NEW YORK STATE LEGISLATURE

2011-2012 JOINT BUDGET HEARING

MARCH 3 - 10:00

HEALTH & MEDICAID

HEARING ROOM B
LEGISLATIVE OFFICE BUILDING

Time	Organization	Speaker
10:00	New York State Department of Health	Nirav Shah, M.D. Commissioner
10:30	Medicaid Inspector General	James Sheehan Medicaid Inspector General
11:00	Greater NY Hospital Association	Kenneth E. Raske President & CEO
11:10	HANYS	Dan Sisto President
11:20	Iroquois Health Alliance	Gary Fitzgerald President & CEO
11:30	Medical Society of the State of New York	Leah S. McCormack, M.D. President Gerard Conway, Esq.
11:40	Association Health Care Providers	Christine Johnston President
11:50	Home Care Association	Joanne Cunningham President

12:00	NY Association & Services for the Aging	Dan Heim Interim President & CEO
12:10	Comm. Health Care Association of NYS	Edwin Graham Vice President of Policy
12:20	Hospice & Pallative Care Association Of New York State	Kathy McMahon President & CEO
12:30	Managed Long Term Care & PACE Coalition	Jim Lytel
12:40	AARP	Neal Lane Member Executive Council
		David McNally Manager, Government Affairs
12:50	NYS Bar Association	John Bracken Former President
1:00	Summit Security Services, Inc.	Nick Auletta Vice President
1:10	Pharmacists Society of the State of New York	Craig Burridge Executive Director
1:20	NYS Nurses Association	Shaun Flynn Director of Governmental Affairs
1:30	New York State Association of Counties	Steve Acquario Executive Director
		Maggie Brooks Monroe County Executive
1:40	Coalition of NYS Public Health Plans	Mark Lane President & CEO
1:50	NYPIRG	Blair Horner
2:00	Primary Care Development Corporation	Daniel Lowenstein
2:10	Maternity & Early Childhood Foundation	Joy Griffith Executive Director

2:20	Associated Medical Schools of NY	Joe Widerhorn President/CEO
2:30	Spinal Cord Society	Terry O'Neill Paul Richter
2:40	Schuyler Center For Analysis & Advocacy	Kate Breslin President & CEO
2:50	ADHEC	Mary Sienkiewicz Director
3:00	Family Planning Advocates	M. Tracey Brooks President & CEO
3:10	NYAPRS	Harvey Rosenthal Executive Director
3:20	Coalition for the Homeless	Shelly Nortz Deputy Executive Director
3:30	Empire Justice Center	Cathy Roberts Senior Paralegal
3:40	Lupus Foundation of Mid & Northern New York	Kathleen Arntsen President & CEO
3:50	Center for Disability Rights	Leah Farrell Policy Anaylst
4:00	Continuing Care Leadership Coalition	Scott Amrhein President
4:10	1199 SEIU United Careworkers East	Helen Schaub
4:20	Housing Works	Charles King CEO

Testimony Presented by
Nirav R. Shah, M.D., M.P.H.
New York State Commissioner of Health

Joint Legislative Budget Testimony

New York State Department of Health

Hearing Room B
Legislative Office Building
Albany, New York

March 3, 2011
10 a.m.

JOINT LEGISLATIVE FISCAL COMMITTEES BUDGET HEARING

State Fiscal Year 2011-12 Executive Budget
March 3, 2011

Nirav R. Shah, M.D., M.P.H. Commissioner
New York State Department of Health

Good morning Senator DeFrancisco, Assemblyman Farrell, other distinguished members of the Senate Finance and Assembly Ways and Means Committees, Senator Hannon and Assemblyman Gottfried. I am Nirav Shah, Commissioner of Health, and I am pleased for this opportunity to appear before you today to discuss the Executive Budget as it relates to the mission of the Department of Health.

Governor Cuomo's message to me as a Commissioner, to you as legislators, and to stakeholders in the health care field has been crystal clear: maintaining the status quo is simply not an option. Restoring New York to national prominence in health care delivery and outcomes demands that we make tough choices and do business in new ways. As we make these choices, we must also recognize that this is a time of opportunity to bring together the best minds and ideas to reshape our health system and serve New Yorkers more efficiently and cost-effectively.

The Executive Budget maintains core public health programs in critical areas such as tobacco control, obesity prevention, and HIV/AIDS Prevention and Services.

Tobacco use continues to be the number-one cause of preventable disease and death in the State. Health care costs related to treating smoking-caused diseases total approximately $8 billion annually for New York alone, with lost productivity costs associated with smoking totaling more than $6 billion a year. Sustaining support for the Tobacco Control program will help us reach the goal of reducing adult prevalence of smoking to 12 percent and adolescent prevalence to 10 percent by 2013.

Obesity and overweight are the second-leading preventable causes of death. More than 24 percent of adults in New York are obese, which puts them at increased risk for chronic diseases like type 2 diabetes, heart disease, stroke, and some types of cancers. Treating obesity-related illnesses and conditions costs New York State more than $7.6 billion a year. Consistent with the principle that we must pay for performance, the budget continues support for the evidence-based strategies and initiatives proven to reduce rates of obesity, especially among children.

The Executive Budget also sustains New York's commitment to fighting the HIV/AIDS epidemic, which remains a major public health issue in New York State. Funding to the AIDS Institute for Aid to Localities and the AIDS Drug Assistance Program remains level in this budget. The Executive Budget also maintains access to health care and related services for persons with HIV/AIDS and will strengthen our evidence-based prevention programs, including sexual health promotion and enhanced access to testing for HIV and enhanced integration between HIV and STD testing and care.

New York State has been living beyond its means for far too long. Medicaid is a prime example. Our spending is the highest in the nation, and we aren't getting the value we should demand. Medicaid spending has increased at an annual rate of 6.4 percent over the last 10 years, close to three times the rate of inflation. These increases have been borne by the people of this State – the very people who have had to make hard choices in balancing their own household budgets. New York's mean property tax is 96 percent higher than the national average, fueled in large part by the escalating cost of Medicaid, making owning or maintaining a home unaffordable for many New Yorkers.

The State needs to change the way it does business and there is no better example than the Medicaid Redesign Team created by the Governor's Executive Order. As a member of the Medicaid Redesign Team, I have been fortunate to join my colleagues from the Health Department, the Legislature, and health care stakeholders in traveling across the State to hear thousands of suggestions from health care providers, consumers, and taxpayers alike. The Medicaid Redesign Team's recommendations, which were accepted by Governor Cuomo on February 24, will redesign and restructure the Medicaid program to be more efficient and get better results for patients.

The 79 recommendations submitted to the Governor meet his budget target by introducing a global cap on State Medicaid expenditures of $15.109 billion through a variety of mechanisms, including:

- Reforming the Medicaid payment and program structure to generate $1.138 billion in total state savings;

- Eliminating the permanent law statutory cost drivers which generate $186 million in state savings;

- Implementing a 2 percent across-the-board rate reduction to generate $345 million in savings; and

- Prepaying certain Medicaid payments to leverage additional enhanced Federal matching funds made possible under ARRA, which generates a $66 million benefit.

The recommendations also include industry-led cost containment initiatives totaling up to $640 million in savings, representing an unprecedented partnership between the state and its health care industry. The Medicaid program will be subject to a contingency reduction if this goal is not met.

These proposals will benefit both taxpayers and patients. One million New Yorkers will have access to patient-centered medical homes, and within 3 years almost the entire Medicaid population will be enrolled in some kind of care management.

The first phase of the Medicaid Redesign Team's mission was an unprecedented effort, but our work continues. This is an ongoing process and we will continue to review opportunities for reform and submit our final report on comprehensive reform to the Governor in November.

I am proud to be part of this effort and I am confident that by working together to implement this plan we can make the Medicaid program better for those who rely on it for essential health care services as well as for those who pay for it.

Governor Cuomo has called upon me and other Commissioner and agency heads to lead by example and make a 10 percent reduction in our budgets. As Commissioner, I will ensure that these reductions are enacted responsibly, so that we continue to fulfill the Department of Health's critical mission while meeting our budgetary targets. In reshaping our agency and making the necessary reductions, I will seek to work in conjunction with our workforce and with outside stakeholders. Like Medicaid Redesign, we do not pretend to have a monopoly on good ideas for change, and I will listen to all interested parties who genuinely want to help in this challenging process.

We've had to make some tough budget decisions to respond to the current economic challenges. But I am optimistic that New York is poised to once again become a national leader in health and health care. One of my highest priorities as Health Commissioner is to reduce health problems and improve health outcomes through greater integration of public health priorities into the delivery of medicine. We will use all the tools at our disposal to further integrate public health priorities and best practices into medicine, Medicaid policy, health information technology, and new models of health care delivery. We will focus on low-cost and no-cost ways to achieve environmental changes that support better health outcomes for New Yorkers, and we will focus on policies that improve health.

Governor Cuomo and I are dedicated to working in partnership with the Legislature, health care stakeholders, and all New Yorkers to transform our health care system with the ultimate goal of making access to high-quality, affordable health care available to New Yorkers at a cost that reflects our fiscal realities.

Thank you. I am happy to answer your questions.

Mechanisms to Achieve Governor's Target:

- Payment/Program Reform: **$1.138** billion
- Elimination of statutory cost drivers: **$186** million
- 2% across-the-board rate reduction: **$345** million
- Prepaying certain claims during enhanced ARRA FMAP period: **$66** million
- Industry-led cost containment initiatives: **$640** million (totaling up to)

TOTAL: $2.375 billion

**Note: DOB Medicaid re-estimate reduced MRT target by $475 million*

Key Medicaid Reforms

from the Medicaid Redesign Team Report:

- Enact a Global Medicaid Budget Cap.
- Allow 1 million New Yorkers to have access to patient-centered medical homes (PCMHs).
- Major expansion in use of care management – virtually all Medicaid members will be enrolled in care management within 3 years.
- New controls in personal care and home health that will reign in out-of-control spending.
- Reform Medical Malpractice and lower health care costs by $700 million.
- Streamline/eliminate program regulations in ways that will lower costs for providers and make the program easier to navigate.

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STATE OF NEW YORK
OFFICE OF THE MEDICAID INSPECTOR GENERAL

TESTIMONY OF JAMES G. SHEEHAN
MEDICAID INSPECTOR GENERAL
OFFICE OF THE MEDICAID INSPECTOR GENERAL

JOINT LEGISLATIVE BUDGET TESTIMONY
HEARING ROOM B
LEGISLATIVE OFFICE BUILDING
ALBANY, NEW YORK

MARCH 3, 2011
10:00 A.M.

Good morning Chairman DeFrancisco, Chairman Farrell, other distinguished members of the Senate Finance and Assembly Ways and Means Committees, Chairman Gottfried and Chairman Hannon. I am James Sheehan, New York's Medicaid Inspector General, and I appreciate the opportunity to appear today to talk about Governor Cuomo's 2011-2012 Executive Budget for the New York Office of the Medicaid Inspector General (OMIG).

The Governor's budget outlines a transformative approach to managing New York State government. As Medicaid Inspector General, I fully embrace the forward-thinking plan that the Governor has proposed to bring essential reforms and improved results for New Yorkers. I applaud the Governor's leadership in creating the Medicaid Redesign Team, and the hard work and dedication of the Team's members and the stakeholders who brought thousands of ideas to the table to reduce the cost and improve the quality of the State's Medicaid program. Our office worked closely with the Medicaid Redesign Team and we will continue to work with them as the reforms are implemented.

OMIG's mission is to enhance the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive and wasteful practices within the Medicaid program and recovering improperly expended funds while promoting high quality patient care. Each day, OMIG employees work on audits, investigations, data mining and analysis of our State Medicaid program. We work closely with the New York State Department of Health and New York's Mental Hygiene Agencies including the Office of Mental Health, the Office of Alcoholism and Substance Abuse Services and the Office for People with Developmental Disabilities. We also work closely with the Office of the Attorney General's Medicaid Fraud Control Unit (MFCU).

New York's achievements in program integrity, in recovery of improperly paid funds, and in working with providers to develop effective compliance programs lead the nation, and have served as a model for program integrity efforts, not only in other states, but in the program integrity provisions of the federal Affordable Care Act (ACA).

Working with trade and professional associations, we have increased our efforts to require and assist providers in assuring compliance with the provisions of the Medicaid program. Our goal is to minimize improper payments before they occur by assuring that providers have robust internal compliance programs, and that they have a clear understanding of new and existing laws and regulations - a particular challenge in light of the large number of changes initiated by the passage of ACA. To this end, OMIG has sponsored seven free webinars in the past nine months, each provided to over 800 unique sites. These webinars include extensive practical advice and documentary support, and are available on our website after broadcast. Since June 2010, we have had over 750 direct contacts with Medicaid providers through individual letters, telephone calls and site visits advising providers of compliance issues requiring their attention.

The 2010 ACA law mandates that every provider report, refund and explain each overpayment to OMIG within 60 days of identification, and the False Claims Act imposes penalties for knowingly failing to repay such an overpayment. OMIG has encouraged providers to report overpayments and has developed a clear, step-by-step

process explaining how to do this, which is available on our website. Last year, self-disclosure reports made by New York providers exceeded reports by all providers to the federal Office of Inspector General (OIG) for the entire country. This is not only a testament to OMIG's outreach and education efforts, but also to New York providers' commitment to program integrity and compliance.

In 2010, OMIG trained over 185 staff members on the use of our new Salient tool, developed by an upstate New York company, and used by a number of counties working with us in the County Demonstration Project. Salient is a state of the art system which expands the abilities and results of audit, clinical, and investigative staff. Our Medicaid Match and Recovery contract, which identifies other sources of coverage for Medicaid enrollees, had its most successful year in 2010 and continues to expand. We also have pilot projects with a number of industry leaders in data analytics, using the robust New York Medicaid database, a data warehouse that surpasses the federal system used for Medicare.

Working with the Centers for Medicaid and Medicaid Services (CMS) and the Medicaid Integrity Institute (MII), which funds 100 percent of training and travel provided to OMIG staff through the Institute, our office will continue to assure the availability of professional training for OMIG staff.

Over the past year, OMIG has worked with provider groups and on its own to reduce some of the burdens imposed by federal requirements and mandates for Medicaid. We have met with CMS on multiple occasions to reduce the burdens on home health providers that result from differing Medicare and Medicaid payment systems; we have commented, together with industry groups, on ways to clarify and streamline federal rules related to excluded persons and mandated compliance; we have given over 100 in-person presentations to professional and industry groups in New York during 2010; we established an audit advisory committee with interested stakeholders last fall and are in the process of implementing recommendations resulting from the committee. We have met with OIG, and CMS' Medicaid Integrity Contractor to reduce the number, scope, and documentary requirements of audits undertaken by those entities.

In 2011-2012, under Governor Cuomo's leadership, OMIG will continue its efforts to work in collaboration with providers to improve program integrity in Medicaid, and to assure that Medicaid enrollees receive the quality, value, and access to services for which New Yorkers are paying. Like other areas of the state government, my office will implement a ten percent reduction in our budget. Our office is committed to implementing this reduction in a way that does not diminish the effectiveness of our work for the taxpayers of New York.

Governor Cuomo and I look forward to partnering with the Legislature to promote the integrity of the New York Medicaid program which serves as a lifeline for 4.9 million New Yorkers. Thank you again for this opportunity to testify and I am happy to answer any questions.

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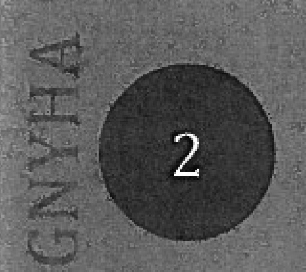
GREATER
NEW YORK
HOSPITAL
ASSOCIATION

Testimony of Kenneth E. Raske
before the
Joint Fiscal Committees
of the New York State Legislature

The Executive Budget Proposal for 2011-12

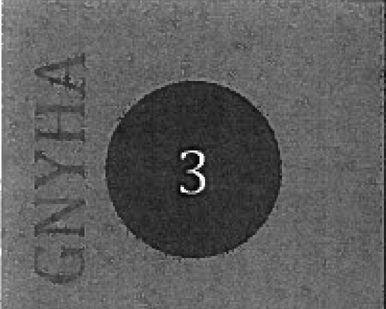
March 3, 2011



9 Rounds of Cuts and Taxes Cut Hospital Revenue by $1.2 Billion

Annual Recurring Value of Hospital Losses, $ in Millions

Date	Value
Apr-07	(60)
Apr-08	(242)
Aug-08	(314)
Feb-09	(381)
Apr-09	(795)
May-09	(866)
Dec-09	(892)
Jun-10	(1,114)
Aug-10	(1,235)



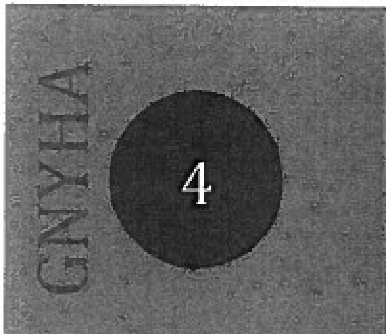
Major Change is on the Horizon from Washington, DC

The Affordable Care Act (ACA) contains $155 billion in Medicare and Medicaid reductions to hospitals over ten years

- **10% of these reductions will be borne by NYS hospitals**

In addition, the ACA contains many reforms aimed at reducing hospitalizations

It will also place pressure on the State budget beginning in 2014 when the major Medicaid expansions take effect



Financial Distress

28 hospitals in New York State have closed over the last ten years

4 have closed in New York City in the last two years alone

- St. John's Queens
- Mary Immaculate, Queens
- St. Vincent's, Manhattan
- North General, Manhattan

In Order to Survive Challenging Times...

Hospitals must work to reform the system

- Provide better, more coordinated care
- Reduce unnecessary utilization
- Improve quality to reduce costs

The Medicaid Redesign Team (MRT) recommendations *do* cut hospital reimbursements

- No trend factor for the fourth year in a row
- 2% cut on top of that
- Also, outpatient and quality-related inpatient cuts
- Total hospital loss ≈ $400 million*

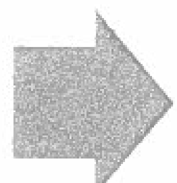
However, rather than cutting more up-front

- The MRT challenges hospitals and other providers to live within an overall Medicaid spending cap
  - $52.8 billion
  - At risk for ***100%*** of any overage

* Excludes clawback from medical malpractice, see slide #9.

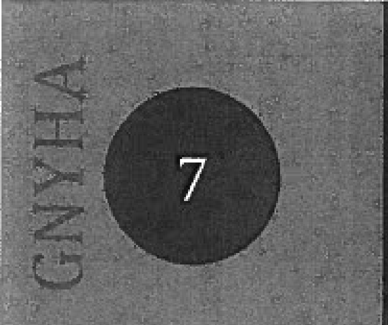
How will providers live within the cap?

If providers don't live within the cap, more cuts are in store



This provides an incentive to work together:

- Hospitals working with nursing homes to reduce avoidable hospitalizations
- Hospitals working with home care agencies to reduce preventable hospital readmissions
- Hospitals working with community physicians, clinics, and health plans to improve care coordination for high cost populations



GNYHA Quality & Patient Safety Initiatives: Improve Quality *and* Reduce Costs

Infection Control & Prevention

- Central Line–Associated Bloodstream Infections CLABSI) Collaborative
- *Clostridium difficile* (*C. difficile*) Collaborative
- Antimicrobial Stewardship Project
- *STOP* Sepsis Collaborative
- Catheter-Associated Urinary Tract Infection (CAUTI) Prevention Collaborative
- Infection Prevention Coach Training Program

Transitions in Care

- Initiative to Reduce Preventable Readmissions
- Pressure Ulcer Improvement Collaborative
- The Colors of Safety Across the Continuum of Care

Building Infrastructure for Clinical Advancement

- Perinatal Safety Collaborative
- Rapid Response Systems (RRS) Collaborative
- Critical Care Leadership Network (CCLN)
- Surgical Safety Campaign

Workforce Development & Training

- Clinical Quality Fellowship Program (CQFP)
- Communication Skills Training
- Root Cause Analysis Training

In Addition, the MRT Contains Reforms to Reduce Unnecessary Costs

Coordinated care through medical homes and health homes

- Will help reduce duplication and unnecessary hospital care

"Management" of previously unmanaged benefits

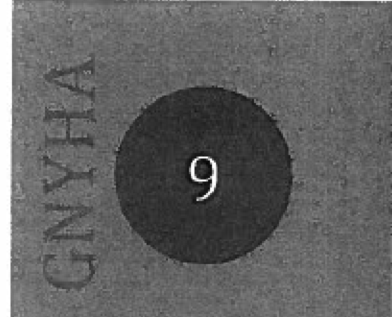
- Mental health
- Pharmacy
- Community long term care benefits

Significant payment reforms

- Home care
- Personal care
- Nursing homes

Eligibility Loopholes Closed

- Spousal refusal
- Asset "look back" for community long term care benefits



MRT's Major Focus on Quality and Patient Safety

Creation of Quality and Patient Safety Institute

- Designed to educate providers on latest evidence-based practices and procedures
- Improve quality, particularly in the obstetrical area
- Institute funded by recoupment of $170 million in medical malpractice reform-associated savings to hospitals

More robust policies on hospital-acquired conditions

Focused effort to reduce avoidable procedures

- E.g., Caesarian sections

GNYHA

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Medical Malpractice Crisis

Unsustainably high med mal costs

- Hospitals Statewide pay > $1.6 billion/year
- Some hospitals pay as much as $130 million/year
- Obstetricians in certain areas pay $200,000/year

Negative impact on access, public health, and quality

- Large losses for hospitals providing OB and other services
- Loss of key services in certain areas; OB services in the Bronx threatened at this very moment
- High cost of defensive medicine: $25b-$190b/year nationwide
- Diverts resources needed for delivery of quality services

GNYHA

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Preserving Access

The MRT proposals contain a huge amount of change for providers, including essential community providers

It is essential that the State work with the health care community to ensure that access is preserved, particularly in vulnerable, already under-resourced communities

GNYHA

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Concern for SUNY Hospitals

The Executive Budget reduces funding for SUNY hospitals

GNYHA urges the State to restore this critically needed funding

Why we agreed to health cuts

BE OUR GUEST

BY GEORGE GRESHAM and KENNETH RASKE

Leaders of New York's hospital association and health worker union justify their landmark deal with Cuomo

Something remarkable happened in Albany last week.

At a time of year when hospitals, nursing homes, home care providers and health care workers are usually at war with the governor over proposed reimbursement cuts, we instead joined the rest of New York's health care community and stood beside Gov. Cuomo as he announced groundbreaking Medicaid reforms that will improve quality and efficiency – including a "global spending cap" on Medicaid for the upcoming fiscal year.

Make no mistake: This is a very big deal that will profoundly change the health care industry in New York State.

In addition to sustaining significant funding cuts, health care providers have agreed to improve quality and reduce costs in order to help New York stay within a Medicaid spending limit of $52.8 billion next year – an estimated 2% reduction from current year spending. And a growth cap would be imposed the following year that would account for changing economic conditions such as inflation.

Why, after years of conflict and resistance to spending reductions, did things happen differently this year?

The governor's leadership was indispensable in driving a unique process that was spearheaded by a 27-person Medicaid Redesign Team – of which we were members. While searching for savings, the team never lost sight of the purpose of Medicaid: delivering quality health care to low-income individuals and families. So the end result represented shared sacrifice and cooperation at its finest.

Indeed, the global spending cap was supported by health care leaders and organizations that have long competed with one another for available health care dollars and pursued interests that often came at one another's expense. Anyone even vaguely familiar with health care advocacy in New York knows how challenging it has been in the past for us to agree on anything.

And let's not sugarcoat this: This path will be very difficult for New York's hospitals, nursing homes and home care providers, which struggle financially in the best of times and have seen their funding cut time and again over the last few years. We are agreeing to hundreds of millions in cuts, with the looming threat of even more cuts if it appears that Medicaid spending will exceed the global cap.

Cuts have consequences. The once-unthinkable closing of St. Vincent's Hospital last year is a sober reminder of how quickly a bedrock health care provider can disappear.

But even anticipating the serious fiscal pain that will soon be coming, this year we recognized that something would have to change.

For starters, these are not the best of economic times. New York faces a gaping budget deficit, and there's no magic bullet or hidden money to make it go away. Everyone needs to do more with less. New York's hospital community is committed to being part of the solution – and to making reductions without compromising patient care.

Second, this agreement is about much more than cuts. We are also making comprehensive reforms that will lower costs, make the Medicaid program more efficient and – most important – improve health care quality for all New Yorkers. The reforms will ensure that Medicaid is more patient-centered, eventually providing every patient a "home," or team of providers, to deliver care at the right place, at the right time and in the most efficient manner.

The agreement also includes two much-needed medical malpractice reforms: a $250,000 cap on noneconomic "pain and suffering" damages and a new fund for neurologically impaired infants. Both measures would reduce health care costs for consumers and be an immense help to resource-challenged hospitals.

Further, the global spending cap gives health care providers the flexibility to develop and implement their own strategies to reduce costs and become more efficient. And the very real possibility of additional cuts gives them every incentive to do so.

We look forward to working with the New York State Legislature to enact these trailblazing reforms into law as part of the final budget.

Gresham is president of 1199SEIU United Healthcare Workers East. Raske is president of the Greater New York Hospital Association.

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Testimony of

The Healthcare Association of New York State

Concerning the 2011-2012 State Budget

Presented to the Joint Hearing of the

New York State Senate Finance Committee and Assembly Ways and Means Committee

March 3, 2011

Thank you, Chairmen DeFrancisco, Chairman Farrell, Chairman Hannon, Chairman Gottfried, and members of the Legislature, for the opportunity to speak to you today. I am Daniel Sisto, President of the Healthcare Association of New York State (HANYS).

As you know, the dynamics associated with the 2011-2012 state budget process are like no others in recent memory, especially regarding the Medicaid program. New York faces an historic $10 billion deficit, presenting challenges of equally historic magnitudes, and requiring sacrifices from every sector. In response to this crisis, Governor Cuomo engaged an unconventional strategy by creating the Medicaid Redesign Team (MRT), turning the normal process on its head and requiring all of us to think differently and more collaboratively than ever before.

The MRT was an entirely new approach for New York, empowering stakeholders to assume responsibility for meeting the state's savings target, while at the same time recommending and facilitating systemic reforms desperately needed to stabilize and sustain the Medicaid program.

Most would agree that a new approach was necessary. In just the last three years, the Legislature has been compelled to take eight distinct budget actions, including numerous deficit reduction actions, which, combined, cut more than $5.3 billion from hospitals, nursing homes, and home health care providers. The magnitude and unpredictability of these actions wreaked chaos for health care providers as they tried to continually adjust to these seasonal reimbursement reductions, pushing fragile organizations nearer and nearer to the brink.

During this same time, numerous reforms to the hospital reimbursement system were imposed, creating more challenges and unpredictability for providers. All the while, the unsustainability and looming potential collapse of the Medicaid program remained largely unaddressed.

The Governor's charge to the MRT was to simultaneously redesign the Medicaid system and achieve historic savings. We therefore needed to try something different.

As you weigh the Governor's budget proposal, specifically the elements recommended by the MRT, I would ask you to view them as I do: as a groundbreaking two-year experiment.

The Legislature's role is central in this experiment, not only in terms of your consideration of the proposal before you, but also your vigilance and supervision throughout its two-year life-cycle. Equally critical will be your role at the conclusion of this experiment, when we will collectively determine which elements to continue, which require modification, and which should potentially be abandoned.

I would also ask you to consider the tremendous cost hospitals and other providers have agreed to pay to secure the MRT agreement. These costs are substantial:

- Loss of the annual trend factor cost of living increase. The Governor's proposal permanently eliminates the trend factor. This is one of several elements that will need reconsideration at the end of this two-year period.
- A 2% across-the-board Medicaid rate cut.
- A global cap on the state's Medicaid expenditures.
- Potential recoupment of expenditures that pierce the cap.

The known cuts to hospitals alone in this agreement amount to more than $400 million, without including any cuts that may accrue if the cap is pierced. Clearly, no sectors have been spared.

Moreover, consider this proposal within the context of the last three years, during which time:

- Eight distinct budget actions imposed hospital cuts of more than $2.4 billion.
- Hospitals have been subjected to numerous significant state reforms, some of which are now being applied to other sectors of care.

Rationale for Supporting the MRT Recommendations

The MRT by its nature realistically was fraught with potential for disagreement, disparity, and tension. Notwithstanding these perils, the group worked earnestly to meet the seemingly insurmountable challenge the Governor presented. This process resulted in a product that, while not perfect, was extraordinarily successful in achieving consensus for meaningful reform and hitting the Governor's savings target.

As you know, I supported the MRT recommendations. I did so for two global reasons:

1) The recommendations contain options preferable to additional major across-the-board taxes and cuts that threatened us if we failed. These preferred elements include:

- A reduction of the state's savings target from $2.85 billion to $2.35 billion.
- A number of fundamental redesign elements that incentivize savings through better care coordination and other reforms.
- Long-needed reform to the medical malpractice system. The termination of insurance coverage for obstetrics at a major New York City hospital just this week illustrates how access to care is threatened because of inaction on meaningful reform. Capping non-economic damages and establishing an indemnity fund for neurologically impaired infants would help ensure access to care and reduce costs throughout the entire health care system.
- A global cap on state Medicaid expenditures and the concept of a two-year Medicaid budget. This core element is very daring, ambitious, creative, and experimental. As such, it will require the vigilance of the Administration and the Legislature to ensure that its implementation, progression, and ultimate disposition are sound public advocacy. In the budget amendments, the cap and the elimination of the trend factor are presented as permanent changes. As an MRT member, I viewed them as a major challenge for two years and accepted that challenge for HANYS. Whether this approach, and the permanent elimination of the trend factor in state fiscal year 2013-2014, should be

maintained beyond two years should be reassessed by the Administration and Legislature as key federal reforms accelerate in October 2013, the start of federal fiscal year 2014.

  - If state Medicaid expenditures fail to stay within the designated cap, then any amount over the cap would be recouped. However, the MRT did not specify a mechanism to monitor this evolution or prescribe a proposed formula or policy that defines how these potential "take-backs" would be implemented, which is one of several elements we ask the Legislature to watch closely over the course of this two-year experiment.

- Reform to the state's outdated regulatory structure.
- Better managed spending on optional services.
- Other proposals.

2) Many harmful proposals were eliminated in the MRT process, including:

- Increasing the gross receipts tax on hospitals.
- Deep cuts to indigent care funding.
- A flawed pay-for-performance proposal that penalized providers yet afforded no discernable value.
- The Health Care Reform Act streamlining proposal.
- And others.

The MRT vote was a simple up or down on the entire package of recommendations, compelling HANYS in some instances to appear to support items that we would not normally support individually. We did not have that option. We therefore approached our role on the MRT as an opportunity to first, if possible, realistically reduce the state's savings target (which we successfully accomplished in concert with others), and second, to mitigate the damage and chaos that would result from far larger across-the-board cuts and taxes (as high as 10% to 15%) that could have been imposed if the MRT failed. A far better alternative was agreeing to a 2% reduction and an experimental cap that can be modified by the Administration and Legislature in the future.

Moreover, the MRT agreement gives providers far more control over how a large percentage of the savings will be generated, granting our members much more flexibility than would be possible under a rubric of all state-defined cuts.

In the end, given the powers afforded to the Governor through popular support and the threat of budget extenders, it seemed likely that the state's savings target would be met, one way or another. To us, the final MRT package, which we were compelled to generate within an extraordinarily tight timeframe, provided the most rational, equitable, and responsible plan to adjust and achieve that target.

As you weigh this proposal, I also ask that hospitals operating in areas where access to care is limited be given special consideration to ensure the viability of the health care safety net in every region. It is also critical that appropriate safeguards are built into the home health care system as it transitions to an episodic-based payment model.

Importantly, the issue of nursing home reimbursement and the intersection between rebasing and pricing urgently needs to be addressed. The MRT process did not address this critical issue, which must be resolved, with so many nursing homes having relied on rebasing funds after years of underpayments.

Notwithstanding these considerations and the imperfect elements contained within this proposal, I ask the Legislature to adopt the MRT plan as soon as practicable.

Thank you.

Testimony of the

Iroquois Healthcare Alliance

presented to the

New York State Senate Finance Committee
and
New York State Assembly Ways & Means Committee

regarding

2011-2012 Executive Budget Proposal on Health

by Gary J. Fitzgerald
President, Iroquois Healthcare Alliance

March 3, 2011

Good afternoon Chairman DeFrancisco and Chairman Farrell, legislators, and staff. I am Gary Fitzgerald, President and CEO of the Iroquois Healthcare Alliance, a membership organization representing 57 hospitals and their affiliated organizations in 31 upstate counties. IHA's membership is diverse in that it comprises 32 rural hospitals including 5 Critical Access Hospitals, and represents the smallest hospitals in the state as well as some of the largest teaching hospitals in Upstate New York. I want to thank you for conducting this public hearing regarding the Executive's proposed healthcare budget.

My colleagues from HANYS and GNYHA have given you extensive and thorough testimony as to the problems of the New York State Medicaid system. They have also presented rational solutions that they agreed to as members of the Medicaid Redesign Team to reform Medicaid. The Iroquois Healthcare Alliance supports many of the recommendations made by HANYS and GNYHA, and will work with them, and with you, to see that these reforms become reality. I will not repeat their testimony, but would like to speak briefly on the concerns of Upstate hospitals, nursing homes, and physicians.

The Cap

The creation of the "Voluntary Health Care Cost Containment Initiative," to enforce the global spending cap, has many elements of concern for Upstate providers:

- Under the initiative, DOH will be given the authority to implement utilization controls and rate reductions if Medicaid expenditures exceed the cap agreed to by the MRT. IHA believes that the Legislature should be actively involved in monitoring Medicaid utilization and expenditures. The Legislature should provide input into any implementation of controls or rate reductions.
- The initiative provides an "incentive" for providers to work collaboratively to find efficiencies. However, if the cap is pierced, the reason for the spending growth should be

examined for regional and sector impact, and there should not be across-the-board responsibility for additional cuts or taxes. The language that we received late yesterday does not reference geographical differences.

- There are many variables that can impact the cap, including enrollment. Enrollment in Medicaid is expected to increase. The MRT did not propose any eligibility cuts, and there is limited change in optional benefits.
- The Commissioner of Health should not be given unilateral authority to set Medicaid rates, or to tax health care providers.

Medicaid cuts

The Governor has proposed a 0% trend factor increase and a 2% across-the-board cut for hospitals, nursing homes and home care. This is regardless of the increased costs for labor, pharmaceuticals, enrollment and other costs. Hospitals can not sustain cuts to Medicaid while the patient population and utilization increases. According to the New York State Health Foundation, New York State's Medicaid enrollment will increase by 150,000 to 500,000 enrollees due to the implementation of federal health care reform enacted in 2010.

The cap essentially represents additional cuts. Hospital CFOs are faced with the dilemma of preparing budgets – budgets that determine which services they can provide to their community. Without knowing the detail of how the industry would be held accountable to piercing the cap, CFOs will be forced by their auditors to establish additional reserves.

Efficiency

Within the health care sector, Upstate's hospitals are the most efficient in the nation. The federal government recently rewarded hospitals for their efficiency. Forty-nine hospitals in New York

State, all of which were located in Upstate New York received awards. New York ranked first in the nation for the number of hospitals qualified and also ranked first in award value. Using a national measurement for efficiency it is clear that Upstate hospitals are among the most efficient in the nation, and Medicaid should follow the lead of the Medicare program and reward hospitals for their efficiency.

Financially Fragile Upstate Nursing Homes

Currently, 26 of Iroquois' members operate hospital-based nursing homes. Nursing homes in Upstate New York can not sustain additional cuts or taxes. The Upstate nursing home industry was not represented on the MRT. Two years ago, the Legislature recognized the financial problems of nursing homes by enacting legislation which created a new base year for rate calculations. This has not been implemented by DOH.

Safety Net

As the term "Safety Net" is being defined, it should include Sole Community Providers and Critical Access Hospitals, and recognize geography and outpatient volume, not just Medicaid inpatient volume.

Personal Care

The MRT proposes new controls in personal care and home health to reign in unsustainable growth in these programs. IHA believes that even more controls and limits are necessary.

From 2003-2009, the number of patients receiving long term care has remained flat, while total Medicaid spending on long term care rose, largely due to rising per-patient cost of at-home care in New York City which rose by 89.5%.

In 2008, New York spent $2.3 billion on its personal care program; with $1.9 billion of that spent in New York City alone. That amount spent on the program in New York City is 4.5 times more than in the rest of New York State. New York City does have more personal care recipients, but adjusting for the number of recipients do we really believe that Medicaid patients in New York City are 2 times sicker than Medicaid patients in the rest of New York State? In 2006, according to the Kaiser Commission, the State spent $25,896 per personal care recipient while the national average for that same type of patient was $9,637. Another report by the New York City-based United Hospital Fund reported that New York City spent $28,804 on each personal care Medicaid recipient (elderly duals) while Upstate spent $7,878 per recipient.

The MRT began deliberations on changes in the personal care program which would have resulted in $242 million in State Medicaid savings; the final package only results in $57 million in State savings.

Living Wage

There is statutory language in the MRT proposal which mandates that home care providers pay a "living wage" to their employees. There are only a few municipalities that have a "living wage" law and they are New York City, Westchester, Nassau, and Suffolk counties. This unfunded mandate could impact other counties in the future. This proposal does not save any money for the Medicaid program.

Medical Malpractice Reform

To reduce Medicaid costs and health care costs in general, New York State's medical malpractice system must be reformed. The MRT proposal begins this process; however, if an

increase in trial lawyers' contingency fees is added to this proposal as the budget is negotiated, it will negate any savings to the health care system.

Health Provider Gross Receipts Tax

Although an increase in the GRT is not part of the MRT proposal, legislators must be attentive that a GRT not be added during the budget negotiations.

- The GRT is a tax on hospitals' revenues.
- The GRT combined with cuts to Medicaid reimbursement leads to cost shifting to private insurance. To maintain as many services as possible, hospitals must negotiate higher rates from private insurance companies to offset government underpayments. In turn, the insurance companies impose higher premiums for employers and individuals.

Physician Recruitment

Weakening the hospitals' finances with additional cuts and taxes limits Upstate hospitals' ability to invest in physician recruitment. At a time of a shortage of physicians in Upstate New York, hospitals can not afford to have less available to recruit more.

Communities in Upstate New York desperately need to recruit new physicians. IHA members are struggling with recruitment of physicians – primary and specialty. Physicians of all types are needed and in short supply, and in some cases non-existent in many Upstate communities. The most recent study form the SUNY Center for Health Workforce Studies shows that the average age of a physician in New York State is 52, and slightly older in rural counties, with 15% over the age of 65 in rural counties. The aging physician population and the need for additional health care services in Upstate due to its aging general population, creates a challenging environment.

And, although medical malpractice is not the only challenge for recruitment, as more of our Upstate hospitals must employ their physicians, the cost of medical malpractice has become a growing cost to hospitals. Hiring physicians is frequently cited as the only available option of bringing physicians on staff. Physician employment has become an important recruitment and retention tool. The employment of physicians by the hospitals has led to the hospitals assuming more of the cost of medical malpractice insurance of individual physicians. Malpractice reform to reduce that cost would be beneficial to hospitals that continue to struggle financially.

IHA supports proposals that improve patient safety, enhance efficiency, and reduce costs for patients and providers, and supports the MRT's recommendation to expand the medical home model. IHA believes the collaborative efforts of the Adirondack Medical Home could benefit more communities.

Upstate and rural health care providers need to be included in the Medicaid reform discussions as the MRT continues its work.

Thank you again for your time and the opportunity to comment. I hope that during your deliberations you will seriously consider the issues that I have discussed with you today. The members of the Iroquois Healthcare Alliance look forward to working with you in making sure that quality, affordable health care is accessible to all of the citizens of New York State. I am happy to respond to any questions.

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The Medical Society
of the State of New York

Testimony Of
The Medical Society of the State of New York
Before The
New York State Assembly Committee
on Ways & Means And Senate Finance Committee
On the Governor's Proposed Public Health Budget
For State Fiscal Year 2011-2012

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

1. **Addressing Medical Liability Reform in the Context of the State Budget for Fiscal Year 2011-2012 Will Reduce Medicaid Expenditures for Liability Exposure and Defensive Medicine Costs**

We are extremely pleased that included in the recommendations of Governor Cuomo's Medicaid Re-Design Team are recommendations which will meaningfully reform our failed civil justice system providing much needed medical liability premium relief for physicians and hospitals. Perhaps nowhere else in the country does the exorbitant cost of medical liability insurance impact more

substantially on a State's Medicaid budget and access to medical care than it does in New York, where physicians pay among the highest premiums in the country. In July 2010, medical liability insurance premiums were permitted by the Superintendent of Insurance to be increased by 5%. This followed two policy years, 2008-09 and 2009-10, where the New York State Legislature and Governor Paterson had enacted legislation that prevented the imposition of a medical liability insurance rate increase or the imposition of a surcharge to make up for past insurance company deficits. Without these actions by the Governor and the Legislature, there would have been severe consequences to access to care in New York.

The 5% average increase (it was close to 9% for some physicians in some regions of New York State) was on top of the 14% imposed on physicians for the 2007-08 policy year. Adding these increases to the 55-80% premium increases which had occurred over the previous 5 years, the premiums paid by many physicians, particularly those in high risk specialties, in New York reached unprecedented levels often in the hundreds of thousands of dollars.
For example, with the 5% increase, for just a single year of coverage, the cost of medical liability coverage is:

- $306,393 for a neurosurgeon in Nassau and Suffolk counties;
- $144,522 for an Ob-GYN in Orange, Rockland and Westchester counties;
- $131,531 for an orthopedic surgeon in Bronx and Richmond counties; and
- $106,354 for a cardiac surgeon in Kings and Queens counties.

Overall, from 2003-2008, liability insurance costs have increased by the percentages listed below for the following physician specialties:

- ER physicians - 72-80%;
- general surgeons - 72-80%;
- neurosurgeons - 72-80%;
- internists - 72-80%;
- radiologists - 63-72%; and
- OB-GYNs - 63-72%.

These unbearable increases have forced many physicians to move out of state, retire early, or modify their practice. In Suffolk County alone in 2007, 14 OB-GYNs left practice altogether or downgraded their practice to gynecologic care only.

In Oswego County, there remains only one OB- GYN practice. In that county, medical liability premium costs have increased by 63% (from $32,539 to $53,151). These dedicated OB-GYNs have been able to meet the needs of their patients only by remaining on call 24/7, often sleeping overnight at the hospital. This is not dissimilar to the practice of other high- risk specialty physicians practicing in Oswego and other upstate communities.

During the same period of time that these costs continued their steady rise, physicians have been squeezed by the ongoing efforts of health plans to constrain payments for health care services delivered to the patients they insure. Also, since 2001, physician Medicare payments have remained essentially flat, despite the fact that practice costs have risen steadily, eclipsing the rate of inflation.

In Peconic Bay, Suffolk County a three member OB-GYN practice has seen its practice income drop in recent years to a level that is about the same, or even less, than what these skilled physicians made as residents in 1985.

The enormous costs of our liability premiums are driven by a wildly unpredictable medical liability adjudication system. Numerous studies have shown awards are made despite the absence of any negligence whatsoever and that those truly injured by negligence often do not sue. In one recent review of closed claims in the *New England Journal of Medicine*, in more than 1 out of 4 claims, a patient was awarded payment where no negligence was committed, or a patient was not awarded payment where there was negligence. The famous Harvard Study, cited by the trial bar as an example of incompetence in the health care system, was actually an indictment of the civil justice system. It showed that over 80% of the persons who sued for malpractice were not victims of negligence. Moreover, statistics provided to us by the Medical Liability Mutual Insurance Company (MLMIC) show that 71% of the neurosurgeons currently insured by MLMIC have been sued; 67% of its OB-GYNs; and 62% of its surgical classes.

As a result of the randomness and unpredictability of the current medical liability adjudication system, settlements are often made even where no negligence has occurred. Instead, determinations are very frequently made based upon the severity of an injury rather than on whether negligence occurred.

The fact remains that without resolution of the medical liability premium crisis, access to physician services both in private physician offices and in critical hospital inpatient and ambulatory care settings-- will be negatively impacted, to an extent which few can imagine. Already, we have witnessed the elimination of hospital obstetrical services and the closure of the birthing center at Brookhaven Hospital on Long Island. This one action has forced women, many of whom are uninsured or underinsured, to travel great distances to deliver their babies.

In several regions across New York State, including Western New York, Southern Tier, and Mohawk Valley, there has been an alarming drop in the number of critically needed primary care physicians, OB-GYNs, and surgical specialists, according to the Center for Health Workforce Studies (CHWS). Since 2002, over 250 MLMIC-insured OB-GYNs have sharply curtailed their deliveries by changing their classification from obstetrics to gynecology or family practice, including 75 in just the last year alone. Hospitals are having a harder time keeping specialist services available on-call for emergencies.

We agree with Dan Sisto and Ken Raske that, to the extent that meaningful medical liability reform can be effectuated as part of the state budget, tangible direct savings will accrue to the state by way of reduced liability costs for hospitals, clinics and ambulatory care facilities. Moreover, major reduction in and the ultimate elimination of the defensive medicine caused by fear of liability and not clinical needs of patients will produce even greater savings. To the extent that the state budget exigencies may compel reductions in payments for needed care, the terrible pain of such reductions can be ameliorated by actions that reduce operational costs, including medical liability insurance costs.

It is now beyond argument that meaningful tort reform is essential and will result in significant savings for New York State and for our health care system. Something must be done to rein in the outrageous liability costs borne by physicians. If it is not done, New York's magnificent health care

system will be irreparably harmed. Medical liability tort reform IS Medicaid redesign and health care reform. To that end, the Medical Society of the State of New York supports the recommendation of the Medicaid Redesign Team (MRT) to effectuate meaningful medical liability reform as part of the budget for FY 2011-12 including a $250,000 cap on pain and suffering and Neurologically Impaired Infant Medical Indemnity Fund. Moreover, we support legislation to: (1) require disclosure of the identity and deposition of an expert witness prior to trial; (2) require that a physician consulted for a Certificate of Merit be identified, be of the same specialty as the physician against whom the suit is filed and be required to file a certification statement; (3) protect physicians who express sympathy to a patient for an unanticipated outcome from having such statement used against the physician in any subsequent litigation that may arise; and (4) extend existing confidentiality protections to all statements and information volunteered at peer-review quality assurance committees. The addition of these measure to the $250,000 cap on pain and suffering and a Neurologically Impaired Infant Medical Indemnity Fund constitute meaningful medical liability reform which we urge the Legislature to include in the State Budget for FY 2011-2012.

2. Continuation of an Adequately Funded Excess Medical Liability Program

We are grateful that Governor Cuomo has proposed to continue the Excess Medical Liability Insurance Program and we urge that the Legislature include funding for the Excess program in the final budget adopted for 2011-2012. The Excess Medical Liability Insurance Program provides an additional layer of coverage to physicians with hospital privileges who maintain primary coverage at the $1.3 million/$3.9 million level. The cost of the program since its inception in 1985 has been met by utilizing public and quasi-public monies. Beginning January 1, 2002, monies from the Health Care Reform Act's (HCRA's) tobacco control and initiatives pool were allocated to fund the cost of this program. The 2010-2011 State Budget adopted by the Legislature included funding to cover the cost of the program through June 30, 2011. The Excess program was extended by Chapter 58 of the Laws of 2008 until June 30, 2011. Importantly, the proposed state Budget for 2011-12 would appropriate $127.4M for the Excess program.

The Excess Medical Liability Insurance Program was created in 1985 as a result of the liability insurance crisis of the mid-1980's to address concerns among physicians that their liability exposure far exceeded available coverage limitations. They legitimately feared that everything they had

worked for all of their professional lives could be lost as a result of one wildly aberrant jury verdict. This fear continues since absolutely nothing has been done to ameliorate it. The size of verdicts in New York State has increased exponentially. From 1999-2005, 59% of all verdicts exceeded $1 million, thereby making the continuation of the Excess liability coverage even more essential today than when first authorized. Consequently, approximately 25,000 physicians currently have excess coverage.

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

3. Re-involve Physicians In The Delivery of Health Care to New Yorkers Covered by Medicaid Through Physician Payment Reform

Medicaid, as historically administered, has failed the taxpayer, failed the providers, and most importantly has failed its intended beneficiaries—our state's most needy citizens. For too long, Medicaid has paid for the delivery of health care in the highest cost delivery setting, rather than in the more clinically appropriate and cost efficient setting- a physician's office. We agree with the Medicaid Re-Design Team that we must restructure Medicaid to eliminate the distortions that have significantly diminished the program as it exists in New York State. Medicaid costs too much because its payment structure is not consistent with clinical needs. As the cost of the Medicaid fee- for-service program increased between 2004 and 2007 from $28B to $34B, the percent of fee-for-service Medicaid dollars which have been allocated to pay for physician services remained at 0.9% in 2004, 2005 and 2006 and decreased even further to 0.77% in 2007. Out of the $34B spent on fee- for-service Medicaid in 2007: $8.3B was allocated for hospital inpatient services; $6.7B was allocated to

skilled nursing home services; and $1.5B was allocated to free- standing clinic services. Less than $268M was devoted to pay for physician services. The abysmal Medicaid physician payment rate is well documented. For more than a decade, the Urban Institute has tracked physician Medicaid fee-for- service payment across the nation and compared state payment rates to Medicare payment rates. Until recently, New York has ranked among the lowest three states in Medicaid to Medicare fee ratios. Beginning in 2009, fees paid to physicians were increased modestly but even with this fee increase, New York is ranked the sixth lowest in the nation in Medicaid to Medicare fee ratios.

Because New York's Medicaid fee for service program has woefully underpaid physicians, very few physicians in private practice participate in the Medicaid fee for service program in any substantial way and those that do, cannot afford to see many Medicaid patients. This has been a problem decades long in the making and it will take a number of years to overcome medicine's view of the Medicaid program. This is an unfortunate state of affairs because it is the physician and his or her team of non-physician colleagues who can best coordinate and manage the care of the Medicaid patient. Of course, a larger number of physicians participate in Medicaid managed care and provide services to Medicaid beneficiaries through the Medicaid managed care program. However, reimbursement under the Medicaid managed care generally is also inadequate. To the extent that physician reimbursement under the Medicaid managed care program is enhanced, so will physician participation in the Medicaid.

In our opinion, the Governor's Medicaid Re-Design Team agrees with this perspective and has recommended new initiatives which will for the first time in the history of the program establish structural changes to effectuate greater physician-directed care coordination and management, improved quality and outcome performance and cost efficiencies which will translate into better value for the tax dollars appropriated to the program.

We must be mindful that access to physician services under New York's Medicaid program has been severely restricted not because physicians don't want to treat the poor, but rather they simply have not been able to historically for financial reasons. This is true for primary care physicians but also for specialty care physicians as well. This reality is particularly problematic because many Medicaid beneficiaries who remain in the fee-for-service Medicaid program are individuals with chronic

illnesses or significant disabilities and need acccss to specialty care. Without physician specialists in the program, beneficiaries have no other choice but to defer seeking treatment and/or to receive services on a chronic, episodic basis from the highest cost institutional and clinic settings. Moreover, this lack of access to specialty care severely limits the ability of primary care physicians' to assure access to the most effective clinical care. Coordinated primary and specialty care is far better and less costly than random, episodic care in these high cost care settings

Patient Centered Medical Home

MSSNY supports new payment reform strategies such as the expansion of the Patient Centered Medical Home Demonstration. The state has begun experimentation of payment reform strategies to incentivize the development of patient-centered medical homes wherein physicians will coordinate and integrate patient care in accordance with medical home standards that are consistent with those of the National Committee for Quality Assurance's (NCQA) Physician Practice Connections ® - Patient-Centered Medical Home Program (PPC®-PCMH^{tm}).

Beginning on July 1, 2010, physicians who participate in the Medicaid Managed care program and have achieved PPC®-PCMH^{tm} status will receive an additional $2, $4, or $6 per member per month (Level 1, Level 2 or Level 3 respectively) payment. Medical Home payments will flow to the physicians through health plans as a pass-thru. Fee-for-service office-based physicians, who have achieved Level 1, Level 2 or Level 3 PPC®-PCMH^{tm} status, will receive an add- on to certain evaluation and management codes of $7, $14.25 and $21.25, respectively. Physicians in Article 28 clinics will receive an incentive payment that is slightly less - $5.50, $11.25 and $16.75, respectively. Additionally, a separate multi-payer demonstration is evolving in the Adirondacks that will provide additional per member, per month, payments to participating physicians. This particular demonstration proceeded as a result of the enactment of budgetary language which allows for a state action doctrine exception to the antitrust rules. Under the auspices of the state, the physicians and payors came together to negotiate the amount of the additional payment to physicians which will be used for enhanced patient care coordination and management. In effect, these physicians and other clinicians will provide coordinated disease management services, thereby reducing the number of preventable hospitalizations and, realizing cost savings over time.

We applaud the investment the state and federal governments are making to encourage adoption of much needed health information technology. Having said this, however, organized medicine across all specialties is deeply concerned that neither the enhanced payment rates, nor the physician adoption rate of EMR/EHR technology, are anywhere near adequate to assure that physicians can immediately achieve PPC®-PCMH^{tm} status. To some degree, the Health Information Technology Extension Center (HITEC) funding will defray some of the expenses associated with the purchase and implementation of needed technology. However, this will take several years to complete. Many of the standards will require additional staff resources and a sizeable capital investment for the purchase of adequate technology and/or software licenses, thereby increasing practice costs far beyond the level of the payment increases that havc been implemented. The added payments provided through the patient centered medical home demonstrations must be sufficient to assure that the payment rates reflect transitional costs associated with operational changes which these standards seek to induce. Moreover, we would recommend the expansion of the state action doctrine exception to other emerging PCMH projects across the state.

