to each provider, asking for information within 15 days about who provided the service, who billed the service, and whether the patient was actually deceased.

We have learned a great deal from this project. A number of providers responded, identifying errors they had made (wrong service date, billing for a dead twin instead of a live one, billing from a roster of scheduled patients instead of upon performance of the

service). Over 150 providers claimed that the patients were still alive at the time of the service. We are currently obtaining death certificates from DOH's Vital Statistics Office to confirm the date of death. Two months after the letters went out, 14 providers had not responded at all, despite a certified mail receipt and follow-up phone calls, including some I made myself.

Some responses were instructive. In one pharmacy, the patient's prescription was picked up two days after her death by a family member. In another, the patient's physician requested delivery of the patient's prescription to his office after she died. One dead patient's Medicaid number visited three different dentists in a week. A family accepted delivery on a new bed paid for by Medicaid after the patient's passing. One provider explained that the person responsible for the improper transportation billing had "returned to Miami." A major teaching hospital received the body of a deceased Medicaid patient to harvest organs for transplant, but billed Medicaid as though they were treating the live patient.

The Medicaid program is one of the most reliable payers of claims submitted to it, despite the fact that the law says it should be the payer of last resort. So, we have spent time specializing some of our work to make sure that private insurers, the federal government, or the appropriate insurer liable for those payments, is the one to pay first. That's because we believe, as the Governor and you do, that taxpayers should never foot the bill when someone else is really responsible. Through this work we have been able to meet each year's audit plan goals. New York leads the country in this work.

The OMIG is an agency that prides itself on openness and transparency. We have a seventy-page work plan that is published annually and is available on our website. We do more than 60 public speaking events a year and we are training our staff to make sure that we walk every provider through what the audit process is going to look like, as much as possible. Through these measures, we try to ensure that the audit process is understandable and approachable. We have also begun a survey of auditees to measure our auditor's performance.

All of this work has been done with your support. In order to continue and build upon these results we will need your help again.

Our audit target for 2010-11 has increased by \$300 million to an overall state fiscal year target of approximately \$1.2 billion. We have been asked if that number is achievable. Based on past experience we believe that it is, but we will need the resources that the Governor has requested more this year than any year before.

All of this does not take into account our need to achieve our federal targets under the FSHRP agreement. Under FSHRP, we will be required to start our work on the last year of FSHRP in October 2010, with a recovery target of \$644 million as demonstrated by chart 2. This goal is something that no state has ever achieved.

In line with this, I recently testified at a Senate hearing where I and my staff listened to concerns raised by provider groups about OMIG audits and their effects on provider operations. As I stated before, OMIG practices a commitment to continuous improvement, so we take those matters to heart. We have put controls in place that can cancel an audit when we find low levels of non-compliance (1 percent rule). We work closely with our agency partners and providers to listen, learn and broaden our staff's understanding of the Medicaid system, past practices, and emerging trends to help maintain the stability of the Medicaid system. I have lead an effort in the agency to assess, absorb, review and take action where appropriate. A few weeks back we took all of our senior staff off-line to discuss what was said at the hearing and plan for the year ahead. The result has been a renewed commitment to core values, and an improved focus on our mission. In the coming months, providers and recipients will see some of the fruits of those labors.

I thank you for your continued support and for the opportunity to speak here today.

Chart 1

**NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL**

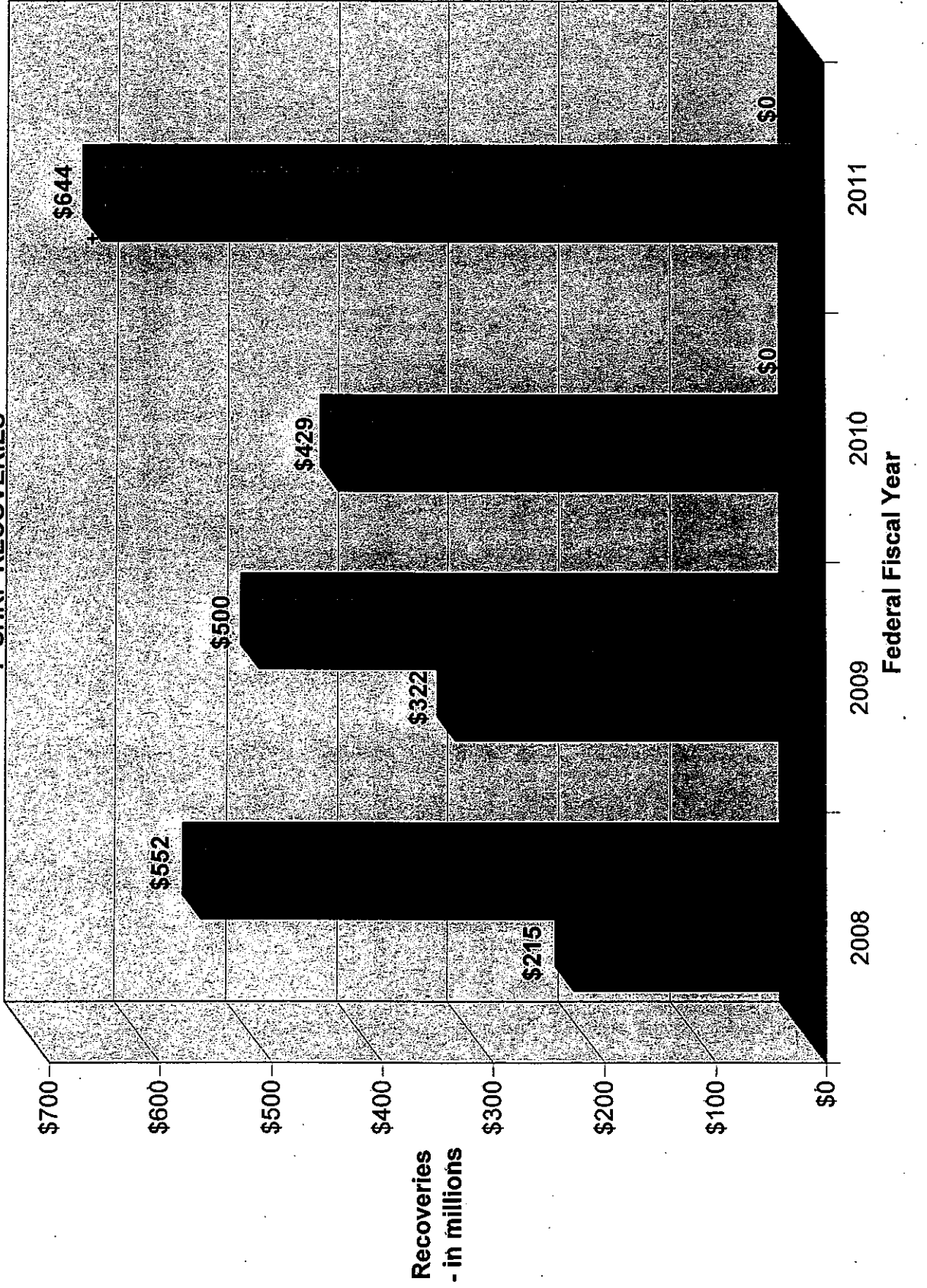
STATE AUDIT PLAN TARGET GROWTH

STATE FISCAL YEAR	BUDGET TARGET (STATE SHARE -- IN MILLIONS)	PERCENT INCREASE OVER 2006-07
2006-07	\$300	
2007-08	\$505	68.33%
2008-09	\$695	131.67%
2009-10	\$870	190.00%
2010-11	\$1,170	290.00%

NOTE: The 2010-11 savings target reflects an increase of \$300M -- \$150M pursuant to the 2009-10 Deficit Reduction Plan and an additional \$150M increase pursuant to the 2010-11 Executive Budget.

Chart 2

NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL
F-SHRP RECOVERIES



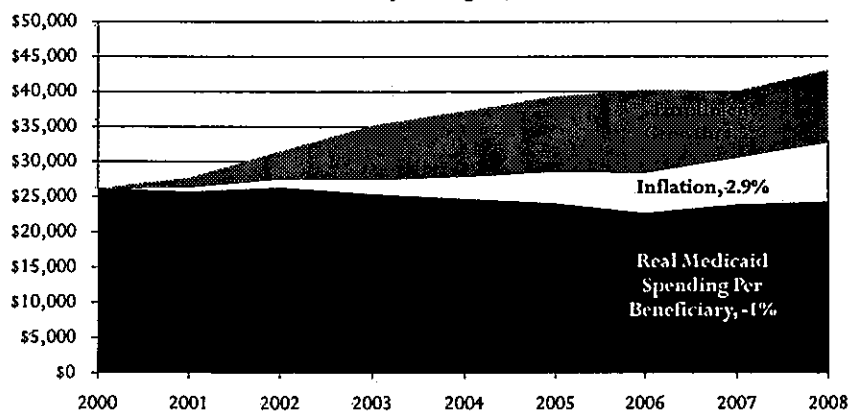
3

Testimony Before the Senate Finance Committee
and the Assembly Ways & Means Committee on
the State Fiscal Year 2010-11 Executive Budget

Kenneth E. Raske, President
Greater New York Hospital Association
February 9, 2010

Medicaid Spending Growth is Almost
Solely due to Enrollment Growth

Components of New York's 6.4% Compound Annual Growth in
Medicaid Spending, 2000-2008

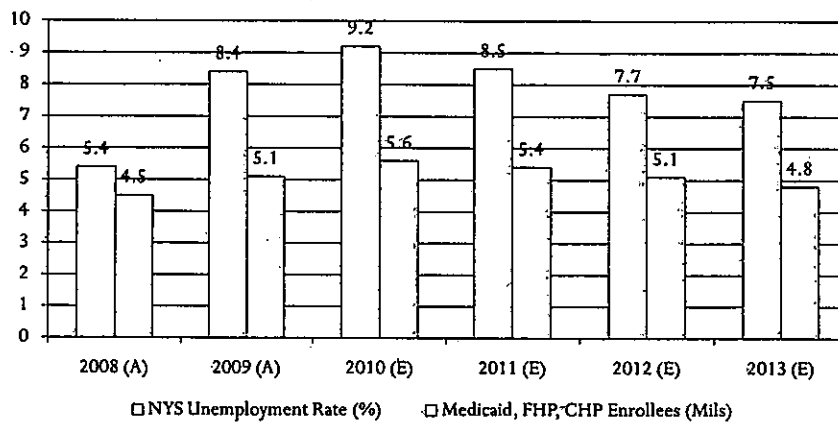


Source: GNYHA analysis of CMS 2082 data, 2000-2008.

GNYHA

As New York State Unemployment Abates, Medicaid/FHP/CHP Enrollees Will Decrease

Division of the Budget Projections for
NYS Unemployment and Public Insurance Enrollment



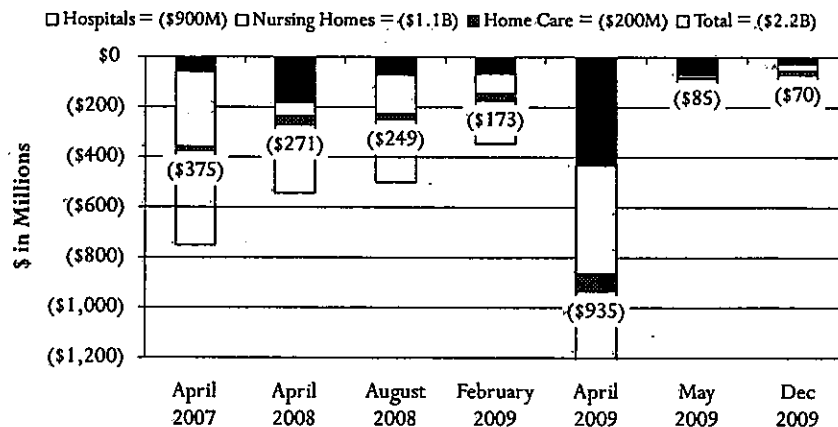
Source: SFY 2010-11 Executive Budget and supporting documents.

GNYHA

3

Provider Revenue Has Been Cut 7 Times in 3 Years, Causing a \$2.2 Billion Annual Loss

Annual Value of Recurring Cuts Based on Date of Enactment

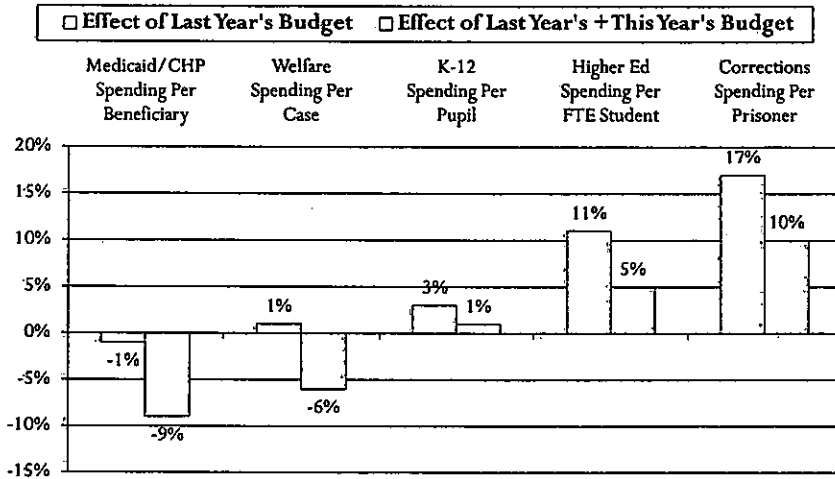


Source: GNYHA and Continuing Care Leadership Coalition (CCLC) analysis of fiscal impact data from the New York State Department of Health (DOH) and Division of the Budget (DOB).

GNYHA

4

The Executive Budget Continues Last Year's Tighter Squeeze on Health Care



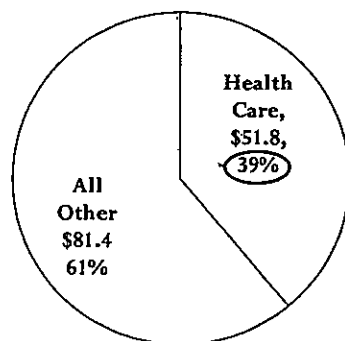
Source: GNYHA analysis of SFY 2010-11 Financial Plan.

GNYHA

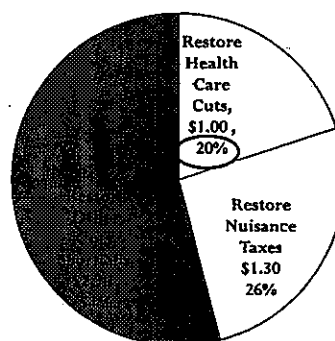
5

Last Year, Health Care Did Not Get Its Fair Share of the \$5 Billion FMAP Increase

Health Care's Share of the \$133.2 Billion 2010-11 State Budget



How Last Year's \$5B Increased FMAP Was Spent



Source: GNYHA analysis of SFY 2010-11 Financial Plan and other DOB documents.

GNYHA

6

The Executive Budget Saves the General Fund \$459M But Causes \$1B in Provider Losses

\$ in Millions	SFY 2010-11 State Savings	SFY 2010-11 Provider Loss	Fully Phased In Provider Loss
Hospitals	(\$245)	(\$498)	(\$550)
Nursing homes	(\$140)	(\$258)	(\$258)
Home and personal care services	(\$74)	(\$156)	(\$182)
Total	(\$459)	(\$912)	(\$991)

GNYHA

Source: GNYHA analysis of State hospital impact estimates.

7

Components of the Hospital Loss (\$ in Millions)

	SFY 2010-11 State Savings	SFY 2010-11 Provider Loss	Fully Phased In Provider Loss
Total	(\$245)	(\$498)	(\$550)
2010 trend factor elimination	(\$27)	(\$107)	(\$107)
Gross receipts tax increase	(\$130)	(\$143)	(\$143)
Bad debt and charity care cut	(\$70)	(\$187)	(\$187)
Readmissions penalties	(\$20)	(\$49)	(\$108)
Miscellaneous effect of reforms	\$0	(\$12)	(\$6)

The provider losses account for the typical cash-flow lag in State savings, the loss of Medicaid Federal matching funds, and the impact on Medicaid managed care, Workers' Compensation, and No Fault rates.

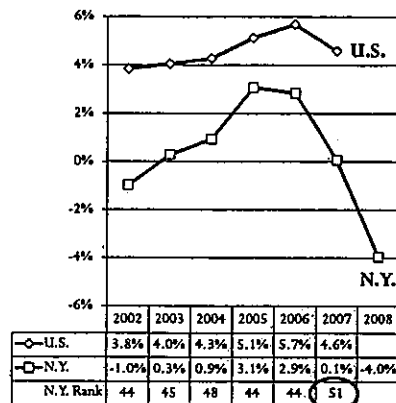
GNYHA

Source: GNYHA analysis of State hospital impact estimates.

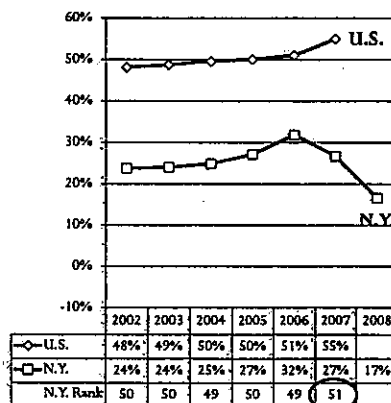
8

The Financial Condition of NY Hospitals Is the Worst in the U.S.

Total Margin Trend



Equity Financing Ratio Trend



Source: GNYHA analysis of Medicare cost report data (2002-2007) and New York State Institutional Cost Report data (2008).

GNYHA

9

Increased Medicaid Losses Exacerbate Increased Charity Care Losses

From 2006 to 2008, total hospital uncompensated care increased by \$1.1 billion (32%) to \$4.5 billion:

- Total uncompensated care = Medicaid + charity care losses
- Medicaid losses increased by \$900 million (57%) to \$2.4 billion
- Charity care losses increased by \$200 million (12%) to \$2.1 billion
- *This is no time to cut charity care funding by \$187 million*

Example of Medicaid underpayment: ED visits

- New payment is \$240 per visit, including last year's increase
- DOH says payment is now *only* 36% less than cost

Source: 2008 New York State Institutional Cost Reports.

GNYHA

10

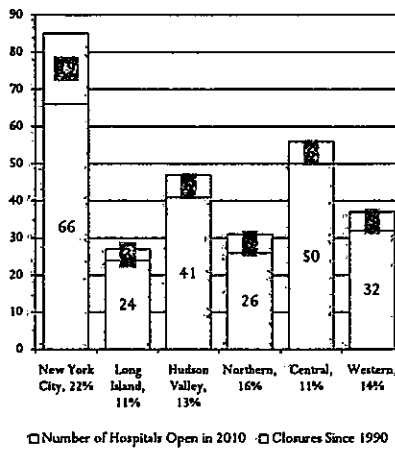
NY Has Lost 44 Hospitals Since 1990 and Will Likely Lose More with the 2009 and 2010 Cuts

283 Hospitals in 1990

44 Closures (16%)

239 Hospitals in 2009

Hospital Closures by Region



Source: GNYHA historical records compared with current facilities reported on the DOH Web site, *Hospital Profile*.

GNYHA

11

GNYHA Recommendations

Enact the soda tax

FMAP

- If the increase is extended, as expected, allocate funding to restore health care cuts
- If the extension does not occur before the 2010-11 budget is final, specify in law that, if enacted, FMAP will replace health care cuts

Residual health care cuts

- Work with the Legislature and Executive to minimize the damage to individual communities

GNYHA

12



Greater New York Hospital Association

555 West 57th Street / New York, N.Y. 10019 / (212) 246-7100 / (212) 262-6350
Kenneth E. Raske, President

**TESTIMONY OF
KENNETH E. RASKE
PRESIDENT
GREATER NEW YORK HOSPITAL ASSOCIATION**

**AT A JOINT HEARING OF
THE NEW YORK STATE ASSEMBLY
COMMITTEE ON WAYS AND MEANS
AND
THE NEW YORK STATE SENATE COMMITTEE ON FINANCE
ON
THE EXECUTIVE HEALTH CARE BUDGET**

February 9, 2010

9:30 am

Legislative Office Building

Albany, New York

Testimony of Kenneth E. Raske
President
Greater New York Hospital Association

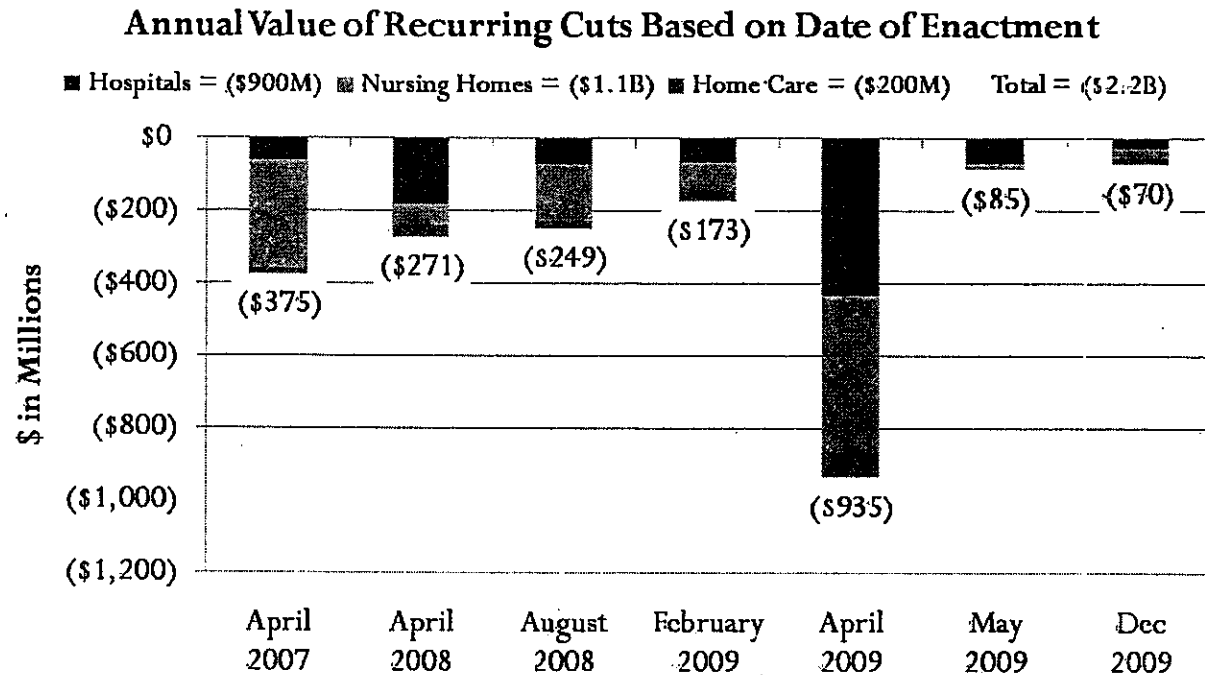
Chairman Farrell, Chairman Kruger, Vice Chair Krueger, Chairman Gottfried, Chairman Duane, and distinguished members of the Committee, my name is Kenneth E. Raske. I am the President of the Greater New York Hospital Association, which represents 250 not-for-profit and public hospitals and continuing care facilities throughout the metropolitan New York region and throughout New York State. I appreciate the opportunity to testify today on the Executive Budget proposals.

We are living in extraordinarily difficult times. There is no question that the challenges facing our State and nation are enormous, and we must all take the time to work together to find thoughtful, balanced solutions to the fiscal problems facing us. The health care community understands the crisis confronting the State government and State legislators. We stand ready to work with you and to help you find acceptable solutions—indeed, we feel strongly that we *must* be part of the solution, and have offered many health care savings and reform ideas that can bring greater efficiency to the State's health programs.

To be clear, though, while we stand ready to pitch in, our hospitals, nursing homes, and home health members must be protected from the cuts and tax increases proposed in the Executive Budget.

This is because the health care sector has already given more than its fair share. Our hospitals and nursing homes have been cut or taxed in seven different rounds of budgeting since April 2007 (see Figure 1). These actions have reduced revenues for hospitals, nursing homes, and home health care providers by \$2.2 billion on a recurring annual basis. No other sectors of the State budget have seen such reductions or have been so repeatedly asked to sacrifice. Our hospitals and nursing homes have cut staff, have cut services, and have frozen salaries. They recently worked with New York's largest health care union to eliminate scheduled wage increases, resulting in a wage freeze for hard-working hospital and nursing home workers in both 2009 and 2010, and no increase for pensioners.¹ Many institutions are teetering on the brink of bankruptcy or even closure. To understand the depth of the financial crisis in our health care community, one need only look at what is happening to St. Vincents Manhattan, a proud institution in Greenwich Village, and its Westchester division with 133 critically needed psychiatric beds.

Figure 1. The State has Cut Health Care Provider Revenue 7 times in 3 years, Causing a Net Recurring Loss of \$2.2 Billion a Year



And, unfortunately, more chaos is in store. Major reimbursement changes, enacted in last year's budget, are just now being implemented, with the effect of shifting funding dramatically among hospitals and reducing funding inappropriately for teaching and safety net hospitals. And the recession is taking its toll. Just as the State reports unanticipated increases in the Medicaid caseload due to the recession, hospitals are seeing more uninsured and underinsured patients, adding to the uncompensated care burden. As shown in Figure 2, total hospital-based uncompensated care (losses from Medicaid underpayments and charity care) grew from \$3.4 billion in 2006 to \$4.5 billion in 2008, an increase of \$1.1 billion, or 32%, in just two years. As significantly, because of the relentless cuts in Medicaid reimbursement rates, the Medicaid loss component of uncompensated care increased by \$900 million, or 57%, and now exceeds losses from charity care.

Figure 2. The Increase in Uncompensated Care Cost and in the Portion of that Cost Caused by Medicaid Underpayments

	2006	2008	\$ Change	% Change
Total losses	(\$3.4)	(\$4.5)	(\$1.1)	32%
Medicaid losses	(\$1.6)	(\$2.5)	(\$0.9)	57%
% of total	46%	54%		
Charity care losses	(\$1.8)	(\$2.1)	(\$0.2)	12%
% of total	54%	46%		

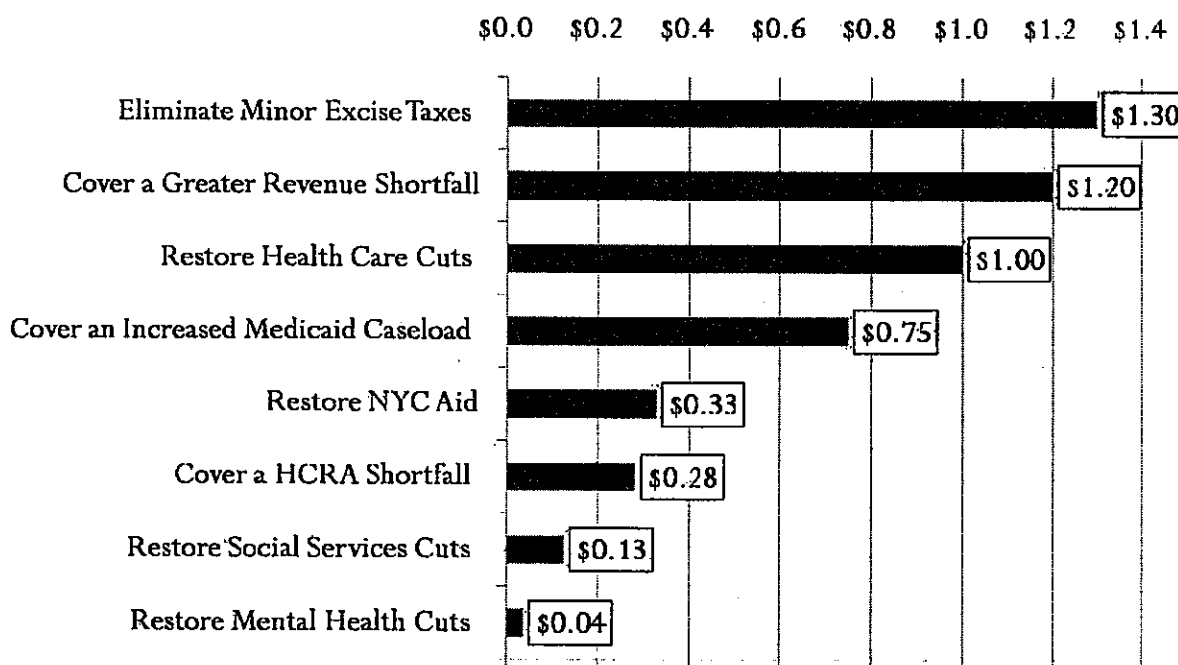
So even before assessing the impact of the 2010-11 Executive Budget proposal, the health care community is struggling due to seven rounds of budget cuts, multiple years of cross-cutting State reimbursement “reforms,” and effects of the recession. And yet, despite this, the Executive budget would impose another \$550 million in cuts and taxes annually on hospitals, \$258 million on nursing homes, and \$182 million on home care, for a total provider loss of nearly \$1 billion. Meanwhile, many program areas in the State budget have been spared from cuts, some have actually seen increases, and many State employees have continued to enjoy wage increases throughout the recession, while our workers have endured freezes and layoffs.

This is unacceptable. Financially struggling hospitals, nursing homes, and home health agencies must be protected from the cuts and taxes proposed in the Executive Budget. In addition, reforms must be enacted to reduce the health care sector’s cost of doing business, such as managed care and medical malpractice insurance reform, so that the health care community can cope with reduced revenue from the State. Given the cuts and new taxation that have already taken place, our members will not be able to survive without simultaneous reforms to reduce their costs.

Help is On the Way: FMAP

As you know, the American Recovery and Reinvestment Act of 2009, commonly referred to as the economic stimulus bill, provided states with temporary help with their Medicaid budgets. Specifically, the bill provided New York State with a Federal Medicaid matching rate of 62% for the period October 1, 2008, through December 31, 2010, as opposed to its normal 50% Federal match. This provided New York State with \$6.8 billion in extra Federal Medicaid funds in the last fiscal year and the current fiscal year, including \$1.8 billion in funding for New York City and counties across the State. Figure 3 below shows how the State used the remaining \$5 billion at its disposal.¹¹

Figure 3. Last Year’s Use of \$5 Billion in Increased Federal Medicaid Matching Funds (FMAP) (\$ in Millions)



We were chagrined last year when the decision was made to use only \$1 billion of the FMAP funding to eliminate cuts to hospitals, nursing homes, and home care, which according to the President was the intended use of the funding. This was only 20% of the funding available to the State. More than that amount—\$1.3 billion—filled a “hole” in the financial plan when the Legislature declined to accept the Executive’s proposed taxes on a host of items, including sugary soda, massages, golf outings, etc. We strongly felt at the time that this was a case of misplaced priorities. To make the choice to use Federal Medicaid funding to eliminate minor excise taxes and to choose instead to cut financially struggling hospitals, nursing homes, and home care agencies was wrong, plain and simple. It also went against the stated purpose of the economic stimulus bill:

“TITLE V—STATE FISCAL RELIEF

– SEC. 5000. PURPOSES; TABLE OF CONTENTS.

(a) PURPOSES.—The purposes of this title are as follows:

(1) To provide fiscal relief to States in a period of economic downturn.

(2) To protect and maintain State Medicaid programs during a period of economic downturn, including by helping to avert cuts to provider payment rates and benefits or services, and to prevent constrictions of income eligibility requirements for such programs, but not to promote increases in such requirements.”

– American Recovery and Reinvestment Act, signed into law by President Obama, February 17, 2009

In the 2010-11 fiscal year, the State estimates that it will receive \$4.2 billion in Federal Medicaid funding due to the stimulus bill before the Federal FMAP provision expires on December 31, 2010. Despite this, the Executive Budget seeks \$459 million in State savings from hospitals, nursing homes, and home care—11% of the Federal Medicaid relief it will receive (see Figure 4). Where is the \$4.2 billion going? What is it paying for? With all that Federal Medicaid relief, why is there a need to cut health care again at this time?

Figure 4. Executive Budget Proposed State Savings and Provider Losses

\$ in Millions	SFY 2010-11 State Savings	SFY 2010-11 Provider Loss	Fully Phased In Provider Loss
Hospitals	(\$245)	(\$498)	(\$550)
Nursing homes	(\$140)	(\$258)	(\$258)
Home and personal care services	(\$74)	(\$156)	(\$182)
Total	(\$459)	(\$912)	(\$991)

In addition, Congress is acting to extend FMAP relief for states beyond December 31, 2010. The House of Representatives already passed a six month extension of FMAP relief in the jobs bill on December 16, 2009 (H.R. 2847). The Senate is scheduled to pass its companion version by

February 12, 2010, with a hoped-for final agreement by the end of February. President Obama included an extension in his 2011 budget proposal, released on February 1. The State has estimated that the FMAP relief extension would bring over \$1 billion to the State government in the 2010-11 fiscal year, and over \$1 billion in the 2011-12 fiscal year.

This is more than enough to completely eliminate the hospital, nursing home, and home care cuts in the Executive budget.

In other words, less than half of the anticipated FMAP relief would be needed to completely eliminate the Governor's proposed cuts and taxes to these health care providers.

The Executive Budget does not assume the extension of Federal FMAP relief. We believe that the Congress will act expeditiously to extend the Federal law; however, even if the law is not extended before the State Legislature completes action on the 2010-11 budget, we strongly support enactment of a provision that explicitly dedicates new Federal FMAP relief to the elimination of health care cuts and taxes on health care providers.

There is precedent in State law for making sure that Federal FMAP relief is spent as intended—on health care. Chapter 1 of the Laws of 2002, signed into law by Governor Pataki on January 25, 2002, contained the following provision, which states that if the Federal government approves a temporary Medicaid matching rate (FMAP) increase, the full amount would go into the HCRA tobacco control and insurance initiatives pool to fund health care programs:

§ 27. Notwithstanding any inconsistent provision of law, and in
33 accordance with section 4 of the state finance law, the comptroller is
34 authorized and directed to transfer, upon request of the director of the
35 budget, monies from the general fund to the tobacco control and insur-
36 ance initiatives pool established pursuant to section 2807-v of the
37 public health law, up to an amount equivalent to the state savings
38 resulting from an increase in the federal medical assistance percentage
39 available to the state pursuant to the applicable provisions of the
40 federal social security act.

At the time, the United States Senate, with a bare majority of Democrats, was considering an FMAP increase, and later that year passed one. However, the Republican House of Representatives and President Bush resisted. It wasn't until May 28, 2003, when President Bush signed the Jobs and Growth Tax Relief Reconciliation Act of 2003 (P.L. 108-27) that five calendar quarters of FMAP relief for states went into effect—16 months after the Governor and State Legislature enacted the provision above. This year, the timely enactment of FMAP relief is much more likely, since it enjoys the support of the leadership of the House and Senate as well as the President.

The remainder of my testimony will concentrate mainly on the Executive Budget proposals for hospitals. My colleague, Scott Amrhein, President of the Continuing Care Leadership Coalition, GNYHA's long term care affiliate, will testify later today in detail regarding our concerns about nursing homes and home care.

Hospital Financial Conditions Make Major Cuts Untenable

This budget will do enormous damage to the health care community. It will unquestionably lead to significant layoffs, closure of needed services, bankruptcies, and, in some cases, complete financial failure and closure. This statement is not meant to be alarmist—it is simply factual. And given the strong, first-hand knowledge you have of the needs of the health care institutions that serve your constituents, you know this to be true. You have seen hospitals in your communities shutter important services like obstetrics and psychiatry just to survive.

As has been the case for many years, New York's hospitals have the worst bottom line margins and equity financing ratios in the country (see Figures 5 and 6). However, the further deterioration of these measures in 2008 was devastating, due to relentless cuts in Medicaid and other State funding, as well as the current recession, the most severe since the Great Depression. Again, we remind the Legislature that the State is not the only entity to suffer financially during this period. The hospital community has had to accommodate lower investment income, higher medical malpractice contributions, higher pension contributions, and higher borrowing costs for capital. Indeed, due to the recession and the crisis in the financial markets, the ability for our hospitals to borrow has deteriorated alarmingly from an already precarious position.

Nationwide, the tax-exempt bond market has remained either extremely tight or prohibitively expensive for all institutions except for those with the very highest of bond ratings—which would include very few, if any, New York hospitals. This means they cannot finance and must defer new construction, renovation of extremely old physical plants, and replacement of aging equipment. This is particularly problematic because delay greatly increases the cost of capital projects. According to the New York Building Congress, a year's delay increases construction costs by 12%. And all of this hospital fiscal distress occurred *before* the 2009 cuts and taxes were implemented, much less the Executive Budget's proposed additional cuts and taxes.

Figure 5. The Low and Deteriorating Profitability of New York Hospitals

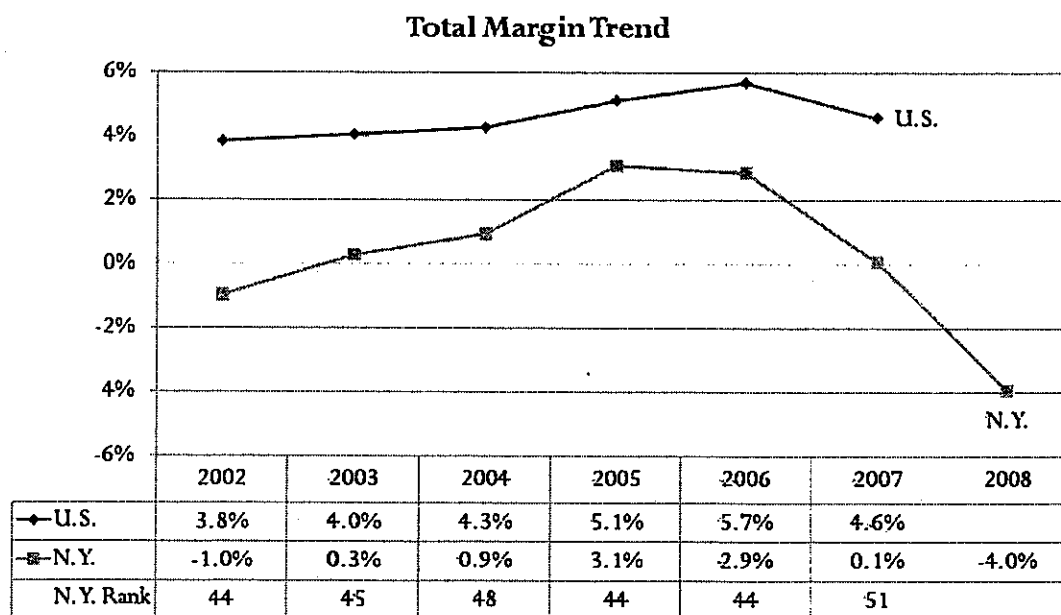
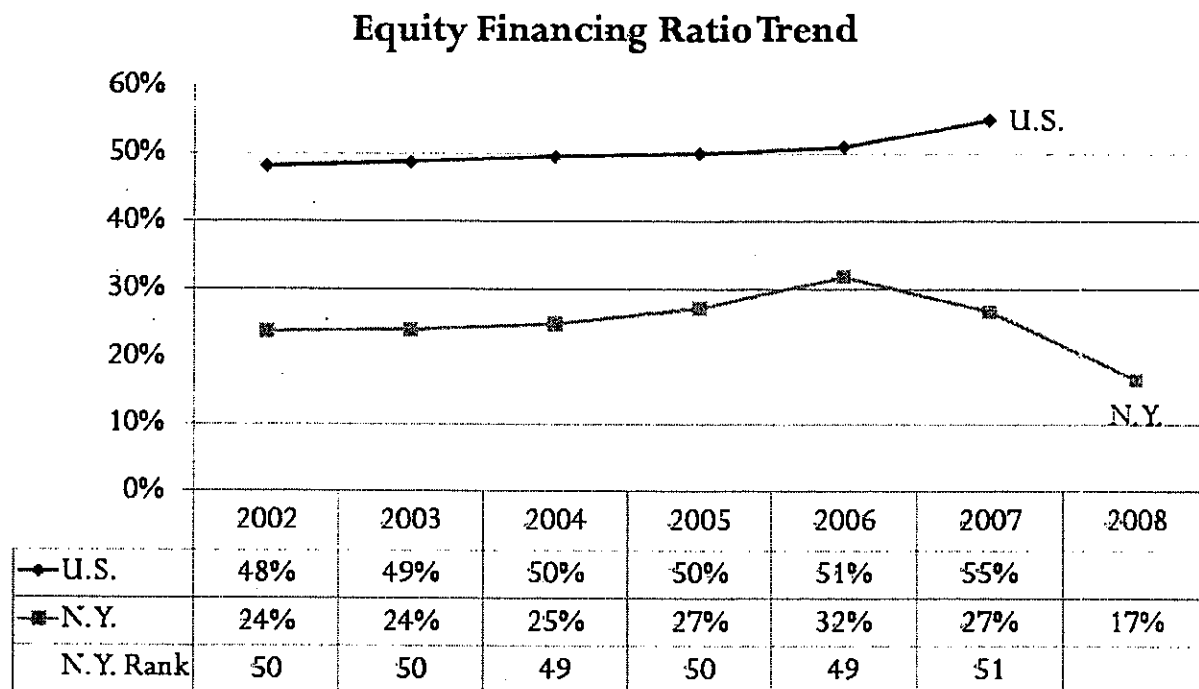


Figure 6. The Low and Deteriorating Ability of New York Hospitals to Finance Capital Projects with Retained Earnings



As you know, financial distress in the hospital community has forced many closures and conversions. The Berger Commission was formed to oversee the contraction of the hospital infrastructure so that essential hospitals would be preserved. The Commission closed six hospitals in 2007 and 2008. In 2009, however, three additional hospitals closed—two in already under-bedded Queens—because they were no longer financially viable and, again, the St. Vincents hospitals are now imperiled. Figure 7 provides a list of hospital closures since 1990.

Figure 7. New York State Hospitals that have Closed Since 1990

Hospital	County	Year Closed
Adirondack Regional Hospital	Saratoga	1990
Highpoint Hospital	Westchester	1990
Mohawk Valley General Hospital	Herkimer	1991
Taylor-Brown Memorial Hospital	Seneca	1991
Saint Francis Hospital of Buffalo	Erie	1992
Columbia-Greene Medical Center	Greene	1993
Medical Arts Center Hospital	New York	1994
WMC/Westchester Institute for Human Development	Westchester	1995
Julia L. Butterfield Memorial Hospital	Putnam	1996

Wyckoff Heights/Jackson Heights Division	Kings	1996
Flushing Hospital/Little Neck Division	Queens	1997
Samaritan Medical Center/Stone Street Division	Jefferson	1997
Salamancas Health Care Complex	Cattaraugus	1998
Buffalo General Hospital/Columbus Community Healthcare Center	Erie	1999
Flushing Hospital/North Division (Parsons)	Queens	1999
Craig House Center, Inc.	Dutchess	2000
Massapequa General Hospital	Nassau	2000
Union Hospital	Bronx	2000
Genesee Hospital	Monroe	2001
Olean General Hospital/West Division	Cattaraugus	2001
Seton Health System/Leonard Campus	Rensselaer	2001
Brooklyn Hospital Center/Caledonian Campus	Kings	2003
Interfaith Medical Center/Brooklyn Jewish Division	Kings	2003
Island Medical Center	Nassau	2003
Mary McGlellan Hospital and SNF	Washington	2003
Myers Community Hospital	Wayne	2003
St. Agnes Hospital	Westchester	2003
Staten Island University Hospital/Concord Site	Richmond	2003
Beth Israel Medical Center/Singer Division	New York	2004
CMC/St. Joseph's Division	Queens	2004
Four Winds Syracuse	Onondaga	2004
OLM/Florence D'Urso Pavilion	Bronx	2004
Our Lady of Victory Hospital	Erie	2004
CMC/St. Mary's Hospital of Brooklyn	Kings	2005
New York United Hospital Medical Center	Westchester	2005
Brunswick Hospital Center	Suffolk	2007
St. Vincent's/Midtown Division (St. Clare's)	New York	2007
Cabrini Medical Center	New York	2008
Manhattan Eye Ear and Throat Hospital	New York	2008
Parkway Hospital	Queens	2008
Victory Memorial Hospital	Kings	2008
CMC/Mary Immaculate Hospital	Queens	2009
CMC/St. John's Queens Division	Queens	2009
Eddy Cohoes Rehabilitation Center	Albany	2009

Given the severe financial pressure on the State's hospitals and the service contractions already underway, State policymakers must internalize the fact that further cuts in hospital funding will

cause more closures and service reductions. There is no other choice. This is because the Governor's proposed cuts to hospital payment rates are *not*, as some have portrayed them, "reductions in the rate of growth." To the contrary, they are reductions from 2009 payment rates. This is because the Executive Budget eliminates inflation increases, or so called "trend factors," for the remainder of this year and then, *on top of that*, imposes:

- A 0.4% increase in the tax on hospital non-outpatient revenues, which will cost hospitals \$143 million a year;
- A \$187 million a year cut in hospital charity care funding; and
- Phased-in (but unspecified) penalties of \$108 million a year for "potentially preventable readmissions and complications."

Medicaid cuts harm institutions and the economy far beyond the deficit reduction benefit to the General Fund because of the fact that Medicaid spending by the State is matched by the Federal government. Therefore, to save a dollar, the State usually ends up cutting two dollars from our financially-strapped health care providers. Now, due to the economic stimulus bill, non-"disproportionate share hospital" (DSH) Medicaid cuts result in a loss of \$2.60 for every dollar the State cuts, which means that cutting Medicaid at this point in time leaves even more Federal funding in Washington rather than bringing it to economically distressed communities in need.

