

Center for Disability Rights, Inc.

February 9, 2010

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Legislative Office Building Room #913
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RE: 40 copies: Testimony to Legislature for HEALTH CARE (February 9, 2010)

Thank you,



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Center for Disability Rights, Inc.

The Center for Disability Rights' Testimony to the Joint
Senate Finance and Assembly Ways and Means Committees Hearing on Health Care/Medicaid

February 9, 2010

The Center for Disability Rights, Inc. (CDR) is a non-profit service and advocacy organization devoted to the full integration, independence and civil rights of people of all ages with all types of disabilities. With services in 13 counties in New York State and offices in Rochester, Corning, Geneva, Albany and New York City, CDR represents the concerns of thousands of people with disabilities.

The State's disability community has been advocating for policy changes in New York that would increase the independence of seniors and people with disabilities *and* save the State money by reducing Medicaid expenditures. Even in the face of serious financial difficulties, New York State has an unprecedented opportunity to improve the lives of seniors and people with disabilities by supporting them to live in the most integrated setting as mandated by the 1999 U.S. Supreme Court's decision in *Olmstead*. Unfortunately, instead of developing state policy that promotes savings through people receiving services in the most integrated setting appropriate for their needs, the Administration has once again proposed significant Medicaid cuts that directly impact people's ability to transition to or remain in the community.

"A redistribution in long-term care spending from institutional to noninstitutional settings, and from agency to independent providers, appears to offer the potential for a sizable reduction in spending or for an expansion of services to a broader population for the same expenditure."

- *Health Affairs*, Vol. 9, No. 1 January 2010

The Center for Disability Rights has identified critical health care proposals in the Executive Budget that impact people with disabilities and has provided our position on the proposals below.

Long Term Care

Oppose

(1) **Oppose: Cap on PCA/CDPAP hours at 12**

In the 2010-2011 Executive Budget, the Governor proposes a requirement that individuals who are assessed to need more than 12 hours of personal care services a day on average within an authorization period (either through traditional personal care or through consumer directed personal assistance) switch to another program, such as the Long Term Home Health Care Program (LTHHCP), the Nursing Home Transition and Diversion Waiver (NHTD), or the Medicaid Managed Long Term Care Program (MLTC). The State projects savings of \$30M in

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2010-11 and \$48.7M in 2011-12. [S.6608/A.9708, Part C Sec 13 and 13-b] This is clearly an example of discrimination based on acuity of disability.

Targeting people who are the most significantly disabled, yet living in the most integrated setting possible, is reckless and discriminatory. We vehemently oppose this proposal. The Administration's proposals have the potential to reverse thirty years of progress in disability policy, ultimately costing the State more in institutional care. There are a myriad of flaws with this proposal and, in the end, these alternative programs will not be able to serve this population.

(a) Proposal to shift to Nursing Home Transition and Diversion Waiver (NHTD)

- While theoretically a good option, the NHTD waiver has been the victim of massive infrastructure and bureaucratic problems! Providers are currently struggling to enroll a slow trickle of applicants in the face of numerous administrative obstacles, let alone the potential flood that this proposal presents. For example, the waiver is in program year three and there are currently only 23 enrollees in NYC.
- There are no consumer directed services in the waiver! Many individuals would lose their existing attendants (direct care workers) who would not necessarily be eligible to provide HCSS through the NHTD waiver.
- The number of slots in the waiver is currently capped and cannot be increased without Federal approval. This will prevent the over 22,000 people currently in nursing facilities in NYS, who have indicated that they wish to return to the community, from getting onto the waiver.
- The aggregate cost effectiveness of the waiver will be compromised by the disproportionate and rapid influx of people with significant needs.
- In part to address the limitations on waiver slots, the State is proposing an NHTD program whereby the State will supplement the cost difference for those who cannot access the NHTD waiver – (a) how is this a cost savings proposal? and (b) why would the Feds approve this when the individual would be ineligible for waived services? If there are “extra” funds for a state-NHTD Program, then why not redirect these funds toward expanding the waiver or maintaining current federally matched personal care options?

The Center for Disability Rights is a strong advocate for the waiver and supports efforts to expand enrollment, but not at the expense of consumer choice. If the State is looking to save significant funds in long term care, then the State must resolve bureaucratic issues within the waiver and establish an expedited enrollment process to allow people to more efficiently enroll.

(b) Proposal to shift to Long Term Home Health Care Program (LTHHCP)

- The LTHHCP has an individual cost cap of 75% cost of a nursing facility; not an aggregate cap that looks at the average of all program enrollees. Consequently, the vast majority of people targeted in this proposal would not be eligible for this program.
- It is highly improbable that any more than an extremely small number of individuals receiving more than 12 hours of personal care could even qualify for the LTHHCP.

(c) Proposal to shift to Medicaid Managed Long Term Care Program (MLTCP)

- MLTCP is a voluntary program and people should never be forced into it.

- Most providers do not allow the option for consumer directed services, so the State would essentially be eliminating the opportunity for consumer direction for this population, shifting funds from crucial direct care workers to unnecessary scheduling and supervisory staff.
- Several MLTCP providers have indicated that they will not be able to afford to serve the influx of high service consumers because of the need for balancing budgets within aggregate managed care cost caps.

(d) Proposal to shift to a Certified Home Health Agency (CHHA)

- (e) This is predicated on the antiquated medical model, which holds that consumers cannot manage their own care.
- (f) This will require frequent nursing visits, with rates which are among the most costly for long term care. (Note that consumer directed programs allow the individual or family member to supervise and take responsibility for routine medical care, such as catheter care.)
- (g) CHHAs primarily serve post-acute patients and are not designed for providing services for a prolonged period of time.
- (h) CHHAs do not always accept consumers with significant needs – and the proposed episodic payment methodology will only further disincentivize CHHAs from serving this population.

Consequences of all of the proposals:

- *Lack of empowerment and personal control!* For individuals who receive services in CDPAP, they will be forced into a new program with an antiquated, agency-based, medical model of care where the individual does not have control over who comes into their home, at what time, and how the services are provided.
- *Unemployment and loss of benefits!* Personal care attendants will lose their jobs and often their benefits. In some regions, well managed personal care programs provide better direct care worker wages and benefits than other service delivery models.
- *Loss of available workforce!* A consumer may receive services from her neighbor or other acquaintance because they have a strong relationship and the consumer is comfortable with the neighbor entering her home and providing intimate personal care. If forced out of a consumer directed model, the neighbor will now be forced to gain employment through an agency provider or may leave the field. A large number of the affected workers will not continue to provide home services and there will be significant disruptions in services for the consumers. Does the state really want to limit the available workforce when workforce shortage is frequently identified as a significant problem in long term care?

Language is more restrictive for consumers in CDPAP than traditional PCA:

This proposal is a 180-degree turn from the State's commitment to shifting away from institutional models toward more cost effective community-based programs, such as CDPAP. In the 2009-2010 enacted budget, the Legislature established a CDPAP expansion initiative, recognizing the many benefits of CDPAP – in particular the cost savings benefit, which results from lower hourly rates and reliance on the consumer for scheduling, training and supervision (rather than a costly nurse or service manager). Now, the Governor is proposing more restrictive measures for consumers in CDPAP than for those receiving traditional PCA. Specifically, the language in Section 13-a indicates that consumers in CDPAP must be transferred and receive personal care services from a CHHA, LTHHCP, AIDS HC, or NHTD waiver in order to be exempt from the cap. In contrast, Section 13

provides that traditional PCA consumers may stay in that program and be exempt from the cap as long as they are receiving any type of CHHA service (e.g. nursing). This is discriminatory.

Of the approximate 80,000 personal care consumers in NYS, DOH projects that 4,980 consumers will be impacted by this proposal, (6% of total personal care population). The breakdown is 4,381 in NYC (88% of total consumers who require \geq 12 hours) - 3,955 traditional personal care and 426 CDPAP. Of the 599 non-NYC consumers, nearly a quarter are served through CDR's consumer directed program. This is most likely attributed to the fact that CDR has been very successful at transitioning people with complex needs out of nursing facilities who would not otherwise be likely to receive traditional home care. CDPAP provides an exceptionally effective approach to allowing this population to live independently and receive services in the community.

(2) Oppose: Cash assessment increase from .35% to .7%

The proposed assessment of providers' (CHHAs, LTHHCP, and LHCSAs) gross receipts will increase from .35% to of .7% of the provider's gross receipts starting April 1, 2010. CDR fought this proposal in the last budget. This is a cut in state investment in home care/personal care and a tax on providers who are already struggling to support people in the community. The state projects savings at \$17.6M for 2010-11 and \$19.2M for 2011-12. [S.6608/A.9708 Part C Sec 7-Sec 11]

(3) Oppose: Elimination of 2010 trend factor

Operating costs increase every year as things become more expensive. Eliminating the trend factor makes it more of a challenge to operate. This approach further reduces reimbursements. CDR is currently operating on the 2007 base year. The State projects savings at \$25.8M in 2010-2011 and \$32.3M in 2011-12. [S.6608/A.9708 Part B Sec 1]

(4) Oppose: Elimination of the 2010 Human Services Cost of Living Adjustment (COLA)

This would impact providers under designated Human Services programs, including OMRDD, OMH, OASAS, DOH, SOFA and OCFS. There will be no COLA for the purpose of setting rates, contracts, or any other reimbursements. Direct care workers, who are employed through human services programs, are already significantly underpaid for their work. Recruitment and retention of quality direct care workers is essential to supporting community-based care. By not supporting direct care workers who provide services to people with disabilities in the community, the state is once again establishing policies that are inconsistent with its claim that they support reducing institutional placements in favor of community-based care. Appropriate wages and benefits for these workers are a *critical component* of reforming long term care services toward community-based initiatives. [S.6608/A.9708 Part N]

(5) Oppose: SNF Quality Incentive Pool

According to 2007 Thomas-Reuters data, in terms of per capita spending by states, New York spends dramatically more for nursing facility care than other states, three times more than Washington State. In fact, only two other states – Connecticut and Pennsylvania – spend more than \$300 per day per capita on nursing facility placements, like New York.

If the State can find \$50M to redirect toward a quality pool for nursing facilities, than the State can find \$30M to eliminate the personal care cap proposal. At a time when drastic budget proposals target seniors and disabled people living in the community, it is unconscionable to put additional money into the nursing facilities. This is clearly institutionally biased. While

these are not new monies – rather, the State is shifting existing monies from the nursing home rebasement reform – it is still concerning that the State is not doing the *right* shifts. The State needs to stop investing in this antiquated and dysfunctional model of long term care and shift monies toward consumer directed personal care and other community-based programs. While we recognize that for those who are unfortunately trapped in an institution there is a need for high quality of care, this proposal comes at a time when every dollar counts and any investment into institutions is a poor investment for the State. [S.6608/A.9708 Part C Sec 5-a]

Similarly, there appears to be an appropriation for an Adult Home Quality Enhancement Account. According to DOH, this funding comes from the consolidation of various adult home-related programs. More information is necessary; however, in the wake of *DAI v. Paterson*, putting money into adult homes does not support the direction of the State to end discriminatory segregated residences. These funds should be redirected to community-based alternatives, not shuffled back into the same outmoded facilities. [S. 6604/A.9704, Department of Health]

(6) Oppose: CHHA episodic payment system

The subgroup to the 2009 legislatively formed Home Health Care Reimbursement Work Group issued a report as an addendum to the formal Work Group Interim Report that outlines their concerns over the proposed episodic payment system for CHHAs. According to the subgroup, which is represented by LHCSAs, CHHAs, and consumer advocates,

“...the methodology for the treatment of outliers is seriously flawed. Consumer and provider representatives on the Workgroup cannot support the system as proposed because the modeling conducted by Workgroup members confirmed that the Department’s proposed episodic payment system will result in substantial losses every single 60-day period for the remainder of a young disabled person’s lifetime. This will require providers to ‘balance’ the number of these high need, high loss patients with many more patients who might represent a financial gain, thereby creating the need to limit access for patients such as those with HIV/AIDS, Multiple Sclerosis, the OMRDD population and those with complex non-healing wounds (such as individuals with paraplegia, quadriplegia).”

CDR echoes the concerns identified by this subgroup that the proposed episodic system has a built-in disincentive for home care agencies to serve people with significant disabilities.

There are a few positive elements in the proposal in Article VII: (a) It is delayed until 2012, which will give DOH more time to correctly implement the system. (b) The originally proposed elimination of contracting between CHHAs and LHCSAs is off the table, which is a win for people with disabilities. (c) It exempts children under 18 and “other discrete groups as determined by the Commissioner,” which provides some room for discussion. (d) There is a small quality incentive pool. However, we still approach this proposal *very* cautiously and more information is needed. [S.6608/A.9708 Part C Section 14] We absolutely do not support reforms that result in reduced access to community-based care.

(7) Oppose: Voluntary Residential Health Care Facility Rightsizing Demonstration Program

This demo would encourage nursing facilities to convert up to 5,000 beds statewide into “another type of program.” An additional 2,500 beds was added to the originally planned 2,500. This appears to be another attempt by the State to encourage nursing facilities to operate as institutions of a different color (i.e. convert nursing facility beds to assisted living beds). We

were not in support of last year's proposal to convert 6,000 nursing home beds into ALP beds because these are, as is with the nursing facility quality pool, misdirected efforts. These facilities are still a form of segregated institutional placement. In fact, some ALPs operate in the same building as a nursing facility and some are just converted beds, an alternative to genuine right-sizing. A better solution would be for NYS to reduce nursing facility beds and conversely increase home and community-based funding. [S.6608/A.9708 Part C Section 23]

Support

(8) Support: County LTC Financing Demonstration Program

This demonstration authorizes up to five counties to participate in a County Long Term Care Financing Demonstration Program. The purpose of the demo is to provide incentives for counties to reduce beds and ultimately close their county-operated nursing facilities and then redirect the funds toward enhancing community-based services. Community-based programs include, but are not limited to, PACE, LTHHCP, MLTC, adult day services, expanded senior housing, and assisted living programs. Most notable is the state's authorization to counties to provide subsidies to private skilled nursing facilities to accept residents who are hard to place (e.g. behavioral). [S.6608/A.9708 Part C Section 21]

While all counties would benefit, CDR is particularly pleased to see this proposal on the table during a time when Albany County's long term care plan is highly contested. County Executive Mike Breslin has committed to focusing the County's budget on community-based alternatives; however, the County Legislature is pushing back and demanding that the County build a new skilled nursing facility. This debate has been ongoing for about a year and has been extremely intense, often devolving into political gamesmanship. Albany County has the potential to be a model for community-based long term care supports and services, but instead they may be heading down the counter-productive and costly road of rebuilding the status quo. These types of demonstrations, as the Administration is proposing, are exactly the kind of forward thinking that NYS needs.

(9) Support: LTHHCP reassessment from 120 to 180 days

This is a cost savings proposal that will not negatively impact people with disabilities' access to services. It is about reducing paperwork and streamlining an already cumbersome system for dual eligibles on Medicare and Medicaid in the Long Term Home Health Care Program (LTHHCP). The State projects a savings of \$.6M in 2010-11 and \$1.5 in 2011-12. [S.6608/A.9708 Part C Section 15]

(10) Support: Allow HC providers to collaborate under dual waivers to jointly provide services

There are some individuals who are enrolled in the LTHHCP waiver but require non-health related services through alternative waiver programs, such as through HIV/AIDS programs. However, due to DOH's restrictive interpretation of CMS' regulations, individuals must choose one program. This proposal would allow individuals to receive case management services from the program that best suits their needs, regardless of the waiver that currently serves them. This is an attempt to better meet consumers' needs for case management across complex, silo'ed systems of service delivery. [S.6608/A.9708 Part C Section 16]

(11) Support: Create a Federal-State Medicare Shared Cost Savings Partnership Program

This appears to be an attempt by the state to draw down federal Medicare dollars by recouping savings attributable to the Medicaid system. Currently, when Medicaid-funded programs and

services reduce hospitalization or physician visits, the savings are attributed to Medicare and the State does not recover the savings to the Medicaid system. This proposal, which requires federal approval, would work to rectify this systems gap and reinvest the savings in the State's health care system. [S.6608/A.9708 Part C Section 19]

(12) Support: Stricter penalties for LHCSAs that do not report

This emerged from the Home Health Care Work Group in response to the Department of Health's claim that more than half of Licensed Home Care Services Agencies do not submit state required reports on time. This data is essential to formulating the policy directives of the State. [S.6608/A.9708 Part C Section 18]

(13) Support: Medicaid streamlining initiatives

Finally, after years of pushing for Medicaid streamlining initiative that benefit general Medicaid consumers but excluded the aged, blind and disabled consumers, the Governor has made a proposal for the long term care population. Individuals who receive Medicaid long term care services in community-based programs ("including but not limited to waiver services provided or authorized by the OMRDD") will be able to personally attest to their income for *recertification* into the same program. If the consumer switches to a different program, then they will be subject to standard income attestments and documentation. [S.6608/A.9708 Part B Section 47-48]. However, it should also be noted that the streamlining enrollment initiatives (i.e. asset test, fingerprinting, face-to-face interviews) that were enacted in the last budget for the general Medicaid population have still not been extended to the SSI population and we urge the State to make these available to people with disabilities.