Physician-Driven Accountable Care Organizations and other Demonstration Programs Facilitated by the Federal Patient Protection and Affordable Care Act

Federal health reform legislation requires pilot demonstrations of Accountable Care Organizations for Medicaid and Medicare. ACOs are organizations that contract to provide services for a defined population of patients (at least 5000 Medicare beneficiaries) in a delivery model which includes primary care physicians, specialists and hospitals. The ACO model allows successful participants to share in savings if certain medical care quality objectives are achieved and financial savings are demonstrated. The ACO model is to be in effect January 1, 2012. Integral to a successful ACO is a community of physicians who can coordinate care delivery across the healthcare spectrum and reliably measure performance in order to achieve and share in system savings while enhancing overall quality of care. The ACO concept affords flexibility in the type of organizational model to choose and the available provider payment method. We await federal regulations that will establish protections from violations of Anti-Kickback Statute, the Stark Law and other antitrust restrictions. We urge the state to consider similar exceptions to state Stark and corporate practice of medicine prohibitions to enable physician- driven ACOs to develop and flourish.

Two other federal demonstration programs authorized by the federal health care reform law should also be considered for their implications on quality of care and cost savings:

Independence at Home Demonstration: An incentive program for high-need Medicare beneficiaries with two or more chronic illnesses such as congestive heart failure, diabetes, dementia, chronic obstructive pulmonary disease, ischemic heart disease, stroke, Alzheimer's Disease, neurodegenerative diseases, and other diseases and conditions designated by the Secretary, that result in high costs. The incentives are based on a spending target and a risk corridor for primary care physicians or nurse practitioners to be paid for care coordination, and must provide home-based primary care. Participants must demonstrate that actual expenditures are less than estimated spending targets for the year. Shared savings would flow to providers through: (a) reduced preventable hospitalizations; (b) reduced preventable hospital readmissions; (c) reduced emergency room visits; and (d) improvements in health outcomes commensurate with the beneficiaries' stage of chronic illness. This demonstration is slated to begin on Jan. 1, 2012.

Community Based Collaborative Care Network: A consortium of health care providers with a joint governance structure that provides a comprehensive range of coordinated and integrated health care services for low-income patient populations or medically underserved communities. The services will be provided by participants in a community-based collaborative care network and will include support services appropriate to meet the health needs of low-income populations in the network's community. Such services may include chronic care management, nutritional counseling, transportation, language services, enrollment counselors, social services and other services as proposed by the network.

Health Homes

The Medicaid Re-Design Team recommends the adoption of health homes to coordinate care to Medicaid recipients with chronic medical and/or mental health conditions and/or substance abuse disorders. Provider networks meeting state and federal health home standards will provide care management, prioritized housing and integrated physician and behavioral services to chronically ill Medicaid beneficiaries who in the past have received episodic care in the emergency department or inpatient setting. As a result of the federal Patient Protection and Affordable Care Act, these care

coordination efforts are eligible for a 90% federal match. Populations will be enrolled beginning in the summer of 2011.

Behavioral Health Organizations

The Medicaid Re-Design Team has recommended that the state contract with five or six regional behavioral health organizations (BHOs) which will begin to manage those behavioral health benefits that are carved out of the current mainstream Medicaid managed care plan including services provided to the individuals eligible for Medicare and Medicaid. The concept of care coordination and management to reduce overutilization including unnecessary emergency room visits and inpatient care is sound. We also support the use of entities accountable to the state other than mainstream managed care organizations as care coordinators and managers of behavioral health services. We look forward to receiving more detail around important aspects of care coordination and management utilization review, which are to be implemented and monitored.

It is important to the medical community that entities which are not mainstream managed care organizations are used to address the care management needs of the Medicaid population. With six health insurance companies controlling close to 80% of the commercial managed care market in New York State (as of the beginning of 2009), and most regions of the State dominated by one or two health insurers, it is very difficult for most physicians to negotiate relevant patient care terms. Health plans offer physicians "take it or leave it" contracts which are often grossly unfair. At the same time these companies wield such market domination, their profits have grown significantly. According to a recent report issued by the Greater New York Hospital Association, New York health plan profits increased 30% from 2008 to 2009 to approximately $1.3 billion. Oxford and Empire had a combined net income of nearly $900 million. Certainly it is foreseeable that these profits will grow even more substantially as a result of the health insurance coverage mandate in the federal health care reform law. The use of care management entities accountable to the state which are not traditional managed care organizations is far preferable provided that they assure that care coordination and management strategies are consistent with evidence based quality practices developed by the medical community and not implemented for the profit which can be generated or cost savings generated.

4. Enhance Efforts to Facilitate Smoking Cessation Among the Medicaid Population

We support the recommendation of the Medicaid Re-Design Team to expand smoking cessation counseling and therapy to Medicaid adult non-pregnant women and men. The impact of tobacco use on Medicaid costs is enormous. These costs can be reduced by increasing the rate of cessation among beneficiaries. The most effective way to reduce smoking cessation is to remove existing barriers and to follow recommendations issued by the Public Health Service's Clinical Practice Guideline for Treating Tobacco Use and Dependence (2008). Recommendations include but are not limited to the following: cover all seven first line cessation medications and remove annual and lifetime limits on duration and frequency of use; expand coverage of cessation counseling during a medical visit to all beneficiaries; cover group counseling for all adult beneficiaries; and eliminate co-pays and prior authorization requirements.

5. Surcharge on Payors for Certain Health Service Payments

We are very troubled by the recommendation of the Medicaid Re-Design Team which would require certain payors to pay a 9.63% surcharge for services billed as surgery or radiology services which have been provided in physician offices or in urgent care facilities. We ask that you carefully evaluate the implications of this language.

We believe that it is time for payors – the most solvent sector within the healthcare delivery system- to re-invest the equity they have for years extracted from the system back into the HCRA financial pools through this surcharge so that it might be redistributed to healthcare providers, enhanced patient access and public health programs. The Medical Society, however, is concerned with the potential impact of this surcharge on the fees paid to physicians by the payors for surgical and radiological services provided in the physician office and to premiums paid by employers and individuals for health care coverage. Simply put, individual physicians and even group practices lack sufficient leverage now enjoyed by much of the hospital sector to forestall or prevent a possible 9.63% cut in their reimbursement which might be imposed by health insurers to offset the surcharge imposed on them. The proposed law is clear, and it should not be perverted. This is a surcharge on health insurers and not providers, employers, or patients. It does not apply to physicians or patients, but only to insurers. If there is no insurance payment, there is no surcharge. It is not assessed on deductibles or co-insurance. Many physician practices today are barely solvent. There are a number of reasons for this including rapidly escalating practice costs and declining practice revenue. Already in every

region of New York we are experiencing a significant shortage of critically needed physicians in a number of specialties, including primary care specialties. The impact of this one proposal, if the proper protections are not established, could cause an even larger number of physicians to retire early, alter their practices, or relocate their practices outside of New York State. Alternatively, MSSNY is also very much concerned about the potential for payors to simply pass this surcharge along to employers and individuals who purchase coverage. MSSNY, therefore, urges the incorporation of language to assure that such surcharge will not be passed along to physicians by way of reduced fees or to our patients through increased premiums for employers or through coverage reductions. Alternatively, we ask that you explore other mechanisms to tax health insurers to achieve the revenue sought to be obtained through this proposal.

6. Remove Constraints on Prescribing Practices

We are also concerned by the Medicaid Re-Design Team recommendation which would include antidepressants, atypical anti-psychotics, anti-retrovirals and immunosuppressants in the PDP and the concomitant requirement for prior authorization for such drugs not included on the PDL. Individuals who take these types of medications are suffering from chronic conditions. Once a physician has diagnosed such a condition, he or she should be permitted to prescribe the most effective drug without having the burden of also obtaining prior authorization through the processes established by the Medicaid program. Moreover, in our view, the physician prevails language should continue to apply to the Medicaid pharmacy benefit. For that reason, we would discourage your adoption of proposals which would negatively impact upon the physicians prescribing authority including any proposal to carve the pharmacy benefit into Medicaid managed care.

7. Eliminate Inappropriate Scope of Practice Expansion for Non-Physician Providers

We are also very concerned by the opportunistic advocacy attempts by certain non-physician providers to use the budget crisis now facing the state to advance their effort to expand their scope of practice. Their attempt to camouflage this effort under the guise of cost-efficiency is misplaced. Such proposals can only be appropriately considered through the spectrum of quality of care. Although nurses, nurse practitioners, physician assistants, pharmacists and other non-physician providers are competent within their own fields, they should not be allowed to work in areas beyond their competence and training and/or without an appropriate relationship with a physician. The purpose

of defining scope of practice in statute is to ensure that practitioners are only practicing within the parameters of their education and training and, if required, in a defined relationship with a physician. This provides protection and safety for patients in their care. These proposals would seriously endanger the patients for whom they care. Moreover, expansion of scope of practice for non-physician providers without an adequate educational base will inevitably increase health care costs – not decrease them. Nor will such proposals address our physician workforce shortage. Non-physician practitioners wish to practice in the very same regions of the state in which physicians now practice. Studies show clearly that they do not chose to practice in rural or urban underserved communities.

8. Restoration of Optional Services Under the General Public Health Work Program

The Medical Society notes that the 2011-12 budget calls for the elimination of optional services under the General Public Health Work (GPHW) Program. Optional services include county Medical Examiners Offices. It is our understanding that 24 counties have a medical examiner office that would be impacted by this change. A medical examiner is a licensed physician who investigates violent, suspicious or unnatural deaths for the counties and assists law enforcement and the district attorney's office. These individuals determine the identification of the deceased, the time of death, the manner of death (natural, accident, suicide or homicide) the cause of death and if the death was by injury, the nature of the instrument used to cause the death. Medical examiners would also serve an integral role in any public health response to a bioterrorist attack, pandemic or a mass casualty incident. The Medical Society, therefore, respectfully requests restoration of this funding for the medical examiner's office.

Conclusion

Thank you for allowing me, on behalf of the County and State Medical Societies, to identify our concerns and suggestions for your consideration as you deliberate on the proposed budget for state fiscal year 2011-2012. To summarize, we believe that the state can achieve significant savings through the enactment of meaningful medical liability reform. Continued savings can also be achieved through implementation of reimbursement and operational reform of the Medicaid program including expansion of patient centered medical homes, health homes, accountable care organizations

and other demonstrations which are being facilitated as a result of the Patient Protection and Affordable Care Act. The continuation and dedication of funding for two programs- the Excess medical liability program and the *Doctors Across New York* program- are critical to facilitate the retention and recruitment of needed primary care and specialty physicians in certain rural and underserved urban communities in New York State. We support the recommendation which will further assure the facilitation of smoking cessation counseling and access to smoking cessation products for the non-pregnant adult Medicaid population. We have concerns regarding three MRT recommendations including one which would impose the 9.63% HCRA surcharge upon payors for surgical and radiological services provided in private physician office settings and another which would eliminate certain patient protections which currently exist as part of the preferred drug and clinical drug review programs and proposals which would inappropriately expand the scope of practice of certain non-physician providers. We also are concerned by the proposed elimination of optional services under the General Public Health Work (GPHW) Program.

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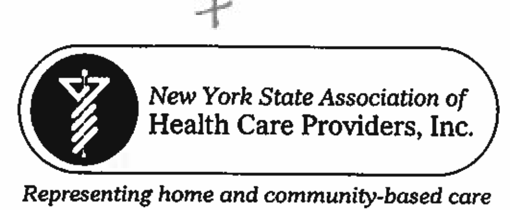

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TESTIMONY OF

THE NEW YORK STATE ASSOCIATION

OF HEALTH CARE PROVIDERS, INC.

PRESENTED BEFORE A JOINT PUBLIC HEARING OF THE

SENATE COMMITTEE ON FINANCE,

THE HONORABLE JOHN DEFRANCISCO, CHAIR

AND THE ASSEMBLY COMMITTEE ON WAYS AND MEANS,

THE HONORABLE HERMAN D. FARRELL, CHAIR

MARCH 3, 2011

Good afternoon Senator DeFrancisco, Assemblyman Farrell, distinguished members of the Senate Finance, Assembly Ways & Means, and Senate and Assembly Health and Aging Committee. My name is Christine Johnston, President of the New York State Association of Health Care Providers, Inc (HCP), a trade association representing approximately 500 office of Licensed Home Care Services Providers (LHCSAs), Certified Home Health Agencies (CHHAs), Long Term Home Health Care Programs (LTHHCPs), Hospices, and related health organization throughout New York State. With me today is Bader Reynolds, Chair of the HCP Board of Directors and Vice President for CareGivers, which provides home care services throughout Upstate New York.

On behalf of the HCP Board of Director and members, thank you for the opportunity to comment on Governor Cuomo's 2011-12 Executive Budget and its impact on home and community-based care.

One of the State's largest commitments is the Medicaid program. Health care is no doubt expensive, but when managed and provided appropriately, it can lead to reduced health care costs today and for the future.

A 2009 Health Affairs study reports that states that invested more in home care experienced a 15.3% decrease in institutional long-term care spending, while states that invested less encountered 3.4% growth in nursing home spending.

According to a study released in 2011 by Frank Lichtenberg, the Courtney C. Brown Professor of Business at the Columbia University Graduate School of Business, greater use of home care has resulted in reduced hospital stays and generated an estimated $25 billion in hospital payroll savings nationwide in 2008 alone.

Despite evidence that greater investment in home and community-based care saves money, home care programs in New York continue to be on the receiving end of relentless cuts to reimbursement and ever more burdensome regulatory requirements and unfunded mandates.

HCP recognizes the daunting task set before the Administration and State Legislature. The $2.85 billion State share savings target set by the Governor for the 2011-2012 State fiscal year is massive and will require creativity and ingenuity to generate savings while preserving access to care.

The home care proposals contained in the amended Executive Budget, as recommended by the Medicaid Redesign Team (MRT), will decimate access to cost-effective home care services that are key to generating critical health care savings sought by the State.

HCP finds it incredibly disturbing that the most cost-effective, lowest levels of care for the elderly, disabled and chronically-ill are being considered for wildly disproportionate cuts. Upon review of the 79 proposals presented to Governor Cuomo by the MRT, the proposals with the highest cuts to the system are primarily focused on home and community-based care.

HCP's analysis of what details are currently available on the home care proposals, indicate that the proposed home care cuts and unfunded wage mandate have a over a $1 billion impact on home care providers. When put into the context of cuts to other health care providers, home care is facing 36% of proposed cuts, yet home care represents just 12% of current Medicaid spending.

Home care is more cost-effective than institutional care in most cases and prevents hospitalization and re-hospitalizations. The State must invest in these services to help hold the line on health care spending – any proposed cuts to home care will ultimately result in an increase in costs in more expensive health care settings.

It is also critical to put current cuts in the context of the past three years when home care has been cut by nearly half-a-billion dollars. The result of a continuation of these conditions is less access to care, which means increased costs in other areas of the health care system.

Essential trend factor updates for 2008, 2009, and 2010 have been eliminated from home care programs, and providers are paying a health care assessment/tax of almost $15 million a year. A 1.1% rate reduction from September 2010 through March 2011 has also impacted providers as well as numerous costly and burdensome unfunded mandates. Agencies are struggling under the crushing weight of out-of-touch government policies, which direct scarce resources away from patient care.

Home care providers have persevered, although not without struggle, to adjust to what appears to be the new normal of operating on rates that barely even cover an agency's operating costs from 2008. Yet, they have continued to provide care to New Yorkers in need, even if it means taking a loss on a case-by-case basis.

What is also shocking is that in a year in which billions of dollars are being cut from Medicaid, the Administration has proposed to increase the cost of delivering home and community-based care by more than $400 million by including an unfunded worker wage mandate in the Executive Budget.

Agencies support their workers and would like to be able to do more, but are unable to do so within the current reimbursement structure. A home care worker wage mandate comes with a steep price tag for providers and the State's Medicaid system. In this fiscal environment and in the context of the work of this group, proposal that ignore significant costs to the system should not be under consideration. Nor should the State be mandating new floors on wages for a particular health care provider sector or category of worker.

If, however, the Governor and Legislature make the decision to move forward with such a mandate, the State must be willing to invest in this mandate and ensure that the funding reaches the employers of home care workers and thus the workers.

Overall, the evidence in support of home care is clear – the statistics and data provide convincing proof that cuts to home care programs are illogical. We urge you to look beyond the numbers to understand why support for home care is essential – it could be your mother, father, spouse, child, sibling – it could even be you who needs assistance with daily tasks, managing chronic conditions, rehabilitation from surgery, an accident or health event, or even life-sustaining skilled care. Where would you want to be?

Every day, thousands of individuals coping with the challenges associated with aging, disabilities and chronic illness wake up in their own bedrooms and enjoy the comforts of their home. Most of us take this for granted, but there is a renewed appreciation when it is threatened by the prospect of institutional placement.

Home and community-based care is more than lines in the budget—it is a sensible, rational and cost-effective approach to providing long and short term care that is focused on the needs and desires of real New Yorkers such as 3-year old Alex who receives nursing services at home; Jerry who is wheelchair-bound and needs help getting ready for work in the morning; and 86-year old Sophia who wants to stay in the home where she raised her family but needs help with activities of daily living such as bathing, getting dressed, and cooking.

Home care is many things to many people, but most importantly it is a philosophy that improves the quality of life for thousands of people who depend on home and community-based care and preserves scarce State resources by delaying and/or preventing use of more costly care settings.

We urge you to reject proposed cuts to home and community-based care.

2012-2012 MRT/Executive Budget

Impact on Home and Community-Based Providers

4% global Medicaid spending cap and a 2% across-the-board cut to providers of home and community-based services **(2011-12: $194.0 million total share and $97.0 million State Share; 2012-13: $194.0 million total share and $97.0 million State Share)**

A proposed global spending cap under Medicaid which would give the State Department of Health the unilateral authority to impose utilization controls, provider cuts or other spending reductions if State spending in Medicaid exceeds 4% in annual growth. A 2% across-the-board cut is proposed to keep the growth of Medicaid under 4%.

Rate cuts strike directly at funding needed to provide direct patient care. Patients and workers will experience the brunt of such deep cuts as agencies are forced to reduce services, programs, staff or, most troublesome, close their doors entirely. If enacted in conjunction with a trend factor elimination, home care providers will be operating at a reimbursement level that barely covers the level of expenses incurred before 2009, and this is a best case scenario.

It is also extremely troublesome to have the open-ended prospect of adjustments to reimbursement by the Department of Health if the caps are not maintained.

Elimination of the 2011 Trend Factor **(2011-12: $53.2 million total share and $26.6 million State Share; 2012-13: $63.0 million total share and $31.0 million State Share)**

- **LHCSAs: $25.8 million total share and $12.9 million State Share 2011-12; 2012-13 $30.0 million total share and $15.0 million State Share.**
- **CHHAs and LTHHCPs: $27.4 million total share and $13.7 million State Share 2011-12; 2012-13 $32.0 million total share and $16.0 million State share.**

The Executive Budget eliminates the 2011 Trend Factor. HCP strongly opposes this elimination and stresses that patients and workers will experience the brunt of such deep cuts as agencies are forced to make decisions about whether to reduce services, programs and staff, or to close. Demand for home care services is only anticipated to grow, but under this proposal access to home care services will shrink.

Without the full trend factor increase, agencies will continue to be challenged to deliver services in a 2011 economy with reimbursement levels based on expenses incurred in 2009. A two-year lag exists in home care rates. An agency's 2011 Medicaid rate is based on 2009 data, reported in 2010 to DOH and then paid in 2011, creating a two-year payment lag.

The trend factor is the only way to attempt to bring rates that are based on two year old data in line with today's costs of doing business. The trend factor is designed to make agencies closer to whole for the time period being reimbursed. In order for agencies to

continue to provide these essential services, they must receive a rate that is in line with today's costs.

The trend factor elimination further complicates operations for providers in counties with local living wage mandates. These local mandates impact State Medicaid programs, but increased reimbursement from the State is not available to providers that are subject to the local living wage laws. The two-year lag between incurred costs and reimbursement leaves them without funding for living wage increases for two years. Elimination of the trend factor exacerbates this reimbursement discrepancy.

Another reimbursement methodology issue that is exacerbated by trend factor eliminations is the Personal Care aide/nurse direct care and training regional ceiling. As established by Department of Health regulations, portions of the Medicaid Personal Care rate are subject to a regional ceiling, including the direct care and training cost component. Personal Care providers are not reimbursed by the Medicaid program for components of the rate that exceed the regional cap. Included in the aide/nurse direct care and training component are all wages and benefits for Personal Care Aides. As wages and benefits for workers increase, so do the direct wage components of the Medicaid Personal Care rate.

If the direct care component of the regional ceiling is surpassed as a result of Healthcare Workforce Recruitment & Retention (HWRR) initiatives or other market-driven forces (e.g., living wage requirements), providers will incur Medicaid costs that will not be reimbursed under the current Medicaid reimbursement structure. In fact, many providers are already at or near the regional ceiling and more will surpass that mark as time goes on.

The elimination of the trend factor also serves to lower the ceilings, resulting in even less reimbursement for wages and benefits.

Unfunded Home Care Wage Mandates **(Over $400 million annually once fully implemented with exponential growth anticipated)**

HCP strongly opposes this proposal, especially in the context of the current economic environment and efforts to control the cost of Medicaid. This proposal requires as a condition of provider enrollment in the Medicaid program that all Certified Home Health Agencies (CHHAs), Long Term Home Health Care Programs (LTHHCPs) and Managed Long Term Care (MLTC) programs comply with any local wage law within a geographic area in which they serve Medicaid recipients. It also gives the Commissioner of Health the discretion to raise home care worker base wages.

The home care industry has long supported workforce incentive programs, including improved wages, benefits, career advancement opportunities and specialty training to attract and retain valuable and committed caregivers. Despite the home care industry's commitment to its workers, providers can stretch scarce resources only so far, which is why the proposed unfunded wage mandate for home care workers raises significant concerns.

This is yet another unfunded mandate that merely drives up the cost of Medicaid and ultimately hurts patients and workers as providers are forced to make difficult decisions about their participation in Medicaid, which jeopardizes access to home care and increases utilization of more costly levels of care.

New York City Personal Care Reform **(2011-12: $114.0 million total share and $57.0 million State Share; 2012-13: $114.0 million total share and $57.0 million State Share).**

The Executive Budget proposes several reforms to the New York City personal care program, including:

- Implementation of "improved management and utilization for split shift and other high intensity users."
- Cap housekeeping cases at eight hours a week; and
- "Increase technology and improve assessment for all personal care recipients."

Few details are provided on these reforms, which hinders a more complete analysis of patient impact. It is critical that "improved management" does not equate to reduced utilization for patients with clinical and functional needs that justify their level of care. Similarly, an arbitrary cap on housekeeping services should instead be a focus on finding cases where levels of housekeeping services are not warranted.

HCP supports the increased use of technology to help keep patients safe in their homes. Tools such as Personal Emergency Response Systems (PERS) have made major advancements since first introduced, including built-in accelerometers that can help determine if a patient has fallen. Other patient and home-monitoring technologies should also be utilized, with appropriate reimbursement for their management.

Technology, however, cannot entirely replace human interaction and in no circumstances should it be used to reduce arbitrarily or eliminate visits by a personal care aide at an appropriate level.

HCP is also supportive of the development of a statewide uniform assessment tool for long-term care services; however, this proposal appears to only change the assessment process within New York City. Any assessment tool must be designed in a manner that calls on the expertise of health care professionals and must recognize the myriad clinical and functional characteristics that are represented by Medicaid home care patients.

Cuts to Home Care Utilization and Reimbursement/Implementation of a CHHA Episodic Payment System **(EPS) (2011-12: $200.0 million total share and $100.0 million State Share; 2012-13: $140.0 million total share and $70.0 million State Share)**

The Executive Budget proposes that effective April 1, 2012, Medicaid payments for services provided by CHHAs be based on a 60-day episodic payment similar to the Federal home health Prospective Payment System (PPS). An interim EPS system, effective April 1, 2011, is also proposed to transition to the full EPS. HCP continues to support the implementation of a CHHA Episodic Payment System (EPS) and was actively involved in the Home Care Reimbursement Work Group where EPS was discussed in detail, but is

alarmed by the huge level of proposed cuts as part of the EPS implementation as well as the unrealistic timeframe to implement both systems.

This interim EPS institute's provider spending limits based on a weighted average of the provider's average claims per patient during the 2009 base period and the statewide average for all CHHAs during the same period. The limit would be adjusted for the provider's case mix and for regional differences in labor costs. Providers that reduce aggregate per patient spending levels below their limit would receive a payment and providers that did not adjust their spending levels would have their payments further reduced.

The fully-implemented EPS is based on 60-day episodes that are adjusted for patient acuity and regional wage indexes. While HCP has long been supportive of sensible reimbursement methodologies that streamline the provision of care and encourage quality services, including PPS, HCP has serious concerns about enacting such sweeping reform in concert with massive budget cuts.

The EPS concept can be an effective reimbursement methodology; however, adjustments to the case mix index can be made to produce savings in the system. Any adjustments to the case-mix must be based on the actual cost of providing services and not used merely as a way to close budget deficits. Doing so will endanger access to home and community-based care.

Eliminate Spousal Refusal **(2011-12: $56.6 million total share and $28.3 million State Share; 2012-13: $113.0 million total share and $56.5 million State Share)**

This provision would require legally responsible relatives to declare income and resources when a dependent applies for Medicaid eligibility. This proposal could lead to greater Medicaid use and potentially increased nursing home usage.

Eliminate Case Mix Adjustment for AIDS Nursing Services in CHHA and LTHHCP **(2011-12: $4.0 million total share and $2.0 million State Share; 2012-13: $.62 million total share and $.31 million State Share)**

The proposal eliminates the case mix adjustment factors for AIDS Nursing Services provided by CHHAs and LTHHCPs.

Unfunded Billing Mandate **(2011-12: TBD; 2012-13: TBD)**

As part of the Office of the Medicaid Inspector General's (OMIG) proposal, there is a proposed billing requirement that mandates that all CHHAs and Personal Care providers that exceed $15 million in annual Medicaid revenues be required to hire vendors to review Medicaid claims prior to submission. This is yet another unfunded mandate on providers, which contributes to cost growth in the Medicaid system.

Managed Care and Home and Community-Based Care

HCP has broad concerns about the inclusion of home and community-based care services in any managed care program, including inadequate reimbursement to providers, patient restrictions, and instability in provider networks.

Mandatory Enrollment in MLTC Including Those in Need of Community-Based Long-Term Care Services in Excess of 120 Days

- Beginning April 2012 in New York City, individuals who need community-based long term care services for more than 120 days would be required to enroll in MLTC plans. This includes patients currently served in personal care, LTHHCP, and CHHAs and those who are new to long-term care. Mandatory enrollment would expand throughout the State as MLTC plans become available. Consumer Directed Personal Assistance Program (CDPAP) services would also be included. Similar efforts would be made across the State as MLTC plans become available.

Add Personal Care Services to the Managed Care Benefit Package

- Personal care services, including CDPAP, would be offered by Medicaid Managed Care programs.

Managed Care for Dual Eligibles

- Develop care models and reimbursement mechanisms for people who are dually-eligible and residing in the community or nursing homes.

Continuation of the Gross Receipts Tax at 0.35 percent **(2011-12: $14.8 million total; 2012-13: $14.8 million total)**

HCP strongly opposes the current 0.35% tax on gross receipts on all CHHAs, LTHHCPs, LHCSAs and personal care providers. For CHHAs and LTHHCPs the assessment is applied on gross receipts from all patient services and other operating income. For LHCSAs and personal care providers, the assessment is applied to gross receipts received from all personal care services and other operating income.

This tax applies to the majority of an agency's revenue. Additionally, the taxes that home care providers incur through this initiative are non-reimbursable; that is, there is no Federal pass-through mechanism making this yet another reduction in reimbursement. This cut comes directly out of a provider's bottom line and can be the difference between operating in the black or incurring losses.

Funding and Appropriations: Investing in Home and Community-Based Care

HCP supports the following measures and recommends that the Legislature approve these proposals. This funding is essential to recruiting and retaining home care workers during a time when the need for these valuable caregivers is growing.

- $11.2 million State share for the continuation of the Homecare Workforce Recruitment and Retention funding for Upstate and $136 million State share annually for continuation of the Homecare Workforce Recruitment and Retention funding for the New York City Home Attendant Program.

- Ongoing funding for the 3% rate enhancement for CHHAs, LTHHCPs, Private Duty Nursing, Subcontracting LHCSAs and Hospice.

- Continuation of Homecare Workforce Recruitment and Retention funding for CHHAs, LTHHCPs, AIDS Home Care, Hospice, Managed Long Term Care Programs and Subcontracting LHCSAs.

- An appropriation of $11.7 million for reimbursement to LHCSAs for Criminal History Record Checks. CHHAs and LTHHCPs are to be reimbursed for CHRCs through their Medicaid cost report rates.

- An appropriation of $2 million for the Home Care Registry.

Adequate Reimbursement Rates for High-Tech Nursing Services

HCP urges the Legislature to address abysmally low rates in the High-Tech Nursing program. The High-Tech Nursing Services delivered through the Private Duty Nursing Program (PDN) provide disabled children and adults with skilled nursing services in their homes. Many of these individuals rely on technology and certain devices to maintain themselves at home and in the community. These are two of the key populations for which the Legislature and Governor continue to provide community-based services under numerous nursing home diversion efforts.

Most troubling is that current reimbursement rates for these services are abysmally low, and in some instances, providers have higher reimbursement for personal care services than for nursing services. Some rates for RN and LPN services have not been increased since 1989.

Medicaid PDN payments are determined by each county and limited by a regional cap set by the New York State Department of Health. Counties may also set the rates according to one of three indicators: county-wide rates; rates specific to individual beneficiaries; or rates specific to agencies. Counties have complete control over what rate is paid and do not collect any documentation from providers to determine the actual costs of delivering the care.

In 2006 an initiative was passed in the budget to provide rate enhancements to those home care providers delivering nursing services to medically fragile children. These rate enhancements were intended to be helpful in recruiting and retaining the nursing workforce to service these children.

Unfortunately, while the funds have been released, the restrictions on the use of these funds have hampered the ability of agencies to address many issues related to workforce

shortage and better access to care. HCP recommends that these funds be used in the same way as worker recruitment and retention funds that are available for other home care workers. The ability to use these funds in a flexible manner will appreciably improve the ability of home care agencies to attract and retain nurses to serve this vulnerable population. Additionally, action must be taken to increase rates for adults receiving similar services through these programs.

Currently there is legislation to address this issue. A.2800 (Jacobs) and S.980 (Hassell-Thompson) would increase Medicaid reimbursement by $15 million for Private Duty Nursing services for the State Fiscal year 2011-12. The bill would allocate $20 million thereafter for such reimbursement on an annual fiscal year basis. The much needed increase in reimbursement this legislation provides would help to address nursing shortages and would recommit New York to quality health care for those most in need.

Office of Medicaid Inspector General

HCP firmly believes that there is no room for fraud or abuse in the home care industry or other sectors of the health care system; however, we also believe that the health care system in New York should not be criminalized.

There is growing concern that OMIG targets are being met by vigorously seeking and securing recoveries from providers that have made incidental or isolated errors, or have been held liable for the errors of others that play a role in the authorization or oversight of care. There is a significant difference between fraud and abuse and these other common circumstances that providers are being severely penalized for.

Ongoing audits of LHCSAs, CHHAs, LTHHCPs and TBI Waiver Providers have generated concern statewide about the overwhelming magnitude of recoupments being sought, the OMIG extrapolation methodology, providers being held liable for the roles and responsibilities of others, and the overarching concern that providers are subject to payment withholds and recoupments based on simple error, and not fraud. OMIG Extrapolation Methodology

HCP hears of providers that have completed an audit by OMIG and have watched $700 in billing errors turn into a bill for $500,000 to $700,000. These are numbers that will become increasingly frequent if the recovery targets continue to grow by this magnitude. They are also staggering figures that will close home care agencies. These drastic amounts are due to a specific formula the OMIG uses for expanding their audit findings to a large number of cases.

A health care system that is run in this manner will never survive, making access to care a real concern. HCP strongly urges you to become involved in this issue to seek a better understanding of the methodologies employed and oppose any methodologies that take a punitive approach to errors.

Liability for the Responsibility of Other Entities

Providers under OMIG audit are held responsible for the failure of other entities to fulfill their roles and responsibilities in the authorization or delivery of Medicaid services or have received inconsistent guidance from State agencies on State policy or regulation.

For example, this year one of our rural agencies with national accreditation was audited by OMIG and spent $60,000 unbudgeted dollars, for legal and staff services. In the end, the majority of the audit findings was that one of the county Department of Social Services offices was noncompliant with State regulations and because of that, the agency is facing possible disallowances of millions of dollars. This agency may now close, resulting in loss of jobs and patient services.

Another company with national accreditations and consistently clean DOH surveys has already spent $115,000 for legal services to address ongoing OMIG audits focusing on clerical errors. None of the findings in this case are related to patient care being delivered or its quality.

We urge you to oppose any sanctions on providers that are due to the responsibility of others and also promote consistency and accountability to State agencies relative to the guidance they provide. We ask the Legislature to encourage such agencies to work with the OMIG to develop uniform compliance policies and procedures.

Continuation of Home Care Contracting

HCP is pleased that the Governor did not include any proposals that threaten effective and efficient contracting relationships between personal care providers, Certified Home health Agencies (CHHAs) and Long Term Home Health Care Programs (LTHHCPs). The elimination of contracting was proposed in the 2009-10 Executive Budget based in part on the rationale that it creates inefficiencies in the home care delivery system.

The Legislature rejected this proposal, recognizing the efficiencies created by these long-standing arrangements. Several analyses, including an independent analysis from Loeb & Troper, one of New York's top 20 regional accounting firms, found that the "vast majority of tasks and resources associated with home health aide placement are exclusive to the LHCSA or the CHHA," confirming that contracting is an effective way to deliver home health aide services. This proposal would have sparked agency closings and severely disrupted the availability of care.

Regulatory Relief

The economic crisis for New York State is also a crisis for home and community-based care providers, which as a rule are small businesses in New York. The increasing difficulties in securing credit, rising wages and other costs of employing a workforce and delivery of care are becoming a crushing burden for home care providers.

The home care industry in New York is heavily regulated by the State and is facing costly new and expanding statutory and regulatory requirements despite an economic

environment that demands streamlining and flexibility. The fiscal and human resource costs of compliance greatly exacerbate the challenges home care providers have in serving their patients and families in the midst of budget cuts.

This regulatory overreaching imposes substantial additional costs on these agencies at a time when State reimbursement for home care services has failed to keep pace with these escalating costs. Furthermore, regulations are not always directly related to the health and safety of patients or workers. To address this, HCP sent numerous recommendations to the Governor's Office of Regulatory Reform and the Department of Health on how to improve the regulatory system including solutions to current challenges providers are facing on home health aide training programs, the Home Care Registry, survey inconsistencies and the anticipated return of the home care worker flu shot mandate.

HCP also recommends that all home care regulations, DOH policies, and reporting requirements be reviewed and assessed to determine whether or not they are necessary in the context of the current health care system. All regulations, policies, or reporting that are not essential for patient and worker health and safety or key policy goals should be repealed or suspended. These reviews should take place on a regular basis and all new regulations, policies or reporting requirements should also meet these criteria.

Conclusion

HCP urges the State Legislature to resist any more cuts to home care and instead open the door for constructive discussions with HCP on these recommendations. These recommendations make the home and community-based care system more efficient and remove the duplication and layers of administrative costs and establish the right care in the right setting at the right price.

In an effort to implement smart reforms for Medicaid and home and community-based care, HCP has authored a working document containing common-sense approaches to improving access to home care. *Home Care: Today's Solutions...Foundations for Tomorrow: Evolving approaches and recommendations on generating cost-saving efficiencies for both the State and providers in home and community-based care* (Winter 2001 Edition Working Document) proceeds HCP's testimony. It can also be found on HCP's Web site at www.nyshcp.org/content/aspx?id=306.

Thank you for the opportunity to speak to you today. As always, HCP staff is available to answer any questions you might have about the contents of this testimony or any other home care issue. We look forward to working with you in the coming months.

New York State Association of Health Care Providers, Inc.
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2011-2012 MRT/Executive Budget Proposals Overview (last updated 3/2/11)

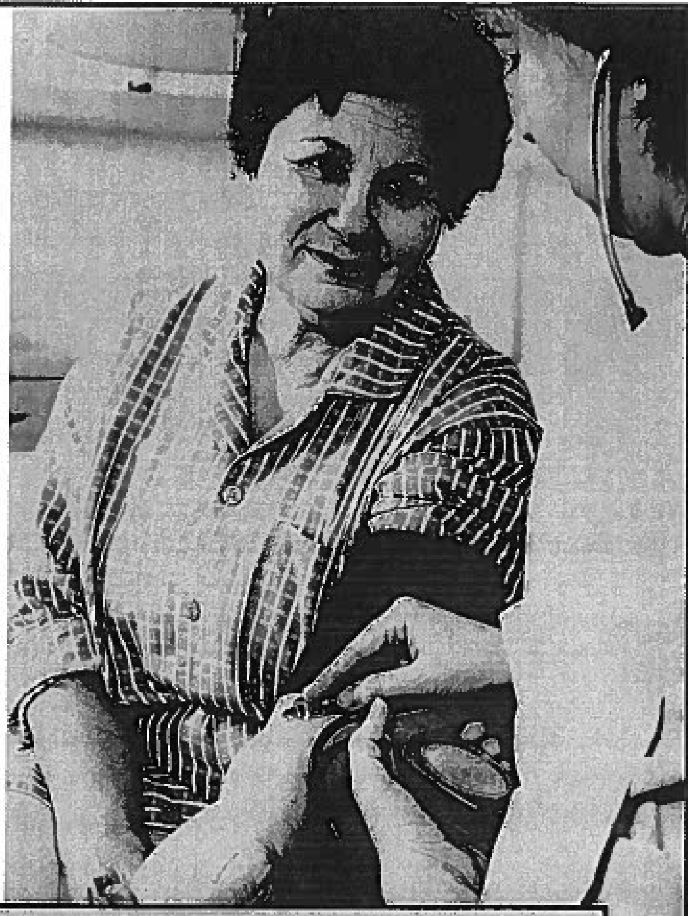
Medicaid Redesign Team Proposals: Medicaid		
Initiative	**Proposal**	**Impact**
2% Across-the-Board Rate Cut	2% rate cut to Medicaid home and community-based care providers.	2011-12: $97 million State share and $194 million total.
Eliminate 2011 Trend Factor	Eliminate the 1.7% Medicaid rate trend factor for 2011.	2011-12: $26.6 million State Share and $53.2 million total. Personal Care: $12.9 million State Share and $25.8 million total. Home Care: $13.7 million State Share and $27.4 million total.
"Home Care Worker Parity"	Requires as a condition of provider enrollment in the Medicaid program that all Certified Home Health Agencies (CHHAs), Long Term Home Health Care Programs (LTHHCPs) and Managed Long Term Care (MLTC) programs comply with any local living wage laws. Three-year phase-in.	2011-12: No State Impact Recognized by MRT. HCP analysis suggests $400+ million provider impact with eventual impact on Medicaid costs.
Reduce CHHA Reimbursement and Utilization via Pre-EPS Interim Payment System	Implement a provider-specific aggregate annual per patient spending limits effective April 1, 2011. The spending cap would be based on provider case-mix and regional wage index factors.	2011-12: $100 million State share and $200 million total.
CHHA Episodic Pricing System (EPS)	CHHA EPS, per the refinements made by the Home Care Reimbursement Workgroup, effective 4/1/12.	2011-12: Savings reflected in CHHA spending cap proposal. 2012-13: Net impact $69.9 million State share and $139.8 million total.

New York City Personal Care Reform	Reform personal care in NYC by implementing improved management and utilization for split shift and other high intensity users; cap housekeeping cases at eight hours a week; and utilize technology and an improved assessment for all personal care recipients.	2011-12: $57.0 million State Share and $114.0 million total share.
CHHA/Personal Care conflict and exception reports (OMIG)	Require that all CHHAs and Personal Care providers that exceed $15 in annual Medicaid revenues be required to hire vendors to review Medicaid claims prior to submission.	This is an unfunded mandate for certain providers. 2011-12: TBD
Eliminate case-mix adjustment for AIDS Nursing Services	Eliminate the case mix adjustment factors for AIDS Nursing Services provided by CHHAs and LTHHCPs.	2011-12: $2.0 million State Share and $4.0 million total.
MLTC Home and Community-Based Care	Effective April 2012 in New York City, individuals who need community-based long term care services for more than 120 days would be required to enroll in MLTC plans.	2011-12: $8.33 million State Share and $16.65 million total.
Managed Care for Dual Eligibles	Develop care models and reimbursement mechanisms for people who are dually-eligible and residing in the community or nursing homes.	2011-12: TBD
Managed Care Personal Care Services	Add Personal Care Services, including Consumer Directed Personal Assistance Programs services, to the Medicaid Managed Care Benefit Package in year 1 of a three-year phase into enroll current exempt patient categories.	2011-12: TBD
Gross Receipts Tax	Continuation of the 0.35% Gross Receipts Tax (GRT).	2011-12 $14.8 million total.
Uniform Assessment Tool (UAT)	Continues development of UAT to standardize individual needs assessment across programs.	2011-12: No Savings 2012-13: No Savings 2013-14: $5 million State share and $10 million total.

Eliminate Spousal Refusal	Requires legally responsible relatives to declare income and resources when a dependent applies for Medicaid eligibility.	2011-12: $28 million State share and $56 million total.
2011-12 Executive Budget		
Upstate Personal Care	Continuation of the ongoing Homecare Workforce Recruitment and Retention funding for Upstate Personal Care.	Continuation of funding 2011-12: $11.2 million State share and $22.4 million total.
New York City Home Attendant/ Personal Care	Continuation of the ongoing Homecare Workforce Recruitment and Retention funding for the New York City Home Attendant/Personal Care Program.	Continuation of funding 2011-12: $136 million State share and $272 million total.
3% Rate Enhancement—CHHAs, LTHHCPs, Private Duty Nursing, Hospice	3% Recruitment and Retention rate add-on.	Ongoing funding.
Additional funding for CHHAs, LTHHCPs, AIDS & MLTC programs	Continued Homecare Workforce Recruitment and Retention funding.	Continuation of funding 2011-12: $50 million State share and $100 million total.
Criminal History Record Check Reimbursement for LHCSAs	Funds are appropriated to reimburse LHCSAs, CHHAs and LTHHCPs for CHRCs.	$11.75 million is appropriated for 2011-2012.
Uniform Assessment Program	Appropriation to fund the establishment of a uniform assessment tool.	$4.8 million for 2011-2012.
Traumatic Brain Injury/ HCBS Waiver Program Reimbursement	These funds are appropriated for services for persons enrolled in the Federally-approved Home & Community-Based Services (HCBS) Program to prepare for an increase in recipients moving out of nursing homes.	Appropriates $13.2 million for 2011-2012.
Expanded In-Home Services for the Elderly Program (EISEP)	Maintains funding for the EISEP program.	$15.3 million for 2011-12.
Home Health Aide Registry	Appropriates $2 million for the Department's expenses related to the Home Health Aide Registry.	$2 million for 2012-2012.

Representing home and community-based care

Christine L. Johnston, President



Home Care: Today's Solution...Foundations for Tomorrow

Evolving approaches and recommendations on generating cost-saving efficiencies for both the State and providers in home and community-based care

Winter 2011 Edition
Working Document

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Executive Summary of Home Care Reform Proposals

The preservation and enhancement of home and community-based services is essential to providing cost-effective and appropriate care to New Yorker's today and for generations to come. The State must take decisive action on the following recommendations to stabilize home and community-based care and rebalance the State's long-term care system to capitalize on the benefits of home care.

- Generate Medicaid cost savings over time through the aggressive use of home and community-based care.
- Create a Home and Community-Based Care Regulatory Reduction Workgroup operating with an expedited timeframe.
- Eliminate Duplicative Department of Health surveys; recognize national accreditations; scale back regulatory requirements; and increase flexibility.
- Implement a Uniform Assessment Tool to ensure consistency across the State in the authorization of services and develop and assess the use of Regional Long-Term Care Assessment Centers.
- Streamline home care programs.
- Reform Medicaid reimbursement methodologies to ensure fair, accurate and timely reimbursement.
- Eliminate existing and prevent the creation of unfunded State regulatory, reporting, wage or other mandates.
- Support investment in and adjust regulations accordingly to embrace home care technology.
- Streamline the administration of Medicaid services.

New York: A Pioneer in Delivering Home and Community-Based Care

The New York State Association of Health Care Providers, Inc. (HCP) is a statewide trade association representing home and community-based care providers through advocacy, information and education. Founded in 1974, HCP represents approximately 500 offices of Licensed Home Care Services Agencies, Certified Home Health Agencies, Long Term Home Health Care Programs, Hospices and related health organizations throughout New York State. Through a strong network of regional chapters and an active State office in Albany, HCP is a primary authority of the health care industry.

For decades, government and health care industry leaders have discussed the need to establish a cost-effective system of providing quality care to New York's residents and an expanding population of aging citizens. Today, the discussion about how to provide long and short-term care efficiently and effectively continues with an acute sense of urgency as government spending on health care services has swelled and revenue has dwindled. Now, more than ever, it is critical that government and health care industry representatives come together to secure the future viability of the State's health care system.

New York State has been a leader in developing common-sense approaches to delivering cost-effective care in the comfort and security of the home setting. The financial benefits of providing home and community-based care are clear and the positive benefits to recipients, families and communities are indisputable.

Although New York's home and community-based care programs have served as a model to other States and nations, there is always room for improvement. Because of its value to individuals and the State, home care will continue to play a growing and important role in the care delivered to New York's elderly, disabled, and chronically-ill. Real people and real families depend on home care, and it is the State's responsibility to ensure that it remains accessible.

As a primary authority on home and community-based care, HCP takes seriously its responsibility to work with government and home care providers to verbalize industry concerns and propose solutions to improve the delivery of home and community-based care. Home care offers common-sense solutions to addressing the State's most immediate budgetary concerns and continued investment in home and community-based care builds on a solid foundation of cost-effective and patient-preferred care.

This document offers HCP's preliminary insights on how to best move forward with improving New York's home and community-based care programs and to safeguard home care for current and future generations.

Find HCP on the Web at:
www.NYSHCP.org www.HomeCareInfo.org www.Facebook.com

An electronic version of this report is available at www.nyshcp.org/content.aspx?id=306

Cost-Savings Over Time Through Aggressive Use of Home Care

Home and community-based care is preferred by patients and their families. It allows those facing illness, disability and aging to maintain their dignity, respect, privacy and comfort. Home care also delivers extreme value to the State and taxpayers. On average, home care services are half the cost of care provided in a skilled nursing facility (Appendix A).

Unlike institutional care, family members typically share responsibility for the delivery of home care services, significantly reducing the cost burden on Medicaid. Coordination of services between paid and unpaid caregivers is a key part of a home care agency's responsibilities and is critical to keeping a patient successfully and safely at home.

Over $316 million could be saved if 10% of New York's Medicaid institutional care population utilized home care instead.

HCP's analysis of long-term care Medicaid spending data by county revealed that if just 10% of current institutional long-term care patients received their care at home, the State could save over $316 million in just one year (Appendix B). If just 5% of Medicaid recipients receiving nursing home care received services in the home setting there would still be a Medicaid savings of over $158 million a year. And the more care that is diverted from higher cost settings as a result of greater efforts to utilize home and community-based care, the greater the ultimate savings to the State of New York.

A study published in the January 2009 edition of Health Affairs addresses the impact that greater investment in home and community-based care can have on State finances. Researchers found that States that invested more in home care experienced a 15.3% decrease in nursing home spending, while States that invested less encountered 3.4% growth in nursing home expenses. The report concluded that "home and community-based services programs may be one instance in which offering people greater choice also reduces cost."

The United States Congress sent a powerful message on the value and benefits of home and community-based care with the passage of the Patient Protection and Affordable Care Act (ACA) of 2010. The landmark health care reform legislation included several provisions that seek to expand the use of home care and even went so far as to create a voluntary long-term care insurance program called the Community Living Assistance Services and Supports (CLASS) Act to help seniors pay for home care services.

The bill also included a section outlining the "sense of the Senate regarding long-term care." The statement recognized that it is critical for States to offer ample access to home and community-based care, particularly for those who are facing institutionalization. The bill language urged Congress to address long-term services and supports in a comprehensive way that guarantees elderly and disabled individuals the care they need and noted that long-term care services and supports should be made available in the community.
A more aggressive campaign to encourage and support the use of home and community-based

care for appropriate patients is necessary to increase the use of cost-effective home care services. The State should consider provisions in the ACA that provide an enhanced Federal Medical Assistance Percentage (FMAP) for States that take advantage of options to expand home and community-based care. Some of these opportunities include the Community First Choice Option, which provides a 6% FMAP increase, and the extension of the Money Follows the Person program, which seeks to transition nursing home residents back into the community.

Greater Home Care Efficiencies Through Regulatory Reform

The home care industry faces growing regulatory compliance costs that drain scarce fiscal and human resources. Home care in New York is heavily regulated by the State and is facing new and expanding statutory, regulatory and policy requirements despite an economic environment that demands streamlining. The fiscal and human resource costs of compliance, with often inconsistent regulations or policy interpretations, greatly exacerbate the challenges home care providers have in caring for their patients in the midst of budget cuts and changing health care system operating realities.

Many of these requirements, which impose unrealistic timeframes and burdensome data entry and paperwork, are not directly related to the health and safety of patients or workers. At a time when all have been asked to be part of the solution to the fiscal challenges the State faces, regulatory flexibility, creative solutions, and streamlining are imperative.

Review and Eliminate Regulatory Burdens

HCP recommends the creation of a Home and Community-Based Care Regulatory Reduction Workgroup to review, on an expedited timeframe, all home care regulations, Department of Health and other relevant State agency policies and reporting requirements to determine what regulations, policies, reports or other State-mandated requirements are necessary for the health and safety of patients or workers and continue to serve a valuable purpose in the context of the current health care system. The Workgroup would be charged with making regulatory reduction and other recommendations for increasing flexibility and streamlining.

HCP recommends the creation of a Home and Community-Based Care Regulatory Reduction Workgroup.

The Workgroup also would be responsible for reviewing and making recommendations on the impact of all new regulations, policies or reporting requirements that impact home and community-based care prior to implementation. The majority of home care Medicaid reimbursement is based on a cost-related reimbursement methodology, and increases in administrative costs directly impact Medicaid rates, resulting in rate increases and higher Medicaid expenditures. A significant, yet safe, reduction in administrative burdens is in the best interest of eliminating inefficiencies and lowering expenditures in home care.

Eliminate Duplicative DOH Surveys

A near continuous flow of surveys and audits consumes a hefty amount of scarce resources at the provider and State agency level. Providers operating multiple programs can be faced with numerous State audits or surveys a year, many of them duplicative in their focus. When providers operate in more than one county, the numbers of potential surveys increase dramatically.

HCP recommends the creation of one streamlined provider survey to eliminate duplication.

HCP recommends the creation of one streamlined provider survey, including waiver program surveys if applicable, that is consistent among all regional offices statewide. This tool will allow providers with two or more branches and/or providers serving more than one county to benefit from fewer annual surveys, while still ensuring that the collection of appropriate information and oversight necessary to protect the health and safety of patients is preserved.

This will also save State agencies significant funds in staff resources and administrative hours, as they will have to prepare for and conduct significantly fewer surveys. Just one DOH surveyor could survey an entire agency on its various programs, eliminating the cadre of surveyors, conflicting survey interpretations and actual surveys.

Deemed Status Reduces Oversight Burden

A number of home care agencies in New York State follow the standards, are surveyed and receive accreditation from national oversight organizations, such as The Joint Commission (JCAHO) or the Community Health Accreditation Program (CHAP).

The level of professionalism and quality assurances that are necessary to achieve these accreditations should be recognized by the Department as it conducts ongoing surveillance. The State should consider the accreditation of providers as sufficient evidence of regulatory compliance and focus surveys on those that are not accredited–placing a particular emphasis on those providers that have a documented history of problem surveys.

Scale Back Regulatory Requirements and Increase Flexibility

New York State home care regulations that go above and beyond the Federal minimums should be reviewed and scaled back appropriately. With the exception of regulations that are unique to New York's home care industry or are necessary to remain in compliance with other State laws or programs, Federal standards should be utilized.

A concerted effort must also be made to identify programs and regulations that could reduce expense and relieve regulatory burden by creating more flexible regulatory approaches. For example, home care worker training programs can be made more efficient and less costly by permitting more collaborative training efforts, greater provider flexibility as to how frequent training programs must be run and where, and what training must occur to retain approvals.

Providing the Right Care in the Right Setting

Uniform Assessment Tool for Long-Term Care Services

The State must aggressively move forward with the development of a Uniform Assessment Tool.

The development and implementation of a uniform assessment tool to measure a patient's need for long-term care services available through the Medicaid program is a necessary step toward establishing more consistent and appropriate levels of care throughout the State. The creation of such a tool has long been a topic of conversation in the State, but has never been fully realized.

It is time to move forward aggressively with the development of a uniform assessment tool in a manner that calls on the expertise of health care professionals. It is essential to create a tool that sufficiently recognizes the myriad clinical and functional characteristics that are represented by Medicaid home care patients. No two patients are exactly alike and the tool must be flexible enough to recognize variations in cognitive needs and social supports. The tool must also include measures that are appropriate for patients with chronic diseases or basic long-term care needs, whose conditions are not likely to improve over time.

Regional Long-Term Care Assessment Centers

Regional Long-Term Care Assessment Centers could be an important component of ensuring regional and Statewide consistency in the authorization of services.

The 2009/10 State Budget established the Regional Long-Term Care Assessment Center demonstration. The Centers are designed to assume responsibility for assessment, authorization and related activities for a range of Medicaid long-term care services with the goals of improving the administration of services; achieving improved accuracy and standardization of assessments and authorizations; identifying changes and providing recommendations to further improve management of such programs; and ensuring that consumers are entitled to the same medical assistance benefits and standards as if authorizations and assessments were made by a governmental entity.

HCP recommends that the Regional Long-Term Care Assessment Center demonstration, currently sited in Brooklyn and the mid-Hudson region, move forward as soon as possible. The demonstration will provide necessary insight into how this major structural change will impact patients, providers, and the Medicaid program.