All told, as shown in Figure 8, the hospital-related actions are projected to cost hospitals \$550 million a year once fully phased in. This amount includes (1) the loss of State and Federal matching funds from cuts in Medicaid fee-for-service rates; (2) associated losses from cuts in Medicaid managed care rates (which are usually tied to Medicaid fee-for-service rates) and cuts in Workers' Compensation and No Fault rates (which *are* tied to Medicaid fee-for-service rates); and (3) new hospital taxes.

Figure 8. Hospital Losses are Much Higher than State Savings Because of Cash Lags, Lost Federal Matching Funds, and the Effect on Medicaid Managed Care and Other Rates
(\$ in Millions)

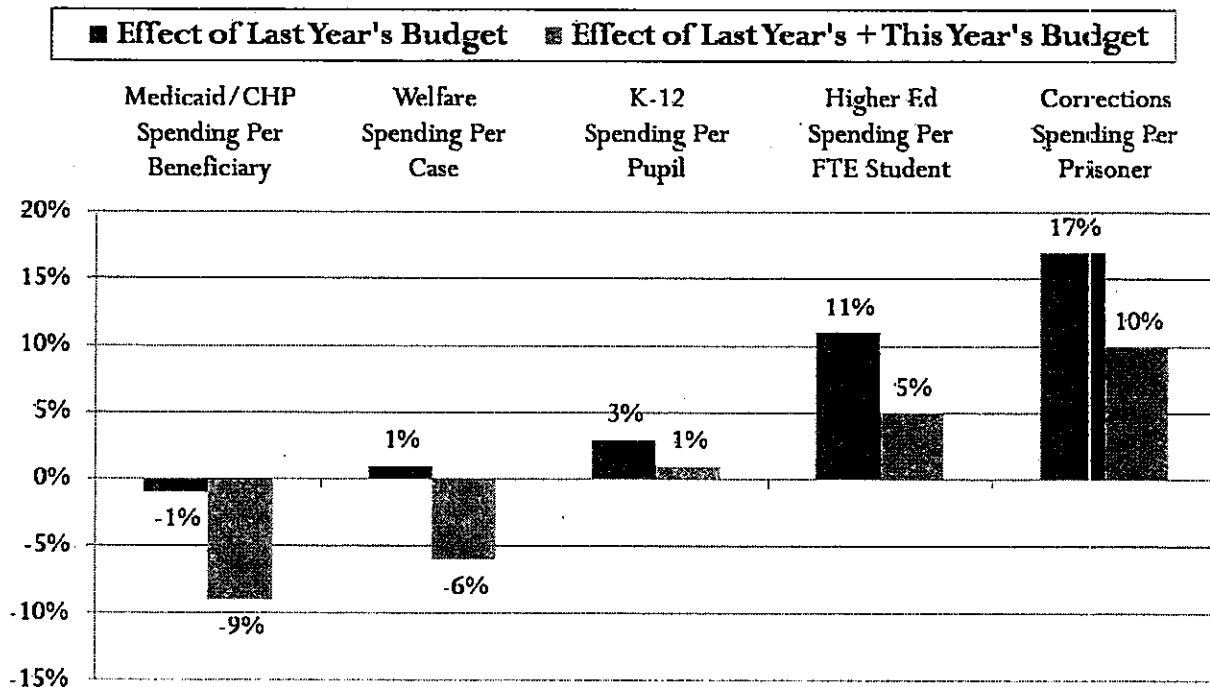
	SFY 2010-11 State Savings	SFY 2010-11 Provider Loss	Fully Phased In Provider Loss
Total	(\$245)	(\$498)	(\$550)
2010 trend factor elimination	(\$27)	(\$107)	(\$107)
Gross receipts tax increase	(\$130)	(\$143)	(\$143)
Bad debt and charity care cut	(\$70)	(\$187)	(\$187)
Readmissions penalties	(\$20)	(\$49)	(\$108)
Miscellaneous effect of reforms	\$0	(\$12)	(\$6)

As mentioned before, the cuts to hospital, nursing home, and home health agency payment rates are *real* cuts, not merely cuts in the rate of growth. Moreover, the Executive Budget proposes to hold aggregate Medicaid spending in SFY 2010-11 (Federal, State, and local funds) to the same level as aggregate spending in SFY 2009-10, despite a projected 9% increase in combined

Medicaid, Family Health Plus, and Child Health Plus enrollment. This would result in an 8% decrease in total Medicaid spending per beneficiary and a 9% decrease over the past two years—i.e., from SFY 2008-09 to SFY 2010-11.

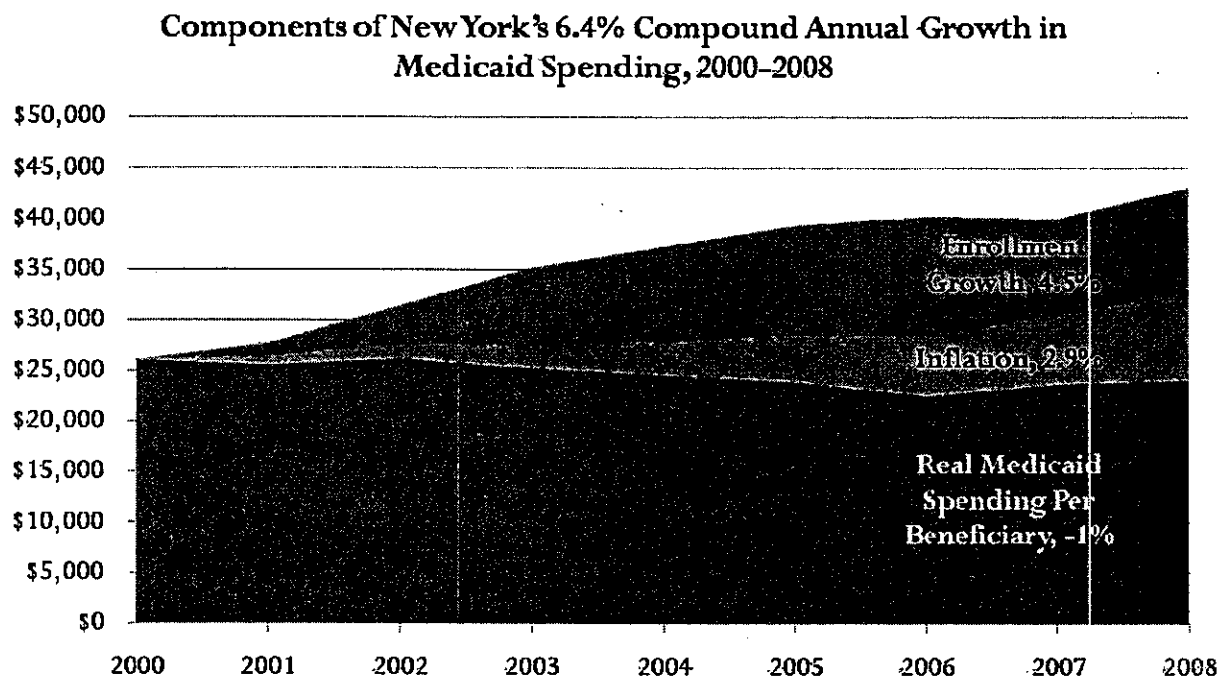
While the Executive Budget would reduce aggregate funding for most other sectors in SFY 2010-11—for the first time—health care providers continue to be squeezed more than other service providers, as shown in Figure 9. This is to the great detriment of all who seek medical attention because Medicaid revenue is not dedicated to Medicaid patients. Rather, it is comingled with all other funding to pay for services to all patients. Continuing to degrade the Medicaid “margin,” therefore, degrades all hospital care and New York’s appeal as a place in which to work and live and in terms of economic development.

Figure 9. Health Care Continues to Be Squeezed More Than Other Sectors



This disparate treatment is not new. As shown in Figure 10, real Medicaid spending per beneficiary has decreased at a compound annual rate of 1% since 2000. This is because over the past decade, Medicaid enrollment (including Family Health Plus) has grown from 2.7 million as of January 2000 to 4.5 million in September 2009, an increase of 67%. New York’s hospitals strongly support improved access to coverage and have vigorously advocated for the programmatic changes that have contributed to this major expansion. However, this growth has a cost associated with it and it is time for government to recognize that it can no longer try to pay for this growth merely by cutting provider payment rates.

Figure 10. Enrollment Growth Accounts for Almost All of New York's Medicaid Spending Growth



Source: Centers for Medicare & Medicaid Services, Medicaid Statistical Information System (MSIS) State Summary Datamart.

"Reforms" Are Already Devastating Safety Net and Teaching Hospitals

The State has instituted myriad reforms in hospital reimbursement over the past three years and is in the midst of implementing many more. Figure 11 is a list of many of them, along with the current status of their implementation.

Figure 11. Reforms Enacted Since SFY 2007-08 and Implementation Status

Type	Budget Year	Reform	Effective Date	Current Status
Inpatient				
	SFY 2007-08	Update AP-DRG weights to 2004 costs, phase-in over 3 years	Apr. 1, 2008	2009 rates not yet promulgated; methodology superseded by rebasing (below)
		Cut and redistribute workforce R&R payments	Apr. 1, 2007	Sunset Nov. 30, 2009 w/ rebasing
		Eliminate Priority Restoration Pool; create \$158M in new restoration pools	Apr. 1, 2007	Sunset Nov. 30, 2009 w/ rebasing
	SFY 2008-09	Implement new payment methodology for detox services	Dec. 1, 2008	Implemented
		Cut \$154M from Medicaid inpatient rates to fund OP investments	Dec. 1, 2008	Implemented
	SFY 2009-10	Rebase Medicaid inpatient rates, cut \$225M to fund additional OP investments and for budget savings	Dec. 1, 2009	Implemented January 25, 2010
		Implement new payment methodology for psych services	Dec. 1, 2009	New methodology in development
Outpatient				
	SFY 2008-09	Implement new payment methodology (APGs); invest \$182M	Dec. 1, 2008	Implemented
	SFY 2009-10	Increase clinic rates by \$92.5M	Dec. 1, 2009	Not yet approved by CMS
		Permit physician billing in the hospital setting	Feb. 1, 2010	Scheduled for 2010
BDCC Pool				
	SFY 2008-09	Redistribute voluntary hospital BDCC pool		
		2009: Redistribute 10% based on uninsured units of service priced at the Medicaid rate	Jan. 1, 2009	Implemented
		2010: 10% based on uninsured units of service + offset for cash collections	Jan. 1, 2010	Not yet implemented
	SFY 2009-10	New DSH pools for high Medicaid and non-teaching hospitals	Mixed	Approved by CMS
GME				
	SFY 2007-08	Cut Medicaid GME payments to "cost"	Apr. 1, 2007	Implemented
	SFY 2008-09	Cut GME pool to fund "Doctors Across New York"	Apr. 1, 2008	Implemented
	SFY 2009-10	Eliminate GME pool to fund increase in BDCC pool		
		2009: Eliminate GME pool and move to BDCC pool	Apr. 1, 2009	Implemented
		2010: Redistribute to teaching hospitals based on "unmet" BDCC need	Jan. 1, 2010	Not yet implemented
		Academic Medical Center Pool	Jan. 1, 2010	Scheduled for 2010

Prepared by GNYHA, January 26, 2010.

Many of these actions have redistributed money among hospitals all over New York State and have harmed, in particular, safety net and teaching hospitals. This is mainly because last year's "reform," which completely revised the Medicaid inpatient reimbursement methodology, eliminated a number of dedicated funding streams for hospitals serving a large number of Medicaid patients, including \$158 million from the high need Medicaid pool and other restoration funds, and \$243 million in workforce recruitment and retention add-ons (which under an earlier "reform" were skewed toward high Medicaid hospitals) and workforce recruitment and retention grants for public hospitals. With respect to teaching hospitals, last year's budget ended decades of support for teaching hospitals by private payers by eliminating the \$306 million Professional Education, or "GME" pool, converting it to Medicaid, and then redistributing the funds.

These "reforms," which are still in the process of being implemented, will wreak havoc on the hospital safety net. Already, safety net hospitals suffer the worst financial conditions of any hospitals in the State. The Executive Budget proposals, including tax increases and Medicaid cuts, will only make this situation worse. Figure 12 contrasts hospitals losses from across-the-board Medicaid cuts with hospital losses from the Executive Budget proposals for several subcategories of hospitals, including New York City hospitals, teaching hospitals, voluntary safety net hospitals and providers of obstetrical services.

Figure 12. The Executive Budget Proposals Impose Disproportionate Losses on Safety Net Hospitals, Teaching Hospitals, OB Providers, and Hospitals in New York City

	% of Medicaid Inpatient Payments	% of Fully Phased in Loss
By Region		
New York City	76%	85%
Rest of State	30%	7%
By Teaching Status		
Teaching	90%	104%
Non-Teaching	10%	4%
By Safety Net Status		
Voluntary Safety Net	40%	66%
Non-Teaching	60%	34%
By OB Status		
NYC OB Hospital	65%	86%
ROS OB Hospital	25%	0%
Non-OB Hospital	10%	14%

Cutting Charity Care Funding During A Recession Is Unconscionable

The Executive Budget seeks \$70 million in State savings through a cut in funding for the Indigent Care, or “bad debt and charity care” pool. Due to the loss of Federal funds, this will result in a loss of \$187 million a year for hospitals.

This is the worst possible time to consider cutting charity care funding for hospitals. Last week, the State Division of the Budget stated in a press release:

“Medicaid is an entitlement program that provides health care services to vulnerable populations meeting certain income requirements. Economic downturns typically increase the amount of New Yorkers who are eligible for this program. In fact, the current recession has driven Medicaid caseload to record levels of 4.2 million in October 2009 (latest month caseload data is available), which is 474,069 or 13 percent above the previous record of 3.7 million in August 2005. By the end of 2009-10, caseload is forecast to reach 4.3 million, which is approximately 200,000 above original 2009-10 Enacted Budget projections.

“As a result of continued recession-driven increases in demand for Medicaid services, State spending on this program in the month of January 2010 was approximately \$100 million above Executive Budget projections. Based on these figures and underlying caseload analysis, the Division of the Budget forecasts that, through the end of 2010-11, increased Medicaid spending will result in a net negative financial plan impact of approximately \$400 million.”

The same recession that is causing an increase in Medicaid enrollment for the State—and increased State costs—is causing an increase in hospital uncompensated care. The State’s Medicaid rolls are swelling because New Yorkers have lost their jobs and, with their jobs, their employer-provided health insurance. Many of those who have lost their jobs are not-eligible for Medicaid, and so become uninsured. When they need hospital care, the care is often uncompensated. In a March 2009 survey of New York hospitals, for 2008, 74% of hospitals reported an increase in bad debt and charity care, 69% an increase in financial aid applications, and 69% reported an increase in services provided to the uninsured.ⁱⁱⁱ

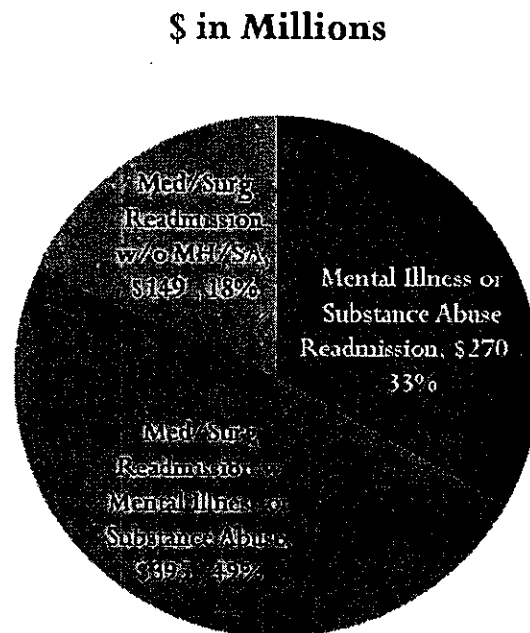
The proposed cut in the indigent care pool, then, is coming at the worst possible time—i.e., as hospital uncompensated care costs are increasing. This cut will add greatly to the financial distress of our hospitals, already struggling to cope with the effects of the severe recession, past rounds of Medicaid cuts and taxes, and redistributive “reforms.”

The State’s Readmissions Penalties Will Harm New Yorkers with Mental Illness

The Executive Budget proposes to save \$20 million in 2010-11 and \$54 million in 2011-12 by imposing unspecified penalties on hospitals for potentially preventable complications and 30-day Medicaid readmissions. The fully phased-in hospital loss will be \$108 million a year, or 2% of all Medicaid inpatient spending in the State. The 2% loss would actually be a 3% cut offset by 1% in incentive payments to certain hospitals meeting unspecified criteria.

The State does not yet know how it plans to implement this program and State officials have said that they would like to work with the hospital community to devise an appropriate methodology. We appreciate that the State is willing to work with the industry on this proposal. However, we are seriously alarmed that the State inappropriately chose a very large savings target that may have little to do with the amount of Medicaid spending on “preventable readmissions.” This is particularly troubling since the State’s data show that 82% of Medicaid spending on potentially preventable 30-day readmissions pertains to patients with severe mental illness or substance abuse problems, as shown in Figure 13.

Figure 13. Medicaid Payments for 30-Day Readmissions = \$814 Million



The key to preventing readmissions is to ensure that a patient who is discharged from a hospital receives the community care and support necessary to promote proper health and healing. When it comes to the portion of the Medicaid population with severe mental illness and substance abuse problems, it is clear that a lack of community services, particularly in poor inner-city communities, greatly contributes to hospital readmission rates. In addition, severely mentally ill patients pose many challenges, including compliance with treatment protocols and drug regimens, and follow-up care. Many Medicaid beneficiaries with mental illness and substance abuse are homeless, which creates another set of challenges when they are discharged from the hospital.

All of these factors argue for a much more reasoned and thoughtful approach to reduce potentially preventable readmissions. GNYHA and our members welcome the opportunity to work with the State to analyze data and to test innovative approaches to reducing readmissions. In the meantime, the Executive Budget proposal should be rejected.

Cost Reduction

The Executive budget proposal imposes huge cuts on health care providers while doing nothing to reduce their costs. The only way there can be cuts to health care providers without wholesale closings, bankruptcies, layoffs, and service disruptions is for the State to enact simultaneous reforms that can either reduce provider costs or increase provider revenue from other, non-State sources. For instance, the State should immediately enact medical malpractice insurance reforms. The cost of medical malpractice insurance for hospitals and physicians has grown to be so significant that many providers have made the decision to reduce or stop providing altogether services in specialties with high medical malpractice insurance costs. As many of you know, hospitals in the metropolitan area have closed completely, or reduced or closed their obstetrics services as a way to keep from closing, due to the high cost of malpractice insurance.

Medical malpractice reform is extremely important to the State's Medicaid program. This is because a very high proportion of deliveries are covered by the Medicaid program: nearly half—48%—statewide, nearly 60% in New York City, over 80% in the Bronx, and over 70% in Brooklyn. Yet, due to the high cost of medical malpractice insurance, hospitals lose thousands of dollars on every single Medicaid delivery. This problem is a Medicaid access problem, as more and more financially struggling hospitals are grappling with the difficult decision of discontinuing obstetrics services entirely.

The high cost of medical malpractice takes its toll on the Medicaid program and other insurers in an additional way: providers who are worried about being sued for medical malpractice often order additional tests, procedures, and consultations, many of which are not medically necessary, all in order to avoid litigation in the future.

This issue must be addressed. In the spirit of shared responsibility, a way must be found to relieve health care providers of the high cost of medical malpractice insurance. Yet at this time of sacrifice, all we have heard from the guardians of the tort system status quo is that they want increased contingent fees, which would rob injured consumers of large portions of their awards and drive up hospital medical malpractice insurance costs by 15%-25%. Shared responsibility must extend to this portion of our health care system. Unfortunately, the Executive Budget ignores this important problem.

Similarly, provider cash flow problems could be partially alleviated through common sense managed care reforms. It is outrageous that in the State of New York health insurers can deny payments to hospitals and physicians for medically necessary care based on technicalities such as late notification, even though a consumer or employer has paid premiums in full and all sides agree the care was necessary. When a payer makes an administrative error and fails to pay a claim on time, it simply gets charged interest. When a hospital makes an administrative error, it can be subject to substantial penalty or a complete denial of the claim. Similarly, as insurers encourage more and more consumers and employers to utilize high-deductible health plans, hospital and physician bad debts multiply. The responsibility of collecting the high deductibles and copayments should be the insurer's, not the provider's. It is the insurer who knows how much the consumer has already spent toward their deductible and other cost-sharing responsibility. GNYHA has put forward a number of insurance reforms that could help to alleviate some of the financial pressures on hospitals and we urge the Legislature to enact them.

Sugary Soda Tax and Tobacco Taxes

The Executive Budget contains two extremely important actions to encourage healthy behavior, save health care dollars in the future, and raise revenue to fund important health care programs: increasing the cost of unhealthy, sugary drinks and an increase in the tobacco tax.

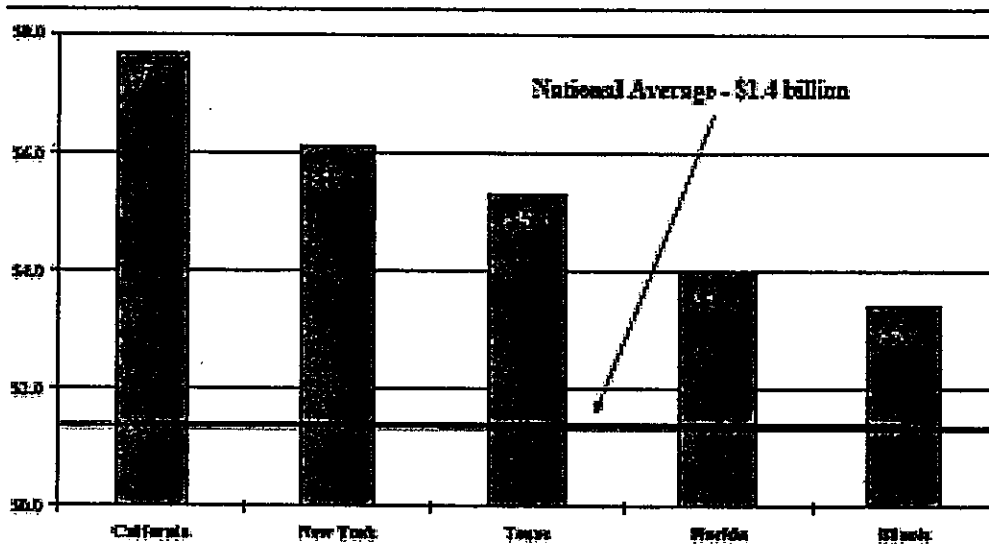
New York is facing a serious public health crisis: according to the New York State Department of Health, one out of every four New Yorkers is obese. The Executive Budget briefing book contained the following statistics:

- The percentage of adults in New York State who are overweight or obese increased from 42 percent in 1997 to 60 percent in 2008, and obesity among children and adolescents has tripled in the past three decades.
- Low-income populations, those with low educational attainment and communities of color experience higher rates of obesity.
- The Surgeon General estimated that obesity is associated with 112,000 deaths each year and poor diet and physical inactivity cause up to 365,000 deaths per year.

The State Department of Health also reports that obesity causes serious health problems like Type 2 diabetes, heart disease, high blood pressure, high cholesterol, cancer and osteoarthritis. Obese children are at much greater risk of having a heart attack, having a stroke, getting cancer, and losing a limb.

Obesity also has serious and substantial public health costs. According to the New York State Comptroller, New York spends an estimated \$7.6 billion on adult obesity-related health problems, more than almost every other state. Around eighty percent of this cost is paid through publicly-funded health care programs such as Medicare and Medicaid.

Figure 14.^{iv}
States with Highest Estimated
Adult Obesity Related Medical Expenditures in 2003
(in billions)



An analysis of 88 studies published in the American Journal of Public Health concluded that sugar-sweetened soft drink consumption was associated with increased caloric intake and body weight.^v Soft drink intake also appears to “crowd out” healthier alternatives, as drinking soda has been associated with lower intakes of milk, calcium and other nutrients. Research has demonstrated that soft-drink consumption is one of the main drivers of childhood obesity. For example, a study by Harvard researchers found that each additional 12- ounce soft drink consumed per day increases the risk of a child becoming obese by 60 percent. For adults, the association is similar. According to the New England Journal of Medicine, Americans consume about 250 to 300 more calories daily today than they did several decades ago, and nearly half this increase is accounted for by consumption of sugared beverages.

New York has learned from its successful efforts to reduce smoking by increasing the cost of tobacco products. To improve the long-term health of New Yorkers while making investments in the State’s health programs, the Executive Budget proposes an excise tax of \$7.68 per gallon for beverage syrups or simple syrups, and \$1.28 per gallon for bottled soft drinks, powders or base product, an approximately one cent per ounce increase in the cost of soft drinks. According to the New England Journal of Medicine, a penny-per-ounce excise tax could reduce consumption of sugared beverages by more than 10 percent.^{vi}

Taxable sugar-sweetened beverages will include those that contain more than ten calories per eight ounces, such as soda, sports drinks, “energy” drinks, colas, fruit or vegetable drinks containing less than 70% natural fruit or vegetable juice, and bottled coffee or tea. Milk, milk products, milk substitutes, dietary aids, and infant formula would be exempt.

Revenue generated from the tax will be dedicated to health care spending through the Health Care Reform Act (HCRA).

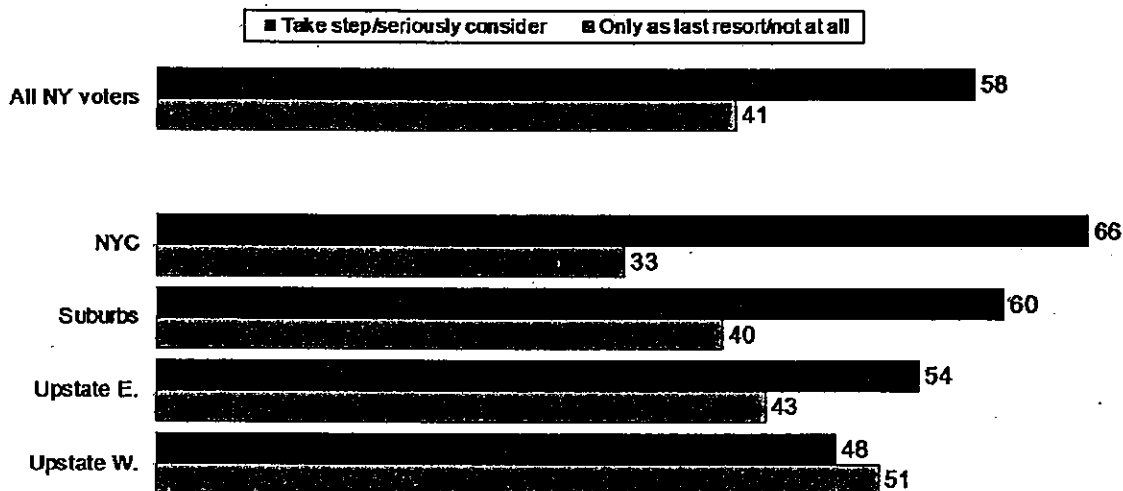
GNYHA strongly supports this tax, and our polling indicates that the public supports it as well. A poll conducted for the Healthcare Education Project, a joint project of GNYHA and 1199 SEIU found that 58% of New Yorkers support the tax as a way to reduce childhood obesity. When asked to choose between this tax and Medicaid cuts, support was overwhelming.

Figure 15.

New York/January 2010

Support for 18% Soft Drink Tax

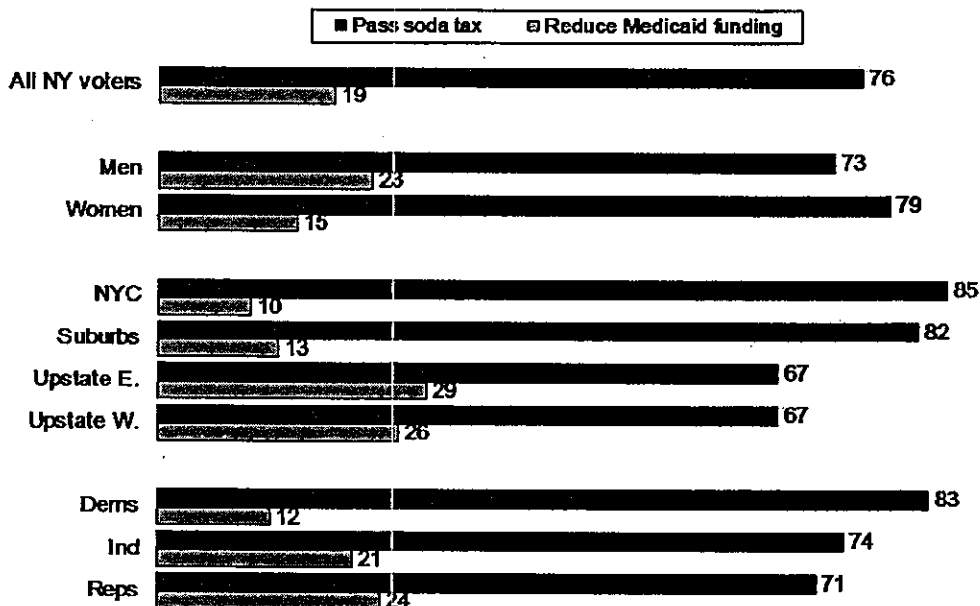
Please tell me whether you feel the state should take that step in order to help balance the budget, should seriously consider it, should consider it only as a last resort, or should definitely not consider taking that step: "Imposing a new 18% tax on sodas and other soft drinks containing sugar, which would also reduce childhood obesity."



Kiley & Company Opinion Research Consultants

Voters Also Favor Soda Tax Over Medicaid Cuts

If it came down to a choice between reducing state funding for the Medicaid program or passing a new 18-percent tax on sodas and other soft drinks with sugar, which option would you favor?



Kiley & Company Opinion Research Consultants

GNHYHA strongly supports this portion of the Executive Budget proposal, as well as the proposal to increase the tobacco tax to raise another \$200 million. Rejecting these two taxes would reduce revenue from the Executive Budget by \$650 million, thus putting more pressure on health care spending. We would strongly oppose a repeat of last year's folly, when precious Federal Medicaid relief dollars were dedicated to plugging a hole in the budget created with the Legislature rejected the proposed soda taxes and a variety of other excise taxes. Those dollars will be needed to reduce health care cuts and proposed taxes on hospitals, nursing homes, and home care providers.

Conclusion

In conclusion, I thank you for your interest in our views. As I said, we stand ready to help find solutions to the State's serious budget problems, and look forward to working with you on a truly balanced approach in the coming months. Hospitals in New York are dedicated to providing quality care to the Medicaid population, the uninsured, and all the patients they serve. We hope to be able to partner with you to make sure that this important mission is not compromised by the State budget at a time when New Yorkers need their hospitals more than ever.

¹1199 SEIU and League of Voluntary Hospitals and Homes of New York, "1199 SEIU and League of Voluntary Homes Reach Landmark Collective Bargaining Agreement," July 20, 2009.

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- ⁱⁱ NYS Division of the Budget, *2009-10 Enacted Budget Financial Plan*, April 28, 2009.
- ⁱⁱⁱ GNYHA/HANYS Survey of New York Hospitals, March 2009 (130 hospitals responded).
- ^{iv} Office of the State Comptroller, "Preventing and Reducing Childhood Obesity in New York," October 2008.
- ^v Vartanian LR, Schwartz MB, Brownell KD. "Effects of soft drink consumption on nutrition and health: a systematic review and meta-analysis." *American Journal of Public Health*. 2007; 97:667-675.
- ^{vi} Brownell KD, Farley T, Willett WC, Popkin BM, Chaloupka FJ, Thompson JW, Ludwig DS. The public health and economic benefits of taxing sugar-sweetened beverages. *The New England Journal of Medicine*. 2009.

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Testimony before the
Joint Legislative Hearing of the
Assembly Ways and Means and Senate Finance Committees
2010-2011 Executive Budget Proposal

Daniel Sisto, President
Healthcare Association of New York State

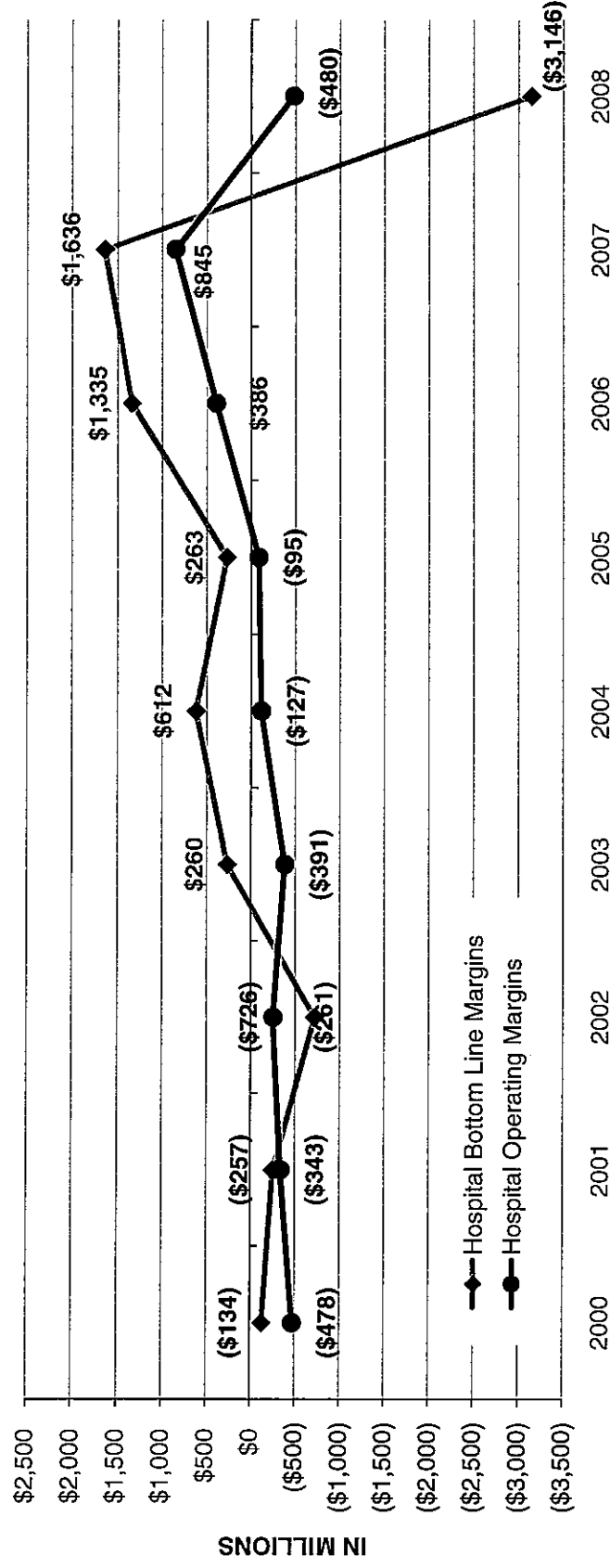
February 9, 2010



Healthcare Association
of New York State

AN EXCEEDINGLY FRAGILE HEALTH CARE SYSTEM

Hospital Finances Plummet— Even Before Recent State Budget Actions



- Not Reflected in this Hospital Analysis:
- \$500 million in annual hospital cuts and taxes from the February 2009 Deficit Reduction Plan (DRP), the 2009-2010 budget in April 2009, the May 2009 Metropolitan Transit Authority payroll tax, and the December 2009 DRP.
- Hundreds of millions in annual hospital cuts in the Governor's 2010-2011 Executive Budget proposal.

Federal Budget and Reform Implications

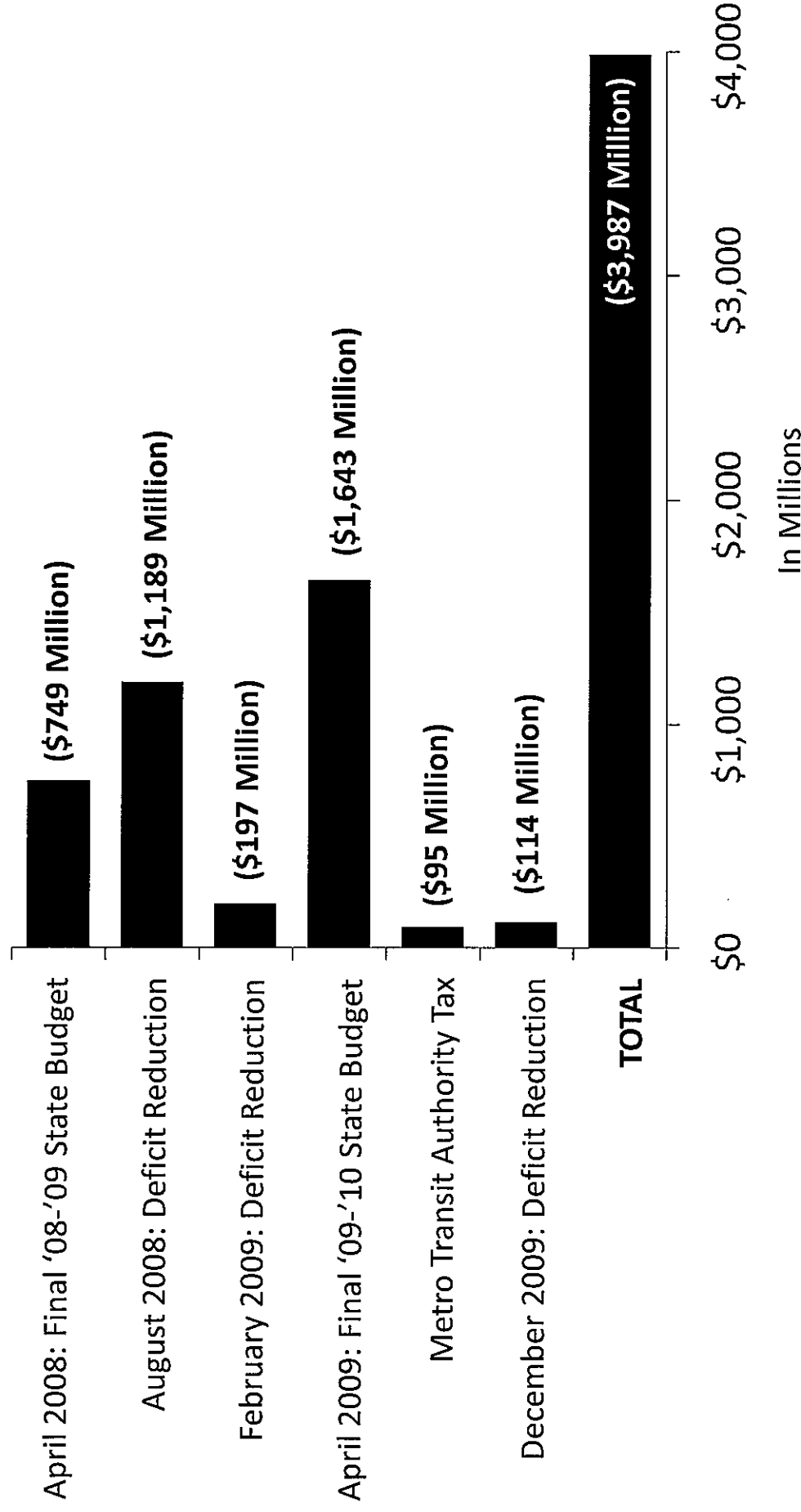
**New York hospitals, nursing homes, and
home care providers to be**

cut \$15 billion

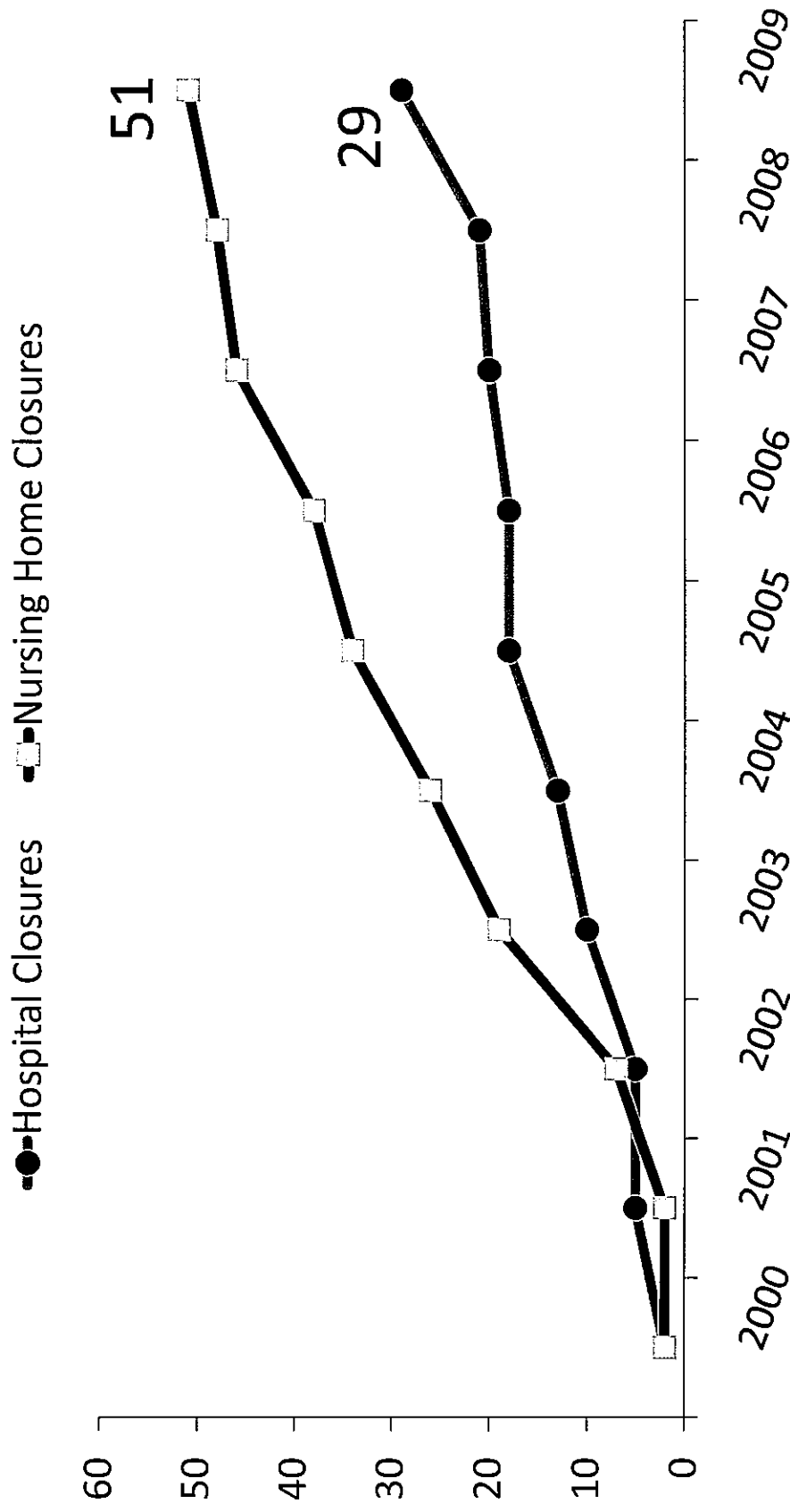
over the next ten years.

If federal coverage reform fails, the President has made it clear that reductions in the rate of health care spending—similar cuts to Medicare and Medicaid—remain a priority.