(14) Support: LTC Financing Demo Program

This demonstration, based off of the former "New York State Compact," would be available for up to 5,000 individuals statewide to enter into a program to receive long term care services without having to spend down to Medicaid financial eligibility levels. Similar to the concept of the Partnership for Long Term Care for long term care insurance, this proposal would require the individual to contribute toward the cost of their long term care but would not require him or her to do so to the point of poverty. People with significant needs (e.g. MS) who would otherwise not qualify for long term care insurance, would be able to purchase an affordable plan. The Commissioner will submit a report on the findings from the demo to the Legislature on November 1, 2015. [S.6608/A.9708 Part C Section 204]

The Center for Disability Rights has submitted specific proposals to the Executive to achieve structural savings in Medicaid long term care services and supports:

- Establish an expedited enrollment process for the Nursing Home Transition and Diversion Waiver;
- Amend the NYS regulations to be consistent with federal regulations regarding who can receive payment for personal care services;
- Facilitate transitions to less costly models of care; and
- Use assistive technologies to reduce personal care hours

A detailed fiscal analysis of these proposals is attached as an appendix to this testimony.

We trust that the Legislature will make the right choices for New Yorkers with disabilities.

Center for Disability Rights, Inc.

Disability Advocates' Proposal to Restore \$30M 2010-2011 Cut to Personal Care

January 28, 2010

The following figures are more conservative than the original proposal submitted to the Executive, Legislature, and NYS Department of Health on November 13, 2009¹. The recommendations to establish an expedited enrollment process for the Nursing Home Transition and Diversion Waiver; amend the NYS regulations to be consistent with federal regulations regarding who can receive payment for personal care services; facilitate transitions to less costly models of care; and use assistive technologies to reduce personal care hours, all serve to reduce the State's Medicaid expenditures while promoting the independence and integration of people with disabilities. The calculations are amortized over one year to allow the State to restore the proposed \$30M cut to personal care achieved by capping average hours during and authorization period at twelve; ranging in \$30M -\$95M in annual savings.

Assumptions	
Total NYS Skilled Nursing Facility Population (CMS MDS 3Q)	107,800
Medicaid Percentage (CMS MDS 3Q)	61%
Medicaid Population (Based on percentage)	65,758
CMS MDS 3Q: Q1A – yes (Rounded down)	22,000
SNF residents over 85	46%
SNF residents 75 - 84	32%
SNF residents 65 - 74	12%
SNF residents < 64	10%
Average daily cost of SNF in NYS (U.S. Department of HHS, 2008)	\$319.00
Average daily savings of TBI waiver (DOH report to CMS, Form 372, FY07)	\$56.00
CHHA Average Hourly Rate* (DOH 2008 Recorded Rates)	\$29.25
PCA Average Hourly Rate* (DOH 2008 Recorded Rates)	\$21.19
CDPAP Average Hourly Rate* (DOH 2008 Recorded Rates)	\$19.73
<u>Admissions - 2009 CMS Q3 Data</u>	
Total Admission Assessments	39,015
Percentage Non-Medicare	33.80%
No. of potential MA-eligible admissions	13,187
1. Savings from Transitions on the NHTD Waiver	
Q1A Positive Responders (Rounded down)	22,000
Medicaid Percentage (CMS MDS 3Q)	61%
MA Q1A Positive Responders	13,420
Option A:	
Percentage Transitioned	10%
No. Transitioned (per year)	1342
No. Transitioned (per month)	112
Daily Savings (85% of calculated number)	\$50.00
Annualized Savings (Total)	\$13,084,500
Option A: Annualized Savings (non-federal)	\$6,542,250

¹ *Proposals that Reduce NYS Spending and Promote the Independence and Integration of Seniors and People with Disabilities*. November 13, 2009. Prepared by the New York Association on Independent Living, the Center for Disability Rights, and the Consumer Directed Personal Assistance Association of New York State.

Option B:	
Percentage Transitioned	25%
No. Transitioned (per year)	3355
No. Transitioned (per month)	280
Daily Savings (85% of calculated number)	\$50.00
Annualized Savings (Total)	\$32,711,250
Option B: Annualized Savings (non-federal)	\$16,355,625
2. Savings from Diversions on the NHTD Waiver	
No. of MA-eligible admissions	13,187
Option A:	
Percentage Diverted	10%
No. of Diverted MA admissions	1319
No. of Diverted MA admissions (per month)	110
Daily Savings (85% of calculated number)	\$50.00
Annualized Savings (Total)	\$12,857,393
Option A: Annualized Savings (non-federal)	\$6,428,697
Option B:	
Percentage Diverted	25%
No. of Diverted MA admissions	3297
No. of Diverted MA admissions (per month)	275
Daily Savings (85% of calculated number)	\$50.00
Annualized Savings (Total)	\$32,143,483
Option B: Annualized Savings (non-federal)	\$16,071,742
Savings from Shifting to Less Costly Models of Community-Based Care	
3. CHHA to CDPAP	
CHHA Average Hourly Rate*	\$29.25
CDPAP Average Hourly Rate*	\$19.73
Option A:	
No. of people Shifting (per year)	1000
No. of people Shifting (per month)	83
Average No. of Hours (per day)	5
CHHA Cost	\$28,518,750
CDPAP Cost	19,236,750
Annualized Savings (Total)	\$9,282,000
Option A: Annualized Savings (non-federal)	\$4,641,000
Option B:	
No. of people Shifting (per year)	5000
No. of people Shifting (per month)	417
Average No. of Hours (per day)	5
CHHA Cost	\$142,593,750
CDPAP Cost	96,183,750
Annualized Savings (Total)	\$46,410,000
Option B: Annualized Savings (non-federal)	\$ 23,205,000
4. PCA to CDPAP	
PCA Average Hourly Rate*	\$21.19
CDPAP Average Hourly Rate*	\$19.73
Option A:	
No. of People Shifting (per year)	2000
No. of People shifting (per month)	167

Projected Average No. of Hours Per Day	10
PCA cost	\$82,641,000
CDPAP cost	\$76,947,000
Annualized Savings (Total)	\$5,694,000
Option A: Annualized Savings (non-federal)	\$2,847,000
Option B:	
No. of People Shifting (per year)	10000
No. of People shifting (per month)	833
Projected Average No. of Hours Per Day	10
PCA cost	\$413,205,000
CDPAP cost	\$384,735,000
Annualized Savings (Total)	\$28,470,000
Option B: Annualized Savings (non-federal)	\$14,235,000
5. Savings from Expanding the Pool of Direct Care Workers	
<i>Allowing family members to care for aging elder could be significant impact.</i>	
Total NYS NF Population (CMS MDS 3Q)	107,800
Percentage 65+	90%
Medicaid Percentage (CMS MDS 3Q)	61%
Option A:	
Percentage who would transition	1%
Average Cost of NF Care	\$37,323,000
<u>Average Cost of CDPAP</u>	
CDPAP Average Hourly Rate*	\$19.73
Average number of hours per day	10
CDPAP Cost	\$23,084,100
No. of Transitions (per year)	592
No. of Transitions (per month)	50
Annualized Savings (Total)	\$14,238,900
Option A: Annualized Savings (non-federal)	\$7,119,450
Option B:	
Percentage who would transition	3%
Average Cost of NF Care	\$110,442,863
<u>Average Cost of CDPAP</u>	
CDPAP Average Hourly Rate*	\$19.73
Average number of hours per day	10
CDPAP Cost	\$68,308,391
No. of Transitions (per year)	1775
No. of Transitions (per month)	148
Annualized Savings (Total)	\$42,134,471
Option B: Annualized Savings (non-federal)	\$21,067,236
6. Use of Assistive Technology to reduce cost of personal care services	
Option A:	
Number of proposed people (per year)	150
Number of proposed people (per month)	13
Annualized Savings (from reduction of 8 hours of PCA)	\$4,958,460
Option A: Annualized Savings (non-federal)	\$2,479,230
Option B:	
Number of proposed people (per year)	250
Number of proposed people (per month)	21
Annualized Savings (from reduction of 8 hours of PCA)	\$8,264,100

Option B: Annualized Savings (non-federal)	\$4,132,050
Summary of Savings – Options A	
Savings from Transitions on the NHTD Waiver	\$6,542,250
Savings from Diversions on the NHTD Waiver	\$6,428,697
Savings from Shifting to Less Costly Models of Community-Based Care:	
CHHA to CDPAP	\$4,641,000
PCA to CDPAP	\$2,847,000
Savings from Expanding the Pool of Workers	\$7,119,450
Savings from Use of Assistive Technologies to Reduce Personal Care	\$2,479,230
Total Projected Savings (non-federal) Option A	\$30,057,627
Summary of Savings – Options B	
Savings from Transitions on the NHTD Waiver	\$16,355,625
Savings from Diversions on the NHTD Waiver	\$16,071,742
Savings from Shifting to Less Costly Models of Community-Based Care:	
CHHA to CDPAP	\$ 23,205,000
PCA to CDPAP	\$14,235,000
Savings from Expanding the Pool of Workers	\$21,067,236
Savings from Use of Assistive Technologies to Reduce Personal Care	\$4,132,050
Total Projected Savings (non-federal) Option B	\$95,066,652
<i>*Excludes NYC rates because the DOH does not include them in the recorded rates</i>	

MEDICARE RIGHTS

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JOINT LEGISLATIVE PUBLIC HEARINGS ON THE 2010-2011 EXECUTIVE BUDGET PROPOSAL FEBRUARY 9, 2010

In response to New York's fiscal crisis, the Governor's budget saves State funds while preserving much of his "patient first" agenda. However, the proposed changes that significantly cut the Elderly Pharmaceutical Insurance Coverage (EPIC) program will place a heavy burden on people with Medicare. EPIC helps older New Yorkers access and pay for necessary prescription drugs. While the state is forced to confront financial hardship, it should not be forgotten that New York State residents are hurting as well. Eliminating EPIC protection will only exacerbate the burden on people with Medicare.

From our experience helping thousands of New Yorkers access needed prescriptions, the Medicare Rights Center is concerned about the effect this cut will have on people with Medicare. We are a New York-based nonprofit, consumer service organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs and public policy initiatives.

Instead of making general cuts to EPIC, the State should pursue alternative methods of savings through streamlining low-income programs and maximizing federal dollars. This saves State funds, and also ensures that vulnerable populations, such as those who have experienced drops in retirement income, remain protected.

Protect EPIC

When the Medicare Part D Prescription Drug benefit began in 2006, New York led the nation in ensuring that its older citizens had access to prescription drugs through EPIC. The proposed 2010-11 Executive Budget, however, removes this critical safety net by eliminating the EPIC wrap-around coverage for Medicare Part D beneficiaries. EPIC will no longer fill in gaps in Part D coverage for approximately 300,000 older New Yorkers with Medicare. EPIC wrap-around coverage of Part D should be maintained to protect these individuals.

Medicare Rights has not yet received a briefing from EPIC or the Department of Health about how these changes will be implemented, and this testimony may be revised if a briefing is presented. However, from our experience working with thousands of New Yorkers with Medicare, we can anticipate that there will be two groups of Medicare beneficiaries who will suffer most harshly from this cut: individuals who cannot access coverage under Part D and individuals who face obstacles in the Medicare appeals process.

Without EPIC protection, these individuals may not be able to access medically necessary prescriptions. Research demonstrates that if a person with Medicare is unable to afford a drug out of pocket, he or she will likely stop taking that drug.¹ These interruptions in treatments could cause dangerous health complications.

1. Gaps in Part D Coverage

Some EPIC enrollees who have relied on EPIC for coverage will find that they have no option for coverage under Medicare. This occurs when a prescription fails to meet the regulatory definition of “Part D drug.”² This happened in the case of Ms. Q, a Medicare Rights’ client:

Ms. Q has been diagnosed with diabetes and a digestive disorder that causes frequent nausea and vomiting. After she tried several medications with no success, Ms. Q’s doctor prescribed an antiemetic drug that is used to prevent nausea related to chemotherapy and/or in postoperative patients. This new drug has stabilized Ms. Q. and eliminated her need for frequent hospitalizations for dehydration and malnutrition.

However, Ms. Q relies on EPIC to access this drug because Medicare Part D does not cover it. Regardless of doctor support and medical necessity, Part D prohibits coverage of “off-label” prescriptions, drugs used for indications not approved by the FDA, unless the prescribed use is supported in medical compendia specifically-cited in law. Because Ms. Q’s medication is not FDA-approved for her specific diagnosis nor listed in the compendia, her Part D plan disregarded her doctor’s statement that this drug is medically necessary and denied coverage for this “off-label” treatment. Unfortunately, there is no exception to this blanket prohibition. As a result, without EPIC, Ms. Q would not have coverage for this required drug.

Because Part D coverage is not always available, EPIC wrap around coverage must be maintained. If it is not, New Yorkers, like Ms. Q, will go without medically necessary – sometimes life-sustaining – medications.

2. Obstacles in the Medicare Appeals Process

The Governor’s budget rightfully preserves EPIC’s authority to represent enrollees in the Medicare Part D appeals process. This effort has proven to be largely successful. However, every year, Medicare Rights receives calls from thousands of people with Medicare who have tried to appeal without assistance, but have found the process to be too challenging. For instance, Part D plan representatives often provide false, inaccurate or incomplete information to enrollees seeking authorization of a prescription. Additionally, plans often fail to abide by relevant rules and regulations – making it difficult even for those who are aware of their rights to pursue appeals.

Because EPIC will no longer provide immediate access to prescriptions, more EPIC enrollees will bear the burden of fighting for their prescriptions. As a result, many EPIC enrollees are likely to go without needed prescriptions while in the appeals process - with or without EPIC representation. This happened in the case of Mr. M:

Mr. M received a letter on January 31, 2008 from his Medicare Prescription Drug Plan that he would need to appeal for coverage of Provigil, which was prescribed for the depressive episodes of bipolar disorder, because it had a prior authorization requirement. Mr. M submitted the necessary documentation to overcome the prior authorization requirement including a coverage request with the written support of his psychiatrist. The plan never responded. Mr. M called the

¹ “Medicare Part D 2010 Data Spotlight: The Coverage Gap”, The Henry J. Kaiser Family Foundation, <http://www.kff.org/medicare/upload/8008.pdf> (November 2009).

² 42 C.F.R. § 423.100.

plan but was not able to get substantive information on the status of his appeal. Later, Mr. M's physician submitted an expedited appeal. The plan did not respond within the requisite 72 hours. Mr. M called once a week for several weeks, was transferred from one department to another, and never received a definitive answer as to the outcome of appeal. Mr. M was only able to access a favorable decision after requesting assistance from Medicare Rights.

As a result of bureaucratic delays, many people like Mr. M, face interruptions in care. Currently, EPIC acts as a failsafe allowing people to access medications while navigating the appeals system. EPIC should continue pursuing Medicare appeals on behalf of its enrollees, but without EPIC wrap around coverage, many will still go without needed prescriptions while fighting for Part D coverage.

Alternative Savings Achievable Through the Medicare Savings Programs

To achieve alternative savings for the State, the Medicare Rights Center suggests that the State maximize enrollment in the Medicare Savings Programs (MSPs). MSPs help pay the health costs of Medicare beneficiaries with low incomes. Most importantly, enrollment in an MSP automatically qualifies the recipient for the federally funded Extra Help program to assist with Part D costs, thereby reducing state costs in the EPIC program. The State may achieve additional savings by creating greater efficiency in the EPIC and MSP enrollment process through online applications.

1. Automatic MSP Enrollment & Recertification Through the EPIC Program

EPIC, as a State Pharmaceutical Assistance Program (SPAP) and authorized representative pursuant to the Medicare Modernization Act of 2003, may automatically enroll and recertify individuals into MSPs; however, it does not currently do so. If EPIC were to enroll eligible individuals in MSPs, this could dramatically increase the number of New Yorkers enrolled in these programs. As a result, these individuals would automatically be enrolled in Extra Help, maximizing federal dollars and saving EPIC funds. This would achieve savings for EPIC without requiring an across the board cut that would substantially reduce benefits.

2. Modernization of Application Systems for EPIC and MSP

The State has made great strides in simplifying enrollments in MSPs over the past two years. While New York serves as a model for other states, simple improvements to the enrollment process for both EPIC and MSPs must be made to further save State funds.

Currently, both EPIC and MSP applications cannot be submitted over the internet. Allowing online submission would create efficiency and savings. Both the federal government and other states have realized the benefits of allowing online applications for programs. For example, the SPAP of Pennsylvania, PACE, uses an online portal to enroll their new members. Similarly, the federal Extra Help application is available online through the Social Security Administration. In addition Florida and Maryland have an online application process for MSPs.

Electronic submissions would not require EPIC or Medicaid offices responsible for MSP enrollment to manually enter data. Additionally, electronic data transfer would prevent human errors from occurring during data entry that create roadblocks in processing applications. In Medicare Rights' experience, we frequently spend hours working with State staff to sort out complications arising from these errors.

Additionally, the State could use existing data to automatically recertify individuals already enrolled in MSPs. People with MSPs must re-certify for the programs every year; however, people enrolled in MSPs usually have incomes that do not dramatically change from year to year. Automatic recertification of these individuals would save administrative costs in addition to providing continuous access to these vital programs. The State

could potentially reduce man-hours, mailings, and other resources necessary to do recertification outreach under the current system.