The regionalization of Medicaid home care programs could prove extremely effective at introducing greater efficiency into provider and government administration of services. There are significant variations from county to county in the way Medicaid home and community-based services programs are managed. With 62 counties in New York State and multiple programs operating in each county, the chance of costly and confusing inconsistencies among counties and

programs results in problems for providers, patients and the State.
Additional assessment centers could help alleviate this variation, but should not be implemented until sufficient information exists on their success. The demonstration is critical in determining if the regional centers are a viable option, and if so, what adjustments need to be made before a widespread implementation. The implementation of additional long-term care assessment centers without an initial analysis of the program could result in unexpected and unintentional problems that create barriers to accessing care.

Long-Term Care Program Streamlining

In New York State there exists a broad array of home and community-based care services, program options, and entry points into the health care system. While many programs are similar in the types of benefits provided, there are various nuances in the rules and regulations that govern each program. Small program variations can come at a big expense for providers and the State.

LTC program streamlining can increase program efficiencies, saving money for providers and the State.

Compliance with program regulations and policies require immense administrative resources. Streamlining the governance of programs, coordination of services, and finding the right place for the right person more efficiently can reduce the level of administrative compliance oversight, expense, and confusion, which leaves greater resources for the delivery of services.

Direct savings can be realized by the State and other agencies with responsibility for program administration by streamlining or consolidating programs and their oversight.

There are many home and community-based care programs that provide long-term care options that should be included in discussions about streamlining.

- Home Health Care
- Personal Care/Home Attendant
- Private Duty Nursing
- Hospice
- Long Term Home Health Care Program (LTHHCP)
- Traumatic Brain Injury (TBI) Waiver Program
- Nursing Home Transition and Diversion (NHTD) Waiver Program
- Consumer Directed Personal Assistance Program (CDPAP)
- Program of All Inclusive Care for the Elderly (PACE)
- Expanded In-Home Services for the Elderly Program (EISEP)
- Care at Home (CAH) Waiver

Investments in Home Care's Future

Adequate Reimbursement—Appropriate Reimbursement Methodologies

CHHA EPS

Reform Medicaid reimbursement methodologies to ensure fair, accurate and timely reimbursement.

Since 2008, HCP supported the creation of a workgroup to consider the creation and utilization of an Episodic Payment System (EPS) for Certified Home Health Agencies (CHHAs). The resulting Home Care Reimbursement Workgroup established in 2009 was a positive opportunity for stakeholders to meet and address ideas and concerns surrounding an EPS. HCP was an active public participant in the process and made recommendations and raised concerns about the Department's original EPS proposal, many of which were taken into consideration and resulted in critical changes to the proposed EPS.

HCP supports an EPS for CHHA services, but the new reimbursement model must be refined, tested and implemented with industry guidance. Analysis by the Home Care Reimbursement Workgroup (HCRW) found that OASIS – the assessment tool used as a basis for the new model - does not capture all of the needs of CHHA Medicaid patients, resulting in insufficient reimbursement that could severely impact an agency's ability to deliver services. Additional refinements based on HCRW member feedback significantly improved the reimbursement model.

Special Needs CHHA patients, with unique and often the most complex needs, were still disproportionately impacted by the EPS model developed by DOH in 2009. A new model should be tested and refined to ensure that it addresses these program variations.

Personal Care Technical Advisory Council

Just as HCP supported an open dialogue addressing the CHHA reimbursement system, HCP supports the creation of a Technical Advisory Council (TAC) to review the State's current Medicaid Personal Care reimbursement methodology. The TAC should be comprised of providers participating in the Medicaid personal care program.

New York's Medicaid Personal Care rate setting methodology is a roadblock to equitable and adequate reimbursement that threatens the financial stability of agencies, ultimately impacting the elderly, disabled and chronically-ill who receive care in the home.

The current cost-related methodology results in rates that do not reflect actual expenses, particularly because rates are based on two year old cost data. Medicaid cost reporting is burdensome, expensive, and fails to consider dramatic cost increases such as rising fuel prices and local living wage mandates in a timely manner.

Other components of the rate setting process, such as regional rate ceilings and trend factor eliminations make operating under the current personal care reimbursement methodology even

more challenging. Factor in significant delays in State Plan Amendment approvals resulting in the prolonged payment of erroneous rates. There is also a great administrative burden to monitor the use of lines of funding with specific spending requirements. The current system becomes a major roadblock to working effectively and efficiently within the personal care program.

Reform Payment Systems for Critical High-Tech Nursing Services

High-Tech nursing services, which enables thousands of severely disabled, technology-dependent patients, to remain in the community and out of more costly institutional care, are paid abysmally low reimbursement rates. The Private Duty Nursing (PDN) program reimbursement methodology must also be reviewed and reformed. Many of the PDN patients are children and these services help keep them at home with their families.

Currently, New York State is experiencing a critical shortage of nurses for the PDN program. A major factor is that rates of reimbursement have not kept pace with market demands. In some areas of the State, rates have not changed in well over a decade. This makes recruiting and retaining qualified nurses particularly difficult, including nurses trained in specialty areas such as technology-dependent pediatric care. In the past, the death of a seriously ill child in Central New York was a direct result of the inadequate nursing staff. The tragic misfortune experienced by the family demonstrates that the scarcity of services has reached crisis proportions.

Local social services districts often authorize more service hours than agencies can fill, which results in the most vulnerable disabled children and adults deprived of care or institutionalized-generally at a significantly higher cost for the State. Reforming the structure of the program and reimbursement methodology is critical.

Eliminate and Prevent Unfunded Mandates

Regulations, reporting requirements, registries, background checks, wage and benefit requirements, transition to new technologies, changes to training programs, mandatory immunizations, and countless other unfunded mandates continue to consume scarce financial and human resources from home and community-based care providers. In an environment of fiscal constraint and evolving health care systems, it is critical that the State seek to eliminate existing unfunded mandates and make a concerted effort to prevent new unfunded mandates from being enacted and implemented.

Unfunded Wage Mandates Unsustainable

A strong, caring and dedicated workforce of 200,000 individuals is the backbone of the home care industry. Home care workers are an essential component of keeping the elderly, disabled and chronically-ill in the comfort of their own homes.

Any wage and/or benefit mandate must not be made without considering implications to the entire home care system.

The home care industry is extremely supportive of its workforce and strives to attract and retain valuable and

committed caregivers. Agencies provide a variety of worker benefits, including flexible scheduling, paid time off, insurances, employee recognition programs, and educational opportunities. These benefits help retain a well-trained, compassionate workforce, which translates into better patient care.

Reimbursement rates, unfortunately, have not included critical annual updates to reflect increased business expenses and rising worker wages and benefits. For over two decades, home care has had rate cuts and growing regulatory burdens, and faces more in Washington, D.C. and Albany. In the past three years alone, New York's Medicaid home care providers have been subject to over $400 million in budget cuts and taxes.

In 2010, a proposal sought to extend local living wage mandates to all home care employees working in New York City and Nassau, Suffolk and Westchester counties. HCP estimated that this would have cost providers, and ultimately the Medicaid system, well over $400 million a year with exponential increases every year thereafter (APPENDIX C).

Home care supports its workforce, but unfunded living wage laws are not sustainable. Any wage and/or benefit mandate must be funded and all providers must be assured that any funding made available, reaches the employing provider in its entirety. Particularly in this economic environment, any unfunded mandates will result in lost jobs and reduced access to care.

Resources for Home Care Technology

New technology has the potential to modernize the home care industry and save significant State resources. HCP urges the State to invest in funding for telehealth equipment and services, electronic health records (EHRs) and medication management devices in order to save in the long-term. Such tools enable home and community-based providers to care for more patients more efficiently, while also improving the quality of care.

Investments in home care technology have the potential to generate significant savings.

In the current reimbursement environment, it is extremely difficult for home care providers to make investments in technology. State funding should be available to home and community-based providers to the same extent that it is provided to other sectors of the health care system.

Home care agencies offer valuable clinical data to physicians managing patients' primary care. Through home monitoring of vital signs and physical activity, physicians can access key medical indicators, such as pulse, weight, medication adherence, blood sugar, etc. This data is a valuable resource for physicians who strive to improve care across settings and reduce avoidable, unplanned hospitalizations, which drive up health care costs. In order to achieve this coordination and reduce preventable expenses, initial investments in the monitoring and EHR technologies must be made.

Moving Too Fast Without Adequate Input and Resources

Payment Bundling Jeopardizes Patient Access and Choice

Payment bundling entails allocating a set amount of funding based on patient acuity to reimburse hospitals and physicians for an episode of care. Medicare demonstrations have used payment bundling to pay for hospital and physician care as well as the first thirty days of post-acute care provided by home care providers.

Payment bundling raises significant concerns for home care providers because most discussions about bundling assume that bundled payments would be made to hospitals. As a result, hospitals retain immense control over the process. This type of control over post-acute care services reduces patient access to home care and, if home care services are approved, patients could have limited choice of providers.

Payment bundling is designed, in part, to reduce patient re-hospitalizations; however, these arrangements remove control over already scarce resource from home care providers, threatening access to post-acute services needed to prevent re-hospitalizations. Efforts to examine this type of reimbursement methodology, as well as others, should be done as demonstrations to ensure that the methodology works for all providers and the patients involved.

State Consolidation of Medicaid Management

New York State is currently in the process of planning and implementing the transfer of responsibilities of New York State Medicaid from the county to the State level. The New York State Medicaid Administration November 2010 Report recommends the creation of a uniform assessment tool, which HCP supports. The report also recommends further exploration of regional long-term care assessment centers. This "exploration" should entail a review of the centers created under the Regional Long-Term Care Assessment Center Demonstration. The creation of new regional centers should be considered in the context of adequate data from the current demonstration.

The report calls for a meeting of stakeholders to consider a "point of entry" approach for all long-term care services in New York State. There are currently several county-based single point of entry entities as part of the State's NY Connects program. These offices serve as a resource for residents seeking information about long-term care options. The level and quality of these point of entry organizations vary by county. Some are exceptional patient resources that work well with providers to secure care for residents efficiently, while others are not quite as advanced and can sometimes complicate the provision of care.

HCP looks forward to continuing to be part of the State's discussion surrounding the establishment of a single point of entry system.

Real People and Families Depend on Home Care

Nearly 800,000 New York residents receive home and community-based care services. Over 200,000 New Yorkers earn a living as home care workers, and millions of New Yorkers are directly impacted when loved ones receive home care services.

The preservation of the State's home and community-based care system is critical to so many New Yorkers, which is why home care policy proposals must be carefully considered before being implemented. Real people and real families will be hurt if the State enacts deep cuts and dramatic and fast-paced policy shifts that change home and community-based care programs.

Home care providers recognize the immense challenge that the State continues to face, and have already made significant sacrifices to help balance recent State budgets through hundreds of millions of dollars in cuts. We must not surrender the immense progress our State has made in increasing access to home care services that are both cost-effective and preferred by patients of all ages and their families.

Home and community-based care is critical to reducing and preventing the use of care in more costly health care settings. Any cuts must be put in the context of their impact on the entire health care continuum. Additionally, policy proposals that impact the structure and operations of home care programs must include input from industry leaders who are best able to understand the impact such proposals would have on access to care.

HCP looks forward to working with Governor Cuomo and the State Legislature to address the deficit in a reasonable and measured manner that preserves access to home and community-based care for all New Yorkers.

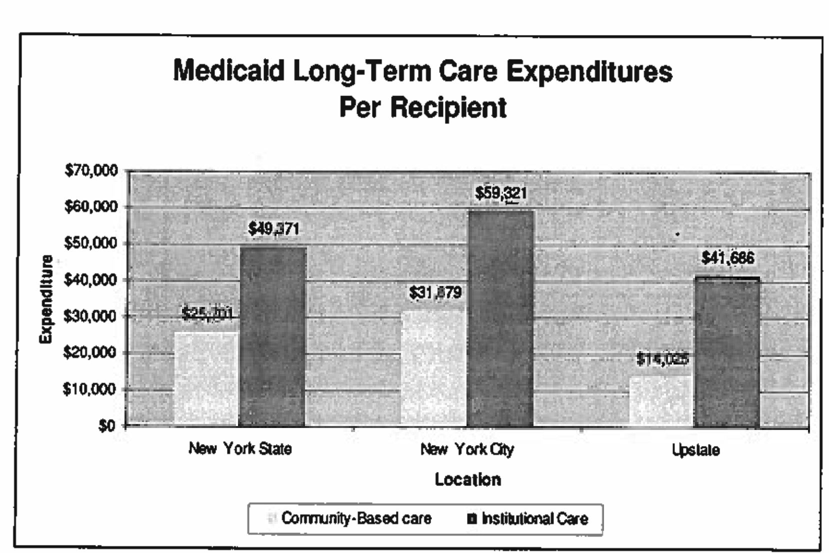
Home Care is the Cost-Effective Solution for Long-Term Care

New York must invest in home and community-based care

Home Care Saves Medicaid Dollars

The average home care visit costs significantly less than a day of nursing home or inpatient hospital care. This is true across all regions of the State.

According to 2009 data obtained from the New York State Department of Health, compared to individuals who receive their care at a facility, the State spends approximately half as much on individuals who receive long-term care at home.



Home Care is in Financial Distress

Home and community-based care programs are in financial distress. Home care has sustained over $400 million in cuts since 2008, including reimbursement rate cuts, a gross receipts tax and the elimination of the 2009 and 2010 trend factor. Providers are also experiencing a $22.5 million FMAP Contingency Fund payment reduction through the end of the State Fiscal Year.

Home care providers are saddled with other significant financial burdens, including outdated reimbursement cost ceilings, volumes of unfunded regulatory mandates, local unfunded living wage laws, the MTA payroll tax, unsustainable workers' compensation assessments, and the sizable costs of defending against aggressive audits by the Office of the Medicaid Inspector General (OMIG).

New York State Must Invest in Home Care

The State needs home care to help hold the line on health care spending. A 2009 *Health Affairs* report shows that states that invested more in home care experienced a 15.3% decrease in nursing home spending, while states that invested less encountered 3.4% growth. To ensure the stability of the State's Medicaid Program, New York must invest in home and community-based care.

APPENDIX B: State Medicaid savings resulting from the transfer of current institutional care recipients into a home and community-based care setting.

	Institutional Long Term Care			Medicaid Savings from Transition to Home Care	
	Dollars	Recipients	Dollars Per Recipient	Savings 5% Transfer Rate	Savings 10% Transfer Rate
Statewide	$8,935,321,952	146,837	$47,231	$158,075,541	$316,151,082
New York City	$3,645,472,853	67,348	$54,129	$74,925,021	$149,850,043
Upstate	$3,208,806,790	78,176	$41,048	$105,619,678	$211,239,352
Albany	$83,968,858	2,330	$36,995	$2,717,900	$5,435,799
Allegany	$10,295,043	344	$29,927	$412,699	$825,399
Broome	$59,016,093	1,842	$32,039	$2,780,086	$5,536,172
Cattaraugus	$24,269,372	669	$36,828	$1,059,086	$2,118,172
Cayuga	$19,412,663	663	$29,728	$819,110	$1,639,221
Chautauqua	$44,435,728	1,223	$36,333	$1,696,171	$3,392,342
Chemung	$31,280,323	901	$34,717	$1,355,786	$2,711,573
Chenango	$18,878,318	489	$38,885	$771,763	$1,543,526
Clinton	$18,164,274	582	$31,210	$564,551	$1,129,102
Columbia	$19,843,518	516	$38,456	$652,407	$1,304,814
Cortland	$11,162,899	341	$32,734	$384,151	$759,302
Delaware	$16,516,861	404	$40,884	$663,730	$1,327,459
Dutchess	$82,409,509	2,029	$40,618	$2,560,648	$5,121,297
Erie	$248,287,808	7,226	$34,362	$9,362,974	$18,726,948
Essex	$9,676,903	294	$32,911	$415,787	$831,574
Franklin	$11,542,822	390	$29,597	$338,642	$677,284
Fulton	$19,522,109	534	$36,558	$650,917	$1,301,836
Genesee	$16,082,317	479	$33,575	$667,952	$1,335,905
Greene	$11,652,465	326	$35,774	$422,113	$844,226
Hamilton	$1,647,461	50	$32,949	$71,629	$143,259
Herkimer	$24,373,976	725	$33,619	$976,656	$1,953,312
Jefferson	$27,068,369	833	$32,496	$1,027,962	$2,055,924
Lewis	$7,287,291	225	$32,399	$300,557	$601,114
Livingston	$17,641,727	429	$40,586	$813,404	$1,626,808
Madison	$19,770,627	550	$35,947	$855,629	$1,711,259
Monroe	$180,174,762	5,146	$35,010	$5,897,657	$11,795,313
Montgomery	$18,781,419	497	$37,790	$639,691	$1,279,382
Nassau	$391,644,881	7,080	$55,225	$9,763,781	$19,527,562
Niagara	$62,354,509	1,799	$34,913	$2,335,679	$4,671,358
Oneida	$89,961,876	2,843	$31,615	$3,115,880	$6,231,760
Onondaga	$128,061,882	3,327	$38,492	$4,747,246	$9,494,493
Ontario	$30,124,682	787	$38,279	$950,145	$1,900,290
Orange	$86,492,240	2,089	$41,321	$2,469,841	$4,939,682
Orleans	$9,762,706	309	$31,595	$329,977	$659,954
Oswego	$29,003,633	874	$33,185	$1,204,634	$2,409,268
Otsego	$17,962,562	470	$38,197	$650,752	$1,301,504
Putnam	$20,643,860	439	$46,797	$461,820	$923,639
Rensselaer	$46,669,203	1,266	$36,852	$1,733,877	$3,467,754
Rockland	$83,414,302	1,724	$48,384	$2,274,778	$4,549,556
Saint Lawrence	$26,963,395	829	$32,513	$894,759	$1,789,517
Saratoga	$43,119,449	1,229	$35,086	$1,365,871	$2,731,743
Schenectady	$39,807,018	1,088	$36,585	$1,437,761	$2,875,522
Schoharie	$5,658,408	153	$36,983	$196,564	$393,128
Schuyler	$4,463,664	132	$33,739	$89,409	$198,818
Seneca	$9,920,483	270	$36,743	$432,239	$864,487
Steuben	$28,410,113	826	$34,395	$1,284,479	$2,568,969
Suffolk	$470,675,800	8,970	$52,472	$15,592,960	$31,195,599
Sullivan	$31,904,930	748	$42,760	$1,099,504	$2,199,008
Tioga	$10,969,223	360	$30,248	$418,824	$837,648
Tompkins	$12,646,186	436	$29,073	$476,145	$952,289
Ulster	$56,044,155	1,369	$40,939	$1,450,999	$2,901,999
Warren	$17,141,209	509	$33,676	$684,583	$1,369,167
Washington	$16,991,684	488	$34,819	$693,689	$1,387,379
Wayne	$26,423,478	616	$42,894	$1,143,545	$2,287,090
Westchester	$324,344,656	6,687	$48,504	$7,793,312	$15,586,624
Wyoming	$10,670,061	283	$37,703	$454,977	$909,955
Yates	$6,909,642	185	$37,349	$268,379	$536,757

NYSDOH/OHIP FFY09 Reference File

APPENDIX C: Advocacy document from 2010-11 State Budget negotiations detailing impact of expansion of unfunded wage mandates in New York City, and Suffolk, Nassau and Westchester counties.

Home Care Needs State Support to Increase Worker Wages

Unfunded Living Wage Mandates Jeopardize Patient Access to Care

The home care industry is committed to its workers; they are the backbone of the home care delivery system. Unfunded living wage laws are not the way to recognize workers, because they do not address the serious fiscal implications they create.

HCP's analysis of 2007 Department of Health Statistical Report data found that increasing home health aide wages to meet current local personal care aide living wage mandates would cost approximately $418 million. This number will only continue to grow as demand for services increases and additional local living wage laws are enacted.

County	Local Living Wage	Impact of Increase
Nassau	$14.10 *(as of August 2010)*	$88,000,000
Suffolk	$12.33	$5,700,000
Westchester	$13.00	$23,500,000
New York City	$11.50	$295,000,000
	TOTAL	$418,200,000

**Assumes a wage increase from $8 for Home Health Aides (HHAs) providing 12,290,000 hours of service. Amounts rounded to the nearest million.*

Funding Must Accompany Mandates

Proposals that mandate wage and benefit packages must also include changes to Medicaid and other reimbursement systems to ensure that adequate funding is provided directly, or through contracts, to accommodate the increased costs.

Home care providers cannot increase worker wages without State support. Over the past two years, home care has sustained over $370 million in cuts, including the recently approved elimination of the 2010 trend factor. These cuts have forced providers to do more with less, and leave no room for wage increases and other workforce investments.

Home care cannot absorb any more cuts, including an unfunded living wage mandate. If these proposals are enacted, home care agencies will have to make difficult decisions about cutting programs, reducing the workforce, or closing their doors. Protect the real people and real families who depend on these services by rejecting unfunded mandates.

APPENDIX B: State Medicaid savings resulting from the transfer of current institutional care recipients into a home and community-based care setting.

	Institutional Long Term Care			Medicaid Savings from Transition to Home Care	
	Dollars	Recipients	Dollars Per Recipient	Savings 5% Transfer Rate	Savings 10% Transfer Rate
Statewide	**$6,935,321,952**	**146,837**	**$47,231**	**$158,075,541**	**$316,151,082**
New York City	**$3,645,472,853**	**67,348**	**$54,129**	**$74,925,021**	**$149,850,043**
Upstate	**$3,208,806,790**	**78,176**	**$41,046**	**$105,619,676**	**$211,239,352**
Albany	$83,968,859	2,330	$36,995	$2,717,900	$5,435,799
Allegany	$10,285,043	344	$29,927	$412,889	$826,369
Broome	$69,016,003	1,942	$32,039	$2,769,096	$5,536,172
Cattaraugus	$24,289,372	659	$36,829	$1,059,086	$2,118,172
Cayuga	$19,412,563	663	$29,729	$919,110	$1,839,221
Chautauqua	$44,436,720	1,223	$36,333	$1,696,171	$3,392,342
Chemung	$31,289,323	901	$34,717	$1,355,786	$2,711,573
Chenango	$19,078,318	489	$39,696	$771,763	$1,543,526
Clinton	$18,164,274	582	$31,210	$564,551	$1,129,102
Columbia	$19,843,516	516	$38,456	$652,407	$1,304,814
Cortland	$11,182,899	341	$32,794	$354,151	$708,302
Delaware	$16,615,961	404	$40,984	$663,730	$1,327,459
Dutchess	$82,409,509	2,029	$40,616	$2,560,648	$5,121,297
Erie	$248,267,505	7,226	$34,362	$9,362,974	$18,725,948
Essex	$9,676,903	294	$32,911	$415,787	$831,574
Franklin	$11,642,622	390	$29,697	$338,642	$677,284
Fulton	$19,622,108	534	$36,668	$650,917	$1,301,836
Genesee	$16,082,317	479	$33,575	$667,952	$1,335,905
Greene	$11,662,465	326	$35,774	$422,113	$844,226
Hamilton	$1,647,451	50	$32,949	$71,629	$143,259
Herkimer	$24,373,976	726	$33,619	$976,656	$1,953,312
Jefferson	$27,068,069	833	$32,495	$1,027,962	$2,055,924
Lewis	$7,287,391	225	$32,388	$300,557	$601,114
Livingston	$17,641,727	429	$40,906	$813,404	$1,626,808
Madison	$19,770,827	550	$35,947	$855,629	$1,711,259
Monroe	$198,174,782	5,146	$38,510	$5,897,667	$11,795,313
Montgomery	$18,761,418	497	$37,730	$639,691	$1,279,382
Nassau	$391,644,981	7,098	$55,226	$9,763,781	$19,527,562
Niagara	$62,364,509	1,786	$34,913	$2,336,678	$4,671,356
Oneida	$89,961,976	2,843	$31,615	$3,115,880	$6,231,760
Onondaga	$128,061,962	3,327	$38,492	$4,747,246	$9,494,493
Ontario	$30,124,682	787	$38,278	$950,145	$1,900,290
Orange	$85,492,240	2,069	$41,321	$2,469,841	$4,939,682
Orleans	$9,762,706	309	$31,696	$329,977	$659,954
Oswego	$29,003,833	874	$33,185	$1,204,634	$2,409,268
Otsego	$17,962,562	470	$38,197	$650,752	$1,301,504
Putnam	$20,543,060	439	$46,797	$461,820	$923,639
Rensselaer	$46,666,203	1,298	$36,062	$1,733,877	$3,467,754
Rockland	$83,414,302	1,724	$48,384	$2,274,778	$4,549,556
Saint Lawrence	$26,963,386	829	$32,513	$894,768	$1,789,517
Saratoga	$43,719,449	1,229	$35,586	$1,365,871	$2,731,743
Schenectady	$39,807,018	1,086	$36,655	$1,437,761	$2,875,522
Schoharie	$6,659,406	163	$30,363	$196,564	$393,128
Schuyler	$4,463,564	132	$33,739	$99,409	$198,818
Seneca	$9,920,493	270	$36,743	$432,233	$864,467
Steuben	$28,410,110	826	$34,395	$1,284,479	$2,568,959
Suffolk	$470,675,800	8,970	$52,472	$15,592,950	$31,185,899
Sullivan	$31,964,306	749	$42,760	$1,099,504	$2,199,008
Tioga	$10,909,223	360	$30,248	$418,824	$837,649
Tompkins	$12,648,185	430	$29,073	$476,145	$952,289
Ulster	$55,044,186	1,369	$40,338	$1,450,999	$2,901,999
Warren	$17,141,288	509	$33,679	$684,583	$1,369,167
Washington	$15,991,984	459	$34,819	$698,689	$1,397,379
Wayne	$26,422,479	616	$42,894	$1,143,545	$2,287,090
Westchester	$334,344,636	6,887	$48,504	$7,793,312	$15,586,624
Wyoming	$10,670,061	283	$37,703	$454,977	$909,955
Yates	$6,908,642	185	$37,349	$268,378	$536,757

NYSDOH/DHP FFY98 Reference File

8

THE 2011-12 EXECUTIVE STATE BUDGET

A Joint Hearing Before
THE SENATE FINANCE AND
ASSEMBLY WAYS AND MEANS COMMITTEES
March 3, 2011

Testimony by:
Joanne Cunningham
President
Home Care Association of New York State (HCA)

Introduction and Background: A $1 Billion Assault on Home care

My name is Joanne Cunningham and I am the President of the Home Care Association of New York State.

HCA represents approximately 500 members, including Certified Home Health Agencies (CHHAs), Long Term Home Health Care Programs (LTHHCPs), Licensed Home Care Services Agencies (LHCSAs), Managed Long Term Care Plans (MLTCs), and Hospices which form the core of New York's cost-effective home and community based care system.

Altogether, HCA's provider-based home care members represent decades of clinically successful care-management expertise and are vital to New York's health care system: 1) as a less expensive home-based alternative to nursing home care; 2) so that patients can safely recuperate at home for post-hospital care, at less expense to the health care system; and 3) as a means of preventive chronic care management, reducing a patient's chances of having to go to the hospital and utilize costlier services.

Newborns and mothers, the frail-elderly, persons with disabilities, chronically-ill patients and their families – as well as hospitals, nursing homes and physicians – all rely on the home care safety-net to reduce costs, ensure the most appropriate utilization of services, prevent premature or unwanted nursing home placement, support family efforts to manage an individual's chronic or disabling health condition, and keep patients home, where the vast majority of New Yorkers want to be, especially when they become sick and require additional supports.

Key Resources and Appendices
(attached to testimony)

- *MRT Proposals Impacting Home Care* – an impact analysis showing $1 billion in proposed reductions to home care)
- *Vital Signs* – a report on the fiscal condition of home care providers
- *HCA Analysis of Medicaid Redesign Team Proposals*
- *A Blueprint for Home Care Reform and Efficiency* – HCA's reform proposals
- *HCA's Fact Check* – a report that sets the record straight about home care costs/utilization profiles

Every single day, home care saves millions of Medicaid dollars and keeps the health system functioning while providing life-saving and life-sustaining care to hundreds of thousands of New Yorkers. Without these services, hospitals and emergency rooms would overflow; elderly, chronically ill, and disabled patients would be institutionalized; and taxpayers would be paying higher Medicaid costs.

The disastrous proposals advanced this year by the Executive's Medicaid Redesign Team (MRT) pursue a lethal and misguided path of direct cuts, unfunded wage mandates and a one-size-fits-all approach to care management that will collapse long-standing, successful program models as part of an **unprecedented $1 billion blow to New York's home care system. (Please see the attached spreadsheet entitled *MRT Proposals Impacting Home Care* for details of each cut.) This assault on home care is not only unwise and untenable, but it is disproportionate. While home care represents 12% of Medicaid, the home care cuts, reduction actions, and unfunded wage mandates total 36% of all provider impacts included in and resulting from the MRT package.**

Largely designed internally within the Executive, and therefore reflective of the Executive's own policy perspectives, the MRT proposals are rooted in inaccurate assumptions about New York's home care system (as shown in the attached HCA-prepared *Fact Check* report) and represent a tangle of conflicting, ill-defined and inexact policy goals patched together with little consideration for the impact on patients, the system as a whole, and the existing care-management expertise that exists in our provider-based home care infrastructure.

In the strongest terms possible, I urge the Legislature to reject, amend and reshape critical features of this destructive MRT package – which directly, irresponsibly and disproportionately threatens the very survival of New York's home care system. Instead, I ask the Legislature to embrace the constructive, cost saving reforms and efficiency provisions that have been advanced by HCA from our position outside the MRT.

MRT Cuts, Structural Changes and Unfunded Wage Mandates

HCA has identified three main categories that pose the greatest threat to New York's home care system as part of a $1 billion assault on home care in the form of: 1) direct cuts, 2) mandatory managed care enrollment, and 3) unfunded wage mandates.

Together, this represents the perfect storm that will quite literally be the death knell for New York's home care system. Patients will lose services, jobs will be cut, hospitals and nursing homes will be overwhelmed with increased care needs, and any short-term cost savings will just morph into higher costs to other sectors.

HCA's position on each of these reductions, and others included in the MRT package, are described in the attached *HCA Analysis of Medicaid Redesign Team Proposals*. What follows is a summary of our position on the three main home care impacts.

Direct Cuts The MRT package includes several direct home care cuts, including: 1) a global spending cap of no greater than a four percent annual growth rate on Medicaid spending; 2) an expenditure cap totaling $200 million (state and federal shares) aimed at CHHAs; 3) elimination of the Medicaid Trend Factor

for CHHAs, LTHHCPs and personal care providers; and 4) an across-the-board two percent cut.

The global spending cap created by the MRT reflects an astounding contradiction of state policy. While on one hand the state is maintaining and expanding an open entitlement to services and benefits, on the other hand, the state is imposing an arbitrary cap that will cut payment to providers regardless of their service obligations under the entitlement. This sets in motion a system that, over a short period of time, could drive providers into bankruptcy. The budget language gives the Commissioner unbridled discretion as to how to reduce spending to meet the cap, including changes to rates, programmatic features to the Medicaid program, benefit coverage and others. HCA's analysis of MRT fiscal impact on providers does not even account for the damage that will be done by the imposition of the global cap.

The direct cuts to providers are devastating to New York's home care system, given that 70% of home care providers are already operating in the red, due to past budget cuts and unfunded mandates, based on data contained in independently certified cost reports submitted to the Department of Health (DOH). The financial condition of New York's home care system, based on this data was reported in a financial condition analysis completed by HCA and New York Association of Homes and Services for the Aging (NYAHSA) called *Vital Signs*, which is attached to this testimony.

Our findings are based on a review of home care Medicaid cost reports for 2008, the most recent year available. Yet home care services have been hit with $434 million in state and federal share cuts since 2008. If 70% of providers were operating in the red in 2008, the devastation of nearly half-a-billion cuts enacted since that time, as well as the new onslaught of direct-cut reductions under the MRT proposal, will lead to home care agency closures, setbacks in patient care, and major job losses.

Managed Care Enrollment

Beyond traditional rate cuts, which alone would ravage much of New York's home care infrastructure, one of the most devastating and misguided proposals in the MRT package would divert chronically ill, disabled and frail elderly patients into Managed Long Term Care (MLTC) programs and others care coordination programs as identified by the Commissioner. This policy change, unless explicitly including CHHAs and LTHHCPs, would omit these entities and eradicate decades of successful care management experience that already exists in these models.

MLTCs are an important component of the long term care continuum, but New York's CHHAs and LTHHCPs – along with MLTCs and LHCSAs – form the backbone of our system to coordinate and manage health care at home by ensuring that patients get the appropriate level of care to help them stay out

of the hospital or nursing home and manage complex health conditions at home.

From a cost-saving perspective, CHHAs utilize pioneering methods of chronic-care management that focus on the integration of primary care, acute care and home-based care to manage patients' health, improve outcomes, and reduce costs, while the LTHHCP, also known as the "Nursing Home Without Walls," provides a home-based alternative to nursing-home care for chronically ill, elderly and disabled populations, at an average of 50% the cost of nursing-home care. The hallmark of the services provided by CHHAs and LTHHCPs *is* care coordination and care management of patients. By definition, this is the clinical expertise these programs offer patients.

Given the existing clinical, health-utilization, and care-management successes of these current programs, there is no reason to force New York's chronically ill, frail elderly and disabled patients into any one model of care when the diverse needs of these highly vulnerable patients are being successfully and cost-effectively met by a continuum of home care programs with a proven, specialized care-management expertise.

Direct cuts and projected enrollment changes alone amount to **$593 million in state and federal share reductions to home care.**

Unfunded Wage Mandate

A third disastrous and misguided MRT proposal would unfairly mandate so-called "living wage increases" for workers at the same time that providers are deluged with chronic cuts and underpayments which already fail to provide the reimbursement necessary to support such wage increases.

The home care community certainly supports a payment system that provides adequate reimbursement for services and compensation for caregivers. But this proposal amounts to an unprecedented form of state wage control for a single category of worker without any corresponding payment support from the state.

Given that the MRT's primary charge is to reduce Medicaid costs, the inclusion of a wage mandate shows the conflicting, contradictory and incoherent goals of this entire Medicaid Redesign process. Rather than reduce costs, the proposed wage mandate will add new expenses for providers who are already struggling to stay financially stable due to prior-year cuts – which, as previously mentioned, have left 70% of providers operating in the red – at the same time that home care agencies face the threat of unprecedented devastation to existing programs and care-management models under other proposals advanced in the MRT process. Unbelievably, the budget language would authorize the Commissioner to actually increase the wage mandate on home care providers at his or her discretion. This is outrageous state control of the wages of a non-public entity.

Additionally, the budget language would enable a labor organization to bypass an employer and bargain directly with the state over the wages that would be required to be paid to workers.

This wage mandate proposal alone would have an impact of **$418 million** for home care and personal care in the 2011-12 state fiscal year. This fiscal analysis was done by HCA's sister home care organization, the New York State Association of Health Care Providers (HCP).

HCA Efficiency Proposals

Despite the enormous importance of home care in the overall functioning of New York's health system, neither HCA nor any other statewide representative of long term care is a member of the MRT; therefore, HCA's perspectives have not been adequately heard or addressed in the shaping of policies that disproportionately impact the home care system.

New York's home care system was designed with the express purpose of addressing patient needs in the most appropriate settings, and saving health care costs. It is ironic that the vast majority of cuts, reductions and restructuring proposals target this cost-effective infrastructure.

HCA's exclusion from the MRT process has not only disenfranchised the home care sector and the citizens that receive these services, but also created a missed opportunity to employ HCA's policy expertise in examining ways that home care reforms and efficiencies can be achieved in a responsible manner that doesn't imperil access to services and demolish our existing cost-effective home care system.

Despite not having a seat at the MRT table, HCA has repeatedly shared with the Executive and Legislature our own proposals for making the Medicaid system more efficient. These proposals are outlined in HCA's *Blueprint for Home Care Reform and Efficiency* (also attached to this testimony).

Our eleven proposals include such cost-savings ideas as:

- $150 million to $200 million in savings through the use of new tools to precisely and consistently authorize home health aide and personal care services;

- $150 million in savings by ensuring that nursing-home-bound patients, whenever possible, are appropriately matched to the LTHHCP, a model of care whose very existence is threatened by the MRT package despite a record of serving patients in the community at 50% the cost of nursing home care;

- $20 million in savings by allowing for flexibility in the use of home care staff resources; and

- Millions of dollars in payment reforms.

Conclusion

HCA's *Blueprint* provides dozens of reform and efficiency ideas largely ignored by the Cuomo Administration in its vetting of proposals for MRT consideration. HCA understands that the state faces enormous fiscal challenges and we are prepared to work with the Legislature on a more responsible approach to achieving Medicaid efficiencies. Unfortunately, the MRT process has left less outside community stakeholders with less than a month for public and legislative review of proposals that affect care for millions of patients, leaving little opportunity for a truly deliberative, multilateral process.

The time is now for the Legislature to aggressively get engaged in this process. Without significant amendment and rejection of the MRT proposals impacting home care, New York's home and community based care system will be substantially shut down.

MRT Proposals Impacting Home Care

Proposal #	A: Proposal Description w/ Direct Dollar Impact to Providers (Factored into MRT Total)	2011-2012 State Share Impact	2011-2012 State & Federal Share Impact
5	CHHA Medicaid expenditure cap, PPS and MLTC Transfer	$100,000,000	$200,000,000
4651	Across the Board Provider Cuts plus Global Medicaid Spending Cap	TBD	TBD
	• Elimination of Medicaid Trend Factor (Home Care & PC)	$26,500,000	$53,000,000
	• 2% Across the Board Rate Reduction (Home Care & PC)	$57,810,000	$115,620,000
	• Global Medicaid Spending Cap (could amount to at least $640M for all sectors due to MRT gap)	TBD	TBD
4652	Reform Personal Care Program in NYC	$57,000,000	$114,000,000
90	Enrollment into MLTC and Coordinated Care Models (proposal still evolving)	$8,330,000	$16,650,000
154	OMIG Proposals - Conflict and Exception Reports and PECOS (OMIG breakout not avail; estimate only)	$45,000,000	$90,000,000
37	Eliminate Case-Mix Adjustment for AIDS Nursing Services	$2,010,000	$4,020,000
101	Managed Care for Dual Eligibles	$0	$0
	Subtotal - Direct $ Impact to Home & Personal Care (A)	**$296,650,000**	**$593,290,000**
Proposal #	**B: Proposal Description w/ Direct Dollar Impact to Providers (Not Included in MRT Total)**	**2011-2012 Provider Impact**	**2011-2012 Provider Impact**
61	Mandated Home Care Wage in Counties w/ Living Wage	$418,000,000	$418,000,000
	Total - Direct $ Impact to Home & Personal Care (A+B)	**$714,650,000**	**$1,011,290,000**
Proposal #	**C: Additional Reduction Actions/Efficiencies Attributable to Home Care**	**2011-2012 State Share Impact**	**2011-2012 State & Federal Share Impact**
153	Enhanced Telemedicine thru Provider Incentives	$230,000	$460,000
69	Create a Uniform Assessment Tool	$1,850,000	$1,850,000
139	Implement New Service Enhancements Under LTHHCP Waiver	$0	$0
1427	Allow Consumer Direction in MLTC	$0	$0
1032	Established Housing Disregard - Incentive to Join MLTC	$0	$0
	Total - $ Additional Reductions/Efficiencies to Home & Personal Care (A+B+C)	**$2,080,000**	**$2,310,000**
	Total - $ Direct Impact and Reductions/Efficiencies to Home & Personal Care (A+B+C)	**$716,730,000**	**$1,013,600,000**
Proposal #	**D: Patient Eligibility Reductions to Home Care Recipients with Fiscal Ramifications for Home Care**	**2011-2012 State Share Impact**	**2011-2012 State & Federal Share Impact**
18	Eliminate Spousal Refusal	$28,300,000	$56,600,000
1116	Apply 60 Month Look Back Period to Non-Inst. LTC	TBD	TBD
	Total - Patient Eligibility Changes $ Impact to Home & Personal Care (D)	**$28,300,000**	**$56,600,000**
	Total Dollar Impact to Home Care and Recipients (A+B+C+ D)	**$745,030,000**	**$1,070,200,000**

HCA ANALYSIS OF MEDICAID REDESIGN TEAM PROPOSALS
ADOPTED BY THE MRT ON FEBRUARY 24, 2011

OVERVIEW

On February 24, the Cuomo Administration staff provided members of the Governor's Medicaid Redesign Team (MRT) with a list of 79 major Medicaid actions to consider. The proposals, many of which were new to the discussion, were presented to the MRT in simple form only, with no thorough detail, legislative or administrative language to assess their content and implications. Following this presentation of proposals, the MRT was abruptly requested to provide a final "up-or-down" vote on the entire proposal package – a vote the MRT members and the public were originally told would not occur until March 1, providing what would have been an extremely limited but invaluable opportunity for analysis, public comment, MRT deliberation and possible amendment/substitution.

The MRT proceeded to move the package, leaving the Administration's staff the purview to form and draft the details of a legislative/administrative plan for implementation. Despite national, statewide and regional representation by a number of other stakeholders, the MRT failed to include statewide home care representation in its membership or decisions.

The following is a summary of 18 of the 79 MRT proposals most directly impacting the home care system. Each proposal is identified by the MRT number that was assigned by the Administration staff for a matrix of proposals compiled for the MRT.

The majority of these proposals, as presented, would impact providers by a staggering $745 (stat/provider share) million from the home care system, cause the closure of exceptional patient care programs and services, and heap significant new costly and burdensome mandates on home care providers. The proposals would fundamentally undermine the sustainability and future of home care in New York State.

In order for New York's home care system to remain viable, these proposals must be rejected in favor of more responsible, nondestructive ways of maintaining home care for the chronically ill, disabled and frail elderly under the Medicaid program.

Additional information on each of the 79 proposals is at http://www.health.ny.gov/health_care/medicaid/redesign/.

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A number of proposals from an earlier list released on February 14 were **excluded from** the February 24th list. These include: an increase in the Gross Receipts Tax; the elimination of Personal Care Level - I services; and the limitation of personal care eligibility to only those requiring a nursing home level of care. HCA supports the exclusion of these proposals from the MRT list.

(Fiscal projections shown in the ensuing analyses are those provided by the MRT staff, unless otherwise indicated.)

MRT PROPOSALS RELATED TO HOME CARE

PROVIDER CUTS

Proposal #5: Imposes CHHA Spending Caps ($200 million state/federal shares 2011-12), PPS Episodic Payment ($140 million state/federal shares in 2012-13) and Mandated Patient Transfer to Managed Care (see discussion of proposal 90, page 6)

Spending Caps: This proposal would cut CHHA reimbursement for services to 2009 levels (and 2007 costs) by imposing CHHA-specific aggregate annual per-patient payment caps effective April 1, 2011 through March 31, 2012.

The provider specific caps would reduce home care reimbursement and utilization to a provider's average claims per patient during the 2009 base period (the use of 2009 rates to set the caps would further take the provider back to 2007 costs since CHHA rates are set using rates which are already two years old). The provider-specific caps would be calculated using a weighted combination of the provider-specific average total paid Medicaid claims per patient during the 2009 base period and the statewide average for all CHHAs during the same period. DOH would apply an agency specific case mix factor as well as a regional wage index factor.

DOH anticipates cuts of $200 million in state and federal shares to CHHAs as a result of the provider-specific caps.

Cuts of this magnitude will hit providers extremely hard in a cascading combination of all of the other cuts and changes proposed by the MRT, as well as $434 million in state cuts enacted since 2008.

CHHA PPS: Effective April 1, 2012, DOH would succeed the CHHA payment cap by transitioning to a CHHA episodic prospective payment system (PPS) based upon 60-day episodes of care. A statewide base price would be established, based on paid Medicaid claims data during a specified base period, and this price would be adjusted for case mix and differences in regional labor costs. CHHA patients under the age of 18 and low utilization

claims (under $500/less than 25 hours of care in 60-day period) would continue to be paid under fee-for-service.

HCA supports an episodic prospective payment system that is: constructed using an appropriate base; case sensitive (for acuity, complexity, intensity) and addresses further patient considerations; adequate to staffing and compensation; provides for capital, regulatory, quality innovation, system development and other necessary adjustments; pilot-tested and refined prior to implementation; and appropriately transitioned. The current MRT proposal does not fulfill these essential criteria and cuts home care by $140 million.

Mandatory Transfer to Managed Care: As represented in the February 24 MRT proposal, the episodic pricing system would apply only to short-term CHHA patients (patients anticipated to require less than 120 days of care), whereas CHHA patients requiring more than 120 days of care (DOH estimates about 2000 such patients in 2011-12) are proposed to be transitioned into Managed Long Term Care (MLTC) plans. HCA believes these aspects of the proposal are in conflict with HCA's discussions with the Governor's office held just prior to the February 24 MRT meeting in which it was maintained that CHHAs and LTHHCPs be appropriately treated as "care coordination/care management" options along with MLTCs for enrollment purposes. (See Proposal #90, page 6, for additional detail.)

Home Care Fiscal Impact: $100 million state share ($200 million in state and federal shares) for SFY 2011-12 and $70 million state share ($140 million in state and federal shares) for SFY 2012-13

Proposal #4651: Enact global Medicaid spending cap (fiscal implications potentially profound but not subject to advance measure), eliminate trend factor ($53 million state/federal shares 2011-12) and apply 2 percent reduction in Medicaid rates ($115 million state/federal shares)

The Governor's Budget proposes a global spending cap that would limit total Medicaid spending to no more than 4 percent annual growth.

It would also eliminate the trend factor for 2011-12 (1.7 percent) and 2012-13 and impose a 2 percent across-the-board reduction in Medicaid rates for all health sectors.

Sectors will ostensibly be offered the flexibility to develop and propose new ideas in lieu of additional across-the-board reductions.

The MRT package also leaves a $640 million gap to be either voluntarily made up by the health care industry (a so-called voluntary health care cost containment initiative") or unilaterally by DOH. DOH will monitor and report on sector spending. Failure to meet the global cap would under the MRT proposal default to DOH purview to unilaterally address as it chooses (rate cuts, program changes, etc,).

In addition, the Governor proposes to shift the Medicaid spending plan to a biennial budget with two-year appropriations. Again, if total state share spending exceeds the global cap, the Governor proposes that DOH have the authority to take action to reduce spending to meet the target, including the imposition of additional rate reductions.

The continued elimination of the trend factor and the additionally devastating 2 percent across-the-board rate cut will further accelerate the insolvency of home care providers which ironically are: *saving* dollars in the broader health and Medicaid system; enabling patients to avoid hospitalization and, when hospitalized, to properly transition from hospital to home; and enabling others to stay out of nursing homes. Seventy percent of New York's home care agencies are already operating in the red due to state budget cuts and other state actions, and this proposal would drive providers into deeper instability.

This proposal would also create the unprecedented step of a global Medicaid spending cap limiting Medicaid spending to no more than 4 percent annual growth. This would essentially lock providers under such a payment cap without regard to provider obligation to deliver "entitlement" services, and risks their potential bankruptcy. The proposal would further cede unprecedented authority from the Legislature to the Executive for policy, expenditure and fiscal reduction decisions about the Medicaid program.

Home Care Fiscal Impact of Trend Factor Elimination: $26.5 million state share ($53 million in state and federal shares) for home health and personal care for 2011-12. HCA is concerned that this DOH projection far understates the impact of the trend factor loss, particularly when compared to the impact of the 2 percent cut shown below.

Home Care Fiscal Impact of 2 Percent Rate Reduction: $57 million state share ($115.62 million in state and federal shares) for 2011-12.

The fiscal impact of the global cap is not measurable in advance, but could trigger untold millions in additional cuts in payment for services.

Proposal #37: Eliminate the case-mix adjustment for AIDS nursing services in CHHAs and LTHHCPs ($4.01 million state/federal shares 2011-12)

Since 1990, Medicaid rates for home care nursing services provided to patients with AIDS have been increased by a fixed case-mix adjustment factor of 1.2988.

DOH states that based on its analysis of the 2009 CHHA and LTHHCP Medicaid cost reports, the average costs of nursing services provided to AIDS patients was $119.03, while the average costs of nursing services provided to other patients was $123.07 and because of this DOH proposes to eliminate this case-mix adjustment.

According to cost report data, 28 CHHAs and 25 LTHHCPs provided AIDS nursing services in 2009 and would be impacted. The estimated impact of this proposal would be concentrated in New York City (NYC), where providers would experience rate reductions of $3.7 million in 2011-12 and providers in the rest of the state would face rate reductions totaling $300,000. Four NYC providers account for $3.3 million of the first year total impact.

HCA is concerned about the effect of this additional rate cut ($3.3 million on 4 HIV/AIDS home care providers), in combination with the other MRT rate cutting proposals, breaking the ability of already challenged agencies to remain accessible for the delivery of AIDS care at home.

> **Home Care Fiscal Impact: $2.01 million in state share savings ($4.01 million in state and federal shares) for 2011-12 and $310,000 in state share savings ($620,000 in state and federal shares) for 2012-13.**

MANDATORY MANAGED CARE, CARE COORDINATION/MANAGEMENT

Proposal #90: Mandatory MLTC enrollment/Home Care Conversion ($16.65 million in state/federal shares 2011-12)

HCA's understanding is that this proposal and other managed care proposals of the MRT will evolve to the plan reached between HCA and the Governor's office to include MLTCs, LTHHCPs and CHHAs as "care management/coordinated care" programs to serve complex/chronic care patients. Consistent with this policy, CHHA and LTHHCP reimbursement which is now fee-for-service would transition to case payment through PPS or a similar provider-based payment approach.

In its current form, MRT Proposal 90, which is to change to mirror the above, advances the requirement that all Medicaid recipients age 21 and older who are in need of community-based long term care services are to enroll entirely into MLTCs. Mandatory enrollment would begin April 2012 in New York City and then gradually expand throughout the state. MLTCs include partially capitated plans, Medicaid Advantage Plus and the Program of All Inclusive Care for the Elderly (PACE). Mandatory enrollment would include the transfer of those currently served in the LTHHCP and CHHAs, as well as personal care and other community-based long term care programs. Exempt would be recipients in the Assisted Living Program, Nursing Home Transition and Diversion waiver, Traumatic Brain Injury waiver and those served through the Office of People with Developmental Disabilities.

> **Home Care Fiscal Impact: $8.33 million in state share ($16.65 million in state and federal shares) for 2011-12 and $42.53 million in state share ($85.05 million in state and federal shares) for 2012-13. In addition, financial impact to providers due to termination of service under this proposal could be exponential.**

The loss of the CHHA/LTHHCP infrastructure, and its chronic care management value and expertise as would occur under this and related MRT proposals (see for example Proposal 5 described on page 2 and Proposal 101 described below), would be a catastrophic error for New York State.

These proposals would needlessly eliminate one of the most successful care management models in the nation (the Long Term Home Health Care Program); would also eliminate highly successful and innovative models of chronic care management in Certified Home Health Agencies that are also being effectively integrated with hospitals, physicians and other disciplines; and ignore the reality that LTHHCPs, CHHAs, and MLTCs **all** play a vital role in the care-coordination process and continuum of care.

These proposals would force the dislocation of thousands of patients from their caregivers while resulting in job losses and the harmful closure of long-standing agencies that are experts in chronic care management. Meanwhile, enrollment of all high risk, adverse selection into capitated plans with no alternate options risks the fiscal stability of these plans and the stability of the broader long term care system. HCA supports increasing care management capacity in the provider-based home care system and facilitating access to these programs rather than forcing all patients into one modality of care and management. HCA has given the MRT proposals that would accomplish these objectives, while improving efficiency and outcomes, and saving Medicaid dollars.

Care management is at the core of evolving state and national policy. MLTCs can and do offer an effective model of care management and delivery, but likewise do LTHHCPs and CHHAs. For all of the above reasons, HCA opposes Proposal 90 as presented to the MRT and instead, consistent with HCA's discussions with the Governor's office, supports an appropriately inclusive plan for complex/chronic care patient enrollment into care management models through the MLTCs, LTHHCPs, and CHHAs.

Proposal #101: Develop and implement initiatives to integrate and manage care for dual eligibles

Under this proposal, the state will develop care models and reimbursement mechanisms for people who are dually eligible for Medicare and Medicaid and reside in the community and in nursing homes.
Possible initiatives to be examined include, but are not limited to, New York State assuming risk for all Medicare services for duals, mandatory enrollment of all duals in a managed care plan for all Medicaid services and developing a gain-sharing demonstration that would allow New York to share in the savings from reduced hospitalizations and emergency room use resulting from care management of nursing home residents and people residing in the community.

While HCA has developed and gained passage of state legislation that allows for New York to develop a shared savings program, we have similar concerns with this proposal's mandatory enrollment of vulnerable populations into managed care which we have previously identified and which should be modified in accordance with the same plan as for the modification of MRT Proposal 90.

Fiscal Impact: No savings in 2011-12 or 2012-13 which are planning years.

PERSONAL CARE PROGRAM CHANGES

Proposal #4652: Institutes Changes to the Personal Care program in NYC ($114 million in state/federal shares 2011-12)

This proposal, which was reshaped during the February 24 MRT meeting itself, replaces the prior personal care reform proposals presented to the MRT. This new proposal replaced prior proposals to cap personal care expenditures at prior year levels, eliminate Personal Care Level - I services and eliminate personal care for patients below the nursing level of need.

This replacement proposal, for which there are few other details to date, includes: (i) implementing improved management and utilization for split shift and other high intensity users; (ii) capping personal care level one (housekeeping) cases at 8 hours a week; and (iii) providing for "technology solutions" to reduce costs for personal care recipients.

HCA offered many proposals to the MRT, DOH and the Executive to reform the personal care program with responsible policies that would assure the neediest patients continue to have access to care, while opening up access to more intense care-managed models that will reduce costs while providing an appropriate level of care for those who need it. HCA also recommended payment reform and the use of a home health aide assessment tool that would more precisely and consistently quantify the appropriate level of services in the personal care program. HCA opposed the original MRT personal care proposals and is pleased that they were ultimately rejected. More detail is required on Proposal 4652 in order for HCA to be able to assess its impact on personal care providers and patients, and its contribution to the overall home care reform and efficiency package.