Hospitals, Nursing Homes, and Home Care Have Accumulated \$4 Billion in Cuts Over the Last Six State Budget Actions



New York State Hospital and Nursing Home Closures; 2000-2009, Cumulative



29 Hospitals Have Closed Since 2000

-
- Massapequa General Hospital
 - Olean General Hospital-West Division
 - Genesee Hospital
 - McClellan Health System, Inc.
 - The Caledonian Hospital
 - Staten Island University Hospital-Concord Site
 - ViaHealth of Wayne-Myers Campus
 - Island Medical Center
 - St. Agnes Hospital
 - Interfaith Medical Center-Jewish Hospital Medical Center Division
 - Our Lady of Mercy Medical Center-Florence Durso Pavilion
 - Beth Israel Medical Center-Herbert and Neil Singer Division
 - St. Joseph's Hospital of Flushing
 - Brunswick Hospital
 - Doctors Hospital
 - The Hospital in Sidney
 - Bayley Seton Hospital
 - United Memorial Medical Center-Bank Street Division
 - New York United Hospital Medical Center
 - St. Mary's Hospital of Brooklyn
 - St. Vincent's Midtown Hospital
 - Manhattan Eye, Ear, and Throat Hospital
 - The New Parkway Hospital
 - Cabrini Medical Center
 - Victory Memorial Hospital
 - Eddy Cohoes Rehabilitation Center
 - Albert Lindley Lee Memorial Hospital
 - Mary Immaculate Hospital
 - St. John's Queens Hospital

51 Nursing Homes Have Closed Since 2000

-
- United Helpers Cedars Nursing Home
 - Lake Shore Nursing Home, Inc.
 - Ann Lee Home & Infirmary
 - Community General Hospital of Greater Syracuse, Nursing Home Unit
 - Nazareth Nursing Home
 - Mount View Health Facility
 - Episcopal Residential Health Care Facility, Inc.
 - Clifton-Fine Hospital
 - Brunswick Hospital Center, Inc.
 - Eden Park Health Care Center
 - Lemberg Home & Geriatric Institute, Inc.
 - Manor Oak Skilled Nursing Facilities, Inc.
 - Southampton Care Center
 - St. Joseph's Manor
 - Cedar Hedge Nursing Home
 - Childs Nursing Home Company, Inc.
 - Beechwood Residence
 - Livingston County Campus SNF
 - The Hospital SNF
 - Menorah Home and Hospital for Aged and Infirm
 - Rehab Institute of New York at Florence Nightingale Health Center
 - Hebrew Home for the Aged at Riverdale-Baptist Division
 - New York United Hospital Medical Center Skilled Nursing Pavilion
 - Sunrest Health Facilities, Inc.
 - Faxton-St. Luke's Healthcare—Allen Calder
-
- Loeb Center, Montefiore Medical Center
 - St. Luke Manor of Batavia
 - Manor Oak Skilled Nursing Facilities, Inc.
 - Hutton Nursing Home
 - Kresge Residence
 - Williamsville View Manor
 - St. Clare Manor
 - Norloch Manor
 - Eden Park Health Care Center
 - The Gardens at Manhattan Health and Rehabilitation Center, LLC
 - Manor Oak Skilled Nursing Facilities, Inc.
 - St. Mary's Manor
 - Eden Park Health Care Center
 - Potsdam Nursing Home
 - Mt. St. Mary's Long-Term Care Facility, Inc.
 - Mary McClellan Skilled Nursing Facility
 - Wesley-on-East, Ltd.
 - Bethel Methodist Home
 - Lyden Care Center
 - Albany Avenue Manor
 - The Waters of Syracuse
 - Chandler Care Center
 - Genesee Hospital ECF
 - Our Lady of Victory Health Trauma Rehabilitation Unit
 - Dover Nursing Home
 - Dorothy & David I Schachne Institute for Nursing Rehabilitation

Health Care Jobs Lost as Cuts and Taxes Mount

Hospital mass layoffs hit new high in 2009

2/8/2010 American Medical News

RPCI, Batavia hospital reduce staff
3/6/2009 Business First of Buffalo

Hospital in Brooklyn Lays Off 250 Workers

9/4/2009 NY1

**North General Hospital
On the Brink of Bankruptcy**
1/18/2009 Crain's

**City's Public Hospital System
to Cut Jobs and Programs**
3/19/2009 NY Times

Memorial Medical Center cutting staff
12/30/2009 Niagara Gazette

St. Vincent's Hospital in NYC lays off 180
12/8/2009 Crain's

Westchester Medical Center cuts 100 more jobs
3/30/2009 The Journal News

Hospital lays off 16, closes clinic over state cuts

6/18/2009 Buffalo News

**Albany Med implements hiring
freeze, leaving 125 positions vacant**
4/6/2009 The Business Review

Claxton-Hepburn to lay off 30 employees

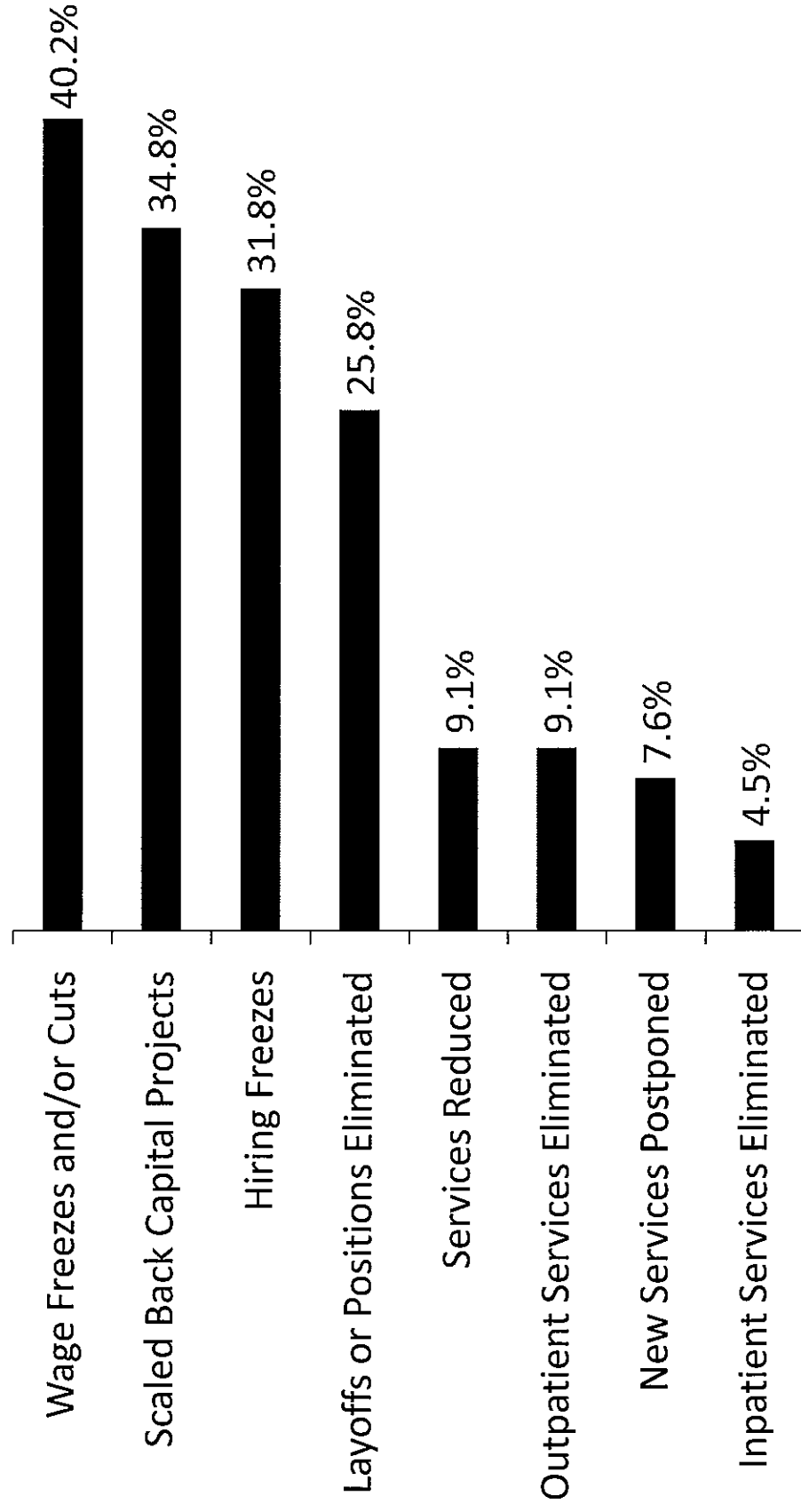
7/8/2009 NewsWatch 50

Hospital to Close Nursing Home, Lay Off Staff
1/13/2009 The Journal News

**St. Vincent's Hospital on brink
of second bankruptcy**
1/26/2009 Crain's

Crouse Hospital is latest to close its pediatric unit
6/29/2009 The Post-Standard

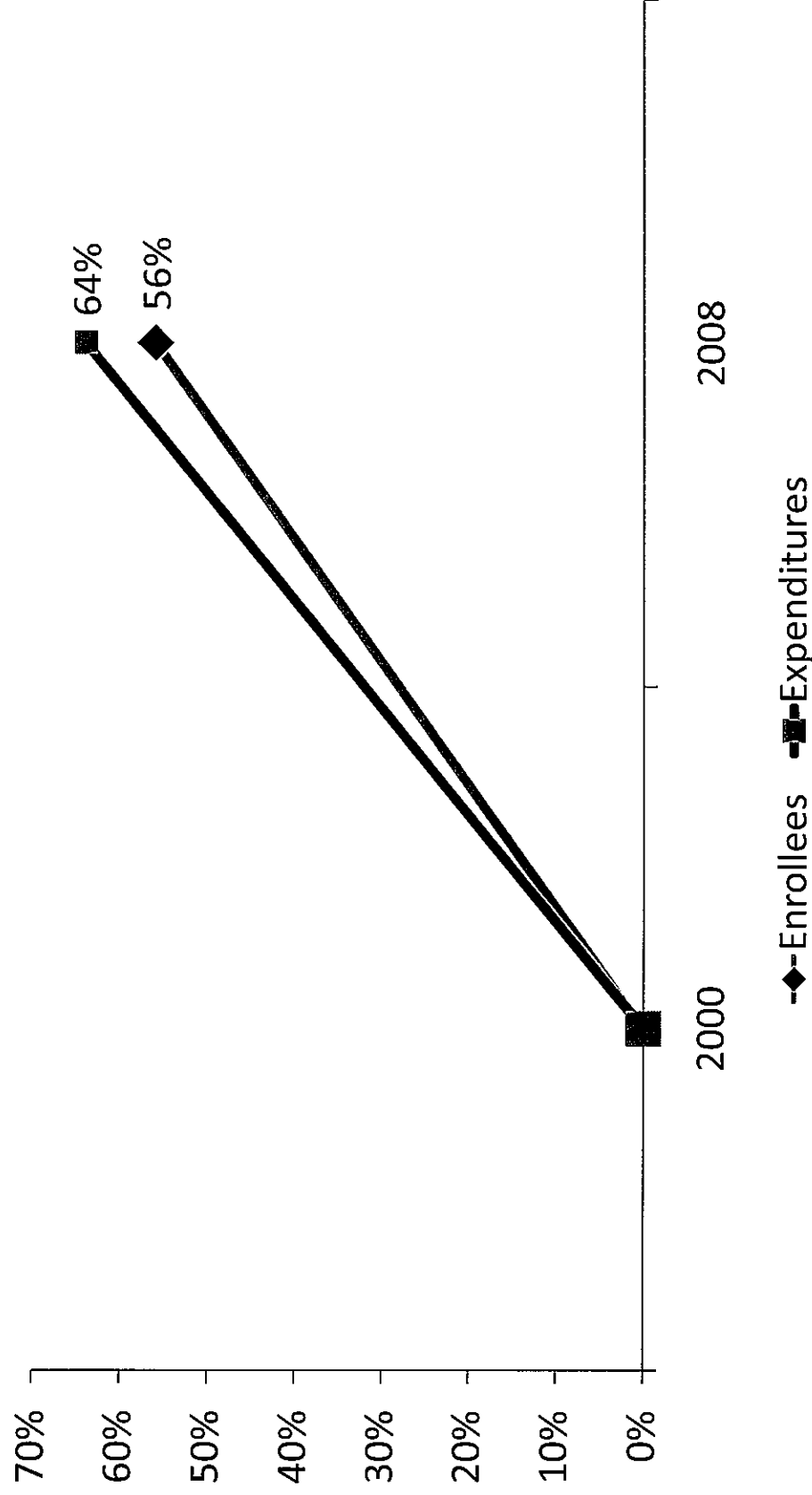
Hospitals Took Action in 2009 to Cope with Cutbacks



Source: HANYS' Quarterly Financial Crisis Survey, 2009, 1st through 3rd Quarters

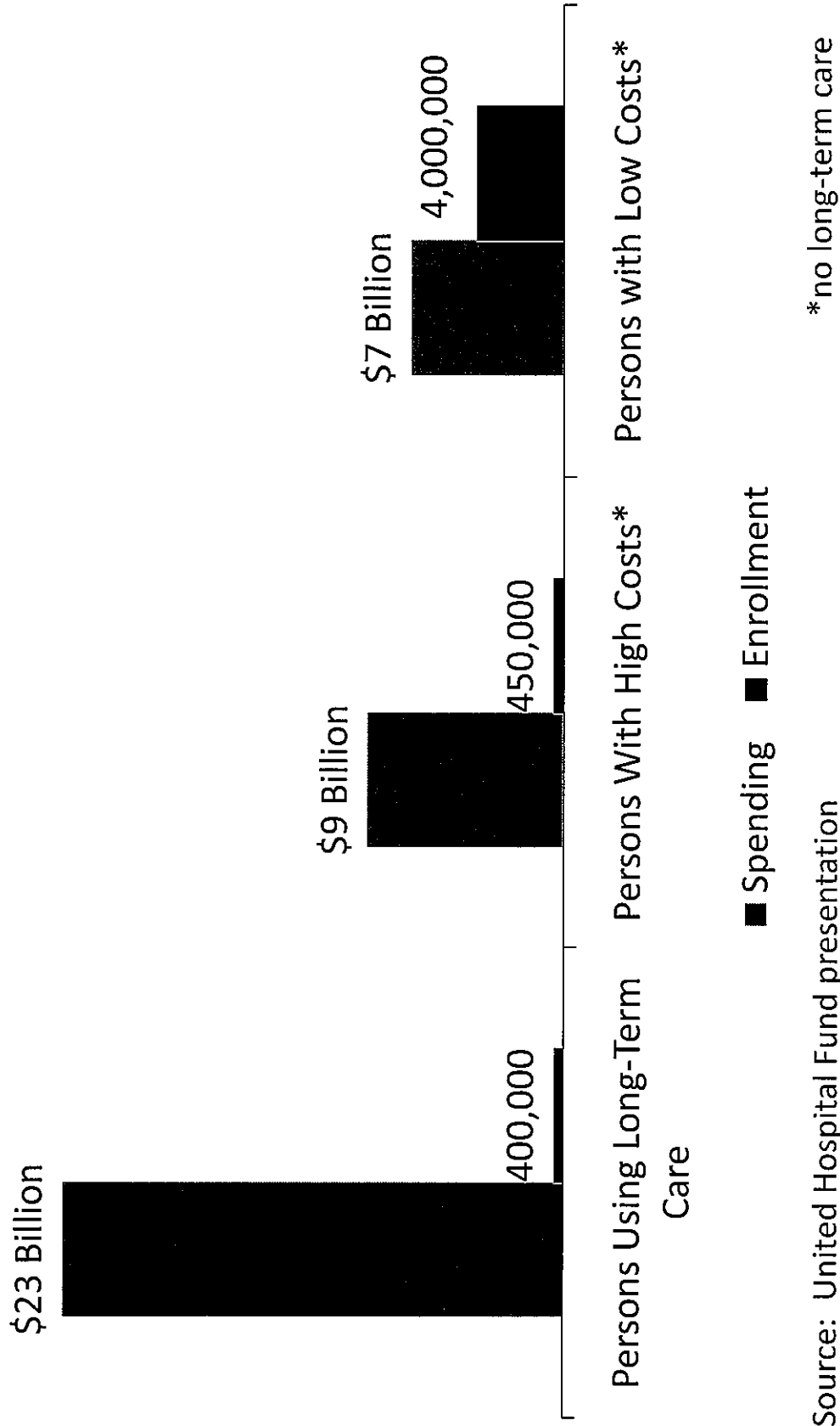
STATE POLICY IS PRIMARY DRIVER OF MEDICAID SPENDING GROWTH

The Number of Medicaid Enrollees and Expenditures Grew from 2000 to 2008



- One in five (19.3%) New Yorkers are covered under Medicaid, Child Health Plus, or Family Health Plus
 - Nearly 40% higher than the national average (14%)

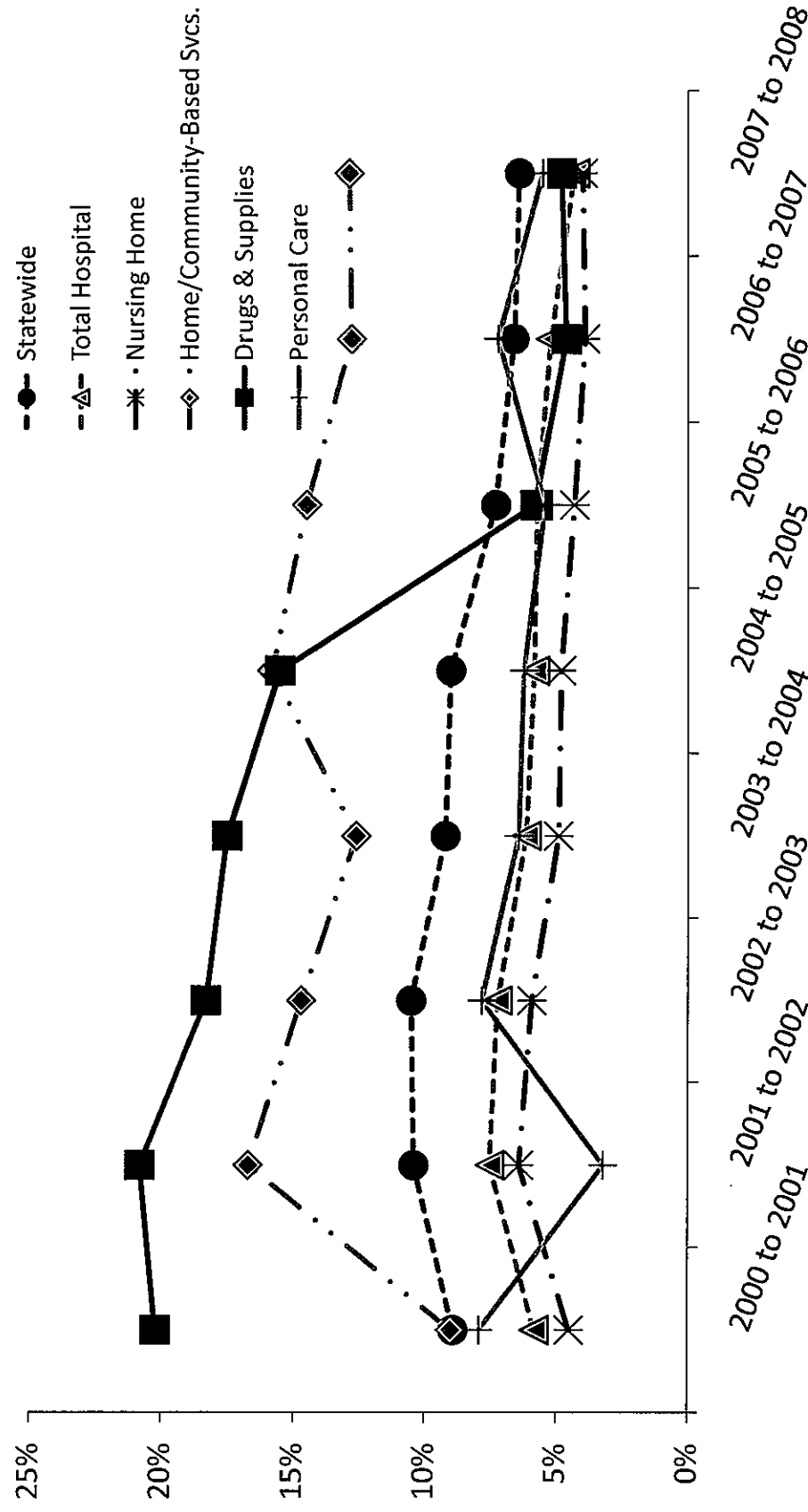
Medicaid spending is heavily concentrated on a small group of beneficiaries; the vast majority of enrollees are low-cost.



Hospitals and Nursing Homes are Not Driving Medicaid Spending Growth

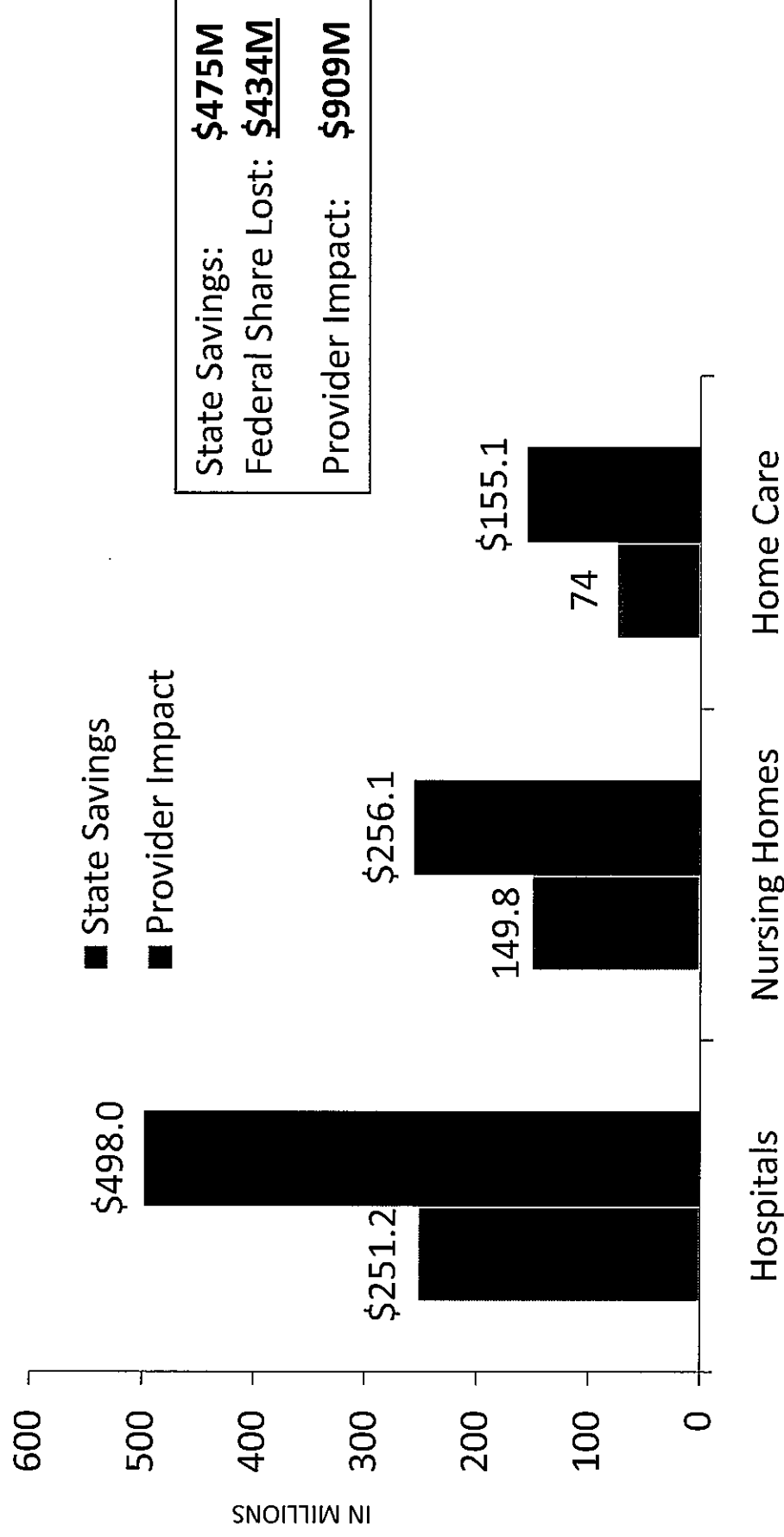
Medicaid Spending Growth, 2000-2008

Average Annual Total Spending Growth, 2000-2008



2010-2011 EXECUTIVE BUDGET PROPOSAL

State Savings Drive Loss of Federal Match to Double Impact on Providers



Governor's Proposal Compounds Losses in Prior Budget Actions

- Fully implementing the Governor's proposal includes nearly \$1 billion in taxes and cuts to hospitals, nursing homes, and home care.
- Governor's proposal follows six budget actions amounting to \$1.7 billion in losses to providers annually.

Governor's Proposed Budget Taxes and Cuts to Hospitals: \$498 Million Impact

IN MILLIONS	
Reduce and Redistribute Indigent Care Payments	(\$187M)
Increase Gross Receipts Tax ("Sick Tax") from 0.35% to 0.75%	(\$143M)
Redirect \$166 Million Indirect Medical Education (IME) —First Year Impact	No State Savings*
Limit Preventable Readmissions/Conditions	(\$49M)
Eliminate 2010 Trend Factor	(\$107M)
TOTAL SFY 2010-2011 IMPACT	(\$498M)

*Total includes provider impact due to transfer of funds to Doctors Across New York and impact on Workers' Compensation Insurance

Governor's Proposed Hospital Taxes and Cuts, by Region

(in millions of \$)	Increase Hospital Gross Receipts Tax	Medicaid FFS Reductions and Redistributions	Medicaid Managed Care, Workers' Comp, and No-Fault	Total Hospital Impact
HANYS Region				
Western NY	(\$8.2)	(\$0.9)	(\$0.8)	(\$9.9)
Rochester	(\$6.9)	(\$10.5)	(\$2.0)	(\$19.3)
Iroquois-CNY	(\$7.5)	\$0.4	(\$1.2)	(\$8.3)
Iroquois-NENY	(\$7.1)	(\$3.4)	(\$0.5)	(\$11.0)
Northern Met.	(\$12.5)	(\$3.7)	(\$0.2)	(\$16.4)
New York City	(\$81.5)	(\$223.5)	(\$39.4)	(\$344.4)
Long Island	(\$19.7)	(\$19.3)	(\$0.7)	(\$39.8)
Potentially Preventable Readmissions				(\$49.0)
TOTAL	(\$143.3)	(\$260.9)	(\$44.8)	(\$498.0)

*Regional impacts do not include the \$ impact of limiting payments for potentially preventable readmissions.

Smarter Revenue Options

- FMAP dedicated to health care
- Promote public health and reduce long-term health care expenditure
 - Excise tax on sugared beverages and tobacco
- Keep health plan profits in New York State
 - Expand HCRA surcharges on health insurers that divert billions in profits to out-of-state corporate parents
- Level the playing field
 - HCRA surcharge on select physician office services

Federal Match—FMAP



- \$5 billion provided by federal government in FMAP increases for the 2009-10 budget
- Just \$1 billion, or 20%, was made available for health care restorations

FMAP

- Six-month extension proposed by President
 - \$3.3 billion more to NY
 - Of that, \$1.1 billion available to state in SFY 2010-2011—enough to offset all of the Governor’s health care taxes and cuts

Governor's Indigent Care Proposal

Total Impact Will Cut \$187 Million from Pool

- Reduce total distributions from the Indigent Care Pool by \$187M annually, 20% cut to voluntary, non-profit hospitals
- Redefines “need” to omit \$400 million in uncompensated care costs incurred by hospitals
- Leaves hospitals solely responsible for underinsured who cannot pay

Governor's Indigent Care Proposal

Safety net hospitals hardest hit

- Urban “high need” hospitals would lose \$109 million
 - High need hospitals are the facilities with the highest uncompensated care costs
- Rural hospitals would be cut by \$10 million
- High volume Medicaid hospitals would lose \$106 million
 - Hospitals with over 35% of patients covered by Medicaid

LEGISLATIVE ACTION NEEDED:

Reject Governor's Charity Care Cuts and Redistribution

Governor's Bad Debt and Charity Care Proposal is an Assault on Our Poorest, Neediest Communities

NEW YORK CITY (sample facilities)

Bronx—Total Losses: (\$38.6M)

- Bronx-Lebanon Hospital Center, Fulton (\$19.6M)
- Montefiore Hospital and Medical Center (\$21.8M)

Queens—Total Losses: (\$23.9M)

- Flushing Hospital and Medical Center (\$3.9M)
- Jamaica Hospital (\$12.5M)
- Long Island Jewish—Hillside Medical Center (\$4.7M)

Manhattan—Total Losses: (\$48.6M)

- Mount Sinai Hospital (\$10.1M)
- St. Luke's-Roosevelt Hospital Center (\$14.9M)
- St. Vincent's Hospital and Medical Center of New York (\$8.5M)
- Beth Israel Medical Center (\$7.8M)

Kings—Total Losses: (\$38M)

- Brookdale Hospital Medical Center (\$8.6M)
- Interfaith Medical Center (\$4.7M)
- Lutheran Medical Center (\$12.5M)
- Wyckoff Heights Hospital (\$6.6M)

Richmond—Total Losses: (\$6.8M)

- Staten Island University Hospital (\$3.4M)
- Richmond University Medical Center (\$3.4M)

REST OF STATE

Top 10 Hardest Hit Hospitals

- St. Joseph's Hospital, Yonkers (\$6.6M)
- Mount Vernon Hospital (\$5M)
- North Shore University Hospital (\$7M)
- Southside Hospital (\$3M)
- Unity Hospital (\$2.7M)
- St. Peter's Hospital (\$2.8M)
- Kingston Hospital (\$2.3M)
- Catskill Regional Hospital, Harris (\$3.3M)
- United Health Services, Inc. (\$2M)
- Summit Park Hospital-Rockland County Infirmary (\$2M)

Governor's Proposal Increases Provider Gross Receipts Tax ("Sick Tax")

- Increase taxes effective April 1, 2010
 - Hospital Impact: **(\$143 Million)**
 - Nursing Home Impact: **(\$85 Million)**
 - Home Care Services Impact: **(\$19 Million)**

LEGISLATIVE ACTION NEEDED:

Reject the GRT Increases

Governor's Indirect Medical Education Proposal

- NO state savings
- Redistribute \$166 million first year, \$499 million when fully implemented
- Robs one provider to benefit another
- Will only worsen physician shortage
- Latest installment of implementing a disruption and calling it “reform”

LEGISLATIVE ACTION NEEDED:

Reject Governor's IME Redistribution

Governor’s Proposal Would Excessively Penalize Providers for Undefined “Preventable Readmissions”

- Would cut \$49 million in 2010-2011; \$162 million in 2011-2012
- Needs a clear, well-defined approach informed by clinical principles
- No methodology available; no specific medical conditions identified
- Over 80% of potential patient population are high risk—with behavioral health or substance abuse conditions
- No lessons borrowed from federal proposals that target a few specific conditions

LEGISLATIVE ACTION NEEDED:

Proposal is too much, too soon, too undeveloped.

A workgroup should be formed including clinicians to develop a sound proposal for future implementation.

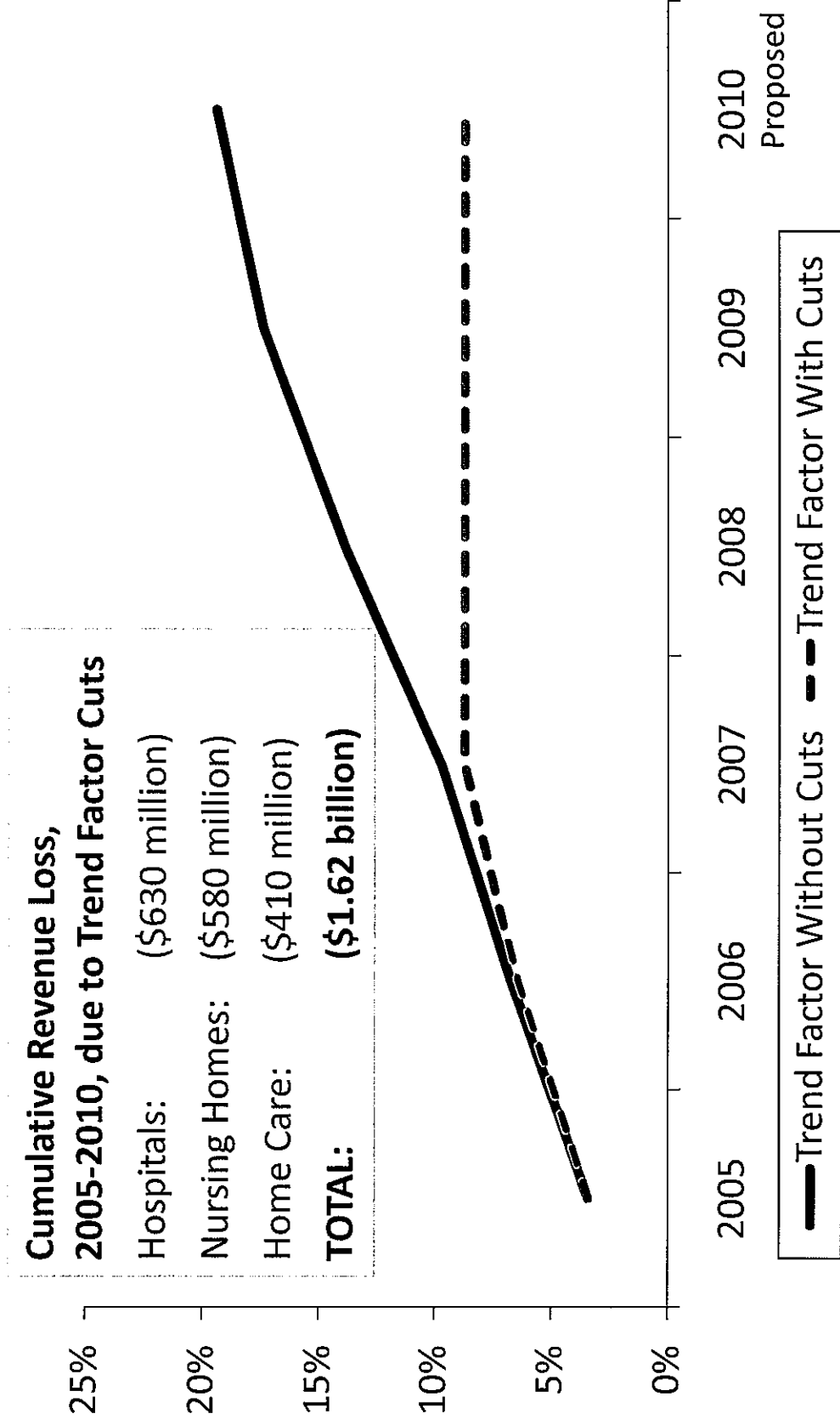
Governor's Budget Proposal Eliminates Trend Factor Adjustment

- Eliminate 2010 trend effective April 1, 2010
 - Hospital Impact: **\$107 Million**
 - Nursing Home Impact: **\$113 Million**
 - Home Health and Personal Care Services Impact: **\$63 Million**
- Last full trend adjusted in 2005

LEGISLATIVE ACTION NEEDED:

Restore trend factor

Health Care Providers Keep Losing Ground to Inflation



Governor's Proposed Taxes and Cuts to Nursing Homes: \$256 Million Impact

Eliminate 2010 Trend Factor	(\$113M)
Increase GRT by 1%	(\$85M)
Reduce payment for bed hold days	(\$19M)
Limit rate appeals	(\$40M)
Proposal delays regional pricing to March 1, 2011	No State Savings
TOTAL SFY 2010-2011 IMPACT	(\$256M)

LEGISLATIVE ACTION NEEDED:

Reject taxes and cuts.

Further delay regional pricing plan.

Governor's Proposed Nursing Home Cuts and Taxes by Region—Over \$250 Million Impact

(in millions of \$)	1% Gross Receipts Tax Increase	Remaining 2010 Trend Factor	Total Nursing Home Impact
HANYS Region			
Western NY	(\$5.8)	(\$7.6)	(\$13.4)
Rochester	(\$5.2)	(\$7.0)	(\$12.2)
Iroquois-CNY	(\$6.9)	(\$9.0)	(\$15.9)
Iroquois-NENY	(\$5.5)	(\$7.1)	(\$12.6)
Northern Met.	(\$9.3)	(\$11.9)	(\$21.2)
New York City	(\$39.6)	(\$51.9)	(\$91.5)
Long Island	(\$12.2)	(\$16.1)	(\$28.3)
Subtotal	(\$84.5)	(\$110.5)	(\$194.9)
Additional cuts not allocated by region			
TOTAL	(\$84.5)	(\$110.5)	(\$256.1)

Includes in statewide total the cap on rate appeals (\$40M), bed hold reduction (\$19M), assisted living trend factor cuts (\$2.2M)

LEGISLATIVE ACTION NEEDED: Reject Nursing Home Taxes and Cuts

Governor's Proposed Home Care Taxes and Cuts:

\$155 Million Impact

Eliminate 2010 Trend Factor	(\$63M)
Increase GRT tax from 0.35% to 0.70%	(\$19M)
Limit utilization of personal care services	(\$73M)
Authorize additional provider efficiencies	(\$1M)
Delay new CHHA rate system until 1/1/12	--
TOTAL SFY 2010-2011 IMPACT	(\$155M)

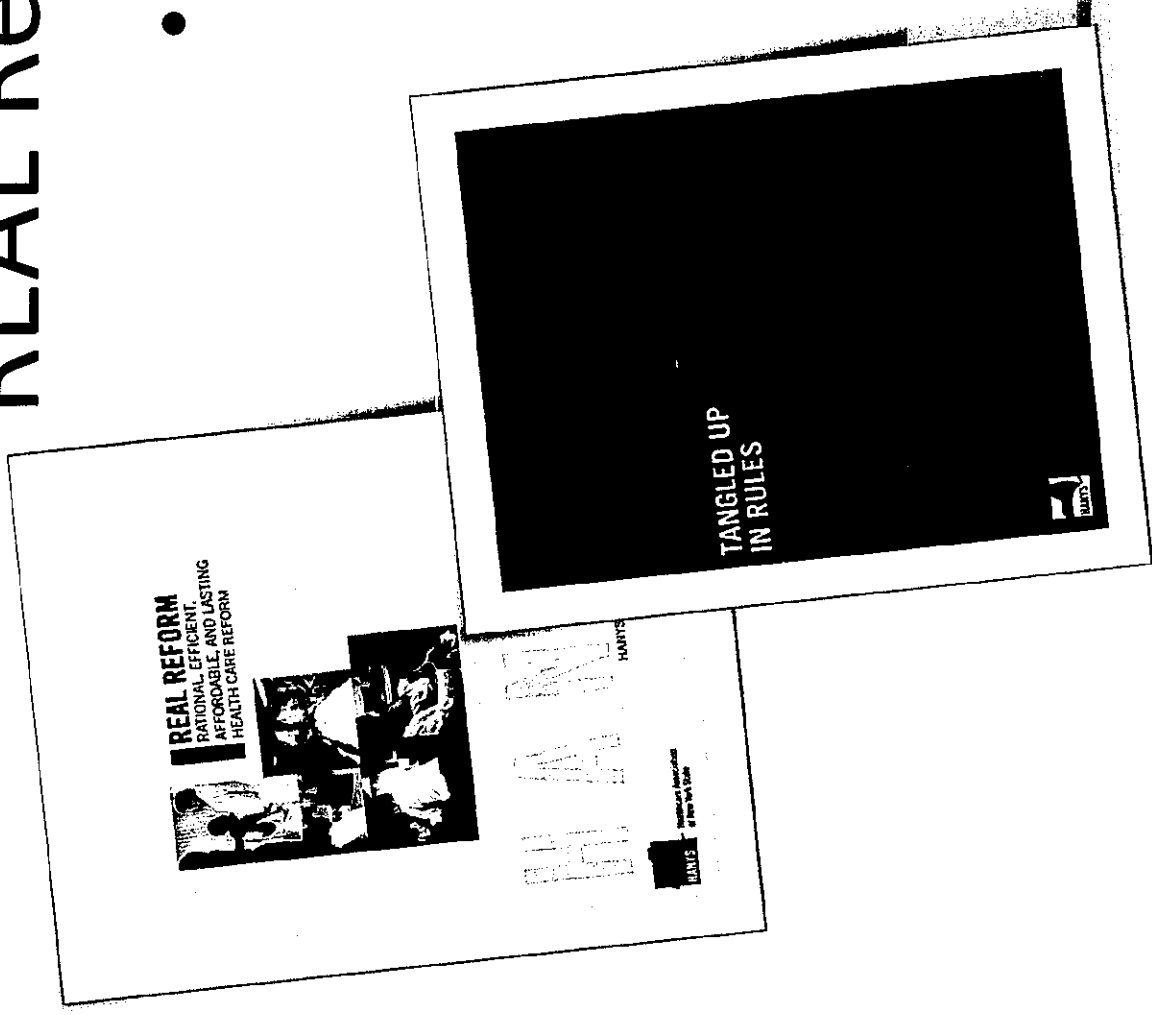
LEGISLATIVE ACTION NEEDED:

Reject Home Care Taxes and Cuts.

Preserve legislative authority over rate system changes.

REAL Reform

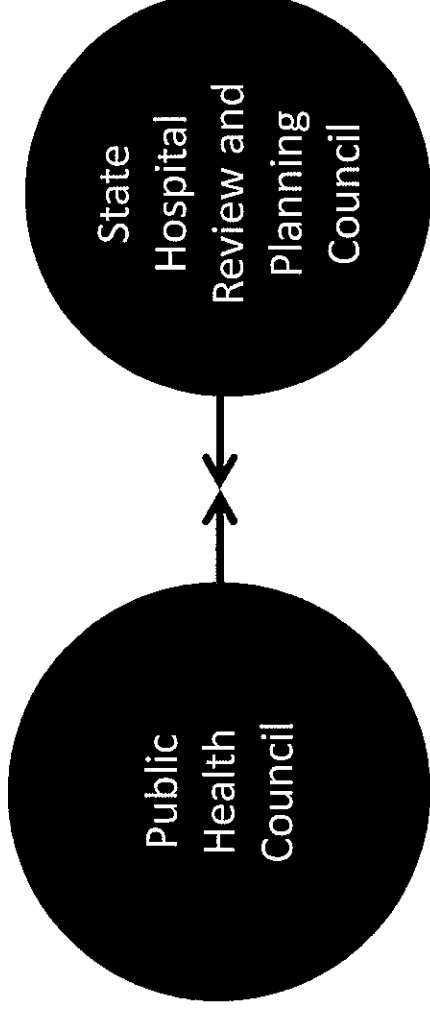
- HANYS' proposed compendia of true reform include:
 - Medical malpractice
 - Medical home model
 - Meaningful CON reform
 - Increase of Transitional Care Units
 - Clinical integration
 - Others



State Reform Agenda Has Lagged

- No medical malpractice reform
- Only one medical home project
- No meaningful CON reform
- Only 5 more TCUs proposed in budget
- No protection on policies to encourage clinical integration
- No new innovations for payment reform

Governor Has Proposed Consolidating PHC and SHRPC



- Support consolidating two councils if it improves efficiency and timeliness
- Oppose transferring full authority to Commissioner of Health to promulgate all
 - Reimbursement regulations
 - CON regulations
 - Hospital code regulations

State's "reform" effort more disruption than reform

Billions of dollars have been redistributed among hospitals as a result of inpatient, outpatient, and indigent care payment "reforms" in the past two years.

- DRG Reweighting
- Serious Adverse Events
- Outpatient APGs
- Inpatient Detox Payments
- Indigent Care Changes
- Behavioral Health Payment
- Inpatient Acute Payment
- Inpatient Exempt Payment
- Elimination of GME Pool
- Physician Billing Changes
- Nursing Home Regional Pricing
- Medical Home Incentives
- Home Care Payments
- Medicaid Preventable Readmissions
- Medicaid Preventable Complications



What's at Stake

New York's hospitals generate \$101.1 billion for state and local economies each year:

	TOTAL DIRECT IMPACT	TOTAL DIRECT AND INDIRECT IMPACT
JOB	356,780	671,730
TOTAL ECONOMIC IMPACT	\$46,761,724,000	\$101,136,257,000
TOTAL STATE/LOCAL TAXES	\$2,610,095,000	\$4,452,040,000

What's at Stake

Services eliminated or diminished include:

- Cancer treatment and diagnostic services, and equipment purchases
- Numerous emergency room (ER) expansion and modernization projects necessary to eliminate ER backlogs and wait times
- Surgical services
- Adolescent mental health services
- Autism and other outpatient clinics
- Community-based health services

In conclusion . . .

- Health care providers are fragile, many have closed while others are on the brink
- Cumulative cuts in last six budget actions, totaling \$1.7 billion annually, weakens us further
- Proposed \$1 billion in new taxes and cuts in Governor's budget will mean thousands of lost jobs, reduced access to health care services
- Reform agenda has been disruptive; there is no assessment of the impact of these actions
- True structural reform is critical

3B



TESTIMONY OF

JO WIEDERHORN

PRESIDENT AND CHIEF EXECUTIVE OFFICER

ASSOCIATED MEDICAL SCHOOLS OF NEW YORK (AMSNY)

AT A JOINT HEARING OF

THE NEW YORK STATE ASSEMBLY

COMMITTEE ON WAYS AND MEANS

AND

THE NEW YORK STATE SENATE COMMITTEE ON FINANCE

ON

THE EXECUTIVE HEALTH CARE BUDGET

February 9, 2010

10:00 am

Legislative Office Building

Albany, New York

Good afternoon. Chairman Kruger, Chairman Farrell, Chairman Duane, Chairman Gottfried and other distinguished members of the State Legislature. Thank you for this opportunity to testify on the Executive proposed budget for 2010-11.

My name is Jo Wiederhorn, President and Chief Executive Officer (CEO) of the Associated Medical Schools of New York (AMSNY), a consortium of the fifteen public and private medical schools in New York State. AMSNY works in partnership with its members to improve healthcare through education, advocacy, and collaboration.

In my testimony today, I would like to discuss several important components of the health budget that impact medical schools. Specifically, I would like to discuss Stem Cell funding, Spinal Cord Injury (SCI) Research, the AMSNY Diversity/Post-Baccalaureate Programs, Doctors Across New York (DANY), Medical Malpractice Reform, and Indirect Medical Education (IME).

Before I begin to outline our recommendations, I would first like to briefly describe how academic health care is a driving force in the overall economy and is a critical growth engine for the State of New York.

Economic Impact Analysis

New York is home to more medical schools than any other State in the country. The advancements in healthcare that have resulted from the research undertaken by these institutions have had a significant impact on the lives of individuals living in New York and beyond. Just as important as the medical advancements, is the economic impact of these institutions on the State as well as local economies.

New York's medical schools leverage Federal funding for the training of physicians, research and direct care of patients. In addition, these institutions employ tens of thousands of employees and provide excellent salaries and benefits.