Online applications and automatic recertifications would allow eligible individuals quicker access to EPIC and MSPs, prevent bureaucratic disentanglements, streamline enrollment efforts, and potentially decrease-costs in administrative overhead.

Declaration of Adirondack Apothecary, LLC

I, **James L. Bowen**, declare as follows:

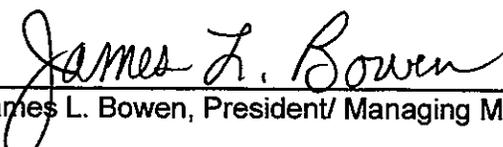
1. I make this declaration in support of the New York State community pharmacies request for fair and equitable reimbursement for all state sponsored prescription insurance plans. The facts set forth here are true and based on my own personal knowledge, related to my pharmacy owner/operator experiences.
2. I am the president/managing member of Adirondack Apothecary, LLC, with pharmacies licensed in the State of New York. **Schroon Lake Pharmacy**, business address of 1081 Main St., Schroon Lake, NY 12870; **Moriah Pharmacy**, business address of 4315 Main St., Port Henry, NY 12974; **Willsboro Pharmacy**, business address of 3932 NYS Rt. 22, Willsboro, NY 12996. All three pharmacies qualify as rural locations and provide pharmacy services to a **Limited Access** region. At all three apothecaries, the patient's access to the next nearest pharmacy requires patients to travel between 1 to 1 1/2 hours per round-trip.
3. Our three supervising pharmacists received their doctorate in pharmacy 1) U of Georgia and 2) Albany College of Pharmacy in 1999, 2006 and 2009. We are all members of the Pharmacists Society of the State of New York, and as part of Adirondack Apothecary's pharmacy practice and business; it provides drug products and services to Medicaid/ Epic / Family and Child Health Plus beneficiaries who reside in New York. Our three practices consist of an average of approximately 2% cash patients, 71% private insurance (including Medicare part D plans), and 27% in NYS beneficiary plans.
4. Services provided include dispensing of prescriptions and over-the-counter medications and durable medical devices, delivery services, refill requests, compounding, compliance packaging, providing 340-B federal funding to our three local health centers in each community we serve. Most importantly the personal service and consultation to all our patients with regards to drug and OTC interaction (even for our local patients who have been forced to turn to out-of-state mail-order pharmacies) as well as helping them deal their insurance complexities.
5. The current rate of Medicaid reimbursement for drug products barely covers my drug acquisition costs. Moreover, my cost of dispensing medications to Medicaid beneficiaries exceeds the professional dispensing fee paid by New York State. We nevertheless provide services to, and currently continue to serve all NYS plan beneficiaries.

6. I understand that many U.S. states Medicaid Authorities have approved and adjusted their reimbursement rates with regards to the First Data Banks, Inc. settlement agreement. We are now several months passed the September 26, 2009 adjustment to the Average Wholesale Price (AWP) and must add the blunt fact that all private insurances (PBM's) made the fair and equitable adjustment to the AWP pricing, leaving **NYS the only insurance entity that did not conform**. This court ordered 4% reduction in AWP reimbursement pricing almost represents our total prescription-operating margin we achieve when dispensing our mix of brand and generic drugs. So in the case of NYS, not providing this 4% adjustment, it has effectively removed most of our operating margin. In simple terms, we are currently being reimbursed just enough to cover paying our drug wholesalers invoices, leaving minimal to cover labor and all other overhead costs. Another fact, independent pharmacies like ours average 90% of total revenue from the Rx Dept., leaving limited possibilities to make up lost margin with out-front retail sales.

7. This reimbursement reduction was imposed without any public notice or opportunity for comment and will significantly affect our ability to continue to provide services to NYS beneficiaries as well as our operations overall ability to provide to all patients long-term.

8. I believe under normal economic/ financial models, when your revenue equals your combined direct and indirect costs; you are forced into hard decisions with regards to continuing an ongoing business. It must be understood that in the retail pharmacy business, pharmacy comes first, and our licenses an accreditation's remind us to assist the patient, (not abandon) them with their healing and/or health maintenance needs. I cannot realistically say or threaten that if NYS reimbursement rates do not improve soon, we will be forced to withdraw from NYS sponsored prescription programs, just because of the before mentioned belief we have in caring for our patients, to the bitter end. As I plan for the immediate future, some uncomfortable steps may have to be taken though; reduced business hours, lay off employees, eliminate delivery/ specialty services... in order to buy time, hoping that NYS DOH and Elected Officials realized that were not all big-box retailers but a critical ingredient within the healthcare system. The services that are provided by **Schroon Lake Pharmacy, Moriah Pharmacy and Willsboro Pharmacies** in these limited access regions, should be recognized for our value to New York State's communities, the healthcare centers we financially support, the patients we serve and a state as a whole.

Executed on February 9, 2010, at Schroon Lake, New York.


James L. Bowen, President/ Managing Member

Cc: NYS Senator Betty Little
NYS Assemblywoman Teresa Sayward
NYS Assemblywoman Roann Destito
Ms. Valerie Grey, NYS Gov. office
Dr. John Rugge, CEO, Hudson Headwaters Health Network


WINTHROP
University Hospital

Care without compromise.

Senator Carl Kruger,
Legislative Office Building
Senate Finance Committee Chair
State Street
Room 913
Albany, NY 12247

Dear Mr. Kruger,

February 5, 2010

Accompanying this cover letter are the statements of concern on behalf of the New York State Poison Control Center Network regarding the proposed budget cuts to the Poison Centers in New York State.

Should your committee have any questions or require additional information, please let me know.

Thank you for your consideration.

Regards,



on behalf of the New York State Poison Control Center System,

Thomas R Caraccio, PharmD
Managing Director,
Long Island Regional Poison & Drug Information Center
107 Mineola Boulevard, 2nd Floor
Mineola, New York 10011

Tel: 516-663-2650

NEW YORK STATE POISON CONTROL CENTER NETWORK

New York State Poison Control Center Network Concerns

- Governor David Paterson's budget proposal recommends reducing the number of Poison Centers from five to two and reducing the Poison Control Center (PCC) budget from \$5 to \$2.5 million. A reduction of this magnitude will jeopardize the NYS PCC Network and, as a result, put the health of the population of NYS at risk.
- We ask that the Legislature reconsider this potentially devastating budget cut.

Poison Centers in New York State

- There are five poison centers (in Buffalo, Rochester, Syracuse, New York City and Mineola) serving the 19.5 million people of New York State (NYS). Each Center has met the strict criteria for certification by the American Association of Poison Control Centers (AAPCC). These centers are staffed by highly trained physicians, pharmacists and nurses who provide up-to-date, comprehensive information on poison management 24-hours a day, 7 days a week.

History of the New York State Poison Centers

- PCC services have been available in New York State since 1955. At one time, there were more than twenty poison control centers providing services to the residents of New York State, primarily through hospital emergency rooms. In 1986, the Poison Control Network Act established regional poison control centers throughout the State. Eight regional centers were originally designated, formulating the statewide network dedicated to preventing injury and death from poisoning by providing poison emergency assessment and treatment information, public education, and health professional education. In 1990, the number of centers comprising the New York Poison Control Network was reduced to six. This was the case during the first six months of 2001.
- In mid-2001, the Hudson Valley Regional Poison Center, located at Phelps Memorial Hospital Center in Sleepy Hollow, New York, converted to a public education only center. Responsibilities for other than public education services were handled by the Central New York Regional Poison Control Center (Syracuse) for all counties originally handled by the Hudson Valley Regional Poison Center, except for Westchester County. The Long Island Regional Poison and Drug Information Center (Mineola) assumed responsibility for other than public education services in Westchester County.
- With this structural modification, the New York State Poison Control Network is now comprised of five regional PCCs and one public education center. The Network is dedicated to preventing injury and death from poisoning by providing poison emergency assessment and treatment information, public education, and health

professional education. The centers disseminate expert information to the general public as well as to professionals, participate in the collection of uniform data and conduct research to enhance the science of toxicology.

- Currently, NYS provides PCCs with \$5 million per year in funding from the health care initiatives pool, which is funded by all non-Medicare payers through surcharges added to their payments for service. Poison center funding does not come from the general pool of the Department of Health.

Functions and Activities of Poison Centers

- The PCCs are immediately available, 24 hours per day, seven days per week, to health care professionals and the general public for the purpose of providing expert telephone consultation for emergency poison exposures and inquiries. The emergency telephone numbers and services are widely publicized in each of the regions.
- Calls from the general public are evaluated to determine if further medical action is needed. Similarly, calls from Emergency Departments, Intensive Care Units and other healthcare providers are evaluated and treatment is streamlined. These activities reduce the burden care in hospitals.
- In addition, the PCCs respond to a variety of information questions that include life saving antidotes and vaccines, as well as being a primary resource for education and research on poison related issues.
- The PCCs provide advanced education to medical students, physicians, pharmacists, nurses and other health care professionals.
- The Network strives to promote poisoning prevention among the general public through a variety of outreach programs, various education programs and literature distribution designed for specific age groups.

Please see Appendix 1 for further details on the following important activities that the PCCs conduct:

Toxicosurveillance
Early Warning System
National Poison Data System (NPDS)
911 System
Pesticide Reporting
Hazardous Materials
Bioterrorism
Quality Assurance
Public Education and Awareness
Collaborations
Special Populations
Toxicology Training
Research and Publications

Poison Centers are a Benefit to Society

- The public, physicians, hospitals, public health departments, and others depend on PCCs to provide immediate emergency advice and treatment information, 24 hours a day, seven days a week.
- Each center trains health care professionals in toxicology and provides poison prevention and awareness education to the entire state on a routine basis to the lay public.
- The caller to the poison center may be rich or poor, insured or non-insured, educated or non-educated, citizen or recent émigré. No questions are asked: all are served.
- The Centers are a valuable resource for local and State stakeholders for their knowledge of regional trends in drugs of abuse, herbals, foreign drugs and therapies used by particular cultures.
- PCCs reduce morbidity and mortality. NYS Poison Centers handled nearly 850,000 calls from 2005 to 2009. Approximately 50% of the 613,037 exposures involved children aged six years and under. Due to PCC intervention, less than 1% of poison exposures resulted in major medical effects or death.
- PCCs save money. Poison Centers are cost efficient and economical because they handle over 70% of their cases over the telephone with simple first aid instructions, while the patient remains at home. This avoids unnecessary emergency department visits, physician office visits, ambulance use, hospital admissions and treatment delays. Poison Center personnel and toxicologists improve the quality of patient care. It is estimated that NYS. Poison Centers have saved the residents in NYS more than \$98 million a year or about \$19.74 for every dollar spent on providing poison center services to New York State residents (1). This savings is more than double the national average of \$7.75 per case.

Poison Centers' Request of the NYS Legislature

- We urge the governor and legislators to learn more about our services and support the five Certified Poison Centers in NYS as a progressive budget saving and health reform measure.
- We request these proposed budget cuts be removed for the sake of the people of NYS.
- For additional information, please call your local poison control center at 1-800-222-1222 on the following page:

1) Calculation basis: 613,037 human exposures were reported between 2005 and 2009 to 5 NYS PCC. The average # human exp/yr was 122,607/yr.

According to Dr F LoVecchio's article entitled "Poison Control Centers Decrease Emergency Healthcare Utilization Costs" published in *J Med Toxicology* 2008; 4: 221, 70% of cases that called a Poison Center were kept at home. Additionally, they showed the emergency charge would be ~\$1,150 per ER visit for a poisoning that could be treated at home. Extrapolating this to NYS, would mean that there was an average of 85,825 cases/yr that were managed at home. The estimated health cost savings is \$98,698,635

million dollars/yr in NYS for the last 5 years (85,825 x \$1,150/yr). Since the total budget for the 5 Poison Centers is 5 million dollars that would mean for every dollar spent on Poison Centers in NYS would save \$19.74 per year. It is important to note that this number is more than twice the national average of \$ 7.75/per case estimated as cost savings reported for all Poison Centers in the US.

Potential Consequences of Budget Cut

- Having five PCCs may appear, on the surface, to be redundant but each region is unique in its needs. Reducing the number of PCCs to two covering nearly 55 thousand square miles from the crowded urban areas of downstate to the rural Adirondack, upstate New York, western, and southern areas would be a significant, if not impossible, challenge. Besides giving poison treatment advice by phone, the PCCs reach out to the communities they serve to assess local needs and provide tailored prevention strategies to meet these needs. Keeping people healthy and giving them information to prevent exposure to harmful situations is also the mission of the PCCs.
- Certified regional PCCs know the needs of the residents in their region and have ties to various agencies throughout the State. This requires time and travel.
- The AAPCC national certification standards for PCCs do not recommend a PCC to serve a population exceeding 10 million (American Association of Poison Control Centers Criteria for Certification of Poison Centers and Poison Center Systems, Revised: July 29, 2005). While two PCCs could be fashioned to meet this requirement, the number is insufficient in practice.
- Two PCCs do not allow for surges in call volumes in the event of a national or local emergency; a network of five PCCs spread across the State is capable of responding in the event of a national or even local disaster. When the September 11th terrorist attacks disrupted telephone service for both the New York City and Mineola PCCs, the overflow of calls were quickly distributed to the other NYS PCCs without any loss of service. A single PCC could not absorb the sharp increase in call volume should the other PCC fail.
- Poison centers are vulnerable to a variety of Internal and External threats that can create disruptions and delays in operations. A list of ones that can occur is provided below:

Internal Threats:

Equipment based:

Telephone service failure (e.g., landline and cellular phones).

Electrical power failure or power outages.

Computer equipment failure due to viruses, hardware or software issues.

Facility Deficiencies:

Heating and ventilation malfunction.

Weather-related problems (floods, leaks).

Environmental contamination from mold and other air pollutants including carbon monoxide, asbestos, and rodents.

Personnel Issues:

Staff shortages due to illness, transportation delays, disciplinary issues; time management conflicts.

Call related problems:

Complicated cases that require extra time by staff for consultation with specialists such as mycologists, nephrologists, hyperbaric chamber units, herpetologists, intensive care specialists.

Callers in crisis who require extra time on the telephone.

Increasing population of elderly callers who need additional time on the telephone.

Health care providers who don't follow recommendations and place patients at harm.

Hospitals that don't stock sufficient antidotes place patients at greater risk of developing more serious poisoning and require more time on the telephone.

Unknown products that can not be readily identified including chemicals, drugs that are very old/new/foreign or of unfamiliar ethnic background.

Exotic envenomations involving reptiles or other venomous creatures.

Non-English speaking callers that require extra time to connect with language interpreters.

Product recalls or contaminations.

External Threats

Environmental/weather related problems.

External telephone issues such as misrouting of calls.

Disasters from nearby states, such as New Jersey, result in additional calls from out of state or region.

Nuclear/Biological/Chemical accidents or incidents.

- The risk of increasing the waiting time for emergency calls to be answered or the possibility of missing some calls during busy times seems much more likely to be problematic with only two PCCs compared to having five centers. If this were to occur even once in an emergency, it could easily lead to catastrophic consequences for those involved in such a situation.
- This budget reduction would decrease the staff and resources for public and professional education in the affected areas and could easily decrease the effectiveness of the poison treatment and prevention efforts.
- There is also a critical shortage of trained health care professionals (HCP) that are qualified to work in a PCC. Many months are required to train a HCP to work in a PCC. The expertise of these health care professionals and service is unparalleled and needs to be protected not impinged upon.

Western New York Regional Poison Center

Children's Hospital of Buffalo
219 Bryant Street
Buffalo, New York 14222

Location

Population Served 1,529,043 (from US Census Bureau 2008 Estimate by County)

Counties Served Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming

Telephone Numbers Emergency TOLL-FREE: 1-800-222-1222
Poison Center: (716) 878-7654

Website Address www.wchob.org/poison

Ruth Lawrence Regional Poison and Drug Information Center

Strong Memorial Hospital
University of Rochester
601 Elmwood Avenue
P.O. Box 321 Rochester, New York 14642

Location

Population Served 1,485,097 (from US Census Bureau 2008 Estimate by County)

Counties Served Cayuga, Monroe, Livingston, Chemung, Steuben, Schuyler, Seneca, Wayne, Yates, Ontario, Tioga, Tompkins,

Telephone Numbers Emergency TOLL-FREE: 1-800-222-1222
Office/Administrative: (585) 273-4155
Public Educator: (585) 273-4621
TTY: (585) 273-3854

Website Address www.fingerlakespoison.org

Upstate New York Regional Poison Control Center

University Hospital,
Upstate Medical University
SUNY Health Science Center
750 East Adams Street
Syracuse, New York 13210

Location

Population Served 4,354,088 (from US Census Bureau 2008 Estimate by County)

Counties Broome, Herkimer, Lewis, Jefferson, Oneida, Onondaga, Chenango,

Served Oswego, Cortland, Madison, St. Lawrence, Albany*, Clinton*, Columbia*, Delaware*, Dutchess*, Essex*, Franklin*, Fulton*, Greene*, Hamilton*, Montgomery*, Orange*, Otsego*, Putnam*, Rensselaer*, Rockland*, Saratoga*, Schenectady*, Schoharie*, Sullivan*, Ulster*, Warren*, and Washington*.
Emergency TOLL-FREE: 1-800-222-1222

Telephone Numbers Office/Administrative: (315) 464-7078
Public Educator: (315) 464-5423

Website Address www.cnypoison.org

Long Island Regional Poison and Drug Information Center

*Winthrop University Hospital
107 Mineola Boulevard
2nd Floor
Mineola, New York 11501*

Location

Population Served 3,817,792 (from US Census Bureau 2008 Estimate by County)

Counties Served Nassau, Suffolk, Westchester*

Emergency TOLL-FREE: 1-800-222-1222
Office/Administrative: (516) 663-4574
Public Educator: (516) 663-2650 or (516) 663-2592

Telephone Numbers TTY: Nassau (516) 747-3323
TTY: Suffolk (516) 925-8811

Website Address www.lirpdic.org

New York City Regional Poison Control Center

*New York City Dept. of Health & Mental Hygiene
455 First Avenue, Room 123
New York, New York 10016*

Location

Population Served 8,363,710 (from US Census Bureau 2008 Estimate by County)

Counties Served Bronx, Kings, Queens, Richmond and New York

Emergency TOLL-FREE: 1-800-222-1222

Telephone Numbers Office/Administrative: (212) 447-2666 or 477-8152

Public Educator: (212) 447-2599

TTY: (212) 689-9014

Website Address www.nyc.gov/html/doh/html/poison/poison.shtml

Footnotes

- * Telephone Inquiries Only. Educational Programs provided by Hudson Valley Poison Education Center.