Home Care Fiscal Impact: $57 million state share ($114 million state and federal shares) for 2011-12 and future years.

NEW UNFUNDED MANDATES

Proposal #61: Mandates "living wage" pay requirements by CHHAs, LTHHCPs and MLTCs

This proposal mandates that CHHAs, LTHHCPs and MLTCs pay according to any local "living wage" law in the geographic area in which they serve Medicaid patients. The proposal is intended to attain local living wage level over a 3-year period.

An additional component of this proposal that was removed prior to the MRT vote would have mandated that 85% of all payments for home care be passed on to the direct care worker.

HCA supports a payment system that provides for adequate reimbursement for the cost of delivering services, operating agencies and compensating direct care personnel. However, this proposal would unfairly link providers to local wage laws without the state being simultaneously required to reflect Medicaid payment increases that would fully fund the increases required by these laws, and would be an unprecedented form of state wage control for a single class of workers.

> **Home Care Fiscal Impact: While there is no state fiscal impact noted in the MRT documents, this change is expected to result an extraordinary (potentially hundreds of millions) in fiscal impact to home care agencies.**

Proposal #154: New OMIG Mandates – Home Care Agency Review/Reconciliation of Conflict and Exception Reports Prior to Billing, and PECOS Enrollment Requirements ($90.0 million state/federal shares 2011-12), plus other new OMIG requirements affecting other providers and recipients

The proposal contains a number of provisions related to home care.

It would require that all CHHAs and Personal Care providers statewide above a $15 million threshold in annual Medicaid reimbursement utilize a vendor to provide "conflict and exception" reports. These reports would be reviewed and reconciled prior to claim submission. Additionally, each service in a claim would need to be verified prior to submission.

It would mandate that physicians who order services for dually eligible individuals be enrolled in both Medicare and Medicaid consistent with Medicare Provider Enrollment, Chain and Ownership System (PECOS) requirements.

Other elements of the proposal would require the OMIG to coordinate state Medicaid audits, review claims approved and paid by Medicare for dual eligible recipients, which are also submitted to Medicaid for payment, and refine existing edit logic to prevent duplication.

While HCA supports strong agency compliance with existing regulations and laws, providers and organizations across the continuum of care have expressed concerns with regard to OMIG audit practices, including accusations of fraud for minor clerical errors and then extrapolation into thousands of dollar repayments, protocols that hold providers accountable for the action of others such as local departments of social services and physicians, audits of records that have been audited by other entities, and the unfunded costs of compliance efforts, among

others. HCA has worked with other associations and the Legislature to develop legislation that would curtail some of these audit practices and provide some protections for providers and HCA asserts that such legislation should first be enacted before OMIG audit duties are expanded. One HCA provider member reported to HCA that it was being to asked to host 18 different and simultaneous audits; a reasonable line must be drawn to mitigate the cost, burden and patient care distraction of these audit processes.

Fiscal Impact: OMIG's proposed new home care mandates have a projected Medicaid impact of avoided/denied claims of $45.0 million state, $90.0 million state/federal shares for 2011-12. The total OMIG package including home health and other sectors would result in $80.3 million in state share ($160.6 million in state and federal shares) for 2011-12.

MEDICAID ELIGIBILITY CHANGES

Proposal #18: Eliminate spousal refusal ($56.6 million in state/federal shares 2011-12)

This would eliminate the right of legally responsible relatives (spouses and parents of children) to refuse to make their income and resources available in determining the Medicaid eligibility of a spouse or child under 21 who requires home care.

Fiscal Impact: $28.3 million in state share ($56.6 million in state and federal shares) for 2011-12 and $56.5 million in state share ($113 million in state and federal shares) for future fiscal years.

Proposal #1116: Apply a 60 month look-back period to non-institutional long-term care

This would apply the 60 month look-back period for transfer of asset purposes to non-institutional long-term care applicants and include spousal impoverishment protections.

Fiscal Impact: no savings in 2011-12 or future fiscal years.

HCA-PROPOSED REFORMS ON MRT MATRIX

In HCA's *Blueprint for Home Care Reform and Efficiency* ideas and additional proposals submitted to the MRT, HCA offered many suggestions to improve and responsibly reform the home care system including **payment reforms** (one of which, a CHHA episodic pricing methodology, is discussed on page 2 of this document) as well as the need for a uniform assessment tool across long term care services, as included in the MRT matrix of proposals detailed below.

HCA looks forward to working more closely with the Legislature and Executive to advance these proposals in a way that will offer stability, increased efficiency and quality enhancement for providers, patients and the state.

The following proposals contain all or some of the components of HCA's MRT proposals.

Proposal #69: Create uniform assessment tool ($1.85 million in state/total share 2011-12)

This would require the development and implementation of a uniform assessment tool for long term care services, a proposal championed by HCA and others. This proposal seems to support the state Department of Health's current work to develop such a tool. HCA has proposed that the state accelerate and proceed to establish a common data set and instrument for long term care for determining an individual's needs, eligibility for services, identification of program options best matched to those needs and channeling of patients to those service options. In addition, HCA has advocated that development of this tool must be accompanied by eliminating paperwork, duplication and costly administrative requirements.

Fiscal Impact: $1.85 million state share savings in 2011-12, $7.8 million state share savings in 2012-13, $4.8 million state share savings in 2013-14 and no savings in 2014-15.

Proposal #139: Implement the new service enhancements under the recently approved renewal of the LTHHCP

The State Department of Health received Federal approval for the renewal of the home and community based services waiver for the LTHHCP in September 2010. The renewed waiver contains a series of service enhancements (including assistive technology, community transition, community support services) designed to create efficiencies, reduce Medicaid costs, and further enable the LTHHCP to provide an alternative to institutionalization, including the enhanced ability to return institutionalized individuals to the community.

HCA recommends that the state immediately proceed to implement the enhancements of the new waiver, initiating the opportunities for increased Medicaid cost-savings and performance.

Home Care Fiscal Impact: DOH does not indicate savings in 2011-12.

Proposal #200: Nurse Flexibility in Provision of Services to Promote Efficiency and Lower Medicaid costs

This proposal would increase the capacity of RNs, LPNs and home health aides (HHAs) to improve access to services and decrease associated costs in delivering services. HCA's proposal, which is included as one of the items in Proposal 200, would also allow nurses/patients (under their existing scope of practice/self-directed patient exemption) to orient/direct HHAs and personal care workers to provide "nursing care" as is currently allowed in the consumer directed personal assistant program.

Home Care Fiscal Impact: Though HCA had attributed $20 million in state share savings ($40 million in state and federal shares) for 2011-12, as did the original MRT matrix; the February 24 MRT document does not list savings.

Proposal #153: Develop innovative telemedicine applications by reducing regulatory barriers and providing payment incentives ($450,000 in state/federal shares 2011-12)

Under this proposal, New York would coordinate the various efforts under way to promote use of telemedicine, including the DOH tele-stroke initiative, Office of Mental Health adolescent tele-psychiatry program, use of remote monitoring to improve primary care within the concept of "health homes," as described in federal health reform, and other initiatives.

HCA submitted to the MRT proposals which contributed to this initiative to authorize new applications of telecare and telehealth for Medicaid recipients, aimed specifically at reducing costs and promoting chronic care management. HCA also drafted with Senator David Valesky and Assemblyman Joseph Morelle legislation (the NYS Telehealth/Telemedicine Development Act) to coordinate and advance comprehensive state policy and program development with regard to telehealth/telemedicine. HCA supports incentives to further allow for the use of telemedicine, including allowing doctors who use it to meet the Medicare requirement for a face-to-face encounter with a patient prior to initiating home care services.

Fiscal Impact: $230,000 in state share savings ($450,000 in state and federal shares) for 2011-12 and future fiscal years.

OTHER PROPOSALS AFFECTING HOME CARE

Proposal #1032: Establishes a housing disregard as an incentive to join a MLTC program

This would allow nursing home eligible individuals to receive a "disregard" of a portion of their housing expenses if they join a MLTC. This will result in a deduction of a certain amount related to housing from their income in determining their Medicaid eligibility. HCA would support such a disregard **both** for MLTC and for LTHHCP patients and urges that the provision be enacted to cover patients in both programs.

Fiscal Impact: No savings in 2011-12 and $13.8 million in state share ($27.6 million in state and federal shares) for 2012-13 and future fiscal years.

Proposal #1427: Allow consumer direction in MLTC

This would add Consumer Directed Personal Assistance Program (CDPAP) services to MLTC plans. HCA had included in the Home Care Accessibility and Efficiency Improvement Act (S.5179 of 2010-11) a provision that would have allowed MLTCs, LTHHCPs and CHHAs to collaborate with CDPAP on a **voluntary** basis as both program collaboration and consumer service opportunity. This MRT proposal however is a mandate to add CDPAP to MLTC.

Fiscal Impact: No savings are indicated in 2011-12 or future fiscal years.

Proposal #209: Hospice expansion

This proposal would expand concurrent hospice and curative care to Medicaid adults; expand the definition of terminal illness to 12 months; and integrate hospice into medical home and accountable care organizations.

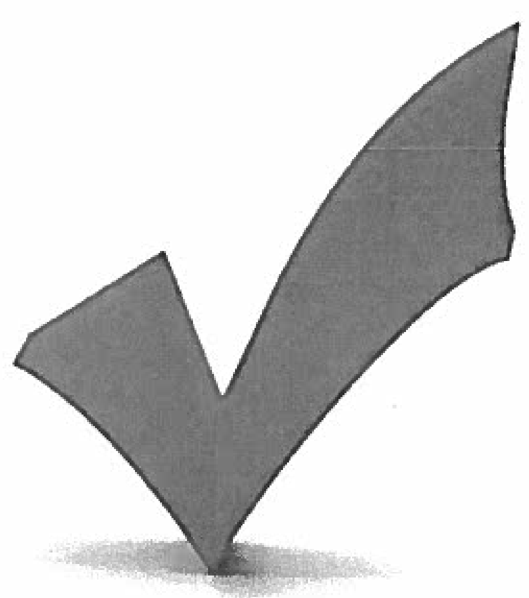
Fiscal Impact: No savings in 2011-12 or future fiscal years.

For additional information, contact HCA Policy staff.

Governor Cuomo FACT CHECK

Medicaid and Home Health Spending

On February 1, 2011, Governor Andrew Cuomo submitted his 2011-12 State Budget Proposal to the Legislature. Included in the Governor's budget message were many claims about the Medicaid Program, specifically New York's home and community based care system. Some of the Governor's claims in these areas were either misleading or wholly inaccurate. Given that the Governor's assumptions about home care continue to be used as a basis for major, system-altering proposals in the Medicaid Redesign Team (MRT) process – with enormous ramifications for patient access to services – HCA policy and reimbursement experts conducted the following Fact Check to shed light on the realities of home care delivery.



Governor's Claim: "$1 of Medicaid money first goes to what is called a certified home health agency, a CHHA, they call it. The CHHA then takes 26 cents for administrative overhead and contracts with a licensed home care services agency, called a LHCSA, which takes 26 cents of overhead and then contracts with the actual caregiver, who is the person who is going to go into the home to provide the care, who gets 48 cents ... The Medicaid System was not supposed to be spending more than 50 cents on the dollar for overhead."

1.

Fact Check: FALSE and MISLEADING

Background: While it is not known where the Governor actually derived his numbers in this particular talking point, the Governor could be referring to a misnomer known as home care "Administrative and General," or A&G, costs. A&G is a label established by the state Department of Health (DOH) to categorize certain CHHA and LHCSA service costs and includes many activities that few reasonable people would consider as "overhead," as detailed below. The most recent data (2011) indicates that, for CHHAs, the statewide average cost for A&G was 20.43%, which DOH policy sets as the cap for A&G expenses – a cap that already creates hardship in that it precludes vital agency services. In addition, DOH has recently required LHCSAs to complete a statistical report in order to profile different cost categories for services, overhead, salaries, etc. At present, no state-calculated A&G exists for LHCSAs.

Fact 1: What the State Calls "Administrative" is actually patient-care-related expenses, not "Overhead."

The Governor's speech did not explain that the A&G includes many expenses that the state categorizes as "administrative" but which are actually clinical costs directly related to the provision of care to patients. These include: screening of patients in hospitals, conducting clinical assessments, scheduling of patients, consultation with physicians, education of family caregivers, patient monitoring using technology, case management, follow up phone discussions with patients or family members, corporate compliance programs, education and training of staff, technology investment, and others. Simply put: consulting with a doctor about a patient's medication needs is not an "overhead" expense. HCA has even advanced legislation – with bipartisan support from both houses of the State Legislature – to "carve-out" these patient-care-related activities from the A&G cost category.

Fact 2: "Administrative" costs – including those which are patient-care-related – are subject to a spending cap.

What a CHHA receives in payment from Medicaid for home health aide and other services is determined by a state-designed cost report. The cost report is an official financial statement independently certified by auditors and submitted to the state as a condition of participation in the Medicaid program. This report conveys the agency's costs in the manner required by DOH. Data in these reports are used to impose spending caps on each and every service discipline provided by a CHHA (including home health aide services). These costs are then subject to an additional cost ceiling, called the A&G cap, which controls the amount an agency can spend on A&G activities, including many activities that are patient-care-related.

Fact 3: CHHA-LHCSA contractual relationships reflect a common arrangement in health care.

Many CHHAs contract with LHCSAs, since LHCSAs have expertise in educating, orienting, training and deploying home health aides to provide services that enable many patients to remain in their homes. CHHAs negotiate with LHCSAs for these contracted services just like any other contractual relationship that exists frequently in health care. Such coordination is no different than a hospital contracting out the administration of its Emergency Department. As with hospitals, a CHHA's decision to contract these services is more efficient than duplicating the LHCSA service infrastructure and specialized expertise within its own organizational structure.

BOTTOM LINE: The Governor's equation of 26 cents in administrative costs each for LHCSAs and CHHAs is not reflective of the data, and amounts to a misnomer that is misleading and overly simplistic about the true nature of the activities that fall under the state-defined category of "administrative and general" costs. To reduce costs further, the Governor should look to the unfunded mandates that his own administration and others have thrust on providers, at a cost of $70 million a year, rather than employ misleading assertions about contractual relationships in home care that are no different from the care coordination structures in other areas of health care.

Governor's Claim: "The home health care program... is one of the fastest growing Medicaid Programs in the law. From 2003 to 2009, almost a 90% increase (89.5%) in the benefits that go to a recipient."

2.

Fact Check: MISLEADING

Fact: On the broadest level, growth in New York's home care system reflects a deliberate state policy goal which, in the past, has recognized that home care, for many patients, is the most cost-effective and most appropriate form of care delivery. Unfortunately, the Governor's assertion of 90% growth does not reflect the home care system as a whole and instead focuses on a small minority of Certified Home Health Agencies (CHHAs). For the overwhelming majority of CHHAs in New York State (96%), Medicaid spending has been nearly flat; the Governor's assertion of 90% growth in home care spending is attributable almost exclusively to a very small percentage (4.2%) of CHHAs. The Executive and DOH have misused this data point for several years to make a broad assertion about home care spending. HCA has directed DOH to use the tools at its disposal, if deemed necessary, to better understand the factors behind any potential spending variances in home health care, and to accurately reflect these realities in its data. HCA has repeatedly offered proposals which would assist in more precise measurement and authorization of services, especially for home health aide and personal care services.

Governor's Claim: "What is the Medicaid rate of growth in the current budget passed last year? Maybe it's the rate of inflation; maybe it's the CPI; maybe it's 4%; maybe it's 5%; maybe it's 6%? No, 13.2% is the projected growth in Medicaid. That's what the budget passed last year said ... Permanent law has built in rates and formulas that continually drive up this unsustainable spending."

3.

Fact Check: MISLEADING

Fact: 90% of this 13.2% increase is **NOT** solely due to "rates and formulas," as the Governor's statement would lead the public to believe, but to state policy decisions made by prior Executives and the Legislature as part of an expressed state policy goal to increase enrollment in the Medicaid program for children and the working poor. Other policy decisions fueling this growth include the state takeover of the local government/county share of Medicaid costs. By stating that this growth is due to "built-in rates and formulas," the Governor implies that provider costs are responsible for this growth, which is not accurate.

Real reform requires a real understanding of the system and the ways in which home care is already saving costs and sustaining the care needs of hundreds of thousands of patients. HCA supports meaningful reforms to the home care system that build on the strengths of the current home care infrastructure, incentivizing efficiency and eliminating unnecessary bureaucracy and waste. Our ideas and proposals are highlighted in HCA's *Blueprint for Home Care Reform and Efficiency*, a multipart plan that harnesses the care-management expertise of the home care system while recognizing the many ways this system can be enhanced. The professional experience and clinical knowledge of New York's home care delivery system has been carefully constructed by state policymakers in partnership with front-line providers over the last several decades, to ensure that patients get the appropriate level of care to help them stay out of the hospital or nursing-home and manage complex health conditions at home. By building on this expertise, we can further strengthen this safety-net system for New Yorkers.

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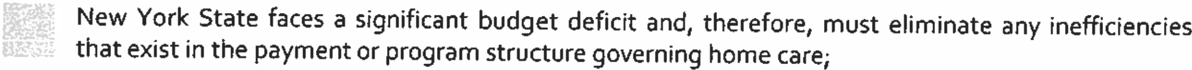
A BLUEPRINT FOR HOME CARE REFORM AND EFFICIENCY

Eleven concrete, implementable, and game-changer reforms and efficiency recommendations for New York State's Medicaid Home and Community-Based Care System – improving the system, cutting costs, and enhancing access for patients who need services.

January 2011

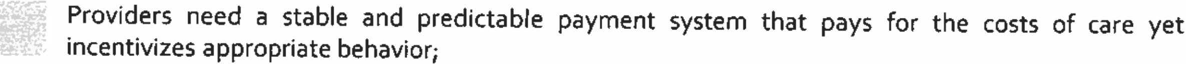
THE CASE FOR REFORM AND EFFICIENCY

Reform of New York's home care system is on the minds of policymakers and interested stakeholder organizations. There are many reasons why reform is needed:



- New York State faces a significant budget deficit and, therefore, must eliminate any inefficiencies that exist in the payment or program structure governing home care;

- The structure of the system must include payment incentives that help to drive inefficiency and inappropriate utilization out of the system;



- Providers need a stable and predictable payment system that pays for the costs of care yet incentivizes appropriate behavior;
- New York State's home care providers are financially fragile and need stability and flexibility to structure programs and services that will meet the needs of patients and fulfill the integral role of home care in the evolving health care system.

Recognizing this imperative, many organizations have issued reports offering suggestions to reform the state's home care system. Many of these suggestions, while well intended, are unrealistic and would undermine the core noninstitutional care infrastructure, holding the potential to waste invested resources, create senseless and expensive upheaval, dislocate patients and the providers who serve them and create dysfunction and added costs in the overall health system.

There is a better way to reform the state's home care system – a way that taps the best of what New York State has to offer and builds on New York's role as the national leader in home and community based care development, with effective and innovative models, a core provider infrastructure, and health professionals which, working together, *already* lower the cost of the Medicaid program.

The following document offers policymakers eleven far-reaching, game-changer reforms and efficiency recommendations to improve the state's home care system. What's more, these reforms were not constructed in an academic or theoretical vacuum or think-tank; they arise from a thoughtful, methodical policy process that has engaged the creative energy of those who know the home care system best – the home care leaders and clinicians in our state who have been working in this sector for years and who represent every facet of the home care provider infrastructure. In addition, each of these reform ideas is well developed, and, in most cases, legislative language is already prepared that would operationalize the changes that are recommended. In other words, the reforms and efficiencies contained in this report are "shovel ready."

The time is now for meaningful, practical, creative and realistic reform. But for reform to work, it must take what is workable, innovative and good about New York's home care system and build on it. This is imperative, given that home care's role in the continuum of care and in the successful implementation of state, federal and health system reforms is pivotal and vital – and becoming ever more so. Home care can and needs to be a greater part of the solution to an affordable Medicaid program and a central part of a better plan to meet the overall health care needs of the state's citizens. Home care is also where New York's population of elderly and disabled individuals wants to be – aging and receiving vital services in place, in the comfort and security of their own homes.

To bring meaningful and realistic change, the following reform and efficiency ideas are recommended:

1. Enact Comprehensive Home Health Payment Reform – Across All Programs
2. Implement a Standardized, Consolidated Assessment for Home Care
3. Establish a Standard, Streamlined "No Wrong Door" Patient Entry into Home Care as Part of the New Assessment Tool, Eliminating Administrative Layers, Bureaucracy and Cost
4. Establish an Interim Measure to Eliminate Variation and Guide Utilization of Services
5. Expand and Ramp Up Care Management Capacity – Focusing on High Need/High Cost Patients
6. Focus and Better Manage Personal Care
7. Ramp Up and Expand Nursing Home Diversion
8. Maximize Federal Revenue Opportunities
9. Get Rid of Meaningless Regulations that Don't Add Value to Patient Care and Add Unnecessary Cost to the System
10. Invest in the Home Health Workforce
11. Rid the System of Inefficiencies that Add Cost to the System

Enact Comprehensive Home Health Payment Reform – Across Programs

Proposal Overview

Convert the current fee-for-service payment systems for home care into methods more aligned with state budget predictability, patient acuity, provider stability and efficiency, and flexibility in the provision and management of care.

Background and Detail

The State Department of Health's current Medicaid reimbursement methodologies are unresponsive to home health provider cost requirements for the operation or delivery of services, intensity of patient need, incentives for agency efficiency or utilization control, patient access to care, staffing needs or flexibility in the delivery of services. The Department has twice proposed an episodic, prospective payment system (PPS) for Certified Home Health Agencies (CHHAs) but each time failed to address core issues associated with the design and implementation in order to ensure system stability, quality care and patient access. In response, the Legislature mandated that the Department of Health convene an advisory group to formulate such a system, but the discussions have thus far not produced resolution of the core methodological issues.

HCA proposes to:

- Convert the current CHHA fee-for-service payment methodology into an episodic PPS that is: constructed using an appropriate base; case sensitive (for acuity, complexity, intensity) and addresses further patient considerations; adequate to staffing and compensation; provides for capital, regulatory, quality innovation, system development and other necessary adjustments; pilot-tested and refined prior to live implementation; and appropriately transitioned.

- Convert the current fee-for-service payment methodology for Long Term Home Health Care Programs (LTHHCPs) into a case-payment system based on the results and efficacy of initial reimbursement pilots, including: a per diem approach similar to nursing homes and assisted living programs; a PPS designed specifically for long term populations; and/or other case payment reimbursement options. The converted payment system will offer significant savings, reforms and critical advantages to the state, LTHHCPs, the patients and the long term care system overall, including: more predictable and stable state expenditures and reimbursement; additional utilization control incentives; access to the LTHHCP for patients now unable to access the program – due to the logistics of the current fee-for-service rates and patient expenditure cap – and who are either institutionalized or enrolled in unmanaged services as a result; elimination of unnecessary costs and administrative burden for local districts and providers; elimination of the unnecessary and duplicative costs associated with the forced transfer and admission of patients to different settings due to the cap; and other benefits.

- Reform the payment system for personal care to reduce unexplained variability and control utilization.

- Establish a state structure authorizing "collaborative care models" (e.g., among home health, hospitals, physicians) for improved outcomes and cost-effectiveness, providing for alternative methods of reimbursement and regulation supporting these models and goals.

- Establish rural home health access financing under the Health Care Reform Act (HCRA) parallel to that existing for rural hospitals. Like rural hospitals, rural home health providers are especially challenged by the need to provide services in areas of sparse population, extreme resource limitations and other cost/system obstacles. Without sufficient rural home health infrastructure, only higher cost pathways will prevail.

2 Implement a Standardized, Consolidated Assessment for Home Care

Background and Detail

The basis for nearly all meaningful efficiency, service advancement, quality benchmarking, integration and other reform in home care and long term care is tied to the clinical assessment process and the need for more refined patient measures, standardization, consolidation/computerization of paperwork, and exchange of information across settings, among other improvements.

Providers and patients are buried in duplicative and in some cases antiquated state/federal assessment procedures, forms and criteria – the cost and brutal inefficiency and inadequacy of which are borne by all.

While the Department Health has begun work toward a uniform assessment, HCA proposes that the state (with input from the provider, consumer and worker communities) accelerate and proceed to establish a common data set and instrument for home care/long term care for determining an individual's needs, eligibility for services, identification of program options best matched to those needs and channeling of patients to those service options (see next section).

Along with providing a more precise and guiding measurement of patient needs and program options, the reformed process must eliminate paperwork, duplication and costly administration by consolidating/eliminating current formats and requirements, moving to electronic tools and building off of federally required instruments such as the Outcome and Assessment Information Set (OASIS).

Proposal Overview

Establish a standardized, efficient and consolidated assessment/electronic data set for assessing the needs of individuals for home and community based care.

3 Establish a Streamlined "No Wrong Door" Patient Entry into Care

Proposal Overview

Provide for a streamlined, standardized patient entry into the home care system as a core function of the new assessment instrument, providing for more appropriate patient-program matching and eliminating consumer/provider confusion in the system, delays in access, duplication of effort, and administrative cost and burden.

Background and Detail

The current methods of patient access into services vary from program to program, and from county to county. This combines with variations in service options, lack of public and professional education about options and other conflicts to create a difficult-to-navigate system where patients do not always end up with options most capable or suited to meeting their needs. The state and some localities have attempted various remedies including stepped up local social services department roles and single point of entry concepts (where in some areas all long term care referrals are funneled to the county or other entity for assessment and placement), but these strategies by-and-large backlog the system, are fertile for local bias and control, and require the expense of another layer of bureaucracy and staff.

HCA proposes that the standardized, common assessment instrument be constructed to also serve as the mechanism for identifying the option or options best matched to patient needs and for channeling patients to these options. This would represent the most efficient use of resources, expedite patient access and transitions to care and increase the prospects for patient enrollment in programs and services most suited to their needs.

This mechanism must also be used to replace expensive, human-intensive and double-layer processes of utilizing county-based or state-designated regional entities to perform assessments, and should consequently also halt and replace the state's implementation of Long Term Care Assessment Center demonstrations.

Establish an Interim Measure to Eliminate Variation and Guide Utilization of Services

Background and Detail

As the state proceeds to develop a new standardized, common assessment instrument for home care/long term care services along with changes in the payment process, an interim measure could be taken, until the transition to these new systems is accomplished, to further refine and standardize assessment and assignment of aide services in all programs – Personal Care, CHHAs, LTHHCPs and other. Such an instrument has already been developed, validated and successfully used for several years by a home care agency across a broad spectrum of its home care programs and services. While achieving standardization, the tool has also achieved a net reduction in assigned hours of care while maintaining or improving quality. Other agencies have implemented or are pursuing similar strategies.

HCA proposes that the state utilize such existing, successful models as the basis for broader implementation regionally (such as in New York City where such models are already being used by some agencies) or statewide.

Proposal Overview

Implement a tool (based on already successfully tested models) to further standardize and make consistent the method of assessing the need for and assigning hours of home care aide services across the continuum.

Care Management – Expand the Capacity, Clinical Benefit and Cost-Effective Use of Home Health's Care Management Models, Focusing on High Utilizers of Home Care Services

Proposal Overview

Direct those patients with intensive and/or complex care needs to models with robust, professional care management, including CHHAs, LTHHCPs and Managed Long Term Care programs (MLTCs), and further strengthen the care management capacity of these programs with new tools and approaches to care.

Background and Detail

Effective, expert management of patient care is critical to both health outcomes and cost exposure, particularly for patients with intensive and complex care needs and/or unstable conditions. This level of clinical management is essential in the care of the highest need/highest risk individuals, who, although comprising a proportionally small percentage of the population, exhibit the greatest needs and utilize the highest volume of services resulting in the highest associated costs.

There is currently no mechanism to appropriately and efficiently channel individuals into those home health programs which have strong and expert capacity for care management of chronic, complex and/or high risk, unstable conditions. There is also currently little activity by the state to eliminate obstacles to entering and/or remaining in these programs as well as to further strengthen these programs' care management capabilities.

HCA proposes a mechanism, through the assessment and referral process (described in the assessment section of this document) and through a new high need patient initiative consisting of a state/provider partnership, to channel appropriate individuals to beneficial care management models in home health – CHHAs, LTHHCPs, MLTCs and (as a self-management model) the Consumer Directed Personal Assistance Program, or CDPAP– and to further bolster the care management capacity and benefits of these models by addressing access obstacles (e.g., eliminate inordinate procedures, replace the LTHHCP expenditure cap, etc.), strengthening components of the models and adding new features or approaches to management (e.g., collaborative care management combining home care, physicians and hospitals, integrating primary care and/or clinical nurse specialists, and including behavioral health services) that will support both clinical and cost control goals.

Focus and Better Manage Personal Care

Background and Detail

New York's Personal Care Program, in particular the Home Attendant Program in New York City, serves a broad spectrum of needs from housekeeping to twenty-four-hour personal care, from patients with mild functional deficits, to patients most heavily impaired in activities of daily living (eating, dressing, transferring, etc.). Personal care does not include care management (like a CHHA or LTHHCP) beyond the local social services district casework function nor does it contain discrete utilization or cost controls (e.g., like the LTHHCP patient budget and expenditure cap or MLTC capitation). As a result of the breadth of the population, generic and safety-net nature of the program, limited patient management, and absence of cost/utilization control mechanisms, there is great and unexplained variance in services provided as well as enrollment/retention of patients whose care management needs would be better and more cost-effectively served in other more robust programs of care managed home care.

HCA proposes:

- A clinical review process for high need personal care recipients to determine appropriateness of services and the program options (personal care or more robust care managed home care models) that best meet the patient's needs.
- The establishment of performance standards for fulfillment of local districts' personal care responsibilities, with financial accountability.
- Implementation of the aide assessment standardization tool (as discussed elsewhere in this document) or other benchmarking system for more appropriately and consistently determining patients' need for personal care hours.
- Payment reform for personal care services reimbursement (see payment reform section).

Proposal Overview

Enact a series of reforms to better focus and manage the Personal Care Program, improving: the enrollment of appropriate patients into the program; the consistency and refinement of the assessment for and authorization of aide hours; the in-depth review of high needs cases; referral of recipients to care managed options (as described earlier) if more appropriate to their needs (respecting recipients' choice and process rights); and reimbursement adequacy and control.

Increase and Enforce Nursing Home Diversion

Proposal Overview

Maximize nursing home diversion and minimize premature and unnecessary institutionalization by enhancing and enforcing New York's principal diversion law established under the LTHHCP.

Background and Detail

While ranges vary (some estimates have ranged from 15 to 70 percent), estimates are that a significant percentage of the individuals admitted to nursing homes for long term care could potentially be cared for at home instead, with substantial opportunity for cost-savings.

Under Social Services Law provisions for the LTHHCP, New York State has perhaps the strongest and strictest nursing home diversion statute in the nation. Section 367-c provides that, before a local social services official can authorize Medicaid payment for nursing home care for an individual, the official must ensure that such person is first assessed for and offered the LTHHCP as an alternative to institutionalization. Strictly enforced, the statute would prevent Medicaid expenditures for avoidable institutionalization. Despite the state's purported patient and policy goals of avoiding premature or unnecessary institutionalization, the state has lapsed on its enforcement of this diversion statute.

HCA proposes state Medicaid savings and greater patient centered care by maximizing nursing home diversion and minimizing premature and unnecessary institutionalization through upgraded, strict enforcement and financial accountability for abiding the state's nursing home diversion statute under the LTHHCP law.

In connection with this proposal, HCA recommends the expansion of nursing home right-sizing, for increased conversion of nursing home beds to LTHHCP and Assisted Living Program capacity.

Federal Revenue Opportunities

Background and Detail

HCA proposes to increase state revenue through the Federal-State Medicare Shared Savings Partnership plan (originally conceived and proposed by HCA and subsequently enacted in the 2010-11 State Budget), by incorporating within the plan home care models and initiatives that reduce Medicare utilization. There are models currently operating throughout the state that have demonstrated improved patient outcomes, reduced hospitalizations and readmissions, reduced emergency room utilization and avoidance of other costly Medicare and/or Medicaid covered services. These models are tailor-made and already functioning candidates for inclusion in the Federal-State Partnership Plan for leveraging federal shared savings through this program. HCA is further engaged with the state hospital association (HANYS) and state medical society (MSSNY) on collaborative initiatives which could also be included to secure federal revenues under the Partnership Plan.

HCA also proposes that the state pursue enhanced federal Medicaid participation through the home and community based services and collaborative care management provisions of the Affordable Care Act (ACA) in a manner that would utilize or build upon the current home care infrastructure. ACA provisions which HCA recommends, and which HCA will partner with the state to pursue, include: Health Homes and an appropriate form of Long Term Care Rebalancing. While pursuing ACA's enhanced Medicaid shares, HCA cautions that the state avoid (or develop workarounds to) ACA "conditions" – such as "conflict-free" case management and "single point of entry" requirements – which would unravel the state's long-standing structures and policies for long term/community based services delivery.

Proposal Overview

Increase state revenue from federal sources through new state/federal health reform initiatives.

9 Regulatory Relief

Proposal Overview

Provide for regulatory relief to reduce state and provider costs and to permit improved, more efficient functioning of the system.

Background and Detail

New York is the most, or among the most, heavily regulated states in the nation in relation to health care, Medicaid and a plethora of additional areas that saddle taxpayers and the health care sector with inordinate costs.

At a time when the state is considering curtailment or elimination of needed services, or reducing reimbursement to the point of forcing provider closures, the state must *first* consider whether all of its regulations are truly worth the cost.

HCA proposes that: (a) in conjunction with other proposed reforms, the role of local social services districts be streamlined or reduced in connection with the LTHHCP and other home care services; (b) state mandates that exceed federal regulations be identified and pared back to conform to federal obligations (unless the more restrictive state requirement is necessary due to a unique aspect of New York's home health system); (c) the state pursue federal Conditions of Participation waivers or other federal regulatory waivers or changes in cases where federal regulations result in unjustifiable costs; (d) the state enact HCA's regulatory relief legislative proposals to reactivate the Health Occupation Development and Workplace Demonstration Program and establish the Rural Home Health Flexibility Program; and (e) the state enact HCA's Medicaid efficiency proposals (referenced in section 11 of this plan); among other measures.

Support the Development of the Home Health Workforce

Proposal and Background

HCA proposes regulatory relief measures which will create opportunities for home health workforce development. Examples include the following:

- Several of the regulatory proposals referenced earlier will provide opportunities for modification in duty which could be aligned with increased training and/or job advancement.

- A legislative change also proposed by HCA would enable nurses and patients to orient and train home health aides and personal care workers to perform tasks which are ordinarily limited to nursing but which nurses routinely train patients' families to perform. In addition to the patient and fiscal benefits of this change, it would similarly provide for opportunities for increased training and/or job advancement for these individuals.

HCA proposes that HCRA funds provided pursuant to section 2807-v of the public health law and distributed pursuant to section 3614 of the public health law for recruitment, training and retention of direct care workers in home care be continued but that the manner of funding be changed so that funds are part of and cycle with the ratemaking process.

HCA proposes that HCRA funds provided pursuant to section 2807-l of the public health law for Health Workforce Retraining – which support the retraining of health care personnel with experience in one setting to work in a new, alternate setting – be amended to specifically include retraining for employment in home health care.

Proposal Overview

HCA proposes regulatory relief measures which will create opportunities for home health workforce development.

Enact Additional Medicaid Efficiencies

Proposal Overview

HCA has developed and proposes an extensive series of additional changes to the statutes and regulations to yield significant savings to the Medicaid Program.

Background and Detail

HCA has developed and proposes an extensive series of additional changes to the statutes and regulations to yield significant savings to the Medicaid Program, including but not limited to:

- Permit nurses and patients to direct home health aides and personal care workers to provide care currently limited to family members (as explained earlier);
- Establish LDSS performance standards for personal care and other aspects of home care;
- Modernize the Insurance Law coverage provisions for home care (which have not been updated since the early 1970s and bear no resemblance to the role played by home care in today's health care system), which would result in Medicaid avoidance;
- Reform the state's supervision and orientation regulations for home health aides and personal care workers;
- Enact efficiencies in medical transportation services for home care patients;
- Explore the elimination of restrictions on nurses' ability to function in certain settings, allowing nurses in these settings to perform duties consistent with their scope of practice rather than requiring outside nurses to perform the duties;
- Authorize new applications of telehealth for Medicaid recipients, aimed at reducing costs;
- Enact meaningful fair hearing reform.

CONCLUSION

The time is now for real reform to positively realign payment incentives and programmatic changes that make the delivery of care to patients more efficient. New York's home care providers are not only demanding it – they have been leaders of the movement to offer creative solutions for reform and change over the past two years. For New York's mission-driven providers, the imperative is now because providers can no longer sustain the "business as usual" budget-making approach that has resulted in an unprecedented level of home care reimbursement cuts, including over $430 million in state budget actions just since April 2008. This comes on top of an additional $65 million in new unfunded mandates aimed at home care during that same period.

The home health care system is extraordinarily financially fragile and is in danger of collapse in many parts of the state. Given the tremendous need for a strong and stable home care system to support the movement of patients from the acute care system, and the desire, ability and need for chronically ill patients to receive care at home, real reform and change is critically needed. HCA and its member organizations stand ready to work to enact meaningful policy change that will result in real reforms and efficiencies to improve patient care and reduce costs.

The Home Care Association of New York State (HCA) is comprised of over 500 health care providers, organizations and individuals involved in the provision of home health care services to hundreds of thousands of patients and hundreds of thousands more family members each and every year.

HCA and its home health care provider members – including Certified Home Health Agencies (CHHAs), Long Term Home Health Care Programs (LTHHCPs), Licensed Home Care Services Agencies (LHCSAs), Managed Long Term Care (MLTC) plans and Hospices – work to promote excellence and support high-quality, cost-effective home care and community services to the citizens of New York State. HCA providers cover the entire state, caring for patients who span the gamut from newborns and new mothers to centenarians, from post-surgical and other post-acute hospital discharges to countless New Yorkers whose every day goal is life at home and in the community instead of in a nursing home.

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VITAL SIGNS:

A Report on the Financial Condition of
New York's Home Care System

Background – Effect of State Actions on New York's Home Care System

The Home Care Association of New York State (HCA) and the New York Association of Homes & Services for the Aging (NYAHSA) conducted an analysis of official, independently-certified financial statements, along with other data, to assess the impact of state budget cuts on New York's home care system.

Key Findings At-a-Glance

A cross-method financial analysis of New York's home care system yielded the following "Key Findings"

70% of home care agencies reported total operating losses

79% of LTHHCPs reported total operating losses

84% of all county-run home health agencies reported operating losses

$75M – the impact of recent home care unfunded mandates

73% of providers expect to delay investment in life-saving, cost-saving technologies under a 10% Medicaid cut

Executive Summary

An analysis of official, independently-certified financial statements, along with other data, reveals that a **devastating $434 million in state Medicaid cuts** to home and community-based care enacted since April 2008, combined with other state actions, have pushed home care agencies to the brink financially, with perilous consequences for patients, families, communities and the health care system as a whole.

The vast majority of these cuts strike at the core of New York's home care system: specifically, the state's front-line Certified Home Health Agencies (CHHAs) and Long Term Home Health Care Programs (LTHHCPs) which directly support New York's home and community-based Medicaid infrastructure.

CHHAs traditionally provide post-acute, preventive and rehabilitative health services to countless patients at home and also manage patients with chronic illness. LTHHCPs, also known as the "Nursing Home Without Walls," offer long term care, including care management, at home to 25,000 to 30,000 elderly, disabled and chronically ill patients who are nursing-home-eligible, providing a cost-effective alternative to institutionalization.

Continued on p.2

Summary - continued from cover

Patients depend on home care nurses, therapists, aides and other direct-care staff to manage complex health conditions at home, preventing illness, injury, and costlier levels of care. In addition, elderly New Yorkers and persons with disabilities rely on home care to support their independence through services otherwise available only in a facility. These programs are the safety-net for our entire health care system.

The Home Care Association of New York State (HCA) and the New York Association of Homes & Services for the Aging (NYAHSA) recently conducted a thorough financial analysis of home care providers in New York State. At the center of this analysis, HCA and NYAHSA examined the official, independently certified financial statements that CHHA and LTHHCP providers submit every year to the state. This analysis was further supplemented by a detailed survey of home care provider members.

HCA and NYAHSA's cross-method analysis discovered, among other "key findings," that an alarming **70% of home care providers are operating in the red**, with many of these agencies approaching closure – and patients at risk of losing services – as state policies continue to erode the home care service infrastructure.

Blend of cost report and survey analysis yields key findings

At the core of this analysis, HCA and NYAHSA examined the 2008 Medicaid Cost Reports that must be submitted by every CHHA and LTHHCP in the state. These independently-certified financial statements are required for agencies to participate in the state's Medicaid program and are the intended vehicle for informing the state's Medicaid reimbursement-setting policies.

Cost reports provide official financial and statistical data related to all categories of an organization's revenues and expenses (not just for Medicaid, but for all payors). Given the array of reliable, independently-certified data shown in these reports, the documents are a fundamental instrument for gauging an organization's financial health, especially in the context of discussions about Medicaid policy.

It should be noted that 2008 is the most recent data year available to HCA and NYAHSA, given that the state uses two-year-old cost reports as a base for setting provider reimbursement rates; therefore, the financial impact of $434 million in enacted state budget cuts to home care since 2008 will not be evident in the reports.

As a supplement to the cost report analysis, HCA and NYAHSA also surveyed their CHHA and LTHHCP members to assess the impact of recent cuts, since 2008, and to gauge the fiscal, operational and regulatory challenges confronting agencies that serve New York's most vulnerable patients.

Blended together, the cost reports provide data about an agency's operating margins as of 2008 – well before the home care system was hit with $434 million in unprecedented state budget cuts – while the home care provider surveys offer a more current "snapshot" of provider experiences since that time.

What follows on page 3 is a summary of key findings from the HCA/NYAHSA analysis.

Key Findings

1

According to the HCA/NYAHSA cost report analysis, **more than 70% of New York's home care providers had negative operating margins in 2008,** and the size of those losses is mounting, due to chronic reimbursement cuts and unfunded mandates. For two-thirds of those providers operating in the red, the depth of operating losses increased from the amount reported in 2007.

In this context, CHHAs face a unique crisis as they wait for the state Department of Health (DOH) to issue them their final 2009 and 2010 Medicaid rates, which include massive retrospective rate reductions. These retroactive cuts will begin upon the federal government's approval of the state's Medicaid Plan Amendment. Thus, while the State Legislature and Executive have approved $434 million in cuts to home care since 2008, many of these providers still face a wave of retroactive cuts already budgeted by the state for that period. Like a financial "Doppler Effect," those cuts will compound the impact of any future reductions proposed as part of the upcoming budget process.

2

Medicaid cuts have greatly and disproportionately hit high-need providers like the LTHHCP. The LTHHCP is a cornerstone of New York's community-based long term care system and is essential to the functioning of the state's entire health care continuum, providing long term care at **half the Medicaid rate paid for nursing home care.**

LTHHCPs exclusively serve high-need patients, from individuals with severe disabling conditions to the chronically ill and frail elderly, all of whom would otherwise require care in a facility. The LTHHCP, therefore, produces great cost savings to the system. The LTHHCP – because it primarily serves nursing-home-eligible individuals, the vast majority of whom are covered by Medicaid – has been disproportionately affected by state budget cuts.

HCA and NYAHSA's cost report analysis found that: **79% of LTHHCPs reported total operating losses in 2008**; the median operating margin for LTHHCPs fell from negative-6.7% in 2007 to negative-9.3% in 2008; 58% of LTHHCPs experienced operating losses in each of the past three years; and Upstate LTHHCPs saw their operating losses increase by 70% from 2007 to 2008. Additionally, the HCA/NYAHSA survey discovered that further disproportionate reductions of 10% or more would jeopardize the financial viability of 40% of these essential care providers.

3

According to the HCA/NYAHSA cost report analysis, **84% of all county-run home health agencies had operating losses in 2008.** These agencies provide vital public health services and are the safety net of the service delivery system for many areas of the state, especially in rural New York where health services are scarce.

The consequences of this fiscal situation for patient care are very real. Nine county-run agencies have closed and/or sold their licenses in the last two years and an additional seven are in the process of closure or sale or are contemplating such action now, destabilizing the health care infrastructure in these predominately rural communities and threatening access to care.

4

CHHAs and LTHHCPs report that new unfunded mandates and taxes have approached $75 million. This $75 million in unfunded mandates compounds the $434 million in cuts to create the extreme financial instability of the home care infrastructure. In addition, this litany of unfunded mandates diverts precious staff time from actual home care services. Along with unfunded responsibilities, all home care providers also face a gross receipts tax, while providers in New York City, Long Island, Westchester, Rockland, Orange, Putnam and Dutchess counties must additionally pay a Metropolitan Transit Authority (MTA) commuter tax.

5

Cuts and fiscal instability further block cost-saving and lifesaving technology investments. Home care's use of health-related technologies – including home telehealth, electronic medical records and disease-management technologies – has resulted in dramatic reductions in hospitalizations and ER visits, saving payors millions of dollars by reducing health system utilization.

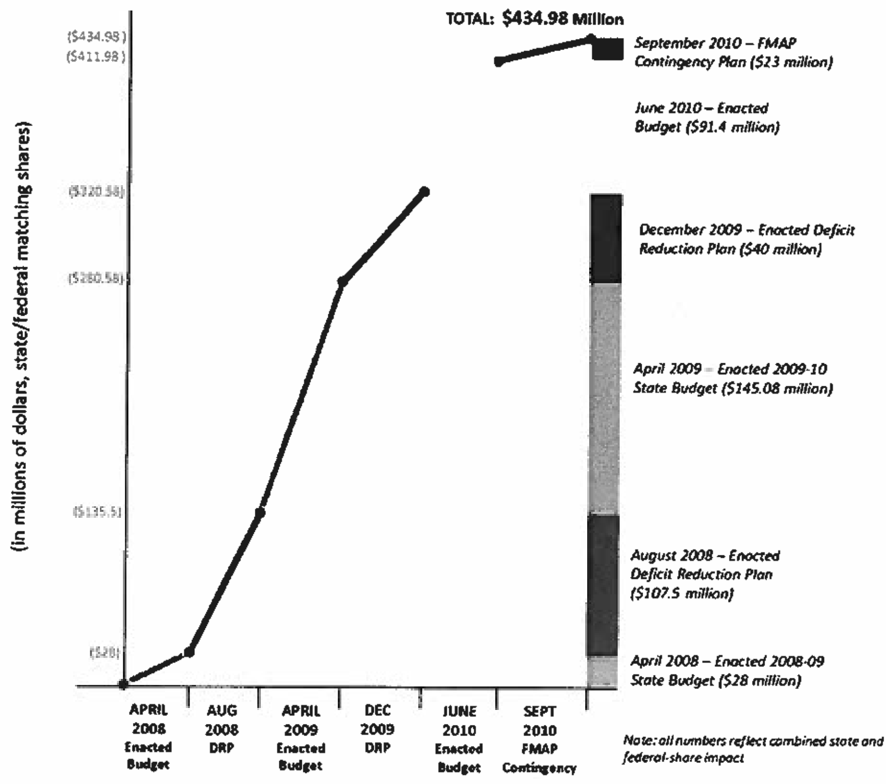
The state's home care reimbursement methodology already lacks a component for capital support, and providers have been severely restrained in their technology development capacity due to the toll of previous cuts. Of further significance, according to the HCA/NYAHSA survey, **66.7%** of providers reported that a 5% cut in Medicaid will delay or cancel new technology investments, while a 10% Medicaid cut will lead **73%** of providers to delay investment in these lifesaving technologies.

Conclusion

As HCA and NYAHSA's study shows, New York's home care system has already seen the effect of chronic rate and formula reimbursement cuts and past attempts to advance structural overhauls that, under the banner of Medicaid reform, have functioned as a back-door vehicle for imposing even deeper cuts, leading to the seriously destabilized home care infrastructure revealed in this study.

Meaningful reforms that make the system more efficient and enhance the care that New York provides its citizens are certainly possible. At the Association level, both HCA and NYAHSA have advanced productive reform and efficiency proposals that build off the strengths and opportunities created by the current infrastructure, supporting the effective models which have otherwise made New York a leader in home health and long term care.

It is clear from HCA and NYAHSA's analysis that blunt reimbursement cuts – including cuts cloaked in the mantle of reform – cannot be the answer. With 70% of home care providers operating in the red and care for hundreds of thousands of patients at risk, it is obvious that the state's recent cost-cutting efforts are threatening the viability of one of the most cost-effective and pivotal components of the health care system.



www.nyahsa.org

Founded in 1961, the New York Association of Homes & Services for the Aging (NYAHSA) is the only statewide association that represents the full range of not-for-profit, mission-driven and public continuing care providers, including home care agencies and other community services providers, senior housing, adult care facilities, assisted living, continuing care retirement communities, managed long term care programs and nursing homes. NYAHSA's 500+ members employ 150,000 professionals serving more than 500,000 New Yorkers annually.

www.hcanys.org

The Home Care Association of New York State (HCA), the state's premier home care association, represents approximately 500 providers, individuals, and associate members who collectively serve thousands of New Yorkers. HCA and its home health care provider members work to promote excellence and support high-quality, cost-effective home care and community services to the citizens of New York State. HCA providers cover the entire state, caring for patients who span the gamut from newborns and new mothers to centenarians, from post-surgical and other post-acute hospital discharges to countless New Yorkers whose every day goal is life at home and in the community instead of in a nursing home.

9

Public Hearing Testimony:

Joint Legislative Budget Hearing on Health & Medicaid

Submitted to:

Senate Finance Committee
John A. DeFrancisco, Chairman

and

Assembly Ways and Means Committee
Herman D. Farrell, Jr., Chairman

Presented by:

Daniel J. Heim
Interim President/CEO
The New York Association of Homes and Services for the Aging

March 3, 2011

Albany, New York
Legislative Office Building
Hearing Room B

13 British American Blvd., Suite 2, Latham, N.Y. 12110-1431 / (518) 867-8383 / fax: (518) 867-8384 / www.nyahsa.org

Introduction

The New York Association of Homes and Services for the Aging (NYAHSA) appreciates the opportunity to submit testimony on Medicaid, health and aging services priorities that should be addressed in the 2011-12 state budget. My comments today will focus on our concern that the short-term impact of significant cuts proposed by the Medicaid Redesign Team (MRT) could derail any of the positive reforms included in the package. Frail elderly and disabled New Yorkers could be displaced; providers could go out of business and health care workers could lose their jobs as the first series of MRT proposals are implemented.

Founded in 1961, NYAHSA is the only statewide organization representing the entire continuum of not-for-profit, mission-driven and public continuing care, including senior housing, nursing home, adult care facility, continuing care retirement community, assisted living, home care, adult day health care and community services providers. NYAHSA's more than 550 members serve an estimated 500,000 New Yorkers of all ages annually. This broad representation gives NYAHSA a unique understanding of the impact of the budget and MRT proposals on the entire long term care (LTC) system.

Overall Perspective on Medicaid Redesign

NYAHSA has advocated for many years for long range budget planning and fundamentally redesigning Medicaid, rather than simply cutting provider rates year after year. In this regard, NYAHSA commends the governor and the MRT for setting the stage for longer term reforms to bend the cost curve and improve quality rather than relying exclusively on devastating rate cuts.

NYAHSA embraces the major themes of Medicaid redesign – expanding care management; recalibrating Medicaid benefits; revisiting reimbursement systems and incentives; promoting personal responsibility; eliminating government barriers; empowering patients and aligning with federal policy objectives. We also support individual MRT proposals in each of these areas. The MRT package creates a framework within which consumers, government, providers and other payors can collaborate to advance broader system objectives of containing cost, improving quality and ensuring access.

At the same time, NYAHSA is deeply concerned about the level of short-term cuts aimed at long term care services in this plan and about the potential for further cuts if other planned savings do not materialize. We are also concerned about the potential for over-reliance on "mainstream" managed care, given the unique care needs of frail elderly and chronically ill people, and the abandonment of successful, time tested models of care for these individuals. Medicaid redesign will have implications far beyond the confines of the 2011-12 state budget; accordingly, decisions about redesign should be made carefully and deliberately.

Damaging Cuts to the LTC System

The proposal advanced by the MRT creates great uncertainty and risk for LTC service providers by: (1) relying on additional payment cuts in the short-term on top of major cuts in recent years; and (2) leaving open the potential for major additional cuts if the $640 million of unaccounted state savings fails to materialize; if enrollment or utilization is higher than anticipated; or if there are delays in implementing reform measures.

LTC providers are already reeling from cuts enacted since 2008 that exceed $2.4 billion. Hundreds of millions of dollars of these cuts have not yet even been implemented, meaning that further major impacts will be felt even before the next budget is adopted. Even now, 70% of voluntary and public nursing homes and 70% of all home health care agencies are already operating in the red. Since LTC organizations are economic drivers across the state and the largest employers in some areas, cuts to these providers and the resulting job losses will only exacerbate the state's financial crisis. This is because each direct LTC job supports secondary employment. On average, every 100 LTC jobs support another 50 jobs throughout the state's economy.

Here are some realities about the cuts proposed in the MRT package:

- LTC services provided by nursing homes, home care/personal care agencies and adult day health care programs would be cut by over $900 million in SFY 2011-12 alone, which equates to an 8.7% cut. If the $640 million of unspecified MRT savings do not happen, LTC services could be severely cut again during the fiscal year.

- LTC services represent 26% of total Medicaid spending, but these cuts represent a staggering and disproportionate 40% of the total MRT cost containment. With LTC providers serving a higher percentage of Medicaid recipients than most other service sectors, this disparity is even more devastating.

- As the result of the added cuts in the MRT plan, as many as 45 nursing homes and 60 home care providers could be forced to close, leaving service gaps in communities across the state.

- The LTC cuts proposed in the MRT plan could cost the state an estimated 8,100 health sector jobs and drive an additional 3,500 job losses, while decreasing economic activity in state and local economies by $2.2 billion.

Will LTC Medicaid Expenditure Growth be Contained?