Summary of Key Findings

AMSNY will issue a report shortly that measures the economic impact of AMSNY-member institutions and their core teaching hospital affiliates. It demonstrates how these institutions provide substantial economic impact to the State. For example:

- The **combined total economic impact** of New York's medical schools and primary hospital affiliates on the State of New York **equals more than \$85.6 billion**.
- AMSNY member medical schools and primary hospital affiliates **support nearly 694,000 full-time equivalent (FTE) jobs** directly and indirectly throughout the State of New York.
- Collectively, AMSNY member medical schools and the primary hospital affiliates **generate nearly \$4.2 billion in taxes for the State of New York** through income taxes and sales taxes, corporate net income taxes, and capital stock/franchise taxes produced by business receiving revenue from New York's medical schools and primary hospital affiliates.
- New York medical schools and primary hospital affiliates **generate over \$3.1 billion in medical tourism** by attracting out of state patients, visitors, and conference attendees. They also **attract international dollars from outside of the U.S., in the areas of medical research and clinical expertise**.
- Research efforts at New York medical schools and primary hospital affiliates **generate \$7.45 billion in the economy on an annual basis** for the State of New York.

- **For every dollar in research funding invested in medical schools in the State, New York receives a return of \$7.50.**

I would now like to discuss several important components of the health budget that impact medical schools.

Stem Cell Research

AMSNY requests that the Legislature restore \$5.2 million for stem cell funding that was cut in the proposed budget for 2010-11. This restoration will return the total appropriation back to \$50 million, reinstating the commitment to provide \$600 million over 11 years for stem cell research projects. Without this restoration, the reduction compounded, would mean that stem cell research projects would lose a total of \$47 million over the duration of the remaining 9 year commitment level (\$553 committed over an 11-year period instead of the original \$600 million commitment level).

New York State is home to one of the strongest biomedical research communities in the world. With fifteen medical schools, and approximately 100 teaching hospitals and other top quality research institutions, New York scientists are conducting some of the most cutting-edge, exciting research. Governor Paterson and the Legislature's support of these initiatives positions New York as a leader in stem cell research, and brings hope to millions of people suffering from a range of debilitating diseases. One day, scientists say, stem cells may be used to replace or repair damaged cells and have the potential to drastically change the treatment of conditions like cancer, Alzheimer's and Parkinson's disease and other conditions.

Since 2007, New York State has funded stem cell research projects. This funding encourages collaborations among scientists, facilitates the acquisition and development of specialized equipment, helps the State attract the best scientists in the field, supports researcher-initiated stem cell research, and increases the capacity of New York State institutions to engage in stem cell research.

The program is working well with 150 grants having been made to 25 institutions throughout the State for a total of \$165 million. In addition to funding research, the Empire State Stem Cell Board (ESSCB) is supporting the creation of a new stem cell workforce. Most recently, the Funding Committee of the ESSCB approved \$2.1 million in new funding that will offer college students in New York State the opportunity to learn about stem cell science and experience first-hand the specialized techniques required for pursuing a stem cell research career.

The investment in stem cell research is also helping to make New York a global leader in the New Economy. In addition to supporting numerous stem cell research projects, the \$600 million investment is creating new jobs and attracting top researchers. Stem cell scientists from across the country are coming to New York because they are able to conduct cutting-edge stem cell research here. In doing so, these scientists are often bringing with them their National Institutes of Health (NIH) grants and post doctoral students. This will reposition New York as the leader in NIH funding, the country's largest and most prestigious source of biomedical research money.

For these stated reasons, AMSNY recommends that the Legislature restore \$5.2 million for stem cell research projects.

Spinal Cord Injury (SPI) Research

The Governor's budget also proposes to eliminate the Spinal Cord Injury Research Board (SCIRB) and phase-out funding for the Spinal Cord Injury Program. When the Spinal Cord Injury Research Board and Trust Fund were created in 1998, the sole purpose was to support innovative scientific ideas and approaches that will lead to a breakthrough in curing spinal cord injury paralysis. Since 1998, more than \$54 million has been awarded to fund basic neurological tissue regeneration research projects. The spinal cord injury research projects are not funded through the State's General Fund, rather they are

financed by surcharges from certain motor vehicle traffic moving violations in New York State.

As you may recall, Christopher Reeve was a tireless activist for this initiative and at the time of the program's inception, New York was the first in the nation to establish a Trust Fund dedicated solely to finding a cure for spinal cord injuries.

This funding stream holds the promise of finding a cure for spinal cord injury. It is estimated that 250,000 Americans suffer from spinal cord injuries, with 11,000 new injuries occurring each year. The average estimated lifetime cost to care for a quadriplegic is \$1.35 million. The research projects funded through this program bring real hope to those suffering from paralysis.

For these reasons, AMSNY recommends the restoration of \$6.7 million in 2010-11 to ensure that this worthy program is continued.

AMSNY Diversity/Post-Baccalaureate Programs

AMSNY requests the Legislature continue to fund the AMSNY Diversity Programs at the proposed 2010-11 budget level of \$1.7 million. The AMSNY Diversity Programs increase the number of minorities in medicine and seek to alleviate the maldistribution of health professionals in underserved areas. The diversity programs include the Post Baccalaureate Program at SUNY Buffalo School of Medicine and Biomedical Sciences; the Post Baccalaureate Masters Degree Programs at Upstate University Medical Center, Stony Brook University Medical Center and New York Medical College; the Learning Resource Center at Sophie Davis School of Biomedical Education; the Pathways to Careers in Medicine at the City College of New York and the Physician Career Enhancement Program at Staten Island University Hospital.

The outcome data illustrates the success of these programs. For example, 85 percent of students who participated in the Post-Bac program at SUNY Buffalo matriculated into the

referring medical school and successfully graduated from that medical school. A majority of the students, 70 percent, that participated in the Stony Brook Masters program are currently enrolled or applied to medical school. At SUNY Upstate, all of the students that enrolled in the Medical Scholars program enrolled in medical school.

The success of these programs demonstrates the need to continue funding the AMSNY Diversity programs at \$1.7 million. The continuation of these programs will ensure that a higher number of minority students enroll in medical school, as well as other health care professions, to help diversify the health care workforce.

The need to increase the diversity in medicine pipeline is especially acute in light of the impending physician shortage nationally and in New York State. In 2005, the federal Council on Graduate Medical Education (COGME) forecasted a substantial shortage of physicians by 2020, between 85,000 to 96,000 physicians. To help alleviate the shortage, the Association of American Medical Colleges (AAMC) called for a 30 percent increase in medical school enrollment by 2012.

Minority physicians play a critical role in the physician workforce shortage. While underrepresented minorities (URM) makeup 33 percent of the State's population, they only account for 9.5 percent of the State's physicians. Increasing the number of minority physicians in New York State is vital for the State's health. URM physicians are more likely to work in primary care or obstetrics/gynecology (39 percent) compared to all other physicians (27 percent). Additionally, URM physicians are more likely to work in downstate New York (82 percent vs. 69 percent) and in urban areas (94 percent vs. 91 percent) compared to all other physicians.

Doctors Across New York (DANY)

AMSNY supports the new \$3.5 million investment for the Doctors Across New York (DANY) program. The Doctors Across New York (DANY) program is a state-funded initiative enacted in 2008 to help train and place physicians in underserved communities. The program provides Physician Loan Repayment and Physician Practice Support to

physicians in any specialty, if they can demonstrate that the specialty is in need in the underserved community.

The proposed budget will fund a second cohort, thus providing 100 additional slots for the program: 50 for Physician Loan Repayment and 50 for Physician Practice Support.

Several years ago, AMSNY convened the New York State Ad Hoc Physician Workforce Planning Group with a variety of other health care stakeholders to advocate for the creation of a program to address the State's maldistribution of physicians in both our inner cities and rural communities. AMSNY applauds the State's efforts and progress on the DANY initiative. The implementation of this program is a tremendous step forward to reducing the burden of an anticipated physician shortage and addressing the problems of access to care for millions of people.

AMSNY also recommends a small grant to increase participation in the DANY program. Currently, most residents and medical students throughout New York are not aware of this worthwhile program. With a small grant for administrative funding, AMSNY could work to increase participation within the DANY program by partnering with the medical schools to inform residents, residency directors and medical students about DANY activities.

Medical Malpractice Reform

AMSNY supports real and comprehensive medical malpractice reform in the proposed 2010-11 budget including early settlement programs, caps on non-economic damages, the establishment of standards of care to provide "safe harbors", and compensation pools to fund the long-term care of neurologically-impaired infants.

The costs associated with medical malpractice in New York State are among the highest in the nation, a problem that has gone without a comprehensive solution for decades. The shortage of physicians (e.g. obstetricians) in New York is worsening. The problem is felt

statewide as several counties in upstate New York have no licensed obstetricians and last year Long Island College Hospital in Brooklyn announced that it would stop delivering babies.

It costs an average of \$210,000 annually to insure an obstetrician/gynecologist (OB/GYN) in New York City. The average annual premium for a neurosurgeon is \$230,000 per year. The number of physicians who have been targeted in lawsuits is also alarmingly high. Approximately 80 percent of neurosurgeons will be sued in their first 10 years of practice. More than 90 percent of OB/GYNs have had at least one claim filed against them.

There are also significant economic benefits to all New Yorkers in enacting comprehensive medical malpractice reform. Approximately 17 percent of all resident physicians in the United States are training in New York State, and reducing the burden of high malpractice insurance premiums will ensure that more of these physicians remain in New York where they contribute substantially to our local economies.

It is also estimated that medical malpractice reform has the potential to not only reduce malpractice premiums, but also reduce health care utilization caused by “defensive medicine” practices. For example, the Federal Congressional Budget Office (CBO) stated that recent research has provided evidence that malpractice reforms do reduce the use of health care services. If malpractice reforms were adopted, the State may experience savings in its Medicaid program, as well as the Child Health Plus (CHP) program and Family Health Plus (FHP) program.

Several bills introduced in the State Legislature also focus on proposed solutions to the State’s current medical malpractice problem. One such bill, the “Sorry Works Pilot Program” introduced by Senator Valesky and Assembly Member Magee (S.6321/A.9488), would provide a mechanism through which health care providers could analyze adverse events immediately, identify errors if they existed, present a plan of action whereby future errors could be avoided and offer compensation and apologize to

the parties impacted by the adverse event while keeping both the apology and the case out of the tort system.

For these reasons, AMSNY urges the Governor and the Legislature to support the aforementioned measures in pursuit of real comprehensive medical malpractice reform.

Indirect Medical Education (IME)

Lastly, AMSNY opposes the Governor's proposal to phase-down over a three-year period hospital reimbursement for Indirect Medical Education (IME) expenses. Under the proposal, IME would be reduced by one percent per year over three years from April 1, 2010 to March 31, 2013 – decreasing the IME adjustment from 4.2 percent to 1.2 percent over three years. This action would reduce Medicaid payments to New York's teaching hospitals totaling \$79.8 million (gross) in 2010-11.

New York trains about 16,000 physician residents per year, more than twice as many as any other State. This training commitment represents approximately 17 percent of all physician resident training in the United States.

Any cut to Graduate Medical Education (GME) or Indirect Medical Education (IME) negatively impacts medical students and the teaching hospitals that train these students. It is for these reasons that AMSNY opposes any reductions to IME in the 2010-11 budget.

Closing

I would like to thank you for the opportunity to testify today and I welcome any comments or questions.

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150 State Street, Suite 301 - Albany, New York - Telephone (518) 449-2707 - Fax (518) 455-8908 - www.nyahsa.org

Public Hearing Testimony:

Health, Medicaid & Aging Budget

Submitted to:
Senate Finance Committee
and
Assembly Ways & Means Committee

Presented by:
Dennis R. Bozzi, President/CEO
New York Association of Homes and Services for the Aging

Sherrie Dampeer, President of the CNR Family Council
Beth Abraham Family of Health Services

Lee Kirby, Family Member of a Resident
Beth Abraham Family of Health Services

February 9, 2010

Albany, NY
Legislative Office Building
Hearing Room B

Chairman Farrell, Chairman Kruger and esteemed legislators, thank you for this opportunity to testify on the impact that the Executive Budget proposal will have on our states elderly and disabled population.

I am Dennis Bozzi, President/CEO of NYAHS, the only statewide organization representing the entire continuum of mission-driven not-for-profit and governmental long term care providers, including senior housing, adult care facilities, retirement communities, assisted living, home care agencies, adult day health care and nursing homes. NYAHS's nearly 600 members serve an estimated 500,000 New Yorkers of all ages annually throughout the state.

I am joined today by Ms. Sherrie Dampeer, President of the Family Council at Beth Abraham Family of Health Services in the Bronx as well as Mr. Lee Kirby, a family member of one of the residents at Beth Abraham Family of Health Services. After my opening remarks, they will share with you their personal experiences accessing the long term care system and their concerns with any additional cuts.

Of course, it will be no surprise to you that once again we are opposing cuts to Medicaid and community services and that every long term care provider across the state is struggling to meet the needs of our elderly and disabled residents.

Unfortunately this is a message that we repeat year after year. We need to get beyond this dynamic of across the board cuts to services and begin developing a vision for the provision of care to our seniors and disabled.

We are very pleased to see a number of Executive Budget proposals that will do just that, including:

- creation of a long term care financing demonstration program to encourage private pay
- expansion of the nursing home rightsizing demonstration – creating an additional 2500 assisted living, adult day health care or long term home health care program slots
- commitment to encourage the coordination of services for people with complex needs, particularly those served by federal waiver programs and specialized case management services
- establishment of the county nursing home demonstration, which will allow counties to develop plans to expand home and community services to meet the specific needs of their community.

All of these proposals help to plan for the future reality of long term care needs and we therefore support them, though we do have some suggestions for improvement to each of these proposals and will work with you throughout the budget process to perfect them.

While welcoming these reform proposals, we are deeply troubled by the additional cuts to long term services. All told long term care providers stand to lose about \$400 million in funding under the Executive Budget. Our members are facing increased costs in labor,

insurance, transportation and energy while at the same time they have been cut 5 times in 2 years, totaling \$1.2 billion. The numbers just don't add up and it means that programs and services for our elderly and disabled continue to be significantly reduced or eliminated all together.

The following outlines all the budget provisions that will impact senior care services and discusses our position on each. But now, I would like you to hear from Ms. Dampeer and Mr. Kirby, who can tell you the real impact that budget cuts have had from a personal perspective.

Proposals Affecting Multiple Long Term Care Services

1. **Eliminate remaining 2010 trend factors:** Eliminate the 2010 Medicaid trend factor of 1.7 percent entirely, for purposes of calculating rates from 4/1 – 12/31/10 and subsequent years. Nursing homes, home care providers, adult day health care programs and assisted living programs would be affected.

NYAHSA opposes this proposal. When trend factors are eliminated entirely, they create large and ongoing impacts for multiple years thereafter. More importantly, eliminating trend factor adjustments ignores the economic reality that employee wage and benefit costs and other expenses such as utilities, transportation and insurance increase each year and are largely outside of a provider's control. The DRP legislation enacted in November 2009 eliminated the 2010 trend factor for the period 1/1/10 – 3/31/10.

2. **Increase unreimbursed assessment taxes:** Cash receipts assessments levied on nursing homes, adult day health care programs and home care agencies/programs would permanently increase. In the case of nursing homes and adult day health care programs, the tax rate would go from 6 percent to 7 percent, and from 0.35 percent to 0.7 percent for home care. These added assessments would not be reimbursable by Medicaid.

NYAHSA opposes these proposals. These added taxes will simply raise the cost of care. They are tantamount to cuts because they would not be recovered on revenues from Medicaid or managed care/commercial insurance plans. If the Legislature accepts this proposal, at a minimum, collections from such added taxes should be capped and the tax increases should sunset after one year. In addition, an amnesty provision should be made available for providers experiencing financial hardship.

3. **Expand transitional care units:** The transitional care unit (TCU) demonstration would be extended by 5 years, and expanded from 5 to 10 sites. TCUs are units within acute care hospitals that provide skilled nursing subacute care to Medicare Part A beneficiaries.

NYAHSA opposes this proposal. There is evidence that TCUs duplicate subacute care services that nursing homes and home care agencies already offer. Both types of providers are already required by the state to meet certain targets for Medicare utilization, and this proposal works against that. Moreover, this works against the state's policy of reducing the number of nursing home beds in general. If in spite of

our opposition, the Legislature accepts this proposal, the language should at least be modified to require: (1) applicants to demonstrate a lack of local access to these services through nursing homes and home care agencies; (2) reporting by the sponsoring hospital of efforts to place these patients in area nursing homes and home care agencies; and (3) survey and regulatory requirements comparable to those of nursing homes.

4. **LTC financing demonstration program:** The Department of Health (DOH) would be authorized to implement a long term care (LTC) financing demonstration program, subject to federal approval, for up to 5,000 individuals using alternative approaches to establish Medicaid eligibility. Modeled after the Partnership for LTC, the program would encourage individuals to spend a certain amount of their resources on services, in exchange for having other resources disregarded as part of the Medicaid eligibility determination process.

NYAHSA conditionally supports this proposal. We support this concept, which is intended to encourage consumers to spend more of their own resources on long term care services, and to lessen reliance on Medicaid. Among other things, however, it is less than clear: (1) whether there would be caps on provider charges for services during the period participants are spending down their own resources; (2) how collection responsibilities and violations of agreements would be handled; and (3) the amount and scope of services participants would receive under Medicaid.

5. **Federal-state Medicare savings partnership:** DOH would seek federal approval of a demonstration program designed to achieve savings and efficiencies in serving individuals who are eligible for both Medicaid and Medicare. The state would seek a share of the savings in Medicare expenditures for hospital, long term care and other medical care for dual eligibles resulting from care management initiatives. The savings could be reinvested in the health care system and shared with providers.

NYAHSA conditionally supports this proposal. While short on details, NYAHSA supports this concept and has made similar proposals in the past. The additional federal dollars that would be made available if certain conditions are met by the state could be used to provide grants and other financial assistance to LTC providers seeking to rightsize/reconfigure their facilities, diversify their services, and deploy promising technologies. It is unclear how the savings would be measured, how any funds from the federal government would be shared with the provider community, and the role that long term care providers would play in the initiative.

Proposals Affecting Nursing Home Care

1. **Reduce payment for bed hold days:** Payments would be reduced to 95 percent of the nursing home rate, and limited to 14 days annually for hospitalizations and 10 days annually for therapeutic leaves. Pediatric facilities would be excluded. This proposal supercedes the proposed regulations from last year's budget that would cut payments to 75 percent of the rate and reduce the maximum facility vacancy rate from 5 percent to 3 percent.

NYAHSA opposes this proposal. With more facilities providing intensive post-acute and other care, and with regulatory expectations to hold beds for residents who are

hospitalized, these payments are essential. Furthermore, it is more difficult to provide short-term care and still operate at a higher occupancy due to patient turnover. The proposed annual caps on days are particularly problematic. Having said that, this proposal may be less damaging to residents and providers than last year's proposed regulations.

2. **Limit rate appeals and authorize settlements:** Cap the amount of rate appeals that can be certified in SFY 2010-11 and 2011-12 at \$80 million per year, and authorize DOH to prioritize appeals processing and negotiate settlements with facilities facing financial problems.

NYAHSA opposes this proposal. While we acknowledge this would be less damaging than an outright rate cut, it will create added hardships for facilities that have been waiting long periods of time for their appeals to be processed. Providers are charged interest on overpayments identified by OMIG and DOH, yet they are not paid interest on rate appeal funds. If this proposal is seriously considered, it should be limited to one year and provide some greater equity to providers on the interest issue. Specifically, the state should net the value of pending rate appeals against any recovery amounts when assessing interest, and pay interest on funds inappropriately withheld by OMIG. We are in favor of the concept of allowing negotiated settlements of appeals.

3. **Delay regional pricing:** The budget would extend nursing home rebasing through February 28, 2011 and implement regional pricing model on a budget-neutral basis on March 1, 2011. A quality incentive funding pool of up to \$50 million would be implemented on April 1, 2010 out of the existing \$210 million of rebasing funding.

NYAHSA conditionally supports this proposal. We are recommending a two-year delay in regional pricing to give facilities a reasonable period of rate stability/predictability. The rebasing rates from 2008 were just issued, and will not actually be paid out for several weeks. Facilities are unable to budget their revenues. Added time is also needed to work through several methodology issues to ensure any new system promotes stability, assures patient access, advances quality and reflects the realities of care delivery. We are in favor of proceeding with a quality incentive beginning April 1, 2010, but have concerns about the integrity of the proposed metrics. Faulty measures will lead to some number of top performers being denied incentives and vice versa. The amount of the pool should be more modest initially, given that this is very inexact science and that the source funding would come out of all facilities' rates.

4. **Remove drug costs from rates:** Remaining prescription drug costs would be carved out of nursing home rates and reimbursed on a fee-for-service basis, allowing the state to collect rebates on these drug costs.

NYAHSA conditionally supports this proposal. Provided this would not create unfunded mandates for facilities or eliminate overhead and other expenses of providing pharmaceutical services from facilities' rates, we support it.

5. **Expand rightsizing demonstration:** The Voluntary Nursing Home Rightsizing program, which allows nursing homes to temporarily decertify or permanently

convert beds to other long term care options, would be expanded by an additional 2,500 beds statewide.

NYAHSA supports this proposal. This program gives providers an opportunity to voluntarily convert beds to alternative services such as assisted living, adult day health care and the long term home health care program. However, for those providers not interested/able to initiate or expand these alternative services, the state should offer a Medicaid rate incentive or bed "buyback" program to encourage more nursing home rightsizing.

6. **County nursing home demonstration:** This program would operate in up to 5 counties, and is intended to encourage transformation of county nursing home beds into other long term care options. A county that downsizes or closes its nursing home could use the savings to: (1) expand community-based services; (2) expand senior housing; (3) increase assisted living capacity; and (4) contract with and pay subsidies to other facilities to accept hard-to-serve residents. The county's local share cap could be adjusted to reflect savings from the demonstration.

NYAHSA supports this proposal. It would provide counties with a flexible alternative to discontinuing the provision of long term care services entirely, and presumably to ensure that the safety net function of accepting hard-to-serve individuals is preserved. In fact, NYAHSA believes that the nursing home reimbursement methodology should make rate incentives available to all facilities to serve hard-to-serve individuals.

Proposals Affecting Home Care

1. **Limit on personal care services:** Personal care and consumer directed personal care services to recipients aged 21+ would be capped at an average of 12 hours per day. Recipients needing service hours over the cap would be exempted if they receive services from a CHHA or are enrolled in the LTHHCP, an AIDS home care program, a managed long term care (MLTC) plan or the Nursing Home Transition and Diversion (NHTD) waiver. Under the proposal, the state would redirect affected recipients to these case-managed programs.

NYAHSA is concerned about this proposal. While this proposal seems somewhat less onerous than past efforts aimed at reining in utilization of personal care, it does raise some concerns. Would there be enough capacity in the case-managed programs (i.e., LTHHCP) to accept these referrals, as well as mechanisms to expedite enrollment to MLTC (as separately proposed legislation would do), LTHHCP and NHTD? Is 12 hours the right threshold? The proposal could have the unintended consequence of leading to disenrollment from these case-managed programs by the many recipients who receive less than 12 hours of personal care a day under the programs.

2. **Implement Episodic Payment System:** An Episodic Payment System would be implemented for CHHA services effective January 1, 2012. An EPS was first proposed in the 2009-10 Executive Budget, but was delayed by the Legislature pending the results of a DOH workgroup report.

NYAHSA opposes this proposal. While budget-neutral to the state, major concerns remain that the new system could result in dramatic redistributions of funding between and within regions, significantly reduce payments for more costly complex cases (i.e., "outliers"), and lead to more agency closures and service cutbacks. With all of the unknowns, it would be premature to authorize such a system in law. Since the proposed implementation is not until 2012, the workgroup process should be allowed to conclude before any such system is codified in law.

3. **Change in frequency of assessment:** Existing law would be amended to change the frequency of comprehensive assessments for LTHHCP, AIDS home care program or CHHA recipients from every 120 days to every 180 days.

NYAHSA supports this proposal. We have long been advocating for this change, which would reduce providers' nursing and administrative costs and enhance efficiency. Cost savings would also inure to the benefit of the Medicaid program.

4. **Coordination of services:** DOH would establish procedures to allow LTHHCPs, other waiver programs and other providers that furnish case management to provide joint case management services when the services of more than one such program are needed to meet a recipient's needs. The providers would need to maintain distinct yet coordinated service and case management responsibilities and not duplicate benefits.

NYAHSA supports this proposal. We have advocated for this change, which would streamline case management, reduce service duplication and ultimately save costs.

5. **Reporting penalties:** Civil money penalties of up to \$5,000 could be imposed on any home care provider which fails to submit required statistical, cost reporting, and contracting data to the DOH. This penalty extends to CHHAs which fail to provide the necessary statistical/cost reporting data to any subcontracting LHCSA.

NYAHSA is concerned about this proposal. We do not object to imposing reasonable penalties on providers that willingly fail to comply with reporting procedures prescribed in law or regulation. However, providers that fail to timely file due to certification issues with accounting firms or problems obtaining timely data from other parties should not be penalized as if they were willful violators.

Proposal Affecting Managed Long Term Care (MLTC)

1. **Eliminate Insurance Department role:** Statutory authority for certification of plans and Medicaid rate setting and for MLTC services would be transferred from the Insurance Department to DOH. The Insurance Department's role in determining and approving premiums for non-Medicaid enrollees would be maintained, and DOH's responsibility to regulate fiscal solvency, reserves and provider contracts would be clarified.

NYAHSA supports this proposal. Eliminating the dual and overlapping responsibilities for DOH and the Insurance Department's to determine and approving Medicaid premiums for MLTC would lead to administrative streamlining and improve timeliness of rate promulgation. It is also consistent with DOH's move to replace the previous negotiated rate structure with a risk-adjusted capitated

payment system. Current requirements that MLTC-certificates of authority also be approved by the Insurance Department add bureaucracy, -cause confusion and do not provide any additional safeguards. Further administrative streamlining would encourage MLTC to expand.

Proposals Affecting Other Community-Based Services

1. **Congregate Services Initiative (CSI):** The 2009-10 NYSOFA budget provided \$806,000 for CSI, which provides older persons in senior-centers and other settings with information and assistance, referral, transportation, nutrition, socialization, education, counseling, caregiver support, volunteer opportunities and health promotion and wellness activities. The program would be eliminated.
2. **Supplemental Nutrition Assistance Program (SNAP):** SNAP funding is used to provide home delivered meals, some congregate meal funding and other nutrition related services to eligible frail elderly, including in senior housing settings. SNA finding would be cut by \$2 million to \$21.3 million.
3. **Community Services for the Elderly (CSE):** NYSOFA services funded through CSE include case management, personal care, caregiver services, congregate and home delivered meals, information and assistance, referrals, social adult day care, transportation, respite, wellness activities, senior centers and other congregate programs. CSE funding would be cut by \$1 million to \$15.3 million.
4. **Expanded In-home Services for the Elderly Program (EISEP):** EISEP is a community based long term care program that provides case management, non-medical in-home, non-institutional respite, and ancillary services needed by New Yorkers aged 60 and over. EISEP program funding would be cut by \$2 million to \$46 million.

NYAHSa opposes these proposals. We support continuing and funding these cost-effective programs at the 2009-10 levels. The state's efforts to rebalance its long term care system and lessen dependence on Medicaid will not work unless programs such as CSI, SNAP, CSE and EISEP are promoted and adequately funded. These services and supports are vitally important to efforts to delay or prevent reliance on much more costly Medicaid-funded health care and long term care services.

Proposals Affecting Adult Care Facility/Assisted Living Program Services

1. **Changes to QUIP and EnAble:** The budget would repeal the Quality Incentive Payment Program (QUIP) and restructure funding for the EnAble program as part of a new quality improvement program for adult homes. DOH would develop a methodology to allocate funds that would take into account the financial status of a facility as well as resident needs. This program would be funded at \$6.9 million, whereas last year QUIP was funded at \$4.66 million and EnAble at \$5.5 million (which included dollars for air conditioners and generators).

NYAHSA opposes this proposal. We cannot support an overall-cut of \$3.2 million to this vitally important funding. With SSI payments well below the cost of care, these programs provide added resources to help facilities deliver quality services. With regard to the proposed restructuring of the program, we believe that greater flexibility and attention to the financial status of the facility could be helpful, but are concerned that facilities serving primarily seniors (as opposed to mentally ill residents) could lose funding under this new process.

2. **Study on ALP rates:** DOH would conduct a study, using resident data collected from a uniform assessment tool, to evaluate and adjust Medicaid rates of payment for Assisted Living Programs. DOH would report results to the Legislature by July 31, 2011.

NYAHSA conditionally supports this proposal. We have advocated for a study on the appropriateness of the assessment tool and the resulting adequacy of ALP rates. Our members report that the Patient Review Instrument – the currently used assessment – does not capture the resources needed to care for various types of residents, and that ALP rates are generally inadequate. However, we do not know whether the uniform assessment tool would validly describe the functional and clinical needs of ALP residents or be able to form the basis for a revised reimbursement system.

Proposals on Fraud and Abuse/Medicaid Eligibility

1. **Increase recovery target:** The budget increases the Medicaid fraud recovery target by an additional \$300 million. It is expected that the state share of recoveries will reach a record level of \$1.17 billion.

NYAHSA is concerned about this proposal. As the “fraud and abuse” recovery targets increase, well-intentioned providers are increasingly penalized and are losing entire payments for services they provided due to clerical errors and oversights. This is occurring at far greater dollar levels than the small number of providers that are actually defrauding or abusing Medicaid. This deprives providers of needed funding for medically necessary services that have already been provided, and perpetuates the myth that Medicaid fraud and abuse is rampant. NYAHSA is working with several other groups on legislation to promote due process, clarity and transparency, compliance, and audit recoveries that are proportionate to the cited infractions. We are also advocating for the Office of the Medicaid Inspector General (OMIG) to assume responsibility for Medicaid estate recoveries, which could bring tens of millions of dollars to the state.

2. **Expand estate recoveries:** The definition of “estate” for the purpose of Medicaid recoveries would be expanded to enable recoveries from assets that individuals could otherwise shelter from recovery by bypassing probate. This would save the state \$1.1 million in 2010-11 and \$2.6 the following year.

NYAHSA supports this proposal. We have proposed this change in the past, and believe that the savings could be significantly greater than has been estimated, particularly if the state takes over estate recovery activities either through the OMIG or a private contractor.

3. **Require irrevocable funeral accounts:** The budget would require pre-need funeral accounts established for consideration in a Medicaid eligibility determination, including those for a spouse or family members, to be irrevocable. State savings is estimated at \$1 million in each of the next two years.

NYAHS supports this proposal. Revocable trusts can be used to shield assets and divert them to uses other than funeral expenses. This proposal would close a loophole and create Medicaid savings.



150 State Street, Suite 301 · Albany, New York · Telephone (518) 449-2707 · Fax (518) 455-8908 · www.nyahsa.org

Public Hearing Testimony:

Health, Medicaid & Aging Budget

Submitted to:
Senate Finance Committee
and
Assembly Ways & Means Committee

Presented by:
Dennis R. Bozzi, President/CEO
New York Association of Homes and Services for the Aging

Sherrie Dampeer, President of the CNR Family Council
Beth Abraham Family of Health Services

Lee Kirby, Family Member of a Resident
Beth Abraham Family of Health Services

February 9, 2010

Albany, NY
Legislative Office Building
Hearing Room B

insurance, transportation and energy while at the same time they have been cut 5 times in 2 years, totaling \$1.2 billion. The numbers just don't add up and it means that programs and services for our elderly and disabled continue to be significantly reduced or eliminated all together.

The following outlines all the budget provisions that will impact senior care services and discusses our position on each. But now, I would like you to hear from Ms. Dampeer and Mr. Kirby, who can tell you the real impact that budget cuts have had from a personal perspective.

Proposals Affecting Multiple Long Term Care Services

1. **Eliminate remaining 2010 trend factors:** Eliminate the 2010 Medicaid trend factor of 1.7 percent entirely, for purposes of calculating rates from 4/1 – 12/31/10 and subsequent years. Nursing homes, home care providers, adult day health care programs and assisted living programs would be affected.

NYAHSA opposes this proposal. When trend factors are eliminated entirely, they create large and ongoing impacts for multiple years thereafter. More importantly, eliminating trend factor adjustments ignores the economic reality that employee wage and benefit costs and other expenses such as utilities, transportation and insurance increase each year and are largely outside of a provider's control. The DRP legislation enacted in November 2009 eliminated the 2010 trend factor for the period 1/1/10 – 3/31/10.

2. **Increase unreimbursed assessment taxes:** Cash receipts assessments levied on nursing homes, adult day health care programs and home care agencies/programs would permanently increase. In the case of nursing homes and adult day health care programs, the tax rate would go from 6 percent to 7 percent, and from 0.35 percent to 0.7 percent for home care. These added assessments would not be reimbursable by Medicaid.

NYAHSA opposes these proposals. These added taxes will simply raise the cost of care. They are tantamount to cuts because they would not be recovered on revenues from Medicaid or managed care/commercial insurance plans. If the Legislature accepts this proposal, at a minimum, collections from such added taxes should be capped and the tax increases should sunset after one year. In addition, an amnesty provision should be made available for providers experiencing financial hardship.

3. **Expand transitional care units:** The transitional care unit (TCU) demonstration would be extended by 5 years, and expanded from 5 to 10 sites. TCUs are units within acute care hospitals that provide skilled nursing subacute care to Medicare Part A beneficiaries.

NYAHSA opposes this proposal. There is evidence that TCUs duplicate subacute care services that nursing homes and home care agencies already offer. Both types of providers are already required by the state to meet certain targets for Medicare utilization, and this proposal works against that. Moreover, this works against the state's policy of reducing the number of nursing home beds in general. If in spite of

hospitalized, these payments are essential. Furthermore, it is more difficult to provide short-term care and still operate at a higher occupancy due to patient turnover. The proposed annual caps on days are particularly problematic. Having said that, this proposal may be less damaging to residents and providers than last year's proposed regulations.

2. **Limit rate appeals and authorize settlements:** Cap the amount of rate appeals that can be certified in SFY 2010-11 and 2011-12 at \$80 million per year, and authorize DOH to prioritize appeals processing and negotiate settlements with facilities facing financial problems.

NYAHSA opposes this proposal. While we acknowledge this would be less damaging than an outright rate cut, it will create added hardships for facilities that have been waiting long periods of time for their appeals to be processed. Providers are charged interest on overpayments identified by OMIG and DOH, yet they are not paid interest on rate appeal funds. If this proposal is seriously considered, it should be limited to one year and provide some greater equity to providers on the interest issue. Specifically, the state should net the value of pending rate appeals against any recovery amounts when assessing interest, and pay interest on funds inappropriately withheld by OMIG. We are in favor of the concept of allowing negotiated settlements of appeals.

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NYAHSA conditionally supports this proposal. We are recommending a two-year delay in regional pricing to give facilities a reasonable period of rate stability/predictability. The rebasing rates from 2008 were just issued, and will not actually be paid out for several weeks. Facilities are unable to budget their revenues. Added time is also needed to work through several methodology issues to ensure any new system promotes stability, assures patient access, advances quality and reflects the realities of care delivery. We are in favor of proceeding with a quality incentive beginning April 1, 2010, but have concerns about the integrity of the proposed metrics. Faulty measures will lead to some number of top performers being denied incentives and vice versa. The amount of the pool should be more modest initially, given that this is very inexact science and that the source funding would come out of all facilities' rates.

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NYAHSA conditionally supports this proposal. Provided this would not create unfunded mandates for facilities or eliminate overhead and other expenses of providing pharmaceutical services from facilities' rates, we support it.

5. **Expand rightsizing demonstration:** The Voluntary Nursing Home Rightsizing program, which allows nursing homes to temporarily decertify or permanently

***NYAHSA opposes this proposal.** While budget-neutral to the state, major concerns remain that the new system could result in dramatic redistributions of funding between and within regions, significantly reduce payments for more costly complex cases (i.e., “outliers”), and lead to more agency closures and service cutbacks. With all of the unknowns, it would be premature to authorize such a system in law. Since the proposed implementation is not until 2012, the workgroup process should be allowed to conclude before any such system is codified in law.*

3. **Change in frequency of assessment:** Existing law would be amended to change the frequency of comprehensive assessments for LTHHCP, AIDS home care program or CHHA recipients from every 120 days to every 180 days.

***NYAHSA supports this proposal.** We have long been advocating for this change, which would reduce providers’ nursing and administrative costs and enhance efficiency. Cost savings would also inure to the benefit of the Medicaid program.*

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***NYAHSA supports this proposal.** We have advocated for this change, which would streamline case management, reduce service duplication and ultimately save costs.*

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***NYAHSA is concerned about this proposal.** We do not object to imposing reasonable penalties on providers that willingly fail to comply with reporting procedures prescribed in law or regulation. However, providers that fail to timely file due to certification issues with accounting firms or problems obtaining timely data from other parties should not be penalized as if they were willful violators.*

Proposal Affecting Managed Long Term Care (MLTC)

1. **Eliminate Insurance Department role:** Statutory authority for certification of plans and Medicaid rate setting and for MLTC services would be transferred from the Insurance Department to DOH. The Insurance Department’s role in determining and approving premiums for non-Medicaid enrollees would be maintained, and DOH’s responsibility to regulate fiscal solvency, reserves and provider contracts would be clarified.

***NYAHSA supports this proposal.** Eliminating the dual and overlapping responsibilities for DOH and the Insurance Department’s to determine and approving Medicaid premiums for MLTC would lead to administrative streamlining and improve timeliness of rate promulgation. It is also consistent with DOH’s move to replace the previous negotiated rate structure with a risk-adjusted capitated*

NYAHSA opposes this proposal. We cannot support an overall cut of \$3.2 million to this vitally important funding. With SSI payments well below the cost of care, these programs provide added resources to help facilities deliver quality services. With regard to the proposed restructuring of the program, we believe that greater flexibility and attention to the financial status of the facility could be helpful, but are concerned that facilities serving primarily seniors (as opposed to mentally ill residents) could lose funding under this new process.

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NYAHSA supports this proposal. We have proposed this change in the past, and believe that the savings could be significantly greater than has been estimated, particularly if the state takes over estate recovery activities either through the OMIG or a private contractor.

4A

CONTINUING CARE LEADERSHIP COALITION



**TESTIMONY OF
SCOTT C. AMRHEIN
PRESIDENT
CONTINUING CARE LEADERSHIP COALITION**

**AT A JOINT HEARING OF
THE NEW YORK STATE SENATE COMMITTEE ON FINANCE
AND
THE NEW YORK STATE ASSEMBLY
COMMITTEE ON WAYS AND MEANS
ON
THE EXECUTIVE HEALTH CARE BUDGET
FOR SFY 2010-11**

**FEBRUARY 9, 2010
10:00 A.M.
LEGISLATIVE OFFICE BUILDING
ALBANY, NEW YORK**

Introduction

Good afternoon, Chairman Farrell, Chairman Kruger, Chairman Gottfried, and Chairman Duane. My name is Scott Amrhein, and I am president of the Continuing Care Leadership Coalition (CCLC). CCLC is an affiliate of the Greater New York Hospital Association representing more than 100 not-for-profit and public long term care providers in the New York metropolitan area and beyond.

Building on almost two decades of work at GNYHA in the realm of long term care policy and advocacy, CCLC was formed in October 2003 to create a forum where the collective knowledge, experience, and vision of our members could be brought to bear in shaping positive changes in the delivery and design of long term care for the people of New York.

I am here today to speak on behalf of the many dedicated health care provider organizations that are members of CCLC. But I am also very much here to speak on behalf of the more than 100,000 nursing home residents, the nearly 200,000 home health care clients, the close to 300,000 employees, and the thousands of family members who have a deep personal stake in the budgetary decisions that this body will make in the coming weeks. Virtually every family in this State has one or more family members for whom there is no more important issue than ensuring the availability of high quality long term care services. For them, protecting health care is not a special interest. It is an absolutely critical *public* interest.

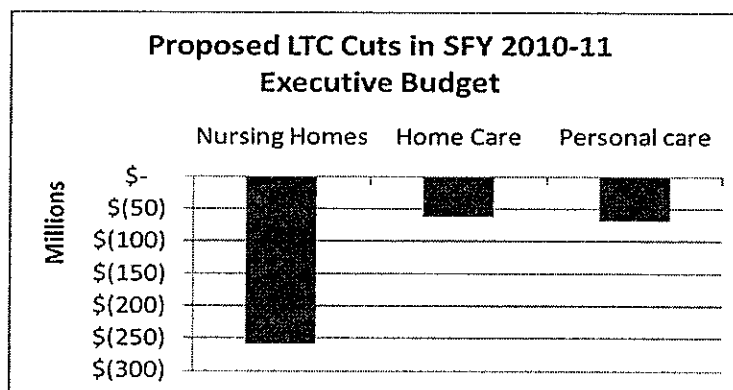
Before I go into the major points of my testimony, I want to take just a moment to say thank you to each of you at the dais today, and to your colleagues in the Legislature who cannot be here, for having demonstrated tremendous leadership during the Deficit Reduction Plan (DRP) deliberations during the months of October and November, 2009. The people of this State were facing some of the most severe proposals ever put forward to cut healthcare in New York, and you heard their concerns. Standing up to the proposed cuts was not easy. It was not always the popular position. It took courage, but at the end of the day it meant that services that would have been threatened or

eliminated by the proposed cuts would still be there for thousands of extremely vulnerable older and disabled New Yorkers, and essential supports would still be there for their families.

Unfortunately, when the Governor released his budget on January 19th, it contained proposed cuts to nursing homes and home health providers that are even more severe than those proposed in last year's Deficit Reduction Plan. The nursing home cuts in the Governor's budget will effectively cut payments to nursing homes by \$258 million. This exceeds the size of the proposed cuts in the DRP by \$20 million, and it will translate into a Medicaid operating revenue cut of 4%. Likewise, the home and personal care services cuts in the Governor's budget will cut payments to vital community based providers by more than \$182 million. This is fully 40% greater than the size of the cut to home and personal care services proposed in the DRP.

In this testimony, I will review the proposed long term care cuts of greatest concern to CCLC; I will talk about context of the proposed cuts (including the financial fragility of New York's long term care providers in the wake of years of cuts); I will talk about the real human and economic consequences of the proposed cuts; I will present CCLC's recommendations for protecting consumers and providers from the consequences of the cuts; and I will suggest several alternative actions that we should be taking now to begin achieving real long term care system reforms that, over the long term, will improve quality and continuity of care while controlling long term care costs in our State.

Overview of Proposed Cuts and Related Actions



Nursing Home Cuts. The Governor's proposed budget would implement the following nursing home cuts:

- **Elimination of the 2010 Trend Factor.** The Governor's budget would eliminate the remaining share of the calendar year 2010 trend factor for nursing homes. It would make 2010 the third consecutive year in which nursing homes received no trend factor, despite the fact that medical cost are estimated to have increased by 7.9% over the same three year period. This proposal would translate into provider cuts in SFY 2010-11 of *\$111 million*.
- **Imposition of an Additional 1% (Non-Reimbursable) Assessment on Nursing Homes.** The Governor's budget would increase the current assessment on nursing home cash receipts by one percent - from six percent to seven percent. This additional 1% assessment would not be reimbursable by Medicaid. This would translate into provider losses in SFY 2010-11 of *\$87 million*.
- **Limitation on Rate Appeals.** The Governor's budget would establish a statutory cap on the processing of nursing home rate appeals for two years and DOH would be authorized to negotiate settlements where appropriate. This provision, which would arbitrarily limit rate appeal payments, would translate into provider losses in SFY 2010-11 of *\$40 million*.
- **Reduction in Reimbursement for Bed Hold Days.** The Governor's budget would reduce nursing home bed hold payment levels to 95 percent of operating rates and would limit the number of days eligible for bed hold payments to 14 days annually for hospitalizations and ten days annually for therapeutic leaves. This would translate into provider losses in SFY 2010-11 of *\$19 million*.

Nursing Homes - Related Actions: The Governor's proposed budget would implement the following additional actions related to nursing home payment:

- **Removal of Drug Costs from Nursing Home Rates.** The Governor's budget would exclude all prescription drug costs from nursing home rates and would reimburse these costs on a fee-for-service basis, allowing the State to collect rebates on drug costs estimated to total \$2.4 million in 2010-11.
- **Establishment of New Target Date for Nursing Home Regional Pricing Implementation.** The Governor's budget would extend nursing home rebasing through February 28, 2011, and would establish a new implementation date for a regional pricing payment model for nursing homes of March 1, 2011. CCLC has serious concerns about the implications of moving to a regional pricing model, which are described in greater detail later in this testimony. This recommendation has no savings or costs to the State, but the implementation of regional pricing would have extreme impacts on many nursing homes across New York States, with the most severe impacts being felt by those facilities that have invested the most in quality staffing and quality outcomes.
- **Establishment of a New Nursing Home Quality Incentive Pool.** The Governor's budget would implement a quality incentive funding pool on April 1, 2010. The resources for the proposed \$50 million pool would come out budgeted Statewide Medicaid base payments, and as a consequence the proposal would entail no new costs for the State of New York in SFY 2010-11.

Home Care and Personal Care Services Cuts. The Governor's proposed budget would implement the following home care and personal care services cuts:

- **Elimination of the 2010 Trend Factor.** The Governor's budget would eliminate the remaining share of the calendar year 2010 home and personal care trend factor. This would translate into provider cuts in SFY 2010-11 of *\$63 million*.
- **Increasing the Home and Personal Care Services Assessment to 0.7 Percent.** The Governor's budget would increase the assessment on total home and personal care provider revenues from 0.35 percent to 0.7 percent. This would translate into provider losses in SFY 2010-11 of *\$19 million*.