Appendix 1

Please see more details at the following website:
http://www.health.state.ny.us/professionals/poison_control/

Toxicosurveillance

Early Warning System

Recently the 5 Poison Centers in New York State collaborated with the New York State Department of Health in establishing a Uniform Data Collection Surveillance System. The Network participates in early warning surveillance by notifying each other of local trends, personal hazards, hazardous material incidents, and product recalls. In addition, the New York State Network shares and reviews this information with centers nationwide through the American Association of Poison Control Centers. Each center conducts a survey of hospitals, their services and their antidote availability periodically.

National Poison Data System (NPDS)

Administered by the American Association of Poison Control Centers (AAPCC), all poison centers nationwide contribute to the NPDS database. During 2001, the AAPCC initiated an auto upload program that immediately collects and categorizes all cases entered into each poison center's database. The data is immediately analyzed and monitored for trends in poisoning as well as chemical and/or bioterroristic events. In case of a recognized sentinel event, the AAPCC will notify the local poison center that, in turn, will notify the proper governmental agencies. Other information or feedback that is recovered can be used to monitor product safety and can provide an early opportunity to consider product reformulation or repackaging. The information collected by the AAPCC is distributed to poison centers, governmental agencies and industry.

911 System

Centers provide training and education to the 911 dispatchers. Protocol stipulates that all 911 calls involving a poison exposure are called into the poison center prior to dispatching an ambulance. With 911 on the line, the centers triage the calls and then determine if the patient needs to be transported. If the patient is unconscious or experiencing life-threatening problems, 911 dispatches an ambulance and the EMTs on the scene contact the poison center for recommendations during transport. If the patient is asymptomatic and no serious effects are expected from the exposure, 911 are advised that a transport is not necessary and the poison center handles the case, including follow-up.

Pesticide Reporting

Each center in the Network reports information on pesticide poisonings to the New York State Department of Health, which maintains a registry that monitors both the acute and chronic effects of pesticide exposure. It investigates occurrences of pesticide poisoning

and may perform environmental monitoring to determine the source and circumstances of exposure. Both occupational and environmental incidents are followed. Appropriate acute and long-term interventions (changes in work practice/protective equipment) work to prevent pesticide poisoning.

Hazardous Materials

Centers work with local emergency planning boards and emergency services to assist and advise during toxic spills, fires and hazardous incidents. They also participate in disaster drills conducted by host institutions.

Bioterrorism

Since the events of September 11, 2001, the Network has continued to train health care professionals, governmental, and uniformed agencies regarding biological and chemical agents. In addition, the Network has also focused on the development and distribution of public education within the communities served. Network members were also involved in: the development of decontamination rooms and hospital medical response systems in their local areas;

- serving as advisors to local and State health Bioterrorism Task Forces;
- assisting in the Metropolitan Medical Response System; and
- participating in the enhanced health Alert Network.
- providing Bioterrorism programs to various Health Department agencies, school groups and community organizations.

Since poison centers are considered sentinel units, the members of the Network assist local health departments in bioterrorism surveillance, including daily reports. Training, including mock drills in coordination with other governmental and uniformed agencies, has been ongoing.

Quality Assurance

Centers conduct quality assurance activities on a daily basis. Direct assessment occurs with peer review of active cases and supervisory review of active, random and high-risk cases. Feedback is provided and instruction given at staff meetings to address recurring problems and unusual poisonings, as well as review of protocols and guidelines. In addition, centers conduct periodic satisfaction surveys, hospital services and antidote availability. Fatalities are reviewed and discussed and abstracts written for submission to the national database. Staff receives periodic evaluation and skills assessment for competency.

Public Education and Awareness

The Network strives to offer a variety of outreach programs throughout the state in an effort to instruct the public in poison prevention and to create an awareness of the services of poison centers.

Various education programs have been designed and developed for the general public targeting specific age groups and are provided in different areas of the state. Examples of the types of programs provided are available in the New York State Annual Report for Poison Centers.

A statistical summary of public education outreach efforts is available on the New York State Department of Health Annual Report

Poison control centers collaborate with many community groups in their respective communities including the following:

Collaborations

- American Association of Retired Persons
- American Red Cross
- BOCES
- Boy & Girl Scouts
- Child care councils
- Community action organizations
- Community health coalitions
- Cornell Cooperative Extensions
- Day care centers
- Department of Transportation
- Elementary, middle and high schools
- Emergency medical services
- Fire departments
- Grocery Stores
- Head Start
- Health departments
- Hospitals
- Human service organizations
- Junior League
- Literacy organizations
- Migrant health centers
- National Safe Kids
- Office of the Aging
- Parenting programs
- Pharmacies
- Public libraries
- Religious organizations

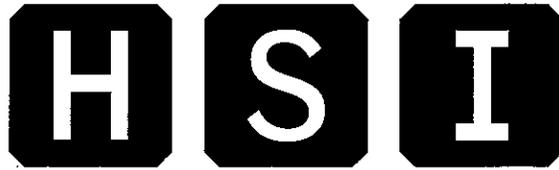
- School nurses
- Senior centers
- Social service agencies
- Volunteers/auxiliaries at hospitals
- Women, Infant and Children (WIC)
- YMCA/YWCA

Special Populations

- Children under five
- Parent/caregivers
- Seniors
- Foster care
- Migrant workers
- Day care/preschool workers
- Developmentally challenged
- Hearing Impaired
- Pregnant teens
- Adult learners
- Diverse populations and cultures

Toxicology Training

In order to stay abreast of changes in the field of toxicology, all staff at the poison centers participate in toxicology symposia, in-service training, electronic continuing education, conferences and meetings. In turn, staff of the poison center teaches pharmacy and nursing students, ambulance personnel (EMT), physicians and physician assistants.



Housing and Services, Inc.

**Testimony of Jim Dill
Executive Director
Housing and Services, Inc. (HSI)**

**New York State Assembly
and
New York State Senate
Budget Hearing
Wednesday, February 10, 2010**

Thank you Senators and Members of the Assembly for receiving my written testimony for this year's budget hearing and regarding proposed cuts to SRO Support Services.

HSI develops and manages programs for lower income households and New Yorkers with special needs. We were founded in 1987, and we are a pioneering organization in supportive housing. Our units throughout Manhattan at Kenmore Hall, The Narragansett and Cecil Hotel, and a Scatter Site I Program in the Bronx are 535 in total. Each program provides affected populations customized services to maintain them in safe, suitable and affordable housing. Clients include the elderly, people who live with HIV/AIDS, the mentally ill, people with physical disabilities and those who struggle with addiction. On-site programming includes medical care, mental health counseling, educational/vocational training, and other comprehensive services designed to promote housing stability and greater independence.

SRO Support Services pays for the Case Management, Front Desk personnel and 24-hour, 7-day-a-week on call HSI staff at The Cecil Hotel and Kenmore Hall; services vital to our clients.

The Cecil in Harlem was one of the country's first supportive housing residences. HSI leases the Cecil and the land beneath it from Harlem Community Development Corporation (Harlem CDC), a subsidiary of the Empire State Development Corporation. The Cecil is currently under much-needed rehabilitation construction thanks to a \$9.4 million NYC Department of Housing Preservation & Development (HPD) Supportive Housing Loan. Harlem CDC provided HSI with a \$100,000 predevelopment loan to get the project started.

The Cecil is home to 89 mostly African American, mostly elderly, and mostly formerly homeless men and women.

The Kenmore was established in 1999 when HSI was selected by the New York City Office of the Mayor and the federal government to take over this federally-seized SRO, which was a bane on its community. Verizon invested in Kenmore's rehabilitation as a low income housing tax credit investor and NYC HPD also helped fund the rehabilitation of this once-renowned SRO hotel. In its conversion to supportive housing, the monument was restored to dignity, contributing to HSI's winning a HUD best-practices award and achieving continued service improvement through public and private funding over the past 10 years, including an annual SHP Grant through HUD's Continuum of Care. HSI's conversion of Kenmore Hall turned that block of the Flatiron District near Gramercy Park from a blight into a welcome member of the community. The ribbon cutting of Kenmore Hall was a proud moment, mostly because we know that it continues to be an excellent case example of how HSI's work in providing homes for homeless New Yorkers creates a better New York City.

The Kenmore is home to 325 men and women. About 80% are from the NYC shelter system and half of the population was chronically homeless when they arrived at our door. However the median length of stay with us is over seven years. These clients come to us after having spent years in and out of shelters or living on the street and, through customized services, which are funded by SRO Support Services, they are cured of homelessness. When they move out, it is usually into more independent housing or they age in place at the Kenmore.

Without SRO Support Services funding, HSI would be forced to eliminate ten case management positions, all of our on-call, 24/7 staff, and 15 front desk employees. The immediate results would be increases in calls for Emergency Medical services, Fire Department services, and Police Intervention services. Without case management services and within a brief period of time clients would be unable to manage their rent obligations and would lose government rent subsidies, putting at risk \$40 million in city-state capital funding. Many of our residents would return to streets or shelters, and ultimately our projects would fail, both programmatically and financially. HSI's 22 years of serving thousands of New York's homeless will come to an end.

Not only is supportive housing widely known as the lowest cost alternative for New York's homeless, but it is also a more manageable and humane response to the problem than the more complicated and volatile systems of emergency care. Corporation for Supportive Housing estimates average costs per person per day for supportive housing as \$41.85 compare to \$164.47 of jail, \$74 for prison, \$54.42 for shelters, \$467 for mental hospitals and \$1,185 for hospitals. Eliminating a systematic approach for expensive and logistically burdensome alternatives is contrary to a fiscally conservative and proactive approach.

Finally, the loss of these service dollars could trigger a breach of my organization's capital and operating funding agreements, setting in motion a domino effect that would jeopardize tens of millions in federal funds and clear the market of private investors needed to underwrite tax-credit-funded developments.

On behalf of HSI's 84 staff, 7 Board members, the more than 400 people who call SRO Support Services-funded Kenmore Hall and Cecil Hotel home, as well as the 120 HASA-funded residents of The Narragansett and HSI's Scatter Site, and with the New York City supportive housing community, we strongly urge you to restore the \$4.6 million in SRO Support Service funding to save lives that would be lost to homelessness; retain State funds that will be spent in crisis care; and preserve the federal and corporate funds that could disappear without matching service dollars. Unless this program is funded with the \$22.2 million needed to provide services in all new and existing units, any projected savings to the State will be negated by immediate economic and human costs.



Rippe Lifestyle Institute

James M. Rippe
Founder and Director, Rippe Lifestyle Institute
Associate Professor of Medicine (Cardiology)
Tufts University School of Medicine
Professor of Biomedical Sciences
University of Central Florida

**Written Statement of
James M. Rippe, M.D.
Founder and Director
Rippe Lifestyle Institute
Professor of Biomedical Sciences
University of Central Florida
Submitted to the New York State Legislature
Senate Health and Assembly Health Committees
Health/Medicaid Joint Budget Hearing
February 9, 2010**

The purpose of this written statement is to express concern regarding the proposed measure to tax sugared beverages as part of the 2010-2011 Executive Budget being considered at the Health/Medicaid Joint Hearing of the New York State Senate Health and Assembly Health Committees.

As a board certified cardiologist and Professor of Biomedical Sciences, my background in this area comes from extensive research over the last 25 years in cardiovascular disease, metabolism, obesity, and diabetes. My research laboratory has been a leading source of information on nutritive sweeteners over the past decade. My research team has published extensively in the metabolic effect of nutritive sweeteners, and I have testified in front of the American Medical Association and elsewhere concerning these issues.

The issue of obesity is a complicated one. There are multiple causative agents that impact on obesity. The simple fact is that we are eating more from all sources than we were 25 years ago and are exercising less. In fact, as a percentage of calories the calories from all nutritive sweeteners combined have actually declined over the last 25 years. In our diet we consume 3-1/2 times as many calories as fat than we do from all nutritive sweeteners combined. Historically, every effort to combat obesity by singling out one component of the diet has resulted in abysmal failure. There is significant risk in targeting any one segment of the diet as a causative agent of obesity. Such efforts are doomed to failure and when this latest attempt fails, the public will once again be left with less trust in our government when it comes to the important public health issue of obesity.

The argument that taxing or banning certain substances in the food supply will result in decreasing their consumption may be true, but it will not have any measureable impact on the overall calorie consumption or prevalence of obesity in our country.

Sincerely,

James M. Rippe, M.D.
Founder and Director
Rippe Lifestyle Institute
Professor of Biomedical Sciences
University of Central Florida

THE GEORGE WASHINGTON UNIVERSITY
WEIGHT MANAGEMENT PROGRAM

ARTHUR FRANK, M.D. AND ASSOCIATES

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Written Statement of
Arthur Frank, M.D., Medical Director
George Washington University Weight Management Program
Submitted to the
Senate Health and Assembly Health Committees
Health/Medicaid Joint Budget Hearing
New York State Legislature
February 9, 2010

I am writing to express concern regarding the proposed taxation of sodas and sports drinks being considered by the New York State Senate Standing Committee on Health and the Assembly Health Committee at the Health/Medicaid Joint Budget Hearing.

Part of my perspective on the issues of diabetes and obesity derives from my professional activities for the past 33 years in research and in the clinical management of obese patients as the Medical Director of the George Washington University Weight Management Program. With this background I have served also as a member of the scientific advisory committee of the Corn Refiners Association.

There is no single culprit in the puzzle of obesity. There is no single process that causes the disease. Eating is regulated by complex neurochemical signals, and food selection *alone* is not likely to be a significant cause of the problem. A substantial body of epidemiological and metabolic evidence establishes that obesity is not caused only by misguided food selection. Focusing the blame on a single food or beverage will be simplistic and potentially misleading. It will create a target for directing the public's concern on one component of the food supply which happens to be an incidental part of the problem. There is a risk that this focus on this one component of our complex food supply will do more harm than good.

Taxing or banning certain components of the food supply will result in decreasing the consumption of these food components but, unless we modify the complex neurochemical system that regulates the control of eating and calorie balance, we will have the risk that total calorie consumption and body weight problems will remain unchanged.

Sincerely,



Arthur Frank, M.D.
Medical Director
George Washington University Weight Management Program



Written Testimony of
Audrae Erickson
Corn Refiners Association
Submitted to the
Senate Health and Assembly Health Committees
For the
Health/Medicaid Joint Budget Hearing
February 9, 2010

The Corn Refiners Association thanks the members of the Senate Health and Assembly Health Committees for the opportunity to submit written testimony for the Health/Medicaid Joint Budget Hearing. We urge that the provision regarding a proposed tax on sodas and sports drinks in the 2010-2011 Executive Budget be rejected.

The Corn Refiners Association (CRA) is the national trade association representing the corn refining (wet milling) industry of the United States. CRA and its predecessors have served this important segment of American agribusiness since 1913. Corn refiners manufacture sweeteners, ethanol, starch, bio-products, corn oil, and feed products from corn components such as starch, oil, protein, and fiber.

Singling out certain foods or beverages for government penalization, whether through nutrition or tax policies, will only serve to further confuse consumers and will not lead to meaningful results in assisting Americans to adopt healthier lifestyles.

According to James M. Rippe, M.D., cardiologist and biomedical sciences professor at the University of Central Florida, "We are eating too much of everything, not just sugar. Over the last three decades, the average American has increased their calorie consumption by 24% and physical activity has declined. People are singling out sugar as the one smoking gun in the obesity epidemic when there are guns everywhere." (Boyles S. "Fresh Take on Fructose vs. Glucose." WebMD Health News. April 21, 2009)

A peer-reviewed study published in the August 2007 issue of *Food and Chemical Toxicology* found that those who frequently consume sweetened soft drinks do not have a higher obesity rate than those who rarely drink them. The study found higher obesity rates correlated with several other factors, such as the amount of time in front of the computer or TV, or the consumption of high amounts of dietary fat.