Provider rate growth is not the cost driver in LTC Medicaid – it is volume – and the MRT package fails to adequately and fully address eligibility-related issues fundamental to Medicaid expenditure growth. Medicaid has become the state's *de* facto LTC insurance program rather than a safety net for the indigent. While Medicaid serves an essential role in providing LTC coverage for low-income individuals, even consumers with financial means have become dependent on the program for their LTC needs. Over-reliance on Medicaid has desensitized the public to the risk of needing LTC services, reinforced entitlement mentality, created confusion about who pays LTC bills and adversely affected the marketability of private LTC insurance.

NYAHSA, through its *Vision 2020* process, developed 14 specific initiatives that the state could undertake to preserve Medicaid and generate alternative sources of program financing. We are pleased that some of these proposals and others are included in the MRT package including: (1) eliminating spousal refusal; (2) centralizing responsibility for Medicaid estate recoveries; (3) expanding the definition of an "estate" for recovery purposes; (4) applying the asset transfer look-back and penalties to community-based LTC services; and (5) enhancing incentives to purchase LTC insurance. NYAHSA strongly supports these proposals and encourages the Legislature to adopt them. We also maintain that much more must be done to ensure that

Medicaid is preserved as a safety net for the poor, and have shared our ideas with the Legislature.

Care Management of Medicaid Recipients

NYAHSA applauds the administration and MRT for recognizing the cost effectiveness and patient outcomes achieved through provider based managed LTC. However, policymakers must keep in mind that the considerable successes demonstrated by Medicaid Managed Long Term Care (MLTC), Program of All-Inclusive Care for the Elderly (PACE) and Medicaid Advantage Plus (MAP) plans were achieved primarily by mission driven, not-for-profit, provider-based organizations. The state should ensure that expansion of managed care in New York State – especially for vulnerable populations – reflects the expertise and experience of these successful provider-based models.

However, the overall MRT package seems to rely too heavily on a "one size fits all" approach to having mainstream managed care organizations (MCOs) coordinate care, rather than adapting already successful models for managing care across settings. The proposal contemplates broad-based reliance on MCOs to coordinate services and act as the state's intermediary for payment and service authorization for nearly all LTC Medicaid recipients in the future. MCOs largely do not have the experience and expertise to manage care and services for chronically ill, frail elderly people, and may instead create another administrative layer without necessarily adding value.

Provider-based MLTC, PACE and MAP programs have demonstrated expertise in managing the needs of this population and should be expanded to serve more frail elderly people in their homes. Other models, such as Long Term Home Health Care Programs (LTHHCPs), Certified Home Health Agencies (CHHAs) and adult day health care (ADHC) programs serve tens of thousands of New Yorkers each year, and have a demonstrated track record of coordinating LTC services and supports, managing patients' clinical and social needs, and forestalling institutional placement. These programs should remain as care options and be adapted to achieve broader system goals, rather than abandoned in favor of broad-based managed care.

A Major Unfunded Mandate

The MRT proposal includes a provision that would require CHHAs, LTHHCPs and MLTC plans to comply with local living wage laws. This unfunded mandate – which could costs hundreds of millions of dollars annually – will be unaffordable to providers in a climate of shrinking revenues, and is tantamount to government-imposed wage controls that may have ripple effects on other health care providers. NYAHSA's mission-driven members work hard to offer their employees fair and competitive compensation and benefits. However, Medicaid reimbursement rates simply do not meet the cost of providing care and the cuts proposed in the 2011-12 budget will only exacerbate the problem. Absent additional funding to support the increased wages envisioned here, this proposal will ironically force providers to cut direct care staff, threatening the viability of many programs and impacting quality.

The Building Blocks of Reform are Needed

In order for the LTC infrastructure to remain viable and for providers to play a major role in Medicaid redesign, the following building blocks are essential:

- **Stable and predictable Medicaid funding.** At present, nursing homes have not known what their Medicaid rates are since April 2009. A dizzying array of cuts, delayed payment changes and after-the-fact audit disallowances have left nursing homes, home care agencies and other providers utterly unable to budget and make business decisions. With all of the changes envisioned in redesign, informed decision-making will become an even bigger issue.

- **Meaningful mandate and liability relief.** LTC is heavily regulated, particularly in New York. An accumulation of legislative mandates, regulatory requirements and inconsistent oversight add tremendous cost and other burdens to service delivery, depriving the system of resources that could be devoted to hands-on services. Providers cannot survive in an environment of shrinking resources without reducing their costs of doing business. Similarly, the issue of liability must be addressed in LTC. NYAHSA was disappointed that the MRT package did not include some common sense proposals to reduce nursing home legal and liability insurance costs.

- **Access to supportive housing for seniors.** Senior housing with supportive services is an essential building block in any effort to serve more low-income seniors in the community, to promote aging-in-place and to forestall the need for more expensive Medicaid supports. NYAHSA is pleased that the MRT package includes our proposal for an inter-agency supportive housing workgroup to develop a plan to address the need for expanded supportive housing capacity. We will also be urging the Legislature to pass our Freedom of Choice legislation to ensure seniors can receive supportive services in their housing facility without inadvertently triggering assisted living licensure.

- **Access to adult care facility and assisted living services.** Many seniors need 24 hour supervision and cannot be served safely in their own homes. These facilities save Medicaid funds by delaying or preventing nursing home placement. Those with private means are willing to pay for these services, which also reduces Medicaid costs. Despite the state's policy to encourage the conversion of nursing home beds to lower cost Medicaid assisted living program (ALP) slots, the ALP has been cut the last three years in the row, with more cuts proposed this year. There is also a state imposed cap on ALP slots. These short-sighted cuts and the arbitrary cap will increase, rather than reduce costs over time and should be addressed. NYAHSA proposed other ways of streamlining the delivery of these services to the MRT, and has shared those with the Legislature.

- **Financing assistance.** NYAHSA is pleased that the MRT package includes proposals to renew authority for local industrial development agencies to finance LTC facilities, to address financing for nursing home sprinkler systems and to otherwise improve access to capital. With a large number of aging facilities, demands for technology investments and start-up costs for new collaborative ventures envisioned in Medicaid redesign, LTC providers need assistance with cost-effective borrowing alternatives and targeted grants. To date, federal and state governments have made relatively nominal health information technology investments in LTC; this will need to change if LTC is to meaningfully participate in health reform.

Conclusion

A combination of significant Medicaid cuts and major policy changes will have major short and long-term effects on the integrity of the LTC service system and the broader economy, including the following:

- Quality providers, and entire service models, may go out of business.
- Seniors will have a harder time finding the services they need and will have to go outside of their communities – or even out of state – to find what they need.
- Home care, adult day health care and other supportive community based services would take significant and disproportionate hits in this budget; and people will have to go to nursing homes unnecessarily in communities where these services are eroded.
- Unable to survive persistent and worsening underpayment, the providers that do not go out of business may have to serve less Medicaid recipients.

For decades, New York's mission driven, not-for-profit LTC providers have been the leaders in promoting quality, diversifying their services, developing innovative models of care and investing in their communities. These organizations are willing to partner with the state to reform Medicaid and service delivery, but they cannot retool while they are struggling even more to stay afloat in the short term. Ultimately, cuts to save money now will cost jobs, increase health care costs, threaten quality and erode a system of services.

Thank you for the opportunity to testify today.

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Community Health Care Association of New York State

Senate Finance and Assembly Ways and Means Joint Legislative Hearing on the 2011-12 Executive Budget Health & Medicaid March 3, 2011

Thank you for the opportunity to speak with you today about the recommendations of the Medicaid Redesign Team (MRT) and the integral role that primary care and Federally Qualified Health Centers (FQHCs) play in improving health and quality of care and reducing Medicaid costs.

My name is Edwin T. Graham and I am the Vice-President of Policy for the Community Health Care Association of New York State (CHCANYS), the state's association of community, migrant and homeless health centers.

Community, migrant and homeless FQHCs provide high-quality, affordable and accessible primary and preventive health care for more than 1.4 million New Yorkers at over 470 sites in urban, rural and suburban communities. Our community health centers provide comprehensive primary care including: family medicine; pediatrics; obstetrics and gynecology; dental; laboratory; mental health; substance abuse and pharmacy services. FQHCs are the backbone of New York's primary care system and health care safety net.

The fiscal challenges faced by New York State are unprecedented and affect every area of health care and all New York residents. ***We thank our State elected officials and government leaders for boldly attempting to identify and implement fundamental health system reforms designed to reduce costs while improving health status and quality of care.***

These challenging times have presented a unique window for our elected leaders, health care providers, business leaders and employers to embrace the opportunity and challenge of real health care reform.

CHCANYS strives to ensure that all New Yorkers, and particularly those living in underserved communities, have access to high-quality, community-based health care services by promoting policy priorities focused on these goals. With this in mind, New York's FQHCs and CHCANYS proudly support the following policy proposals:

- **Implement the approved recommendations of the Medicaid Redesign Team (MRT)**
- **Approve the Executive Budget's proposed $54.4 million for Diagnostic and Treatment Centers (D&TC) Indigent Care Pool distributions**
- **Aprove the Executive Budget's proposed $430,000 for continued funding for community health centers serving migrant and seasonal farm workers and their families**
- **Utilize HEAL funds for primary care capital expansion**
- **Restore $392,000 in annual funding for the Center for Health Workforce Studies.**

Implement the Approved Recommendations of the Medicaid Redesign Team

CHCANYS commends the work of the Medicaid Redesign Team and is extremely encouraged by the outcomes that will protect the most vulnerable people in the State and move the health system toward greater investment in high-quality, cost-effective primary care. While making the necessary reductions in Medicaid spending, several of these reforms will produce better quality healthcare for the patients who need it most. What is more, with its recommendations, the Team has taken a significant step forward in the implementation of health care reform.

We recognize that any real progress towards our goals of greater access to high-quality, affordable primary care for all New Yorkers will only be accomplished through the thoughtful implementation of these reforms. As New York State's Primary Care Association, CHCANYS stands ready to lead this effort alongside our partners inside and outside the health system.

The plan recognizes that primary and preventive care is critical to reforming New York's healthcare system, and it proposes the right kinds of initiatives to make the system work. CHCANYS authored several of the proposals considered by the Team, including two of the approved primary care proposals:

- *Expanding access to Patient Centered Medical Homes (PCMH) for New Yorkers*

  Patient Centered Medical Homes are proven to improve health status, quality of care and reduce overall costs. Investment in comprehensive coordination of primary and preventative care results in reduced hospitalizations and lengths of stay, avoidance of unnecessary ER visits, and improved medication management. This provision of the MRT recommendations enables coordination and streamlining of regulatory and operating requirements in order to facilitate the rapid expansion and development of PCMHs for New Yorkers.

- *Creating an Office of Patient Centered Primary Care Initiatives*

  We applaud the creation of a dedicated office for primary care which assures that New York takes advantage of the opportunities under the Patient Protection and Affordable Care Act (PPACA). It gives providers and stakeholders a single point of contact at the Department of Health to help reduce regulatory barriers, promote the expansion of primary care and provide leadership on addressing workforce shortages.

Through highlighting only two of the MRT recommendations involving primary care, we strongly support the intent to intelligently evaluate, reprioritize and redesign New York's health care delivery system. With the evidence of sound medical practice and proven fiscal results, primary care and Patient Centered Medical Homes are core components of New York's solution to improve health, quality of care and reduce costs.

Maintain the Indigent Care Pool for Diagnostic and Treatment Centers

The Executive Budget proposes to continue funding at $54.4 million for the Diagnostic and Treatment Centers (D&TC) Indigent Care Pool. On average, 28% of FQHC patients in New York are uninsured, and at some centers, more than 50% of all patients are uninsured. The Diagnostic &Treatment Center Indigent Care Pool provides funding to health centers for services to uninsured patients. This Pool is vital to ensuring FQHCs are able to continue to serve as the primary care safety net for uninsured New Yorkers.

Continue Migrant Worker Health Care Funding

We strongly support the Executive Budget's proposed funding of $430,000 for Migrant Health Care Programs across New York State. Migrant and seasonal farm workers are integral to New York State's agribusiness. Yet three in five farm workers live below the federal poverty level, and farm work ranks as the third most hazardous occupation in the nation, behind mining and construction. New York's migrant health centers keep farm workers healthy by providing primary and preventive health care services, including culturally competent outreach, interpretation, transportation, health education and dental care. FQHC migrant health programs proudly serve this special population at high risk for injury and illness.

Support HEAL funds for Primary Care Capital Expansion

New York needs modern facilities in underserved communities for the efficient delivery of primary care. The continuing credit crisis, layered on top of already unmet capital need in the primary health care market, may severely limit New York's ability to expand its primary care capacity as part of its overall effort to reform the healthcare system and reduce Medicaid costs.

We are very encouraged that one of the MRT recommendations is to use HEAL funds for restructuring and repurposing safety net facilities. We urge that special attention be given to ensuring that any downsizing plans include expansion of primary care in the affected communities, and that sufficient operating and capital resources be allocated to ensure successful transitions.

We know that HEAL funds are a finite resource – but it doesn't have to be that way. CHCANYS supports the creation of a permanent, revolving primary care capital fund that would leverage private sector capital and provide low-cost capital to build and expand facilities for years to come.

Restore Funding for the Center for Health Workforce Studies

We also strongly support the restoration of $392,000 in funding for the Center for Health Workforce Studies (Center) which was eliminated in the Executive Budget. The Executive Budget for SFY 2011-2012 instead proposes a competitive grant process for funds through the Local Competitive Performance Grant Program. We believe the Center was inappropriately placed in this grant program. This misplacement would result in the loss of effective planning for primary care growth and system redesign, and in the loss of federal funding. Together, these losses would mean a missed opportunity to grow the primary care delivery system and realize significant Medicaid savings.

In closing, primary care and FQHCs are the reform cornerstone for improving the health of New Yorkers while reducing New York's Medicaid costs. FQHCs help keep people healthy - prevent unnecessary hospitalizations, reduce ER visits and avoid other high-cost care. The importance of health centers is ever present and only increases in difficult economic times.

CHCANYS proudly serves as the voice for the primary care safety net and Federally Qualified Health Centers. We stand ready to work in partnership with other sectors of our complex health care delivery system to do a better job of coordinating care, meeting the needs of New Yorkers while reducing and containing health care costs.

I thank you for the opportunity to share our perspective with you today.

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Testimony

Joint Legislative Public Hearings
2010-2011 Executive Budget Proposal
Health / Medicaid

March 3, 2011

Thank you for the opportunity to comment on the State Fiscal Year 2011-12 Health/Medicaid Budget. I am Kathy McMahon, President and CEO of the Hospice and Palliative Care Association of New York State.

As you deliberate the Executive Budget proposal, I would urge you to consider hospice and palliative care as part of the solution to New York's healthcare challenges both in Medicaid as well as implementing federal healthcare reform. The Hospice and palliative care models embody what many would agree are important components to provide quality and affordable healthcare -- case management and patient centered care.

Background

The Association represents the state's certified hospice providers and palliative care providers, as well as individuals and organizations concerned with care for patients at the end of life. Hospice serves patients at the end of life and provides pain and symptom management, addresses social, emotional and spiritual needs and provides care and support to the bereaved. Hospice services are provided in the home, nursing home, and inpatient facilities. Hospice:

- Embraces all patients coping with advanced illnesses
- Focuses on comfort rather than cure
- Emphasizes quality of life
- Promotes personal choice and individual dignity

- Respects the traditions and wishes of the patient and the patient's family
- Most often provides care in the patient's home, but when necessary, also provides care in the nursing home and inpatient setting
- Utilizes current treatments and medications
- Addresses physical, social, emotional, and spiritual needs
- Provides care and support to the bereaved

Palliative care extends the principles of hospice care to a broader population that could benefit from receiving this type of care earlier in their illness or disease process. Palliative care seeks to address not only physical pain, but also emotional, social and spiritual pain to achieve the best possible quality of life for patients and their families. A number of hospice programs have added palliative care to their names to reflect the range of care and services they provide, as hospice care and palliative care share the same core values and philosophies.

In 2008 New York State's hospices served a total of 43,747 patients. Of those patients, 9,551 were residents of nursing homes. Medicaid beneficiaries represented 4.8% of all hospice patients in 2008.

Median length-of-stay in hospice continues to be low, however. Even though eligibility for hospice is a terminal prognosis of 6 months or less, on average a patient only uses 9 to 33 days worth of hospice. Considering the list of services hospice provides, terminally ill patients and their loved ones would stand to benefit greatly by accessing the hospice benefit earlier.

Medicaid Redesign and Healthcare Reform

Again hospice and palliative care are part of the solution to New York's Medicaid challenges! The Hospice and palliative care models embody case management and patient centered care. Hospice and palliative care offer appropriate, high quality, cost-effective care to patients and their families.

Hospice is one of Medicare's most cost-effective programs:

- According to an independent study conducted at Duke University, hospice saves Medicare an average of $2,300 per patient, or nearly $2 billion a year.
- A recently published study by Aetna found that "Liberalization of hospice benefits that permits continued curative treatment and removes limits on hospice benefits is a strategy that is financially feasible for health plan sponsors, insurers, and Medicare."
- Data from the 2008 Dartmouth-Atlas study, "Tracking the Care of Patients with Severe Chronic Illness" demonstrates "...more resources and more care (and more spending) are not necessarily better."

As you develop your Medicaid budget for 2011-2012, first and foremost, I would urge you to preserve the Medicaid Hospice Benefit, which enhances patient healthcare quality while also controlling costs. In addition, I would urge your consideration of the following proposals that would help to remove barriers to access to hospice and palliative care:

- Provide incentives for nursing homes to make hospice and palliative care available through contracts with their local hospices; the State could realize considerable Medicaid savings. A study conducted by Brown University supported the role of hospice in nursing homes, concluding that hospice patients:
  - Are less likely to be hospitalized in the last 30 days of life; and
  - Received superior pain assessments.

  According to federal rules, Medicaid pays hospice 95% of what it compensates nursing homes for room and board, saving 5%. Hospice, in turn, must pay the nursing facility. Medicaid is the primary payer for care in nursing homes, and this expenditure is the largest portion of the state's Medicaid budget. For nursing facility hospice eligibles that are not using their hospice benefit, Medicaid would pay 100% of the room and board charges to the nursing facility. Encouraging appropriate use of hospice in nursing homes would save Medicaid significant dollars.

- Amend NYS Hospice licensure law, Article 40, to expand the definition of terminal prognosis from 6 months to 12 months for recipients of the Medicaid Hospice Benefit. The Medicaid Redesign Team included this proposal in their report to the Governor. In addition, this proposal recommends integrating hospice into Medical Home pilot projects and into Accountable Care Organizations.
- Offer palliative care to Medicaid recipients with advanced, progressive chronic illness (also included the MRT's proposals)
- Include hospice and palliative care in the protocols for chronic illnesses.
- Make Hospice accessible to patients enrolled in the Long Term Home Health Care Program (LTHHC). Although this proposal was not included in the Medicaid Redesign Team's final short-term report presented to the Governor, I would urge your support for continued work on this proposal.

Palliative Care Education and Training Act – In 2007 the legislature appropriated $4.6 million for the purpose of implementing the Palliative Care Education and Training Act. The Palliative Care Education and Training Council has worked diligently to carry out the provisions of the Act. The majority of the dollars were intended to fund grants to palliative care certified medical schools and residency programs. I urge you to recognize the Palliative Care Education and Training grants as a wise, capacity building, cost-effective investment in the future of New York's health care system so that the RFPs for the grants can be released by the New York State Department of Health.

Article 6 Funding – County Departments of Health

I urge you to reconsider last year's elimination of hospice as an optional program under Article 6 funding. Currently five County Departments of Health—Cortland, Lewis, Livingston, Oswego, and Washington Counties—operate the hospices in their counties. All except Oswego are the sole hospice provider for the residents of their county. Elimination of these vital programs put these rural hospices at risk for closure, which would deny a very vulnerable population access to quality end-of-life

care services. I urge you to restore the Article 6 funding for hospice. Without access to hospice care, terminally ill patients who are eligible for hospice will seek care through emergency departments and acute care hospitals—at a much higher cost to the Medicaid program.

Conclusion

Speaking on behalf of the patients and families served by New York's hospice and palliative care providers, **HOSPICE AND PALLIATIVE CARE PROVIDE CASE MANAGEMENT AND PATIENTED CENTERED CARE—THEY ARE PART OF THE SOLUTION YOU ARE SEEKING!** Thank you for your ongoing support of Hospice and palliative care. I look forward to working with you in the coming year to ensure that the FY 2011-12 budget provides the people of New York with access to quality hospice and palliative care.

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The New York State Coalition of Managed Long Term Care and PACE Plans
Testimony to the Joint Legislative Budget Hearing
March 3, 2011

Senator DeFrancisco, Assemblymember Farrell, members of the Joint Legislative Committees: thank you very much for the opportunity to testify on behalf of the New York State Coalition of Managed Long Term Care and PACE Plans, which I represent. The Coalition was formed in 2006, to provide a single voice for not-for-profit, provider-sponsored Managed Long Term Care and PACE plans. The Coalition now represents plans that provide coverage for 95% of the approximately 33,000 elderly and disabled New Yorkers enrolled in MLTC or PACE.

MLTC/PACE Background: Managed Long Term Care (MLTC) provides an option for elderly or disabled Medicaid beneficiaries who require nursing home level care but wish to remain in the community. A Program of All-Inclusive Care for the Elderly (PACE) is a special kind of MLTC plan serving individuals dually-eligible for Medicaid and Medicare; these plans are responsible for providing both the physician and hospital services covered by Medicare and the long-term care services covered by Medicaid. MLTC and PACE plans are operated or sponsored by a variety of health care organizations, including homecare providers, multi-provider health care networks, and nursing homes.

MLTC and PACE have proven track records of providing access to an appropriate level of long term care, with extraordinarily high rates of patient and family satisfaction, and at a cost that is a fraction of what would be spent on institutional care. On average, MLTC plan saves the state $2,600 per month for members they keep in their homes and out of a nursing home and $1,290 per month for personal care provided to members through an MLTC plan instead of through fee-for-service Medicaid. In a recent report, the Citizens Budget Commission characterized MLTC and PACE as the "one bright spot" on New York's long term care landscape. The Department of Health prepared the chart below for the Medicaid Redesign Team, which documents that MLTC is the only long term care program in New York State that actually reduced per recipient expenditures over the last six years:

LTC Per Recipient Spending Trends by Service ($ 000)

	2003			2009			% Change in Per Recipient Spending
	# of Recipients	Total ($)	$ Per Recipient	# of Recipients	Total ($)	$ Per Recipient	
Nursing Homes	139,080	5,946,989	42,759	128,377	6,345,047	49,425	15.6%
ADHC	16,365	266,248	16,269	22,954	461,442	20,103	23.6%
LTHHCP	26,804	510,250	19,036	26,572	695,666	26,180	37.5%
Personal Care	84,823	1,824,729	21,512	75,023	2,232,735	29,761	38.3%
MLTC	**12,293**	**444,341**	**36,146**	**33,826**	**1,219,055**	**36,039**	**-0.3%**
ALP	3,538	50,488	14,270	4,720	86,028	18,226	27.7%
Home Care/CHHA	92,553	760,347	8,215	86,641	1,349,000	15,570	89.5%
Total	**318,617**	**9,803,392**	**30,769**	**318,984**	**12,388,973**	**38,839**	**26.2%**

MLTC plans coordinate an array of medical and social services providers to ensure that every client is receiving the full range of care that they need in order to stay in their homes as long as possible. MLTCs cover:

- Intensive case management
- Home nursing and home health aides;
- Social services and supports for beneficiaries and family members;
- Occupational or rehabilitation services;
- Meals and nutritional assistance;
- Assistance with chores and household management;
- Medical equipment;
- Non-emergency transportation; and
- Coordination of physician and hospital care, even when, for the non-PACE plans, they are not responsible for providing it directly.

The intensive care coordination provided by MLTC/PACE plans allows institutionalized patients to come home, nursing-home-eligible patients to stay home, and all of their members to remain comfortable and safe in their homes. And, MLTC/PACE plans create these positive outcomes at a far lower cost than nursing homes or fee-for-service long term care.

MRT Recommendation on MLTC: The Coalition supports the recommendations of the Medicaid Redesign Team that recognize the uniquely successful track record of MLTC and PACE plans in coordinating and enhancing the care of frail and disabled nursing-home eligible New Yorkers who can be safely cared for at home. In particular, the Coalition supports the MRT Proposal No. 90, which proposes the following:

- Beginning in April, 2012, individuals in New York City who require more than 120 days of community-based long term care services would be transitioned to enroll in MLTC plans or other care coordination programs as specified by the commissioner.
- As more MLTC and PACE plans became available elsewhere, the requirement to enroll in MLTC or PACE would be expanded throughout the rest of the State;
- In addition, the proposal would streamline enrollment in plans by relieving local social services districts of what has proven to be an unnecessary pre-authorization process, and giving the State authority to conduct post-enrollment audits;
- A workgroup would be established to work with the State to implement the proposal.

The MRT projects savings, over the next four years, in excess of $400 million. We believe the cost savings could be even higher, particularly if the state can negotiate for a share of the federal savings associated with effective care management for those New Yorkers who are eligible for both Medicare and Medicaid. A recent report issued by the New York State Health Foundation estimates 10-year savings of $10.8 billion if all of New York's dually eligible members were enrolled in managed care. The incentive to move in this direction is even greater, thanks to provisions in the federal Affordable Care

Act, which allows states to receive 90% federal reimbursement for care management services for two years, beginning in October, 2011. The MRT report estimates the state could save $100 million through maximizing these federal care management funds in relation to recipients requiring long term care.

We look forward, of course, to having the opportunity to review the final legislative language advanced by the Governor to achieve these objectives. We welcome the recommendation that a working group will be established to address the many implementation issues raised by the proposal and would welcome the opportunity to participate in that effort.

We are concerned that, in an effort to maximize savings, the State may seek to reduce payments even further to MLTC/PACE plans, at the same time that more complex and more frail patients are being transitioned to enrollment in the plans. The proposal already signals an intention to reduce administrative reimbursement to plans, ostensibly to reflect increased enrollment, and we fear that those reductions will be enacted even before the enrollment materializes. Other issues may arise during this transition, including a need to rationalize how the fair hearing process applies to MLTC/PACE enrollees.

Nevertheless, we believe the MRT has presented New York State with an opportunity to enhance the quality and the coordination of care for New Yorkers who require long term care services, while reducing unnecessary expenditures. Keeping people in their homes increases their quality of life, while decreasing the state's costs. Coordinating services so that patients can successfully navigate the healthcare system to get the care and support they need when they need it has been proven to be as critically important for recipients as it has been cost-effective. Transitioning New Yorkers who need long-term care services to proven and successful models like MLTC and PACE will benefit both the recipients and the State, and we urge the Legislature to support the proposal.

Thank you.

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AARP New York State Office

Testimony before the

New York State Legislature Joint Hearing

Senate Finance and Assembly Ways and Means

Health/Medicaid

March 3, 2011

Hearing Room B

Legislative Office Building

Albany, New York

Introduction

Good afternoon Senator DeFrancisco, Assemblyman Farrell, and members of the Committee. My name is Neal Lane. I am an AARP member, and I serve on the AARP New York State Executive Council as well as AARP's National Policy Council. With me today is David McNally, our Manager of Government Affairs for New York. AARP is a membership organization with approximately 2.4 million members in New York State. I would like to thank you for allowing us to speak today about budget issues related to health care and Medicaid.

I would like to focus my remarks today on three basic areas that are very important to our membership: the EPIC program, Long Term Services and Supports, and Medicaid.

EPIC

Background

Creating and maintaining access to affordable prescription drugs is a fundamental goal of AARP. According to AARP's Rx Price Watch Report, released in August 2010, the average annual increase in retail prices for the 217 most widely used brand named prescription drugs was 8.3 percent in 2009 – notably higher than the rate of increase observed during any of the

prior four years (i.e. 2005 to 2008), which ranged from 6 percent to 7.9 percent. In contrast, the rate of inflation was -0.3 percent over the same period.

Much evidence exists that hospital re-admissions are reduced when people have access to and correctly take the prescriptions they need.

With that said, AARP is very concerned to see the EPIC program set to be virtually eliminated except to cover the Medicare Part D doughnut hole. The cut is $58.4 million this fiscal year and $93.2 million for the next fiscal year. According to our preliminary analysis, if the Governor's Budget proposal is enacted, the average EPIC enrollee would pay about $1,100 in additional drug costs.

Currently, Medicare Part D is the primary payer and EPIC coverage is secondary. Using the two plans together has resulted in great savings for both the EPIC enrollee and for New York State. EPIC enrollees have benefited from support in paying premiums and co-pays, as well as from the assurance that they will always get their needed prescription drugs. Our analysis shows New York has saved about $339 million since Medicare Part D became the primary payer five years ago.

The Governor's proposal specifically eliminates EPIC coverage for Medicare Part D premiums and deductibles along with co-pay assistance and the financial hardship exemption for mandatory enrollment in Medicare Part D. EPIC will only provide coverage for drugs in the Medicare Part D coverage gap – the doughnut hole. In addition, the Governor's proposal does away with the long-standing consumer protection that no EPIC enrollee walks out of the pharmacy without his or her prescription drug. We simply cannot let this happen.

The EPIC changes proposed by the Governor contradict the assurances made by New York State that EPIC would continue to be there for enrollees. The average EPIC enrollee is 78 years old and takes four prescription drugs. Subjecting this population to increased cost sharing could result in many individuals stopping or cutting back on their prescriptions and even increasing the use of medical services as their health declines. New York State should not go back on its commitment to this vulnerable population.

AARP believes the Legislature should fully explore opportunities to maintain vital access to prescription medications for EPIC enrollees by

maximizing federal funds. Currently, EPIC is funded with state-only dollars and access to Part D subsidies is limited to individuals who meet the current eligibility levels for Extra Help or those with very low incomes that meet New York's Medicare Savings Program (MSP) eligibility levels, the highest of which is 135% of the federal poverty level.

New York should explore whether an expansion of the MSP is feasible and at what level would be acceptable to the federal government to cover as many EPIC enrollees. AARP strongly believes that whatever proposal might be considered as an alternative to the Governor's harsh approach to cost savings that all EPIC enrollees receive the same benefit and that they continue to have access to affordable prescription drugs.

Recommendation – **Reject the Governor's Article VII language and preserve EPIC.**

Long Term Care

Background

A recent survey commissioned by AARP showed that of New Yorkers age 50 and over, 72 percent say they prefer to have long-term care provided at home, either with help from home-care professionals (45%) or with help

from family and friends (27%), while just three percent say they would most want to go to a nursing home and just one in eight (13%) would want to be in a residential care facility, such as assisted living. These results demonstrate the strong support for New York to reform its long-term care system by investing in quality, cost-effective home- and community-based services that keep older people in their homes and out of expensive nursing homes.

State Balancing Incentive Payments Program (BIPP)

AARP strongly believes New York State should seize the opportunity to utilize the significant financial incentives and grant opportunities under the new federal health care law to improve our long term-care system and infrastructure and provide needed services to individuals and families in their homes.

The first of these opportunities is the State Balancing Incentive Payment Program (BIPP). New York could likely receive an additional two percent federal match on its Medicaid non-institutionally-based services and supports spending if it applies and is selected for this grant program. The BIPP, beginning October 2011 and continuing through September 2015, provides an incentive for states to offer home- and community-based

services (HCBS) as a long-term care alternative to nursing homes. It requires states to detail a plan for expanding and diversifying HCBS. Although the federal Centers for Medicare and Medicaid Services (CMS) has not yet finalized how it will calculate the additional federal match, we do know that New York Medicaid spent over $9.5 billion on non-institutional services and supports in FY 2009. A reasonable interpretation of the legislative language could mean over $190 million of federal funds to New York per year for each year of the four-year grant program.

In order to qualify, New York would have to commit to achieving a target HCBS spending percentage of 50 percent by October 2015 and have in place within six months of application three structural components in its LTC system. These are: 1) a statewide no wrong door-single entry point system; 2) core standardized assessment instruments; and (3) conflict-free case management services. To achieve #1, New York would likely have to invest some resources in a program such as NY Connects to broaden available information and ensure that people can obtain easy access to eligibility determinations for public programs. Unfortunately, the Governor's budget proposal eliminates funding for New York Connects which appears to us to be a shortsighted approach to balancing the budget, potentially making it

harder for NY to access the substantial funds from the 2 percent increased FMAP.

Community First Choice Option

The second financial incentive that New York should pursue is the Community First Choice Option. New York could potentially receive an additional **six percent** federal Medicaid match rate for implementing a Medicaid State Plan option providing person-centered, consumer-controlled home- and community-based attendant care services. This Community First Choice (CFC) option is available starting October 2011. This option is a permanent part of the new health care law and has no ending date. Services must include assistance in accomplishing and the acquisition, maintenance, and enhancement of skills for activities for daily living, instrumental activities for daily living, and health-related tasks, in addition to back-up systems for continuity of services and supports and voluntary training on the selection, management, and dismissal of attendants. States must set income eligibility levels up to 150 percent of the federal poverty level (FPL) and up to a state's Special Income Limit for those who meet the institutional level of care criteria (NY has no Special Income Limit). Proposed federal rules

have made it clear that New York would not have to change its eligibility rules to qualify for this program.

States that choose this option must maintain or exceed their prior fiscal year home- and community-based care expenditures for older adults and individuals with disabilities. States must also establish and maintain a comprehensive, continuous quality assurance system for attendant services and develop this option in collaboration with a Development and Implementation Council, a majority of whose members are individuals with disabilities, older adults and their representatives.

If New York implemented this Medicaid State Plan option and was able to move the 8,500 individuals who currently receive services in the $325 million Consumer Directed Personal Assistance Program into this new option, New York would immediately gain almost $20 million annually in new Medicaid funds. New York would continue to receive this additional 6 percent federal match for every new person choosing this option. In addition, if an additional 5,000 of the approximately 70,000 individuals currently receiving agency-based home care services in the traditional Medicaid Personal Care program chose to receive consumer-directed

services under this new Community First Choice Option, New York could achieve further savings. Clearly, it will be important to ensure that beneficiaries who move from other programs into the Community First Choice Option do not experience any disruption in service or loss of benefits.

AARP recommends that New York immediately begin to analyze projected costs and potential savings and plan for the implementation of this option so it can be ready to take advantage of the 6 percent enhanced federal Medicaid match when the program begins this year. Since CFC is a Medicaid state plan option, all Medicaid-eligible enrollees who need these services must have access to them. Given that New York already provides broad access to its personal care option, there should not be a large number of new enrollees eligible for these benefits. There are some cautions: (1) additional benefit costs could result from the legal requirement that there needs to be back-up systems or mechanisms to ensure continuity of services and supports and training for consumers on selecting and managing their personal attendants; and (2) there is also a state maintenance of effort requirement in the first full fiscal year in which the option is implemented.

We see that the Governor's budget does not include savings attributable to CFC. With the release of CFC proposed rules last week, we hope that NY will do the needed analysis.

Medicaid Redesign Proposals

As we review the proposals of the Medicaid Redesign Team, we are struck by the enormity of the volume of recommendations that directly impact persons aged 50 and over in their homes or other settings as they need medical care or long-term services for themselves or for a loved one. Based on our initial review of the final report, we see the outlines of a number of potentially positive and needed reforms that could result in bending the Medicaid cost curve while ensuring and even potentially improving the health of individuals over the age of 50, especially those with chronic conditions or who are dually eligible. However, as programs are designed and redesigned, the devil will be in the details. AARP looks forward to working with other key stakeholder to further develop these and other promising proposals including:

- Implementation of Health Homes for high-cost, high-need enrollees (#89) and taking advantage of the 90 percent increased FMAP available through the Affordable Care Act;

- Developing initiatives to integrate and coordinate care for dual eligibles (#101) and presumably again taking advantage of funding available through the Affordable Care Act for this effort;
- Developing and implementing a Uniform Assessment Tool (UAT) for long-term care services (#69);
- Changing scope of practice provisions for certain health providers to improve access to services and decrease costs (#200);
- Enhancing and improving the State's Medicaid program integrity efforts which should help reduce fraud and abuse;
- Instituting automatic Medicaid renewals for people with disabilities and the elderly on fixed incomes (#133); and
- Instituting enrollment and retention simplification practices (#1029).

However, as we review many of the other proposals, or rather thumbnail sketches of proposals, we are seriously concerned by the lack of details provided and the enormity of the transformations under consideration. We believe that each of these, given its potential impact on vulnerable individuals, should be submitted to a three- prong test:

- First: Will the recommendation actually result in the cost savings identified over both the short and long term?

- Second : Will the recommendation, at the very least, minimize harm or, better yet, improve the quality of care and quality of life for many vulnerable individuals; and
- Third: Could another approach more effectively accomplish these goals?

Persons who rely on the Medicaid program, as well as all taxpayers and the state, deserve such a thorough review. As we submit the recommendations to our very preliminary analysis, we find many of them appear to fail to meet the test. These include, but are not limited to:

- The elimination of reimbursement to nursing homes to hold a resident's bed when he or she leaves the nursing home for a brief hospital stay which could result in a nursing home resident being denied return to his or her home;
- The imposition of what AARP believes to be arbitrary and unreasonable caps on recoveries by victims of medical malpractice, such caps having a disparately negative impact on seniors and persons with disabilities;
- The imposition of arbitrary limits on physical therapy, occupational therapy, and speech therapy which could make it more difficult for individuals with disabilities to maintain or improve their functioning

and may result in deterioration and the need for higher levels of (and more expensive) care; and

- Increased copays for many Medicaid fee-for-service and Family Health Plus enrollees, despite the fact that increasing copayments has a negative impact on the health of older people – and particularly those with multiple conditions.

One of the key recommendations of the Medicaid Redesign Team to control utilization and reduce costs is to transition many long-term care consumers to managed long-term care. While managed long-term care has the potential to drive improvements in the coordination of care and fiscal efficiency, and even improve access to home- and community-based services, it can also present serious challenges to maintaining quality and assuring choice and access to care if implemented poorly.

We strongly believe that any managed long-term care program must be developed deliberatively with consumers involved in the program's creation, implementation, and ongoing oversight. Furthermore, plans must be held to strict quality and transparency standards and be required to incorporate appropriate quality measures. For example, plans should be held

accountable for unnecessary hospitalizations or inappropriate nursing home stays. In addition, plans must offer consumer-directed models that give consumers flexibility in care options. Furthermore, and of utmost importance, the state must assure that managed long-term care programs have the necessary experience to manage the unique care, service, and support needs of seniors and persons with disabilities.

The challenge for New York will be how to improve the coordination of care while preventing unintended consequences that work against consumers' interests. We do not see that this serious issue has yet been appropriately addressed, but look forward to engaging in a meaningful conversation on this with other stakeholders.

With respect to reforming personal care services in NYC (#4652), the vagueness of the proposal does not allow us to fully understand what improving the management of split shift and 24-hour care cases would entail. Furthermore, with respect to cuts to personal care, we strongly believe that home care offers cost-effective alternatives to nursing home services and we must do all we can to support individuals' desire to remain in their homes. We fully understand disparities in the availability of home

care between NYC and upstate and the long-standing problem of the high cost of NYC's personal care program, and we believe that these issues merit a careful review as much could be done to improve the cost effectiveness of the program to help people remain in their homes. That being said, we need much greater detail on specific cuts and their impact.

As New York considers recommendations to redesign Medicaid, we urge you to reject actions that will not result in savings over the longer term. Attached to our testimony is a March 2009 AARP research brief ***"Taking the Long View: Investing in Medicaid Home and Community-Based Services is Cost Effective,"*** which details recent evidence that expanding HCBS can be cost effective in the long run when combined with efforts that reduce reliance on nursing home care. Moreover, states that shift their mode of service delivery away from institutional services and toward HCBS can serve more beneficiaries with available dollars. With declining revenues, states should take the opportunity to focus on longer-term and more cost-effective reform options for their long-term care (LTC) systems, such as promoting HCBS over institutional care. Doing so has the dual benefit of not only slowing the growth in Medicaid LTC spending but also improving consumer choices.

As various workgroups are established to address major reform issues (#1451), **we strongly urge that seniors, persons with disabilities and those who advocate for them are at the table, fully engaged, and that the work of these groups is transparent for and inclusive of all stakeholders including consumers.**

Conclusion

Thank you again for allowing AARP to testify today. In tough economic times, priorities have to be set. We have outlined two main concerns for AARP and our members: first, creating a long-term care system that is consumer directed and provides a full range of services and support; and second, continuing to make prescription drugs accessible and affordable. We believe these issues should be top priorities for our elected officials. These programs will not only help thousands of New Yorkers and their families but will undoubtedly bring down costs in our Medicaid program for the reasons cited earlier. We would be happy to answer any questions.

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AARP®

Long Term Services and Supports in New York: a Blueprint for Action

A Policy Report by AARP, October 25, 2010

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Introduction

AARP is a nonprofit, nonpartisan organization creating positive social change. AARP helps people 50+ have choice and control in their lives. In New York, AARP works to help our 2.4 million members and all New Yorkers live with independence and dignity.

In 2010, AARP New York staff and volunteer leaders conducted a listening tour across the state to assess the status of current support and services for older New Yorkers who wish to remain in their homes and communities as they age, and to learn what the future might be with shrinking resources and increased populations needing care.

We spoke with consumers, local and county officials, providers, advocacy groups, as well as with state officials at the Department of Health and the State Office for the Aging to hear their concerns and ideas. Our questions to stakeholders were simply stated:

- Is New York prepared to provide care to the burgeoning 50+ population so that people can continue to live in their own homes and communities for as long as possible as they grow older?

- Are we planning ahead for the support, services and resources necessary to provide people with the choice and independence they want to stay active and engaged in community life?

- When care is needed, are the formal and informal care systems in place to support family caregivers in caring for their loved ones?

Unfortunately, the answer we heard most often to these questions was, "NO!"

So where do we go from here? What is the blueprint to get us to a place where New York State is a model for growing old with independence, security, choice, dignity and purpose?

How we care for the frail and older New Yorkers is at a crossroads. Will we do what needs to be done to provide choice, independence, and dignity for all New Yorkers as they grow older, or will we accept the status quo – a fragmented, antiquated system still primarily based on expensive institutional care? AARP believes we must seize this moment to create long term services and supports (LTSS) that provide what is needed and wanted by the state's rapidly aging population.

Numerous AARP and other surveys have documented the fact that people needing LTSS want to receive those services and supports in their homes, whenever possible. Although the types of services they need may vary considerably, services provided at home, as opposed to costly institutional care, save money for individuals, their families and public programs. On average, three people can be served at home or in the community for the cost of serving one person in a nursing home.

This blueprint outlines a number of critical steps New York can take now to strengthen its LTSS system to better respond to strong consumer preferences, increasing demand for services and the imperative need to control costs. Several of these recommendations call for action on provisions within the Affordable Care Act of 2010 that can provide financial and other assistance to help New York move forward on these recommendations. The dual challenges of increasing numbers of New Yorkers needing LTSS combined with the escalating cost of providing those services heightens the urgency for action.

Identified below are actions New York should immediately pursue to reform its LTSS system[1].

These complementary recommendations reflect the strong preferences of AARP members and other consumers, and have great potential to positively impact their lives. By adopting these recommendations, New York can also restrain cost growth in long term care spending and improve state finances.

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[1] While this paper is focused primarily on the needs of older adults, it is important to understand that the need for services and supports can begin at birth as well as any time in a person's life as a result of an event or an increase in an existing disability.

Timely, Unbiased Information and Counseling

Individuals and families need unbiased, understandable information about LTSS, very often during the stressful period after a sudden medical event. Most often, these are the first decisions that need to be made after a hospitalized person's condition has been stabilized. Commonly, a hospital discharge planner will inform the individual and family that the doctor has authorized the patient to be discharged in 24 hours. The discharge planner will then ask about where the patient should be discharged: back to the patient's home; to a rehabilitation facility; to a nursing facility. This is the point where the individual and family need a plan. They need to know what services might be available as well as how to pay for those services. Families are confronted with the new realities of having a loved one who may need support for a long time. If the individual needs to go to a facility for rehabilitation or extended care, how long will it be before they can return home? Does the home need to be modified to support the person's new need for assistance? Will the individual need temporary services or permanent support to be able to function well at home? These are only a few of the questions that must be addressed.

New York has made a commitment to giving its residents helpful, unbiased information about LTSS through NY Connects. The NY State Office for the Aging (NYSOFA) describes the program as a statewide, locally-based system that provides one stop access to free, objective and comprehensive information and assistance on long term care, links individuals of all ages with the most appropriate services regardless of payment source, and helps consumers identify services to prevent or delay institutional care. NY Connects programs operate in 54 counties and since July 2007, over 300,000 contacts have been made. Most of these contacts were from individuals seeking home and community-based services.

New York's families, regardless of their financial circumstances, need and deserve conflict-free consultation and assistance in order to make the best decisions for themselves and those they care for when the need for LTSS arises. NY Connects provides New Yorkers with unbiased information and assistance as they seek to comprehend the complexities of the LTSS system, but it must receive stronger financial support if it is to fully realize the goal of helping people avoid unnecessary and costly institutional care and preventing avoidable readmissions to hospitals. The U.S. Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services (CMS) have been funding Aging and Disability Resource Centers (ADRCs) such as NY Connects since 2003. In addition to providing objective and comprehensive information and assistance, AoA required the ADRCs to intervene in "critical pathways" to institutional care in order to reduce unnecessary and costly care. Some states and localities have focused information and counseling resources at these critical pathways (hospitals, nursing facilities, and doctors' offices), but New York has not yet accomplished this.

Recommendation:

The budget for NY Connects was cut during the last budget cycle. New York State should fully fund NY Connects so that it can continue its information and assistance activities. Furthermore, NY Connects must be charged with and funded to provide LTSS options counseling to all individuals, regardless of income at crucial times and places such as in hospitals and in nursing facilities. This will help avoid unnecessary nursing facility stays and hospitalizations and save money for both private and public sources.

The new Federal Health Law's Balancing Incentive Payments Program (BIPP) may offer New York funding for these services. See discussion of BIPP, below.

Opportunities to Reform New York's Long Term Care System in the New Federal Healthcare Law

New York should seize the opportunity to utilize the significant options and grant opportunities under the Affordable Care Act (ACA) of 2010 to improve its LTSS system to provide needed services to individuals and families in their homes. Below is a brief description of a few of these programs that New York should pursue to increase opportunities for individuals to receive services and supports at home. Not only are there additional funds that could be utilized to support NY Connects, but there are also new resources that might help family caregivers and volunteers provide needed services, support paid care workers, develop affordable and accessible housing and promote livable communities.

State Balancing Incentive Payments Program

New York could receive an additional 2% federal match on its Medicaid non-institutionally-based services and supports spending if it applies and is selected for this program. The program is described in the law as an incentive for states to offer home and community-based services (HCBS) as a long-term care alternative to nursing homes. It requires state applications to detail a plan to expand and diversify HCBS and project costs of the new and expanded services. Although the Centers for Medicare and Medicaid Services (CMS) has not yet decided how it will calculate the additional federal match, a reasonable interpretation of the legislative language could mean hundreds of millions of federal dollars to New York State over the four-year program.

In order to qualify, New York would have to commit to a target HCBS spending percentage of 50% by October 2015 (it was 47% in fiscal year 2009) and make three structural changes to its LTSS system within six months of application to achieve: 1) a statewide no wrong door-single entry point system; 2) conflict-free case management services; and 3) core standardized assessment instruments. New York would likely have to invest some resources in NY Connects to broaden available information and ensure that individuals can obtain easy access to eligibility determinations for public programs. It would also need to prioritize its work towards having a standardized assessment system statewide and across all LTSS programs.

The program begins October 2011 and continues through September 2015. CMS will likely release a program announcement approximately summer of 2011. This appears to be a significant opportunity for New York to strengthen its LTSS system and receive federal money to support HCBS expansion and diversification.

Community First Choice Option

New York could receive an additional six percent federal Medicaid match rate for implementing a Medicaid state plan option providing person-centered, consumer-controlled home and community-based attendant care services. This Community First Choice (CFC) option is available starting October 2011. Services must include assistance in accomplishing and the acquisition, maintenance, and enhancement of skills for activities of daily living, instrumental activities of daily living, and health-related tasks, in addition to back-up systems for continuity of services and supports and voluntary training on the selection, management, and dismissal of attendants. States may also choose to cover transition costs for those moving from institutions or services that increase independence or substitute for human assistance. States also have flexibility to set income eligibility levels up to 150% of the federal poverty level (FPL) or to a state's Special Income Limit, typically 300% of SSI, for those who meet the institutional level of care criteria.

States that choose this option must maintain or exceed for the first full fiscal year their prior fiscal year HCBS expenditures for older adults and individuals with disabilities. States must also establish and maintain a comprehensive, continuous quality assurance system for attendant services and develop this option in collaboration with a Development and Implementation Council, a majority of whose members are individuals with disabilities, older adults and their representatives.

CFC, unlike a HCBS waiver, does not mandate budget neutrality. States taking up the CFC option may not cap the number of individuals who can receive supports or offer benefits on a less than state-wide basis, as they may do under a HCBS waiver. Nevertheless, this option should be thoroughly evaluated to determine how New York might implement it in a cost-effective manner and achieve cost savings.

Currently New York offers a personal care program for those up to about 80 percent of the FPL. If those individuals received services under this new state plan option, New York could receive an additional six percent federal match on those expenditures. New York could offer this option to individuals up to 150 percent of FPL. In addition, New York could offer this option to persons who have incomes from above 150 percent of FPL to 300 percent of SSI and who require an institutional level of care, and receive the same enhanced match of six percent. As the state considers the CFC option, it should ensure that individuals continue to receive the services that meet their full range of needs.

Community Living Assistance Services and Supports (CLASS) Program

This new voluntary long-term services and supports insurance program can make it easier for individuals to receive cash benefits for non-medical long-term needs. This program could begin in 2012 and offer most working people over age 18 an opportunity to purchase insurance through a payroll deduction or another alternative mechanism if an employer chooses not to participate, a person is self-employed, or has more than one employer. The program has no medical restrictions on participation and will offer a cash benefit if a CLASS participant meets the eligibility criteria. State protection and advocacy systems will be required to ensure that advocacy counselors are available for those interested.

New York should analyze how CLASS intersects with Medicaid and the existing LTC Partnership program. CLASS has the potential to save public dollars, especially in the Medicaid program, as it makes it easier for many individuals to purchase an insurance benefit to address their future LTSS. New York could help increase enrollment by publicizing CLASS, creating incentives for employers to offer it, and ensuring that people know that they could receive this benefit even if they later qualify for Medicaid. New York State, as an employer, could lead the way on this program by beginning payroll deductions for its employees at the earliest possible date. State employees could opt-out if they did not wish to participate in CLASS.

Medicaid Health Homes for Individuals with Chronic Conditions

New York State should pursue the opportunity under the ACA to create a Medicaid State Plan option to offer health home services to Medicaid enrollees with chronic conditions who select a designated provider, a designated provider and team of health care professionals, or a health team as their health home. These services include care management, care coordination and health promotion, transitional care, patient and family support, referral to community and social support services, and health information technology to link services as feasible and appropriate. Hospitals will be required to refer Medicaid enrollees with chronic conditions to health home providers if they seek treatment in hospital emergency rooms.

Beginning January 2011, states will be eligible to receive planning grants (up to $25 million total for all states) for developing this new option. States will also receive a 90 percent federal Medicaid match for health home services during the first two years of implementation. By 2017, the program will be evaluated for its impact on reducing emergency room visits, hospital and nursing facility admissions.

Money Follows the Person Rebalancing Program

The Money Follows the Person (MFP) program was implemented in 2007 to help states increase the use of home and community-based services, reduce the use of institutionally-based services, and help Medicaid enrollees transition from institutions to community residences. States receive an enhanced federal Medicaid matching percentage for a one-year period for each "qualified" individual who transitions from an institution to a "qualified" HCBS program. The enhanced funding is being used by states to invest in balancing their LTSS systems. The ACA extended the demonstration period through September 2016 and appropriated an additional $2.25 billion to this program. It also changed the definition of "qualified" individual to a Medicaid enrollee who has resided in an institution more than 90 consecutive days (excluding days solely for short-term rehabilitation under Medicare), as opposed to the previously required six-month period.

New York has received a five-year commitment of $82.6 million to assist in transitioning 2,800 qualified Medicaid enrollees out of institutions and into HCBS. The program extension authorized by the ACA will not only allow New York to continue its existing work, but may also allow New York to receive additional enhanced federal matching money for balancing its system and transitioning more individuals. Among the ways New York could explore using this MFP money is to invest in NY Connects, develop affordable and accessible housing and support informal caregiver and volunteer programs.

The Vital Role of Informal Caregivers and Volunteers

The New York State Office for the Aging (SOFA) reports that over 80% of all LTSS are provided by family members, friends and neighbors. AARP estimates that as of 2007, New York has 3.3 million people providing care at some time during the year at an estimated value of $25 billion. SOFA describes a typical caregiver in New York's aging network as a 64-year-old female caring for a parent up to 24 hours a day and assisting with personal care tasks, finances, shopping, housekeeping and arranging for a large variety of other services. The average age of the person receiving this care is 82 years old. The average length of time family support is provided is 5.7 years for parents whose care ranges from not being able to be left at home alone to those who need to be checked-on several times a day.

Last year, the New York State Family Caregivers Council, representing caregivers who support health and long-term care needs across the lifespan, made a series of recommendations aimed at supporting informal caregivers[2]. Among its many thoughtful recommendations were to utilize volunteers to help support informal caregivers. The Council recommended that a patient health care navigator program be developed to pair trained volunteers with patients during hospital discharge planning and with short-term post-hospital needs. SOFA has already begun exploring a program to train volunteers to assist in a care transition program assisting with post-hospital patient needs.

The Family Caregivers Council also recommended that volunteer groups be asked to assist in transportation and escort transportation services that would help both caregivers and care receivers. Additionally, the Council recommended promoting volunteerism to give assistance to family caregivers by visiting and calling care receivers and shopping for the families. A small number of model programs have demonstrated that volunteers can effectively support both caregivers and care receivers.

The Family Caregivers Council report also recommended increased access to and support for NY Connects, enhancing affordable and accessible housing options, support for the Access to Home modification program and better access to consumer-directed respite programs.