- **Reduction in the Frequency of Long Term Home Health Care Program Reassessments.** The Governor's budget would modify current law to extend the time period for long term home health care program reassessments from 120 days to 180 days. This is expected to result in State savings of *\$1 million* in SFT 2010-11 and *\$3 million* when fully phased in.
- **Limiting and Redirecting the Utilization of Personal Care Services.** The Governor's budget would cap fee-for-service payments for personal care services at 12 hours per day. Recipients requiring services in excess of this cap would be redirected to alternative community-based service settings. This would translate into provider losses of *\$73 million* in SFT 2010, and *\$97 million* when fully phased in.

Home Care and Personal Care Services - Related Action: The Governor's proposed budget would implement the following additional actions related to home care payment:

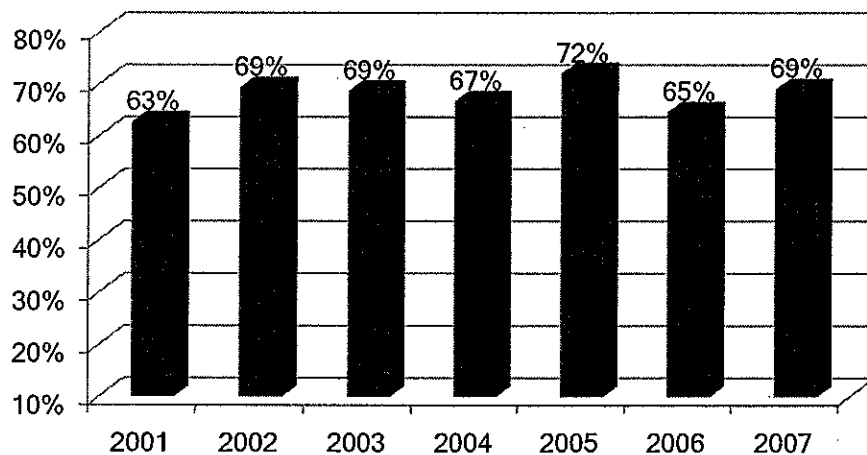
- **Implementation of a Prospective Payment System for Certified Home Health Agencies.** The Governor's budget would implement of a prospective payment system for certified home health agencies (CHHAs), beginning on January 1, 2012. The implementation of this new system would be required to be budget neutral relative to the level of payments that would otherwise be made to CHHAs under Medicaid.

The Cuts in Context

Financial Fragility of New York's Nursing Homes and Home Health Care Providers. New York's nursing homes and home health agencies are among the most vulnerable to Medicaid cuts in the nation. Nursing homes in the New York Metropolitan region rely upon the Medicaid program for payment of 83% of all days of care. Home care agencies in New York are likewise highly dependent on the Medicaid program to pay for the care that they provide to highly vulnerable patients in the community. Consequently, as Medicaid payments have been cut in recent years, the long term care community has been especially hard hit.

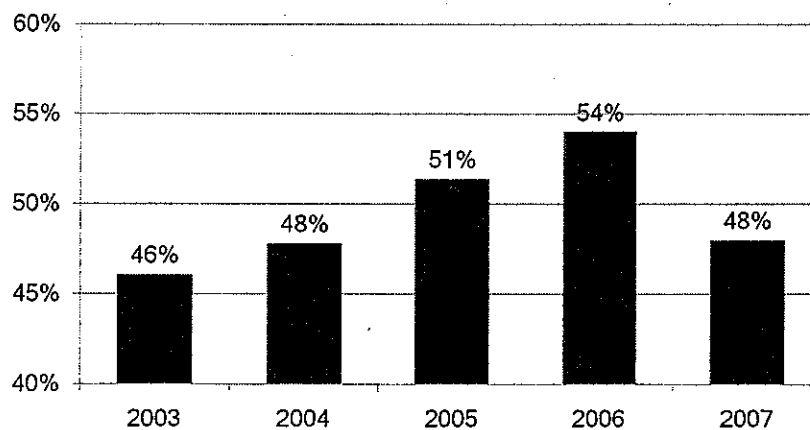
As the tables below indicate, nearly two thirds of all not-for-profit nursing homes currently lose money on operations. Likewise, fully 48% of all home health agencies, and 77% of all Long Term Home Health Care Programs, lose money on their operations. If the financial health of New York's long term care providers worsens further, it will be impossible to sustain the services, innovations, and quality standards that are so important to families in need of long term care in our State.

Percentage of Not-for-Profit Nursing Homes in New York State that Lose Money on Operations



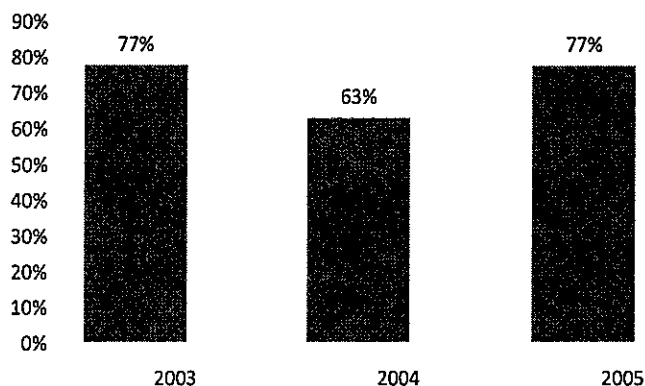
DATA SOURCE: 2001 to 2007 Residential Health Care Facility (RHCF - 4) Cost Reports

Percentage of Certified Home Health Agencies in New York State that Lose Money on Operations



DATA SOURCE: 2003 to 2007 CHHA Cost Reports

Percentage of Long Term Home Health Care Programs (LTHHCPs) in NYS that Lose Money on Operations

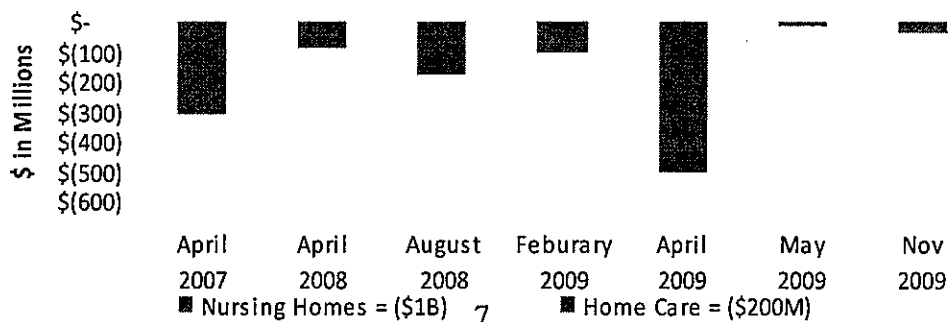


DATA SOURCE: 2003 to 2005 LTHHCP Cost Reports

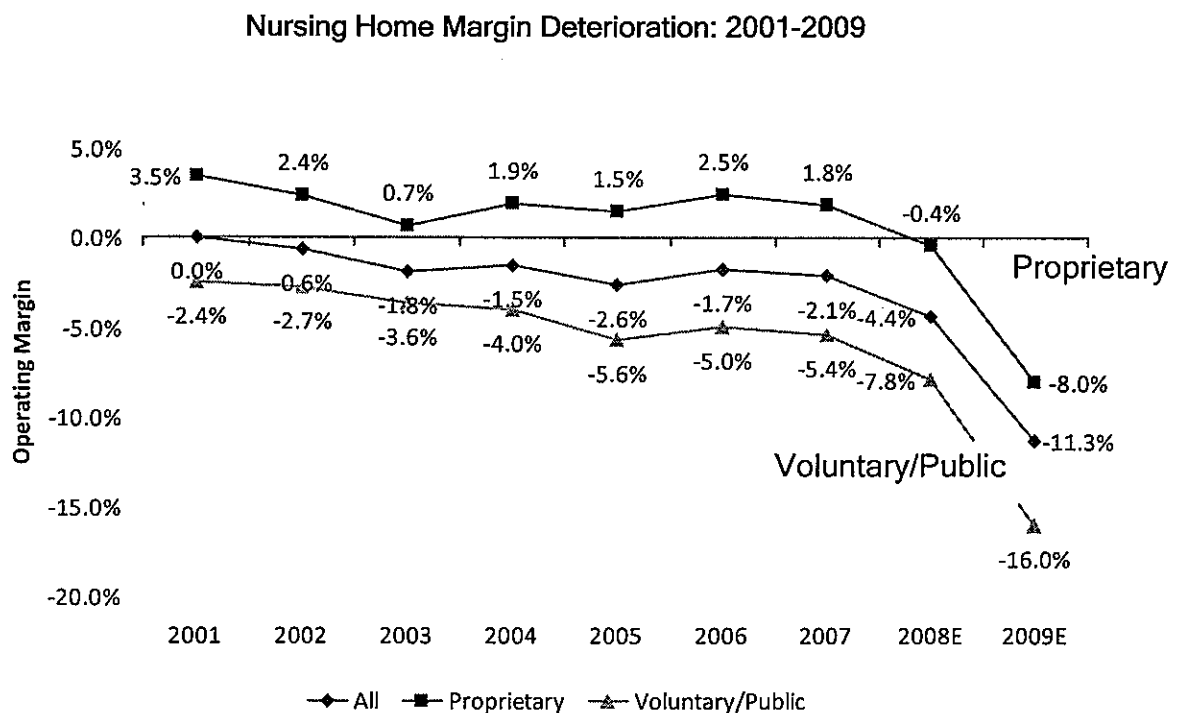
Seven Rounds of Medicaid Cuts Since April 2007 Have Placed Acute Pressure on New York's Long Term Care Providers. The financial condition of New York's long term care providers has been further strained by the enactment of seven separate rounds of cuts since April 2007. As shown in the table below, long term care providers were subjected to a \$315 million cut in the State budget adopted on April 1, 2007, followed by six additional cuts, including \$592 million in cuts imposed in the adopted budgets for State fiscal years 2008-09 and 2009-10, \$319 million in cuts enacted in special budget sessions, and \$14 million in cuts related to the application of the MTA tax to health care organizations. All together, these cuts totaled more than \$1.2 billion and resulted in additional Medicaid losses of more than 10% for nursing homes and 3% for home health providers.

Long Term Care Provider Revenues Have Been Cut 7 Times in the Last 3 years, Causing a Net Recurring Loss for Nursing Homes and Home Care of \$1.2 billion a Year.

Annual Value of Recurring Cuts Based on Date of Enactment



Historic Financial Weakness, Combined with Recent Cuts, Is Driving Long Term Care Margins Down to Unsustainable Levels. As the table below dramatically illustrates, the impact of having been subjected to such extensive cuts over the last three years is driving long term care operating margins deep into negative territory. Between 2001 and 2007, average nursing home operating margins in New York State typically fell somewhere between break-even and negative 2.5%. Beginning in 2008, average nursing home margins began to fall precipitously, dropping to negative 4.4% in 2008, and, based on projections, to a negative 11.3% in 2009. When margins reach these levels - in a field in which labor makes up close to 75% of all operating costs - there can be no doubt that any further cuts will mean significant workforce cutbacks, the elimination of vital programs, unavoidable declines in quality of care, and, increasingly, the loss of entire facilities and agencies.



Data Source: CCLC analysis of data from the Residential Health Care Facilities-4 reports and hospital Institutional Cost Reports for hospital-based nursing homes. 2009 results are based on 2008 revenue increased by the CPI-U minus the State cuts and expenses increased by the CPI-U.

The Real Consequences of the Proposed Cuts

My testimony up to this point has focused mainly on budget impacts that can be quantified with numbers and statistics. These are important measures. But far more important are the *human* measures. These are the *real* consequences of the proposed cuts. They are the consequences that matter to those in need of care, to their loved ones, and to voters across our State.

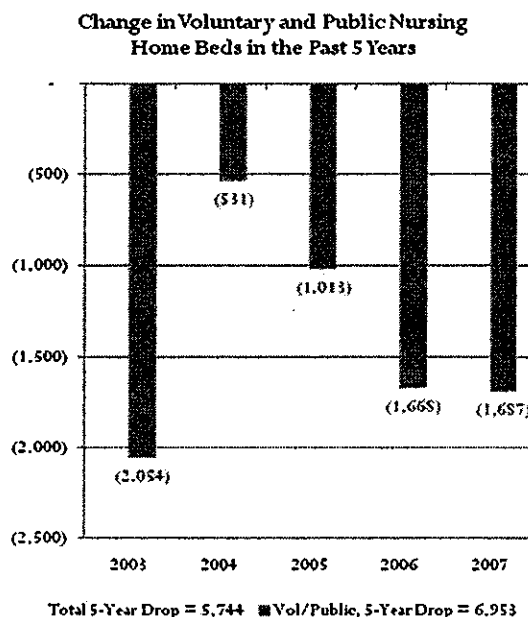
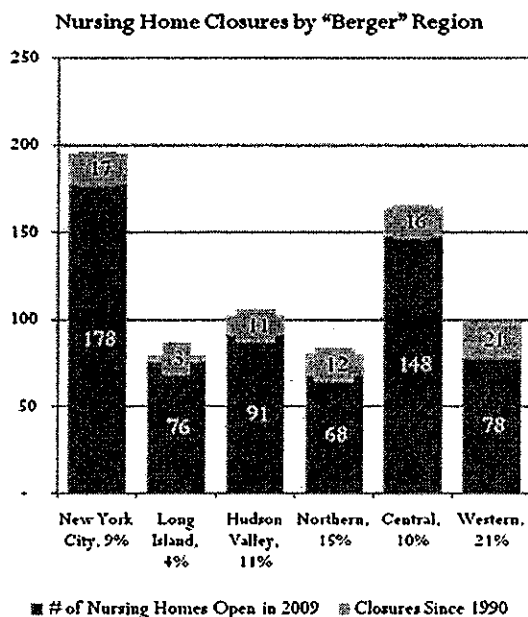
Expressed in human terms, the long term care cuts in this budget - coming on top of the massive long term care cuts enacted in just the last three years - are wrong, and dangerous, on several levels.

The Proposed Long Term Care Cuts Undermine Our Historic Commitment to Meeting the Needs of the Oldest and Sickest New Yorkers. New York has a long history of caring for those in need. This commitment to the needy is codified in our State constitution, which, under Article XVII, Section 1, declares, "The aid, care and support of the needy are public concerns and shall be provided by the state." This statement embodies a truth that is timeless: that is essential to meet the needs of those who - as a result of age, or disease, or disability - cannot take care of themselves. Our obligation to meet these needs is no less great during a time of budget shortfall than it is during a time of surplus. Enacting the long term care cuts proposed in this budget would be an abdication of our duty to care for those who cannot take care of themselves.

The Proposed Long Term Care Cuts Will Devastate New York's Long Term Care Infrastructure When the Need for Long Term Care Services is Greatest. New York is on the verge of an explosion in the number of seniors who are likely to need a spectrum of long term care services. Between 2005 and 2030, the New York senior population is expected to increase from 3.2 million to 5.2 million—a 60% increase. Against this backdrop, we are slowly tearing down our long term care services infrastructure by imposing unsustainable budget cuts. We are literally seeing our nursing homes close in New York State at a rate of one closure every two months. Since 1990, there have

been more than 80 nursing home closures. And in a period of just five years (2003 - 2007), we saw the total number of nursing home beds in our State drop by nearly 6,000 beds. Imposing further cuts now will sacrifice care and services for thousands of aging New Yorkers who will soon be in need of vital long term care supports.

Out of 719 nursing homes in 1990, 80 (11%) have closed, with an accelerating trend toward the closure of voluntary and public facilities.



Source: CCLC analysis of data from the Residential Health Care Facilities-4 reports and hospital Institutional Cost Reports for hospital-based nursing homes.

The Proposed Long Term Care Cuts and Related Actions Will Undermine Quality and Stifle Innovation. Despite the challenges that our long term care system has faced, it has many strengths that make long term care services in New York some of the best in the nation. We have a quality long term care workforce with some of the greatest longevity - and lowest turnover rates - in the nation. The performance of our nursing homes on the federal government's standardized clinical quality measures has consistently placed New York among the five highest scoring states in the country. New York offers a wide range of home and community-based services options - including home care, adult day health care, managed long term care, and senior housing - that help keep people at home and in their communities. And New York has an

unusually strong not-for-profit presence - with not for profit and public facilities representing fully 50% all facilities in our State (while at the national level, not-for-profit and public nursing homes represent only 38.5% of all facilities on average). A strong not-for-profit presence has been linked in national research to overall increases in quality among *all* nursing homes within a given state or region. Moreover, in New York, not-for-profit and public nursing facilities act as the sponsors of 83% of the home health care programs and 74% of the adult day health care programs across the State, and they play a critical leading role as incubators of innovative care models and specialty programs. Fully 78% of pediatric care, 80% of behavioral interventional care, and 100% of HIV/AIDS care is provided by not-for-profit and public nursing facilities in New York State. All of these strengths will be gravely undermined by the severe cuts proposed in this budget. And as I will stress later in this testimony, the viability of many of New York's most innovative and pioneering facilities will be severely threatened by the recommendation in this budget to proceed with a proposed new regional pricing payment system for nursing homes in State fiscal year 2010-11.

The Proposed Long Term Care Cuts will Hurt the Economy and Eliminate Jobs. It makes no sense to implement cuts in the name of helping the economy when the very same cuts will have measurable consequences that are extremely damaging to the economy of the State. Two of the most damaging effects of the cuts will be the loss of federal Medicaid matching dollars that they will trigger, and the severe impact that they will have in the form of job losses in the health care sector.

With respect to the effect of the cuts on federal matching payments, it is critical to note that fully 50% of the proposed nursing home cuts, and 77% of the proposed home and personal care services cuts, would be accompanied by a loss of \$1.60 in federal matching payments for every \$1.00 in cuts that are enacted. This means that if all of the proposed long term care cuts were enacted, New York would lose an estimated \$200 million in Federal Medical Assistance Percentage (or FMAP) payments.

With respect to the impact on jobs, CCLC estimates that if all of the long term care cuts in the Governor's budget were implemented as proposed, we would see in excess of 6,000 job losses in the nursing home sector alone, and close to 4,000 additional job

losses in the home care and personal care sector. Job losses on this scale would have a highly negative impact on the State in the form of foregone tax revenues and increased unemployment benefit costs, while devastating the economic security of families and doing irreparable damage to the quality of care available to Medicaid beneficiaries.

Recommendations:

CCLC respectfully urges action on the following recommendations to protect against the severe potential consequences of the proposed long term care cuts and related actions in the Governor's budget.

General Recommendations:

1. **Dedication of Federal "FMAP" Fiscal Relief to Offsetting Damaging Healthcare Cuts.** It is widely anticipated that the U.S. Congress in the coming weeks will extend New York State's enhanced Medicaid matching rate - which under the provisions of the American Recovery and Reinvestment Act of 2009 was increased from 50% to 61% from October 1, 2008, through December 31, 2010 - for an additional six months. The State has estimated that this action would bring in over \$1 billion to the State government in the 2010-11 fiscal year, and over \$1 billion in the 2011-12 fiscal year. This is more than enough to completely eliminate the health provider cuts in the Executive Budget. More precisely, it would take less than half of the anticipated FMAP relief to completely eliminate the Governor's proposed cuts and taxes to health care providers. CCLC strongly urges the legislature to enact a provision in the budget that explicitly dedicates new Federal FMAP relief to the elimination of health care cuts and taxes on health care providers.
2. **Enactment of the Governor's Proposed Public Health Taxes on Tobacco and Sugary Beverages.** The Executive Budget proposes two new health related taxes - both widely supported by the public health community - that would discourage smoking and seek to reduce the consumption of unhealthy sugary beverages. It is estimated that a proposed new tax on cigarettes will prevent

more than 100,000 children from becoming smokers and will cause more than 50,000 adult smokers to quit. Likewise, it is estimated that a proposed new tax on sugared beverages could reduce consumption of these high calorie drinks by 10%, leading to reduced rates of obesity and related health conditions. In addition to promoting healthier practices, these two proposals are expected to generate combined revenues of \$650 million for the State in SFY 2010-11. Were it not for the State's expectation of realizing these revenues, the magnitude of the proposed health care cuts in the Executive Budget would in all likelihood have been even greater than they are. CCLC believes the proposed public health taxes are critical to promoting health and vital to preserving needed health programs that are funded in the State budget.

Specific Recommendations Concerning the Governor's Proposed Cuts:

1. **Elimination of the Trend Factor Cuts for Nursing Homes, Assisted Living Programs, Home Care Providers and Personal Care Services Providers.** This action would provide needed relief to providers who have already been forced to operate for two full years without a trend factor increase to offset the growth in the costs of labor, energy, materials and supplies. Further, it would avoid a corresponding loss of \$103 million in federal matching payments.
2. **Elimination of the Additional 1% Assessment for Nursing Homes and 0.35% Assessment for Home Care and Personal Care Services Providers.** This would eliminate what are, for both nursing homes and home health providers, among the largest proposed cuts in this budget, and would help to obviate the need for significant corresponding staffing and programmatic cutbacks.
3. **Suspension of Regional Pricing for Nursing Homes.** CCLC has deep concerns about what we consider to be serious inequities and inappropriate incentives inherent in the plan to implement a regional pricing proposal for nursing homes on April 1, 2010. The Executive Budget proposes to delay the implementation of regional pricing by eleven months. CCLC appreciates the recognition on the part of the Executive of the complexities of designing and implementing such a

system, which is reflected in the proposed delay. CCLC takes the position that an eleven month delay is not adequate. There are legitimate concerns about the fairness and serious payment and quality implications of regional pricing, and these, in our view, provide a compelling reason to fully suspend plans for implementation of a regional pricing system. The plan cuts most deeply from the very facilities that have invested the most in a strong and adequate workforce, and from those that have provided the highest quality care. Therefore, we ask that from Section 5.A line 19-28 be stricken from the bill to effectuate the suspension of the regional pricing program. We note that suspension of regional pricing will not impact the State's fiscal plan, as no budget savings were contemplated to result from regional pricing, which would have been required to be implemented in a manner that is budget-neutral to the payment system currently in place. Suspension of regional pricing would not preclude undertaking plans for eventual payment reform. However, we strongly believe that placing constraints on future nursing home payment reforms to make it conform with the regional pricing model is a mistake and will lead to serious unintended consequences to the quality of services in our State's nursing homes.

4. **Elimination of the Proposed Cap on Nursing Home Rate Appeals.** Nursing facilities have a fundamental right to be reimbursed in full according to the provisions of law in place at a given time. Capping the ability of nursing facilities to realize the full reimbursement to which they are entitled is deeply inequitable, especially as the State is moving aggressively increase recovery targets where the recoveries would inure to the benefit of the State. Eliminating this proposal would provide a measure of equity, and would avoid a cut that would have a corresponding loss of \$23 million in federal matching payments.
5. **Elimination of the Proposed Changes in Nursing Home Bed Hold Payment Policy** New York's bed reservation policy allows nursing home residents to remain in their homes when they temporarily must go out for situations such as a hospital visit. CCLC has concerns that the reduction of payment and the limitation to fourteen days for times when residents temporarily leave their residences in the nursing homes will place providers in an untenable position. Providers will still be

required to hold the bed for the resident, forgoing the ability to seek any new residents for the bed, yet at the same time, they will be paid at a lower rate. Additionally, the proposed provision severely limits the number of therapeutic days to allow residents to go out of the nursing home. In many cases residents take a therapeutic leave to be with their loved ones for birthdays, religious holidays, and other special events. The short leaves from the nursing home allow residents to remain an active part of their families and communities, and the limitation to ten therapeutic days per year severely limits residents' rights. Nursing homes are trying to foster environments where the care is a person-centered as possible, where the residents' choices are at the center of all of the care and activity. The proposed changes to bed hold payment policy would undermine the rights of residents living in nursing homes, and should be rejected.

6. **Suspension of the Proposal to Limit and Redirect the Utilization of Personal Care Services.** CCLC is concerned that the proposal to dramatically limit the number of daily hours of personal care services may be a rudimentary strategy with a high potential to cause unintended consequences, including triggering significant job losses. CCLC recommends that the Legislature give serious attention to the ramifications of this approach, including its effect on individuals receiving personal care services and the people who provide the hands-on care.
7. **Enactment of Protections for Specialty Long Term Care Providers.** Several of the broad-based cuts proposed in the Executive Budget would place a particularly severe burden on specialty providers who serve very fragile and hard-to-place populations. Long-term care facilities that service special populations have many costs associated with their facilities that put them under severe financial distress. The trend factor cut will seriously damage the quality of care for these fragile patients. Specifically, we ask that *all* specialty providers, which include those who render services to AIDS patients, specialty pediatric populations, patients on ventilators, people with traumatic brain injuries, and people who need specific behavioral interventions, be exempt from any trend factor cuts in this and in future budgets.

8. **Elimination of The AIDS Occupancy Factor Cut Implemented in Last Year's Executive Budget.** CCLC specifically requests that nursing homes, and units within nursing homes, dedicated to serving patients with HIV and AIDS receive needed fiscal relief through the addition of language to eliminate the AIDS occupancy factor cut that was implemented as a result of provisions in last year's Executive budget.
9. **Implementation of an Assessment Amnesty Program.** CCLC recommends that a tax amnesty program be implemented to enable providers to meet their obligations to the State while protecting them from the potentially crippling fiscal impact of penalties and fees associated with their assessment payments. We urge you to put in place an amnesty program modeled on the plan suggested in A8766 by Assemblyman Colton.

Making a Down Payment on Real Long Term Care Reform

It is CCLC's strong position that our best long term strategy for both reducing the overall cost of long term care services and improving the quality of these services for our most vulnerable citizens would be to undertake a truly comprehensive look at the reform of our long term care system across all of its components. As part of such a strategy, CCLC recommends that the Legislature explore and pursue the following alternative savings approaches - which together have the potential to improve care, choice, fairness, and efficiency - in lieu of the harmful long term care cuts proposed in the executive budget.

Encourage Expanded Enrollment in New York's Managed Long Term Care Programs. New York's pioneering managed long term care programs have improved care management, reduced inpatient hospitalizations, and improved adherence to medication management protocols for thousands of medically-complex, chronically ill individuals. Yet those currently enrolled in these programs represent only a fraction of those whose care could be delivered better and more inexpensively under a managed long term care model. New York should seek a federal waiver so that any federal savings achieved through the expansion of managed long term care enrollment are shared with New York State.

Expand Estate Recovery Initiatives. Federal law requires all states to recover all property and assets that pass from a deceased Medicaid beneficiary under state probate law. Notwithstanding this requirement, New York counties have not pursued these recoveries aggressively. As a result, New York ranks 32nd nationally in estate collections as a percentage of total nursing home Medicaid spending - collecting amounts from estates equal to only 0.5% percent of all nursing home Medicaid spending. We estimate that New York could increase its net revenues by more than \$80 million if it matched the 2.8% collection rate of Minnesota and by more than \$200 million if it matched the 5.8% collection rate of Oregon.

Expand Incentives for Purchasing Private Long Term Care Insurance. New York should dramatically expand its efforts to encourage the purchase of private long-term care insurance as an alternative to Medicaid, including increasing State tax incentives to encourage the purchase of private long-term care insurance and making improvements to the Partnership Plan to encourage greater enrollment.

Provide Opportunities for Individuals to Use Life Insurance Benefits for Long Term Care Costs. Another option for paying for long term care costs while reducing the burden on the Medicaid program is, as has been proposed by Senator Jeff Klein, to require insurance companies to offer new and existing life insurance policy-holders the opportunity to purchase riders allowing them to use some or all of the value of their death benefit to pay for long term care services. This concept holds great potential to expand consumer choice while yielding cost savings for the Medicaid program, and should be actively explored.

Conclusion

In conclusion, I want to thank you for your time and interest in our concerns and recommendations. Please don't ever forget that the debate over this budget is about people every bit as much as it is about numbers. I look forward to working with you to support the development of a budget that will ensure that the needs of our State's most vulnerable citizens are honored and protected.

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Testimony of
**The New York State Health Facilities Association
(NYSHFA)**

Before
The New York State Senate Finance and
Assembly Ways & Means Committees

Bill Numbers:
S 6604/S 6608
A 9704/A 9708

Presented by:

Michael Svendsen

Chairman, Legislative Committee
New York State Health Facilities Association

Robert J. Murphy, CAE

Executive Vice President for Governmental Affairs
New York State Health Facilities Association

**Tuesday, February 9, 2010
Albany, New York**

INTRODUCTION

Good day. My name is Michael Svendsen. I am the Administrator of the Rome Nursing Home, an 80 bed facility in Central New York. I am also the Chairperson of the New York State Health Facilities Association Legislative Committee. Joining me today is Robert Murphy, the Executive Vice President of the New York State Health Facilities Association. We speak to you today on behalf of the approximately 276 skilled nursing and assisted living facilities represented by the Association. Our members each day serve over 43,000 patients and employ well over 60,000 individuals in New York. Our members can be found in every region of the state of New York providing quality long term care services to the patients entrusted to their care.

Over 660 skilled nursing facilities, nursing homes, statewide serve approximately 120,000 patients each day and employ over 170,000 individuals and are vibrant members of their communities, as citizens and purchasers of goods and services. We estimate that, statewide, nursing home wages and benefits in New York (excluding contracted agency staff and other contracted services) exceeded **\$6.34 billion** in 2007 (the latest numbers available) and additionally, in the case of proprietary facilities, we are taxpayers and contributed an estimated **\$92 million** to state coffers in real estate and sales taxes in 2007 alone. To put a fine point on it, nursing homes are often some of the, if not the, largest corporate citizens of many New York communities.

STATISTICAL PROFILE

Attached for your review is a statistical profile of the impact of skilled nursing facilities in New York State statewide (See Attachments #1, #1B and #1C), as well as that of NYSHFA members (See Attachments #2 and #2B). We submit this to you for information and although we will not address it in our verbal presentation, we would be pleased to answer any questions you might have. Please be aware of the financial impact we have on communities in New York State and keep the implications of this in mind as we discuss the past and proposed budget cuts.

OVERVIEW

We will endeavor to be brief in our remarks today and focus on the impact of 2008-09 and 2009-10 budgets, as well as the deficit reduction budgets for the same period concluding with the impact of the 2010-2011 Medicaid proposed cuts relating to nursing homes. Further, we will discuss cuts and proposed cuts of the federal budget actions on nursing homes.

RECENT BUDGET ACTIONS

To understand the precarious state in which nursing homes find themselves today, we must first visit the very recent past. It is important you understand two important facts:

- 75.8% of the nursing home patients in New York today are Medicaid supported with another 12.2 % Medicare supported. Adding in veterans and Medicaid managed care, close to 90% of all our patients are government supported.
- Over 70% of nursing home expenditures are labor related. We are a hands-on patient care profession.

Nursing homes have been, most often, one of the major targets, mostly via the Medicaid reimbursement system, for cuts and assessment taxes. Since fiscal year 2008-09, nursing home rates have been cut four separate times for a rate reduction to facilities of **\$562.5 million**. The cuts have occurred as follows:

- April 2008 \$ 16.7 million
- August 2008 \$265.7 million
- January 2009 \$152.5 million
- April 2009 \$127.6 million

Make no mistake about it; these cuts have taken their toll. Between 2001-09, **55** nursing homes have closed and countless others have cut back services and laid off employees. Additionally in 2009, when the state finally implemented rebasing it was a delayed system that was repeatedly violated with arbitrary budget cuts reducing what was authorized into law in 2006. In the end, when the system was finally put into the rates for April 2009 (not yet paid), due to these arbitrary reductions and numerous other budget cuts, rates paid to facilities were incredibly, actually **reduced by \$127.6 million!**

2010-11 BUDGET

Added to the budget cuts of **\$562.5 million** endured, just since 2008-09, the Governor proposes additional cuts and assessment/taxes of **\$251.9 million** for a total of **\$814.4 million** in just the last three years. Those cuts have sadly been unsustainable as is evidenced by facility closures between 2001-2009. Clearly, there will be more in the days to come. What is difficult to assess, is the real world impact on the employees who have been laid off in the closed facilities as well as in facilities who have been forced to cut back. This year the Governor proposes to:

- **Again cancel the trend inflation factor** which will save the state **\$46.6 million** and reduce reimbursement to facilities by **\$110.4 million**. As a reminder, nursing homes in New York are 75.8% Medicaid, between 12-14% Medicare, some 90% government funded. Approximately 70% of costs are salaries and benefits for our employees. With no other increases, the trend factor is the only way to provide well earned increases for our employees.
- **Enact a 1% non-reimbursed gross receipts revenue assessment/tax.** This would generate **\$67.8 million** in revenue for the state and cost facilities **\$84.5 million**. We do acknowledge that a 1% non-reimbursed assessment has a far less negative impact than a 1% rate reduction (since it does not also cancel the federal share of Medicaid) and we appreciate this consideration. However, again, this represents a significant reduction in what we have to spend on patient care and our employees.
- **Reduction of payments for bed hold** – Existing state law requires nursing homes with an occupancy rate of 95% or over to hold a bed for a patient in the hospital for up to 20 days and places no limits on therapeutic leave as long as the leave is medically necessary. For this, facilities are reimbursed for that bed. This proposal would cut the reimbursement to 95% of the rate and limit each bed hold payment to **14 days annually** for hospitalization and **10 days annually** for a therapeutic leave. This would reduce payments and save the state **\$6.9 million** and cost facilities **\$16.8 million**. So what we would have is, keep the mandate in place; just refuse to pay for it! Simply put, if the state chooses to arbitrarily reduce the payment as well as capping the paid days for this mandate, they should correspondingly reduce the mandate.
- **Capping facility rate appeals** – The budget proposes to cap the amount of money they pay for rate appeals at \$80 million for the next two fiscal years, saving the state **\$16.5 million** in 2010/11 and **\$20.0 million** in 2011/12. A facility, by law, has the opportunity to appeal their rate of payment on the basis of errors in computing the rate. Even though the law requires the state act on an appeal within one year, the processing of literally thousands of rate appeals has languished for over 10 years in some instances. The reason for the incredible backlog is the state just doesn't have the personnel to address the ever growing number of appeals. Regarding the cap, we believe it just isn't right and will cause enormous cash flow problems in addition to the backlog related cash flow problems which exist today. On another issue, our Association and our association partners have proposed a "triage and negotiation" proposal to try and help address the backlog. In the Governor's proposal there is language to let the state "negotiate" settlement of these rate appeals. If the state's language means they are willing to consider the type of process we have proposed, we would be supportive. More details are needed.

- **Reduction of reimbursement by Medicaid for certain drugs.** It appears the proposal is to remove certain drugs from the Medicaid rate and allow them to appropriately be billed separately. If this is the case, we support this proposal which would save the state **\$2.4 million**.
- **The budget proposes to increase the TCU Demonstration Program from 5 to 10 sites.** First of all, we do not believe this is a budget issue and should not be in the budget period. Secondly, our Association has opposed this proposal since it inappropriately creates a system whereby patients are kept in a hospital who should be served in a nursing home at a lower cost, a more appropriate setting for the patient's needs. Finally, when the first demonstration program was approved, the legislation required the Department of Health (DOH) to conduct a study of the impact of the program based on input from the hospitals and nursing homes in the impacted areas. To our knowledge, no such input was sought from non-hospital based nursing homes. The proposal should be rejected.
- **The budget proposal recommends consolidation and reduction** in the membership of the State Hospital Review & Planning Council (SHRPC) and the Public Health Council (PHC) to save the state a modest amount of money. First, SHRPC is an advisory council; whereas, the PHC is a decision making group. There are also specific membership requirements to sit on both councils. There are many unanswered issues which need to be considered and until they are, a fair assessment of this proposal cannot be made. We are, however, concerned this proposal could end up removing an important independent voice in this process.

FEDERAL ACTIVITY

At the same time the state has imposed a seemingly endless series of Medicaid cuts and assessment/tax increases, the federal government has also been retrenching on its payments to nursing homes under Medicare. In the long term health care area, the much publicized "health care reform" offered no reforms, but rather used long term care, via reimbursement cuts, to fund a portion of the "reform," specifically:

- A CMS "rule" was passed, implementing a correction to a "forecast" error, reducing nursing home reimbursement this year by **\$360 million** federally with an impact on New York of **\$66 million**.
- Additionally, the House bill would reduce Medicare reimbursement over ten years by **\$23.9 billion** nationally (**\$1.4 billion** to New York) and the Senate version would slash **\$14.6 billion** nationally (**\$918 million** to New York).

This is important to you because for years we have relied on Medicare to supplement the loss from Medicaid which doesn't pay costs. Further, in light of the statistics we shared earlier, there is no place else to go to subsidize the losses.

CONCLUSION

We are well aware we are painting a most dismal picture of the state of nursing homes in our state. For this we apologize, but sadly, it is what it is. Approval of the latest round of cuts, assessment/taxes and payment delays of **\$251.9 million** will bring the total to **\$814.4 million** in just three fiscal years. Whereas, we acknowledge and appreciate the attempt to "soften" the blow in these proposals, the accumulated damage is truly unsustainable. We also acknowledge the difficult fiscal situation we are confronting as a state, but are constrained to point out that truly you have gone to "this well too often." The closures, service curtailments and layoffs have profoundly impacted New Yorkers, a situation which will only get worse.

Thank you for affording us the opportunity to present to you today and we would be please at this time to answer any questions you might have.

Statistical Profile of Skilled Nursing Facilities (SNFs) in New York State (based on State data from the 2007 RHCF-4s)

Number of facilities •Proprietary 332 •Voluntary 281 •Governmental 49	662
SNF Capacity (# of beds)	119,579
Number of patients Served •Discharged to home or community: 98,343	336,918
Total Days of Care	40,469,185
Number of SNF Employees	173,499
Wages & Benefits by SNFs (excludes personnel agency staff & contracted svcs.)	\$6.34 billion
Total Economic Impact (based on \$10,828,474,086 total expenses *2.1683) *	\$23.5 billion

Attachment # 1 (Continued)

Occupancy Rate	92%*
Real Estate Taxes Paid (proprietary facilities)	\$ 73.6 million
Sales Taxes Paid (proprietary facilities)	\$ 18.6 million
Assessment	\$42.9 million
Total Bad Debt	\$10.3 million

Payer Mix

PAYER	% by CENSUS	% by REVENUE
Medicaid	75.8%	67.5%
Private / Private Insurance	11.4%	12.1%
Medicare	12.2%	16.5%
Other (VA etc.)	0.6%	3.9%

*These are 2007 numbers. It appears that due to increased demand, the closure of facilities and scale back in services the occupancy has and continues to increase.

#1B

Attachment #1 (Continued)

OBSERVATIONS

- The NYS 2007 occupancy rate of 92%, (see note on #1B) though lower than in years past, is still one of the three highest occupancy rates in the country, which considering the aging demographics of the population, could strain the system in the near future.
- In 2007, 29% of patients admitted to a skilled nursing facility were short-term stay rehabilitative patients. This major shift in patients served is a demonstrative and dynamic example of the changing nature of long term care in New York. (Admission of short-term rehabilitation has, as is predictable, lowered statewide occupancy numbers due to higher resident turnover rates.)
- Nursing homes in New York State employ approximately 173,000 citizens, a ratio of approximately 1.45 workers to 1 patient. Employment agency staff (RNs, LPNs, CNAs) and contracted services (e.g. physician services, dental services, speech therapy, etc.) are not included in this number which obviously increases this ratio.
- Wages and benefits in New York State account for an estimated 70% of total expenditures.
- The estimated total economic impact of nursing homes in New York is **\$23.5 billion**
- In 2007 the 332 proprietary nursing homes in New York State paid real estate and sales taxes of approximately **\$92.2 million**.

#1C

Statistical Profile of New York State Health Facilities Association Members (based on State data from the 2007 RHCFA-4s)

Number of skilled nursing & assisted living facilities	276
•Proprietary 252	
•Voluntary 23	
•Governmental 1	
SNF Capacity (# of beds)	42,651
Number of patients Served	126,445
•Discharged to home or community: 36,821	
Total Days of Care	14,427,091
Number of SNF Employees	60,911
Wages & Benefits by SNFs (excludes personnel agency staff & contracted svcs.)	\$1.9 billion
Total Economic Impact (based on \$3,425,561,777 total expenses *2.1683)	\$7.4 billion

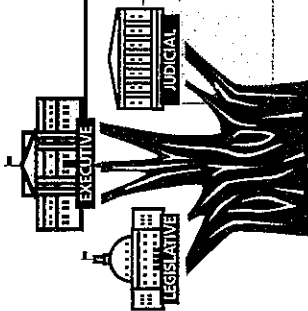
Attachment # 2 (Continued)

Occupancy Rate	93%
Real Estate Taxes Paid (proprietary facilities)	\$ 42.5 million
Sales Taxes Paid (proprietary facilities)	\$ 13.5 million
Assessment	\$42.9 million
Total Bad Debt	\$19.5 million

Payer Mix		
PAYER	% by CENSUS	% by REVENUE
Medicaid	75.6%	66.4%
Private / Private Insurance	10.4%	12.6%
Medicare	13.4%	18.7%
Other (VA etc.)	0.6%	2.3%

#2B

Attachment #3



2008/2009 GOVERNOR'S BUDGET

	ACTION	IMPACT
April 2008	• 35% trend factor cut • R&R additional monies	(\$44.8M) \$28.1M
	Subtotal	(\$16.7M)

	ACTION	IMPACT
August 2008	• 2008 trend factor/banking 1.3% cut • 2009 trend cut 1% • 2008/09 grants reduction • 2009/10 grants elimination	(\$79.5M) (\$61.2M) (\$25.0M) (\$100.0M)
	Subtotal	(\$265.7M)

	ACTION	IMPACT
January 2009	• rebasing cut (1/1-4/1/09)	(\$152.5M)

TOTAL (\$434.9M)

Attachment #4

2009/10 DEFICIT REDUCTION ACT

<p>Additional Funding (consists of rebasing add on, Medicaid Only, Part D and scaleback budget cuts)</p> <p>Less: Additional 2009/10 budget cuts</p> <ul style="list-style-type: none"> • 2008/09 trending • supplemental R&R elimination • elimination of 2010 1st quarter trend factor • transition 6000 SNF beds to ALP • ADHC transportation • AIDS rates • ALP assessment • ALP add • Falls prevention add 	<p>\$210.0M</p> <p>(\$263.2M)</p> <p>(\$10.2M)</p> <p>(\$27.2M)</p> <p>(\$14.2M)</p> <p>(\$16.2M)</p> <p>(\$9.2M)</p> <p>(\$3.2M)</p> <p>\$5.2M</p> <p>\$0.6M</p> <p>TOTAL</p> <p>(\$127.6M)</p>
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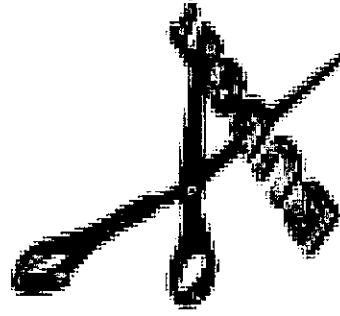
All impacts utilize DOB estimates



Attachment #5

2010/11 GOVERNOR'S BUDGET PROPOSAL

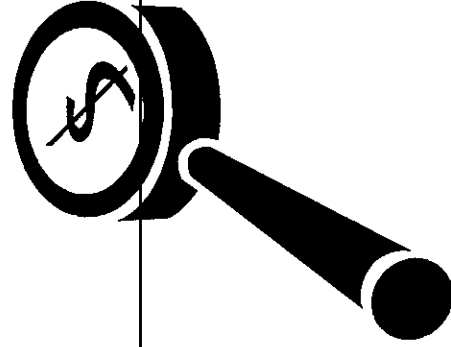
ACTION	IMPACT
<ul style="list-style-type: none">• elimination of remaining 2010 trend factor• increase unreimbursed assessment• bed hold reimbursement reduction• cap rate appeals	<ul style="list-style-type: none">(\$110.4M)(\$84.5M)(\$16.8M)<u>(\$40.2M)</u>
TOTAL	(\$251.9M)



Attachment #6

SUMMARY OF ALL ACTIONS

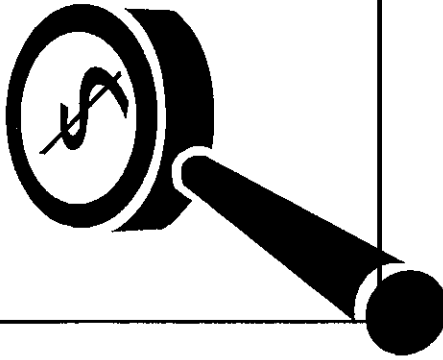
ACTION		IMPACT
2008/09 Budget Cut April 2008	<ul style="list-style-type: none"> • 35% trend factor cut • R&R additional monies 	(\$44.8M) <u>\$28.1M</u>
	Subtotal	(\$16.7M)
2008/09 Budget Cut August 2008	<ul style="list-style-type: none"> • 2008 trend factor/banking 1.3% cut • 2009 trend cut 1% • 2008/09 grants reduction • 2009/10 grants elimination 	(\$79.5M) (\$61.2M) (\$25.0M) <u>(\$100.0M)</u>
	Subtotal	(\$265.7M)



All impacts utilize DOB estimates

Attachment #6 (Continued)

SUMMARY OF ALL ACTIONS (Continued)

	ACTION	IMPACT	
		TOTAL	
January 1, 2009 - March 31, 2009	Rebasing Cut (1/1 - 4/1/09)		(\$152.5M)
2009/10 Deficit Reduction Act 	Additional Funding (consists of rebasing add on and Medicaid Only and scaleback budget cuts Less: Additional 2009/10 budget cuts <ul style="list-style-type: none"> • 2008/09 trending • supplemental R&R elimination • elimination of 2010 1st quarter trend factor • transition 6000 beds to ALP • ADHC transportation • AIDS rates • ALP assessment • ALP add • Falls prevention add 		\$210.0M
		TOTAL	(\$127.6M)
2010/11 Governor's Budget Proposal	<ul style="list-style-type: none"> • elimination of remaining 2010 trend factor • increase unreimbursed assessment • bed hold reimbursement reduction • cap rate appeals 		(\$110.4M)
		TOTAL	(\$251.9M)
All Action Items		TOTAL	(\$814.4M)

All impacts utilize DOB estimates

#6B

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Hello I'm Chris Layo, I'm 25 years old. I'm from Norfolk a town in St. Lawrence County, I'm here today to testify against the proposed plan to cap the consumer directed personal assistance program (CDPAP) to 12 hours of care a day. If it wasn't for the consumer directed personal assistance program I wouldn't of made it this far in life. When I was 19 I couldn't wait to get out and meet the real world. It was 2003 and I was commuting to college. Before I started commuting I tried to live on campus by using St. Lawrence County Health Services. Three days away from moving on campus they called saying they couldn't provide enough staffing for 24-hour care. During my second semester of commuting I learned about the consumer directed personal assistance program. The program sounded too good to be true, but within two months I was in my dorm. The program was easy to use and there were no staffing concerns, since I did the hiring. After being in the program for a few months I learned what true freedom and independence was.