The authors noted, "Obesity is a multi-factorial problem which is rooted in a positive balance between energy intake and expenditure. Lifestyle, behavior, and environment appear to have a more dominant role in obesity prevalence than do individual foods." (Sun SZ, Empie MW. 2007. Lack of findings for the association between obesity risk and usual sugar-sweetened beverage consumption in adults - A primary analysis of databases of CSFII-1989-1991, CSFII-1994-1998, NHANES III, and combined NHANES 1999-2002. *Food Chem Toxicol* 45(8):1523-1536.)

Written Testimony of Audrae Erickson, Corn Refiners Association

February 9, 2010

Page 2

It is especially important to understand that Americans are consuming more calories from all types of foods today than what was consumed 30 years ago, and we expend less energy to burn the extra calories. Consider the numbers reported in the February 2009 Loss-Adjusted Food Availability Data by the U.S. Department of Agriculture. Total caloric intake on a per capita basis for Americans increased from 2,172 calories per day in 1970 to 2,775 calories per day in 2007 – an additional 603 calories.

Major contributors to this 603-calorie increase include 299 calories from added fats and 194 calories from flour and cereal products. Added sugars account for only 57 calories of the daily increase. (U.S. Department of Agriculture, Economic Research Service. 2009. Calories: average daily per capita calories from the U.S. food supply, adjusted for spoilage and other waste. Loss-Adjusted Food Availability Data.)

Many sodas and sports drinks are made with high fructose corn syrup, a safe and natural ingredient that is handled the same as sugar by the body. There has been a lot of confusion about high fructose corn syrup. We would like the following statements from the American Medical Association and American Dietetic Association included on the record.

The American Medical Association stated that, "Because the composition of high fructose corn syrup and sucrose are so similar, particularly on absorption by the body, it appears unlikely that high fructose corn syrup contributes more to obesity or other conditions than sucrose." (Report 3 of the Council on Science and Public Health A-08, June 2008.)

According to the American Dietetic Association (ADA), "high fructose corn syrup...is nutritionally equivalent to sucrose. Once absorbed into the blood stream, the two sweeteners are indistinguishable." The ADA also noted that "Both sweeteners contain the same number of calories (4 per gram) and consist of about equal parts of fructose and glucose." (Hot Topics, "High Fructose Corn Syrup." December 2008.)

For the reasons set forth in this written testimony, the Corn Refiners Association urges the Committee to oppose a tax on sodas and sport drinks. Thank you for considering our concerns.

Respectfully submitted,



Audrae Erickson
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AMA finds high fructose syrup unlikely to be more harmful to health than other caloric sweeteners

**For immediate release
June 17, 2008**

CHICAGO — After studying current research, the American Medical Association (AMA) today concluded that high fructose syrup does not appear to contribute more to obesity than other caloric sweeteners, but called for further independent research to be done on the health effects of high fructose syrup and other sweeteners.

"At this time there is insufficient evidence to restrict the use of high fructose syrup or label products that contain it with a warning," said AMA Board Member William Dolan, MD. "We do recommend consumers limit the amount of all added caloric sweeteners to no more than 32 grams of sugar daily based on a 2,000 calorie diet in accordance with the Dietary Guidelines for Americans."

High fructose syrups are sweeteners produced from starches such as corn, rice and wheat. They can be found in a variety of food products, including breakfast cereals, soft drinks and breads. Currently, there are few available studies on the health effects of high fructose syrup and most are focused on the short-term effects.

"Obesity continues to be a major public health problem in this country. Overweight and obese adults and children are at an increased risk for chronic health conditions like heart disease and diabetes" said Dr. Dolan. "Eating a healthier diet can help maintain a healthy weight and drastically reduce your chances of developing weight-related illnesses."

This report was introduced at the AMA's Annual policy-making meeting in Chicago.

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For more information, please contact:

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Last updated: Jun 17, 2008 Content
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Hot Topics

High Fructose Corn Syrup and Weight Status December 2008

CLAIM OF TOPIC: High fructose corn syrup and its relationship to weight status.

DISCUSSION OF TOPIC: High fructose corn syrup is frequently mentioned in the media as a major culprit in the increased incidence of obesity among Americans. Many of the claims against high fructose corn syrup have suggested that this corn sweetener is metabolized differently than sucrose. The American Medical Association (AMA) recently concluded that high fructose corn syrup "does not appear to contribute more to obesity than other caloric sweeteners." The AMA called for further independent research, and recommends that consumers "limit the amount of all added caloric sweeteners to no more than 32 grams of sugar (8 teaspoons of sugar) daily based on a 2,000 calorie diet...". Most scientific experts now agree that high fructose corn syrup and sucrose produce similar effects on human metabolic responses. Studies comparing high fructose corn syrup and sucrose have found no significant differences in fasting blood glucose, insulin, leptin and ghrelin. Satiety studies of the two sweeteners have found no differences in appetite, feelings of fullness or short-term energy intakes.

Studies conducted with abnormally high levels of pure fructose (which are not found in the human diet) that are misinterpreted as being representative of high fructose corn syrup may have led to confusion about the relationship between high fructose corn syrup and obesity. However, high fructose corn syrup and sucrose both contain about 50 percent fructose and 50 percent glucose. When these two monosaccharides are consumed together in roughly these proportions, glucose appears to moderate or 'balance' fructose.

BOTTOM LINE: High fructose corn syrup may be used as a sweetener in processed foods and beverages and is nutritionally equivalent to sucrose. Both sweeteners contain the same number of calories (4 per gram) and consist of about equal parts of fructose and glucose. Once absorbed into the blood stream, the two sweeteners are indistinguishable. No persuasive evidence supports the claim that high fructose corn syrup is a unique contributor to obesity, however, like all nutritive sweeteners, it does contribute calories. This is where moderation and portion size become important. The greater the consumption of foods and beverages containing large amounts of added sugars of any kind, the more calories are consumed, influencing weight gain. The *source* of the added sugar – whether sucrose, high fructose corn syrup, honey or fruit juice concentrate – should not be of concern; rather it is the *amount of total calories* that is important. Overall, carbohydrates and sugars in foods and beverages can be enjoyed in moderation as part of a balanced diet and active lifestyle. HFCS is a controversial topic and although not all nutrition professionals will readily accept the scientific evidence, this paper represents an evidenced-based, balanced perspective.

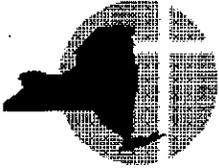
OPPORTUNITIES FOR THE RD/DTR:

RDs and DTRs can help correct common misperceptions about high fructose corn syrup and help consumers make better informed choices related to sweeteners, including making the conversion of grams of sweetener to teaspoons of sugar. This information can be communicated through various practice settings as well as in community education and the media.

Resources/References:

1. American Medical Association. "AMA finds high fructose syrup unlikely to be more harmful to health than other caloric sweeteners," American Medical Association Press Release; www.ama-assn.org/ama/pub/category/18691.html
2. Forshee RA et al. A critical examination of the evidence relating high fructose corn syrup and weight gain. *Critical Rev Food Sci Nutr.* 2007; 47:561-582.
3. Melanson KJ et al. Effects of high-fructose corn syrup and sucrose consumption on circulating glucose, insulin, leptin, and ghrelin and on appetite in normal-weight women. *Nutr.* 2007; 23:103-112.
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5. Fulgoni, Victor III. High-fructose corn syrup: Everything you wanted to know, but were afraid to ask. *Am J Clin Nutr.* 2008;88; 1715S.

Written by: Kristine S. Clark, Ph.D., R.D., FACSM
Director of Sports Nutrition and Assistant Professor of Nutritional Sciences, Penn State University
Corn Refiners Association Independent Scientific Advisory Panel



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RICHARD E. BARNES
Executive Director

Testimony of the New York State Catholic Conference

Presented by
Ron Guglielmo
Director for Health Care

Before the
Joint Fiscal Committees
Regarding the
Health and Medicaid Budget

February 9, 2010

Introduction

The New York State Catholic Conference represents the Bishops of New York State in public policy matters. Our Catholic tradition compels us to actively participate in the civic life of the community, to uphold the dignity of every individual, and to serve and advocate for those most in need. As the Catholic Conference has testified in the past, everyone deserves health care as a right consistent with their dignity, everyone needs health care to lead healthy and productive lives, and society has an obligation to provide access to health care to everyone, especially to the vulnerable aged, the disabled, and the poor.

The Catholic Church's health care ministry represents the largest single not-for-profit provider sector in the state, and provides approximately 10 percent of health care services statewide, in communities large and small throughout New York. The Church is also the largest provider of human services, with more than 700 programs and human services agencies located throughout the state. The broad spectrum of our service provision affords us a unique perspective to view the breadth of need throughout our state.

Mission-based health care providers play a unique role in the provision of health care services throughout the state. In particular, faith-based providers often operate with limited resources in areas serving the greatest need and provide services that other institutions are unable or unwilling to provide. In this regard, Catholic and other faith-based providers are uniquely suited, through their broad service networks of inter-related institutions and service agencies, to address the full spectrum of community needs, in partnership with the state, over the continuum of health and social services.

Our concerns are twofold: Access to health care is critical to the health and well-being of millions of New Yorkers, particularly in a weakened economy; and a financially robust health care infrastructure—whether Catholic-sponsored or sponsored by other entities—must be maintained to provide the health care services needed in every community in this state. Against these two broad concerns, the budget before you contains proposals which are encouraging in some respects and worrisome in others.

Reduced Revenues for Health Care Providers

The sluggish economy continues to place growing demands on health care services, as evidenced by increased Medicaid caseloads—particularly for behavioral health services—and increased use of hospital emergency rooms. In addition, the cumulative effect of nearly \$4 billion in revenue losses and assessments on providers just in the last two years, on top of repeated smaller but no less debilitating cuts over more than a decade, has, as all can see, taken its toll.

It is precisely during periods of economic stress that the state's safety net services must be maintained. Indeed, even in the best of economic times, many low- and moderate-income individuals need assistance to afford the basic necessities, including health care. That need is found in every community even in good economic times, and it is growing as the prolonged economic slump continues.

Formula-driven cuts such as those before you have been proposed repeatedly for over a decade. The Legislature has on many occasions rightly rejected them, and for good reason. Patients do not present in the hospital emergency room by formula. Hospitalizations and

surgeries are not necessitated by formula. And costs which cannot be controlled internally certainly are not governed by formula. These cuts may provide short-term budgetary savings to the state, but they will also have significant lasting consequences. In the short run, they merely weaken the ability of our health care institutions to effectively respond to the growing and rapidly changing nature of our communities' health care needs. And in the long run, they fail to provide an adequate investment in the health care infrastructure necessary to nurture a long-term environment of efficiently provided quality health care for all our citizens. Without adequate recognition of increasing costs that remain largely outside the control of any provider, a facility's revenue base cannot hope to keep pace and provide sufficient resources to support the provision of necessary health care in their communities.

Budget reductions must take into account the needs of our most vulnerable neighbors and the crucial role these safety net services play in maintaining their health and dignity as other resources available to them are reduced or eliminated and as their jobs, other financial resources, and health care coverage are threatened. Providers in communities with the greatest need are often the most adversely affected. For any provider struggling and committed to serving in our poorest communities, remaining "competitive within its market" is not an option.

And yet, the budget would cut revenue for health care providers at all levels—hospitals, nursing homes, and home care agencies—through reduced payments and increased assessments totaling nearly \$1 billion. Our preliminary estimate points to a loss of approximately \$22 million in revenue for the state's 28 Catholic hospitals; approximately \$19 million for our 52 nursing homes; and approximately \$12 million for our home care agencies and programs. Cuts of this magnitude cannot be absorbed without drastic reductions in service provision. In addition, as access to health care becomes more limited due to cost and the loss of jobs and employment-related health coverage, imposition of provider assessments and additional surcharges on insurers can only make health care costs higher still, forcing even greater numbers of individuals into the ranks of the uninsured.

Ironically, in a struggling economy with flat job growth, the health care provider sector is one of the most robust sectors of our economy. Catholic hospitals alone provide \$9.5 billion in economic benefit to their communities and employ nearly 70,000 people.

Let us be clear: Just as we all rightly view cuts in education funding as cuts to students' education, and not as cuts to schools, we must surely view cuts in health funding not as cuts to providers but as cuts to patients' health care. Reduced revenues for providers will mean reduced levels of service, unmet staffing needs, elimination of marginal services, delay of capital investment in technology—ironically, including health information technology which can reduce expenses and increase efficiency over time.

The current heightened focus on both the real and the perceived surplus in the state's institutional capacity belies the need for a systematic, ongoing approach to planning which incorporates analysis of need with availability and commitment of financial resources. In this regard, the yearly struggle faced by hospitals, nursing homes, home- and community-based providers, and physicians to maintain adequate revenue streams demonstrates the underlying need for an integrated approach to support the continuum of health care delivery.

Enhanced Access to Health Insurance Coverage and Service Efficiency

Your efforts over the last few years to extend affordable health care coverage to all of the state's children has served as a model for the nation, and the success of New York's Child Health Plus program is a testament to the state's commitment to the health and well-being of the young members of our community. Provisions before you to implement "Express Lane" enrollment and to further simplify the documentation requirements and enhance public databank matching for enrollment in Child Health Plus and Medicaid Managed Care are welcomed.

However, the proposal to reduce premiums for Medicaid Managed Care and Family Health Plus by 1.7 percent will place greater pressure on plans to adequately provide services to their enrollees. In addition, proposed co-pays in the Family Health Plus buy-in program will make such coverage less affordable to the low- and moderate-income individuals for whom the program was established. With the outcome of federal health care reform uncertain at this time, retrenchment in state supports for subsidized health insurance programs will jeopardize the ability of these individuals to access comprehensive health care through affordable coverage options.

With regard to rationalizing the delivery of home- and community-based services, the proposal to authorize joint case management of waiver services is a step in the right direction, and we commend it to you for your consideration. We believe that more can be done to enhance the delivery of services to the frail elderly and the disabled beyond waiver services, as discussed below.

The Particular Needs of the Frail Elderly and the Disabled

In contemporary American society, our elderly population too often is treated either as a problem or—equally troubling—as an afterthought. Even our public policies can overlook the needs of our oldest and frailest members to whom we owe such a debt. We have made great strides in our treatment of these valuable members of our community through the years, but, sadly, budgetary crises and other factors often lead to unfortunate cuts in services that severely impede that progress. As Catholic health care providers, we see an urgent need for a fresh look at how we are meeting our responsibilities to our elderly population and for adjustments in policies to better serve them.

The state's Catholic bishops have long emphasized this concern and call for a strengthening of the partnership of service between the state and the faith-based and not-for-profit long-term care provider community, which has been a hallmark of our society's commitment to fulfill the needs of our frailest and most vulnerable neighbors.

Demographic trends indicate that the elderly constitute a large and growing segment of the population in the nation and New York. Current methods of health care delivery—along with the delivery of ancillary services needed by the frail elderly—are but one of many factors contributing to the pressure on the long-term care delivery system. As seniors live longer, they face increasingly complex and costly health problems. At the same time, changing attitudes are placing greater emphasis on the ability of seniors to remain in their homes and communities rather than to retreat into institutions.

These factors, along with growing competition for ever-dwindling public financing, have contributed to a steady decline in the state's financial commitment to long-term care, especially

to not-for-profit institutions' role in providing for the needs of the state's frail elderly, the poor, and the disabled.

As the state's Catholic bishops noted in their March 2005 pastoral letter on society's responsibility to the poor and vulnerable entitled *Restoring the Covenant*, a partnership of service between the state and the faith-based and not-for-profit long-term care provider community has been a hallmark of our society's commitment to fulfill the needs of our frailest and most vulnerable neighbors.

In its haste to realize budgetary savings in the short run, the state has rationalized a dismantling of the institutional delivery infrastructure and has based its current policy on formula-driven reimbursement and needs methodologies devoid of an acknowledgment of the impact such actions have on affected individuals.

Current trends notwithstanding, the need continues for a robust and financially stable institutional infrastructure to deliver long-term care services to our frailest and most vulnerable elderly, for whom home- and community-based services are not a realistic alternative. The desire to receive services at home or in the community is justifiable when it is the most appropriate setting for those in need of service, but institutional long-term care is, and will remain, an essential component of a complete health care delivery system.

With these factors in mind, we believe that certain core principles must be applied to the evolving development of long-term care policy:

- Through dialogue with communities of interest, develop a coherent vision, principles and policies for the care of our frail elderly and other dependent populations and adopt specific programs for moving toward that vision.
- Clearly establish and organize the state's accountability for protecting and securing the lives and well being of the frail elderly and other dependent populations.
- Reaffirm the state's historic partnership with voluntary and faith-based agencies in providing care and services to those in our communities who are most vulnerable and unable to care for themselves.
- Commit to a system of Medicaid reimbursement that will pay for the necessary and reasonable costs of long-term care services that will meet acceptable standards for quality of life as well as quality of care.