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[2]See, "Supporting Caregivers in New York State: New York State Family Caregiver Council Report." New York State Office for the Aging, Albany, N.Y. 2009.

Recommendations:

- New York State should make a larger commitment to assist informal caregivers to keep their loved ones at home, where they want to be, and to prevent or delay the use of Medicaid services. Currently, less than $1.3 million of state funds are invested in giving relief (respite) care for these family caregivers. Additional funds should be made available for respite care, information and counseling, and additional investment in cost-effective EISEP, SNAP and Social Adult Day Care. New York should explore utilizing funds available under ACA, in particular MFP, to help finance some of these services.

- New York should expand and publicize community-based volunteer programs that support informal caregivers and care receivers. Volunteers could assist with chores such as shopping and property maintenance, providing social contact for those who have difficulty leaving their home, and help with getting to medical and other appointments. Volunteers might also provide relief for informal caregivers who need a few hours off from caregiving. Finally, volunteers could assist caregivers and care receivers with a variety of helpful tasks post-hospital discharge. As above, New York should explore how ACA funds may support these activities.

Home and Community-Based Workforce Needs

New York has a well-developed system of providing home and community-based services through a variety of provider entities and individuals, regardless of who is paying for these services. However, there are increasing challenges in delivering these services to a growing population of individuals who wish to receive these services in their homes. A critical issue that New York needs to address is ensuring the availability of qualified personnel to deliver these services at desired times and places.

The New York State Department of Labor estimates that New York will need 52,320 additional home health aides between 2006 and 2016; this is an increase of almost 38 percent. Unfortunately, there are a number of obstacles preventing the systematic recruitment and retention of home care workers, including the lack of organized and publicized training opportunities, low wages and inadequate benefits. Furthermore, individuals needing care have few effective methods of locating qualified home care workers and have limited access to fiscal management services to file and pay the required taxes.

One important way New York could increase the capacity of the direct care workforce to meet the needs of consumers in their homes is to facilitate the use of consumer or participant-directed care. This option permits individuals to hire and manage their own care providers, including family members, friends and neighbors.

Recommendations:

1. New York should direct the Departments of Health and Labor, in cooperation with the State Education Department, to identify worker shortage areas, set goals for achieving adequate supply, consolidate and improve worker training, develop methods for improving compensation and working conditions and implement a variety of recruitment strategies. The Governor should establish and ensure a strong coordinated approach to this vital issue working with the Departments of Health, Labor, and Education and with Departments focused on specific populations with disabilities, all which have responsibilities in this program and policy area.

2. New York should direct applicable agency officials to create the needed infrastructure to allow more consumers and their families to hire and manage their home caregivers, including family members, to help fill the need for qualified workers. This infrastructure development should facilitate consumers' ability to identify qualified workers and enhance the current fiscal management services structure to assists consumers in filing the appropriate government forms and paying taxes.

Affordable and Accessible Housing

As discussed above, individuals who need LTSS want to receive those services in their homes, whenever possible. However, people need to have affordable, accessible housing where these services can be delivered; otherwise, they will move to more costly settings, like nursing homes, in order to receive needed services. Whether a person owns or rents their housing, the living space must be designed to support the individual's needs. This may require modifying the residence to facilitate movement throughout, including adapting a bathroom, bedroom and kitchen and ensuring easy access in and out of the housing unit. Additionally, new and remodeled housing must be designed to address the mobility needs of an increasing older adult and disabled population.

Policies should be enacted and reinforced to support people to "age in place". Assisted living facilities provide housing with services options for individuals to age in place in a home-like environment that maximizes dignity, privacy, independence and autonomy. However, New York's current Medicaid assisted living program is exempted from the Assisted Living Reform Act of 2004 that protects consumers and allows them to remain in their assisted living residence for as long as they are able. This exemption also creates consumer confusion and sets up an inequitable two-tier system of care.

People need easy and efficient access to quality, affordable home modification services. They must know where to call for information (like NY Connects), how to finance modifications, and how to secure reliable contractors to do the work. Individuals and families should have access to independent options counselors to assist them.

New York must continue to support the development of new and rehabilitated affordable and accessible housing that can be inhabited by individuals needing LTSS. If individuals cannot modify (or have their landlords modify) their existing residence, some may move to more expensive settings, such as nursing homes.

Recommendations:

- New York should greatly expand the successful Access to Home Program administered by the Division of Housing and Community Renewal. This program provides financial assistance to property owners to make dwellings accessible for low and moderate income individuals with disabilities. The program should be better funded and publicized to enable more people to adapt and remain in their homes.

- New York should mandate that its Medicaid Assisted Living Program meet the requirements of the Assisted Living Reform Act of 2004. While it is a positive step that nursing home beds have been closed while expanding Medicaid assisted living, there should not be a two-tiered system where low income consumers receive fewer protections than other New Yorkers. The Reform Act should also be fully implemented and the Department of Health should license currently unlicensed assisted living facilities as required by the statute.

- The U.S. Department of Housing and Urban Development requires that state and local federal fund grantees produce consolidated Strategic Plans covering a 3-5 year period and an annual Action Plan covering a wide range of affordable housing issues. In these plans, New York should place a high priority on development of new construction and rehabilitation of existing residences for older adults where needed services can be delivered to them. Whether older adults want to live in senior housing or age-integrated residences, more affordable, accessible housing must be developed.

- Housing Choice Vouchers, issued by local housing authorities, allow older adults to secure "all ages" housing that is subsidized with public funds. The Governor should mandate that these vouchers be available on a priority basis for low-income individuals who would otherwise be forced unnecessarily into institutions. New York's housing agencies should coordinate with the state Department of Health and the State Office for the Aging, along with local entities such as the area agencies on aging (AAAs), to develop policies to support housing for those at risk of institutionalization and identify those individuals most in need.

Mobility Options

The lack of mobility options can make it difficult, or impossible, for individuals to access needed services. It can also make it difficult for home care workers to access the transportation services they need to provide appropriate and adequate care – or to get from their homes to people who need care. In addition, social isolation caused by the lack of mobility options can lead to negative health consequences for older consumers

Recommendations

1. New York State must invest in providing more affordable and accessible transportation throughout the state. Public and nonprofit agencies must be sufficiently funded to provide transportation that can meet the special needs of older individuals and individuals with disabilities. In addition, the State should promote public-private partnerships and volunteer programs that seek to expand transportation alternatives and reduce dependence on driving to help all people to maintain their independence.

2. The Governor should direct the Department of Health to examine ways to compensate in-home workers for time spent traveling long distances to provide services to people in their homes. Even with increased payment, these in-home services would save state money by preventing people from moving into higher cost care settings in the event they could not receive appropriate services in their homes

Conclusion

Individuals want to stay at home for as long as they are able. New York can do much to support this growing preference and save taxpayers money by delaying and preventing the use of more costly and less desirable care settings. This will require leadership and focused attention at the gubernatorial level.

Restraining public and private costs for services for a growing population of individuals in a way that better meets consumers' needs and preferences will likely require some initial investment in information, assistance and counseling, support for family caregiving, assuring sufficient, quality direct care workers and increasing affordable and accessible housing and transportation options. However, these investments will likely result in significant cost savings to the state. The Affordable Care Act of 2010 may provide some of the necessary funds for these initial investments and New York should prepare itself to take advantage of the opportunities contained in the law to restrain Medicaid funding while serving people where they want to be–at home and in their communities.

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Testimony

John P. Bracken
Past-President
New York State Bar Association

Joint Legislative Public Hearing

March 3, 2011
Proposed 2011-12 Health/Medicaid Budget

Introduction

Good afternoon. Let me start by saying **thank you** for the opportunity to appear before you today on behalf of the 77,000 members of the New York State Bar Association.

I am John Bracken and I am here to testify on behalf of New York State Bar Association President Stephen Younger, who regrets that he is unable to join you today. In addition to being a past president of the State Bar Association; I also serve on the Board of Directors of Prisoners' Legal Services; I am president of the Alexander Hamilton Inn of Court at Touro Law School; I am a director of the Stony Brook Rotary; and the Vice Chairman of the Board of the Empire National Bank.

The witness list for today's hearing has on it some of the most prominent names in the healthcare industry. Although the leadership of the State Bar traditionally appears before this panel to testify on the Public Protection Budget, an appearance on the Health Budget is extraordinary. In fact, we did not plan to be here today. However, we feel obligated to object to an unfortunate proposal that is before you.

I am here today to urge you to oppose the Medicaid Redesign Team's (MRT) Proposal Number 131, in relation to medical malpractice, because of its negative impact on New York's civil justice system.

The New York State Bar Association seeks to speak as the voice of reason regarding proposals to change the operation of our civil justice system and the impact of changes on individual rights.

NYSBA has among its members thousands of attorneys who represent the whole spectrum of clients, including plaintiffs and defendants in personal injury and medical malpractice litigation. With attorneys on all sides of the issue, we have, and will continue to provide objective analysis of legislative proposals for changing the civil justice system. We have consistently encouraged credible study and reasoned debate about this issue, based on the premise that any change to the civil justice system must be practical, responsible, and fair to all New Yorkers.

MRT Proposal Number 131, also known as the MRT's Medical Malpractice Proposal, seeks to limit New Yorkers' access to our justice system. It would do so by instituting a $250,000 cap on non-economic damages and creating a neurologically impaired infant fund (Fund). The Association strongly objects to Proposal Number 131 for many reasons, not the least of which is the process by which this proposal became a reality.

Caps

The New York State Bar Association has a long-standing position in opposition to caps on non-economic damages in medical malpractice or any other personal injury lawsuit. The Association's position is summarized as follows:

- The purpose of our tort system is to make whole or compensate the victims of harm caused by the negligence of others;
- In addition to out-of-pocket economic damages -- such as lost wages -- our system provides that a victim may be compensated for pain and suffering that results from serious injury. To cap this type of compensation would unjustly discriminate against accident victims who suffer the most devastating physical and psychological losses;
- Considering only economic loss would be unfair to victims because it does not deal with the loss of enjoyment of life.
- Awards for non-economic injuries serve to deter corporate and governmental misconduct and to protect innocent citizens. A cap would weaken the deterrent effect. Victims and society would then have to subsidize the cost of high-risk activities.

Neurologically Impaired Infant Fund

With respect to the Fund, the Association has serious concerns about its impact on the civil justice system. The proposal has not been sufficiently studied, nor has it had the benefit of full and fair review by all interested parties. While the MRT projects a state savings in the Medicaid program, the proposal's method of capitalizing the Fund appears to impose new costs on businesses and consumers. We are also concerned that the potential long-term expenses of creating the Fund are unknown and would likely be costly.

More importantly, at this point we do not even know the details regarding the proposal. This prevents any meaningful input. We are concerned that establishing such a program without input from interested parties will limit New Yorkers' access to the our civil justice system. Further, the Association urges the consideration of measures to enhance patient safety and prevent adverse medical outcomes as a proper topic in any such proposed reforms.

March 3, 2011

ATTN: Joint Medicaid Budget Hearing

RE: Medicaid Fraud, Waste & Abuse – March 3, 2011 Testimony

Good Morning. My name is Nicholas Auletta and I am the Vice President of Summit Security Services, Inc. located in Uniondale, New York. With me today is Joseph Biondo, who is the Managing Partner of Summit's Investigative Division. Joe has been targeting waste in the Medicaid system for the last fifteen years. Our intent today is to present the case for the increased utilization of investigation services to combat fraud, waste, and abuse within the Medicaid program and save New York State much needed dollars.

My firm, Summit, is a growing New York-based security and investigative business currently employing over 3,000 people. Summit was established in New York in 1976 and is now in its second generation of family ownership. Despite our humble beginnings, we are now one of the largest privately-owned security and investigative firms in the country. We are proud of these facts and believe they showcase our hard work and dogged determination to succeed in any economic climate.

Summit's Investigative Division has provided contract investigative services for the past **15 years** to help identify fraud, waste, and abuse in the Medicaid program, as well as other entitlement programs, within the State of New York. As a provider of contract investigative services with the Office of Medicaid Inspector General (OMIG), we were part of the team's success that was able to exceed last year's program goals of recovering over **$429 million** through fraud, waste, and abuse this past year. Working with OMIG, our investigative teams have a vast amount of experience in conducting investigations focused on a variety of sub-specialized medical providers. Two such examples include a Diagnostic/Treatment Center and Mental Health Outpatient facility, which resulted in restitution to the state of $4.6 and $3.2 million, respectively.

In addition, Summit has provided Nassau County with investigative services through the State's Demonstration Project that has identified over **$21 million** in fraud, waste, and abuse within Medicaid and other entitlement programs over the last five years. These funds are then returned to both the federal, state and county government while all investigative costs are deducted from the recovered monies. Currently, Nassau County is only able to utilize eight investigators while reviewing a small portion of claims

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available. As can be seen in the chart below, significant amounts of money can be recovered in overpayments and returned to those who need it most.

Fiscal Year	Amount Identified	Cost of Investigations	Identified Savings
2005 Overpayment	$937,893.09	$785,000.00	$152,893.09
2006 Overpayment	$2,413,901.27	$785,000.00	$1,628,901.27
2007 Overpayment	$2,004,267.06	$785,000.00	$1,219,267.06
2008 Overpayment	$4,342,472.21	$785,000.00	$3,557,472.21
2009 Overpayment	$6,770,377.43	$785,000.00	$5,985,377.43
2010 Overpayment	$4,875,185.50	$685,000.00	$4,190,185.50
Totals	**$21,344,096.56**	**$4,610,000.00**	**$16,734,096.56**

Like everyone in attendance this morning, I am here to fully support the initiative to help improve the New York State Medicaid program. It has been well documented within the state that enrollment in Medicaid has continually been on the rise over the last 10 years thus leading to increased Medicaid expenses. Projections in Medicaid spending for the upcoming fiscal year are in excess of $50 billion, making New York the leading national spender. Through a number of studies it has been estimated that Medicaid dollars squandered to fraud alone, range between 3% to 10%, or roughly $1.5 to $5 billion annually.

Fraud, waste, and abuse has been such a troubling issue due to the many forms, types and schemes available to those who wish to cheat the system. In recent weeks, we have seen headlines all across the country focusing on fraudulent billing within different medical sectors. The Wall Street Journal posted a story in which 114 individuals from Brooklyn, Los Angeles, Chicago and six other cities are being charged with trying to defraud the government of more than $240 million. Some of the more common fraudulent methods highlighted through the article are as follows:

- Pay kickbacks to patients to get their billing information and persuade them to claim to receive services they don't need, or don't get.
- Pay physicians to act as a clinic 'medical director' and sign off on care that isn't given, prescribe tests that aren't necessary, or order equipment such as wheelchairs that patients don't need.
- Collude with ambulance or medical-transport companies to recruit patients. Such companies sometimes bribe patients while covering transportation costs through Medicaid.
- Unbundling, a tactic whereby doctors break down what should be a single charge into many separate charges to increase total reimbursement.

These are not the only widespread tactics that have taken root within New York State. In Nassau County, Summit Security was charged with reviewing the authenticity of citizens receiving state benefits through valid home of record address checks. Our investigators found that in a pool of 1,400 people, over 800 individuals were identified as still receiving Medicaid benefits while no longer retaining Nassau County as a permanent residence. Many of these individuals had moved outside the state, while some were even residing outside of the country.

On January 28th, Summit Security went before Governor Cuomo's Medicaid Redesign Team within the public forum at Hofstra University in Uniondale, New York. There were an overwhelming number of healthcare initiatives presented; all with extreme importance that rely heavily on Medicaid funding. We presented testimony that highlighted the necessity to continue the funding of programs that our New York State beneficiaries rely on, while eliminating careless expenses for those who willfully cheat the system.

It is imperative that we do not lose the momentum that New York State has gained through an aggressive program to combat fraud, waste, and abuse throughout the Medicaid system. Equally important are the many resources available to the Office of Medicaid Inspector General in the pursuit of recovering badly needed dollars to the State. A prime opportunity for the Inspector General and Medicaid program is through increased utilization of the three pillars of fraud recovery: review, audit, and investigation initiatives.

While we noticed that the Medicaid Redesign Team approved the proposal to further auditing services, both investigation and data-mining services were not mentioned. We suggest that the State take advantage of the "low hanging fruit" by ramping up efforts in all three services; data mining, audit, and investigations, which are currently in place. We recommend the State increase the amount of reviews, audits, and investigations that are currently being conducted in our Medicaid program through both Client and Provider forums. These mission-critical intelligence programs are the key to uncovering new leads and monies. Increasing activity in these areas will provide the state with the low-hanging fruit. There are millions of dollars in savings that can be realized if efforts in contract data-mining, audit, and investigative services are applied in a more aggressive manner.

Through first-hand experience, our company believes we can maximize efforts to eliminate a greater percentage of the fraud, waste, and abuse within the system through the following methods:

Suggestions:

1) **Contract Investigation and Audit Services**
   - Through contract investigation and auditing services, New York State can select from a highly trained and talented labor pool of former law enforcement investigators. Based upon New York State pension restrictions, these individuals cannot be hired directly by the state.
   - By using contract auditors and investigators, New York State would be able to easily increase or decrease the amount of personnel needed to accommodate specific projects and save dollars through strategic staffing.
   - Contract auditors and investigators have proven that when properly managed, they provide a return of 60-80% in the total dollars identified through overpayments and identified intentional fraud.

2) **Target Known/Future Areas of Fraud**
   - Focus efforts on data mining and investigations within known high fraud areas such as Pharmacy, Physical Therapy, and Ambulette Transportation.
   - Significantly increase the percentage of claims reviewed.

3) **Look to the Future**
   - Conduct data-mining, auditing, and investigative services in areas not often reviewed, such as dental, optical, and surgical treatments.
   - Set up and monitor front-end detection systems for all enrollment. Focus on facilitated enrollers where oversight is limited.

4) **Create Synergistic Partnerships**
   - Utilize other New York State agencies such as the Department of Motor Vehicles to assist in identifying individuals with multiple identities.
   - Engage federal agencies such as the Social Security Administration to ensure deceased citizens or personnel living outside of state jurisdiction are not receiving Medicaid or other entitlement benefits.
   - Communicate with neighboring and key states on lessons learned and best practices.
   - Continue to work with 'Demonstration Counties' to further increase the resources for identifying fraud, waste, and abuse. As stated, our firm, working with one of the demonstration counties, was able to identify over **$21 million** in fraud, waste, and abuse in the Medicaid and entitlement programs.

We whole-heartedly believe that, should the state implement a more aggressive strategy, those who try to cheat the system will be found and the money will be recouped. Through this practice New York State will benefit from millions of dollars in immediate

recoveries and reap the rewards of future cost avoidance in the potential billions. Let's invest the time and effort into a proven method that will not only diminish the number of those conspiring to steal, but also recover a significant amount of wasted state funds.

Thank you for allowing me this time to offer some suggestions. I look forward to the renewed prosperity of the New York State Medicaid program.

Sincerely,

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Testimony

for the

Legislative Budget Hearing
2011-2012 Executive Budget
Thursday, March 3, 2011

Respectfully Submitted by:

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American Society of Consultant Pharmacists
National Alliance of State Pharmacy Associations
National Community Pharmacists Assn

Bangladeshi-American Pharmacists Assn
Capital Area Pharmacists Society
Hudson Valley Pharmaceutical Society
Indo-American Pharmaceutical Society
Italian-American Pharmacists Society
Korean-American Pharmacists Assn of NY
Long Island Pharmacists Society
Mohawk Valley Pharmacists Society
New York City Pharmacists Society
Northern New York Pharmaceutical Society
Onondaga County Pharmaceutical Society
Pakistani-American Pharmaceutical Assn
Pharmacists Assn of the Southern Tier
Pharmacists Assn of Western New York
Pharmacists Society of Orange County
Pharmacy Society of Rochester
Westchester/Rockland Society of Pharmacists

Albany College of Pharmacy and Health Sciences
Arnold & Marie Schwartz College of Pharmacy and Health Sciences
D'Youville College School of Pharmacy
St. John's University College of Pharmacy & Allied Health Professions
Touro College of Pharmacy
University at Buffalo School of Pharmacy & Pharmaceutical Sciences
Wegmans School of Pharmacy, St. John Fisher College

Executive Summary

Pharmacists Society of the State of New York's

Testimony

Legislative Health & Budget Hearing

Thursday, March 3, 2011

NYS Pharmacy's Continuing Financial Crisis:

- Loss of over 400 independent pharmacies in past 2 years;
- Continuation of large chain consolidations;
- Loss of over 12,000 F/T & P/T pharmacy jobs;
- Half of all pharmacy school graduates have no job offers in NY;
- Mandatory mail order only prescription drug programs draining nearly $6 billion annually from the state and over 18,500 jobs *(see pages 2-3)*

Pharmacy Benefit Managers (PBMs) Claims of Savings Are Nothing More Than Smoke and Mirrors.:

- Despite seven (7) straight years of innovator brand drugs losing their patents and having competing generic drugs at 20% of the cost entering the marketplace, health drug plans are still seeing annual double-digit increases in their plan's prescription drug costs. Even in mandatory mail order only programs.
- If PBMs were so good at managing the drug costs, then why did the Medicare Part D prescription program experience a 60% increase in premiums since 2006, despite annual increases of out-of-pocket costs for participants?
- If a health plan's prescription drug benefit isn't going down by 2% a year through 2014, then they need to get a 'Transparent PBM.'
- The greatest number of branded drugs have already lost their patents in the history of the industry.
- One NYC-based public supported union plan with over 300,00 covered lives moved from a 'mandatory mail order only' back to community-based pharmacies and had a net savings of $50 million.
- From 2005-2009, PBM 10K's filed with the Security and Exchange Commission indicated record 'net profits' with two of the Big Three doubling their net profits and the third 'tripled' its net profits. Together in 2009, the Big Three PBMs had 'net profits' in access of **$5.8 billion.**
- Mandatory mail order prescription programs are used to hide billions in revenue for the PBMs. *(see pages 3-9)*

Medicaid Redesign Team Proposal #11:

We call upon the Legislature to **reject** any proposed plan to move pharmacy services back into managed care.

- This recommendation is based on a 'flawed,' self-serving report issued by The Lewin Group which is a subsidiary of United Healthcare who happens to own a large PBM called Prescription Solutions.
- The Lewin Report was paid for by PCMA, the lobbying arm of the PBM industry.
- Back in the mid-90's, managed care organizations were removing themselves from the Medicaid program and blaming it on the cots of drugs.
- In 1997, you passed the 'Pharmacy Carve-Out' legislation and this has led to extraordinary drug manufacture rebates back to the General Fund that now approach $1.5 billion. $900 million of those rebates are New York's share. Placing the Medicaid pharmacy services back into managed care jeopardizes the $300 million (and growing) supplemental rebates we now receive.
- With the PBM's track record of calling rebates something else, trusting them with the state's other $600 million share of regular rebates is frankly – scary. ***(see pages 9-12)***

Medicaid Redesign Team Proposal #15

- Enhance supplemental rebates - ***supports***;
- Eliminate 'physician prevails' – ***supports***, with exception for the four protected classes of drugs unless patient is 'newly diagnosed;
- Authorize DOH Commissioner to negotiate directly with manufacturers - ***supports***;
- Tighten the early refill edit – s***upports*** as long as it is not less then 5 days and an override for special circumstances still exist;
- *Align dispensing fees between brands and generics* – ***opposed.*** Can you say 'cut?' You want to incentivise generic dispensing, not the reverse. This would have the opposite effect. The State Maximum Allowable Cost (SMAC) is so low today, that many generic reimbursements are already below the cost of dispensing. This is why we requested that Medicaid conduct a 'cost of dispensing' survey.

- *Adopt the California reimbursement for brands* – ***opposed.*** This is just a euphemism for reducing reimbursement from AWP-16.25% to AWP-17%. Why not Wisconsin's reimbursement rate?

- *Require 'prior authorizations'* for the four protected classes of drugs – ***opposed.*** This would be a huge administrative nightmare for both prescriber and pharmacist if you required a 'PA' for every drug an HIV/AIDS patient takes in a year. With multiple changes in drug therapy regimens for many HIV/AIDS or Transplant patients, you would be requiring dozens of phone calls from prescribers to Medicaid for every patient. Then, pharmacists would have to make the same phone calls to get the 'PA' number in order to bill Medicaid. This would overwhelm the staffs of prescriber, pharmacies and Medicaid alike.
    - Medicaid's P&T Committee should do periodic cost analysis of leaving a branded drug on a PDL for the benefit of supplemental rebates versus moving to a 'class A' generic.

- *Voluntary Mail Order program for Maintenance Drugs* – Medicaid already has such a program that recipients use less then 1% of the time. 'Lost in the mail' and 'I never received it' are commonly heard in mail order programs. The OMIG 'requires' the patient's or their caregivers signature for pick-up of their prescriptions in retail settings even if they deliver.

- *Shorten time frames of P&T Committee* – ***support.*** The P&T Committee is at the mercy of DOH who calls the meetings. Shorting the time frame in between PDL approvals would brings millions more in rebates to the state much sooner.

- *Change reimbursement for clotting factor* – **neutral.** This is an issue for the blood disease groups who have their own pharmacy.

- *Limit Opioid prescriptions to four (4) every 30-days* – ***opposed.*** We understand the issue of 'doctor-shopping' by abusers of opioid medications. But, we could only ***support*** this if physicians can get an override for Hospice situations (end of life); cancer or severe physical trauma where a patient may have a need for multiple opioids and may have had a bad reaction to one or more opioids before finding one or a combination that works;

- *Increase the number of immunizations pharmacists can administer* – ***strongly support***. Please see our comments on savings below.

- *Short Cycle Dispensing for Nursing Homes* – ***Concerned*** – We would like to see this work as it is also recommended by CMS for Medicare Part D. Our problem is: *'it will dramatically increase the cost of dispensing.'* Most nursing homes do not have their own in-house pharmacies and rely on outside contracts with Long Term Care (LTC) pharmacies. The drug packaging will not change between a 30-day and a 5-day supply so the cost of packaging remains the same. It takes almost the same amount of effort to prepare, package and bill for 30-days as it does for 5-days.

- *Return and re-stock of unused drugs in LTC settings* – ***Support ONLY*** LTC pharmacies are authorized for a 'return-to-stock and re-use' program that ***pays*** the pharmacy a fee to remove drugs from packaging (which include sealed 'bingo' cards) of unused drugs, restock, reverse bill Medicaid and re-bill for quantity used. This is a much longer process then filling an original prescription and should be reimbursed appropriately. Currently, these medications are being unpackaged and destroyed. Many branded medications cost several dollars per pill. The real savings is in the return and restock program, not in short cycle fills.

I want to thank the chairs and committee members for this opportunity to provide testimony on behalf of the Pharmacists Society of the State of New York.

The Pharmacists Society has represented New York State's pharmacists and the patient's they serve for over 132 years and we hope to continue that tradition for many more years to come. We feel strongly that our pharmacists have performed their duties as health care providers and patient advocates in the honored tradition of this society and their profession despite the many challenges they have faced over the past several years.

Pharmacy's Own Financial Crisis Continues!

Last year, I had mentioned that NY's independent pharmacies and a large regional chain and one national chain were struggling to pay their bills under the continuous cuts they had sustained over the previous two years. Since then, we have had nearly 400 independents close; we had a large regional chain sell out to a national pharmacy chain and a continuation of consolidation of pharmacy outlets throughout NYS. With the Duane Reade purchase by Walgreen's, we expect at least 100 of the 257 pharmacy outlets to be closed within three years. A national chain organization has fallen deeper into debt and is at risk of breaking up by the end of 2012. Pharmacy job losses now exceed 12,000. (F/T & P/T) There are not enough NY-based pharmacist jobs for our graduating classes. In 2010, 20% of our pharmacist graduates had no job offers. This year, that number is 50%. If this trend continues, it may have a negative impact on Pharmacy School enrollments thereby, having a negative effect on the schools themselves and the local economies that feed off those enrollments.

With Medicaid accounting for 4.9 million lives covered under the same low reimbursement added to the 1.2 million covered lives under the state employee prescription drug program, our pharmacies face an unsustainable reimbursement for nearly one in three patients coming through their doors. For our independents, which make up more then 50% of all remaining pharmacy outlets in NYS and don't have big front ends to sustain their operating costs, a less then 12% Gross margin doesn't pay the bills.

To demonstrate the financial plight of our independents, one need only reflect on the sale of Kinray, the largest independent pharmacy wholesaler in the state and the fifth largest wholesaler in the nation with over 1,000 independent pharmacy accounts here in the NYC-metropolitan area. They sold to a much larger national wholesaler because their accounts receivables were bleeding red with more then 40% of their customers being 30-days or more behind in payment. This loss was a crushing blow to many independents who were receiving more favorable purchasing terms then what they could typically get from a national wholesaler. Our concern now is what will happen to those 40% in the NYC-Metropolitan area who are already behind in payments? We have had several cases where pharmacies have had to declare bankruptcy and sell because their wholesaler was forced to sue them for immediate payment.

Can We Turn Pharmacy Job Losses Around to Benefit the State?

We strongly believe that both the state and pharmacy community can benefit if we were to prohibit mandatory mail order prescription drug programs. I know that many people believe that mail order saves money. We have evidence that proves otherwise. Evidence provided to us from a Pharmacy Benefit Manager (PBM) who moved over 360,000 individuals in one NY-based, taxpayer supported prescription

drug plan from an out-of-state mail order pharmacy back to NY community-based pharmacies. The plan was experiencing 16%-21% annual prescription drug cost increases ***despite*** being in a mandatory mail order program. In the first year after the transition, this plan had a ***"net"*** savings of $50 million. I have provided you with a chart given to me by the PBM that made this move and it compares mail order ***per day cost of therapy*** to community pharmacy per day cost of therapy when you compare apples to apples, that is, 90-day supplies. In the nine month period of price comparisons, community pharmacy ***was $0.53 per day, per therapy less expensive.*** It doesn't sound like a lot of savings until you multiply those days of therapy by the $0.53 and that alone was approximately ***$25.5 million in just 9 months!*** This union will save an additional $210 million over the next three years. ***(see Appendix A)***

One of my colleagues recently presented our PBM 101 program to a large Philadelphia Teachers union just a few weeks ago. The program educates payers on how to develop a cost effective, community pharmacy-based prescription drug benefit. The teachers union was also experiencing ***double-digit annul increases*** in their prescription drug benefit costs while participating in a mandatory mail order contract. The teacher's union estimates that they will save $25 million in the very first year and continue those savings through 2012 and then costs will flatten. Mail order only prescription drug programs are nothing more then a ***"black-hole"*** for payers money. I challenge any payer to tell me what they are really paying on a per unit (per pill) basis for a particular drug. Do they know what the real administrative costs are to manage their program? Unfortunately, many managed care organizations are in bed with their PBM. They receive "kick-backs" that range from millions to over a hundred million dollars from their PBM all while

employers and consumers pay higher premiums, higher co-pays and get less access to prescription drugs.

Mandatory Mail Order Only Prescription Drug Plans Rob NYS of Tens of Thousands of Jobs and Wastes Hundreds of Millions of Dollars in Drugs

Let me premise this next statement with this: We are not opposed to mail order pharmacy if it is for the patient's convenience. We do oppose ***"forced"*** mail order pharmacy plans. In 2009, mail order only plans drained approximately $5.6 billion dollars from New York State, including billions in taxpayer supported programs. We fully expect that to increase to $6.0 billion based on 2010 prescription drug sales numbers. Had that money stayed in this state instead of going to out-of-state mail order pharmacies, the gross margin revenue alone could create as many as 18,500 well paying NYS pharmacy jobs and all the revenues those jobs would create for other businesses and the state's treasury. NYS does not have large mail order pharmacy facilities, so prescriptions are filled in New Jersey, Pennsylvania, Florida, Texas, Arizona and Missouri. They create jobs in those states and provide an economic boost to their small businesses and provide tens of millions of dollars in state and local revenues. ***(see Appendix B–Mail Order Cost Methodology)***

How Do We Create Jobs in New York State, Increase Revenues and Lower Prescription Drug Prices?

The Legislature and Governor can take several steps to make this happen. They can pass legislation that **prohibits mandatory mail order only programs** for all non-ERISA prescription drug plans in the state. At the same time, you need to pass strong PBM Transparency legislation that requires PBMs to provide critical missing information to all plan sponsors so they may make ***"informed"*** decisions. This will stop PBMs from denying plans information, such as what they reimburse their pharmacy network, under the guise of 'proprietary information.' Plans can

sign "non-disclosure agreements. That way, plans would know if the PBM has added a huge spread on the price of generics, for instance.

What Is A "Spread" on Generics?

At the end of 2009, I had been contacted by a consumer who hit the Medicare Part D "donut" hole in which she stated that her PBM wanted $400.00 for just one of her generic drugs and that she could not afford that plus her other two medications. These out-of-pocket costs would have been for six months. I asked her to inquire with her pharmacist "how much" he/she was paid for that same generic from the PBM when the patient was still under her Part D coverage. **The pharmacy was paid just $12.00!** His cash price was $16.00 yet, the patient's plan was billed $400.00 every month for six months by the PBM and that PBM expected this patient to continue to pay $400.00 per month for that generic drug out-of-pocket for the remainder of the year while still paying her Part D premium. This is just one of many examples of **PBM pillaging** of scarce health care resources. ***(See Appendix C for copy of an actual patient Part D EOB – Explanation of Benefits)*** The hand written dollar amounts were inserted by her pharmacist and represent actual amount paid to the pharmacy verses the typed amount which was paid by the plan as billed to them by their PBM. The plan had ***no idea*** this was happening.

To demonstrate the middle man roll of PBMs as **"cost drivers"** and **"revenue hiders"** one need only look at their **10K's** they file with the Securities and Exchange Commission (SEC) each year. ***(See Appendix D)*** If you look at just the ***BIG THREE*** PBMs for the past five years ending with 2009, two PBMs' **"net" profits doubled** and one PBMs' net profit actually **"tripled."** This, during a time when most businesses were losing profits, laying off staff, reducing health care benefits, making employees pay higher out-of-pocket co-pays or simply going bust. What you will see going into 2010 is quarter after quarter of record profits for these same

PBMs. Despite paying out hundreds of millions in top executive salaries, bonuses and benefits, the BIG three's "net profits" for 2009 were in excess of **$5.8 billion**. Not bad for being nothing more than an electronic switch.

Mandatory Mail Order Only Prescription Drug Programs Wastes Millions!

In a four hour period, on one Saturday last Fall, the DEA held a national prescription drug take back program. At over 3,000 sites across the nation, the DEA program took back approximately **242,000** pounds of prescription drugs almost all still in their prescription containers. Over 90% of these unused drugs were in the 90-day mail order supply containers as witnessed by pharmacists at the receiving sites. The 242,000 pounds of drugs equates to over **98,800,000** pills costing over **$257 million**. These drugs were later burned by the DEA. All of us pay for this waste in higher premiums and co-pays. Our environment pays a heavy price for this waste as so many drugs have been flushed down toilets or thrown into the garbage. These unused drugs also provide great targets for diversion and dangers for our children.

Passing A.809/Gottfried – PBM Transparency and (A.5502-Heastie/S.3510-Maziarz) – No Mandatory Mail Order legislation will open the eyes of payers that mandatory mail order is being used to **hide billions of dollars in PBM profits** and funnels tens of billions of dollars to the PBM's wholly-owned mail order and specialty pharmacies. Once payers understand that mail order ***does not*** save them money, they will bring that $6.0 billion back to NYS thus creating jobs and state and local tax revenues. New York cannot just cut their way out of unemployment and falling state revenues. This legislation will lead to job creation all over the state while saving both public and private health plans hundreds of millions of dollars annually. It will assist our schools and local governments in getting the best

possible deal for their prescription drug programs saving them tens of millions of dollars each year. Similar savings will come to self-funded unions and employers.

Consolidating State Prescription Drug Plan Processors

We believe that one way to significantly reduce state costs of operating the state employee drug plan is to consolidate the current contract (when it comes due) with the Medicaid prescription drug claims processor. You would be adding the 1.2 million retirees and state and local employees to the power of 4.9 million Medicaid, Child Health Plus and Family Health Plus enrollees as a ***subcontract.*** State and local employees and retirees would continue to have their own distinctive plan and benefits card while saving the state millions in lower processing fees. We would also suggest that Medicaid's staff, who negotiates rebates directly with drug manufacturers, be expanded to do the same for the state employee plan, as a ***subcontract.*** Medicaid averages around 39% in rebates or an estimated $1.5 billion this fiscal year of which $900 million is the state's share. Medicaid's processor has also successfully blocked all of what we refer to as ***"repacker"*** National Drug Code (NDC) numbers that can often result in a reimbursement that is significantly higher then the NDC's provided by the original drug manufacturer. This and elimination of any potential spreads on generic drugs could save the state tens of millions of dollars each year. ***(See Appendix E)*** – Snap shots of pharmacy PC screen when asked to bill **state employee plan** with the manufacturer's NDC number and "repacker" NDC number. As you can see, the ***"repacker"*** NDC provides a reimbursement for Celebrex® 200 mg. 90-day supply of **$1,409.78.** Using the original manufacturer's NDC number for that same drug, same strength, same quantity would only reimburse at **$634.47** or less then half the repacker amount. Also included are two pages from ***The Red Book*** which lists the per tablet/capsule drug cost for pharmacies. As you can see with the repacker numbers on the second

page, that same drug per capsule cost can range form $4.00 per capsule at retail to more then $9.00 per capsule using a repacker number. State Comptroller DiNapoli recently released a report pointing out this very shortfall in the state employee prescription drug plan.

Medicaid Redesign Team Proposal #11:

We call upon the legislature in the strongest terms to ***reject*** any proposed plan to move pharmacy services back into managed care as proposed by Medicaid Redesign Team. The recommendation was based on a 'flawed' self-serving report issued by The Lewin Group. This recommendation, if adopted, would be a train wreck of unintended consequences.

- The Lewin Group is a subsidiary of United Healthcare who happens to own a large PBM called *Prescription Solutions*. The Lewin Group report is just a Medicaid grab by PBMs to pressure tens of thousands of our sickest and most vulnerable citizens into mail order pharmacy.

- The report was paid for by PCMA, the lobbying arm of the PBM industry.

    - Some of you may recall in the mid-1990's when managed care organizations were removing themselves from the Medicaid program and blaming the cost of drugs for the reason for leaving and demanding higher premiums to remain in Medicaid. In 1997, Medicaid Pharmacy carved-out the drug benefit from managed care with no cuts to their monthly premiums. Pharmacy gave up $1.00 per prescription in dispensing fees that cost them $80 million a year.

- o The Legislature must also consider what will happen to the $300 million hole in the state's General Fund when you suddenly have no more supplemental manufacturer rebates.

- PBMs haven't controlled the cost of prescription drugs and in fact have increased costs with their hidden revenues from "spreads" on drugs. Since it's inception in 2006, the Medicare Part D prescription drug program premiums have increased 60% all while participants' out-of-pocket costs increased as well. Each year, non-subsidized participants' out-of-pocket, before coverage prescriptions costs have gone up; more enter the 'donut hole' non-coverage gap and sooner because of 'spreads' on generic drugs.

- A record number of branded drugs have come off patent since 2003 which with proper generic drug utilization should have reduced prescription drug costs by 2% a year starting in 2005. Despite retail pharmacies increasing generic drug utilization, as high as 70% in the Part D program, costs continue to escalate under the 'management' of the PBMs. Is this what the state wants?

If you want to substantially increase the use of generic drug utilization (as community pharmacies have done so successfully in the Medicare Part D program), then you need to incentivize their dispensing. We've also seen more branded drugs moved to the Preferred Drug List (PDL) bringing in nearly $300 million in ***state only rebates*** from drug manufacturers. This needs to be expanded.

The state should dramatically increase the pharmacy reimbursements for generic drugs. By incentivizing pharmacies to dispense more generics instead of the current system that often pays pharmacies below the cost of dispensing.

- This can be done by eliminating the Federal Upper Limit as a "lower of" reimbursement because CMS has not increased the prices on these FULs since April of 2009. No pharmacy in its right mind would dispense a generic drug for significantly less then what they paid for it. This is happening now.

- Second, the state's Maximum Allowable Cost (SMAC) list prices for generic drugs are far too low. Too often, I hear from pharmacists that their reimbursement for many popular generic drugs is literally pennies. A small business cannot survive long when the reimbursement falls below a 5% gross margin.

- The state should also consider "mandatory co-payments" for all Medicaid and Family Health Plus participants. As a protection against undue financial hardship for our poorest citizens, a monthly out-of-pocket limit of no more then $15 could be put in place. Mandatory co-pays worked in the Medicare Part D prescription drug program and with NY's 577,000 dual-eligibles who were s transferred over from Medicaid to Medicare Part D programs and over several months were able to successfully move into more and more generic usage which now hovers around 70% with the assistance of their community pharmacist.

It is our community pharmacists working with prescribers who can assist New York's Medicaid program in moving toward greater generic drug usage. By the end of 2014, all innovator drugs will be off patent and should have a class A generic(s) substitution available for consumers, saving everyone. Although PBMs would like to take credit for the move to much higher generic dispensing in this country, it is the community-based pharmacies that made it happen. Let us not

forget that PBMs still earn hundreds of millions of dollars on brand name drug rebates and will not relinquish those dollars until the very last patent has expired. PBM mail order facilities are consistently far behind community pharmacies in dispensing generics. In the meantime, they also see the writing on the wall. So, they began in 2002 to create huge "spreads" on generic drug prices to keep their very high net profits and the reason why plans continue to see double-digit prescription drug costs increases every year. The yearn by PBMs to generate generic drug spreads from Medicaid by pushing prescription drugs out of Fee for Service and back into managed care is absolutely scintillating, as it is a domain PBMs control.

Additional Pharmacy Related Medicaid Redesign Team Recommendations:

After studying the pharmacy-related policy proposals by the Medicaid Redesign Team, it is obvious that they did not have a single prescriber or pharmacist sitting on the committee. Many of these recommendations are counterintuitive and may actually increase ER, hospitalization and Long Term Care costs. PSSNY has the following positions:

- ***Proposal #15***
    - Enhance supplemental rebates - ***supports***;
    - Eliminate 'physician prevails' – ***supports***, with exception for the four protected classes of drugs unless patient is 'newly diagnosed;
    - Authorize DOH Commissioner to negotiate directly with manufacturers - ***supports***;
    - Tighten the early refill edit – s***upports*** as long as it is not less then 5 days and an override for special circumstances still exist;

- *Align dispensing fees between brands and generics* – ***opposed.*** Can you say 'cut?' You want to incentivise generic dispensing, not the reverse. This would have the opposite effect. The State Maximum Allowable Cost (SMAC) is so low today, that many generic reimbursements are already below the cost of dispensing. This is why we requested that Medicaid conduct a 'cost of dispensing' survey.

- *Adopt the California reimbursement for brands* – ***opposed.*** This is just a euphemism for reducing reimbursement from AWP-16.25% to AWP-17%. Why not Wisconsin's reimbursement rate?

- *Require 'prior authorizations'* for the four protected classes of drugs – ***opposed.*** This would be a huge administrative nightmare for both prescriber and pharmacist if you required a 'PA' for every drug an HIV/AIDS patient takes in a year. With multiple changes in drug therapy regimens for many HIV/AIDS or Transplant patients, you would be requiring dozens of phone calls from prescribers to Medicaid for every patient. Then, pharmacists would have to make the same phone calls to get the 'PA' number in order to bill Medicaid. This would overwhelm the staffs of prescriber, pharmacies and Medicaid alike.
  - Medicaid's P&T Committee should do periodic cost analysis of leaving a branded drug on a PDL for the benefit of supplemental rebates versus moving to a 'class A' generic.

- *Voluntary Mail Order program for Maintenance Drugs* – Medicaid already has such a program that recipients use less then 1% of the time. 'Lost in the mail' and 'I never received it' are commonly heard

in mail order programs. The OMIG 'requires' the patient's or their caregivers signature for pick-up of their prescriptions in retail settings even if they deliver.

- *Shorten time frames of P&T Committee* – ***support.*** The P&T Committee is at the mercy of DOH who calls the meetings. Shorting the time frame in between PDL approvals would brings millions more in rebates to the state much sooner.

- *Change reimbursement for clotting factor* – **neutral.** This is an issue for the blood disease groups who have their own pharmacy.

- *Limit Opioid prescriptions to four (4) every 30-days* – ***opposed.*** We understand the issue of 'doctor-shopping' by abusers of opioid medications. But, we could only ***support*** this if physicians can get an override for Hospice situations (end of life); cancer or severe physical trauma where a patient may have a need for multiple opioids and may have had a bad reaction to one or more opioids before finding one or a combination that works;

- *Increase the number of immunizations pharmacists can administer* – ***strongly support.*** Please see our comments on savings below.

- *Short Cycle Dispensing for Nursing Homes* – ***Concerned*** – We would like to see this work as it is also recommended by CMS for Medicare Part D. Our problem is: *'it will dramatically increase the cost of dispensing.'* Most nursing homes do not have their own in-house pharmacies and rely on outside contracts with Long Term Care (LTC)

pharmacies. The drug packaging will not change between a 30-day and a 5-day supply so the cost of packaging remains the same. It takes almost the same amount of effort to prepare, package and bill for 30-days as it does for 5-days.

- *Return and re-stock of unused drugs in LTC settings* – ***Support ONLY*** LTC pharmacies are authorized for a 'return-to-stock and re-use' program that ***pays*** the pharmacy a fee to remove drugs from packaging (which include sealed 'bingo' cards) of unused drugs, restock, reverse bill Medicaid and re-bill for quantity used. This is a much longer process then filling an original prescription and should be reimbursed appropriately. Currently, these medications are being unpackaged and destroyed. Many branded medications cost several dollars per pill. The real savings is in the return and restock program, not in short cycle fills.

Pharmacists and Pharmacies Expand Access to Immunizations, Saving Millions of Healthcare Dollars

Pharmacists offer a unique opportunity for a modest investment that could bring significant returns in healthcare quality and cost-containment. Immunization provides an excellent example. The statute allowing trained certified pharmacists to immunize adults with flu and pneumococcal vaccine became law in August of 2008. Final regulations soon followed in December of 2008 and by the fall of 2010, just two years from authorization, more than 5,000 pharmacists have completed the rigorous training process and over 4,500 have been certified as immunizers by the NYS Board of Pharmacy. This law will sunset in 2012 and we are asking legislators to expand those vaccines pharmacists can provide and are

already trained to provide; eliminate the barriers to patient access by authorizing the state health commissioner to provide a statewide written protocol authorizing pharmacists to immunize without a "specific" physician order; eliminate the sunset clause and reduce the age limit (appropriately) to allow parents to get their older children approved vaccines.

Tens of millions of dollars in Medicaid savings can be realized from the reduction of Emergency Room treatment and hospital admissions when protected by certain vaccines. Initial indications from the CDC on NYS immunization rates in pharmacists first year of providing such services, shows a significant increase in immunization rates for NY and a significant movement among our minority populations. We know this is not all pharmacists but, pharmacy advertising through TV, print and radio has provided a heighten public awareness of the importance of getting the flu shot. It is a case of "floating everyone's boat."

- *Proposal from OMIG – require every pharmacy to swipe Medicaid cards*, requiring pharmacies to pay $800 for "analog" swiping machines that are 20th century technology. PSSNY ***Strongly Opposes***.

- Many pharmacies have already switched their telecommunications over to digital to save money. This requirement would force them to "re-install" and analog phone line ($250) and pay for a separate analog telephone line ($250 per month) to participate in Medicaid. This will backfire as many pharmacies with few Medicaid patients may choose to drop out of the program. This is an unnecessary burden on pharmacies both financially and administratively.

- We find the card swipe program to be a financial burden on already strapped pharmacies. What the OMIG needs to do instead is to put more then just 4 of

their more than 600 employees into investigating Medicaid recipients who may be "renting out" their benefit cards. This hurts the Medicaid program and those who really need the benefits.

- The OMIG instituted a randomly sequenced numbered card system several years ago to prevent providers from just "billing-up" another number to get paid. To their credit, they saved a lot of money but, when asked if they did a "cost analysis" as to the "additional savings" they would obtain from the "card swipe" program, they had not and this when the OMIG was telling us the taxpayers would pay for these swiping machines.

- In addition, the OMIG has sent letters out to all pharmacies as they are brought into the swiping program that they ***MUST*** swipe at least 85% of all cards under risk of an audit recapture of reimbursements. First of all, more than 25% of the Medicaid cards are not recognized by the machines (Trans 880's) because either the magnetic strip is too worn in some cases missing altogether. To the OMIG's credit they did managed to have a new card developed with a much stronger magnetic strip but, counties do not have the money to buy these new cards and will continue to use the old ones.

- Finally, what kind of burden does this place on home-bound Medicaid recipients who refuse to give their cards to caregivers to pick up their medications in fear that it will either get lost or rented out? Will their families have to bring them to the pharmacy each time they need a prescription filled? What about OMRDD Community Adult Homes? Will they have to bring in all of their clients to get their prescriptions filled? How about Nursing Homes?

The OMIG's card swiping program is 20th century technology that will increase costs to both Medicaid and the counties and only counts as "avoided costs" in the OMIG's Annual Reports. What avoided costs?????

Additional Savings:

- Remove Medicaid co-pays for over-the-counter (OTCs) medications. OTC's are approximately half the cost of generic prescriptions and 1/20th the cost of branded prescriptions. Medicaid should incentivise recipients to use those OTC's (many of which were previously prescription drugs) to relieve seasonal or temporary conditions. They come in smaller package sizes and are for limited use. These may include: allergy and stomach acid symptoms.

- ***Shift 200 OMIG employees over to the Attorney General's Medicaid Fraud Unit.***
    - The OMIG is wasting millions of tax payer dollars in pursuing non-fraud related audits seeking million dollar and more recoveries for 'minor' administrative errors. The patient received the prescription and/or service and in many cases signed for same. Many providers are forced to seek counsel and challenge these ridiculous – business killing audits that in some cases exceed their total Medicaid reimbursement for the period covered. This results in negative findings against the state time and time again and that's why the OMIG finished the last fiscal year $66,000 in recoveries ***less*** then their $90 million annual budget.

- The OMIG is still taking money from pharmacies for unresolved audits and I recently heard that they are NOT returning phone calls to attorneys and providers who are seeking redress on these findings.

A Partial Solution:

- Employee for employee, the AG's Medicaid Fraud Unit recovers three times as much in 'recoupments' for 'real fraud' then the OMIG's staff based on readings of the OMIG's and AG's annual reports. I estimate this will save around $6 million annually.

- By moving employees over, the federal government will pick up 75% of the auditing costs versus only 25% for the OMIG. ***(see Appendix F)***

Once again, thank you for allowing us this opportunity to testify today. I'll address any questions that you may have at this time.

Appendix A

	Average Day Supply	Total Claim Volume	Total Days of Therapy	Total Claim Dollars	Cost Per Day of Therapy	Generic Utilization
Mail Order	89	540,370	48,092,930	$95,367,736.07	**$1.98**	48.4%
Retail 90-Day Supply	90	411,169	37,005,210	$53,654,772.07	**$1.45**	57.5%
Retail 30-Day Supply	24	5,419,450	130,066,800	$322,113,150.81	**$2.48**	59.9%

Based upon Innoviant Book of Business data
January 1 – September 30, 2007
Total cost/claim, including member and plan pay

Appendix B

Mandatory Mail Order Prescription Drug Costs to NYS

(Methodology)

1. Annual prescription drug sales in the U.S. = $300 billion (2009 figures, last available);
2. $31 billion was in hospital purchases;
3. $269 billion were in retail/mail order purchases;
4. Percentage of all prescription drug sales (dollar value) that are for mail order = 22.8%
5. NYS's percentage of U.S. prescription drug sales = 11% or $29.59 billion;
6. NYS prescription drug dollar value is $29.59 bil. - $5 bil. (Medicaid annual drug spend is removed from the equation because Medicaid has less then 1% mail order) = $24.59 bil.;
7. The 2009 NYS drug spend subject to the 22.8% mail order dollar value is $5.606 billion which is what left NYS to out-of-state pharmacies.
8. Using a 16% gross margin on those prescription drugs going to mail order would provide an $897 million economic stimulus and taxable income for the state. At least 12,000 pharmacy positions would be rehired and as many as 18,500.

Appendix C

THIS IS NOT A BILL. Keep this notice for your records.

Explanation of Benefits

For period beginning 01/01/2007 and ending 06/30/2007

1of2

Dates of Service	Name of Drug	Quantity Dispensed	Cost of Prescription	Amount Paid by HealthNet	Amount Paid by You	Notes
01/19/2007	WARFARIN SODIUM 2.5 MG TAB	30.000	$16.96	$16.96 *12.82	$0.00	* actually paid to pharmacy
01/19/2007	METFORMIN HCL 500 MG TABLET	60.000	$22.11	$22.11 *13.54	$0.00	
01/19/2007	METOPROLOL 25 MG TABLET	60.000	$9.79	$9.79 *6.86	$0.00	
01/29/2007	AVANDIA 4 MG TABLET	30.000	$97.13	$62.13	$35.00	98.20
02/02/2007	GLYBURIDE 5 MG TABLET	60.000	$18.21	$18.21	$0.00	*12.22
02/05/2007	SIMVASTATIN 40 MG TABLET	30.000	$45.89	$45.89 *16.86	$0.00	16.86
02/08/2007	OMACOR CAPSULE	120.000	$132.64	$97.64	$35.00	**133.92 actual cost of Rx
02/20/2007	METFORMIN HCL 500 MG TABLET	60.000	$20.61	$20.61 *13.54	$0.00	
02/20/2007	METOPROLOL 25 MG TABLET	60.000	$10.79	$10.79 *6.86	$0.00	
02/20/2007	WARFARIN SODIUM 2.5 MG TAB	30.000	$16.96	$16.96 *12.82	$0.00	
02/26/2007	AVANDIA 4 MG TABLET	30.000	$97.13	$62.13	$35.00	98.20
03/08/2007	SIMVASTATIN 40 MG TABLET	30.000	$45.89	$45.89 *16.86	$0.00	
03/08/2007	OMACOR CAPSULE	120.000	$132.64	$97.64	$35.00	**133.92 actual cost of Rx
03/16/2007	GLYBURIDE 5 MG TABLET	60.000	$17.81	$17.81	$0.00	*12.22
03/22/2007	WARFARIN SODIUM 2.5 MG TAB	30.000	$16.96	$16.96 12.82	$0.00	
03/22/2007	AVANDIA 4 MG TABLET	30.000	$97.13	63.20 $62.13	$35.00	
03/22/2007	METFORMIN HCL 500 MG TABLET	60.000	$21.78	$21.78 16.04	$0.00	

Detailed Prescription History

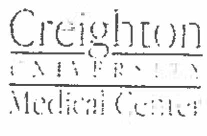
THIS IS NOT A BILL. Keep this notice for your records.