Now for the last five years I've been living in my own apartment and commuting to SUNY Potsdam where I'm a double major in communications and creative writing. I plan on becoming a writer, and a public speaker. I was born with Duchenne muscular dystrophy a muscle wasting disease that leaves me unable to care for myself. I've been receiving 24-hour care through the consumer directed personal assistant program (CDPAP) since I was 19 years old. The consumer directed program is all about choices and being able to live freely in a home of your choice in the community rather than in some facility.

The program allows me to hire anyone I want. In other types of homecare you don't have a choice of who provides care. If I have problems with workers I have the option to let them go. I also get to schedule them according to my needs. I don't have to worry about somebody in an office making a schedule and screwing it up, I don't have to worry about who is coming in for the next shift or if they are going to make it. If a worker needs time off I can schedule it for them, they don't have to go to somebody above me that may not get it right. If a worker calls in I make the decision of who's going to cover. Having control of the schedule makes my life easier and saves the state money because they don't have to pay somebody to do the scheduling. After I hire a new personal care aide I train them in the right way of how to take care of me. I train them in how to safely transfer me using a lift. I teach them how to operate

careers and live that American dream we all strive for. We still have our minds, we still have dreams that we want to fulfill. We are not bedridden people. We know what's going on and we are fully capable of thought. We just want to live peacefully in our communities and not constantly worry about whether or not our freedom is going to be taken away. When it comes to that 93-year-old lady who raised her kids, was a loving wife, worked, and managed to escape dementia, shouldn't she have the right to live the rest of her days in her home rather in some facility or program that offers her no choices? I feel at this moment that I can't plan future goals because they all depend on whether or not I'm going to retain my freedom that the program gives me.

It is a terrible feeling to wake up wondering each day whether or not your freedom is going to be taken away. I feel like I'm going to be ripped out of my home for a crime that I never committed and imprisoned in a nursing home or program that's paternalistic and without choice. I ask how is this possible in this day of age. I feel like I'm being persecuted just because I have a disability. This is not 1930s Germany, but its close. Once we let one group of people lose their rights sooner or later it's another group then another. Let's stop the cycle before it starts, let's not go backwards on 30 years worth of disabled rights just to save money. I am sure that there are better ways to save money, possibly by improving the CDPAP program to even run in a more cost effective manner than it already does, instead of taking 4-5000 people out of it. I still don't see where this proposal saves the state money, anybody and everybody I talked to tells me that this program is the cheapest way to provide in-home care. All other types of care cost more. I'm aware that budget cuts are needed, and agree that they need to be done. The budget cuts might eliminate a lot of jobs, close some facilities, freeze or lower some wages, but nowhere do I see where it affects people's freedom except for in my case.

The first three years I was in the program, I was proud to be a New Yorker. I felt that this state was one of the best for somebody with a disability. I always felt bad for those with disabilities that lived in states that shoved them away into institutions or nursing homes. Those people would love to live the life that I've been living. I was so grateful to know that a severely disabled person such as myself could have true freedom. In March 2008 things began to change. I received a letter from the Department of

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**STATEMENT OF CONCEPTS OF INDEPENDENCE, INC.
AND CONCEPTS OF INDEPENDENT CHOICES, INC. OPPOSING
CAP ON MEDICAID CONSUMER DIRECTED PERSONAL ASSISTANCE
PROGRAM (CDPAP) SERVICES**

Presented by: Anthony G Caputo, CEO acaputo@coiny.org 212-293-9999

Governor Paterson's 2010-11 Executive Budget, with its provision to require individuals that need more than 12 hours of home care to switch to a perhaps more costlier system of care, diminishes an individuals basic right to choose as to how their care will be administered. Our Consumer Directed Personal Assistance Program (CDPAP) is a win-win program. Service recipients, or a designated representative, hires and train the caregiver of their choice at a lower cost to Medicaid than most other service delivery systems. Furthermore, we found that worker retention and Consumer satisfaction, a problem throughout the home care industry, is significantly higher in our program.

Background of our Company

Concepts of Independence (Concepts) was established 30 years ago by a group of severely disabled individuals, who were in need of skilled nursing care, but wanted the autonomy to live their lives with independence and dignity. Previously, the medical profession told these individuals that they must live "imprisoned" in an institutional setting for the rest of their lives.

Many of them quadriplegics with polio, cerebral palsy, multiple sclerosis or muscular dystrophy challenged the medical experts and were given the opportunity to live in the community with the responsibility to hire, fire, train, supervise, schedule and, if necessary, dismiss the worker of their choice. So in 1980, Concepts was established as a fiscal intermediary 501(c) 3 charitable organization to provide payroll and benefit administration services on behalf of the "Consumer" for the "Personal Assistant" of their choice.

The program has grown in New York City from approximately 100 Consumers in 1981 to over 1,300 today. In 2004, an affiliated nonprofit organization was created (Concepts of Independent Choices) to provide CDPAP services to approximately 300 Consumers in counties outside of our New York City contract. In total, our Consumers employ approximately 3,000 workers. We have a significant number of workers that have been with their Consumer for over 20 years, some of them have been together with founding members for 30 years. It is a "bond" that few programs or companies can claim.

You see, when a Consumer finds the right Personal Assistant, the ties (the bond) is closer than family. It is this relationship that has kept many of our most severely disabled Consumers alive. Governor Paterson's current 2010-11 Executive Budget, would destroy that bond for many of our Consumers.

Ira's Story

I would like to tell you the story of one of our founding members, Mr. Ira Holland. Mr. Holland passed away in 2004, but his life is similar to many that will be affected by the Governor's budget. The following is taken from his own writings, including his autobiography "From Rebirth to Eternity".

I grew up in Long Island. I was 15 years old in August of 1955 when the last major Polio epidemic struck Boston, Massachusetts. I was a 15-year-old Counselor at a summer camp when a youngster of seven was admitted to camp with flu-like symptoms. He was diagnosed with Polio. I was also exposed to the virus and within a few days I too became ill. My temperature elevated to 104 degrees and after several days of unconsciousness, I awoke in an Iron Lung machine to learn that I was a quadriplegic.

After three months in the Boston institution, I was transferred by truck with a generator to Goldwater Hospital on Welfare Island (now Roosevelt Island) in New York City. My stay at the New York City rehabilitation center lasted for a period of 21 years. During this time your friends and family abandon you and you are left dependent on an institution that tells you when to wake, when to sleep, what to eat and what to do. This was worse than prison. If I complained to my caregiver, than I would be left in my room for days as though I was placed in "solitary confinement". If I refused to eat in protest of my care, I was given an IV for nutrition. I felt as though every shred of human dignity was lost.

With the use of a portable ventilator, I was permitted to attend college courses in the day and received a degree in Psychology. I was confronted with the reality of living as a quadriplegic with a 24-hour ventilator dependency. When I finally discharged myself in 1976, I was a 36-year-old college graduate, unprepared for the job market.

Having experienced the emptiness of the institution for so many years, I was determined not to return. After a transition period during which I created a life for myself outside the institution, I was comfortable in the first home I'd known in almost a quarter century.

Using a breath-controlled power wheelchair in conjunction with a portable ventilator, I was as mobile as was feasible, and I had thoughts of returning to the academic world. I, and others like me, led us to think about the establishment of a means of enabling severely disabled individuals to live functional and productive lives in the community. We felt certain that we would be more capable, than an agency would, of selecting Personal Assistants with whom we would be more comfortable and more successful living on our own if we made the selection. It seemed to me that the solution lay in the establishment of an agency specifically structured to meet these goals.

At this time, New York City was beginning to utilize not-for-profit "Vendor Agencies." As I spoke with other disabled friends, colleagues, and legal associates, the idea of establishing our own not-for-profit "Vendor Agency" began to take shape. Concepts of Independence for the Disabled (later changed to Concepts of Independence) was incorporated in New York State in 1977 as a 501(c) 3 corporation. After almost three

years of meetings with officials from the City and State of New York, and after lengthy discussions with activist members of the disabled community, the initial formula was cast for a provider of Personal Assistance Services that would be operated by the recipients of such services. In March of 1980 Concepts of Independence for the Disabled, Inc. was awarded its first contract with the New York City Human Resources Administration.

We, and others that follow, now have a choice about who provides our care.

“Living in the community has enabled me to maintain friendships, expand my understanding of the world, work and travel. There is literally no limit to what can be accomplished.”

Financial successes of our Program

In our New York City program we are reimbursed \$16.45 per hour, but due to a restriction of \$.28, we are allowed to spend just \$16.17. Only 3.8% is spent on administration of the program. The remaining \$15.57 is spent on direct worker's wages, payroll taxes or fringe benefits. We pay the workers a base of \$10.00 per hour, but with wage differentials a worker can make up to \$11.40 on the weekend. We also offer vacation, sick, holiday and training pay. In addition to statutory required FICA, workers compensation, disability and unemployment benefits, we offer a full coverage of health care benefits.

Our health plan provides medical, prescription, dental and vision coverage to our workers (and after the first calendar year of employment) to their families. The workers payroll contribution is a modest \$10 for single coverage and \$25 for family coverage. In addition, we provide a pension plan with no employee contribution. Recently, we had a worker with over 20 years of service receive a lump-sum option of approximately \$143,000.

Few, even collectively bargained home care agencies, can make this claim. We know that our proven formula for success has created this win-win program. Costs are down and worker retention is up. Ultimately, Consumers enjoy a better quality of life at a lower cost to government. Please do not let the Governor's budget destroy the lives of those that will be affected by its passage.

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**American Academy of Pediatrics, District II,
New York State**

**Testimony on the 2010 State Department of Health
Budget**

February 9, 2010

**Prepared & Presented by: Elie Ward
Director of Policy & Advocacy
eward@aap.net**

Good morning Chairman Farrell, Chairman Kruger and Health Chairs, Duane and Gottfried and members of the Assembly and the Senate. My name is Elie Ward. I am the Director of Policy & Advocacy for the Academy of Pediatrics, District II, NYS. I am speaking today on behalf of the 6,000 pediatricians across our state who care for more than 4.5 million children.

As we review Governor's Paterson's 2010 state budget proposal, we are most concerned about the financial choices you will make which have the potential for the most positive or the most negative impacts on the health and well being of New York's children. Although we are testifying at the Joint Budget Committee meeting on the Health Budget, our concerns are much broader. Child wellbeing is the core concern of all pediatricians, because we know that children cannot thrive on good medical care alone. Children do not exist in isolation. Their well being is dependent on the strength of their families, the quality of their day care and schools, their access to healthy food and clean water, the safety of their environment, the availability of recreational, socialization and learning opportunities in their communities.

We do understand that our state is facing huge financial challenge. We do not have the revenues necessary to meet the needs of our citizens. But I would like to edit that statement to say that we do not have the revenues from regular or historic sources to meet those needs. Just like any family that has to make adjustments during this difficult time, by cutting back and maybe getting another parttime job to meet financial and social obligations, we have choices. We can and must cut back, but we can also examine and make choices about additional sources of revenue to meet our critical needs.

Taxes on Sugared Beverages, Tobacco & Alcohol

I would like to start my testimony with a clear statement that the Academy of Pediatrics strongly supports the imposition of tax on sugary syrup in soda, fruit drinks, and sports drinks as proposed in this budget. We know that this tax will not solve our epidemic of childhood obesity. But the tax can and should be a part of what we do to address this very serious problem.

Imposing a tax on sugary drinks demonstrates state government's recognition that we have a childhood obesity epidemic. Here in New York more than 25% of our children are obese and almost 40% are significantly overweight. The current obesity epidemic has the potential to bankrupt our already teetering health care system.

We believe that we can and should create public policy which shows that government cares enough about its children to make sugary drinks more expensive. **We do not pretend that any such tax will stop the consumption of soda and sugary drinks. But if such a public policy can reduce consumption, while at the same time bring vital revenues into the state's coffers, we cannot see any downside here.** For those who may see this effort as an overreaching "nanny tax," I urge you to remember the huge outcry when tobacco taxes were first proposed. The beverage industry is big and strong and powerful. But they don't pay the bills when kids are overweight and develop diabetes and heart disease before they even become teenagers.

It is estimated that New Yorkers already pay more than \$8 billion in obesity related health care costs each year. That translates into \$777 per family each year. So, it is not truthful to say that to pay tax on sugary drinks is an additional and unfair burden. Families are already paying; they just can't see it because it is in their increased insurance premiums, their increased costs for co-pays on insurance and their increased federal, state and local taxes to pay for obesity related treatments for Medicare, Medicaid and private insurance. If in fact, if we can reduce consumption and reduce high health costs associated with obesity related disease, we may in the end reduce the costs that families currently bear.

The fear of job losses is another red herring. The beverage industry in New York produces many products. If consumption of sugared sodas is reduced, these companies can switch to their other products and maintain their workforce and participate in our efforts to help New Yorkers stay healthy.

Sometimes state leaders have to lead. The sugared beverage tax gives you a chance to do that. We, as the doctors see the results of high sugar consumption in our patients across the state. We urge you to impose the sugared drink tax this year. Passing the tax this year will send a strong public health message that our state leaders recognize the role that soda and sugary drinks play in our childhood obesity epidemic, and will also to bring desperately needed revenues into our health care system.

Should there be any question, we also strongly support increased taxes on tobacco.

Experience has shown that with each increase in cost, the adolescent use of tobacco decreases. We would hope to have the outcomes with the sugared drink tax.

And as you might guess, we support additional taxes on alcoholic beverages. We see no reason for the state leaders to make it more affordable for people to consume more alcohol than is healthy. And most people, who do not drink to excess, will not be adversely impacted. But for young people, who often indulge in bingeing, higher costs may reduce their ability to afford alcoholic beverages.

These initiatives are not Nanny taxes, obesity and its co-morbidities of asthma, liver disease, diabetes, high blood pressure, heart disease; tobacco with its outcomes of heart disease, lung cancer, high blood pressure; and abuse of alcohol with its outcomes substance abuse, escalation in domestic and stranger violence and car accidents, cost New Yorkers a great deal. They increase health care costs for both public and private insurance and for the state in uncompensated care. They reduce productivity and the ability to work due significant chronic illnesses and injury. They contribute to increased criminal activity and legal and correction costs. They also cost individual families who have sick children, sick parents, or lose loved ones. There is no rational reason not to make these particular products that are not good for people in excess, more expensive to get and to use.

The Early Intervention Program for Infants & Toddlers

We agree that our current Early Intervention Program needs reform, but several of the budgetary and regulatory reforms included in this budget and its Article Seven bills raise concern. **We do not support Parent Fees.** The Early Intervention Program is an entitlement program which was originally designed to provide important physical and developmental therapies to infants and toddlers who were diagnosed with developmental delays. The concept supporting the program design is that the sooner therapists intervene with specific therapies to address diagnosed developmental delays, the better the chance that the child will be able to gain developmental milestones and reduce the intensity of care needed in school and in life.

The program is designed to intervene early and with appropriate intensity. Therefore, introducing eligibility barriers to a program contradicts the programs goals and objectives. It is also probable that building the infrastructure to do proposed income eligibility determinations would cost more for the state and the localities than they would collect.

Rather than imposing Parent Fees, we support the state working to assure that health insurers cover all needed services for these multiply disabled children. Both Medicaid and commercial health insurance policies should cover therapies indicated as "medically necessary." However, in support of this position we encourage our state leaders to make a commitment to providing supported Medical Homes for all children in the early intervention programs. **Rather than the administration's proposal to take pediatricians out of the loop of EI services, we propose increasing pediatric participation and creating and supporting a real Medical Home for these medically fragile children.** The state's current commitment to create and implement Medical Homes for children and, in fact all New Yorkers, should be extended to these very special infants and toddlers. Doing less is not acceptable.

Bright Futures NY & Primary Care Investments

In the area of Primary Care Enhancements we are supportive of the current budget continuing to drive health care dollars to build primary capacity. The Department's efforts to strengthen primary care through targeting additional resources and defining and financially supporting clear indicators of quality assurance and quality service delivery, will go a long way to rationalizing our current unbalanced and very expensive health care delivery system. **Maintaining support for Doctor's Across NY program is also a smart investment in this time of strained resources.**

But we would like to see the state move even further in its commitment to building primary care as a significant component of health care service delivery system across the state. **We encourage the state to continue to work with us to design and implement a Bright Futures NY Medical Home model for all children.** Bright Futures NY would ensure that every child has access to a high quality Medical Home to meet his or her needs. Bright Futures NY will also assure that infants and toddlers receive timely and appropriate screenings and developmental assessments, and all children get the medical care they need when and where

they need it. **Investment in Bright Futures now will pay our health care system back many times over.** As children's health care needs are identified and addressed early in their development, in the Bright Futures Medical Home Model, we can avoid further expensive and intensive health care services and reduce special education and developmental disability investments going forward.

Bright Futures NY can help address ongoing concerns about diagnosis and treatment for infant and toddler physical and developmental delays, autism and Autism Spectrum Disorder, obesity and the new co-morbidities of obesity, including diabetes, liver disease, high blood pressure and heart disease.

Bright Futures NY will also help us address our ongoing challenge to get keep our children protected from deadly and debilitating diseases that can be prevented by timely immunization. As you may know, we have recently have an outbreak of measles, one of whooping cough and an ongoing mumps outbreak in New York. These outbreaks were directly related to breakthroughs in herd immunity caused by under-immunization. In the world we live in, here in NY, infection is just a plane ride away. A person can bring in polio, measles, pneumonia and many other diseases. If our most vulnerable young children are not immunized, we can and will experience severe illness, and in some instances death. This tragic outcome is completely avoidable. But we have to work harder and smarter to reverse current unfounded fears of vaccines. Bright Futures NY Medical Homes can help us in that battle, as parents and pediatricians develop ongoing and strong trusting relationships around the special needs of each family's children.

Other Budget Issues

We support the proposed ongoing support for New York's Child Health Plus and Children's Medicaid programs as outlined in the budget. New York's Child Health Plus and Children's Medicaid programs provide coverage for more than half of the children in our state. The state's continued focus on enrolling eligible children and keeping children covered over time is vital to maintaining and improving children's health. Our next step should be to expand the access to and quality of care through the design and implementation of a Bright Futures NY Children's Medical Home for all children.

We encourage the state to work harder to meet the requirements of new federal law, Fostering Connections. This legislation requires states to assure high quality, consistent health care for children in foster care. We look forward to working with the State Department of Health and the Office of Children and Family Services to implement this legislation across New York.

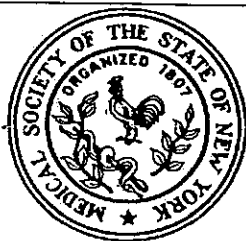
We support the state once again taking responsibility for rate setting in partnership with health insurers. It is reasonable for the state to have significant role to play in establishing affordable premiums for health care. It is also important that the state assure that all premium negotiations include reasonable payments for primary care medical home services.

We support the proposed Physician Gift Ban. The Governor's proposal is reasonable. Doctors, do not need gifts from pharmaceutical companies or medical device makers. What doctors need is easily accessible, objective information on new drugs and new devices that can improve the health outcomes of their patients. How doctors get this information can and should be structured in a way that precludes the appearance of undue influence. Our only suggestion would be that any state legislation should enhance the educational components of the process and that in the first "small" instance, a warning is issued, after which, if there is another infraction, fines could be imposed.

We believe that the huge cuts to programs which can and do enhance child well being are penny wise and pound foolish. The negative impact on some of our most vulnerable children and families will be significant, but the actual dollars saved by the state are relatively small.

We would especially like to see restorations to the state's Home Visiting Program, Advantage Afterschool Program, Child Care and Alternatives to Detention for Court Involved youngsters and of course, education. All of these programs could help keep vulnerable children and their families from needing more costly and more intensive programming to address problems that could have been prevented. These programs are just sampling of wrong decisions. There are many others throughout the budget.

The members of AAP District II, NYS look forward to working with you this year to help make the most reasonable budget decisions in both identifying new sources of revenue and making budget cutting decision that don't make the lives of our most vulnerable children and families more difficult and more dangerous.



The Medical Society
of the State of New York

**Testimony Of
The Medical Society of the State of New York
Before The
New York State Assembly Committee
on Ways & Means And Senate Finance Committee
On the Governor's Proposed Public Health Budget
For State Fiscal Year 2010-2011**

Good morning. My name is Gerard L. Conway, Esq. I am the Senior Vice-President/Chief Legislative Counsel for the Medical Society of the State of New York. On behalf of the State Medical Society and the almost 25,000 physicians, residents and students we represent, let me thank you for providing us with this opportunity to present organized medicine's views on the proposed budget and how it relates to the future of the health care delivery system in New York State. Let me begin by stating that all of organized medicine recognizes the difficult fiscal situation that the State of New York and its residents now face. We are ready to do our part to assure that this challenge is addressed meaningfully, comprehensively and equitably. Moreover, we have a number of suggestions which if effectuated would produce significant savings to the state and to our overall health care delivery system. These proposals will not diminish quality and access but on the contrary they will enhance the extent to which we succeed in achieving these goals.

1. Address Medical Liability Reform in the Context of the State Budget for Fiscal Year 2010-2011.

In each of the last two legislative sessions, the Legislature and Governor Paterson have enacted legislation that held medical liability premium rates level, thereby preventing for the 2008-09 and 2009-2010 policy years, the imposition on physicians of a medical liability insurance rate increase or the imposition of a surcharge to make up for past insurance company deficits. While vitally important, the action by the Legislature and the Governor provides physicians only a temporary reprieve. Unless additional legislative action is taken in the near future, physicians potentially will incur more staggering increases in the cost of liability insurance- increases that they cannot afford and that will drive many of them from practice in New York State. As was stated in an August 2008 *Newsday* editorial following the enactment of the first freeze, this temporary freeze "...won't end the punishing long-term run-up in the cost of insurance. But it does buy time for Albany to fashion a more lasting remedy – time that must be put to good use."

Without this freeze and the freeze enacted in 2009, it would have been necessary to increase premiums by double digit amounts each year. At least part of that increase was ascribed to the need, articulated by then Insurance Superintendent Eric Dinallo, to surcharge physicians up to 8% of their annual premiums in this and in future years to make up for previous insufficient premiums collected by insurers in past years.

Let me be clear on this. Given the incredible increases in practice costs and the constant downward pressure on health care provider compensation imposed by huge and increasingly for-profit health insurers, liability premium increases at this level would devastate New York State's health care system.

And as Governor Paterson himself said in signing the Legislation creating the freeze:

"I want to thank the Legislature for stabilizing malpractice rates for the short term, thereby insuring our doctors can continue to provide quality care in New York without

getting suffocated by more back-breaking fiscal burdens. However, our work is now cut out for us, and we remain committed to creating comprehensive and meaningful medical malpractice reform”.

The increases deemed necessary by the Superintendent in 2008 would have been on top of premium increases of 14% imposed on physicians in 2007, and the 55-80% increases in premiums paid by New York's physicians over the previous 5 years, bringing the premiums paid by many specialists in New York to amounts in the hundreds of thousands of dollars. Even with the freezes which have been implemented, for just a single year of coverage:

- a neurosurgeon on Long Island pays over \$300,000;
- an Ob-GYN in Brooklyn or Queens pays \$173,065; and
- an orthopedic surgeon in Westchester County or Manhattan pays almost \$110,000.

These unaffordable rate levels were reached because, before the rate freeze, high risk specialties such as OB GYN, Neurosurgery, General Surgery and Orthopedic Surgery incurred dramatic increases in their premiums. Between the 2002-03 policy year and the 2007-08 policy year, rates for each of these high risk specialties increased by 63% in Buffalo and as high as 80% in the outer Boroughs of New York City. And the sizeable rate increases over these five years were not experienced by specialists alone. Primary care physicians, including internists and emergency room physicians, experienced 63% increases in the Buffalo area, 72% increases in the lower Hudson Valley, Manhattan and Long Island and 80% increases in the outer Boroughs of New York City.

These unbearable increases have forced many physicians to move out of state, retire early, or modify their practice. In Erie County alone, since 2007, 10 primary care physicians have moved out of state. Communities in the Northern Adirondacks cannot attract or even retain primary care physicians. The exodus from New York is not limited just to primary care physicians. There is also a measureable loss of specialists across New York. Since 2002, over 250 MLMIC-insured OB-GYNs have sharply curtailed their

deliveries by changing their classification from obstetrics to gynecology or family practice, including 75 in just the last year alone. In Suffolk County alone in 2007, 14 OBGYNs left practice altogether or downgraded their practice to include only gynecology and will no longer perform obstetrics. All of the obstetrical services at Peconic Bay Medical Center are provided by a three member OBGYN practice. Their practice income has dropped to a level which is about the same that these dedicated physicians made as residents in 1985. In Oswego County, there remains only one OBGYN practice. Medical liability premium costs there have increased by 63% (from \$32,539 to \$53,151). These dedicated OBGYNs have been able to meet the needs of their patients by remaining on call 24/7, often sleeping overnight at the hospital. This is not sustainable. Our communities can not afford to continue to lose talented and dedicated physicians.

While these and other costs continue to rise, physicians are being squeezed by the ongoing efforts of health plans to constrain reimbursement for health care services. Moreover, physician Medicare reimbursement has essentially remained flat since 2001, and will be cut by an astounding 21% in just a few weeks unless Congress acts to end a payment methodology which all agree is grossly flawed.

The enormous costs of our liability premiums are driven by a wildly unpredictable medical liability adjudication system that numerous studies have concluded results in cases where awards are made despite the absence of any negligence whatsoever.

- For example, in one recent review of closed claims in the *New England Journal of Medicine*, it was shown that, in more than 1 out of 4 claims, a patient was awarded payment where no negligence was committed, or a patient was not awarded payment where there was negligence.
- The famous Harvard Study, cited by the trial bar as an example of incompetence in the health care system, was actually an indictment of the civil justice system. It showed that over 80% of the persons who sued for malpractice were not victims of negligence. Frankly, encouraged by the constant advertisements of the trial bar, these plaintiffs were simply buying their lottery ticket.

- And yet, every five years 65% of the neurosurgeons currently insured by MLMIC are sued and almost 50% of its OB-GYNs, and other surgical specialists are sued.

The studies show that very frequently settlements are made based upon the severity of an injury rather than on the existence of negligence.

Moreover, while approximately 2/3 of all medical liability suits result in no payment, the costs of defending these cases are extensive and significantly add to the astronomical cost of medical liability insurance. For example, MLMIC has spent over \$725 million in this decade alone to defend physicians and hospitals on whose behalf no payment is ever made to the plaintiff.

The fact remains that without resolution of the medical liability premium crisis, access to physician services, both in private physician offices and in critical hospital inpatient and ambulatory care settings will be impacted to an extent which few can imagine.

The Medical Society of the State of New York along with each of its constituent County Medical Societies believes that resolution of this crisis must be accomplished in the context of the State Budget for fiscal year 2010-2011 and beyond.

Meaningful medical liability reform will result in savings to the entire state by way of reduced liability costs for hospitals, clinics and ambulatory care facilities. State budget cuts in payments to providers would be very painful and would clearly harm access for patients. If such cuts must be made this harm can and must be ameliorated by lowering malpractice insurance costs. If the premium liability burden is reduced, more physicians will be able to remain in practice.

We note that the proposed budget for fiscal year 2010-2011 announced earlier this week includes a package of \$1 B in health care funding reductions which will affect almost every sector of the health care community, particularly the hospital, nursing

home and home care sector. The budget also imposes approximately \$900M in dedicated taxes and assessments. Additionally, the health insurance industry, an industry which has extracted significant equity from our health care system for exorbitant corporate salaries and profit would also be made to re-invest that equity through more stringent medical loss ratios and more rigorously controlled premium levels. We must note, however, that the proposed budget, while inflicting pain upon virtually every societal sector, does not affect any change to our prohibitively expensive but miserably failed civil liability system. The liability system in New York State is hurting everyone. It hurts individuals. It hurts government operations and schools. It hurts businesses and homeowners. And, of course, as I have described today, it hurts our healthcare system. The problem of the medical liability adjudication system does not just impact physicians – it impacts the cost of all health care. This was highlighted by President Obama in a speech to Congress last September in which he stated that he has “talked to enough doctors to know that defensive medicine may be contributing to unnecessary costs”. Studies have shown that billions of dollars in health care costs are unnecessarily spent each year due to the practice of “defensive medicine”, such as unnecessary MRIs, CT scans and specialty referrals. The costs of this phenomenon vary based upon the studies, but are undoubtedly immensely significant. One 2002 study by HHS indicated that \$60-\$108 billion was spent on defensive medicine. A Lewin study concluded that \$36 billion could be saved over 5 years by reducing “defensive medicine” costs. More recently, a 2008 study by the Massachusetts Medical Society of eight specialties indicated that \$1.4 billion was spent annually in just the state of Massachusetts alone for “defensive medicine” purposes. Moreover, A recent study from the Congressional Budget Office concluded that enactment of meaningful medical liability reform could result in significant savings to various federal and state health insurance programs. According to the CBO study, such reforms could produce savings of \$41 billion over the next ten years to the Medicare, Medicaid, State Child Health Insurance and Federal Employee Health Benefit Programs.

It is inconceivable in our view to allow such a failed system to go unreformed, while all other societal sectors are being asked to share the pain which confronts us as a society.

Our patients and the business and public entities that finance healthcare delivery have a right to ask, "Why should the grotesque excesses of the inequitable and failed tort system be immune from reform"? Our answer is clear. The tort system – and the trial lawyers who benefit from it- must play their part in addressing the unprecedented financial crisis besetting our state. The failed tort system must be fundamentally reformed. Meaningful medical liability reform will result in savings to the entire state by way of reduced liability costs for hospitals, clinics and ambulatory care facilities. State budget cuts in payments to providers will be very painful and will threaten access for patients. This pain can be lessened by lowering malpractice insurance costs. If the premium liability burden of physicians is reduced, more physicians can remain in practice and our hospitals and clinics will be able to avoid some cuts that would otherwise be necessary.

2.) Continuation of an Adequately Funded Excess Medical Liability Program

We are grateful that Governor Paterson has proposed to continue this extremely necessary program in the proposed budget and we urge that the Legislature include funding for the Excess program in the final budget adopted for 2010-2011. The Excess Medical Liability Insurance Program provides an additional layer of coverage to physicians with hospital privileges who maintain primary coverage at the \$1.3 million/\$3.9 million level. The cost of the program since its inception in 1985 has been met by utilizing public and quasi-public monies. Beginning January 1, 2002, monies from the Health Care Reform Act's (HCRA's) tobacco control and initiatives pool were allocated to fund the cost of this program. The 2009-2010 State Budget adopted by the Legislature included funding to cover the cost of the program through June 30, 2010. The Excess program was extended by Chapter 58 of the Laws of 2008 until June 30, 2011. Importantly, the proposed state Budget for 2010-11 would appropriate \$127.4M for the Excess program but would delay payment of such monies to the medical liability carriers from March 2011 to July 2011.

The Excess Medical Liability Insurance Program was created in 1985 as a result of the liability insurance crisis of the mid-1980's to address concerns among physicians that their liability exposure far exceeded available coverage limitations. They legitimately feared that everything they had worked for all of their professional lives could be lost as a result of one wildly aberrant jury verdict. This fear continues since absolutely nothing has been done to ameliorate it. The size of verdicts in New York State has increased exponentially. From 1999-2005, 59% of all verdicts exceeded \$1 million, thereby making the continuation of the Excess liability coverage even more essential today than when first authorized. Consequently, approximately 25,000 physicians currently have excess coverage.

The severity of the liability exposure levels of physicians makes it clear that the protection at this level is essential. However, given the realities of today's declining physician income levels and the downward pressures associated with managed care and government payors, the costs associated with the Excess coverage are simply not assumable by most physicians in today's environment. Indeed, as mentioned earlier, the ability of a physician to maintain even the primary medical liability coverage is increasingly compromised as a result of escalating costs and decreasing reimbursement. It is important to note finally that the Excess program is not a solution to the underlying liability problem in New York State. That problem is caused by the failed civil justice system and the real solution is reform of that system. Without Excess, however, many physicians will be unable to continue to practice thereby increasing expenses as a result of the need which patients will have to access care in other higher cost settings or, worse yet, such patients will go without care.

3.) Improving Performance of the State Medicaid Program

The Medical Society of the State of New York has fought for decades to secure meaningful payment reform for physicians under Medicaid. The medical community is grateful that over the past two years the Governor and Legislature heeded our pleas for reconfiguration of the state Medicaid program. Such reimbursement reform, we have

long argued, would enhance access and save money. Effective last January, physician payment under Medicaid for ambulatory care provided at a hospital based or community clinic or in a private physician's office was substantially increased to slightly more than sixty percent of Medicare. In most cases, this is an increase of over thirty-five percent, bringing physician fee for service reimbursement to 75% of Medicare. Additionally, office-based physicians practicing in Health Professional Shortage Areas now also receive a ten percent payment enhancement on reimbursement received for care provided to patients covered by Medicaid. Moreover, patient visits in physician offices and clinics which are scheduled and occur in the evening (after 6PM), on weekends or on holidays are receiving a supplemental payment of \$8/visit.

MSSNY is greatly appreciative of the movement toward a fairer Medicaid payment model. However, MSSNY believes that we must restructure Medicaid to eliminate the distortions which have significantly diminished the program as it exists in New York State. Medicaid costs too much because its payment structure is not consistent with clinical needs. Medicaid as historically administered fails the taxpayer, fails the provider and most importantly fails its intended beneficiaries—our state's most needy citizens. The Medicaid fee schedule must be made at least equal with that of Medicare, perhaps through the implementation of a trend factor. In fact, MSSNY advocated for this as part of its advocacy for federal health care reform. Such a provision was contained in the House version of health care reform. MSSNY will continue to work toward this objective. Payment reform along with other steps to promote care delivery in the physician practice setting will, over time, result in physician re-involvement in the Medicaid program, enhanced quality and lower cost. MSSNY is committed to increasing access to quality health care for the Medicaid population. Our commitment can only be successfully met through a successful campaign that educates physicians about the enhancements to Medicaid as well as the public about their improved access to a medical home. Such a campaign is necessary to overcome years of failure. MSSNY is working with the Department of Health's Office of Health Insurance Programs (OHIP) to educate physicians on the revised Medicaid payment structure.

MSSNY over many years has advocated for significant revision of the utilization threshold approval process. Until now, the Medicaid Utilization Threshold (MUTs) process has been complicated, slow and seemingly oblivious to quality patient care. A ten visit threshold applied to all patients, regardless of health status and the process through which physicians could obtain override authority was paper-based and time consuming. A new process, implemented last July, is expected to be more responsive to individual patient needs as it will now customize the utilization thresholds based on the clinical diagnosis of the patient and the severity of the patient's condition as gleaned from physician claim forms. It is intended that the new utilization thresholds for office visits will be more representative of patient health status thereby reducing the need for physicians to make override requests. Moreover, the UT override process will be automated and will enable a physician to review a patients' current utilization threshold status to determine if an override request is needed. In the event that a provider must obtain a UT service authorization, they must go through the Medicaid Eligibility Verification System (MEVS). Since last July, there has been a considerable decline in the number of Threshold Override Applications. MSSNY will continue to work with OHIP to assure that the UT limits are appropriately representative of clinical considerations and that the override system and web portal are easily accessible to physicians and provide physicians with a manageable and reliable mechanism for review by physicians in the same or similar specialty. It is important to note, however, that the MUTs process was implemented long ago - well before retrospective review, the Office of Medicaid Inspector General's work to reduce fraud and abuse and the enhanced use of health information technologies. These latter efforts have made the MUTs system, however streamlined and improved, unnecessary and costly. Consequently, MSSNY urges the passage of legislation as part of the budget which would eliminate the necessity for physicians to submit separate UT requests prior to billing.

Payment reform and implementation of changes to lessen the administrative hassles associated with the Medicaid program including elimination of the MUTs system will produce a more favorable environment for physician participation in the Medicaid

program. There can be no doubt that enhanced physician participation in a more fair Medicaid program will move us toward realizing our shared objectives of enhanced efficiencies and improved health outcomes for this challenging population.

Finally, we have had discussions with the Division of the Budget as well as others concerning several clinical initiatives which, if undertaken in New York State, could produce immediate first year savings to our State's Medicaid program measured in the hundreds of millions of dollars. We will mention here just one of these initiatives - an evidence-based program directed to both fall prevention and pneumonia immunization. Currently, New York spends \$860M every year on these two geriatric conditions. An existing fall prevention program targeted Medicaid dual eligibles in Pennsylvania, Florida and a focused program in New York City. The program yielded 50% savings on hospital costs; 65% savings on nursing home care and 20% savings on outpatient rehabilitation. The pre-hospitalization and in-hospital pneumonia immunization projects, according to recognized professional literature, will yield savings of approximately fifty percent of the monies now spent on this condition. We believe that there are significant savings to our State which can be achieved through these and other clinical initiatives which involve patients, their families, their physicians and other care providers. We are anxious to meet with you and your staffs to discuss in much greater detail these and other clinical initiatives which will both enhance care and save substantial financial resources as well.

4.) Expansion of the Doctors Across New York Initiative

We are grateful that Governor Paterson has proposed to add new money (approximately \$3.5M) to the Doctor's Across New York program. This will enable an additional 50 awards to be given in each of the physician loan repayment and physician practice support programs this year. We support the addition of these new monies and urge their inclusion in the final state budget. Studies published by the Center for Health Workforce Studies, School of Public Health, University at Albany, show a continuing downward trend in the number of practicing physicians in certain specialties, including

OB-GYN, General Surgery, Specialty Surgery (Orthopedic Surgery, Neurosurgery and Thoracic Surgery) and Psychiatry. A growing decline in the number of primary care physicians across the state and of facility-based physicians in some regions are noted as well. As the numbers of practicing physicians in certain areas declines, the maldistribution problems will become more severe with underserved areas feeling the shortage the most. To respond to the growing shortage of physicians in underserved rural and urban areas of the state, the legislature two years ago enacted the Doctors Across New York program to provide financial support by way of physician loan repayment and physician practice support to encourage primary care and specialty physicians to practice in these communities. The physician loan repayment initiative funded awards annually with a maximum of \$150,000 in loan repayment over five years for physicians who practice in rural and inner-city underserved communities. Approximately 100 awards were made in the first year of this program. The physician practice support program provides up to \$100,000 in physician practice support over two years. *Doctors Across New York* places a realistic value on the cost of a medical education and provides necessary funding as well as start-up costs to allow a graduating medical student to begin to practice in a medically underserved area. The program is vital to access to medical care in rural and underserved communities across New York and should be continued and expanded.

5.) Surcharge on Payors For Certain Health Service Payments

We are seriously concerned by language contained in the proposed budget which would require certain payors to pay a 9.63% surcharge for services billed as surgery or radiology services which have been provided in physician offices or in urgent care facilities. We ask that you carefully evaluate the implications of this language.

We believe that it is time for payors – the most solvent sector within the healthcare delivery system- to re-invest the equity they have for years extracted from the system back into the HCRA financial pools through this surcharge so that it might be redistributed to healthcare providers, enhanced patient access and public health programs. The Medical Society, however, is concerned with the potential impact of this

surcharge on the fees paid to physicians by the payors for surgical and radiological services provided in the physician office and to premiums paid by employers and individuals for health care coverage. Simply put, individual physicians and even group practices lack sufficient leverage now enjoyed by much of the hospital sector to forestall or prevent a possible 9.63% payor cut in their reimbursement which might be imposed by health insurers to offset the surcharge imposed on them. The proposed law is clear, and it should not be perverted. This is a surcharge on health insurers and not providers, employers, or patients. It does not apply to physicians or patients, but only to insurers. If there is no insurance payment, there is no surcharge. It is not assessed on deductibles or co-insurance. Many physician practices today are barely solvent. There are a number of reasons for this including rapidly escalating practice costs and declining practice revenue. Already in every region of New York we are experiencing a significant shortage of critically needed physicians in a number of specialties, including primary care specialties. The impact of this one proposal, if the proper protections are not established, could cause an even larger number of physicians to retire early, alter their practices, or relocate their practices outside of New York State. Alternatively, MSSNY is also very much concerned about the potential for payors to simply pass this surcharge along to employers and individuals who purchase coverage. MSSNY, therefore, urges the incorporation of language to assure that such surcharge will not be passed along to physicians by way of reduced fees or to our patients through increased premiums for employers or coverage reductions. Alternatively, we ask that you explore other mechanisms to tax health insurers to achieve the revenue sought to be obtained through this proposal.

6.) Reinstitution of Prior Approval of Health Premium Increases

The proposed budget would restore the authority of the Insurance Department to approve proposed increases in health insurance premium rates. The proposal would also implement an increase from 75% and 80% to 85% in the minimum medical loss ratio for the individual and small group health insurance policies respectively.

There is a continuing effort on the part of health insurance companies to impose unnecessary obstacles in the way of patients seeking necessary care. Moreover, these companies are unfairly and substantially limiting reimbursement for such care.

Premiums continue to go up while reimbursement remains flat or even decreases and patients struggle to gain access to needed care. Meanwhile, these companies are diverting huge resources away from the health care system to their own excessive executive salaries and huge profits. With six companies controlling nearly 77% of the managed care market in New York, patients, employers and physicians have little ability to effectuate meaningful changes in their contracts with health insurance companies.

At the same time these companies wield such market domination, their profits have grown dramatically. In 2007, New York health plan profits were over \$1.4 billion, a 93% increase over the amount earned in 2001, according to National Association of Insurance Commissioners filings. It was the sixth straight year that plan profits exceeded \$1 billion.

According to a study recently released by the Northwest Federation of Community Organizations, many of the major national health insurance companies operating in New York State have made billions in profits over the last several years. For example, in 2007, United Health Group made \$4.65 billion in profits. Wellpoint made \$3.35 billion in profits. Aetna made over \$1.8 billion in profits and Cigna made over \$1.1 billion in profits. United, Aetna and Wellpoint's profits together in New York State were approximately \$1 billion, according to NAIC filings. Their profit margins for New York State significantly exceeded national averages.

The source of these grossly excessive profits of the managed care companies is clear. They are constantly increasing premiums for businesses and other payers and even as they do so they are reducing coverage, limiting patient access and crippling providers. Prior to the 1999 "sunsetting" of the law requiring SID approval of health insurance premium increases of greater than 10%, the average medical loss ratio for small group

policies was 89%. For the six years following the sunseting of the law, the average medical loss ratio dropped to 81%.

These are profits, furthermore, that are often going out of state. For example, just a month ago, the Governor and Superintendent of Insurance issued a press release noting that three insurers had requested over \$1B in dividends. These sums are not being re-invested to protect New York's health care system. This problem is being identified not only by the health care provider community, but increasingly by the business community which pays for a large share of health care in New York State and whose premiums are rapidly increasing even as the product they are purchasing is diminishing in terms of coverage levels. One recent study by C&B Consulting showed that employer health insurance premiums in the metropolitan New York City region have nearly doubled since 2000.

This budget proposal would address this problem by increasing the medical loss ratios that health insurers must meet for the small group and individual policies they write, as well as assuring that the Superintendent of Insurance has authority to approve requests by health insurers to increase the premiums that they charge their customers. We are hopeful that mandating closer oversight by the Insurance Department will encourage health plans to better assure that premium dollars are spent for health care rather than administration or profit.

7.) Improving Population Health through Dedicated Taxes on Cigarettes and Sugared Beverages

The Governor proposes two tax actions designed to lower long term health care costs by discouraging unhealthy consumption habits that put New Yorkers at risk for obesity, diabetes, cancer, heart failure and stroke. The proposed budget includes an excise tax on beverage syrups and soft drinks at a tax rate of \$7.68 per gallon for beverage syrups and \$1.28 per gallon for bottled or powdered soft drinks. Sixty percent of adult New Yorkers are overweight or obese while the obesity epidemic in children continues to

worsen. Obesity has a major deleterious impact on overall health. It causes diabetes, heart disease, high blood pressure, cancer and osteoarthritis. Comptroller Thomas Dinapoli has estimate that New York spends \$7.6B on adult-obesity-related health problems, eighty percent of which is paid through Medicare and Medicaid. Sugar-sweetened soft drink consumption is scientifically associated with increased body weight. It is estimated that a tax on sugary drinks will discourage purchase and, therefore, reduce consumption of sugared beverage by more than ten percent.