In keeping with these principles, we recommend that the following policy initiatives for your consideration:

- Require a comprehensive care plan for every nursing home-eligible individual—developed with the participation of the affected individuals and their families—which reflects the full range of human needs, including spiritual fulfillment, and which takes into consideration the availability of institutional and home- and community-based services appropriate to the needs of each such individual.
- Develop plans related to the decertification of nursing home beds and the substitution of additional assisted living beds or any other form of home- and community-based care. These plans must take into account the circumstances of the populations to be

affected and the specific circumstances of the affected individuals and their families, the availability and capacity of institutional and home- and community-based service providers in the affected area, and the supply of trained health care workers. Such plans should also ensure that every individual has access to appropriate care and should provide priority access to employment opportunities in home- and community-based-care for affected health care workers.

- Establish a standing interagency long-term care planning committee consisting of leadership and appropriate staff from the Department of Health, the Office for the Aging, and the Department of Housing and Community Renewal, as well as providers and consumer groups, which would make recommendations to policy makers and regulators on how to best meet long-term care needs.
- Recognize the importance to care recipients, their families and care providers of the role of spiritual support in their daily lives.

Providing Life-affirming Health Care

Maternity and Early Childhood Foundation

The Executive Budget completely eliminates funding for the Maternity & Early Childhood Foundation, Inc. (MECF), which funds projects throughout the state that provide vital health and social services to pregnant and parenting young women and their infants. The elimination of this funding will devastate a program that has proven to be cost-effective in promoting early pre-natal care and healthy lifestyles for low-income pregnant and parenting mothers, and in preventing serious subsequent health problems and future dependency on the public assistance and foster care systems. Investing in programs like MECF will enhance the health, well-being and dignity of those served and save New York State in the long-term. We strongly urge the Legislature to restore the \$1.2 million appropriation for the Maternity & Early Childhood Foundation.

Stem Cell Research

The Executive Budget contains \$44.8 million for the Empire State Stem Cell Fund, consistent with a ten-year commitment outlined in the 2007-2008 State Budget. Projects funded by the Empire State Stem Cell Board are highly controversial and have flowed to research requiring the destruction of human embryos for their stem cells. Most recently, the Stem Cell Board decided, with no direct legislative approval or oversight, to allow funding to be used to financially compensate women for the harvesting of their eggs for research—an extreme policy which no other state in the union allows. In addition, the Board is currently contemplating the ethical and policy implications of animal-human “chimera” research, and could decide that research involving the integration of human and non-human cells would be eligible for Stem Cell Board grants. Numerous opportunities exist for promising ethical stem-cell research, and we urge the Legislature, as we have in the past, to limit scarce research resources to ethical non-embryonic stem cell projects.

Medicaid Abortion Funding

Funding for abortion through the medical assistance program remains in the 2010-2011 State Budget. We urge the Legislature to mirror the federal Hyde Amendment’s restrictions on abortion funding. Limiting funding for abortion to cases of reported rape or incest and cases in which the life of the mother is threatened by a continued pregnancy would save the state the vast

majority of the approximately \$45 million spent on abortion each year through the Medicaid program.

Conclusion

Make no mistake: As we and others have repeatedly said over the last decade, reductions of this magnitude will result in a loss of health care services for our poorest neighbors, especially for the frail elderly and the disabled. The responsibility to balance the state budget must not be placed on those least able to shoulder the burden, especially when their need for health services—always an issue even in the best of times—is growing. Indeed, those least able to bear the brunt of the state's budget deficit should be disproportionately sheltered from its ill effects.

Without adequate access to care, our citizens cannot hope to live healthy and productive lives. Without adequate compensation, health care facilities cannot provide services needed in every community in this state. We urge you to take the long view, to look past the opportunity for short-term formula-driven savings, and to work collaboratively with the health care provider community to develop long-term savings based on sound strategic investment.

We urge you, therefore, to restore adequate payments to providers to maintain needed health care services for all; to continuing the development of home- and community-based services so seniors can receive necessary care while remaining in their homes among family and friends; and to maintain the hard-won gains in access to affordable health care coverage.

All of us, and especially our most needy fellow New Yorkers, deserve a health care system that is appropriately and adequately funded, and we urge you to reject easy fixes to these difficult circumstances.

We stand ready to work with all policy makers and our faith-based and not-for-profit colleagues to fashion cost-effective and compassionate policies which will ensure the dignity of our most vulnerable fellow New Yorkers.

2010
NEW YORK STATE
BUDGET HEARINGS on
Health/Medicaid

Written Submitted Testimony of
Ellen G. Hollander
Executive Director
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February 10, 2010

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

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

In addition, from 2006 through 2009, both Chambers passed, and the Governor signed, a number of significant pieces of legislation, currently being implemented, that will have long-lasting impact on donation and transplantation in New York. On behalf of my Board, all the individuals needing an organ transplant, those who would benefit from the gift of sight, firefighters in need of burn treatment, cancer patients needing bone replacement, and all the generous donors and their families, thank you. While policy changes will continue to be needed, the unanimous support of legislation with the aim to improve donation and transplantation was historic and greatly appreciated.

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

Organ and tissue donation is a public health imperative. Today, there are over 105,000 people on waiting lists across the country for a donated organ. Almost 10,000 people are on waiting lists in New York; the only state with more individuals waiting is California. From January through October of 2009, the number of New Yorkers giving consent to the option of organ donation at the time of their death was 400, living donors numbered 469 people. Life-saving donations are critical to improving lives in New York. These numbers reflect the significant need to increase awareness about organ, eye and tissue donation.

I encourage the Committee members to think about the people represented by these numbers. People need transplants because of end stage organ failure; they are dependent on dialysis, medications, ventricular assist devices and other extraordinary medical treatments that hopefully will extend their lives until an organ becomes available. All of us are aware of people who need the gift of sight, healing from burns, restoration of physical function, and treatment of cancer. These are men, women and children of all ages, ethnicity and religious beliefs; these people are our family members, neighbors, colleagues and friends. These same descriptions apply to the altruistic donors and their families who have made a gift of life through the donation of organs, tissues, or corneas after death. This is an issue that affects all of us. It is likely that few of us will need a transplant; but all of us can choose to be organ donors. There is a significant opportunity to increase the number of New Yorkers who choose to be donors.

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

The State Donate Life donor registry is the focal point for awareness and action for donor designations in New York. Currently, 1.42 million New Yorkers are enrolled on the New York State Donate Life Registry. Despite the growth of the Registry since its inception in 2000, New York lags behind many other states in the total number of people on the registry. Florida, Ohio, Pennsylvania, Georgia, Virginia and North Carolina had over three million people on their respective donor registries. As of September of 2009, a total of 19 other states had more donor enrollees than New York. Clearly, more needs to be done to increase the level of awareness of donation in New York.

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

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

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

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

We were pleased to find that the consistent commitment for funding by the Legislature over the last several years has translated into appropriations in the Governor's Budget proposal last year, and now again in SFY 2010-2011. The Executive Budget contains two appropriations of interest to the Alliance: an appropriation in the Department of Health budget for \$245,000 for registry promotion and an appropriation for \$372,000 for programs related to donation and transplantation.

The Alliance has concerns about both appropriations. The amount of \$245,000 for registry promotion has been a part of the DOH budget for the past three years and has never been utilized. In addition, the line item of \$372,000 that was originally divided between the Alliance and the New York Center for Liver Transplantation, will now be divided among three organizations. With the addition of a Cardio Thoracic Consortium, the Alliance's appropriation will be cut in half. Since most of the Alliance funding is directed toward educational outreach and registry promotion, this should be of great concern to the State of New York. Donation and transplantation saves money by, for example, getting people off dialysis, in addition to saving lives.

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

Thank you for your consideration.



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TESTIMONY OF DANIEL TIETZ
to the
NYS LEGISLATIVE JOINT BUDGET HEARING ON HEALTH/MEDICAID
February 9, 2010

As Executive Director of the AIDS Community Research Initiative of America (ACRIA), I am grateful for this opportunity to contribute to New York State's budget planning for HIV- and AIDS-related treatment, prevention, and supportive services in the coming fiscal year.

We are all aware of the gloomy financial outlook facing the state and the nation, and I won't belabor the point. Suffice it to say that it is more important than ever that scarce AIDS dollars be used where they will do the greatest good for the greatest number of New Yorkers living with HIV.

New York State's HIV services system, administered primarily through the Department of Health's AIDS Institute, relies primarily on local agencies to provide direct medical and nonmedical services to people living with the virus and prevention services to those at risk of infection. The quality of those services depends upon the knowledge, training, and attitudes of those delivering them. In the constantly—and rapidly—changing HIV landscape, it is vital that these front-line workers are armed with the most up-to-date information about new medications, that their lines of communication with other service providers are strong, and that they have the skills to help their clients participate actively in their own care and treatment decisions.

One concrete benefit of the type of work we do is improved adherence to medication regimens among the clients of organizations whose staff have received our services. Improved adherence translates to better health and diminished likelihood of drug resistance—which in turn translates to monetary savings to the state.

To ensure that local agencies have the ability to meet these multiple responsibilities requires the kind of intensive technical assistance and capacity-building services that ACRIA has developed over its 17 years of existence. Our innovative programmatic approach—combining medical and behavioral research with education and technical assistance—has made our HIV Health Literacy Program (HHLP) vital to organizations providing direct services to people with HIV and AIDS in New York City and throughout the state.

ACRIA currently has two contracts with the AIDS Institute that exemplify the type of services to which I refer. As one of ten Regional Training Centers, we are able to improve programs and

service delivery by offering our expertise on new treatments and changes in the epidemic to thousands of staff and clients at organizations serving people with HIV/AIDS. Through the Clinical Trials Education initiative, we have provided staff of HIV agencies across the state with the knowledge and skills to help their clients investigate and make decisions about participating in clinical trials of new medications.

And these programs are extremely cost-efficient. Both of ACRIA's current contracts (one of which will expire in 2010) are for very modest sums. Yet their impact is immense, not only through the immediate capacity building and technical assistance they provide, but by helping form information-sharing and referral networks and providing a ready and ongoing source of information and help.

There is one aspect of the epidemic that until recently had never been targeted on a statewide level, whose significance is only beginning to be realized. I am referring to the rapidly growing numbers of HIV-positive people over the age of 50. Thanks to the incredible medical advances of the last decade, people with HIV are living longer—which means they are getting older. **In New York State, approximately one-third of people living with the virus are over the age of 50, with the proportion expected to reach 50 percent within five years.**

These seniors' HIV treatments are complicated by being combined with treatments for the common ailments of aging, things like cardiovascular disease, arthritis, diabetes, and the like. Their supportive service needs differ from those of their younger brothers and sisters, and from those of their HIV-negative peers. This growing group of middle-aged and older adults with HIV also puts their HIV-negative peers at greater risk of contracting the virus. From a public health perspective, it is imperative that we develop and implement prevention strategies that specifically address the needs of older people and that reach out to them where they congregate.

Services for middle-aged and older adults are only beginning to be addressed at the state level, and ACRIA is proud to be a part of these fledgling efforts. At the request of the AIDS Institute, and working with the State Office for the Aging, ACRIA's existing Regional Training Centers contract has been expanded during this fiscal year to provide training on older adults-related HIV issues to staff of HIV and aging programs in six areas of New York State outside New York City. This is an important first step, but only a first step.

Other programs that ACRIA has already developed and implemented could be replicated and adapted to the needs of communities across New York State. We are now in Year III of a major initiative sponsored by the New York City Council aimed at bringing HIV education, prevention, and services to older adults in every City Council District in all five boroughs of the city. We have tailored and adapted Community PROMISE (Peers Reaching Out and Modeling Intervention Strategies), a model program included in the Centers for Disease Control and Prevention's (CDC) Diffusion of Effective Behavioral Interventions (DEBI) program to target people over 50. Under New York City's *Communities of Color Initiative*, we are for the second year implementing a prevention and testing program aimed at seniors. We have provided technical assistance and capacity building senior and HIV services providers in New Orleans and South Florida to enable them to replicate our program locally. Our Older Adults Technical

Assistance Manager has recently been named to the CDC's prestigious Institute for HIV Prevention Leadership for HIV.

Because of our early and groundbreaking research into issues concerned with HIV and aging, ACRIA has become a recognized leader in this area. As a result, we have formed the ACRIA Center on HIV & Aging, which investigates, defines, and seeks to address the unique needs and challenges faced by older members of diverse populations living with HIV as they age. Through research, education, and advocacy, the Center fosters the open exchange and dissemination of information within the scientific communities as well as between and among older adults and AIDS service providers.

It is crucial that older adults be specifically targeted in the new budget to receive HIV treatment, prevention, and supportive services. For the sake of efficiency and cost-effectiveness, a wise course would be to draw upon the expertise of those who have pioneered services for older adults and developed programs that work.

Thank you.



Testimony Before the NYS Legislative Joint Fiscal Committees

Health/Medicaid Budget Hearing February 9, 2010

Presented by
Harvey Rosenthal Executive Director
New York Association of Psychiatric Rehabilitation Services

On Behalf of NYAPRS Members and
The NYAPRS Public Policy Committee
Co-Chairs: Ray Schwartz, Carla Rabinowitz

NYAPRS Board of Directors
Co-Presidents William Sullivan, Robyn Krueger President-Elect Doug Hovey

The New York Association of Psychiatric Rehabilitation Services represents a statewide partnership of 40,000 New Yorkers who use and/or provide community mental health services who are dedicated to improving services and social conditions for people with psychiatric disabilities
www.nyaprs.org

Thank you, Chairman Kruger, Chairman Farrell, Chairman Duane, Chairman Gottfried and the other members of the Committees for this opportunity to present to you the concerns of the thousands of New Yorkers represented by the New York Association of Psychiatric Rehabilitation Services. NYAPRS is a unique statewide partnership of New Yorkers with psychiatric disabilities and the community mental health professionals who support them in over 120 community-based mental health agencies from every corner of the state.

I'm Harvey Rosenthal, NYAPRS Executive Director. The following testimony that I will present incorporates the direct input of many hundreds of NYAPRS members who gathered at local forums that were conducted this past fall and winter in localities across the state including Amityville, Binghamton, Brooklyn, Buffalo, Rochester, Westport, White Plains and others.

After decades of being represented by others, New Yorkers with psychiatric disabilities are at long last speaking for themselves. This was once again evidenced by January 26th's Legislative Day that NYAPRS co-organized with our friends at the Association for Community Living and the Mental Health Association of New York State and backed by all of the other leading state and regional mental health advocacy groups.

Throughout that day, the Capitol was filled with 1,500 yellow-hatted New Yorkers with psychiatric disabilities and the community mental health staff who support them came to urge their state legislators and Administration officials to "Protect the Community Mental Health Safety Net."

State health policy is a very personal matter for our NYAPRS community. Many of our members, our board members and our staff all share a common personal journey of recovery from a psychiatric disability. We believe this strengthens our ability to speak to you on behalf of the tens of thousands of New Yorkers with psychiatric disabilities we represent.

Following are the NYAPRS communities' reactions to this year's Health/Medicaid budget and legislative proposals. NYAPRS sees this year's Executive Budget on Health and Medicaid as a mixed bag. At this time of unprecedented fiscal crisis, the Governor has maintained his commitment to community-based, person-centered services in many important ways. At the same time, there are several proposals that are unacceptable and incongruous with the "patient first" agenda.

Budget Agenda
DEPARTMENT OF HEALTH

**STRONGLY SUPPORT PROPOSAL TO BOOST
MEDICAID MANAGED CARE MENTAL HEALTH CLINIC RATES**

NYAPRS has been a strong supporter of the Office of Mental Health's Outpatient Clinic Restructuring Initiative and its efforts to advance a recovery (versus mere symptom management) focus, implement more ambitious and innovative standards of care, add an indigent care pool to reimburse providers for serving those who cannot afford to pay and introduce the use of peers and family members to conduct outreach and engagement for 'hard to serve' individuals.

This programmatic reform has been linked with re-financing efforts necessitated by the phase out of federal supplemental payments (COPS) that are no longer tenable.

However, COPS has often served to compensate for the woefully inadequate Medicaid Managed Care mental health clinic rates prompting concerns about community providers ability to continue to serve those clients.

The Governor's 21 Day amendments released today contain a crucial remedy to such concerns: included is a provision for the transfer of funds from the Office of Mental Health to the Department Health to increase the mental health clinic rates paid by Medicaid managed care organizations.

To be specific, the 21 day amendment, "Part P", reads as follows: "relating to increased Medicaid payments to providers through managed care organizations is added to: transfer funds from OMH to DOH to increase Medicaid payments for managed care organizations, to provide equivalent fees per an ambulatory patient group (APG) methodology. This language is intended to increase payments to managed care organizations to ensure the continued availability of clinic mental health services."

Recommendation: NYAPRS strongly supports this measure and urges state legislators to promptly approve it as part of this year's state budget.

**OPPOSE PROPOSALS TO COLLAPSE ADULT HOME RESIDENT FUNDING
STREAMS AND PROTECTIONS**

NYAPRS strongly opposes Administration proposals to collapse into one funding stream several initiatives that have provided critical aid and guarantees to adult home residents with psychiatric disabilities.