Explanation of Benefits

For period beginning 01/01/2007 and ending 06/30/2007

Dates of Service	Name of Drug	Quantity Dispensed	Cost of Prescription	Amount Paid by Healthfirst	Amount Paid by You	Notes
03/22/2007	METOPROLOL 25 MG TABLET	60.000	$13.29	$13.29 *6.86	$0.00	*actually paid to pharmacy
04/07/2007	SIMVASTATIN 40 MG TABLET	30.000	$45.89	$45.89 *16.86	$0.00	
04/07/2007	OMACOR CAPSULE	120.000	$132.64	$97.64	$35.00	*133.92 - 35.00 - actual cost of Rx
04/23/2007	GLYBURID- METFORMIN 5-500 MG TB	60.000	$25.76	$25.76 *24.12	$0.00	
04/23/2007	METOPROLOL 25 MG TABLET	60.000	$13.46	$13.46 *7.86	$0.00	
04/23/2007	AVANDIA 4 MG TABLET	30.000	$97.12	$62.12	$35.00	98.19 + 35.00 - actual cost of Rx
05/03/2007	SIMVASTATIN 40 MG TABLET	30.000	$45.89	$45.89 *16.86	$0.00	
05/12/2007	OMACOR CAPSULE	60.000	$67.12	$32.12	$35.00	68.01 - actual cost of Rx
05/23/2007	OMACOR CAPSULE	120.000	$132.64	$97.64	$35.00	*133.92 - actual cost of Rx
05/23/2007	METOPROLOL 25 MG TABLET	60.000	$13.46	$13.46 *7.86	$0.00	
05/23/2007	ENALAPRIL MALEATE 20 MG TAB	30.000	$14.70	$14.70 *6.71	$0.00	
05/23/2007	GLYBURID- METFORMIN 5-500 MG TB	60.000	$26.76	$26.76 *12.85	$0.00	
06/11/2007	SIMVASTATIN 40 MG TABLET	30.000	$45.89	$45.89 *16.86	$0.00	
06/20/2007	ENALAPRIL MALEATE 20 MG TAB	60.000	$27.80	$27.80 *16.51	$0.00	
06/23/2007	METOPROLOL 25 MG TABLET	60.000	$13.46	$13.46 *9.86	$0.00	

Appendix C



Mail-order prescription pricing: a critical examination

By
Robert I. Garis, RP, MBA PhD
Aladdin Mohammed, PharmD (Candidate)
Creighton University School of Pharmacy and Health Professions

The pharmacy benefit manager (PBM) is the company that typically administers the employer's prescription benefit. Researchers at the Creighton University Pharmacy School have earned national recognition for innovative research into the PBM industry. Findings by our research/consulting group suggest the use of **PBM-owned mail order pharmacy may NOT be a "bargain" when compared with community pharmacy**. The tables below contain actual prescription found by our group in corporate benefit plans. The four employers below varied in size from 2,500 to over 30,000 employees.

How we performed this study: Employers often have some employees in a PBM-owned mail order program ("mail") and other employees in a retail pharmacy facility ("community"). For orientation, refer to the first entry for Employer #1. This employer had at least one person who got Atenolol 50mg tabs #90 from the PBM mail order and at least one person who got Atenolol 50mg tabs #90 from the community pharmacy. The prices below represent the TOTAL price of each prescription, before either the patient copayment or the employer payment of the balance. That is, for the first entry, the patient and the member would pay the total $38 charge in mail-order. **Far too many examples show that mail-order prices can be significantly higher than community pharmacy prices.**

Employer 1*

Drug Name & Strength	Quantity	Mail $	Community $	Saving in Community
Atenolol 50 mg	90	$38	$8	$30
Cyclobenzaprine 10 mg	90	$43	$8	$35
Fluoxetine 20 mg	90	$120	$54	$66
Gemfibrozil 600 mg	180	$112	$39	$73
Naproxen 500 mg	180	$117	$33	$84
Temazepam 30 mg	30	$13	$5	$8
Trazodone 50 mg	90	$19	$6	$13
Verapamil 240 mg	90	$73	$32	$41
Minocycline 100 mg	60	$102	$47	$55

Employer 2*

Drug Name & Strength	Quantity	Mail $	Community $	Saving in Community
Alprazolam 0.25 mg	90	$31	$10	$21
Atenolol 100 mg	90	$56	$10	$46
Avandia 8 mg	90	$370	$318	$52
Captopril 50 mg	90	$52	$16	$36
Cyclobenzaprine 10 mg	90	$46	$17	$29
Doxycycl Hyc 100 mg	90	$63	$40	$23
Evista 60 mg	90	$177	$159	$18
Fluoxetine 20 mg Cap	90	$120	$56	$64
Fluoxetine 20 mg Tab	90	$126	$86	$40

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Employer 3*

Drug Name & Strength	Quantity	Mail $	Community $	Saving in Community
Atenolol 25mg	30	$3	$2	$1
Doxazosin 4mg	75	$22	$15	$7
Fluoxetine 20mg	60	$35	$23	$12
Hyoscyamine 0.375mg	30	$17	$8	$9
Klor-Con 10mEq	60	$11	$8	$3
Methylphenidate 10mg	60	$25	$19	$6
Tamoxifen 20mg	30	$61	$35	$26
Timolol 0.5%	10ml	$17	$7	$10
Triam/HCTZ 37.5mg/25mg	60	$19	$13	$6

Employer 4*

Drug Name & Strength	Quantity	Mail $	Community $	Saving in Community
Buspirone 10mg	90	$58	$38	$20
Enalapril 20mg	60	$41	$30	$11
Famotidine 40mg	90	$136	$62	$74
Glipizide 5mg	90	$15	$11	$4
Glyburide 5mg	90	$31	$25	$6
Ibuprofen 800mg	100	$17	$13	$4
Isosorbide Mono. 30mg	90	$45	$22	$23
Metformin 100mg	120	$59	$41	$18
Nortriptyline 50mg	120	$61	$29	$32

*Actual amounts were rounded to protect the anonymity of employers and community pharmacies

Retail versus Mail: Issues to Consider

- ***Diminished patient medication compliance:***
  -Patient compliance with their medication schedules may diminish with the use of mail order since there is no professional consultation to assure correct administration, adverse events monitoring or personal attention to patient concerns.[1,2]

- ***Medication wasting and potential stockpiling prescriptions:***
  The prescription may be changed soon after the 3 month mail supply has been received. This necessitates disposal of the old medication—waste of a large amount. Also, a patient may stockpile old Rx's, potentially increasing problems of overuse or abuse.[3]

- ***Shipping and storage concerns:***
  Uncontrolled temperatures in transit may render the medication less effective, ineffective or dangerous.[3]

- ***Decrease in patient acceptance:***
  Patients may resent the lack of choices with mandatory mail-order. Additional problems are shipping delays, and the absence of interpersonal contact with a pharmacist.[5,6]

References:

1. McCormack-JR; Dixon-S; Lyvan-R. Patients' perceptions for pharmacist counseling and patients' preferences for type of counseling in two retirement communities. AACP-Annual-Meeting; 1999; 100(Jul): 80
2. Ghoshal-S. Mail-order pharmacy: good or evil?. Can-Pharm-J (Canadian-Pharmaceutical-Journal); 1996-1997; 129(Dec-Jan Suppl): 11, 14-15
3. Muirhead-G. Mail order no longer has price advantage, says PCS president. Drug-Top; 1993; 137(Jul 5): 50.
4. Gerthoffer-TD; Kirk-KW. Consumer Comparison of Mail-Order and Local Retail Pharmacies. APhA-Annual-Meeting; 1994; 141(Mar): 79.
5. Leary-BW; Donehew-GR; Swanson-L. Does mail-order pharmacy satisfy the needs of the elderly? Pharm-Times (Pharmacy-Times); 1992; 58(Aug): 82, 84-86, 88-89
6. Beatty-J. Freedom of choice endangered species. NJ-J-Pharm (New-Jersey-Journal-of-Pharmacy); 1990; 63(Feb): 17
7. Gerthoffer-TD; Kirk-KW. Analysis of consumers' perceptions of risk associated with using mail order and local retail pharmacies. APhA-Annual-Meeting; 1994; 141(Mar): 17.

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, D.C. 20549

FORM 10-K

☑ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934 FOR THE FISCAL YEAR ENDED DECEMBER 31, 2009, OR**

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934 FOR THE TRANSITION PERIOD FROM ________ TO ________.**

Commission File Number: 0-20199

EXPRESS SCRIPTS, INC.

(Exact name of registrant as specified in its charter)

Delaware (State or other jurisdiction of incorporation or organization)	**43-1420563** (I.R.S. Employer Identification No.)
One Express Way, St. Louis, MO (Address of principal executive offices)	**63121** (Zip Code)

Registrant's telephone number, including area code: (314) 996-0900

Securities registered pursuant to Section 12(b) of the Act:

Title of Class	Name of each exchange on which registered
Common Stock $0.01 par value, including related Preferred Share Purchase Rights	Nasdaq Global Select Market

Securities registered pursuant to Section 12(g) of the Act:
None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☑ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☑

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☑ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☑ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation of S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company"

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Item 6 — Selected Financial Data

The following selected financial data should be read in conjunction with our consolidated financial statements, including the related notes, and "Item 7 — *Management's Discussion and Analysis of Financial Condition and Results of Operations*".

(in millions, except per share data)	2009(1)	2008(2)	2007(3)	2006	2005(4)
Statement of Operations Data (for the Year Ended December 31):					
Revenues (5)	$24,748.9	$21,978.0	$21,824.0	$21,562.6	$21,879.1
Cost of revenues(5)	22,318.5	19,937.1	20,065.2	20,093.7	20,693.3
Gross profit	2,430.4	2,040.9	1,758.8	1,468.9	1,185.8
Selling, general and administrative	932.0	760.4	698.0	643.1	543.5
Operating income	1,498.4	1,280.5	1,060.8	825.8	642.3
Other expense, net	(189.1)	(66.9)	(116.1)	(83.6)	(28.4)
Income before income taxes	1,309.3	1,213.6	944.7	742.2	613.9
Provision for income taxes	482.8	434.0	344.2	266.8	214.3
Net income from continuing operations	826.5	779.6	600.5	475.4	399.6
Net (loss) income from discontinued operations, net of tax(6)	1.1	(3.5)	(32.7)	(1.0)	0.5
Net income	$ 827.6	$ 776.1	$ 567.8	$ 474.4	$ 400.1
Weighted average shares outstanding:(7)					
Basic:	263.5	248.9	260.4	279.6	293.6
Diluted:	266.1	251.8	264.0	284.0	299.0
Basic earnings (loss) per share:(7)					
Continuing operations	$ 3.14	$ 3.13	$ 2.31	$ 1.70	$ 1.36
Discontinued operations(6)	—	(0.01)	(0.13)	—	—
Net earnings	3.14	3.12	2.18	1.70	1.36
Diluted earnings (loss) per share:(7)					
Continuing operations	$ 3.11	$ 3.10	$ 2.27	$ 1.67	$ 1.34
Discontinued operations(6)	—	(0.01)	(0.12)	—	—
Net earnings	3.11	3.08	2.15	1.67	1.34
Balance Sheet Data (as of December 31):					
Cash and cash equivalents	$ 1,070.4	$ 530.7	$ 434.7	$ 131.0	$ 477.9
Working capital	(1,313.3)	(677.9)	(507.2)	(657.3)	(137.8)
Total assets	11,931.2	5,509.2	5,256.4	5,108.1	5,493.5
Debt:					
Short-term debt	1,340.1	420.0	260.1	180.1	110.0
Long-term debt	2,492.5	1,340.3	1,760.3	1,270.4	1,400.5
Stockholders' equity	3,551.8	1,078.2	696.4	1,124.9	1,464.8
Network pharmacy claims processed(8)	404.3	379.6	379.9	390.3	437.3
Home delivery and specialty pharmacy prescriptions filled	41.8	41.9	41.9	42.2	41.0
Other prescriptions filled(9)	3.2	3.2	3.6	4.7	4.6
Cash flows provided by operating activities—continuing operations	$ 1,757.6	$ 1,095.6	$ 848.1	$ 673.5	$ 795.8
Cash flows used in investing activities—continuing operations	(4,822.4)	(320.6)	(55.8)	(100.8)	(1,367.5)
Cash flows provided by (used in) financing activities—continuing operations	3,587.0	(680.4)	(469.7)	(904.7)	887.0
EBITDA from continuing operations(10)	1,608.3	1,378.2	1,158.3	925.6	726.6

(1) Includes the acquisition of NextRx effective December 1, 2009.

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d)
OF THE SECURITIES EXCHANGE ACT OF 1934

For the fiscal year ended December 26, 2009

Commission File Number: 1-31312

MEDCO HEALTH SOLUTIONS, INC.

(Exact name of Registrant as specified in its charter)

Delaware	**22-3461740**
(State or other jurisdiction of incorporation)	(I.R.S. Employer Identification No.)
100 Parsons Pond Drive, Franklin Lakes, NJ	**07417-2603**
(Address of principal executive offices)	(Zip Code)

Registrant's telephone number, including area code: 201-269-3400

Securities registered pursuant to Section 12(b) of the Act:

Title of Each Class	Name of Each Exchange on Which Registered
Common Stock, par value $0.01	New York Stock Exchange
7.25% Senior Notes Due 2013	New York Stock Exchange
6.125% Senior Notes Due 2013	New York Stock Exchange
7.125% Senior Notes Due 2018	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act: **None**

Indicate by check mark if the Registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☑ No ☐

Indicate by check mark if the Registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Exchange Act. Yes ☐ No ☑

Indicate by check mark whether the Registrant: (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the Registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☑ No ☐

Indicate by check mark whether the Registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the Registrant was required to submit and post such files). Yes ☑ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein and will not be contained, to the best of Registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☐

Indicate by check mark whether the Registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☑ Accelerated filer ☐ Non-Accelerated filer ☐ Smaller reporting company ☐

Indicate by check mark whether the Registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☑

The aggregate market value of the Registrant's voting stock held by non-affiliates as of June 27, 2009 was $21,559,406,368. The Registrant has no non-voting common equity.

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Item 6. Selected Financial Data.

The following table presents our selected historical consolidated financial and operating data. The selected historical financial and operating data should be read in conjunction with, and is qualified in its entirety by reference to, Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations," and our audited consolidated financial statements and notes thereto included in Part II, Item 8 of this Annual Report on Form 10-K ($ and volumes in millions, except for per share data and EBITDA per adjusted prescription data):

As of and for Fiscal Years Ended	December 26, 2009	December 27, 2008[1]	December 29, 2007[2]	December 30, 2006[3]	December 31, 2005[4] [5]
Consolidated statement of income data:					
Total product net revenues[6]	$ 58,961.4	$ 50,576.2	$ 43,961.9	$ 42,022.6	$ 37,455.0
Total service net revenues	842.8	681.8	544.3	521.1	415.9
Total net revenues[6]	59,804.2	51,258.0	44,506.2	42,543.7	37,870.9
Cost of revenues:					
Cost of product net revenues[6]	55,523.1	47,308.2	41,402.6	40,012.5	35,827.8
Cost of service revenues	254.1	221.4	158.3	125.8	100.2
Total cost of revenues[6]	55,777.2	47,529.6	41,560.9	40,138.3	35,928.0
Selling, general and administrative expenses	1,455.5	1,425.0	1,114.1	1,109.2	757.6
Amortization of intangibles	305.6	285.1	228.1	218.5	192.5
Interest expense	172.5	233.7	134.2	95.8	73.9
Interest (income) and other (income) expense, net	(9.9)	(6.2)	(34.4)	(29.9)	(34.0)
Total costs and expenses	57,700.9	49,467.2	43,002.9	41,531.9	36,918.0
Income before provision for income taxes	2,103.3	1,790.8	1,503.3	1,011.8	952.9
Provision for income taxes[9] [i]	823.0	687.9	591.3	381.6	350.9
Net income	$ 1,280.3	$ 1,102.9	$ 912.0	$ 630.2	$ 602.0
Earnings per share data[7]:					
Basic earnings per share	$ 2.66	$ 2.17	$ 1.66	$ 1.06	$ 1.04
Shares used in computing basic earnings per share	481.1	508.6	550.2	594.5	576.1
Diluted earnings per share	$ 2.61	$ 2.13	$ 1.63	$ 1.04	$ 1.03
Shares used in computing diluted earnings per share	490.0	518.6	560.9	603.3	587.1
Consolidated balance sheet data:					
Working capital[8]	$ 1,810.9	$ 1,299.5	$ 1,173.5	$ 1,028.2	$ 1,300.1
Goodwill	$ 6,333.0	$ 6,331.4	$ 6,230.2	$ 5,108.7	$ 5,152.3
Intangible assets, net	$ 2,428.8	$ 2,666.4	$ 2,905.0	$ 2,523.1	$ 2,741.6
Total assets	$ 17,915.5	$ 17,010.9	$ 16,217.9	$ 14,388.1	$ 14,447.7
Total debt	$ 4,015.9	$ 4,602.9	$ 3,494.4	$ 1,266.7	$ 1,469.4
Deferred tax liabilities	$ 958.8	$ 1,065.3	$ 1,167.0	$ 1,161.3	$ 1,213.8
Total noncurrent liabilities	$ 5,180.6	$ 5,255.0	$ 4,213.4	$ 2,057.8	$ 2,218.0
Total stockholders' equity	$ 6,387.2	$ 5,957.9	$ 6,875.3	$ 7,503.5	$ 7,724.2

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

☒ **Annual Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**
For the fiscal year ended December 31, 2009

OR

☐ **Transition Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**
For the transition period from to

Commission file number 001-01011

CVS CAREMARK CORPORATION
(Exact name of Registrant as specified in its charter)

Delaware (State or other jurisdiction of incorporation or organization)	**050494040** (I.R.S. Employer Identification No.)
One CVS Drive **Woonsocket, Rhode Island** (Address of principal executive offices)	**02895** (Zip Code)

(401) 765-1500
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Exchange Act:

Common Stock, par value $0.01 per share Title of each class	**New York Stock Exchange** Name of each exchange on which registered

Securities registered pursuant to Section 12(g) of the Exchange Act: None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports) and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Website, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, or a non-accelerated filer, or a smaller reporting company. See definition of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☒	Accelerated filer ☐
Non-accelerated filer ☐ (Do not check if a smaller reporting company)	Smaller reporting company ☐

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Item 6. Selected Financial Data

The selected consolidated financial data of CVS Caremark Corporation as of and for the periods indicated in the five-year period ended December 31, 2009 have been derived from the consolidated financial statements of CVS Caremark Corporation. The selected consolidated financial data should be read in conjunction with the consolidated financial statements and the audit reports of Ernst & Young LLP, which are incorporated elsewhere herein.

In millions, except per share amounts	2009[1]	2008[1]	2007[1][2]	2006[1]	2005[1]
Statement of operations data:					
Net revenues	**$ 98,729**	$ 87,472	$ 76,330	$ 43,821	$ 37,007
Gross profit	**20,380**	18,290	16,108	11,742	9,695
Operating expenses[3]	**13,942**	12,244	11,314	9,300	7,675
Operating profit[4]	**6,438**	6,046	4,794	2,442	2,020
Interest expense, net	**525**	509	435	216	111
Income tax provision[5]	**2,205**	2,193	1,722	857	684
Income from continuing operations	**3,708**	3,344	2,637	1,369	1,225
Loss from discontinued operations, net of income tax benefit[6]	**(12)**	(132)	—	—	—
Net income	**$ 3,696**	$ 3,212	$ 2,637	$ 1,369	$ 1,225
Per common share data:					
Basic earnings per common share:					
Income from continuing operations	**$ 2.59**	$ 2.32	$ 1.97	$ 1.65	$ 1.49
Loss from discontinued operations	**(0.01)**	(0.09)	—	—	—
Net income	**$ 2.58**	$ 2.23	$ 1.97	$ 1.65	$ 1.49
Diluted earnings per common share:					
Income from continuing operations	**$ 2.56**	$ 2.27	$ 1.92	$ 1.60	$ 1.45
Loss from discontinued operations	**(0.01)**	(0.09)	—	—	—
Net income	**$ 2.55**	$ 2.18	$ 1.92	$ 1.60	$ 1.45
Cash dividends per common share	**$0.30500**	$0.25800	$0.22875	$0.15500	$0.14500
Balance sheet and other data:					
Total assets	**$ 61,641**	$ 60,960	$ 54,722	$ 20,574	$ 15,247
Long-term debt	**$ 8,756**	$ 8,057	$ 8,350	$ 2,870	$ 1,594
Total shareholders' equity	**$ 35,768**	$ 34,574	$ 31,322	$ 9,918	$ 8,331
Number of stores (end of year)	**7,074**	6,981	6,301	6,205	5,474

(1) On December 23, 2008, our Board of Directors approved a change in our fiscal year-end from the Saturday nearest December 31 of each year to December 31 of each year to better reflect our position in the health care, rather than the retail, industry. The fiscal year change was effective beginning with the fourth quarter of fiscal 2008. As you review our operating performance, please consider that fiscal 2009 includes 365 days; fiscal 2008 includes 368 days, compared to each of the remaining fiscal years presented, which include 364 days.

(2) Effective March 22, 2007, Caremark Rx, Inc. was merged into a newly formed subsidiary of CVS Corporation, with Caremark Rx, L.L.C., continuing as the surviving entity (the "Caremark Merger"). Following the Caremark Merger, the name of the Company was changed to "CVS Caremark Corporation." By virtue of the Caremark Merger, each issued and outstanding share of Caremark common stock, par value $0.001 per share, was converted into the right to receive 1.67 shares of CVS Caremark's common stock, par value $0.01 per share. Cash was paid in lieu of fractional shares.

(3) In 2006, the Company adopted the SEC Staff Accounting Bulletin ("SAB") No. 108, "Considering the Effects of Prior Year Misstatements when Qualifying Misstatements in Current Year Financial Statements." The adoption of this SAB resulted in a $40 million pre-tax ($25 million after-tax) decrease in operating expenses for 2006.

(4) Operating profit includes the pre-tax effect of the charge discussed in Note (3) above.

Appendix E

State 90 day
CSE 1

1 of 2

Print

Prescription Fill Information

3rd Party Plan	MEDCO HEALTH SOLUTIONS
Dispensed Product	*CELEBREX 200 MG CAPSULE
Quantity Dispensed	* 180
Package Size	100
Prod Unit Cost	4.1863
Prod Pkg Cost	327.53
Prod Acquis Cost	589.55

Payment Request Information

Drug Cost	753.53
Dispensing Fee	4.50
Tax	0.00
Total Price	758.03

Claim Payment Information

Drug Cost	632.97
Dispensing Fee	1.50
Tax	0.00
3pty Pay	604.47
Copay	30.00

3rd Party Messages

Authorization	MX1PMD7	T/A	0.00

Stylesheet:HTML-TCCAccept - $Revision: 153 $

NDC 00025 1 52531
(manufacturer)

Manufacturer's NDC#

Stile 90
CSEA
2 of 2

Print

Prescription Fill Information

3rd Party Plan	MEDCO HEALTH SOLUTIONS
Dispensed Product	*CELEBREX 200 MG CAPSULE QLC
Quantity Dispensed	* 180
Package Size	100
Prod Unit Cost	9.3140
Prod Pkg Cost	400.00
Prod Acquis Cost	720.00

Payment Request Information

Drug Cost	1676.52
Dispensing Fee	7.00
Tax	0.00
Total Price	1683.52

Claim Payment Information

Drug Cost	1408.28
Dispensing Fee	1.50
Tax	0.00
3pty Pay	1379.78
Copay	30.00

3rd Party Messages

Authorization	OPNM9DQ	T/A	0.00

Stylesheet:HTML-TCCAccept - $Revision: 153 $

NDC 49999 0004 00
(repack)

Repacker's NDC #

* Same Drug
* Same Quantity

Appendix E

PROD/MFR	NDC	AWP	DP	OBC
CEFUROXIME NOVAPLUS (Sandoz)				
cefuroxime sodium				
PDS, IJ (PRIVATE LABEL)				
1.5 gm, ea	00781-9206-80	13.46		AP
(PHARMACY BULK PACKAGE) 7.5 gm, ea	00781-9207-46	65.94		AP
(PRIVATE LABEL) 750 mg, ea	00781-9205-70	6.76		AP
CEFUROXIME SODIUM (APP)				
PDS, IJ (VIAL,PF)				
1.5 gm, ea	63323-0353-20	23.90		AB
(BULK PACKAGE,PF) 7.5 gm, 10s ea	63323-0354-61	1167.00		AB
(VIAL,PF) 750 mg, ea	63323-0352-10	12.90		AB
(B. Braun)				
SOL, IV (DUPLEX)				
1.5 gm/50 ml, ea	00264-3114-11	16.80		
(DUPLEX SYSTEM) 750 mg/50 ml, ea	00264-3112-11	10.72		
(Baxter)				
PDS, IJ (USP)				
1.5 gm, ea	10019-0621-20	6.38		
(20ML VIAL) 1.5 gm, 25s ea	10019-0621-03	159.60		
(USP) 7.5 gm, ea	10019-0622-11	28.80		
(100ML VIAL, BULK PKG) 7.5 gm, 10s ea	10019-0622-05	288.00		
750 mg, ea	10019-0620-10	3.01		
(10ML VIAL) 750 mg, 25s ea	10019-0620-01	75.30		
(Cura Pharm) *See CEFUROXIME*				
(Cura Pharm)				
PDS, IJ, 1.5 gm, 25s ea	66860-0031-03	336.00		
750 mg, 25s ea	66860-0030-03	169.00		AB
(Glaxo) *See ZINACEF*				
(Hospira) *See CEFUROXIME*				
(Sagent) *See CEFUROXIME*				
(Sandoz) *See CEFUROXIME NOVAPLUS*				
(West-Ward)				
PDS, IJ, 750 mg, 25s ea	00143-9979-90	6.40		
(USP) 750 mg, 25s ea	00143-9979-22	160.00		
IV, 1.5 gm, 25s ea	00143-9977-90	336.00		
(USP) 1.5 gm, 25s ea	00143-9977-22	336.00		
(BULK PACKAGE) 7.5 gm, 10s ea	00143-9976-91	65.95		AP
(USP,BULK PACKAGE) 7.5 gm, 10s ea	00143-9976-03	659.50		AP
CEFZIL (A-S Medication) REPACK				
cefprozil				
PDR, PO, 125 mg/5 ml, 100 ml	54569-3743-00	46.50		
250 mg/5 ml, 100 ml	54569-3630-00	84.25		
TAB, PO, 250 mg, 20s ea	54569-3652-00	97.31		
(Bryant Ranch) REPACK				
TAB, PO, 250 mg, 20s ea	63629-3169-01	148.10		
(Pharma Pac) REPACK				
TAB, PO, 500 mg, 20s ea	52959-0349-20	127.12		
(Phys Total Care) REPACK				
PDR, PO, 250 mg/5 ml, 50 ml	54868-2017-01	51.05		
100 ml	54868-2017-00	99.08		
TAB, PO, 250 mg, 10s ea	54868-3343-00	58.38		
15s ea	54868-3343-01	86.62		
20s ea	54868-3343-03	114.88		
30s ea	54868-3343-02	161.95		
500 mg, 10s ea	54868-2444-00	104.13		
(Southwood) REPACK				
PDR, PO, 125 mg/5 ml, 100 ml	58016-4148-01	44.64		
250 mg/5 ml, 100 ml	58016-4147-01	80.88		
TAB, PO, 250 mg, 12s ea	58016-0810-12	56.05		
15s ea	58016-0810-15	70.07		
30s ea	58016-0810-30	140.13		
60s ea	58016-0810-60	232.70		
100s ea	58016-0810-00	467.10		

PROD/MFR	NDC	AWP	DP	OBC
CELEBREX (Pfizer)				
celecoxib				
CAP, PO, 50 mg, 60s ea	00025-1515-01	75.74	63.12	
100 mg, 100s ea (10X10)	00025-1520-31	270.13	225.11	
100 mg, 100s ea UD	00025-1520-34	270.13	225.11	
500s ea	00025-1520-51	1350.66	1125.55	
200 mg, 100s ea (10X10)	00025-1525-31	443.08	369.23	
200 mg, 100s ea UD	00025-1525-34	443.08	369.25	
500s ea	00025-1525-51	2215.38	1846.15	
400 mg, 60s ea	00025-1530-02	398.77	332.31	
100s ea UD	00025-1530-01	664.63	553.85	
(4u) REPACK				
CAP, PO, 100 mg, 30s ea	42549-0642-30	172.68		
200 mg, 30s ea	42549-0585-30	246.34		
(A-S Medication) REPACK				
CAP, PO, 100 mg, 14s ea	54569-4671-04	37.52		
20s ea	54569-4671-01	53.60		
30s ea	54569-4671-02	80.40		
60s ea	54569-4671-00	200.67		
200 mg, 10s ea	54569-4672-06	43.96		
14s ea	54569-4672-01	61.54		
20s ea	54569-4672-05	87.91		
28s ea	54569-4672-02	123.08		
30s ea	54569-4672-00	131.87		
60s ea	54569-4672-04	329.14		
90s ea	54569-4672-09	493.72		
(Aidarex) REPACK				
CAP, PO, 100 mg, 7s ea	33261-0653-07	17.99		
21s ea	33261-0653-21	53.97		
30s ea	33261-0653-30	77.10		
60s ea	33261-0653-60	154.20		
200 mg, 14s ea	33261-0019-14	65.49		
30s ea	33261-0019-30	130.97		
60s ea	33261-0019-60	261.94		
90s ea	33261-0019-90	392.91		
(Altura) REPACK				
CAP, PO, 100 mg, 10s ea	63874-0517-10	20.80		
12s ea	63874-0517-12	24.96		
14s ea	63874-0517-14	29.12		
15s ea	63874-0517-15	31.20		
20s ea	63874-0517-20	41.60		
21s ea	63874-0517-21	43.68		
24s ea	63874-0517-24	49.92		
25s ea	63874-0517-25	52.00		
28s ea	63874-0517-28	58.24		
30s ea	63874-0517-30	62.40		
60s ea	63874-0517-60	124.80		
90s ea	63874-0517-90	187.20		
100s ea	63874-0517-01	208.00		
200 mg, 5s ea	63874-0495-05	17.75		
7s ea	63874-0495-07	24.85		
10s ea	63874-0495-10	35.50		
12s ea	63874-0495-12	42.60		
14s ea	63874-0495-14	61.54		
15s ea	63874-0495-15	53.25		
20s ea	63874-0495-20	87.92		
21s ea	63874-0495-21	74.55		
28s ea	63874-0495-28	99.40		
30s ea	63874-0495-30	131.87		
60s ea	63874-0495-60	213.00		
90s ea	63874-0495-90	319.50		
100s ea	63874-0495-01	355.00		
(AQ) REPACK				
CAP, PO, 100 mg, 100s ea	66105-0105-10	272.99		
200 mg, 30s ea	66105-0106-03	250.55		
100s ea	66105-0106-10	835.14		
(Bryant Ranch) REPACK				
CAP, PO, 200 mg, 20s ea	63629-3021-02	57.35		
30s ea	63629-3021-01	191.33		
60s ea	63629-3021-04	382.60		
(Core) REPACK				
CAP, PO, 100 mg, 14s ea	33358-0069-14	37.90		
20s ea	33358-0069-20	61.44		
30s ea	33358-0069-30	90.41		
60s ea	33358-0069-60	131.29		
200 mg, 10s ea	33358-0070-10	46.36		
14s ea	33358-0070-14	47.63		
15s ea	33358-0070-15	65.06		
20s ea	33358-0070-20	86.51		
30s ea	33358-0070-30	159.21		
60s ea	33358-0070-60	203.21		
90s ea	33358-0070-90	302.35		

Brand cost/unit → 4.43 per unit

7.87 per unit ↑ Repackager

3.55 per unit

8.35 per unit ↑ Repackager

6.37 per unit

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PROD/MFR	NDC	AWP	DP	OBC
(DHS, Inc.)				
REPACK				
CAP, PO, 100 mg, 20s ea	55887-0412-20	59.09		
30s ea	55887-0412-30	88.64		
200 mg, 10s ea	55887-0736-10	49.59		
14s ea	55887-0736-14	63.42		
15s ea	55887-0736-15	65.54		
30s ea	55887-0736-30	123.00		
(Direct Pharmaceutical, Inc.)				
REPACK				
CAP, PO, 100 mg, 30s ea UD	67801-0328-03	253.80		
200 mg, 30s ea UD	67801-0329-03	258.23		
(Dispensing Solutions)				
REPACK				
CAP, PO, 100 mg, 10s ea	55045-2671-01	30.00		
20s ea	55045-2671-07	60.00		
30s ea	55045-2671-08	90.00		
60s ea	55045-2671-06	180.00		
200 mg, 7s ea	55045-2680-02	42.00		
10s ea	55045-2680-01	60.00		
10s ea	66336-0727-10	50.74		
14s ea	66336-0727-14	71.03		
15s ea	55045-2680-06	90.00		
15s ea	66336-0727-15	76.10		
20s ea	55045-2680-07	120.00		
20s ea	66336-0727-20	101.47		
30s ea	55045-2680-08	180.00		
30s ea	66336-0727-30	152.21		-6.00
60s ea	55045-2680-09	360.00		
60s ea	66336-0727-60	304.42		-5.07
90s ea	66336-0727-90	456.63		
(HomeMed)				
REPACK				
CAP, PO, 200 mg, 14s ea	51655-0327-84	100.69		-7.19
(IPI)				
REPACK				
CAP, PO, 200 mg, 20s ea	18837-0024-20	97.81		
90s ea	18837-0024-90	395.61		
180s ea	18837-0024-95	791.21		
(Keltman Pharma., Inc.)				
REPACK				
CAP, PO, 200 mg, 15s ea	68387-0552-15	129.12		
30s ea	68387-0552-30	258.23		8.60
60s ea	68387-0552-60	516.46		
(LWP)				
REPACK				
CAP, PO, 100 mg, 30s ea	64038-0030-30	61.96		
60s ea	64038-0030-60	118.92		
100s ea	64038-0030-01	194.86		
200 mg, 30s ea	64038-0031-30	98.43		
60s ea	64038-0031-60	191.85		
100s ea	64038-0031-01	316.41		
(Nucare Pharm)				
REPACK				
CAP, PO, 100 mg, 14s ea	66267-0046-14	74.37		
20s ea	66267-0046-20	106.25		
30s ea	66267-0046-30	159.37		
60s ea	66267-0046-60	318.74		
200 mg, 7s ea	66267-0048-07	51.34		
10s ea	66267-0048-10	73.33		
15s ea	66267-0048-15	109.99		
20s ea	66267-0048-20	146.67		
30s ea	66267-0048-30	229.83		
60s ea	66267-0048-60	440.00		7.33
(Palmetto)				
REPACK				
CAP, PO, 100 mg, 20s ea	23490-7273-01	60.84		
20s ea	23490-9110-02	77.22		
30s ea	23490-9110-03	115.83		
200 mg, 7s ea	23490-7274-07	35.37		
10s ea	23490-7274-01	45.91		
14s ea	23490-7274-04	69.08		
15s ea	23490-7274-00	74.01		
20s ea	23490-7274-02	92.48		
30s ea	23490-7274-03	124.80		
60s ea	23490-7274-05	249.61		
(PD-Rx Pharm)				
REPACK				
CAP, PO, 100 mg, 14s ea	55289-0451-14	55.92		
20s ea	55289-0451-20	79.89		
30s ea	55289-0451-30	119.84		
(REDI-SCRIPT)				
100 mg, 30s ea	58864-0691-30	76.16		
200 mg, 10s ea	55289-0475-10	65.52		
14s ea	55289-0475-14	91.79		
20s ea	55289-0475-20	131.03		
28s ea	55289-0475-28	183.44		
30s ea	55289-0475-30	196.56		

PROD/MFR	NDC	AWP	DP	OBC
(REDI-SCRIPT)				
200 mg, 30s ea	58864-0709-30	149.82		
60s ea	55289-0475-60	393.09		
90s ea	55289-0475-90	568.83		6.32
180s ea	55289-0475-93	1179.30		6.55
(Pharma Pac)				
REPACK				
CAP, PO, 100 mg, 14s ea	52959-0540-14	43.43		
15s ea	52959-0540-15	46.47		
20s ea	52959-0540-20	59.94		
21s ea	52959-0540-21	61.97		
28s ea	52959-0540-28	82.41		
30s ea	52959-0540-30	88.20		
40s ea	52959-0540-40	102.22		
60s ea	52959-0540-60	153.30		
200 mg, 5s ea	52959-0539-05	38.00		
7s ea	52959-0539-07	53.13		
10s ea	52959-0539-10	75.80		
14s ea	52959-0539-14	105.98		
15s ea	52959-0539-15	113.40		
20s ea	52959-0539-20	151.00		
21s ea	52959-0539-21	158.45		
28s ea	52959-0539-28	210.70		
30s ea	52959-0539-30	224.50		
40s ea	52959-0539-40	293.24		
45s ea	52959-0539-45	321.30		
50s ea	52959-0539-50	347.00		
60s ea	52959-0539-60	399.60		
90s ea	52959-0539-90	477.00		
100s ea	52959-0539-00	490.80		-4.90
400 mg, 30s ea	52959-0904-30	150.05		
(Phys Total Care)				
REPACK				
CAP, PO, 100 mg, 10s ea	54868-4107-03	32.67		
20s ea	54868-4107-01	63.38		
30s ea	54868-4107-00	94.09		
60s ea	54868-4107-02	175.98		
200 mg, 5s ea	54868-4101-06	30.38		
10s ea	54868-4101-04	58.15		
15s ea	54868-4101-03	85.92		
20s ea	54868-4101-02	113.68		
30s ea	54868-4101-01	159.96		
60s ea	54868-4101-06	317.31		
90s ea	54868-4101-05	474.65		
100s ea	54868-4101-07	477.04		-4.77
100s ea	54868-4101-08	509.53		-5.09
400 mg, 60s ea	54868-5586-00	401.11		
(Physician Partner)				
REPACK				
CAP, PO, 100 mg, 15s ea	21695-0022-15	95.34		
30s ea	21695-0022-30	162.08		
60s ea	21695-0022-60	324.16		
100s ea	21695-0022-00	540.26		
120s ea	21695-0022-72	762.72		
200 mg, 10s ea	21695-0023-10	92.06		
14s ea	21695-0023-14	145.96		
15s ea	21695-0023-15	156.38		
20s ea	21695-0023-20	184.11		
30s ea	21695-0023-30	265.85		8.86
60s ea	21695-0023-60	531.70		
(Quality Care Prod)				
REPACK				
CAP, PO, 100 mg, 10s ea	49999-0383-10	84.60		
14s ea	49999-0383-14	118.44		
20s ea	49999-0383-20	169.20		
30s ea	49999-0383-30	253.80		
60s ea	49999-0383-60	507.60		
200 mg, 6s ea	49999-0004-06	55.86		
10s ea	49999-0004-10	93.06		
14s ea	49999-0004-14	118.44		
20s ea	49999-0004-20	169.20		
30s ea	49999-0004-30	279.19		
60s ea	49999-0004-60	558.38		
100s ea	49999-0004-00	931.40		-9.31
(Southwood)				
REPACK				
CAP, PO, 100 mg, 10s ea	58016-0169-10	24.50		
12s ea	58016-0169-12	29.40		
20s ea	58016-0169-20	49.00		
21s ea	58016-0169-21	51.45		
28s ea	58016-0169-28	68.61		
30s ea	58016-0169-30	73.51		
60s ea	58016-0169-60	147.01		
90s ea	58016-0169-90	220.52		
100s ea	58016-0169-00	245.02		
200 mg, 10s ea	58016-0223-10	40.19		
12s ea	58016-0223-12	48.23		
14s ea	58016-0223-14	56.26		
15s ea	58016-0223-15	60.28		
20s ea	58016-0223-20	80.38		
21s ea	58016-0223-21	84.39		

PROD/MFR	NDC	AWP	DP
28s ea	58016-0223-28	112.53	
30s ea	58016-0223-30	120.56	
60s ea	58016-0223-60	241.13	
90s ea	58016-0223-90	361.69	
100s ea	58016-0223-00	401.8[illegible]	
120s ea	58016-0223-02	482.[illegible]	
400 mg, 30s ea	58016-0724-30	180.8[illegible]	
60s ea	58016-0724-60	361.7[illegible]	
90s ea	58016-0724-90	54[illegible]	
100s ea	58016-0724-00	602.[illegible]	
(St. Mary's MPP)			
REPACK			
CAP, PO, 200 mg, 20s ea	60760-0525-20	10[illegible]	
30s ea	60760-0525-30	21[illegible]	
60s ea	60760-0525-60	41[illegible]	
(Stat Rx)			
REPACK			
CAP, PO, 100 mg, 30s ea	16590-0045-30	[illegible]	
56s ea	16590-0045-56	[illegible]	
60s ea	16590-0045-60	[illegible]	
200 mg, 10s ea	16590-0046-10	[illegible]	
15s ea	16590-0046-15	[illegible]	
20s ea	16590-0046-20	[illegible]	
28s ea	16590-0046-28	[illegible]	
30s ea	16590-0046-30	[illegible]	
56s ea	16590-0046-56	[illegible]	
60s ea	16590-0046-60	[illegible]	
84s ea	16590-0046-[illegible]	[illegible]	
90s ea	16590-0046-[illegible]	[illegible]	

CELECOXIB
(Pfizer) See CELEBREX

CELESTONE (Schering)
betamethasone
SYR, PO, 0.6 mg/5 ml,
118 ml .... 00085-094[illegible]

CELESTONE SOLUSPAN (Schering)
betamethasone ace/betamethasone [illegible]
SUS, IJ (M.D.V.)
3 mg/ml-3 mg/ml,
5 ml .... 00085-056[illegible]

(Phys Total Care)
REPACK
SUS, IJ (M.D.V.)
3 mg/ml-3 mg/ml,
5 ml .... 54868-[illegible]

(Quality Care Prod)
REPACK
SUS, IJ, 3 mg/ml-3 mg/ml,
ea .... 55[illegible]

(Southwood)
REPACK
SUS, IJ (M.D.V.)
3 mg/ml-3 mg/ml,
5 ml .... 58016-[illegible]

CELEXA (Forest Pharm)
citalopram hydrobromide
TAB, PO (FILM-COATED)
10 mg, 100s ea [illegible]
20 mg, 100s ea [illegible]
40 mg, 100s ea [illegible]

(Altura)
REPACK
TAB, PO (FILM-COATED)
20 mg, 10s ea [illegible]
20s ea [illegible]
30s ea [illegible]
60s ea [illegible]
90s ea [illegible]
100s ea [illegible]

(DHS, Inc.)
REPACK
TAB, PO (FILM-COATED)
10 mg, 60s ea [illegible]

(Dispensing Solutions)
REPACK
TAB, PO (FILM-COATED)
20 mg, 60s [illegible]
40 mg, 10s [illegible]

(Nucare Pharm)
REPACK
TAB, PO (FILM-COATED)
20 mg, 30s [illegible]

(PD-Rx Pharm)
REPACK
TAB, PO (FILM-COATED)
10 mg, 30s [illegible]
20 mg, 30s [illegible]

Appendix F

Attorney General Medicaid Fraud Recoveries 2007-2009

vs. Current OMIG Audit Recoveries 2007-2009

AG Recoveries [1]	**2007**	**2008**	**2009**
AG Staff	310	335	325
Recoveries (millions)	$113.8	$263.5	$283.0
[2] Avg. per staff	$367,000	$787,000	$870,000

OMIG Recoveries	**2007**	**2008**	**2009**
OMIG Staff	500	582	604
Recoveries (millions)	$120.2	$92.8	$121.847
[3] Avg. per staff	$240,000	$159,000	$201,734

1. AG Recoveries are based on "calendar year" as is OMIG's recoveries
2. State's share of AG's Medicaid Fraud Unit staffing expense is **25%**
3. State's share of OMIG's Auditing staffing expense is **50%**

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APTEA Co.

CVS Caremark

Duane Reade, Inc.

Hannaford Brothers Co.

Kinney Drugs, Inc.

Price Chopper Supermarkets

Rite Aid Corporation

Stop & Shop/ Ahold

Target

Tops Markets LLC

Town Total Health

Wakefern

Walgreens

Walmart

Wegmans

Testimony Before:

Senate Finance Committee

Assembly Ways and Means Committee

Thursday, March 3, 2011
10:00 a.m.
Hearing Room B,
Legislative Office Building
Albany, NY

Presented By:

Vincent Mainella
President
Chain Pharmacy Association of NYS

Chairmen DeFrancisco, Hannon, Farrell, Gottfried and other Members of the panel, my name is Vincent Mainella and I am the President of the Chain Pharmacy Association of New York State as well as the Vice President of Pharmacy for Price Chopper Supermarkets. The Chain Pharmacy Association of New York State greatly appreciates the opportunity to testify today regarding the Governor's Proposed FY 2011-12 State Budget as it relates to community pharmacy.

We would first like to express our member companies' appreciation for the past support and leadership of the Senate and Assembly in partially restoring a number of proposed cuts to pharmacy reimbursement over the last two decades. Below we have provided background on the pharmacy industry in New York State including a summary of the history of cuts to community pharmacy enacted over the last decade. Further, we have provided a summary of our concerns with a number of proposals that were recently approved by the Medicaid Redesign Team (MRT) for inclusion in the Executive Budget for 2011-12. Lastly, we provide recommendations to improve patient access to the highest quality of pharmacy care while also reducing Medicaid costs which we would respectfully urge you to consider as viable alternatives to further pharmacy reimbursement costs.

Background/ History of State Medicaid Cuts to Pharmacy Reimbursement

As background, there are over 4,000 community pharmacies, chain and independent, across New York State which collectively employ over 120,000 full and part-time workers including almost 10,000 pharmacists. Chain pharmacies specifically, employ 108,000 of the employees in New York and contribute $1.26 billion of the $1.5 billion in total taxes paid by pharmacies to New York State annually. New York's 2,153 chain pharmacies play a vital role across the State providing high quality pharmacy care to our residents. The services provided by pharmacies help to keep people healthy and in the community, preventing other escalating healthcare costs such as hospitalizations and emergency room and doctor's visits.

Medications are particularly important to the management of chronic diseases that require long-term or lifelong therapy. Community pharmacists are uniquely qualified and positioned to help reduce the problem of poor medication adherence and are skilled to work with patients to manage their medications and chronic conditions. Through well-established relationships with the patient, pharmacists have gained the trust of their patients and have proven to be a reliable source of information to the patient regarding their healthcare needs.

Through services like medication therapy management and administration of immunizations, community pharmacists have the ability provide quality care that is convenient and easily accessible in virtually every community. Community pharmacists are medication experts with the ability to identify patient-specific medication-related issues and communicate those issues to the patient and their provider. Pharmacists have the ability to educate the patient with the necessary information to improve patient compliance, outcomes, overall quality of care, and reduce overall healthcare costs associated with far more costly medical interventions.

New York State has cut pharmacy reimbursement under Medicaid, EPIC and other public programs twelve times over the past fifteen years. These cuts include decreased pharmacy reimbursement paid to pharmacies for brand and generic drugs, implementation of a state maximum allowable cost program, removal of dispensing fees for over-the-counter products, and cuts in reimbursement for prescriptions filled under the Workers' Compensation program. These cuts have resulted in a total loss of $9.47 billion in pharmacy revenue in fifteen years. This is in addition to the $21.08 million

cut to pharmacies from the 1.1% cut in reimbursement imposed in the fall of 2010. It is also important to note that added to the above $9.5 billion loss in reimbursement, community pharmacies are also experiencing a $112.6 million cut in pharmacy reimbursement due to changes which resulted from the First DataBank settlement enacted in 2009. **Together these cuts have resulted in a total loss to pharmacies of approximately $9.6 billion in state and federal operating funds to pharmacies in New York under Medicaid and other public programs since 1994.**

FY 2011-12 Executive Budget/ Medicaid Redesign Team Package
Generally, the Chain Pharmacy Association of New York State is extremely concerned that the Medicaid Redesign Team developed and/or approved a number of proposals related to Medicaid changes to pharmacy providers and prescription medications, yet there were no pharmacy or physician representatives appointed to the MRT to effectively communicate the impact that these proposals would have on pharmacy providers and our patients. Our Association had made a request to appoint someone from chain pharmacy to the MRT yet our request was not honored.

Specific to the package of proposals approved by the MRT on February 24th, below we have summarized our concerns with a number of these approved proposals.

MRT Proposal 4651: The Chain Pharmacy Association of New York State is strongly opposed to this proposal to enact a 2% across-the-board provider cut as well as a global spending cap under Medicaid which would give the State Department of Health the unilateral authority to impose further provider cuts and/or other spending reductions if state spending in Medicaid exceeds 4% in annual growth. As a result of the repeated cuts to pharmacy reimbursement in New York over the last fifteen years as described above, there is major concern about the potential loss of access to licensed, knowledgeable pharmacists as well as local pharmacies in the community which have longstanding relationships with individuals, are available in emergencies, provide important guidance and monitoring to patients and their caregivers and have earned the trust of their patients. Any further cuts to pharmacy reimbursement which would result from the enactment of this proposal could be very detrimental to our patients and their access to needed pharmacy services. We strongly urge the State Legislature to reject this proposal.

MRT Proposal 15, Attachment 15C: We strongly oppose this proposal to further reduce the pharmacy ingredient cost reimbursement (from AWP-16.25% to AWP-17%) and dispensing fee reimbursement (decreasing fees paid for generic drugs from $4.50 to $3.50). As we have stated above, any further cuts to pharmacy reimbursement would significant impact all of the state's pharmacies and their patients since in a number of cases, pharmacies would be reimbursed by Medicaid at a rate below their cost to acquire and dispense prescription medications. Further, it is very important to note that while in statute pharmacies are paid at Average Wholesale Price (AWP) minus 16.25%, the definition of how AWP is calculated was changed as a result of a recent lawsuit (the First DataBank settlement) which pharmacies were not a party to. New York pharmacies are actually paid at a rate equivalent to AWP minus 20% or worse, a $112.6 million cut in pharmacy reimbursement due to these changes in 2009. The current reimbursement rate paid to pharmacies in the State is among the very lowest in the country and lower than rates paid by many commercial payers which made adjustments following the First DataBank settlement to hold pharmacies harmless or to mitigate the impact of the change. For these reasons, we strongly urge the State Legislature to reject this proposal.

MRT Proposal 11: The Association has not taken a formal position on this proposal to bundle the pharmacy benefit into Medicaid Managed Care. However, we believe that Proposals 4651 and 15 are in direct conflict with this proposal. By bundling pharmacy into Medicaid Managed Care, we are assuming that the State would no longer set the reimbursement rates paid to community pharmacy and rather such rates would be subject to negotiations between the Managed Care plan and pharmacies as a condition of participation in their networks similar to other carved in benefits under Medicaid. However, if this is not the case and all three proposals (4651, 15 and 11) are implemented, pharmacy providers would potentially face triple the cuts in reimbursement this year including an across-the-board provider cut, a targeted reduction in pharmacy reimbursement and potentially lower reimbursement from a reduction in rates that are negotiated and paid under the Medicaid Managed Care program. This would be devastating to community pharmacies and is grossly unfair and disproportionately hitting pharmacies as compared to other providers. This would be unsustainable for many New York pharmacies which could then be forced to reduce their workforces, store hours, patient services and some could be forced to close. This, in turn, would mean an inevitable reduction in patient access to pharmacy services.

In addition, we would be concerned if this proposal results in increased copayments under Medicaid if the authority to establish the copayments is turned over to commercial payers. Currently, Medicaid beneficiaries may refuse to pay their co-payments at point of sale. In fact, the average rate of uncollectible co-payments statewide is 50% (and this rate is much higher in certain parts of the state including over 70% uncollectible co-pay rates in New York City). In these situations, it is impossible for pharmacies to recoup payments for co-pay losses and only further exacerbates and compounds the already extremely precarious financial state of pharmacies. For this reason, we would urge the State Legislature to either maintain the current $1 for generic and $3 for brand co-payments in law if the pharmacy benefit is bundled into Managed Care or that the State change its policy to require that the payment of co-pays by Medicaid beneficiaries be mandatory.

Finally, below we have included the following principles of managed care to be considered as part of any effort to bundle the Medicaid pharmacy benefit into Managed Care in order to ensure continued patient access to pharmacy services.

- Open Provider Network: State Medicaid managed care programs should have and maintain open provider networks to ensure continuity of care and maintain patient access to pharmacy services and other healthcare needs.

- 90-day Retail Fills: Participating retail pharmacy providers should be allowed to dispense 90-day supplies for patients enrolled in managed care programs. Allowing retail pharmacy providers to dispense a 90-day supply is a targeted approach to improving patient adherence to their medication regimens as well as achieving savings in state Medicaid programs that focus on effective utilization and drug costs.

- No Mandatory Mail Order: Patient choice should not be restricted once patients are enrolled in a managed care program. Patients should have the choice of using their retail pharmacy or a mail order pharmacy based on their specific needs.

- Prompt Pay: Managed care organizations (MCOs) should be required to pay all pharmacy

claims in a timely manner. All pharmacy claims should be paid within 14 days for clean claims submitted electronically, and 30 days for all other clean claims. MCOs should also be required to pay interest for late payments, and procedures to correct defective/unclean claims. Pharmacies should not be assessed a fee for the adjudication of an electronic or manual claim.

- Standards in Auditing Processes: All audits should be conducted using generally accepted auditing standards and in accordance with state and federal law. State laws should prohibit MCOs and PBMs from using probability sampling and extrapolation to determine overpayment amounts to be recovered by recoupment, offset, or otherwise from pharmacy providers.