The budget also proposes to increase the tax on cigarettes by \$1 – from \$2.75 per pack to \$3.75 per pack. This increase would result in New York having the highest cigarette tax in the nation with a combined state and local tax of \$5.25 per pack in New York City. IT is anticipated that the proposed cigarette tax increase will decrease cigarette use by 14% and prevent more than 100,000 children from becoming smokers and cause more than 50,000 adults to quit.

MSSNY supports the implementation of these new taxes which would produce revenue of \$650M in 2010-11 and \$1.2B in 2011-12 which will be devoted to finance health care spending.

8.) Continuing Medical Education and Restrictions on Gifts To Physicians

The proposed budget includes provisions which would prohibit pharmaceutical companies and their representatives from providing to physicians and other prescribers, and prohibit such prescribers from accepting, inappropriate gifts and payments. The provisions appear to be somewhat similar to the requirements of the PhRMA updated code of conduct which took effect in January of 2009. The PhRMA Code, however, is a compliance guidance not an enforcement tool and has not been written with the precision needed to adequately apprise the physician whether certain behavior falls within that which is being made punishable. There are severe monetary penalties set forth in the bill which would be applicable to either a company (\$15,000-\$250,000 per

violation) or a health care professional (\$5,000-\$10,000 per violation) who violates the provisions. Moreover, the bill would make such a violation an act of professional misconduct thereby threatening a health care professional's license. These severe penalties should not be imposed when the statute doesn't clearly set forth prohibited activity. For example, The Code references sponsoring educational activities at "appropriate" locations – a subjective standard at best.

We are certainly sympathetic to all reasonable efforts to decrease the cost of prescription medication for our patients. However, we are uncertain how the proposed language would actually reduce the cost of prescription drugs because pharmaceutical companies and physicians already adhere to the code of conduct which this initiative would codify. Moreover, we are also unable to identify the manner by which any budgetary savings might accrue to the State. The proposed budget states that this initiative would translate into a savings to the state in this fiscal year of \$300,000. In our opinion, the state would need substantial resources well beyond the amount estimated to be saved to actually implement and oversee the administration of this initiative.

There is no need for this statute. It will not produce any state savings and possibly would increase the amount of fiscal and staffing resources needed to oversee compliance. Moreover, the significant penalties associated with a violation of such provisions which include loss of one's professional license are draconian and unnecessarily excessive. This bill would have a serious chilling effect on important clinical activities, and most importantly on continuing medical education.

We would also question the need to take this action in New York State as Congress is actively considering legislation at this moment that would require pharmaceutical companies and device manufacturers to disclose aggregate payment of \$100 or more made to health care providers. The federal legislation is likely to contain some form of pre-emption language. Moreover, the PhRMA industry and its relationships with providers are already heavily regulated by the U.S. Department of Health and Human

Services, the Office of Inspector General, and the Food and Drug Administration's Division of Drug Marketing.

9.) Economic Impact of Private Practice Physicians in the State of New York

Finally but very importantly, let me note that all members of the Senate Finance Committee and the Assembly Ways and Means Committee and, indeed, all members of the State Legislature will soon be provided a copy of a recently concluded study entitled "Economic Impacts of Private Practice Physicians in the State of New York." We have long been proud of the contribution which the physician community makes to the public good. This Study, however, looks to another vitally important impact which private practicing physicians have in New York State. It demonstrates beyond argument that private practice physicians are a vitally important part of our state's structural economy. Private practicing physicians constitute one of the largest industries in the State of New York by any measure. A few statistics are informative. In 2008 this "industry" ranked second in total business establishments; sixth in total employment; seventh in total personal income; and thirteenth in total corporate sales. The impact of private physician offices, however, goes far beyond these "direct-effect" measurements.

The "indirect effects" (all goods and services consumed by an industry in the process of conducting business) and "induced effects" (all goods and services consumed by employees through utilization of their wages) yields economic impacts of the private practice of medicine on the State of New York which are truly stunning. When viewed in their totality in 2008, private practicing physicians were responsible for employing almost 1/3 of a million people (330,594), generating total personal income of more than \$24 billion (\$24.096), and total corporate sales of \$44.7 billion. New York State tax revenue in 2008 from private physician practices is over \$4.5 billion. Local tax revenue for the same period is nearly \$4.7 billion.

This Study we have provided you is the most comprehensive economic impact analysis of private medical practices ever undertaken in New York. We urge you to review it in all of its important detail. It will provide you with an overview of the economic impact of our profession on New York State's economy both now and projected into the future as well as the specific economic data in each and everyone of our state's communities including the data relevant to your constituents in your specific election districts. We believe that this information is vitally important as you formulate policies which address the very difficult economy we are experiencing here in New York State and the financial stresses to which our state is now being subjected.

As our elected leaders, you truly do hold much of our State's future in your hands. It is imperative, therefore, that the policies you articulate and which are reflected in the budget you will adopt be premised upon the economic realities of New York. Even as you proceed to eliminate waste and inefficiencies, it is important to preserve and expand what is good in our State to the greatest extent possible. New York's medical practices are one of our State's most magnificent resources. We respectfully ask that the policies you pursue recognize and enhance this reality and in no way diminish it.

Conclusion

Thank you for allowing me, on behalf of the County and State Medical Societies, to identify our concerns and suggestions for your consideration as you deliberate on the proposed budget for state fiscal year 2010-2011. To summarize, we believe that the state can achieve significant savings through the enactment of meaningful medical liability reform. Continued savings can also be achieved through implementation of reimbursement and operational reform of the Medicaid program. The continuation and dedication of funding for two programs- the Excess medical liability program and the *Doctors Across New York* program- are critical to facilitate the retention and recruitment of needed primary care and specialty physicians in certain rural and underserved urban communities in New York State. Importantly, we urge the incorporation of language to assure that any surcharge paid by insurers for any services provided by physicians will

not be passed along to physicians by way of reduced fees or to patients through increased premiums for employers or coverage reductions. We look forward to working with you and your colleagues in the Senate, Assembly and within the Administration as we move toward formulation of the state budget for 2010-2011. Together we can provide a foundation through which the quality of the health care delivery system is maintained and enhanced well into the future and we can do this even as we preserve already scarce but preciously needed resources.

Thank you.

GB

**Statement of the
New York State Nurses Association
Before the
Joint Hearing of the
Assembly Ways & Means Committee and
Senate Finance Committee
on the Executive Budget Relating to Health
February 9, 2010**



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Governmental Affairs Department
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Testimony of the New York State Nurses Association delivered by Deputy Executive Officer, Deborah Elliott, MBA, RN, to the joint hearing of Assembly Ways & Means and Senate Finance Committees, February 9, 2010.

Good afternoon. My name is Deborah Elliot, and I am a registered nurse and the Deputy Executive Officer of the New York State Nurses Association. Joining me today is Shaun Flynn, Director of Governmental Affairs for the Association. The Nurses Association is the oldest and largest professional organization for registered nurses in New York State. It represents the interests of more than 240,000 registered nurses and serves as the collective bargaining agent for more than 36,000 RNs at 150 healthcare facilities. On behalf of our members and the patients they serve, I appreciate the opportunity to address the Governor's 2010-2011 Executive Budget as it relates to health issues.

The Nurses Association appreciates the complexity of allocating public funding during such dire financial times. However, the state's fiscal crisis cannot be allowed to result in an unprecedented healthcare crisis in the name of a balanced budget.

There are a number of recommendations that if passed, could have a negative impact on both the practice of registered nurses and the health and well-being of New York's residents. I will speak briefly about the impact of each:

MEDICAID/HEALTH

\$1 billion in proposed cuts to health care that include hospitals, nursing homes and home care services cuts have the potential to severely limit access to care and endanger patient safety. This is not a blanket statement crafted to save jobs, but instead a harsh reality we must face when considering the health and welfare of New York's citizens.

Hospitals/Nursing Homes/Home Care

Under the current proposal, hospitals, nursing homes and public health programs would see a combined reduction of more than \$562 million in payments for services and an increased assessment on services delivered. The Department of Health would also be authorized to link Medicaid rate reductions to quality-related measures pertaining to preventable readmissions and complications.

Historically, reducing provider reimbursement rates and increasing taxes will prompt facilities to mitigate these shortfalls by reducing direct care staff, primarily nurses. And because New York State lacks regulation to ensure safe staffing ratios, the nurses that are spared will continue to be forced to take on more patients than they can safely care for.

While the Nurses Association supports quality measures to prevent negative patient outcomes, the very issue of quality care depends on staff that provides that care. Financial penalties for not reaching established benchmarks will result in layoffs of nursing staff necessary to achieve these standards.

As a rule, hospitals often have functioned with less staff and resources than is required to safely do the job. This is evident at facilities like St. Joseph's Medical Center in Yonkers where nurses must begin their day fielding phone calls instead of caring for patients because the hospital can no longer afford a receptionist.

A hiring freeze at Coler and Goldwater Specialty Hospitals and Nursing Facilities has led to increased patient infection, as the nursing staff struggle to treat scabies and bedsores that are result of unsafe nurse-to-patient ratios. Protest of Assignments, which document the nurse's belief that the patient assignment that shift is unsafe, are up to 75 a month at the facility.

Perhaps the most recent example is that of St. Vincent's Catholic Medical Center in Greenwich Village, an acute-care facility now struggling to stay open. For more than 150 years, St. Vincent's has built its reputation on providing care for New York's poorest citizens. Deeply rooted in public health, the facility has served the state through countless calamities --- from the cholera epidemic of 1849 to the attack on September 11 -- and is an anchor for AIDs treatment and psychiatric care on the lower westside.

These scenarios, though recent, are not new and no facility is immune. Asking our hospitals and nursing homes to sustain further cuts to vital health services will stretch an already overburdened workforce to its breaking point. Should the proposed budget be approved, the frequency and severity of these unsafe patient care situations will escalate.

Public Health Infrastructure

The resilience and efficiency of our public health infrastructure has been tested time and again with response to terrorist attacks, natural disasters, and most recently with the outbreak of the H1N1 virus. It is our nurses who answer questions in the field from concerned citizens seeking care. Ensuring capacity of our emergency rooms, hospital beds and acute-care facilities is essential to maintaining the public's welfare in times of crisis. One need only look to recent catastrophic events to realize that we must protect our public health infrastructure and shore up our network of resources for when we may need them the most.

Home Care

Home care is a vital component of the state's public health system and one that is relied heavily upon by our most vulnerable population. The recommended 12 hour cap per day for fee-for-service payments will place the burden of care on New

York's citizens; requiring them to seek treatment in alternative settings. This plan carries with it the potential for harm as patients and families attempt to navigate an overwhelmingly complex healthcare system.

NURSING EDUCATION

The Health Resources Services Administration predicts that the state's nursing shortage will reach 17,000 registered nurses by the end of this year. Without highly-qualified, competent RNs in the pipeline, that number is expected to grow to 30,000 by 2020. An increased supply of newly licensed nurses is critical to meet current shortages and future demands in New York State. Demand for nursing education programs is on the rise, yet there still aren't enough programs to meet the growing need.

Aid for Public Nursing Education Programs

SUNY/CUNY Programs

New York State must address the nursing shortage by supporting an educational system that produces highly qualified and competent RNs. While the proposed budget includes continued funding of private nursing education, it cuts funding to the program to expand SUNY nursing education by \$143,100. This reduction would severely diminish the state university system's ability to meet the needs of the nursing workforce over the next decade. The proposed budget recommendation of \$212 million in operating cuts to SUNY/CUNY education programs would put an otherwise affordable option out of reach for many. These programs cannot be discounted as integral to easing the nursing shortage and we ask the Legislature to support tomorrow's nurses by restoring cuts to these programs.

TAP

Under the current proposal, TAP awards would also be reduced from \$5,000 to \$4,000 for two-year degree programs and eliminated for graduate students. Many nursing students rely heavily on this award to supplement unique expenses associated with their education, such as the purchase of uniforms and transportation to clinical sites. Elimination of this award for graduate students would discourage an already small pool of nurses who obtain the master's degree necessary to become nursing educators.

Nursing Faculty Scholarship Programs

A major contributing factor to the nursing shortage is a lack of qualified nursing faculty. A minimum of a master's degree is required to teach most nursing programs. Studies have shown that baccalaureate-educated RNs are more likely to obtain their master's degree or higher, yet a very small percentage of associate degree-educated RNs go on to obtain a higher degree. The average age of a nursing student is 31, as many non-traditional students are entering nursing schools. These adult learners often have outstanding personal debt (cars, homes,

child care, and college loans) that make it difficult to pursue higher education opportunities.

We appreciate the Governor's proposed renewal of the Senator Patricia McGee Nursing Faculty Scholarship Program through 2015 and the recommendation to fund the program at its current level for the 2010-2011 fiscal year. Support of this program signals to the healthcare community that we value our nursing educators and their educational advancement benefits us all.

OTHER HEALTH BUDGET PROPOSALS

The Nurses Association supports the proposed \$650 million in excise taxes on cigarettes and unhealthy beverages. These taxes will discourage the unhealthy habits that strain health spending and promote public health by encouraging New Yorkers to make healthier choices. The added savings will be reflected in dollars, but more importantly, in lives.

We also encourage the legislature to explore some of the revenue-generating ideas proposed by New Yorkers for Fiscal Fairness and A Better Choice for New York:

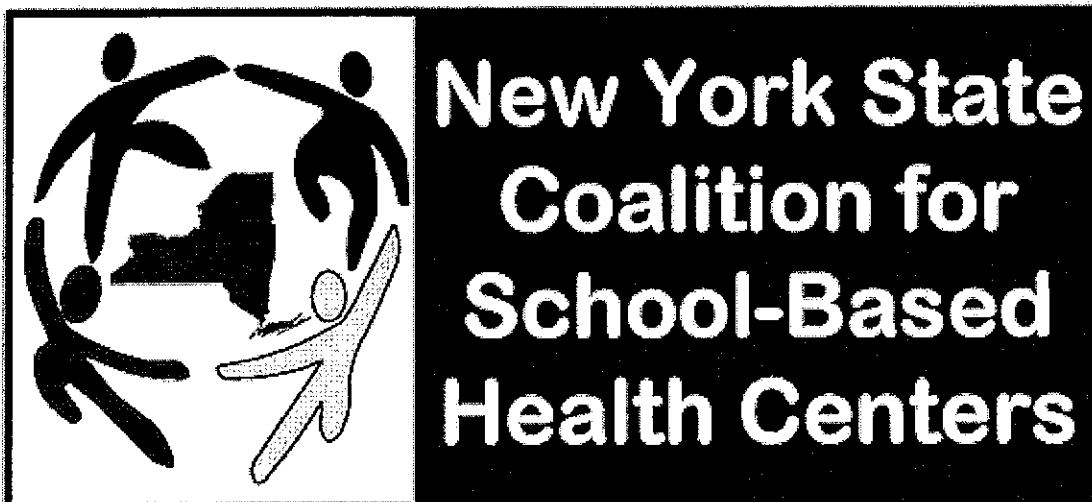
- Stop hiring pricey **private consultants** that cost the state approximately \$200 million per year
- Promote the **bulk purchase of pharmaceuticals** and allow the Department of Health to negotiate directly with drug companies for lower cost drugs
- **Close the Stock Transfer Tax loophole** which allows brokers who pay the tax to receive a 100% rebate, essentially cancelling out any revenue gains

In conclusion, the New York State Nurses Association understands that the state is facing deteriorating economic conditions and revenue shortfalls. However, we hope you'll agree that patient safety and the future of New York's healthcare system cannot be sacrificed in order to close a budget gap.

As you continue your deliberations, we urge you to pass a budget that will protect the public health infrastructure and ensure access to quality healthcare for all of New York's citizens.

Thank you for your time and consideration.

CoC



**Testimony Prepared by:
The New York State Coalition for
School-Based Health Centers**

**Joint Legislative Public Hearings on the 2010-
11 Executive Budget Proposal for
Health and Medicaid**

**February 9, 2010
10:00AM
Legislative Office Building
Hearing Room B
Albany, New York**

Introduction

Thank you for the opportunity to testify at this hearing today. My name is Chris Kjolhede and I the Chairman of the New York State Coalition for School-Based Health Centers. I am a practicing pediatrician and the director of 13 centers in 9 school districts located in 4 counties. All of these centers are sponsored by Bassett Healthcare in Cooperstown, New York.

Also with me today is Natasha Joseph who is an 8th grader at MS 324 in Manhattan.

The Coalition for School-Based Health Centers is made up of 214 School-Based Health Centers (SBHCs) across the State. Located on-site in elementary and secondary schools, they provide comprehensive primary health and mental health services to over 200,000 underserved youth in rural, urban and suburban areas of the State. School-Based Health Centers provide care to every child who enters their door, regardless of income or insurance status. **Studies show that SBHCs increase access to health care for minority youth, improve school attendance and performance, reduce emergency room visits, prevent unnecessary hospitalizations, and lower total annual Medicaid expenditures.**

School-Based Health Centers are a critical part of the State's health care safety net for children. But this safety net is seriously threatened by the impact of recent State budget cuts. Since 2008, centers statewide have had their base funding reduced by over 11%, amounting to \$2.1 million. That might not sound like a lot, but it's devastating to small community providers with a total general fund revenue base of only \$22 million. Many of the centers were not breaking even before the cuts were enacted. If this trend continues services will be reduced and centers will close.

I am here today to ask the State Legislature to support a **restoration in funds of \$507,600** for SBHCs. In addition, the Coalition urges your support for **Child Health Plus (CHP) legislation (S6616Montgomery/A9717Gottfried)** to ensure that SBHCs get reimbursed from managed care plans for the CHP enrollees that they serve. Finally, the **Coalition strongly endorses Governor Paterson's proposals to increase excise taxes on tobacco and sugared beverages.** These excise taxes will raise badly needed revenue and improve the health of children and adults.

Before I begin my testimony today, I would like to thank the members of this panel for their long-standing support of School-Based Health Centers. All of you have been true champions for children's health care and have always recognized how crucial School-Based Health Centers are in caring for the neediest children in this State.

SBHCs: A Children's Health Care Safety Net in Crisis

The need for School-Based Health Centers has never been greater. The recession has created job losses and a spike in the number of uninsured families. This has placed greater stress on families who rely on us even more to provide their children with critical health and mental health care. We are seeing increasing numbers of children enrolling in the centers.

At the same time, the resources of the centers are stretched to the breaking point. In addition to State Budget cuts, SBHCs have suffered severe losses due to the growing number of uninsured children, reduced private funding, and the inability of most centers to bill managed care plans for the CHP enrollees that they serve.

The inability of centers to bill managed care plans for CHP enrollees is creating growing deficits as the State shifts children from the Medicaid program to CHP. School-Based Health Centers have a mechanism to bill Medicaid managed care enrollees under a “carve-out” that permits fee-for-service billing. However, there is no such mechanism under CHP. School-Based Health Centers can not be financially sustainable without access to reimbursement for the services that they provide the target population that they were established to serve. We support legislation to fix this problem that I will discuss later as part of our recommendations.

School-Based Health Centers are playing a major role in preventing and managing the H1N1 virus as well as seasonal flu. Our location on-site in the schools positions us perfectly to reach children who need the vaccine. Governor Paterson recognized this last November when he issued an Executive Order to allow SBHCs to administer vaccine for H1N1 and seasonal flu to children and adults. However, this work is putting a tremendous strain on the staff and resources at the centers. Although we receive the vaccine free from the New York State Health Department, there are a lot of unreimbursed costs in educating children and their families and triaging patients. It’s critical that SBHCs are given the necessary resources to continue this work because many of the children that we care for have underlying health conditions such as asthma, diabetes and HIV that make them especially vulnerable.

If SBHCs don’t receive additional funds this year, services will be reduced and more programs will be forced to close their doors. Two centers closed in the Bronx last June. One center closed in Clifton Fine in Upstate New York in 2009. Four more were slated to close in Brooklyn. With the help and support of many of the legislators on this panel the Brooklyn centers were given an 11th hour reprieve. However, these centers remain extremely financially fragile.

SBHCs: Health Benefits and Cost Savings

A greater investment in the SBHC safety net will improve the overall health of underserved youth and save the State money. As noted earlier, studies show that they increase access to health care for minority youth, improve school attendance and performance, reduce emergency room visits, prevent unnecessary hospitalizations, and lower total annual Medicaid expenditures.

For example, in a study in Cincinnati, children who were treated for mental health services in SBHCs showed significant declines in depression and improvements in self-confidence. The study showed that the most significant progress was made by minority students.

A study at a SBHC sponsored by Montefiore Medical Center in the Bronx found that children with asthma in schools without a SBHC were twice as likely to be hospitalized as those who had a center in their school. The Bronx study also showed that emergency room visits were double for children in schools without a SBHC.

- The fact that the children diagnosed with asthma had fewer complications and were healthier meant that they could stay in school and learn. Asthmatic children in elementary schools without a SBHC missed three more days of school on average compared to those in a school with a center. The students who used the SBHC were more likely to graduate or be promoted than students who did not use the services.

These interventions save money. **In New York, the State's School-based Health Centers saved nearly \$3 million in hospital inpatient costs alone in one year for children with asthma.** In addition, two years after implementation of a SBHC in Atlanta, students had total Medicaid expenditures of less than one-half (\$899) that of their counterparts (\$2,360) in schools without centers. These cost-savings don't even account for the increased productivity of parents who would otherwise have a significant number of lost work days

A list of these and other studies is attached to our written testimony.

Recommendations

I respectfully ask you to consider the Coalition's recommendations for sustaining School-Based Health Centers in this State. Our recommendations are as follows.

Restore \$507,600 in funds. The 2010-11 proposed Executive Budget does not include \$507,600 added by the Legislature in State Fiscal Year (SFY) 2009-10 to fund direct services to children. We ask the Legislature to restore these funds in the final 2010-11 State budget.

Enact legislation (S6616Montgomery/A9717Gottfried) to reimburse SBHCs for CHP enrollees. As noted earlier, most SBHCs can't bill managed care plans for children enrolled in CHP because they are seldom designated as the PCP. CHP requires providers to either be designated by the parents as the PCP, or get a referral from the PCP. Referrals are impossible to get since kids access the centers directly while they at school. As a result, centers provide free care to CHP kids, creating huge deficits in their budgets.

This bill will allow SBHCs. to seek reimbursement for services that they provide to CHP enrollees when the SBHC's sponsoring organization (a hospital or clinic) is part of the CHP provider network in which the child is enrolled

Enactment of this legislation will help CHP managed care plans increase quality and access. Studies comparing SBHCs and managed care programs have found that when adolescents who are enrolled in a managed care plan can still use the SBHC, the adolescents have fewer emergency or urgent visits, more comprehensive health care

visits, and are 10 times more likely to have a mental health or substance abuse visit than those who are in managed care but do not have access to a SBHC.

Enact Executive budget proposal to increase cigarette excise tax. Governor Paterson's 2010-11 proposed State budget increases the cigarette excise tax by \$1.00, from \$2.75 to \$3.75. According to estimates by the Campaign for Tobacco-Free Kids, this increase will prevent more than 100,000 children from becoming smokers and cause 50,000 adult smokers to quit. This is because there is a clear relationship between the price of cigarettes and consumption levels. The Coalition strongly supports this proposal and urges its adoption by the State Legislature.

Enact Executive budget proposal to increase taxes on sugared beverages. Governor Paterson's 2010-11 proposed State budget provides for an excise tax of \$7.68 per gallon for beverage syrups or simple syrups, and \$1.28 per gallon for bottled soft drinks.

The Governor's office estimates that increasing the price of sugar-sweetened beverages by approximately 17% will reduce consumption by 10% and raise \$450 million this year and almost \$1 billion next year. Revenue from this tax will be dedicated to health care spending.

Research has demonstrated that soft-drink consumption is one of the main drivers of childhood obesity. For example, a Harvard study found each additional 12-ounce soft drink consumed per day increases the risk of a child becoming obese by 60%. Obesity leads to Type 2 diabetes, heart disease, high blood pressure, cancer and other diseases. Obese children are at much greater risk of having a heart attack, having a stroke, getting cancer and losing a limb. The Coalition strongly supports this proposal and urges its adoption by the State Legislature.

Conclusion

Thank you for the opportunity to testify today on behalf of the Coalition of School-Based Health Centers. Please support us and help to save this vital safety net for children.

Natasha J.
2/4/10

My name is Natasha Joseph. I would like to be the representative. The Clinic has helped me so much as I've been growing up (5-13 years old).

One reason why we should keep them and you ~~should~~ should fund is because they are familiar with many bodies of the students to detect if anything's wrong.

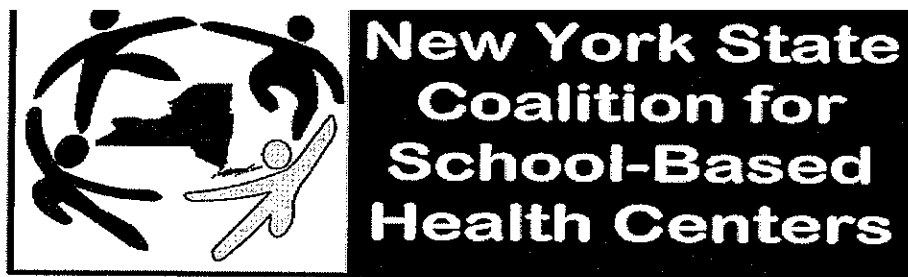
One day when I went to take my physical, the nurse noticed the way my heart beated and found out I had a heart murmur. She told my mom, just so it was nothing serious, that I should see a cardiologist. When I reached the doctor, he said everything was fine but it might not be as I grow up and make bad choices.

Another reason why you should fund the Clinic is because parent might not have money or insurance to pay the bills or the medical attention.

My dad went to jail a few years ago not leaving much money with my mom.

My mom is working late hours and many days just to keep a roof over my 3 brothers and I heads. We also had a dog for many years and it's hard to

get food for him. ~~My mom barely can~~
~~to pay checks and would~~ My mom barely can
afford to pay checks and would
have to barrow hundreds of dollars
from my brothers. She might even
ask for other family members to help
The money for ~~bills~~ medical bills would
make things worse so everything I
do is at the Clinic in my school.



Health Benefits and Cost Savings

A greater investment in the SBHC safety net will improve the overall health of underserved youth and save the State money. Numerous studies show that SBHCs increase access to health care for minority youth, improve school attendance and performance, reduce emergency room visits, prevent unnecessary hospitalizations, and lower total annual Medicaid expenditures.

- ❑ **Increased Health Care Access for Minority Youth.** In a 2003 study average visit rates for Hispanic and African American youth were 6.6 and 10.6 annually compared with an average visit rate of 5.3 for all students who use SBHCs. ⁱ
- ❑ **Improved School Attendance and Progress.** Asthmatic children in elementary schools without SBHCs missed 3 more days on average compared to those in a school with a SBHC. Students who used their SBHCs were more likely to graduate or be promoted than students who did not use the service. ⁱⁱ
- ❑ **Reduced Emergency Room (ER) Use.** In a study in the Bronx, ER visits were double for children in schools without a SBHC compared to those in schools with a SBHC. ⁱⁱⁱ
- ❑ **Fewer Unnecessary Hospitalizations.** The Bronx study also showed that asthmatic children in schools without a SBHC were 50% more likely to be hospitalized than those who attended a school with a SBHC. ^{iv} In an Ohio study, the total annual cost of hospitalization **decreased by 85 percent** (nearly \$1,000 per child) for children at schools with SBHCs. ^v
- ❑ **Lower Medicaid Expenditures.** Two years after implementation of a SBHC in Atlanta, students had total Medicaid expenditures of **less than one-half (\$899)** that of their counterparts in schools **without centers (\$2,360)**. ^{vi}
- ❑ **Kids Use and Trust SBHCs.** SBHC users are more likely than those enrolled in Medicaid or commercial insurance plans to receive critical screening and counseling and they trust their centers as a confidential place to go for care. ^{vii}
- ❑ **Increased Access to Mental Health.** Visits by adolescents were 21 times more likely to be initiated for mental health reasons at SBHCs than at community health network facilities. ^{viii}
- ❑ **Improved Mental Health.** Students who used SBHCs showed significant declines in depression and improvements in self-concept. ^{ix} They were less likely to report considering suicide. ^x

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Healthy Children. Healthy Teens. Healthy School.

ⁱ Juszczak, Linda, Paul Melinkovich, and David Kaplan, "Use of Health and Mental Health Services by Adolescents Across Multiple Delivery Sites," *Journal of Adolescent Health*, Volume 32, Number 6, Supplement to June 2003, pp. 108-118.

ⁱⁱ McCord, M.T., Klein, J.D., Joy, J.M. and K. Fothergill, "School-based Clinic Use and School Performance," *Journal of Adolescent Health*, 1993, 14, pp. 01-98.

ⁱⁱⁱ Webber MP, Carpinello KE, Oruwariye T, Lo Y, Burton WB, Appel DK. Burden of Asthma in Inner-city Elementary Schoolchildren: Do School-Based Health Centers Make A Difference? *Arch. Pediatr Adolesc Med*. 2003; 157, pp. 125-129

^{iv} *ibid*

^v Guo JJ, Jang R, Keller KN, McCracken AL, Pan W, Cluxton RJ. Impact of School-Based Health Centers on Children with Asthma. *Journal of Adolescent Health* 2004.

^{vi} Adams EK, Johnson V. An Elementary School-Based Health Clinic: Can it Reduce Medicaid Costs? *Pediatrics* 200; 105, pp. 780-788

^{vii} Klein JD, Handwerker L, Sesselberg TS, Sutter E, Flanagan E, Gawronski B. Measuring quality of adolescent preventive services of health plan enrollees and school-based health center users. *J Adolesc Health* 2007;41, pp. 153-160

^{viii} Juszczak L., et al.

^{ix} Weist, Paskewitz, Warner, et al., "Treatment Outcomes of School-based Mental Health Services for Urban Teenagers," *Journal of Community Health*, 1996, 32, pp. 149-157.

^x Kisker, E.E. and R.S. Brown., "Do School-based Health Centers Improve Adolescents' Access to Health Care, Health status, and Risk-taking Behavior?" *Journal of Adolescent Health*, 18, pp. 335-343.

6D



Community Health Care Association of New York State

**Senate Finance and Assembly Ways and Means
Joint Legislative Hearing on the
2010-11 Executive Budget
Health & Medicaid
February 9, 2010**

Thank you for the opportunity to talk with you today about the Governor's budget proposal and our perspective on what works, what is missing and what needs to be changed. Our most urgent concern is ensuring that New York does everything it can to make sure that our community-based primary care infrastructure is not further weakened by State policy decisions in the coming months and year.

My name is Kate Breslin and I am the Director of Policy for the Community Health Care Association of New York State, CHCANYS, the state's association of community, migrant and homeless health centers. CHCANYS works to ensure that all New Yorkers, and particularly those living in underserved communities, have access to high quality community-based health care services.

Medicaid Matters

CHCANYS is a founding member of the Primary Care Coalition and also is an active member of Medicaid Matters New York, a coalition of more than 130 organizations focused on what Medicaid policy should be focused on --- the individuals and families who rely on Medicaid coverage.

Medicaid does matter to New York's health centers and to our patients. Forty-five percent of health center patients are covered through Medicaid, Child Health Plus or Family Health Plus and 28 percent are uninsured; Medicaid provides a significant portion of the funds that allow us to care for our patients and serve as New York's primary care safety net. We urge the Legislature to support proposals in the Executive Budget that reduce the number of uninsured New Yorkers, streamline public health insurance programs and devote funding to caring for the uninsured.

New York's Primary Care Safety Net

Community, migrant and homeless health centers serve as the family doctor and healthcare home for over 1.3 million New York State residents at more than 445 sites, rural and urban. Health

With this in mind, we respectfully urge the Legislature to:

Increase funding for the Diagnostic and Treatment Center (D&TC) Indigent Care Pool.

On average, twenty eight percent of health center patients in New York are uninsured, and at some centers, more than half of all patients are uninsured. Last year, the Legislature thoughtfully and prudently added \$8 million to the Diagnostic and Treatment Center Indigent Care Pool, the funds that help to ensure that uninsured patients can be cared for in primary care settings. These funds were swept away in the Governor's 2010-11 Budget proposal and the Governor's Budget also continued a 2% reduction (from last year's DRP) in the pool. These cuts undermine the very primary care safety net that the Department of Health has said we need to strengthen in order to advance broader health reform. New York State covers only 32 cents on the dollar for high quality, cost-effective primary health care for uninsured persons cared for in community-based primary care settings that help patients avoid more expensive settings. New York has applied for federal matching funds to assist the State in providing funding for this care; the waiver is awaiting approval from the Centers for Medicare and Medicaid Services.

Restore funding for Electronic Health Records (eHR) Transition; the Transition funding cut is a significant cut to the primary and preventive care safety net.

The Executive Budget proposal removes last year's (2009-10) Electronic Health Records (eHR) Transition Funding that was passed by the Legislature (by not reappropriating it) for community health centers and other primary care providers. The Executive Budget also eliminates the full \$9.8 million (\$4.9 State share) eHR Transition fund in 2010-11. eHR Transition funding enables primary care providers that care for a high volume of Medicaid and uninsured patients to implement integrated electronic health records. eHR Transition funds of \$4.9 million in State funding draw down a Medicaid match. Primary care safety net providers are not large institutional providers, and do not have large operating margins with which to make these investments that are considered crucial to reducing duplication, coordinating care and measuring and tracking outcomes.

Promote thoughtful Medicaid policy and Medicaid program integrity efforts that target fraud, apply clear standards to program participants and do not make it even harder for needy patients to get the care that they need.

The Governor's Budget proposes an additional \$300 million more than last year in targets for the Office of the Medicaid Inspector General, bringing the OMIG recoupment target to \$1.17 billion. As noted earlier in my testimony, Medicaid is extremely important to New York's health centers and the integrity of the Medicaid program is essential: if Medicaid does not work well, New York's health centers will not survive. We are enthusiastic supporters of efforts to root out fraud and abuse. At the same time, our recent experience with the Medicaid Inspector General has left New York's health centers chilled and confused. OMIG audits over the last 18 months have sought to apply improper standards to payment policy and the audit processes have been extraordinarily and unnecessarily burdensome. Often, the target is not fraud, but technical issues (a misspelled name, misplaced digits in identification numbers, etc.), that permit recoupment even where all agree that high quality services have been delivered to eligible Medicaid participants. In other instances, OMIG has sought to apply interpretations of policy or procedure

that depart from or expand upon existing guidance from the Department of Health. Health centers rely on guidance from the Department of Health to inform their billing policies and procedures. Yet health centers have found that the Medicaid Inspector General often seems unaware of such guidance when initiating an audit, and as a result, applies policies to periods for which there is not clear guidance or interprets policy in different ways than the Department of Health. When this happens, the burden shifts to the health center to prove what the DOH guidance required, a process that can and has required expensive legal fees and considerable time away from focusing on patient care.

In addition to the issues raised above, we share the concerns articulated by many of our colleagues at last month's Senate Investigations and Government Operations Committee hearing, including the use of extrapolation techniques that are not understandable and recouping funds prior to final audit determinations or hearing outcomes and at excessive rates.

We are concerned that the increased recoupment targets, in the absence of changes in the OMIG's methodology and tactics, may allow the State to close budget holes on paper, while making the holes in the primary care safety net even bigger. We urge the Legislature to make budget decisions that are thoughtful and that lay the groundwork for strengthening our system, rather than chipping away at it.

Support the Executive Budget's Doctors Across New York proposal to bring physicians into underserved areas.

The Governor's Budget proposes 50 new slots for physician loan repayment and 50 for grants for physician practice costs in the Doctors Across New York program, the goal of which is to provide incentives for physicians to practice in medically-underserved areas throughout the state. There is a serious shortage of primary care physicians in rural and poor urban areas throughout New York State and over ¼ of the State's population live in areas designated as "underserved." And as primary care providers in economically distressed communities, health centers struggle to find the professional staff that they need. CHCANYS supports Doctors Across New York as an effort to improve access to health care services in needy areas across the state. We continue to seek an expansion of the program to cover mid-level practitioners, like nurse practitioners, and specialists, like dentists and psychiatrists, in areas where they are most needed.

Protect migrant health care.

The 2010-11 Executive Budget continues a funding reduction for Migrant Health Care Programs across New York State from \$442,000 provided in previous years to \$430,000. Migrant and seasonal farmworkers are integral to New York State's agribusiness. Yet three in five farmworkers live below the federal poverty level, and farm work ranks as the third most hazardous occupation in the nation, behind mining and construction. New York's migrant health care centers keep farmworkers healthy by providing primary and preventive health care services, including culturally competent outreach, interpretation, transportation, health education and dental care. CHCANYS requests that funding be restored to \$442,000 in order to serve this special population that is at high risk for injury and illness.

Support efforts to provide “medical homes” for underserved New Yorkers.

CHCANYS urges the Legislature to support efforts to ensure all New Yorkers have a health care home so that patients can access timely and appropriate primary and preventive health care. A medical home is where care is provided in a comprehensive, coordinated, culturally competent way. Evidence shows us that medical homes yield better patient health outcomes and lower costs by ensuring provision of timely and appropriate primary and preventive health care, and, in turn, reducing expensive emergency room visits and avoidable hospitalizations.

Community health centers have built a national reputation for high quality health care based on a commitment to standards that align with the medical home model. We urge Legislature to support programs that align incentive payments to provision of high quality, cost-effective care to Medicaid and other patients and to ensure that standards are patient-focused and that they incentivize increased access for the hardest to reach.

In Sum.

While you, our budget and policy experts, examine where and how to balance New York State’s budget, we respectfully request that while you act to shore up this year’s budget, you do so in the context of a long-term plan. For decades New York State has urgently needed to rebalance its health care delivery system from one reliant on expensive emergency and inpatient care to one that makes available strong, effective, affordable primary and preventive care. Failure to do so continues to leave New York at the high end of spending but near the bottom in addressing the health needs of its vulnerable populations. We respectfully request that the Legislature strengthen our primary care infrastructure and protect those who are most vulnerable.

I sincerely appreciate the opportunity to present my testimony to you today. Thank you.

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Women's Health Matters !

6 E

Joint Budget Hearings
Family Planning Advocates of New York State
February 9, 2010

Testimony of Tracey Brooks, President and CEO

FPA represents the state's Planned Parenthood affiliates, hospital-based and freestanding family planning centers, and a wide range of health, community and social service organizations that collectively represent an integral part of New York's health care safety net for women and men throughout New York State.

Family planning centers provide critical services such as family planning counseling, contraception, pregnancy testing, prenatal and postpartum care, health education, and treatment and counseling for sexually transmitted infections and diseases, to name a few. Patients are primarily women of child-bearing age. With the economic downturn, providers are seeing some variations in patient visits, with most reporting an increase in new patients over 40 who have recently lost health insurance.

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- **For every 1 dollar spent on family planning services in New York, 4 dollars in Medicaid costs are saved.**
 - **For every one of those Medicaid dollars New York spends on family planning, the federal government reimburses the state 90 cents—a 90/10 match.**
-

Strategic reductions prove vital

Just a few months ago, when you were considering the Deficit Reduction Plan, FPA faced the reality of the state's financial situation. We realized that cuts were inevitable, so we worked with you, the Legislature, to identify ways to reduce family planning funding without compromising access to core primary and preventive health care services.

Funding for family planning is a cost-effective public health strategy. In fact, more than **6 in 10 patients** receiving care at a women's health center consider it their **primary** source of health care. For every 1 dollar spent on family planning services in New York, 4 dollars in Medicaid costs are saved. And, for every one of those Medicaid dollars New York spends on family planning, the federal government reimburses the state 90 cents—a 90/10 match. Both of these savings are realized within the SAME BUDGET YEAR.

On behalf of the women and men served by family planning providers, **we thank** you for working with us and targeting reductions. While these reductions did cut into the health centers' ability to provide services, we know that across-the-board cuts would have done much more harm.

We urge you to keep the same family planning considerations in mind as you make the difficult decisions that lie ahead. There are cuts in this proposed budget that will again negatively impact the health care providers we represent; they include cuts to COLA and recruitment and retention funds. We are here today to urge you to be mindful of increasing demands for our services and dwindling health center revenues.



Family Planning Advocates of New York State

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Conclusion

The Legislature has a history of supporting the work of our providers, although it has been zeroed out in the proposed Executive Budget.

Given the continuing fiscal crisis in the state and FPA's continued commitment to partner with you, we are not asking you to restore any other funds lost in the proposed budget; but we do ask for funding traditionally included by the Legislature to be renewed. In this time of fiscal crisis, this funding will be critical in preserving the jobs of those who provide services in our health care centers. This source of support arrives at the health centers during the most expensive operational months of their fiscal year.

We know this will be another difficult year. FPA is prepared to partner once again with the Legislature to preserve access to core reproductive health care services. We urge you to continue to keep FPA involved as you make decisions and to pass a budget we can count on for the 2010-11 year.

Thank you for your consideration.

We urge you to continue to keep FPA involved as you make decisions.

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THE 2010-2011 EXECUTIVE STATE BUDGET

A Joint Hearing Before

**THE SENATE FINANCE AND
ASSEMBLY WAYS AND MEANS COMMITTEES**

February 9, 2010

Testimony on Behalf of:

The Home Care Association of New York State, Inc. (HCA)

Delivered By:

Michelle Mazzacco

Member of the Board of Directors
Home Care Association of New York State

Vice President/Director
Eddy Visiting Nurse Association



Opening Remarks

Good afternoon. My name is Michelle Mazzacco. I am a member of the Board of Directors of the Home Care Association of New York State (HCA), on whose behalf I will be testifying today. I am also the Vice President/Director of the Eddy Visiting Nurse Association.

HCA is a statewide not-for-profit organization representing over 400 home health care providers, allied organizations and individuals involved with the provision of home care in New York State, and approximately 400,000 patients statewide. HCA's mission is to promote and enhance the quality, accessibility and availability of home care by enabling its members to meet the health and assistive needs of frail elderly, chronically ill and disabled New Yorkers.

HCA providers are a core part of the health care system. Our services, through the care provided by visiting nurses, therapists, medical social workers, home health aides and other allied professionals, help patients recuperate and receive rehabilitation safely at home following a hospital stay. We also provide long term home care and management for chronic conditions so that, whenever possible, patients can avoid having to enter or re-enter a hospital or nursing home. By providing care to our patients at home, we are also able to further maximize their functioning, support their quality of life and reduce health care costs.

I come before you today in appreciation of the Legislature's past support for home care and in recognition of the difficult choices that government officials must make to keep the state's fiscal house in order. HCA stands ready to continue to work with the Legislature and

Governor on constructive ideas, including those we have already shared with you – proposals which draw upon home care's cost-effective design, benefits and advantages as part of the solution to the state's fiscal management needs.

I welcome the opportunity to testify today and, of course, do so based on the Governor's January budget submission, not yet knowing what the Governor intends to include among the additional \$750 million dollars in budget cuts and/or actions slated to be announced this day or in other amendments he may propose in his 21-day package.

Among several key messages I hope to leave with you in this testimony are:

- First, home care is not the problem; it is part of the solution, and a part of our system which hundreds of thousands of patients, family members and indeed our state's health care policies greatly depend upon each and every day.
- Second, enormous Medicaid budget cuts to home care exacted in recent years in an attempt to remedy the state's fiscal problems have already left many providers on the brink, unable to withstand further erosion, and enormously challenged in their mission to deliver care and buttress the state's health care infrastructure. You will be greatly alarmed by portions of my testimony today concerning the financial condition of the home care community in this state. Home care needs and merits investment, not further cuts.

- Third, the cuts contained in this new Executive budget – added to the compounded cuts, unfunded mandates and chronic underfunding of services which have left our system so badly damaged – cannot be sustained. These newest cuts undermine the very financial benefit that home care brings to the Medicaid system and otherwise ignore the wisdom it can further bring to the state's fiscal policies. Please reject the Executive's proposed, counterproductive cuts, and the further damage to the system they will surely bring,
- And fourth, we offer and look forward to working with you, the Legislature, as well as the Governor, on creative, constructive solutions to Medicaid efficiency that will help in this fiscal year, and in the years beyond.

Together, through cooperation, we can develop sound policies that solve today's pressing fiscal needs, promote long-term efficiencies rather than prolonged fiscal ruin for our health care system, and continue to care for patients in the most appropriate setting at the right cost. I will be speaking further about our ideas later in my testimony.

The Eddy VNA

I would like tell you a bit about my agency, The Eddy Visiting Nurse Association (VNA), based in Troy, New York. We serve an average of 1,300 patients on any given day in five Capital Region counties through our Certified Home Health Agency (CHHA), Long Term Home Health Care Program (LTHHCP) and Program for All-Inclusive Care for the Elderly (PACE). Most of the services we provide are funded by Medicaid, since most of our patients

are covered by that program. When Medicaid funding is cut, as the Governor's budget again proposes to do, we have little recourse for making up the lost funds.

In the case of such drastic Medicaid cuts, while our options are few, the consequences for patients are innumerable.