Previously, the Executive and the Legislature recognized adult home deficiencies by collaborating to dedicate specific funds that have historically:

1. advanced **recovery initiatives for adult home residents with SSI level psychiatric disabilities (ENABLE)**
2. ensured that residents taking powerful psychiatric medications that produce dangerous ill effects during hot summer months get **financial assistance to turn on critically needed air conditioners** (the operators were charging poverty-level residents high monthly rates)

Further, the state proposes to abandon **requirements that adult home operators consult with and get the formal support of resident councils for their applications to receive state Quality Improvement Program (QUIP) grants.**

Recommendation: We urge state legislators to reject a further weakening of dedicated supports and rights protections afforded to adult home residents with psychiatric disabilities at the exact time New York is under great public, federal and judicial pressure to provide them with more not less.

**PRESERVE OPEN UNRESTRICTED ACCESS TO ANTIDEPRESSANT AND
ANTIPSYCHOTIC MEDICATIONS IN NEW YORK'S MEDICAID PROGRAM**

NYAPRS is greatly troubled about the state's decision to remove the historic and prudent exemption from the Medicaid Preferred Drug Program for medications for our most vulnerable groups: people with psychiatric disabilities, AIDS/HIV and who've received organ transplants. The Legislature has long rejected Administration attempts to weaken access to these medications and has maintained a strong wall of protection by insisting they remain out of the PDL and related Prior Authorization.

(PA)-driven access restrictions that could greatly jeopardize the health and sometimes life of these groups. It often takes years for such individuals to find the right medication and dosage and PA programs can serve to deny access patients to those exact medications in an effort to save the state money.

As the state currently proposes to bring these drugs into the PDL to collect more rebate dollars from the manufacturers without currently subjecting them to Prior Authorization restrictions this year, it takes down a long respected "wall of protection" that moves them only one step away from that terrible possibility in the future.

NYAPRS is hearing growing concerns that the state's Prior Authorization process is more onerous than previously thought; we greatly fear that the current proposal moves us down a very slippery slope to subjecting medications for our most vulnerable groups to such a needlessly risky process.

OPPOSE ELIMINATING MEDICARE PART D AND EPIC WRAPAROUND

Another pharmacy issue of concern to NYAPRS is presented by the provisions in the budget that would eliminate the Medicaid and Elderly Pharmaceutical Insurance Coverage program (EPIC) coverage that wraps around Medicare Part D. When Medicare prescription drug benefit took effect, many people faced barriers when attempting to access medications. Medicaid wraparound coverage was initially much more comprehensive than it is now. In recognition of the gains we have made in helping the elderly and disabled negotiate the complex Part D benefit, New York reduced the Medicaid coverage to the four classes of drugs discussed earlier: antipsychotics, antidepressants, anti-retrovirals (HIV treatment), and antirejection drugs (post-organ transplant surgery).

Similarly, the EPIC wraparound coverage has been tooled back as Part D coverage has improved. EPIC no longer functions as a payer of first resort on drugs covered by Part D. Instead, EPIC pays only when a Part D plan denies coverage, and EPIC staff is authorized to pursue Part D plans when they deny payment for EPIC members. EPIC has saved over \$7 million for EPIC members and the EPIC program in the last 18 months through pursuit of Part D plans. Of appeals initiated by EPIC staff, approximately 1,900 of the initiated appeals have been won.

While the Department maintains that eliminating these already minimal wraparound programs would not affect very many people, the protections they afford to the few they help are critical.

NYAPRS is strongly opposed to realizing savings on the backs of elderly and disabled New Yorkers, and opposes elimination of the Medicaid and EPIC wraparound protection to Medicare Part D.

REJECTING PROPOSAL TO CAP PERSONAL CARE

The Governor has proposed to cap personal care and consumer-directed services at 12 hours per day. Anyone needing more than 12 hours per day would be required to switch to another option – the Nursing Home Transition and Diversion Waiver, the Long Term Home Health Care program, or Managed Long Term Care.

Targeting people with the most significant needs who are already being served in the best, most cost-effective way does not make sense. It threatens the ability for people to stay in the community, rather than turning to nursing facilities because the alternative programs would inherently be inappropriate or unavailable to the people with the most need.

This proposal would be a step backward in achieving the goal of spending Medicaid dollars in the best possible way for the most vulnerable people.

Recommendation: NYAPRS joins our friends at the NYS Association on Independent Living, the broader cross disability community and Medicaid Matters in strenuously opposing this proposal.

CRACKING DOWN ON MEDICAID FRAUD WITHOUT UNDOING THE MEDICAID SAFETY NET

The Governor's budget would increase the Medicaid fraud target by \$300 million. It is up to the state to investigate potential fraud in the Medicaid program, and it is prudent for the Office of the Medicaid Inspector General (OMIG) to have broad authority in how to reach the targets set by the Governor and Legislature. However, the OMIG's unlimited, blanket authority has resulted in particularly difficult and inappropriate audit practices.

Investigations of individual Medicaid beneficiaries lack transparency and reliable procedures. Since they are outside of the fair hearing process, individuals do not have access to the claims against them and are often refused documentation supporting the allegations made against them. Consumers and their advocates have reported abusive treatment by investigators. Language barriers, cultural incompetency and general misunderstanding have led to myriad problems and enormous discrepancies in how individuals are treated by local district investigators. It is understandable that the state has an obligation to go after fraud in the Medicaid program, but people should be treated fairly, equitably and with dignity in investigations. Although these investigations are initiated by local districts, the OMIG sets the tone. Since many individuals who have been investigated were actually eligible or relied on bad advice from a local district or enroller, the imposition of civil penalties should be rejected.

In addition, auditing of providers has become unusually onerous. Community-based clinics, independent living centers, and other providers have reported spending tens of thousands of dollars and innumerable staff hours preparing for and going through OMIG investigations. In some cases, the audits have been dropped mid-stream, so the providers have spent time, money and staff resources for no reason.

NYAPRS agrees with our friends at Medicaid Matters that "going after fraud is important, but draining the resources and energy of community-based, safety-net providers that could be better spent on providing services is inappropriate.

Year after year, state Legislators have been tremendous partners in our joint efforts to advance the recovery, rehabilitation and rights of New Yorkers with psychiatric disabilities. I'd like to thank you for your extraordinary record of support and for your help going forward once again this year.



Testimony

to the
Joint Legislative Budget Committee
on
Health and Medicaid

February 9, 2010

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Representing more than 600,000 professionals in education and health care
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Andrew Pallotta
Executive Vice President
New York State United Teachers
to the
Senate Finance Committee
Carl Kruger, Chair
and
Assembly Ways and Means Committee
Herman D. Farrell, Jr., Chair
on the
Proposed 2010 - 2011 Executive Budget
for
Health and Medicaid
February 9, 2010

Good afternoon, Chairman Kruger, Chairman Farrell, and honorable members of the Senate Finance Committee and Assembly Ways and Means Committee.

I am Andrew Pallotta, Executive Vice President of New York State United Teachers (NYSUT). NYSUT represents more than 600,000 education and health care workers statewide. NYSUT's Health Care Professionals Council (HCPC) consists of representatives of NYSUT's 13,000 professional registered nurses and other health care professionals working in public and private health care settings. Our members work in hospitals, clinics and through home health care agencies. Our members also include physicians, visiting nurses, therapists, lab personnel, school psychologists, psychologists, and registered professional school-based nurses throughout New York state. In addition, NYSUT represents over 160,000 retirees, many of whom use the state's health care system. On behalf of the HCPC and NYSUT, I thank you for the opportunity to submit testimony today on the 2010-2011 Executive Budget Proposal.

I am sure we can all agree that the key to providing critically needed health care services in a high-quality manner is having appropriately trained and knowledgeable health care professionals at every level of the health care delivery system. Having said this, NYSUT is concerned about some of the health care gap closing measures (valued at \$1.9 billion) included in the Executive Budget. Many of these cuts are associated with the delivery of programs and would impact professional health care providers who: work in hospitals-especially SUNY's public teaching hospitals which have been under funded for decades (- \$244.6 million in cuts and taxes); work as home care providers; (- \$73.9 million in cuts and taxes) and who work in nursing homes (- \$140.2 million in cuts). Specifically, we are disappointed by cuts to the Medicaid reimbursement rates and to the increase in assessments for these health care organizations).

Medicaid

We strongly oppose the total elimination of the remaining FY2010 Medicaid trend factor reimbursement update (1.7 %) to hospitals (- \$26.7 million total Medicaid), home care providers (- \$25.8 million total Medicaid) and nursing homes (- \$ 249 million total Medicaid). This action, unfortunately, requires the aforementioned health care facilities to absorb all inflationary increases without any cost-of-living adjustments. Such a harsh approach ignores the mix of services and heightened costs that providers offer and fails to distinguish between high and low occupancy facilities.

A large portion of the Executive's cuts to the Medicaid program also mean an equal loss of matching Federal funds. If enacted in its current form, the Executive's Budget proposal would amount to \$382.1 million (gross) in decreased revenue to hospitals, \$154.8 million (gross) in decreased revenue to home care providers, and \$243.1 million (gross) in cuts to nursing homes. The consequences of the Executive's proposed cuts to health care professionals working in hospitals, home care and nursing homes may be: massive layoffs; elimination and sacrifice of high quality services; and, most likely, facility closings. Clearly, results of this magnitude to the health care community are unacceptable to NYSUT and to New York state citizens, who would be adversely affected by either an elimination or compromise to health care services. We ask that you work closely with the Executive on alternatives to his budget proposals.

Also, the Executive Budget seeks to dramatically increase the assessments for health care facilities which is an additional heavy financial burden to place on them. For hospitals, the Executive places an assessment on inpatient gross receipts by more than double from the previous year (0.35% to 0.75%); which results in a \$130.2 million charge to hospitals. Home health care facilities and personal home care providers are also having their gross receipts assessed at double the previous year's rate (0.35% to 0.70%) resulting in the amount of \$17.6 million. Nursing homes increase in gross receipts tax for services rises from 6% to 7% at a cost of \$67.8 million for them. Needless to say, the act of increasing taxes for health care facilities and eliminating their cost-of-living increases can only have adverse affects for these institutions and their staff and patients.

Health Care Reform Act (HCRA)

NYSUT is always concerned about preserving funding for the Health Care Reform Act (HCRA) as it serves as the centerpiece for a myriad of health care initiatives upon which New York state's health system rely. One major component of HCRA is the recruitment, retention and professional development of nurses and other health care professionals. The nursing shortage in New York state shows no sign of improving. It is imperative for health care institutions to have the means to recruit and retain those who are willing to work in a broad range of settings. Therefore, we were pleased to see that there were no proposed cuts to this area of HCRA. In addition, we also approve of the Executive's proposal to institute a syrup-in-beverages tax and a cigarette excise tax increase which would generate \$450 million and \$200 million; respectively, in additional revenues for HCRA. We are optimistic that you will work to maintain increased HCRA funding so that health care services is New York state does not suffer.

There is no doubt that the state faces enormous fiscal challenges however, health care providers have already endured significant cuts as part of the state effort to close budget gaps. More must be done on the revenue side so that the budgets are not on the backs of health care workers and the patients they serve. One option we look towards is the extension of the current Federal Medical Assistance Percentages (FMAP) for Medicaid enhancement provided under American Recovery and Reinvestment Act (ARRA) (61.5% through the end of 2010) .

Senior Citizens and Prescription Drugs

Promoting affordable and accessible prescription drug coverage for New York residents and union members is a long-term goal of NYSUT's HCPC and the New York State AFL-CIO. Our organization continues to lead an on-going, labor task force to review and study ways New York state government can realize savings by controlling the escalating costs of prescription medications; especially for our seniors and retired members. Therefore, we oppose the Executive's proposal to significantly reduce coverage to those in need of the Elderly

Pharmaceutical Insurance Coverage (EPIC) program through his elimination of the Medicaid/Medicare Part D Drug Wrap Elimination.

NYSUT has always had a long-standing commitment to provide for our retired members who have dedicated numerous years to the health care or the education fields. Advocating for affordable prescription drug programs for these members, both nationally and state-wide, is part of that NYSUT commitment. Most seniors are part of the Medicare/Medicare Part D programs (dual eligibility). The EPIC program provides drug coverage, to primarily low and middle income seniors, for any medications that are denied by a Medicare Part D plan. Yet, enactment of the Executive's proposed elimination of the EPIC and Medicaid wrap around coverage will force seniors to pay top dollar for necessary prescription drugs, as covered under Medicare Part D only, and may leave seniors with the inability to afford their medicine. The total amount of cuts to the Medicaid Wrap Elimination program, if enacted in the SFY 2010-2011, would be \$4.3 million.

Health Reform Initiatives

We would like to thank you for enacting the Nurse Care Quality Protection Act (Chapter 422 of the Laws of 2009) last session. Your collaborative and bipartisan support with this issue showed sensitivity, respect and concern towards New York state nurses. In addition, NYSUT is also supportive of the Executive's 2010-2011 SFY proposal to:

- Increase the Medicaid fraud target by \$300 million, bringing the total collection target to \$1.17 billion;
- Add coverage for medically-needy orthodontia to the Child Health Plus benefit package; and
- Create an Obstetric Access and Quality Pool as a way of providing funds to hospitals to assist in improving the quality of and reducing the shortage of obstetric services in hospitals (\$26 million).

Conclusion

NYSUT's Health Care Professional Council appreciates certain reforms to the health care system proposed in the Executive Budget, however, we oppose any cuts that adversely effects the health care professional workforce and its ability to provide direct quality care to New York state residents, particularly the indigent. Such cuts to essential health care services serve only to compromise our health care professionals' ability to maintain and help the people of New York state. The state should not adopt drastic cuts to Medicaid, increase taxes to hospitals, licensed home care/personal and home care agencies completely eliminate the trend factors these entities or severely restrict a senior's ability to pay for prescription drugs.

The NYSUT Health Care Professional Council, as well as all NYSUT members, look forward to working with the legislature and the Executive to ensure that all New Yorkers have the resources necessary to insure that they receive the highest quality of care possible.

Thank you for your consideration.

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American Cancer Society ☉ Children's Defense Fund/New York ☉ Center for Working Families
Community Service Society of New York ☉ Metro New York Health Care for All Campaign
New Yorkers for Accessible Health Coverage ☉ New York Immigration Coalition
Public Policy and Education Fund of New York/Citizen Action of New York

Testimony of the
Health Care for All New York Campaign
on the
2010-2011 Executive Budget

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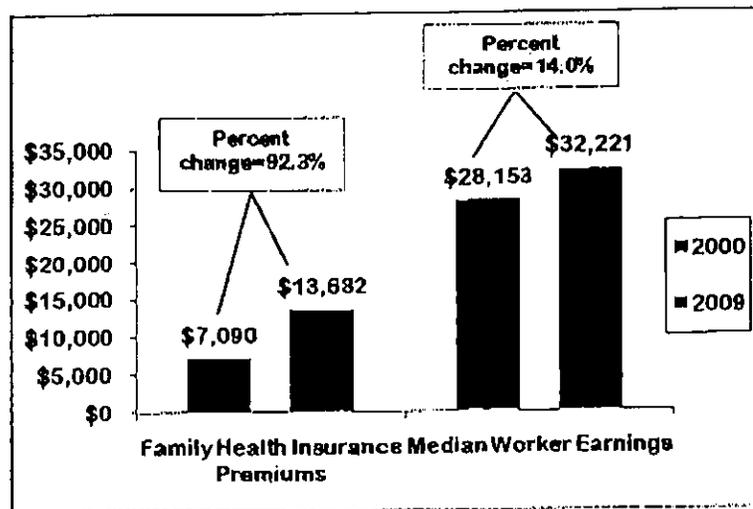


Health Care For All New York (HCFANY) would like to thank the Senate and Assembly committee members for this opportunity to submit comments on the 2010-2011 Executive Budget.

HCFANY is a statewide coalition dedicated to winning affordable, comprehensive, and high-quality health care for all New York residents through State and federal health reform. HCFANY seeks to bring New Yorkers' voices to the health reform conversation. The coalition was founded by eight leadership organizations: The American Cancer Society, The Center for Working Families, The Children's Defense Fund, Citizen Action, The Community Service Society of New York ("CSS"), Metro New York Health Care for All Campaign, New Yorkers for Accessible Health Coverage, and the New York Immigration Coalition. Membership has now grown to nearly 100 organizations statewide. For more information about HCFANY, please visit our website and health reform blog at: www.hcfany.org.

HCFANY understands and represents the real health worries and concerns of New Yorkers who, between 2000 and 2009, have seen their health insurance premiums increase by 92 percent with seeing only a 14 percent increase in median earnings. (See chart below.)

Figure 1: Growth of Premiums in New York Compared to Median New York Worker Earnings, 2000-2009



Source: Families USA, *Costly Coverage: Premiums Outpace Paychecks in New York*, September 2009.

For low- and moderate-income New Yorkers, health insurance premiums now consume an extraordinary portion of the family budget. As described in the chart below, a low-income family of four earning \$44,000 a year can expect to pay eight percent of its family income on employer-sponsored insurance, an impossible 65 percent of its family income if they seek insurance in the



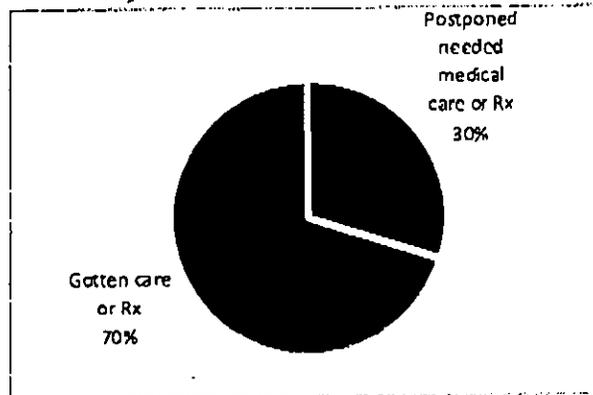
individual direct pay market, and 22 percent of its family income if they try the only public insurance option currently available at that income level—Healthy New York.¹

Table 1: Percent of Pre-Tax Income Consumed by Health Insurance Options for New York Families

Federal Poverty Level	Annual Income	Family of Four (2 Adults 2 Children)		
		Employer Sponsored Insurance	Individual Direct Pay	Healthy New York
100%	\$22,050	17%	131%	45%
200%	\$44,100	8%	65%	22%
300%	\$66,150	6%	44%	NA
400%	\$88,200	4%	33%	NA
500%	\$110,250	3%	26%	NA
600%	\$132,300	3%	22%	NA

Ever-escalating health care costs have real economic consequences for New Yorkers. Polling conducted by Lake Research Partners for the Community Service Society, released in September 2009, found that one in three New Yorkers say that someone in their family has not gotten or postponed getting medical care or a prescription in the past year because of lack of money or insurance.

Figure 2: Delayed Care Due to Lack of Insurance or Cost



Q. In the past 12 months, have you or any member of your household: Not gotten or postponed getting medical care or surgery because of a lack of money or insurance? Needed to fill a prescription but couldn't because of a lack of money or insurance?

¹ Source: CSS analysis of ESI data from MEPS/IC (2006); Direct Pay data based on NYSDOI Premium Rates Index (April 2008); HNY data from NYSDOI 2007 Annual Report on Healthy NY. All costs adjusted to 2009 dollars based on observed premium cost growth in each program.



The same poll found that 81% of New Yorkers say making health care more affordable should be a top priority for their elected officials, including 90% of Democrats, 77% of independents, and 64% of Republicans.²

Given this backdrop, HCFANY would like to submit the following comments about the 2010-2011 proposed Executive Budget. Specific proposals HCFANY supports are: (1) the Governor's original proposal to enhance accountability funding for charity care (subsequently withdrawn in his 21-day amendments); (2) the restoration of prior approval to the State Department of Insurance of health insurance premiums increases; and (3) simplification of public insurance enrollment to support families in lean times.

HCFANY opposes: (1) any increase in co-payments to the Family Health Plus Employer Buy-In program as a stand-alone measure to reduce the program's premiums; (2) efforts to continue state funding for limited coverage under Healthy New York at the expense of the State's more comprehensive individual direct pay market; and (3) the elimination of important task forces such as the Medicaid Managed Care Advisory Panel. Aside from these reservations, HCFANY believes that this Executive Budget lays an important initial foundation towards meeting our goal of achieving affordable health coverage for all New Yorkers.

1. Expanding Accountable Funding for the Uninsured

The Executive Budget originally sought to ensure that all \$847 million in State Indigent Care Pool funds would be allocated using the transparent reimbursement methodology currently in use for only 10% of these funds. However, to HCFANY's deep consternation, the Governor withdrew this proposal in his 21-day amendments.³

Since 1983, New York hospitals have been provided with "bad debt and charity care" funds. Advocates, government officials, and the media have long criticized this system for lacking accountability and transparency and for failing to verify that hospitals actually provide financial assistance to uninsured and underinsured patients in exchange for this funding. While the 2005 Financial Assistance Law required hospitals to adopt improved collection practices and establish charity care policies and applications, it nonetheless left the "back-door" funding allocation unregulated. This is because New York's charity care pools are based on notoriously inaccurate reports from hospitals—resulting in wild swings of funding and unfair allocations. For example,

² See Community Service Society and Lake Research Partners, "A New Poll Reveals New Yorkers' Views on Affordability of Health Insurance and State Health Reform," September 2009, available at: <http://www.cssny.org/userimages/downloads/Statewide%20Health%20Survey%20Report%209.14.09%20-%20Website%20Statement.pdf>.

³ The Governor's 21-day amendments maintained the Executive Budget's original proposal to reduce indigent care funding \$140 million. In the absence of a credible methodology for allocating these funds based on actual services provided to uninsured patients, HCFANY is unable to oppose this budget cut.



New York Presbyterian's allocations fell from \$59.8 million to \$35.5 million (nearly 44%) in a single year. In addition, high-volume indigent care hospitals such as North General Hospital, located in East Harlem, receive paltry allocations (\$5.3 million) compared to their well-heeled neighbors to the South, such as Beth Israel (\$30 million).

Two years ago, New York's state budget partially adopted the findings of the 2006 Legislatively-created Technical Advisory Committee (TAC) which developed recommendations about how the pool allocations should be reformed. The TAC proposed eliminating the current system of complex and unregulated funding allocation formulas that ties hospital funding neither to care provided to uninsured patients nor to the 2005 Financial Assistance Law. To avoid sudden funding disruptions to hospitals, the Budget provided that the new accountable and transparent reimbursement methodology would be implemented for just 10% of the \$847 million pool.

This year, the Executive Budget originally sought to finish the job by requiring that the remaining funds be allocated in the same transparent fashion. However, the Governor has since retracted this provision. At a time of scarce resources and increasing numbers of uninsured, HCFANY urges the Legislature to adopt the Governor's original proposal and switch to an accountable system that ties payments to patients, not providers. While certain hospitals may cry foul, their concerns are untenable given the utter lack of transparency and irregularity in the current allocation.

HCFANY strongly urges the Legislature to adopt, without amendment, the Executive Budget's original proposal to finally tie the state's investment in charity care to services provided to actual uninsured patients.

2. Restoration of Prior Approval of Insurance Rate Hikes

HCFANY strongly supports the Article VII provision of the Executive Budget which seeks to restore government authority to approve or disallow insurance premium hikes prior to their adoption. The Governor's Bill would achieve two fundamental benefits: (1) restoring the Superintendent's ability to approve insurance rates hikes in advance, thereby eliminating the current authorization for health plans to simply file a premium rate increase and use it ("file and use"); and (2) improved regulation of health plan profits by setting a minimum "medical loss ratio" ("MLR") for individual direct-pay and small group markets at 85 percent.

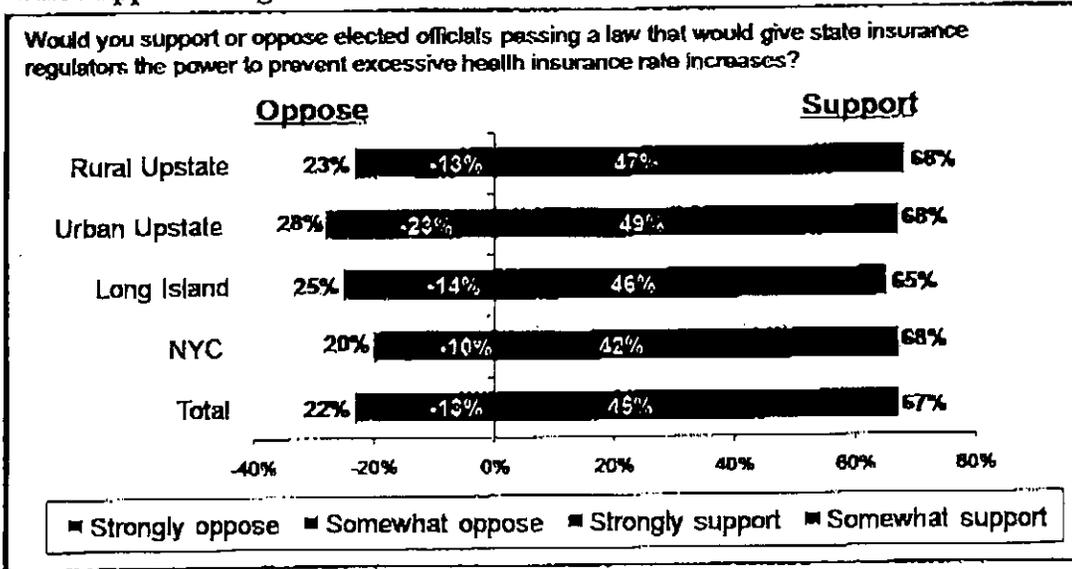
HCFANY supports the Governor's Bill for four reasons:

First, New Yorkers are tremendously supportive of this measure. A statewide poll conducted by Lake Research Partners for the Community Service Society in late 2009 found that two out of three New Yorkers support a proposal similar to the Governor's. (See chart below).



Notably, intensity of support for the restoration of prior approval was strongest in Upstate New York.

Figure 3: 2009 Poll Reveals that New Yorkers Strongly Support Passage of Prior Approval Legislation



Second, this proposal would squarely address New Yorkers' concerns that insurance company premiums are rising at an egregious pace and require government regulation. It is no coincidence that the ten-year period that saw insurance premiums increase six times faster than median worker earnings (see Figure 1) was the same ten-year period during which New York fully implemented the "file and use" system, which this provision would rescind. In the years in which the Insurance Department utilized prior approval (1990-1995), 24 percent of rate increases proposed by insurance companies were found to be excessive and were consequently reduced.¹ Under file and use (1996-2007), only three percent of rate increases were self-reported by insurance companies as excessive.

The dangers of inadequate regulatory approval mechanisms were vividly illustrated just this month as a California insurer, Anthem Blue Cross (a sister corporation to New York's Empire Blue Cross and Blue Shield), having enjoyed an eight-fold increase in profits in the last quarter of 2009, announced a 39 percent rate hike for individual policies at the beginning of 2010. California regulators could only ask the insurer to postpone the rate hikes to allow them to study them, while

¹ New York State Insurance Department, "The Price of Deregulation: How 'File and Use' Has Undermined New York State's Ability to Protect Consumers from Excessive Health Insurance Premiums." June 2009.



the U.S. Secretary of Health and Human Services could only ask the company to clarify its rationale for the hikes.⁵

Third, New Yorkers have paid a steep price under this deregulatory regime. Subsequent investigations by the Insurance Department found that in the period between 2000-2007 insurance companies have overcharged policyholders by at least \$105 million more than they have self-reported.⁶ For many consumers, these refunds come far too late—they have already had to give up their coverage because they could not afford the inflated premiums. While insurers under a prior approval system are able to challenge rate increases deemed inadequate in court through an accelerated special proceeding, consumers who have been charged excessive premiums under a “file and use” system have no similar remedy. When they lose coverage because they cannot pay an excessive premium, their loss is often irreparable.

Fourth, the rise in the MLR is necessary because the small group and direct pay insurance markets are eroding faster than large group coverage in New York, and we must therefore demand maximum efficiency from insurers in those segments of the market. Absent some regulatory curb on premium hikes, such as those envisioned in this bill, more New Yorkers will be unable to pay for coverage, more New Yorkers will become uninsured, and all New Yorkers will bear the burden of increasing uncompensated care costs and stress on our already fragile health care system.

That being said, HCFANY believes the bill could be improved to enhance protections for New York consumers in three ways, which we have described in our Memorandum of Support, available at: www.hcfany.org. On the whole, however, HCFANY supports the Governor’s effort to restore prior approval.

3. Improving Public Insurance Coverage

The Executive Budget also seeks to continue to improve New York’s highly regarded public insurance programs by eliminating onerous obstacles to gaining coverage and increasingly relying on the usage of public data sharing. As described in detail below, HCFANY unequivocally supports all of these proposals.

The budget seeks to: (1) permit individuals enrolled in community-based long-term care to attest to their income, residency and resources at recertification; and (2) eliminate the requirement to provide documentation of interest income; (3) adopt express lane eligibility for a child to be

⁵ “Obama official ‘very disturbed’ by Anthem Blue Cross rate hikes. ‘The insurer should give a ‘detailed justification’ for its plan to raise premiums on individual policies by as much as 39%, Health and Human Services Secretary Kathleen Sebelius says.” Los Angeles Times, February 9, 2010.

⁶ New York State Insurance Department, “The Price of Deregulation: How ‘File and Use’ Has Undermined New York State’s Ability to Protect Consumers from Excessive Health Insurance Premiums.” June 2009.



automatically enrolled in insurance coverage if he or she is already eligible for another public program with similar eligibility requirements (e.g. food stamps); 4) permit the Department of Health to access tax records to establish income eligibility; and (5) allow the state to use social security numbers for data matching.

HCFANY strongly supports all of the administration's proposals to simplify and streamline enrollment in public insurance coverage.

However, HCFANY has reservations about several additional proposals and opposes: (1) any increase in co-payments to the Family Health Plus Employer Buy-In program as a stand-alone measure to reduce the programs premiums; (2) efforts to increase state funding for less-than comprehensive coverage, like Healthy New York, at the expense of the State's more comprehensive individual direct pay market; and (3) the elimination of important task forces such as the Medicaid Managed Care Advisory Panel.

1. Reject Increasing Co-Payments for the Family Health Plus Employer Buy-In Program

In an effort to reduce the exorbitant individual monthly rate of \$540 per month, the Executive Budget seeks to increase co-payments for the non-subsidized enrollees in the Family Health Plus Employer Buy-In (FHP-EBI) program.

The FHP EBI program presents an important opportunity to meet our State's coverage expansion goals, including: (1) providing a high-quality, affordable health option for the nearly 1.1 million uninsured, but employed New Yorkers who earn less than 300% of poverty; and (2) offering an inexpensive health insurance option to thousands of small businesses who are spending as much as 18% of their payroll on health care.

HCFANY supports the idea of bringing down premiums in this program, however, we do not advocate increasing co-pays as a standalone measure. Research has shown that even modest co-pays can prevent many people from seeking care. It is because of this that both federal health reform bills eliminate co-pays for preventive screenings and care. The Executive Budget's initial proposal to increase co-pays would only result in a 9% percent premium reduction, which alone would not be enough to cancel out the deterrent effect of higher co-pays on care received.

HCFANY would support this proposal only if it was tied to one or more of the following additional measures (which cumulatively would result in a 55% premium reduction): (1) adopting public insurance program reimbursement rates; (2) reducing non-essential taxes and surcharges upon this product; (3) adopting the Medicaid default reimbursement rate for out-of-network



hospitalizations; (4) adopting a modified anti-crowd out policy; or (5) accessing the Healthy New York small group stop-loss pool funding.

Because of the incredible need for affordable, high quality coverage for low-waged uninsured New Yorkers, HCFANY urges the Legislature to fix this FHP EBI program in a holistic—rather than piecemeal—fashion.

2. **Halt State Investment in Mediocre Insurance Coverage (HealthyNY): Fund Meaningful Coverage by Expanding the Direct Pay Stop-Loss Pool**

HCFANY opposes the Executive Budget proposal to maintain substantial funding of \$161 million for limited coverage offered through Healthy New York (HNY), while under-resourcing the State's fiscal support (a meager \$39 million) for comprehensive health insurance products in the Direct Pay/Individual insurance market.

HNY provides limited coverage to individuals below 250% of the federal poverty level. It also expends precious state funding for small businesses without any method for strategically targeting these funds to those small businesses most in need. It is one of the few insurance products designed for New Yorkers of limited means that can exclude coverage for pre-existing conditions. It also has a limited benefit package with little or no pharmacy coverage, mental health services, and rehabilitation. In short, HNY is only for *healthy* New Yorkers, who never become sick, have an accident, get cancer, or suffer from chronic conditions that require regular medication. Family Health Plus (FHP) provides better coverage at lower costs than HNY and would make better use of these funds.⁷ Statewide polling indicates that 74 percent of New Yorkers would support an option to allow New Yorkers to purchase public health insurance on a voluntary basis through the Child Health Plus and Family Health Plus programs on a sliding scale, based on income.⁸

HCFANY disagrees with this continued investment in HNY. Instead, the State should be providing good increased funding for the direct pay market stop-loss pools and establish a similar stop-loss pool for the FHP Employer Buy-in program. Continued multi-million dollar increases in Healthy New York serves only to further stratify the insurance market by offering cheaper products for healthier people, while diverting funds from programs that would help people with pre-existing conditions or disabilities.

A foundation for affordable, quality health care for all New Yorkers must begin in this budget year. Uninsured and underinsured New Yorkers should not be asked to make do with over-priced inadequate coverage like HNY for one more day.

⁷ Community Service Society, "*Cornerstone for Coverage: Towards a Universal Health Plan for New York*," testimony presented at Glens Falls, Long Island, December 5, 2007, Slide 36, available at: www.cssny.org.

⁸ Community Service Society/Lake Research, "Findings from a New York Statewide Poll, September 2009," Slide 17, available at: www.cssny.org.



3. **Oppose the Elimination of the MMCARP**

Companion legislation to the Executive Budget seeks to eliminate the Medicaid Managed Care Advisory Review Panel (MMCARP). This panel, which has strong consumer representation, has played an important role in monitoring the development of our State's vibrant public insurance programs. HCFANY strongly urges the Legislature to oppose its elimination.

Thank you for the opportunity to submit this testimony. Should you have any questions about HCFANY or our testimony, please contact Elisabeth Benjamin at: (212) 614-5461.