For instance, without the Eddy's LTHHCP, also known as "the Nursing Home Without Walls," nearly 500 nursing-home-eligible patients throughout the Capital Region would no longer be able to receive needed care at home. The LTHHCP is a statewide program administered locally by providers like the Eddy that rely substantially on their patients' Medicaid coverage to keep them out of higher-cost nursing home settings through sophisticated case management involving a mix of home health aide, skilled nursing, therapy and other services, as ordered by the patient's physician. Statewide, the "Nursing Home Without Walls" serves approximately 25,000 patients at an average cost that is half of what Medicaid pays for nursing home care, making the LTHHCP a primary and cost-effective cornerstone of our home care system, and our health care system generally. Without this program providing services in the home, where would the Eddy's 500 nursing-home-eligible LTHHCP patients go?

Let me describe for you a couple of the Eddy's patients who come to mind when I think of what further budget cuts will mean for those who rely on home care.

Ms. K is a 55-year-old woman with diagnoses of Guillain-Barré syndrome (a disorder in which the immune system attacks part of the peripheral nervous system causing severe muscle weakness, paralysis and sometimes death), chronic obstructive pulmonary disease, type 2 diabetes, hypothyroidism, and sleep apnea. Ms. K also has a tracheotomy and an IV port, is on continuous oxygen and is morbidly obese. Ms. K has been an Eddy home care patient for three years and has had just one hospitalization, for pneumonia. She receives home telehealth monitoring on a daily basis, combined with nursing visits one to two times per month for skilled care, assessment and patient teaching and monitoring. She is clearly a highly needy and medically unstable patient who would lose her ability to remain at home without the care and support of the home care agency, resulting in a severe impact to her personally and enormous additional cost to the system.

Another patient, Ms. M, is a 58-year-old woman with a diagnosis of Pyoderma Gangrenosm (open leg wounds which will never heal), a history of strokes and osteoarthritis. She lives with her elderly father and has been receiving Eddy home care services for over 20 years. The agency provides Ms. M with nursing visits two to four times per week and a home health aide to assist with her personal care needs. Despite the intensity and complexity of her condition, Ms. M has had just one hospitalization in all this time. When Ms. M's father became ill, the agency provided him with services as well, delivering care in a way that was both efficient and critical to the support of his role as his daughter's caregiver. The agency similarly supported Ms. M's mother prior to her passing in 2003. This is a great example of not only what home care can do to keep an extremely ill person at home, but to also incorporate and support the assistance of family caregivers in this effort.

I hope these stories – among countless others I could tell – impress upon you the potential effect of the Executive budget cuts on these individuals, let alone the cumulative effect of budget cuts and other actions over just the past several years alone.

Home Care Today

In order to understand the full effect of state policies on home care, one must recognize that the home care system has evolved into a highly skilled, pivotal part of the overall health care delivery system, as the cases I've just described help portray. As the expectations about home care's role in the health system have changed over time, so has the cost of delivering care.

Today, my agency serves patients with increasingly complex clinical needs at home – many of whom, not so long ago, would have certainly resided in a nursing home. Without home care, most of these patients would be hospitalized more often, experience much longer acute care stays should they be admitted, and would be more likely to eventually need nursing home care as their health, cognitive, or physical condition deteriorated – all at a much higher cost to Medicaid.

In addition to serving patients with more sophisticated needs, both our CHHA and LTHHCP employ leading-edge disease-management programs to combat chronic illnesses among young disabled and elderly patients as well as high-tech medical equipment to care for medically fragile children at home at far less cost than in institutions. We also use technology, such as home telehealth, to monitor patients' vital signs in between nursing visits, leading to substantial reductions in unnecessary emergency room use, doctor visits and hospital stays. These are just some of the vital improvements and savings opportunities brought about

through home care and its incorporation of technology and professional skill. The Eddy's telehealth program, for instance, monitors an average of 230 patients daily, extending the clinical encounter beyond scheduled face-to-face home visits and increasing collaboration with the physician.

This shift to providing complex care at home, as well as the cost-effectiveness of this trend on a national level, has been well chronicled. For instance, a study by Avalere (2009) found that early intervention post-acute home care services for patients with diabetes, chronic obstructive pulmonary disease or congestive heart failure saved Medicare \$1.71 billion and would have saved \$1.77 billion more with wider use. (References to other studies on the cost effectiveness of home care are included in Appendix 2.)

Precarious Fiscal Condition of Home Care

In spite of home care's proven cost-effectiveness and its success in managing an increasingly elderly patient population with more complex health conditions, a legion of past Medicaid cuts has left many providers in dire economic distress, as reimbursement levels fail to keep pace with the increased cost of delivering care. Not only have home care providers been inflicted with over \$320 million in Medicaid cuts during the past two years, but their operations have been further sidelined by new unfunded mandates and taxes that wield an impact amounting to \$65 million per year. To put this in perspective, consider the effect of \$65 million on agencies whose costs are largely personnel-related. Under the streamlined home care operating model, our core cost is the service itself provided by home health caregivers. Given this profile, when \$65 million is factored as a share of home care's overall operating cost

picture, then the toll of unfunded mandates and taxes alone is equivalent to a 3.6-percent Medicaid cut in just one year, packing an enormous blow on top of more explicitly defined reimbursement cuts.

In late 2009, HCA and the New York Association of Homes & Services for the Aging conducted a multi-tier analysis of the financial stability of the home care industry. Our study, entitled *Lethal Doses: Chronic Cuts and New Mandates Threaten Home Care in New York State*, involved a statewide survey of home care providers in conjunction with an analysis of Medicaid cost reports, which providers must file each year with the state. The cost report is an independently certified financial statement that is the basis for Medicaid rate setting policies. It also tells us a lot about the financial condition of the home care industry. Among the report's key findings:

- 67 percent of all home care agencies that are required to file cost reports were operating in the red in 2007, as a result of underpayment by the state, budget cuts and unfunded mandates;
- 75 percent of county-operated agencies and 76 percent of LTHHCPs were operating in the red in 2007, as a result of underpayment by the state, budget cuts and unfunded mandates;
- 44 percent of agencies surveyed by HCA and NYAHSa reported that they must borrow money to meet their operating expenses;

- 44 percent of agencies surveyed by HCA and NYAHSA indicated they are either “likely” or “very likely” to close their doors if hit with an additional five-percent cut; and
- In response to already enacted cuts, 51 percent of agencies have cut direct-care staff, 41 percent have reduced services, 90 percent have delayed filling staff vacancies, and 66 percent have delayed technology initiatives, according to the HCA/NYAHSA survey.

These findings paint a grim picture, revealing how chronic disinvestment in the home care industry threatens home care’s role as a safety net that averts the need for costlier hospitalization, the incidence of hospital readmissions, repeat emergency room visits, and premature nursing home entry. Earlier in my testimony I mentioned the Eddy’s LTHHCP, which serves an average of 475 nursing-home-eligible patients on a given day. The fact that 76 percent of LTHHCPs are operating in the red is a grave sign for the future of home-based long term care in New York State, as a program that has proven its value to patients, the state, and the health care system teeters financially on the edge.

One of the most alarming trends revealed by the HCA/NYAHSA report is the fact that 44 percent of home care agencies that participated in our survey are borrowing money to stay afloat. It has become clear that while the state applies cuts as a remedy to balance its budget, those very same cuts force providers to essentially mortgage their operation, spiraling deeper into the red in order to continue providing services to Medicaid patients. The 67 percent of home care providers now operating in the red have clearly made the difficult choice of risking

financial insolvency for the sake of continuing their mission to serving New York's most vulnerable patients.

This financial picture is clearly rooted in the chronic underfunding of home care. In just two years, home care agencies have had to endure across-the-board funding eliminations; a new gross receipts tax (GRT) on their revenues and other taxes; premium reductions; new regulations and unfunded mandates; and the elimination of vital workforce investment monies for upstate New York – all measures that, ominous enough on paper, in reality rock the very foundation of an infrastructure already faced with the rising cost of patient care and operations, staff shortages, overreaching government audit activities, and other pressures.

These prior-year cuts, coupled with proposals in the 2010-11 Executive Budget to further reduce home care by nearly **\$155 million**, would bring the overall toll to almost a **half billion dollars in cuts to home care**, just since April 2008. (See Appendix 4.) Given the current financial precariousness of home care, further home care cuts of this size will cripple a delivery system already on the brink of collapse.

In addition to recent destructive home care cuts, home care agencies have been dealt a litany of unfunded mandates and taxes that are costing them an additional estimated **\$65 million** per year – itself the equivalent of a 3.6-percent Medicaid cut. This unprecedented level of new mandates has caused an enormous dislocation of home care agency staff and resources, as personnel are pulled away from core tasks related to service delivery and are instead dedicated

to administrative functions. A number of these new mandates are described in Appendix 3 of this testimony.

2010-11 Executive State Budget Proposals

Against this backdrop of severe home care agency financial instability and a succession of newly imposed unfunded mandates, the Governor has proposed a 2010-11 Executive State Budget that includes Medicaid home care cuts estimated by the Administration at \$73.9 million (state share). However, these cuts have a compounding adverse effect on patient services in that Medicaid reductions at the state level also result in the loss of federal matching dollars. Therefore, \$73.9 million in state-share cuts increase to approximately \$155.2 million when the federal matching share is applied in 2010-11. (See Appendix 1.)

Elimination of the Medicaid Trend Factor

A major cut proposed by the Executive is the elimination of the Medicaid trend factor for all of 2010 and the first quarter of 2011 (from January 1 to March 31) for CHHAs, LTHHCPs and Personal Care providers. The Administration estimates these actions would result in over \$25.8 million in state-share cuts. HCA estimates the trend factor elimination would result in \$62.9 million in state/federal-share cuts for 2010-11.

This new trend factor cut is on the heels of prior budget actions which eliminated the 2009 trend factor and greatly slashed the trend factor for 2008. Please be aware that these legislated cuts, as well as the current 2010-11 budget proposal, are not only imposed in these specific years, but are rolled into perpetuity in all future years, eliminating necessary payment to

providers for services that patients need and for activities – *and mandates* – the state expects. These cuts exacerbate an already woefully inadequate trend factor that, even when funded at its intended percentage, fails to generate state rates that meet the cost of delivering services and maintaining a proper infrastructure. The results of our *Lethal Doses* fiscal-conditions report bear out the consequences and perilous forecast of such chronic underfunding and methodological cuts.

The trend factor is often misleadingly viewed as an “equitable” form of cut in the budget process because of its applicability across all sectors of care. However, unlike other services, home care is not a service with embedded “bricks-and-mortar” costs, major medical equipment, the operation of physical plants and the like. Virtually all of home care’s costs are concentrated in direct-care personnel, along with the activities that support the delivery and management of patient care and the transport of staff and equipment to and from patients’ homes. Therefore, the trend factor elimination in home care slices right into the heart of service delivery and the core of our agencies’ operations. There is no other place to turn when these funds are cut.

In addition, the rising level of patient acuity, growing complexity of patient care demands, challenges with the recruitment and retention of direct-care staff, need for investment in home care technology and infrastructure, and constantly mounting state and federal mandates, are unavoidably reflected in provider costs. These real costs in home care can’t just be “zeroed-out,” as if a “zero” inserted into the trend factor statute will make such costs disappear. The costs can’t be ignored and there are no places for home care to shift or make them up, and no

compensatory or mitigating actions taken by government to insulate home care providers against these losses.

As there is always justifiable alarm in the legislative process for the effect of such Medicaid cuts on “high-need” / “high-Medicaid” providers in other health sectors, the impact on home care merits a commensurate level of alarm. A substantial part of home care is covered primarily by Medicaid, including care to special needs populations, medically fragile children and chronically ill elderly who receive long term care at home as an alternative to institutionalization. These services are hit disproportionately hard by such Medicaid cuts. Witness the devastating effects that Medicaid underpayments and cuts are having on the state’s LTHHCP, with 76 percent of these providers experiencing operating losses as of 2007, and with a 65-percent increase in the amount of LTHHCP operating loss between 2004 and 2007. A program that cares for patients at home at an average of about 50 percent of the cost of institutional placement, serving both the patients’ and the state’s goals, is in jeopardy because of the disproportionate effect of such cuts and such chronic underfunding.

Increased Gross Receipts Tax (GRT)

Last year’s budget included the levy of a 0.35-percent gross receipts tax (GRT) on CHHAs, LTHHCPs, Licensed Home Care Services Agencies (LHCSAs), and Personal Care programs (at a then-estimated cost of \$14 million per year). This tax is imposed on all streams of revenue and penalizes those agencies that try to bring in non-Medicaid business. Patients already attempting to pay privately for services face surcharges on their payments as a result of the GRT – in essence, the GRT taxes the uninsured home care patient.

The home care GRT is also disproportionately applied to home care in that it is not reimbursable (as is the nursing home GRT) and is applied to Medicare payments, which the Legislature has explicitly excluded under the GRT applied to nursing homes.

The proposed 2010-11 budget would increase the GRT on home care to 0.70-percent, which would result in approximately \$17.6 million in new home care provider taxes for 2010-11 – on top of a GRT of similar impact that was newly inserted in last year's state budget.

Cap on Personal Care Services

HCA supports efforts to align patients with programs which are most able to appropriately manage the intensity and complexity of their care needs. In fact, we have offered several proposals designed to enhance quality and efficiency through more refined assessment, better flow of patients into services, improved opportunities for provider collaboration and other innovations to support care management service delivery.

Though seemingly complementary to some of these principles, one of the Executive's main home care proposals raises many concerns as to its structure, effect and workability. HCA recommends that the Legislature and Governor instead work with approaches which we have offered and that we would continue to collaboratively develop with our peers in the home care community.

The Executive proposes to place an average 12-hour-per-day cap on personal care services, and to concurrently redirect affected personal care program patients to other community-based programs such as the LTHHCP and Managed Long Term Care (MLTC) on the basis that the care management capacity of these programs is more appropriate to the needs of these patients. The proposal is projected to have a state-share impact of \$30 million and an HCA-estimated state/federal-share impact of \$73.17 million.

The proposal as crafted raises serious concerns about its workability and effects, and has the potential to disrupt patient access and care for an estimated 5,000-plus beneficiaries.

The content of the current proposal offers little insight into the application of the cap or the process for redirecting patients to these other programs. While seeking to establish a threshold for the review and referral of high need patients to appropriate programs of care, the proposal seems devoid of flexibility in relation to personal care in cases where flexibility would be vital for the consumer, and the proposal makes no corresponding adjustments in the programs to which patients would be redirected in order to ensure the ability of these programs to enroll this high-need population. For example, current expenditure constraints applicable to both the LTHHCP (i.e., an individual care plan cost cap) and MLTC (i.e., rate capitation) would have to be concurrently addressed in order for these programs to properly enroll such patients – an action HCA suggests the Legislature consider independent of the Governor's proposal, considering the value of these programs in delivering cost-effective services.

As stated throughout this testimony, HCA has presented the Legislature and Executive with positive alternatives to cuts and ideas for system improvements, including ideas related to the screening and care of high need patients in ways we feel are preferable to those advanced in the Governor's proposal. We look forward to working with the Legislature and the Governor on the establishment of supportive methods of improving patient care access and care management.

Prospective Payment System (PPS) for CHHAs

Last year, the state budget included a proposal to change the reimbursement system for CHHAs from its current fee-for-service structure to a prospective payment system (PPS) under which home health agencies would receive a bundled rate (episodic payment) for delivering care to a patient over a 60-day period, with payment varying according to health severity. The change would have applied to new cases starting in January 1, 2010 and would have assumed built-in reductions of \$200 million (state/federal Medicaid shares).

HCA argued against the imposition of a reform of this magnitude without thorough analysis, statistical modeling, piloting, transitioning and full vetting with providers, consumers and other stakeholders. The proposal lacked responsiveness to certain basic goals – most importantly, the stability of the home care agency safety net in providing accessible, high quality home care services. The proposed methodology was designed to drastically reduce reimbursement for the care of “high-cost” patients who would face limited access to home care services or whose providers would be financially destabilized in attempting to provide the necessary care. Concern was also especially voiced for vulnerable agencies, many of which are

sole community providers, who might not be able to withstand the transition or the reductions in payment associated with the new system. Further concerns were raised regarding the effects of the proposal on direct-care staff and the likelihood that the proposed system could worsen already serious recruitment and retention problems that plague providers in maintaining the needed level of essential health personnel.

As a result of the concerns raised by HCA, consumer representatives and allied health associations, the Legislature rejected the Executive's PPS proposal but instead established a Home Health Reimbursement Work Group for the purposes of studying the home health reimbursement system. The Work Group has been studying the methodology since last July with no resolution on most of the fundamental issues and concerns associated with the Executive's proposal.

Despite the breadth and severity of outstanding issues, this year's budget again proposes a PPS model for CHHAs, starting in January 2012, and contemplates the continuation of the Work Group. As with the concerns voiced by the Work Group, HCA's fundamental concerns regarding the proposed PPS remain outstanding in relation to both the providers and patients.

Other than to postpone the date of implementation, this year's budget proposal, which would essentially lock the Legislature two years hence into an unknown model with unknown effects on providers or consumers, offers no further assurances of a stable, responsive system than that offered last year. We see only unnecessary risk in the adoption of any mandated budget language at this time, considering that: there is no relationship between this proposal and any

savings this fiscal year or even the following year; the proposed transition would result in unknown and major implications on patients and providers; and the Legislatively-established Work Group is expected to further study these issues.

Provision of Home Care by County Health Departments

County-sponsored home care agencies are a vital part of the service delivery system in many communities and provide an array of public health services such as maternal and child health care. While all home care agencies across the state face the challenges of rising costs, as well as difficulties attracting and retaining adequate staff, these challenges are even more severe in rural areas where agencies serve patients dispersed across vast geographical areas and few other community services are available to sustain the health and support needs of residents.

This year's proposed budget would discontinue state reimbursement for local public health expenses attributable to certain services, including home health and hospice programs – a reduction of about \$5.1 million (state share). This proposal would further endanger one of the most fragile parts of the home care system. As previously mentioned, the HCA/NYAHSA *Lethal Doses* fiscal-conditions report found that 75 percent of county-operated home care agencies shouldered operating losses. Such an integral part of the health care system cannot sustain further cuts, which are certain to eliminate services in large stretches of rural New York and add to the growing number of health departments that have had to close their CHHAs. One county agency estimates that its losses would approximate an unsustainable half a million dollars under this cut.

Last year, the Legislature rejected a similar Executive proposal to eliminate local public health funding for home care. However, this year the state Department of Health (DOH) is asserting its intention to effectuate the cut administratively. We urge the Legislature's intervention in preventing DOH from instituting this damaging action.

Increased Medicaid Fraud Targets

This year's budget proposes to increase Medicaid fraud targets by an additional \$300 million to reach levels of \$1.17 billion.

HCA supports efforts to safeguard the integrity of our Medicaid system. Fraudulent activity adds costs to the health care system and diverts resources from patient care. We have actively promoted health provider compliance efforts and initiated programs and proposals to improve system transparency and integrity.

While HCA continues to work with the Office of Medicaid Inspector General (OMIG) on draft audit protocols that set standards, guidelines and parameters for the auditing of CHHAs and LTHHCPs, we nevertheless have serious concerns about the nature of OMIG audits. We are concerned that everything from billing errors to legitimate compliance questions, technical mistakes and departures from standard practice are often lumped together with real instances of fraud under the elastic definition of "fraud and abuse."

The current scope and processes of state Medicaid audits have extended far beyond fraud and system integrity investigation. The situation is unfair, wasteful and oppressive to providers and patient care. We appreciate Senator Craig Johnson's January hearing on Medicaid audits

and the opportunity to have testified jointly with the Healthcare Association of New York State (HANYS) and many others who share these concerns. We would be pleased to also share directly with you the testimony we provided to Senator Johnson.

Given that this year's budget proposes to increase Medicaid fraud recoveries up to a \$1.17-billion-dollar level, we urge you to consider actions that will afford more appropriate treatment of the health care community and ensure that OMIG recovery efforts are aimed at the truly bad actors in our system. We will be joining with our colleagues throughout the continuum of care to recommend a series of important statutory safeguards for your consideration and we respectfully request the adoption of these safeguards along with this budget.

Additional Proposals of Interest and Concern

The Executive budget contains or omits many additional proposals of both interest and concern to home care, such as: a proposal that is included in the budget to consolidate all of the authority for MLTC in DOH while eliminating the State Insurance Department's role, which is a concern to our MLTC members; a proposal contained in the budget to convert county nursing homes to expanded home care capacity; and a past program that is omitted in this budget, but should be funded, to continue targeted support for the home care infrastructure in rural, small city and suburban areas, also referred to as the accessibility, quality and efficiency rate adjustment. HCA and the membership will be providing further information and recommendations to the Legislature and Governor on these additional aspects of the budget.

HCA Proposals in the Budget

Over the past year-and-a-half, HCA has worked closely with its membership in identifying and crafting policy proposals that would generate significant savings for the Medicaid system by instituting home care program enhancements, regulatory reforms, workforce flexibility measures, quality and performance standards, and initiatives to realign health care financial incentives. We developed these proposals knowing that the home care industry is well positioned to apply its knowledge from the field in offering proactive, constructive and creative solutions – rooted in policy – for achieving Medicaid efficiencies during a time of undeniable financial duress. The result of these efforts is HCA's "Home Care Accessibility and Efficiency Improvement Act" (HCA-EIA, S.5179, introduced by Senator Craig Johnson), a comprehensive package of proposals that draws upon the cost-effectiveness of the home care system in achieving further Medicaid savings. These proposals would achieve significant savings, enhance patient access to services, and encourage lasting system reforms at the same time.

A main focus of our advocacy efforts in recent months has been to encourage the Governor and Legislature to embrace these proposals in place of blunt Medicaid cuts. We were pleased and appreciative that Governor Paterson, as a result of HCA's advocacy efforts, incorporated at least three HCA-developed proposals from S.5179 in his proposed budget, including the following:

- A proposal to enhance program efficiency and provide flexibility by changing the minimum reassessment interval for LTHHCP patients from every 120 days to 180 days (resulting in a state-share savings of \$600,000 and a state/federal-share savings of approximately \$1.5 million);
- Another proposal to allow patients to be collaboratively served by the LTHHCP and other waiver or case management programs that together meet a fuller complement of patient needs, as long as the programs “maintain distinct yet coordinated services and case management responsibilities” and don’t duplicate benefits. This provision is not only taken from our HCA-EIA legislation, but has been a policy change for which HCA has advocated directly with the U.S. Centers for Medicare and Medicaid Services, New York’s Congressional Delegation and DOH.
- A third and especially innovative proposal to establish a Federal-State Medicare Shared Savings Partnership Program. This program would provide health care financing revenue to the state from shared federal Medicare savings. The shared federal savings would be derived from state initiatives in the care and management of Medicaid/Medicare beneficiaries resulting in reduced expenditures for hospital, long-term care and other medical care. It would provide for a reinvestment of a portion of the federal savings into the state’s health care system. Provider care-management innovations are demonstrating very favorable outcomes in home care, and this proposal presents opportunities for cutting-edge developments that assist the patients, the system, the state and the federal government. This proposal is not only

substantially taken from our HCA-EIA bill, but HCA has also secured sponsorship of our legislation at the federal level, where it is being prepared for introduction.

These are the kinds of constructive proposals that are possible with the joint effort of those in the field and state policymakers. As another recent example, HCA's proactive work with the Legislature and Governor during the December deficit-reduction plan (DRP) negotiations led to the incorporation within the DRP of another of HCA's proposals from S.5179, which changed the state's policy with regard to medication pre-fills for patients, and is set to save the state nearly \$20 million in state-share savings this fiscal year. We ask you to consider our efforts in contributing such real solutions to the process during your deliberations over the new cuts that the Executive budget proposes to hoist upon the home care community. Unfortunately, this budget is very disproportionately weighed with proposals seeking to slash rather than to create or change. We urge you to reject these new cuts in favor of continued work with our Association and our members in the field.

HCA stands ready to offer additional creative ways to generate efficiencies in home care and in the Medicaid system generally, and to save home care programs from unnecessary financial ruin by substituting constructive proposals in place of draconian budget cuts. We look forward to further working with you and the Executive on these ideas and on making revisions to the proposed 2010-11 budget that reflect positive changes to further enhance the effectiveness and efficiency of the home care system while recognizing the vital role that home care plays in the entire health delivery system.

Thank you.

Appendix 1

PROPOSED 2010-11 EXECUTIVE STATE BUDGET

TREND FACTOR CUT		
	State Share April 1, 2010 to March 31, 2011	Weighted Enhanced Federal Match April 1, 2010 to March 31, 2011
Home Care (LTHHCP, CHHA)	\$11,500,000	\$28,048,780
Personal Care	\$14,300,000	\$34,878,049
Total	\$25,800,000	\$62,926,829

PERSONAL CARE CAP		
	State Share April 1, 2010 to March 31, 2011	Weighted Enhanced Federal Match April 1, 2010 to March 31, 2011
Personal Care	\$30,000,000	\$73,170,732

INCREASED ASSESSMENT		
	State Share April 1, 2010 to March 31, 2011	No Federal Match April 1, 2010 to March 31, 2011
Home Care & Personal Care	\$17,600,000	\$17,600,000

Total Impact	\$73,400,000	\$153,697,561
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Note: the total impact in the chart above does not include an estimated \$600,000 in state-share savings (approximately \$1.5 million total state/federal share) attributed to HCA's proposed change in the LTHHCP minimum reassessment period and a provision to permit LTHHCPs and other waiver programs to collaborate and jointly serve patients.

Appendix 2

Cost Effectiveness of Home Care

1. A Congressional Joint Economic Committee study in 2004 found the costs of an average 60-day home care episode (\$4,000) were less than receiving such care in skilled nursing facilities (\$8,300), inpatient rehabilitation facilities (\$12,500) or long term care hospitals (\$35,700).
2. Avalere found that if patients use home care services for post-acute care at an early time (defined as “in the same quarter as the first hospitalization stay that initiated the period of care”), the costs of caring for individuals with a primary or secondary diagnosis of diabetes, chronic obstructive pulmonary disease (COPD), or coronary heart failure (CHF) were much lower than the costs for patients who received post-acute care in other post-acute care settings – a total savings of \$1.77 billion for Medicare over 2005-2006 (Avalere Health LLC, 2009). In addition, an estimated 24,000 fewer hospital readmissions over 2005-2006 associated with early home health would save another \$246 million for Medicare.
3. A study by Kaye, LaPlante, & Harrington, 2009 (*Health Affairs*) found that states offering well-established noninstitutional services experienced less growth in long term care spending than states with limited noninstitutional programs.

4. Buntin & Kaplan found that when hip and knee replacement patients received care at home for rehabilitation, the total medical expenditure for acute stays plus 120 days of post acute care was \$3,500 and \$8,000 less than in skilled nursing facilities and inpatient rehabilitation facilities, respectively (Buntin & Kaplan, Comparison of Medicare spending and outcomes for beneficiaries with lower extremity joint replacements 2005).

5. A study of New York's Traumatic Brain Injury program found that the program saved \$30,832 for each of its recipients compared with services provided in nursing homes, hospitals, and other institutions, which resulted in a total annual savings of \$60 million (Hendrickson & Blume, Issue brief: a survey of Medicaid brain injury program. 2008). Nationally, the waiver saved a total of almost \$273 million annually (an average of \$30,000 for each patient) compared with institutional care in 17 states in 2006.

Appendix 3

Examples of Recent Unfunded Mandates on Imposed Home Care Providers

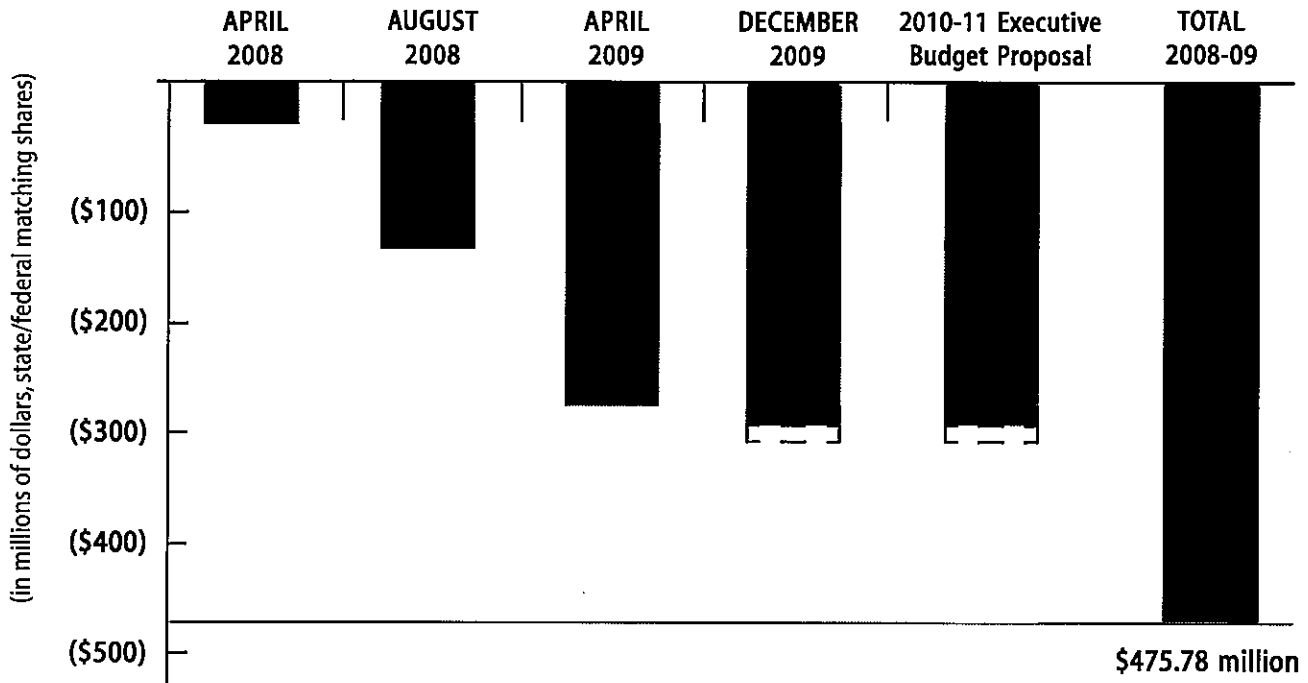
- Participation by home care providers in a massive and costly statewide demand-billing audit following the expiration of a federal program – known as the Third Party Liability (TPL) Demonstration project – for determining whether Medicare or Medicaid is responsible when a patient is covered by both. In essence, the expiration of this program has been an administrative nightmare for providers who now must perform a function previously borne by the federal and state governments for reconciling coverage determinations for dual-eligible patients. The cost of this effort for home care agencies in 2009 has been between tens of thousands of dollars to millions of dollars for larger agencies.
- A new home care registry that agencies must use to verify the credentials of home health staff as well as enter information for new aide trainees. The registry imposes new and costly administrative demands on agencies, including costs related to operational and technical problems that have beleaguered the registry and hampered the program's overall navigability and effectiveness.
- Countless hours of administrative and professional staff time to compile case records in answer to ongoing audits by federal and state officials, often during investigations that concern mere technical errors unrelated to the issue of health care quality.

- Development of corporate compliance policies so that agencies can proactively confront overreaching anti-fraud efforts by federal and state governments and private contractors; and
- Administration of seasonal and H1N1 flu vaccine, and related reporting requirements. Though this requirement was rescinded last year, many agencies have expended resources to meet the then-existing compliance deadline. DOH has indicated that this requirement will be reinstituted later this year.

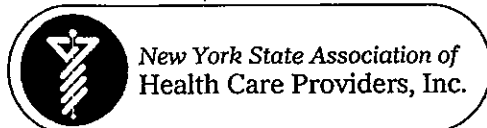
State Budget Medicaid Cuts and Reduction Actions to Home Care



Governor Paterson's 2010-11 Executive State Budget proposal includes approximately \$155.2 million in new state and federal share Medicaid cuts to home care. If enacted, this would bring the total to **\$475.78 million** in cuts and reduction actions since April 2008. (See chart.)



- April 2008 – Enacted 2008-09 State Budget (\$28 million, state/federal)**
 35% reduction to Trend Factor (CHHA, LTHHCP, Personal Care)
- August 2008 – Enacted Deficit Reduction Plan (\$107.5 million, state/federal)**
 1.3-percentage point reduction to 2008 Trend Factor (CHHA, LTHHCP, Personal Care); 1% premium reduction for Managed Long Term Care (MLTC) plans; Upstate workforce money cut by \$960,000
- April 2009 – Enacted 2009-10 State Budget (\$145.08 million, state/federal)**
 Elimination of remaining 2008 & 2009 Trend Factors and Trend Banking Factors (CHHA, LTHHCP, Personal Care); 0.35% Gross Receipt Tax (all home care); MLTC premium reduction; non-renewal of \$16 million Upstate workforce monies; \$5 million Medicare Maximization targets
- December 2009 – Enacted Deficit Reduction Plan (\$17.4 million, state/federal)**
 Elimination of 2010 Trend Factor for final quarter of current state fiscal year (Jan. 1 to March 31, 2010)
- December 2009 – Enacted Deficit Reduction Plan (\$22.6 million, state/federal)**
 Inclusion of HCA-developed medication pre-fill provision that will further reduce Medicaid spending, though constructively and voluntarily, by an anticipated \$2.7 million in the final quarter of the 2009-10 state fiscal year and by \$19.9 million for the 2010-11 state fiscal year
- PROPOSED 2010-11 Executive State Budget (\$155.2 million, state/federal)**
 Elimination of the Trend Factor (CHHA, LTHHCP, Personal Care); 12-hour-per-day cap on Personal Care Services; Increase in the existing home care Gross Receipts Tax – from 0.35% to 0.7%



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TESTIMONY OF
THE NEW YORK STATE ASSOCIATION
OF HEALTH CARE PROVIDERS, INC.
PRESENTED BEFORE A JOINT PUBLIC HEARING
OF THE SENATE COMMITTEE ON FINANCE,
THE HONORABLE CARL KRUGER, CHAIR
AND THE ASSEMBLY COMMITTEE ON WAYS AND MEANS,
THE HONORABLE HERMAN D. FARRELL, CHAIR

FEBRUARY 9, 2010

Good afternoon Senator Kruger, Assemblyman Farrell, distinguished members of the Senate Finance, Assembly Ways and Means, and Senate and Assembly Health and Aging Committees. My name is Phyllis Wang, President of the New York State Association of Health Care Providers, Inc. (HCP), a trade association representing approximately 500 offices of Licensed Home Care Services Agencies (LHCSAs), Certified Home Health Agencies (CHHAs), Long Term Home Health Care Programs (LTHHCPs), Hospices, and related health organizations throughout New York State. With me today is Bader Reynolds, Chair of the HCP Board of Directors and Vice President for CareGivers, which provides home care services throughout Upstate New York.

On behalf of the HCP Board of Directors and members, thank you for the opportunity to comment on Governor Paterson's Executive Budget and its impact on home and community-based care providers.

One of the State's largest commitments is the Medicaid program. Health care is expensive, but when managed and provided appropriately, it can lead to reduced health care costs immediately and for the future. Home and community-based care is one health care service that saves taxpayer dollars.

A 2009 *Health Affairs* report shows that states that invested more in home care experienced a 15.3% decrease in nursing home spending, while states that invested less encountered 3.4% growth in nursing home spending. Home care is part of the solution to the State's fiscal crisis because it prevents and delays the delivery of care in higher cost settings.

forced to choose between putting their loved one in an institutional setting or losing their own job to stay home and care for their family member.

Home and community-based care programs are the glue that preserves family and community by keeping the elderly, disabled, and chronically-ill in their homes with family and friends. The proposed cuts will deal a significant blow to the most vulnerable New Yorker's, resulting in a domino effect that will negatively impact their families, communities, and ultimately New York State taxpayers who will pay more in taxes to fund the ramifications of home care cuts.

Home and community-based programs are more than a line in the budget – they are a lifeline to the community for thousands of New Yorkers and deliver the dignity that goes hand-in-hand with being able to receive care in the home.

We urge you to reject proposed cuts to home care. Home and community-based programs are critical to effectively caring for the elderly, disabled, and chronically-ill in their homes, where they prefer.

2010-2011 Executive Budget

Impact on Home and Community-Based Providers

Proposes to eliminate the remaining nine months of the 2010 Trend Factor (2010-11: \$62.9 million total share and \$25.8 million State Share; 2011-12: \$31.2 million total share and \$15.6 million State Share).

- **LHCSAs: \$34.9 million total share and \$14.3 million State Share 2010-11; 2011-12 \$34.6 million total share and \$17.3 million State Share.**
- **CHHAs and LTHHCPs: \$28 million total share and \$11.5 million State Share 2010-11; 2011-12 \$27.8 million total share and \$13.9 million State share.**

The Executive Budget eliminates the remaining nine months of the 2010 Trend Factor. HCP strongly opposes this elimination and stresses that patients and workers will experience the brunt of such deep cuts as agencies are forced to make decisions about whether to reduce services, programs and staff, or to close. Demand for home care services is only anticipated to grow, but under this proposal, if enacted, access to home care services will shrink.

Without the full trend factor increase, agencies will be challenged to deliver services in a 2010 economy with reimbursement levels based on expenses incurred in 2008. A two-year lag exists in home care rates. An agency's 2010 Medicaid rate is based on 2008 data, reported in 2009 to DOH and then paid in 2010, creating a two-year payment lag.

The trend factor is the only way to attempt to bring rates that are based on two year old data in line with today's costs of doing business. The trend factor is designed to make agencies closer to whole for the time period being reimbursed. In order for agencies to continue to provide these essential services, they must receive a rate that is in line with today's costs.

services would be capped at an average of 12 hours per day over the course of the authorization period (either 6 months or one year, depending on the individual) for patients over 21 years of age if they do not receive other services from a Certified Home Health Agency (CHHA).

If enacted, the cap would take effect July 2010 and impact clients coming into the system and current clients due for reauthorization of services. Patients requiring more than 12 hours of personal care services in excess of this cap would, according to the proposal, be re-directed to other community-based services, including Long Term Home Health Care Programs (LTHHCPs), managed long-term care plans, the AIDS Home Care Program, or the Nursing Home Transition and Diversion (NHTD) waiver.

This proposal also distributes \$1 million to assist consumers affected transition to other programs, creating a new screening process to add to the growing list of various bureaucratic requirements for home care programs. HCP questions where the savings will come as patients moved to these other programs may continue to receive personal care, above the 12 hour cap which has a similar reimbursement to the alternative programs.

HCP is very concerned that patient access and continuity of care will be severely disrupted. A patient's trusted aide or personal attendant, who may not have Personal Care Aide or Home Health Aide certificate, may be unable to, or choose not to, follow their clients in to the other programs causing a disruption in patient continuity of care.

Access to care is another concern. The Executive Budget proposes greater use of the Nursing Home Transition and Diversion (NHTD) waiver to care for patients requiring over 12 hours of care per day. This program is barely functional - successfully moving patients to the NHTD waiver would require significant effort. The program has been plagued by an insufficient number of participating providers because of administrative and financial barriers; it adds another layer of administrative bureaucracy; and does not sufficiently reimburse providers for expenses associated with caring for high-needs patients.

Additionally, the 2009-10 State Budget authorized a Regional Long-Term Care Assessment Center demonstration to review the patient assessment process and better manage the use of various home care programs. It is premature to artificially cap personal care services without a better understanding of the needs of patients who would be impacted by the proposed cap. Restrictions on care should not precede a thorough analysis of the Regional Long-Term Care Assessment Center demonstration findings.

Establishment of Episodic Payment Methodology for CHHAS

The Budget requires that effective January 1, 2012, Medicaid payments for services provided by CHHAs be based on a 60-day episodic payment similar to the Federal Prospective Payment System (PPS). The Executive Budget proposes a home health reimbursement methodology change that closely resembles Medicare's Home Health Prospective Payment System (PPS). It provides for an exception for services provided to children under 18 years of age and other discrete groups, as determined by the Commissioner.

This funding helps address the challenges of costs associated with: increased auto and travel expenses tied to rising fuel costs; telehealth and use of technology in service delivery; training for personnel providing direct care to specialty populations such as pediatric cases and persons with dementia; and enhancing access to high need populations.

With this funding home care agencies offset some of the staggering costs that they have been responsible for as they work to deliver services in a rapidly changing environment. For example, fuel prices alone have significantly impeded the ability of home care providers across the State to address the increasing costs of their employees' travel. Prices are lower right now but agencies spent a great deal of extra money on fuel when it was over \$4 per gallon and many downstate providers are incurring increased costs associated with the Metropolitan Transportation Authority (MTA). Many of New York's aides and nurses who provide home care, travel great distances to deliver vital care services throughout the urban and rural corners of the State and these caregivers will not be able to afford to provide the care their patients require without financial assistance.

Without the assistance offered by this initiative, providers are not able to cover high fuel costs or other similar expenses of doing business in today's health care market.

Funding and Appropriations Investing in Home and Community-Based Care

HCP supports the following measures and recommends that the Legislature approve these proposals. This funding is essential to recruiting and retaining home care workers during a time when the need for these valuable caregivers is growing.

- \$11.2 million State share for the continuation of the Homecare Workforce Recruitment and Retention funding for Upstate and \$136 million State share annually for continuation of the Homecare Workforce Recruitment and Retention funding for the New York City Home Attendant Program through 3/31/2011.
- Ongoing funding for the 3% rate enhancement for CHHAs, LTHHCPs, Private Duty Nursing, Subcontracting LHCSAs and Hospice;
- Continuation of Homecare Workforce Recruitment and Retention funding for CHHAs, LTHHCPs, AIDS Home Care, Hospice, Managed Long Term Care Programs and Subcontracting LHCSAs through 3/31/2011.
- An appropriation of \$11.7 million for reimbursement to LHCSAs for Criminal History Record Checks. CHHAs and LTHHCPs are to be reimbursed for CHRCs through their Medicaid cost report rates.
- An appropriation of \$2 million for the Home Care Registry.

Adequate Reimbursement Rates for High-Tech Nursing Services

HCP urges the Legislature to address abysmally low rates in the High-Tech Nursing program. The High-Tech Nursing Services delivered through the Private Duty Nursing Program (PDN)

Ongoing audits of LHCSAs, CHHAs, LTHHCPs and TBI Waiver Providers have generated concern statewide about the overwhelming magnitude of recoupments being sought, the OMIG extrapolation methodology, providers being held liable for the roles and responsibilities of others, and the overarching concern that providers are subject to payment withholds and recoupments based on simple error, and not fraud.

OMIG Extrapolation Methodology

HCP hears of providers that have completed an audit by OMIG and have watched \$700 in billing errors turn into a bill for \$500,000 to \$700,000. These are numbers that will become increasingly frequent if the recovery targets continue to grow by this magnitude. They are also staggering figures that will close home care agencies. These drastic amounts are due to a specific formula the OMIG uses for expanding their audit findings to a large number of cases.

A health care system that is run in this manner will never survive, making access to care a real concern. HCP strongly urges you to become involved in this issue to seek a better understanding of the methodologies employed and oppose any methodologies that take a punitive approach to errors.

Liability for the Responsibility of Other Entities

Providers under OMIG audit are held responsible for the failure of other entities to fulfill their roles and responsibilities in the authorization or delivery of Medicaid services or have received inconsistent guidance from State agencies on State policy or regulation.

For example, this year one of our rural agencies with national accreditation was audited by OMIG and spent \$60,000 unbudgeted dollars, for legal and staff services. In the end, the majority of the audit findings was that one of the county Department of Social Services offices was noncompliant with State regulations and because of that, the agency is facing possible disallowances of millions of dollars. This agency may now close, resulting in loss of jobs and patient services.

Another company with national accreditations and consistently clean DOH surveys has already spent \$115,000 for legal services to address ongoing OMIG audits focusing on clerical errors. None of the findings in this case are related to patient care being delivered or its quality.

We urge you to oppose any sanctions on providers that are due to the responsibility of others and also promote consistency and accountability to State agencies relative to the guidance they provide. We ask the Legislature to encourage such agencies to work with the OMIG to develop uniform compliance policies and procedures.

OMIG Traditional Medicare Appeals Project

Agencies are also dealing with the Traditional Medicare Appeals Project (TMAP), which places a massive burden on Certified Home Health Agencies (CHHAs) and Long Term Home Health Care Programs (LTHHCPs). TMAP is OMIG's response to the termination of the Federal-State Third Party Liability (TPL) project and requires agencies to submit hundreds of thousands of additional claims to Medicare each year, even when it is clear that patient services are not Medicare eligible.

patients or workers. To address this, HCP sent numerous recommendations to the Governor's Office of Regulatory Reform and the Department of Health on how to improve the regulatory system including solutions to current challenges providers are facing on home health aide training programs, the Home Care Registry, survey inconsistencies and the anticipated return of the home care worker flu shot mandate.

HCP also recommends that all home care regulations, DOH policies, and reporting requirements be reviewed and assessed to determine whether or not they are necessary in the context of the current health care system. All regulations, policies, or reporting that are not essential for patient and worker health and safety or key policy goals should be repealed or suspended. These reviews should take place on a regular basis and all new regulations, policies or reporting requirements should also meet these criteria.

Conclusion

HCP urges the State Legislature to resist any more cuts to home care and instead open the door for constructive discussions with HCP on these recommendations. These recommendations make the home and community-based care system more efficient and remove the duplication and layers of administrative costs and establish the right care in the right setting at the right price.

Thank you for the opportunity to speak to you today. As always, HCP staff is available to answer any questions you might have about the contents of this testimony or any other home care issue. We look forward to working with you in the coming months.