MRT Proposal 104: The Association is opposed to this proposal to increase co-pay requirements under Medicaid from $1 to $1.15 for generics and $3 to $3.40 for brand name drugs. Again as we have discussed above, increased co-payments under Medicaid effectively translate into decreased payments to pharmacies. We would urge that the State Legislature to reject this proposal or that the current policy be changed to require that the payment of co-pays by Medicaid beneficiaries be mandatory so pharmacies do not have to continue to incur these serious losses.

Recommendations for Cost Containment Strategies

The average net profit margin for pharmacies is just 2 percent, a profit margin that has been continuously shrinking due to increasing product, labor, and administrative costs as well as the 15 years of repeated cuts to pharmacy reimbursement in the State. As previously stated, any further reductions to pharmacy reimbursement rates would pose a real threat to New York pharmacies' continued financial viability and, in turn, to the ability of low-income and all New York residents to access prescription drugs and pharmacy services.

We believe that there are a number of steps that the State can take to reduce Medicaid spending in the pharmacy area. First, we would strongly urge the Legislature to pass legislation to address the sunset and expand pharmacist-administered immunizations, as described below.

Remove the Sunset and Expand Pharmacist-Administered Immunizations (Included in approved MRT Proposal 15, Attachment 15D)

Specifically, we urge that legislation be enacted during the 2011 session to remove the 2012 sunset provisions on Chapter 563 of the Laws of 2008 which allows pharmacists to administer immunizations to adults for influenza and pneumococcal. In addition, we would recommend that the current law be expanded to other types of immunizations and age groups.

Immunizations are the best defense against morbidity and mortality for diseases for which vaccines are available. Studies have shown that pharmacist provided immunization services increase the overall immunization rates including physician-administered vaccinations. In New York almost 5000 Registered Pharmacists delivered approximately 750,000 shots in 2010. Since the law was implemented, the State has seen an overall increase in rate of immunizations by New York residents of 2.9% with preliminary statistics showing an increase of 8% for African Americans, 8.6% for Hispanics and over 13% for Asians.

Pharmacist-provided immunization services help protect public health by reducing the number of

unvaccinated citizens. Despite the availability of effective immunizations, many Americans remain unvaccinated and susceptible to vaccine-preventable diseases. Community pharmacies play a key role in providing patients with easily accessible and convenient immunizations services to help reduce the number of inadequately vaccinated Americans, as evidenced by the H1N1 epidemic earlier this year. Expanding the immunizations that pharmacists are allowed to administer could provide other venues for busy individuals, who, absent a convenient, highly accessible location to obtain vaccinations such as their neighborhood pharmacy, might forgo the service. We believe that expanding the number of healthcare settings that provide immunizations as well as the types of immunizations that pharmacists can provide will consequently lead to increased vaccination rates throughout the state.

Most importantly, New York must remove the 2012 sunset in existing law so pharmacists may continue to provide this invaluable service to our residents.

Other Recommendations (Some of which are included in the approved MRT Proposal 15)
In addition, we would ask for your consideration of these cost containment measures under Medicaid as alternatives to pharmacy reimbursement cuts. These include:

- Increasing Generic Utilization: For every 1% increase in the Medicaid generic spending, the State can see $78.8 million in savings. The state can achieve this by adding new generics to the Medicaid formulary upon release similar to the private market to avert the existing 4-6 week process and use Step Therapy to encourage their use. State Medicaid lags behind others in generic substitution rates by 4%, generic substitution rates are lower than other states (62%) and generics account for less than one-fifth of state Medicaid drug spending.

- Improving the Prior Authorization Process: Currently, the Medicaid prior authorization system does not appear to reduce utilization of high cost brands. Although prior authorization procedures are currently in place, these procedures rarely result in a rejection of the prior authorization request.

- Expanding the Preferred Drug List (PDL): The state should follow in the footsteps of private insurance and expand its PDL to include mental health and other high cost drugs not currently covered which would result in significant cost savings.

- Implementing Medication Therapy Management (MTM): The State should broadly implement MTM and disease management programs to address the problem of poor medication adherence among patients and reduce costs by improving the management of chronic diseases and decreasing overall health care costs associated with avoidable hospitalizations, emergency room visits and physician visits.

- Extending E-Prescribing: Through the expanded use of e-prescribing and e-technology the State could realize cost savings and greater efficiencies. E-prescribing provides healthcare providers secure low-cost, electronic access to prescription and health information. Real-time access to prescription and health information at the time the prescription is written can save patients' lives, improve efficiency and reduce the cost of healthcare for all.

Conclusion

The Chain Pharmacy Association of New York State wholly supports reimbursement rates that are fair and adequate to the quality and comprehensive pharmacy services that our members provide. We also believe that through services like pharmacists-administered immunizations, pharmacists have the ability to make a positive difference in patient and public health overall. However, constant cuts to pharmacy reimbursement can lead to the loss of knowledgeable healthcare professionals in the community resulting in decreased patient access to healthcare providers and the services they provide. To that end, we would respectfully urge you to consider alternatives to further pharmacy reimbursement cuts in the final State Budget this year. Also, we would again like to thank you for your past support of community pharmacies which has helped to ensure patient access to high quality and preventative pharmacy services throughout New York State. **We appreciate the opportunity to submit our testimony today and look forward to continuing to work with the Legislature to guarantee access to prescription drugs and pharmacy services for all New Yorkers.**

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Testimony of the
New York State Nurses Association
Before the
Joint Legislative Public Hearing on 2011-2012
Executive Budget Proposal
Health/Medicaid

March 3, 2011

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Advocating for patients. Advancing the profession.

JOINT LEGISLATIVE PUBLIC HEARING ON 2011-2012

EXECUTIVE BUDGET PROPOSAL

HEALTH/MEDICAID

Good afternoon. My name is Shaun Flynn and I am the Director of Governmental Affairs at the New York State Nurses Association. Joining me today is Sally Dreslin, a registered nurse, and an Associate Director in the Governmental Affairs Department. The Nurses Association is the oldest and largest professional organization for registered nurses in New York State. It represents the interests of more than 270,000 registered nurses and serves as the collective bargaining agent for more than 36,000 RNs at 150 healthcare facilities. On behalf of our members and the patients they serve, I appreciate the opportunity to address the Governor's 2011-2012 Executive Budget as it relates to healthcare issues.

The Nurses Association appreciates the challenge involved in developing a balanced budget in light of the State's fiscal insecurity. However, we are exceptionally concerned that the choices made during the evolution of this year's budget, and particularly the Medicaid Redesign Team process, have the potential to significantly and negatively impact patient safety, the provision of healthcare services in the state and the practice of registered nurses throughout New York. If implemented all at once, the reductions proposed by Governor Cuomo will have a severe effect on the state's most vulnerable residents, drastically reducing access to services, increasing morbidity and ultimately adding to long-term healthcare costs.

MEDICAID REFORM

Though the Medicaid Redesign Team has engaged mostly provider and some consumer stakeholders, among others, in seeking appropriate ways to reduce Medicaid costs, many of the solutions proposed are likely to require long-term restructuring. Medicaid reform in New York must focus on reducing costs through better coordination of care, improved outcomes, and the control of fraud, waste and abuse of the program, rather than on an abrupt reduction of more than $2.35 billion in spending. With the right solutions, we can improve care *and* manage costs.

NYSNA participated on the Medicaid Redesign Team and, against the backdrop of severe across-the-board cuts that had been threatened by the Administration, we supported a package of proposals that included some profoundly flawed recommendations. The last-minute change to the Redesign Team's process that resulted in the elimination of time for deliberation and also of the ability to amend individual proposals was not in the public's best interest. NYSNA has significant concerns with proposals that seek to expand the roles of healthcare personnel beyond that for which they have been educated and prepared; proposals that further challenge the ability of safety-net providers to offer accessible, quality care and the proposal to suspend the Nursing Care Quality Protection Act which was

sponsored by many of you and which was signed into law in 2009. Many of the proposals that have been accepted by the Governor will require long-term structural changes and demonstrate no short-term savings, yet they have inexplicably been included in the accepted, short-term package of recommendations without any opportunity for deliberation or amendment.

The Medicaid reform package that the Governor has accepted foreshadows an increasingly precarious healthcare delivery environment. Medicaid providers, healthcare workers and Medicaid enrollees have endured across-the-board reductions in reimbursement rates year after year and the results are closed facilities; under-staffing; poorly coordinated care, fumbled care transitions; cuts in community supports and decreased access to health care among the state's neediest residents. Under the global spending cap with its ill-defined "utilization controls" and rate reductions that the Department of Health will be empowered to implement, facilities that are already in a brittle fiscal state may not be able to endure the further restriction of resources needed in order to fulfill their missions. New York State must respect the commitment that it has made in its Constitution to the aid, care and support of the needy. The safety net represented by Medicaid, while far from a perfect healthcare delivery model, is crucial to the health and well-being of millions of state residents who have no other viable alternative for care.

The future of the Medicaid program must include healthcare homes that provide coordinated, primary and preventive health care for even the most complex and fragile recipients, and a process that holds plans and providers accountable (accountable care organizations, or ACOs) for not meeting established quality outcomes. Additionally, New York will serve itself well, in light of federal healthcare reform implementation, if the Medicaid reforms it enacts today are in line with goals set forth in the Affordable Care Act. New York must ensure that mental health services are provided on par with other services. All services whether acute, sub-acute, residential, or ambulatory, must be accessible and community-based and must include sufficient numbers of registered nurses to ensure they are safe and effective.

QUALITY CARE

The Nurses Association recommends several initiatives that we feel will contribute to the state's ability to provide cost-effective, high-quality health care to the residents of New York.

Coordinated Care

NYSNA supports expanding enrollment in Medicaid managed care programs. The goal of enrolling more recipients in managed care is to engage them in medical homes and to provide them access to high quality, coordinated primary and preventive care services. The Medicaid managed care programs have been successful in improving the quality of care for the recipients enrolled, as measured by the state's Quality Assurance Reporting Requirements (QARR) system. The challenge, however, is that the majority of the state's most costly Medicaid populations are either not enrolled in managed care programs, or the most expensive portions of their care are carved out of the managed care program and are reimbursed on a fee-for-service basis. More of New York's high-cost Medicaid populations, e.g.

those with multiple, chronic co-morbidities; with persistent, severe mental illness; the disabled and the frail elderly, must be enrolled in programs that provide better-coordinated care.

Safe Staffing

Inadequate and poorly monitored nurse staffing practices jeopardize the provision of quality health care services, resulting in dangerous and costly medical errors, sub-optimal patient and resident outcomes, and higher rates of nursing staff turnover. Research demonstrates that safe staffing ratios and minimum hours of care are associated with lower patient mortality, decreased length of stay and improved rates of nurse retention. The Nursing Care Quality Protection Act that was supposed to go into effect on March 15, 2010, was intended as a mechanism to monitor facility staffing levels, staff mix and nursing quality outcomes. This important public safety measure is in grave danger of elimination via the proposal recommendations of the Governor's Medicaid Redesign Team. We strongly urge the legislature to reject any attempts to roll back the Act's provisions and to, instead, use the data for the purposes of evidence-based decision-making in matters of healthcare reform.

Nurse Residency Programs

Nursing staff turnover is a persistent challenge for nursing and hospital executives. NYSNA is disappointed that this issue was not addressed by the Governor's Medicaid Redesign Team and urges further consideration in longer-term reform planning. High rates of turnover, particularly among first-year nurses, costs facilities from $62,000 to $88,000 per nurse; costs patient access to safe and quality care; and costs the nursing profession by exposing new nurse graduates to high-stress, unsupportive work environments. In 2007, the average nurse turnover rate in hospitals was 8.4 percent and 27.1 percent of *newly-hired* nurses left their jobs within one year of hire. There are estimates that up to 40 percent of *new nurse graduates* leave their hospital jobs within one year of hire. Annually, healthcare organizations spent $300,000 in nurse turnover costs for every 1 percent increase in turnover; an average turnover rate of 8.4 percent translates to an annual cost of turnover for healthcare organizations of $2.52 million.

Nurse Residency Programs fill the gap between school and practice by providing continuing education, mentoring, reduced patient loads, and support that enables the new nurse graduate to successfully navigate the transition from novice to competent practicing nurse. These programs generally last one year and research shows that they lower the rates of nurse turnover; improve the quality of patient care through the development of nurses' critical thinking, prioritization skills, professionalism, and improved ability to function in healthcare teams; and improve the retention rates of new nurse graduates.

Many hospital systems are in fact, beginning to implement residency programs, but more need to be encouraged. As Mary Beth Campo, the Chief Nursing Executive for Kaleida Health in Western NY stated in relation to the implementation of a grant-funded collaborative Nurse Residency Program for Kaleida Health, Erie County Medical Center, Roswell Park and the VA Medical Center, "Nursing leaders realize that the success of new nurse graduates is critical to the future of health care in our community and has become a priority for area health providers" (Buffalo General News, June 24, 2010).

Nurse-Managed Health Centers

NYSNA encourages building partnerships between academic and clinical centers as a means of sharing valuable, yet scarce resources. Nurse-managed health centers are community-based health clinics that are managed by nurses; most are either independent non-profits or academically-based clinics that are affiliated with schools of nursing. Key components of nurse-managed health centers include that: clients have direct access to nursing services; advanced practice nurses diagnose and treat, and promote health and optimal functioning; services are client-centered; services are reimbursed; accountability and responsibility for client care remains with the nurse; and overall accountability for the center remains with the nurse executive.

Nurse-managed health centers serve patient populations who are least likely to receive consistent, coordinated care. This includes vulnerable people across the age continuum who are uninsured, underinsured, or living in poverty. As safety-net providers, nurse-managed health centers allow patients who are unable to pay for care, to be charged on a sliding scale or treated for free. As a result, nurse-managed health centers often struggle to remain fiscally sound.

Nurse-managed health centers also serve the population of advanced practice nursing students, as well as students in other healthcare professions. They provide workforce training opportunities in community-based, primary care. Opportunities for community-based clinical education pose significant challenges for the healthcare educational system and the issue has often been identified as one barrier to the development of an adequate healthcare workforce for the future.

A national collection of quality measures for nurse-managed health centers indicates that these centers meet or exceed national quality benchmarks, based on Healthcare Effectiveness Data and Information Set (HEDIS) outcome data. In fact, nurse-managed health centers' quality outcomes are particularly high in areas of chronic disease management. Evidence-based research has shown that the advanced practice nurse providers at nurse-managed health clinics provide high-quality primary care and women's health with outcomes that are similar to, or better than, other primary-care and women's health providers.

Most significantly, the National Committee for Quality Assurance (NCQA), in its 2011 *Standards for patient-centered medical homes (PCMH),* now includes nurse practitioner-led practices as practices or providers who are eligible for NCQA Recognition as a Patient-Centered Medical Home. In January 2011, eight nurse-managed health centers in Pennsylvania received NCQA's recognition and certification as Patient-Centered Medical Homes. This designation is a significant testament to the quality of care that is provided by nurse-managed health centers and also, hopefully, signals a wider acceptance of this important healthcare delivery model. We encourage you to explore creative opportunities that will support both the healthcare workforce and the provision of quality care in New York.

School-Based Health Centers

School-based health centers utilize multidisciplinary teams of providers, including nurse practitioners, to provide comprehensive primary care, preventive care, and early intervention services to underserved elementary and high school children. A series of papers in the American Journal of Public Health in 2010 highlighted some of the outcomes that are associated with access to school-based health centers. These include: an increase in the use of primary care services, a reduced use of the Emergency Department, fewer hospitalizations, expanded access to and improved quality of physical and mental health care, greater engagement in health-promoting behaviors, and improved resiliency among the children and adolescents. The "improved resiliency" outcome is significant because resiliency is measured through important quality of life factors: attending and applying oneself in school, expressing feelings and emotions, expressing a feeling of hope in one's life and in the future, involvement in organized recreational or vocational activities, and motivation to participate in counseling. School-based health centers can significantly and positively alter the course of a vulnerable child's life and registered nurses play a key role in that process. We encourage the Legislature to facilitate both the expansion of school-based health centers and their appropriate reimbursement as patient-centered medical homes.

Appropriate Providers of Care

To ensure that New Yorkers are receiving the best quality care, it is essential that appropriate members of the healthcare workforce are providing the right care in the right place. The Nurses Association is deeply disappointed in the inclusion of proposal #200 in the Medicaid Redesign Team's final package of recommendations. Proposal #200 inappropriately expands the scope of services of home health aides to allow them to administer pre-poured medications to patients who are not self-directing, recommends the introduction of medication techs into nursing homes for the purposes of medication administration and recommends a scope of practice change for licensed practical nurses to allow them to perform assessments in long term care settings. This recommendation is inconsistent with current Education Law; LPNs do not receive the education that is required to assess patients. The entire current LPN workforce would have to undergo a re-education process and be tested. The curriculums of the current practical nursing programs would have to be changed and this would represent an expense for the state. When the LPN scope of practice was changed to allow them to administer medications, some LPNs were not able to meet the competency criteria, resulting in a two-tiered LPN practice.

NYSNA encourages you to look behind the veil of potential short-term workforce savings to see the long-term sacrifices in patient care and well-being when members of the healthcare team are functioning in inappropriate spheres. Proposals that seek to allow unlicensed assistive personnel to administer medication in nursing homes or that would expand the services provided in the home setting by unlicensed assistive personnel, are short-sighted and the ultimate outcome is a poorer quality of patient care leading to unnecessary hospital admissions, re-admissions and adverse events, resulting in increased patient morbidity, mortality, and cost of care.

REVENUE PROPOSALS

To preserve vital healthcare programs, NYSNA encourages the Legislature to explore additional progressive revenue-generating ideas that have been proposed by various organizations. At the top of that list should be the extension of the temporary income tax surcharge on high-income earners. When this surcharge was enacted, policymakers believed that by the time it expired, the state and the nation would be in the midst of a robust economic recovery. Unfortunately, the recovery has been slower than expected and we now face the loss of vital and scarce revenue at the same time as federal stimulus funding is set to expire.

Extending the surcharge would provide the state enough time to implement thorough, meaningful Medicaid reform in a way that will reduce potential negative impacts on access or quality in our healthcare system. Taking almost $2.5 billion out the healthcare system in a single year will produce a financial shock wave that could close facilities, reduce staffing and harm quality. NYSNA strongly believes that it would be irresponsible for the State to cut vital programs for the most vulnerable in order to lower taxes for the most fortunate.

An additional revenue proposal is to reduce the rebate provided on the state's stock transfer tax. Brokers and taxpayers receive a 100% rebate on the tax paid for selling or transferring shares of stocks, essentially cancelling out any revenue gains. Data shows that in 2009 the value of stock transfer rebates was $14.5 billion. Retaining just 20 percent of the rebate would have generated revenue of $2.9 billion.

The Nurses Association continues to support the creation of an excise tax on sugar-sweetened beverages. This tax will discourage the excessive consumption of unhealthy beverages that contribute to the epidemics of obesity, diabetes and heart disease that diminish quality of life and strain healthcare delivery and spending. It will promote public health by encouraging New Yorkers to make healthier choices and the added savings will be reflected in dollars, but more importantly, in healthier lives.

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

We also urge policy makers to be candid with the public about the consequences of the cuts under discussion. Should the Legislature and the Governor seriously consider provisions that will result in hospital and nursing home closures, the provision of care by unqualified healthcare personnel, unsafe staffing levels and reduced government oversight, the public should be informed of these impacts so that they may judge the budget on its overall impact on New York.

As you continue your deliberations, we urge you to pass a budget that will protect the public health infrastructure and ensure access to quality healthcare for all of New York's residents. Leadership during times of crisis doesn't only require government to make the tough choices, but also the right choices.

Thank you for your time and consideration.

For more information, contact the New York State Nurses Association Governmental Affairs Department at **518.782.9400, ext. 283** or by e-mail.

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2011-12 Executive State Budget Testimony

presented by the

New York State Association of Counties
and the
New York State County Executives Association

to the

Joint Legislative Fiscal Committee on Health and Medicaid Public Hearing

March 3, 2011

Hon. Maggie Brooks, President, County Executives Association
Stephen J. Acquario, Executive Director

Thank you Chairman Skelos, Chairman Farrell and members of the joint fiscal committee on Health and Medicaid, for the opportunity to speak today. I am Stephen Acquario, Executive Director of the New York State Association of Counties. NYSAC is the municipal association serving the counties of New York State and the City of New York. For 86 years our mission has been to represent, educate and advocate for counties and the thousands of elected and appointed county officials who serve the public.

As you know, Counties are required under State law to implement and finance many State mandated health and human services programs. Medicaid remains the number one cost driver in county budgets today and it is one of 9 State mandates that consume 90 percent of the county property tax levy statewide. The Medicaid mandate alone typically consumes about half of a counties' property tax levy.

Since the inception of its Medicaid program, New York State has placed tremendous administrative and financial responsibility on the counties and county property taxpayers. Counties do not set eligibility, determine the benefits or set reimbursement rates for the Medicaid program.

County officials, who once directed Medicaid resources to meet the needs of their citizens, are now carried away by an avalanche of State and Federal mandates, rules and paperwork—unable to provide any meaningful direction or control. And yet, with the exception of a cap on the growth of the local share, the county role in financing this radically different program has remained essentially unchanged.

Governor Cuomo's 2011-12 Budget recognizes that New York's current Medicaid program is fiscally unsustainable. The Governor formed a Medicaid Redesign Team (MRT), of which NYSAC is a member, to help come up with a series of reforms to move New York's Medicaid program toward a more fiscally sustainable model. We supported these initial recommendations and look forward to the Medicaid Redesign Team's continued efforts over the next year to evaluate additional proposals.

These initial proposals are not perfect and some of the across the board reductions can be blunt instruments that do not adequately measure the health care quality delivered by a particular Medicaid service or provider against another, but the overall MRT package moves New York closer to a more affordable Medicaid model.

I would like to take a few minutes to highlight a couple of fundamental policies that must be embraced in order to right-size Medicaid for recipients and tax payers alike.

Medicaid Financing

In order to prevent unaffordable expansions of Medicaid in the future and reverse the current structural deficit in the program, the Medicaid Redesign Team must include as a core principle in rightsizing Medicaid in New York, the gradual elimination of any local share financing requirement.

The fiscal responsibility for services should reside with the level of government that has decision-making authority over those services—this fundamental tenet of governing has been ignored in the financing structure of New York's Medicaid program, and now it is unsustainable.

The requirement that counties (i.e., property taxpayers) and New York City fund such a large share of the Medicaid program has allowed the State to expand this program under the guise that it will only cost a fraction of a state dollar (state general fund) with the rest being funded by county property tax payers, New York City residents and the federal government.

NYSAC believes that a portion of the savings generated from MRT ideas, and from savings that can be realized from the implementation of the federal Affordable Care Act, must be used to gradually phase out any local cost share for Medicaid in order to avoid the "off-budget" financing mentality that has contributed, significantly, to a program that is fiscally unsustainable.

This year, counties and New York City will pay $7.2 billion dollars as the "local contribution" to support the Medicaid program. This is more than 46 states spend out of their general fund for their respective Medicaid programs. It is more than what 35 individual states spend in *total* funds for their Medicaid programs. This local Medicaid share requirement is a major reason New York ranks as the highest local tax burden state in the country for 17 of the last 20 years. This reality is a leading contributor to economic and population decline in this State.

The magnitude of growth in New York's Medicaid program must be recognized as a primary reason it is unsustainable today. Since 2000, enrollment in New York's Medicaid program has increased nearly 60 percent. This growth is driven by data that indicates in 2001 about 1 in 7 New Yorkers were eligible for Medicaid or CHIP. Today 1 in 3 New Yorkers is eligible for Medicaid or CHIP.

As a point of comparison, the federal Affordable Care Act, which is designed as a universal health insurance coverage expansion is only anticipating 40 percent growth in Medicaid enrollment over the next decade.

Counties believe that now is the time to recognize that Medicaid is a State program, and that the non-Federal share of its cost is most appropriately financed at the State level, where virtually all the capacity for control and direction resides. NYSAC will continue to advocate for this as part of the current Governor's Medicaid Redesign Team and thereafter.

By assuming all Medicaid financing and administrative responsibilities, the State will be in a better position to control costs, improve health care service delivery, and ensure that consistent quality of care is provided on a statewide basis. This will be consistent with the national model, where states maintain both the operational control and the financing of Medicaid.

Optimizing Opportunities under the Affordable Care Act
The Affordable Care Act will likely provide opportunities to improve the quality of care and even reduce costs over the long term for New York. However, in order to achieve this, the State must pursue policies that do not duplicate what the federal reforms will ultimately offer and fund.

Basically, does the State want to continue to pay for programs, *out of its own taxable resources*, that the federal government is now saying it will cover using federal resources? We would propose, that to the greatest degree possible, if a new federal program is created that essentially provides the same service the State may currently be covering on its own, the State should withdraw from its own program and let the federally financed program take over.

For example:

- *Eligibility for State Public Health Insurance Programs:* New York currently provides Medicaid coverage up to 150 percent of the federal poverty level. Under the Affordable Care Act the federal government will provide a 95 percent federal subsidy for health insurance for low income uninsured individuals above 133 percent of the poverty level. The State currently spends more than $550 million annually in general fund for recipients between 133 percent and 150 percent of the federal poverty level and we should let the federal government take over this responsibility when federal reforms are up and running.

- *Eliminate State Programs that Duplicate Federal Programs:* The State should review the need to offer some of our many targeted health programs such as ADAP, family planning, special screening programs, especially if new federal public health programs and the individual insurance mandate will essentially cover the same things.

- *Do Not Expand Insurance Coverage Requirements Beyond the Threshold Established by the Federal Government in the New Health Insurance Exchanges:* Once the health insurance exchanges are operational and the federally designed health insurance benefit package is defined the State should not

mandate additional health services (beyond the federally defined level) be covered as part of the basic health insurance policy in New York. Currently, New York requires health insurers to cover many more services than most states and this directly translates to the higher cost of health insurance in New York vs. other states. Under the Affordable Care Act, each state that exceeds these federal standards will be required to pay for costs above the federally defined benefit package on their own (over and above the authorized federal subsidy).

The reasoning for not duplicating federal programs or exceeding federally defined coverage options is twofold;

- First, the current State Medicaid program is fiscally unsustainable, as is the overall State Budget. When fiscal relief can be provided with minimal disruption of existing program services, the State should accept the offer of federal help.

- Second, in the case of the Affordable Care Act the federal government is raising federal revenues to pay for Medicaid coverage expansions and tax subsidies for low income people to buy health insurance by:
    - Increases payroll taxes on high income earners (disproportionately located in New York),
    - Adding new taxes on high cost health insurance plans (also, disproportionately located in New York),
    - Creating new taxes, fees and penalties that will be paid by New York based companies, small businesses and individuals, and
    - Cutting Medicare and Medicaid reimbursements to health care providers located in New York.

New Yorkers are already paying for the federal health care expansion and should not be taxed again by New York State, so a duplicative State-only program can continue.

Early Intervention

Another public health program that is operated by the counties is the Early Intervention program. Several years ago New York State broke the historic state/county partnership of Early Intervention. What was once a 50-50 percent state/local split became a 49-51 state/local share.

The Early Intervention program costs county property taxpayers $185 million per year. Counties now pay more for this state mandated program than New York State.

Counties strongly support reform of the Early Intervention program through the adoption of legislation that would require third party commercial insurers to provide coverage for all EI services, that counties' claims are deemed as medically necessary, and that county claims are paid at the Early Intervention approved rate.

48% of children in the Early Intervention program have commercial insurance, yet less than 2% of the $654 million Early Intervention program is paid for by commercial insurance companies. In addition, 80% of reconciled claims in 2007 were denied by commercial insurers.

NYSAC believes that New York State must reform and overhaul the Early Intervention program to ensure the integrity of the EI program, serve the rising number of children in need, and become more accountable to the state's taxpayers.

Article 6 State Aid and State Grant Funding

Additionally, the backbone of public health funding for counties in New York State is Article Six State Aid and State grant funding. Stable and timely funding to support core public health services is essential for the protection of our communities.

Article Six of the Public Health Law provides a core grant, then promises state reimbursement for 36% of local health department costs for mandated core services after the core grant is spent. State grant funding that once provided additional stability to core services

has eroded and state aid and grant payments have been drastically delayed.

In his 2011-12 Executive Budget Governor Cuomo is proposing to eliminate funding for "optional" public health services. Counties have identified these "optional" services as essential and core to their communities based on their assessment of local need.

I can assure you that further reductions of these critical programs will cripple the capacity of local governments to protect their residents and counties cannot continue to absorb the cost shifts.

Human Services

Finally, I would be remiss if I did not address the impact of the Governor's budget proposal regarding Human Services on counties.

The 2011-12 Executive Budget presents counties with several fundamentally flawed and unfair changes in the fiscal structures of human services programs. The first is in the area of Safety Net Assistance.

The State and counties have shared equally in the cost of the Safety Net program for public assistance recipients, 50% state and 50% local share. The Executive now proposes breaking that historic partnership in order to lower the State's cost.

The budget proposal would increase the local share of Safety Net Assistance from 50% up to 70% while reducing the State's share to 30% to limit its financial exposure.

This decision to shift a greater percentage of the cost of public assistance onto local property taxpayers not only reflects a skewed understanding of the governance of the program, but it ties the counties' hands in terms of our ability to manage the program.

There is no programmatic or policy change to the program to warrant this shift, just a fiscal decision to mandate that county property taxpayers pay more for this program.

The State should maintain its commitment to the Safety Net population, and shares should continue at 50/50 State and local.

The Safety Net population is increasing at a faster rate than the Temporary Assistance for Needy Families (TANF) population as families exceed the TANF 5-year limit and as the number of childless adults on assistance increases.

Conclusion

In conclusion, this Executive Budget directly impacts county property taxpayers and our counties ability to continue providing these services.

Our top mandate relief priority is to reform Medicaid in a way that reduces costs for the State and reinvests these savings for a gradual State takeover of county Medicaid costs. Only then can we reduce property taxes and improve New York's economic competitiveness.

We are under no illusions that this task will be simple or easily accomplished. But, at the same time, we firmly believe that it must begin now and continue over the next three years to return New York State to its rightful place as a leader in government service and economic competitiveness.

Thank you for the opportunity to speak with you today.

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TESTIMONY OF

THE COALITION OF NEW YORK STATE

PUBLIC HEALTH PLANS

ON THE GOVERNOR'S PROPOSED FY 2011-2012 HEALTH AND MEDICAID BUDGET

SUBMITTED BY MARK LANE

TO THE

SENATE AND ASSEMBLY COMMITTEES ON

HEALTH, MEDICAID AND THE AGING

MARCH 3, 2011

Introduction

Thank you for the opportunity to provide testimony on behalf of the Coalition of New York State Public Health Plans (PHP Coalition) regarding the Governor's proposed Medicaid and Health Budgets for the State Fiscal Year commencing April 1, 2011. My name is Mark Lane, and I am testifying in my role as President and CEO of Fidelis Care New York and as a member of the Coalition. Established in 1995, the Coalition of New York State Public Health Plans is an important voice for New York's non-profit, publicly-focused health plans and the low-income people we serve. Over the last decade, Coalition plans have grown to serve the majority of children and adults in Medicaid who access their public insurance coverage through health plans. Coalition plans offer decades of experience in delivering high quality services to members that often experience significant barriers to health care. Our plans consistently receive high marks in quality of care and member satisfaction. The Coalition currently represents nine plans serving over 2.5 million, or over two-thirds of, children and adults enrolled in New York's Medicaid managed care, Family Health Plus (FHP), and Child Health Plus programs. All Coalition plans are sponsored by or affiliated with public and not-for-profit hospitals, community health centers and physicians.[1] Today, we would like to comment on how plans are stepping up to be part of the solution to the State's budget crisis and highlight some concerns with the recommendations made by the Medicaid Redesign Team.

While we do not have all the answers to New York State's budget crises, Medicaid managed care (MMC) is one time-tested and proven solution to achieving Medicaid cost-containment and quality improvement. Since 1985, Medicaid managed care has been New York State's primary vehicle for improving the quality of care provided to beneficiaries, while controlling the growth of Medicaid costs. With large current and projected budget deficits, the State needs short- and

[1] A complete list of Coalition plans is included in the appendix.

long-term solutions for its budget crisis. Medicaid managed care offers a robust and "ready-to-go" infrastructure to drive immediate savings, while improving the delivery of care for long-term savings. We look forward to partnering with the governor and legislature on a number of the recommendations made by the Medicaid Redesign Team, including the following:

New Populations and Benefits. The Governor has proposed to implement mandatory Medicaid managed care for a number of exempt and excluded populations over the next three years, enrolling nearly all Medicaid eligibile New Yorkers in health plans by 2014. Health plans are ready to work with the State on enrolling these new populations and expanding the benefit package to include personal care and nursing home care for non-dual eligibles. These expansions and changes, must be implemented in a careful and thoughtful manner—the State can benefit from plans' on-the-ground expertise in outreach, enrollment and care delivery processes. The State must also ensure that plan rates are adequate for these new, complex populations and benefits. Estimated state savings in year one is $10 million.

Pharmacy Carve-In. Pharmacy is currently carved out of Medicaid managed care and Family Health Plus, and paid for through fee-for-service Medicaid. A recent change in federal law now provides an incentive for states to "carve-in" these benefits into managed care. The PHP Coalition is supportive of this proposal as the plans' management of drugs allows for comprehensive and coordinated care by integrating pharmaceutical and medical benefits under the oversight of a single, accountable entity. The coordinated care of a drug carve-in arrangement also reduces costs from inefficient and inappropriate drug utilization. Because they are at financial risk for pharmacy costs, plans have the incentive to detect and control drug over-utilization, manage polypharmacy, and further institute cost-effective pharmacy protocols. For

example, when clinically appropriate, health plans can work with providers to promote the prescription of generic drugs instead of medically equivalent, but more costly, brand-name drugs. Improved care coordination and reductions in Medicaid drug spending will generate considerable savings for the State, estimated to be $50 million in 2011 and $100 million in 2012.

Premium Cuts and 2% Across the Board Cut. Despite the fact that in 2009, the PHP Coalition plans, all of which are not-for-profit organizations, reported as a group a 1% surplus across their public health insurance products and that plans will report even lower surpluses, if any, in 2010, we reluctantly accept the MRT recommendations to reduce the managed care trend factor, cut administrative dollars in the form of marketing resources, and reduce premiums to limit surplus assumptions to 1%. These are significant contributions to closing the budget gap. These cuts to health plan premiums total over $400 million and are all that plans can reasonably absorb. Any additional cuts, including a possible 2% across the board reduction to plan premiums will result in a total 5.5% cut to premiums, while medical expenses are increasing at over 5% per year. Any additional cuts to Medicaid managed care plans will place some of our plans on the brink of closure and will violate federal requirements that mandate actuarially sound rates for Medicaid health plans.

Federal regulations require states to set capitation rates payable to managed care plans on an actuarially sound basis. For a rate to be considered actuarially sound, the actuary must consider an extensive list of factors, including utilization and cost data of the population served, medical trade inflation, risk adjustments for chronic illnesses, and rate cells of the enrolled population served such as age, gender, locality, and health status. The 2% across the board budget cut, as proposed by the MRT, will likely place the state in violation of these federal

actuarial soundness requirements especially since most plans already have slim to no margins and spend upwards of 90 cents on the dollar for medical care.

In summary, MRT cuts to health plans totaling $400M, more than any other sector in the health care industry, come at the same time the state is relying on Medicaid managed care plans to enroll and managed care for more high-cost/high-need populations, while continuing to deliver quality outcomes and cost savings. We recognize the state's fiscal crisis and will do our part to alieviate the state's Medicaid cost burden, but we implore the Administration and the Legislature to reconsider any additional cuts to plans. Failure to do so will undermine the successful and critical Medicaid managed care infrastructure that is central to reforming Medicaid in New York State.

Marketing and Facilitated Enrollment

As noted above, the Medicaid Redesign Team has recommended the elimination of funding for marketing effective April 1, 2011. An earlier version of this MRT proposal, eliminated funding for health plan Facilitated Enrollment. We encourage the legislature to continue to protect the Facilitated Enrollment program, consistent with the MRT's revised recommendation, as you negotiate the final budget.

We remind you that Facilitated Enrollment is the vehicle by which the majority of New Yorkers access and retain public health insurance. In New York City alone, Facilitated Enrollers (FE) help approximately nearly 30,000 uninsured individuals complete applications for the Medicaid and FHP programs every month. Without FE, there is simply no alternative mechanism in New York to reach out, engage and assist the uninsured in accessing the public

health insurance programs. Local districts do not have the capacity to handle the volume of applications if the FE program were to cease operating. And, at the request of several upstate counties, health plan FEs actually work alongside local agency workers in the local district offices to enroll and retain members in the program. In New York City, health plans have worked in partnership and jointly invested with the NYC Human Resources Administration to make application submission virtually paperless. Reverting to paper will be a tremendous step backward, and will be problematic as HRA no longer has the infrastructure to handle the volume of consumer paper applications.

Elimination of funding for FE would eliminate the Medicaid eligibility infrastructure, increase the number of uninsured and add to health care costs. Without specially trained, community based workers to provide application assistance, the ranks of the "eligible but uninsured" will grow by hundreds of thousands of individuals per year. These individuals will then turn to hospital emergency rooms and community health centers for care, straining providers' scarce resources and adding to uncompensated care costs.

Finally, looking ahead, **FE is a critical foundation for federal health care reform implementation.** Now is not the time to dismantle an infrastructure that will engage and enroll the up to 1.2 million New Yorkers who will be eligible for affordable health insurance in 2014 through Medicaid and New York's Health Benefit Exchange.

We urge you to reject any proposals to eliminate the Facilitated Enrollment program as this critical infrastructure is the only mechanism for New York's eligible uninsured to access and retain public health insurance coverage.

Behavioral Health

Plans are committed to working with the Administration and the Legislature to improve outcomes, care management services, and cost of care for those Medicaid beneficiaries who require behavioral health treatment. We believe that New York should provide an integrated benefit package, including behavioral health services, to all Mediciad managed care enrollees. Coordination of care across both the behavioral and physical health spectrums is critical to achieving quality outcomes and cost savings. Indeed, just as physical health and behavioral health are interrelated, so too should be management of physical and behavioral health care. National policy literature consistently echoes the need for integration of physical and behavioral health for both quality improvement and savings in the physical and behavioral health delivery systems.

We welcome the opportunity to work with the Department of Health, the Office of Mental Health, and the Office of Alcoholism and Substance Abuse Services to establish clear requirements and benchmarks for health plans managing behavioral health services for their members. We believe that the MRT recommendation authorizing a behavioral health special needs plan designation is an excellent framework for the agencies to set standards for and certify plans to manage behavioral health care services. By holding plans accountable for results and services—including care management, access, and networks—the State can ensure that individuals receive the appropriate level of care in a patient-centered manner. Such accountability standards have been used for physical and behavioral health services managed by plans with much success and can serve as a model to drive similar improvement in behavioral health services delivery and management in New York. Indeed, plans have shown that by

integrating behavioral health services with the TANF population, costs are lower, average lengths of stay are shorter, and the number of admissions for mental health services is fewer. We are committed to continuing the dialogue with the legislature, DOH, OMH, OASAS, providers and consumer advocates.

While supporting of the MRT recommendation to develop behavioral health SNPs, the PHP Coalition remains concerned about the companion proposal to create an interim behavioral health organization (BHO) that would be responsible for managing behavioral health services for all fee-for-service beneficiaries and for SSI individuals enrolled in MMC. We believe carving behavioral health services out of the SSI populations' managed care is not an acceptable solution as the ability for two accountable entities—the plan and the BHO—to adequately manage the person, not the condition, is severely restricted. Health plans have obtained positive outcomes from integration of behavioral and physical health services. In fact, Fidelis recently implemented an enhanced care coordination program for its highest need members reducing hospital readmissions by 14.6% in 2009 and 13.5% in 2010.

We understand that OMH and OASAS believe that the behavioral health organization is an interim step to achieving management of mental health and substance abuse services. Before authorizing the BHO model, we would encourage the legislature to address the following issues:

- Implementation of a behavioral health organization could take longer than a few months, even if the legislature waives the procurement rules.
- Without effective utilization management and review, it is unclear whether a BHO could actually achieve any cost savings in 2011/12.

- Finally, a BHO bifurcates the Medicaid benefit and beneficiary, perpetuating silos to delivering health care, rather than a coordinated, patient-centered approach. BHO models in other states have problems coordinating care with physical health plans since information sharing is prohibited in many cases. These impediments could have the unanticipated consequence of actually increasing costs to the state as a result of the lack of coordination.

Conclusion

Medicaid managed care can be a key part of the State's solution to its $10 billion budget problem. By building on its existing and successful Medicaid managed care infrastructure, New York can ensure its Medicaid beneficiaries access to coordinated care while simultaneously controlling the growth in costs for high-cost benefits.

Thank you for the opportunity to provide testimony on these critical issues. The Coalition and its members look forward to continuing our work with the Senate, Assembly, and the Governor during these tough times to control Medicaid costs while ensuring high-quality health care for vulnerable populations.

MEMBERS OF THE COALITION OF NEW YORK STATE PUBLIC HEALTH PLANS

HEALTH PLAN	AFFILIATED ORGANIZATIONS	SERVICE AREA
Affinity Health Plan	*Primary care provider organizations with representation on the Board of Directors:* Morris Heights Health Center, Charles B. Wang Health Center and Urban Health Plan	New York City and Nassau, Orange, Rockland, Suffolk, and Westchester Counties
Fidelis Care New York (The New York State Catholic Health Plan)	Diocesan Bishops of the State and Ecclesiastical Province of New York and Catholic healthcare providers	New York City and 53 other counties[1]
Healthfirst	Hospitals in all counties in which the plan operates[2]	New York City and Nassau and Suffolk Counties
Health Plus	Lutheran Medical Center	New York City and Nassau County
Hudson Health Plan	Open Door Family Medical Centers, Hudson River Community Health	Dutchess, Orange, Rockland, Sullivan, Ulster and Westchester Counties
MetroPlus Health Plan	New York City Health and Hospitals Corporation	Bronx, Kings, New York and Queens Counties
The Monroe Plan for Medical Care	The Monroe Plan for Medical Care is an independent, not-for-profit managed care organization that has a contract with Excellus BlueCross BlueShield to manage their Medicaid, Family Health Plus, and Child Health Plus products	Broome, Cayuga, Chemung, Chenango, Clinton, Cortland, Delaware, Essex, Franklin, Fulton, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Oneida, Onondaga, Ontario, Orleans, Oswego, Otsego, Schuyler, Seneca, Steuben, St. Lawrence, Tioga, Tompkins, Wayne, and Yates Counties
Neighborhood Health Providers	Brookdale Hospital and Medical Center, Jamaica Hospital Medical Center	New York City and Suffolk County
Total Care (Syracuse PHSP)	Syracuse Community Health Center	Cortland, Onondaga, Oswego, and Tompkins Counties

[1] Albany, Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chenango, Clinton, Columbia, Cortland, Delaware, Dutchess, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Lewis, Livingston, Madison,

Monroe, Montgomery, Nassau, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Ostego, Oswego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Schuyler, Steuben, St Lawrence, Suffolk, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Westchester and Wyoming Counties.

[2] Beth Israel Medical Center, Bronx-Lebanon Hospital Center, The Brooklyn Hospital Center, Elmhurst Hospital Center, Interfaith Medical Center, Jamaica Hospital Medical Center, Maimonides Medical Center, Montefiore Medical Center, Mount Sinai Hospital, New York City Health and Hospitals Corporation, New York Downtown Hospital, North Shore – LIJ Health System, the NuHealth System, Staten Island University Hospital, St. Barnabas Hospital, St. John's Episcopal Hospital, St. Luke's-Roosevelt Hospital Center, Stony Brook University Hospital, SUNY Downstate Medical Center

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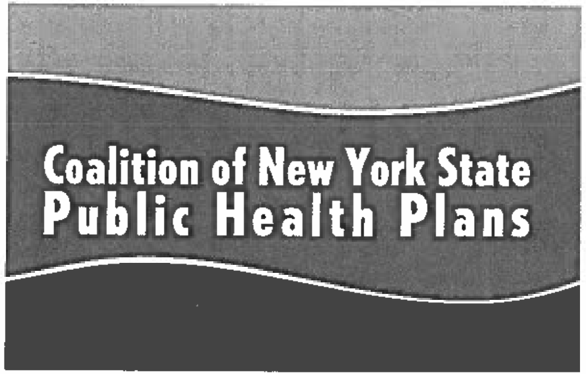
Coalition of New York State Public Health Plans

Providing Access, Quality and Value

2010

Medicaid Managed Care & Family Health Plus Quality Update

January 2011



The Coalition of New York State Public Health Plans represents plans serving over 2.5 million, or two-thirds of, children and adults enrolled in New York's public health insurance programs. They offer decades of experience in delivering high-quality services to populations that often experience significant barriers to health care. Coalition plans are sponsored by or affiliated with public and not-for-profit hospitals, community health centers and physicians.

Affinity Health Plan

Fidelis Care New York

Healthfirst

Health Plus

Hudson Health Plan

MetroPlus Health Plan

The Monroe Plan for Medical Care

Neighborhood Health Providers

Total Care

Going Live with Health Reform in New York
The Role of Public Health Plans

Implementation of the Affordable Care Act of 2010 (ACA) provides an unprecedented opportunity to expand affordable health coverage to nearly all New Yorkers and improve quality of care in the State's health care delivery system. New York's robust and valuable Medicaid managed care infrastructure provides a solid foundation for the State to put health care reform in place. Public health plans' deep experience in outreach, enrollment and retention of previously uninsured New Yorkers as well as in delivery of high-quality, cost-efficient care in the Medicaid, Family Health Plus and Child Health Plus programs makes these plans the State's natural partners in implementing health reform.

Reducing Medicaid Costs

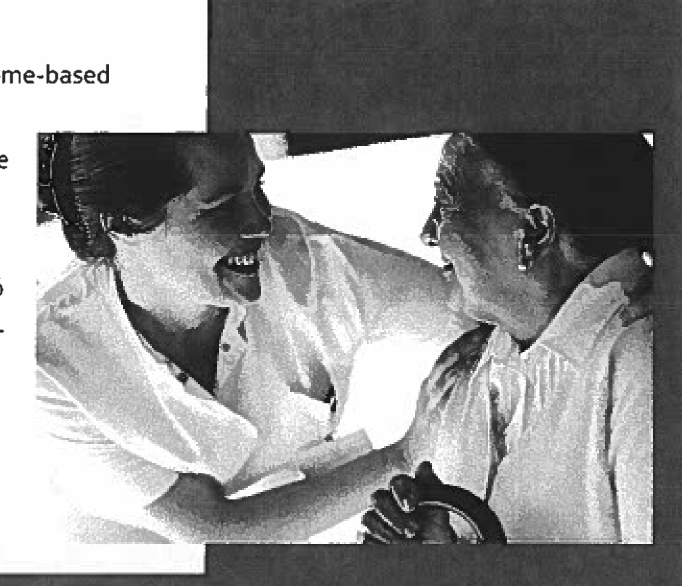
Since 1985, Medicaid managed care has been New York State's primary vehicle for successfully controlling the growth of Medicaid costs. The State has driven delivery system change and accountability through its managed care program as an efficient and effective alternative to attempting to directly change the behavior of thousands of disparate hospitals, clinics and physicians. Public health plans have developed—and continue to improve—innovative delivery models that create medical homes for their members and coordinate primary and specialty care to maximize health outcomes. Plans are driving down health care costs and improving care quality by promoting primary, preventive care and ensuring that the right care is delivered in the right clinical setting. Plans have been particularly successful in improving access to quality, cost-efficient care for medically complex populations, including people with multiple, chronic illnesses that disproportionately drive health care costs in New York's

An Individualized Approach to Ensure Access to Care

Coalition plans use their Member Services call center as an opportunity to promote primary and preventive care through direct contact with members and an individualized approach. Plan computer systems automatically flag members who have not had one or more key preventive services, such as a dental visit for a child, mammography, cervical cancer screening or tests to monitor control of diabetes. Instead of giving general health information to everyone, plan staff are able to provide members with tailored recommendations. Plan staff also offer to make appointments for members. One plan that just launched this service noted that in the first two months of the program, there were 2,800 successful contacts advising members on missed preventive services and over 200 appointments were made for these members.

Home-Based Therapy Program

In July 2009, a Coalition plan implemented an innovative home-based therapy program for members who were discharged from an inpatient psychiatric stay. The program aimed to increase 7- and 30-day ambulatory follow-up rates and reduce hospital readmission. Between July 1, 2009, and June 30, 2010, there were 611 referrals to the program, of which 79% kept their home-based therapy appointment. The 7- and 30-day follow-up performance rates post-inpatient discharge increased 25% compared to the prior 12-month period. Members who kept the home-based therapy appointment were 70% less likely to be readmitted within 90 days of discharge than those who did not keep their appointment.



Medicaid program.[1] Because of the success of New York's Medicaid managed care program, the State has continued to look to health plans to manage complex populations, including mandating Medicaid managed care enrollment for people with HIV/AIDS in September 2010.

Driving High-Quality Care

Public health plans are leading the way in innovations to improve health outcomes. Plans rely on a comprehensive network of providers and services that work together to ensure a coordinated continuum of care for patients. Through solid partnerships with providers, Coalition plans have implemented numerous reimbursement reforms, care quality programs and incentives for improving care delivery. Over the past decade, despite the challenges of providing care to a particularly vulnerable population, New York's public health plans have virtually eliminated the gap that traditionally existed with commercial plans on many measures of quality and access. Based on results from the New York State Department of Health's 2010 Managed Care Plan Performance Report, Coalition plans surpassed national Medicaid benchmarks in 74% of quality care measures and exceeded New York's non-Coalition Medicaid plans in 64% of quality measures.

Expanding Coverage

Since 2000, New York's facilitated enrollment (FE) program, anchored by the public health plans, has been enormously successful in connecting hard-to-reach populations with health insurance coverage and helping them to retain that coverage year after year. Highly trained staff at public health plans conduct community-based outreach to eligible families at community offices, through the telephone and in-home visits. Under health reform, over 1.2 million New Yorkers will be newly eligible for Medicaid and an additional 1.1 million are estimated to become eligible to purchase coverage in the health benefit exchange.[2] States around the country will be attempting to replicate New York's facilitated enrollment infrastructure to maximize and streamline enrollment for newly eligible and eligible but uninsured populations and to ensure their access to care.

New York's FE program will be instrumental in health care reform implementation in 2014. As New York embarks upon health care reform implementation, it can leverage this existing infrastructure to seamlessly expand health coverage, drive quality improvement and bend the cost curve. Public health plans are the State's natural ally in this critical endeavor.

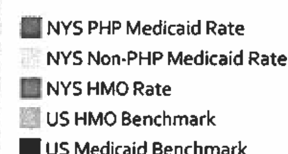
1 The State began mandatory enrollment of SSI beneficiaries into Medicaid managed care plans in New York City in November 2005 and expanded mandatory enrollment for SSI beneficiaries in upstate counties in 2007. As of November 2010, 295,775 SSI beneficiaries were enrolled in Medicaid managed care plans in New York State, representing 10% of the State's total Medicaid managed care plan enrollees. NYSDOH Monthly Medicaid Managed Care Enrollment, November 2010, available at http://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/2010/docs/en11_10.xls.

2 D. Bachrach, P. Boozang, M. Dutton and A. Lam, "Implementing Federal Health Care Reform: A Roadmap for New York State," NYS Health Foundation, August 2010.

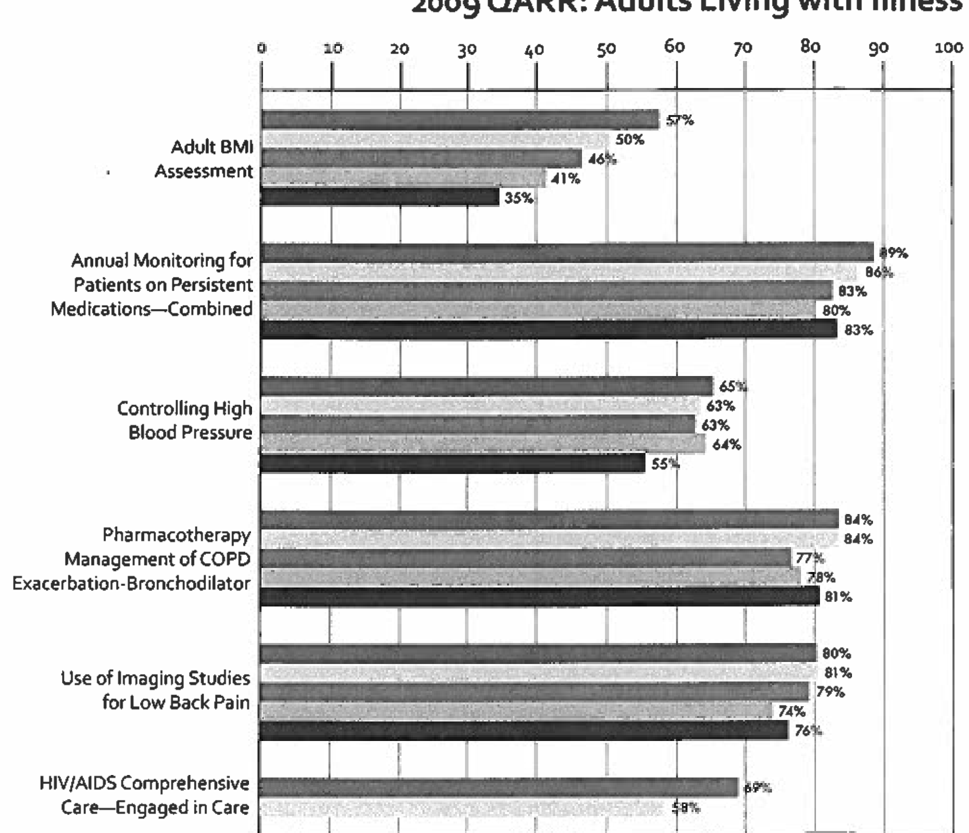
Coalition Plans: Leaders in Care Quality

Quality Measures

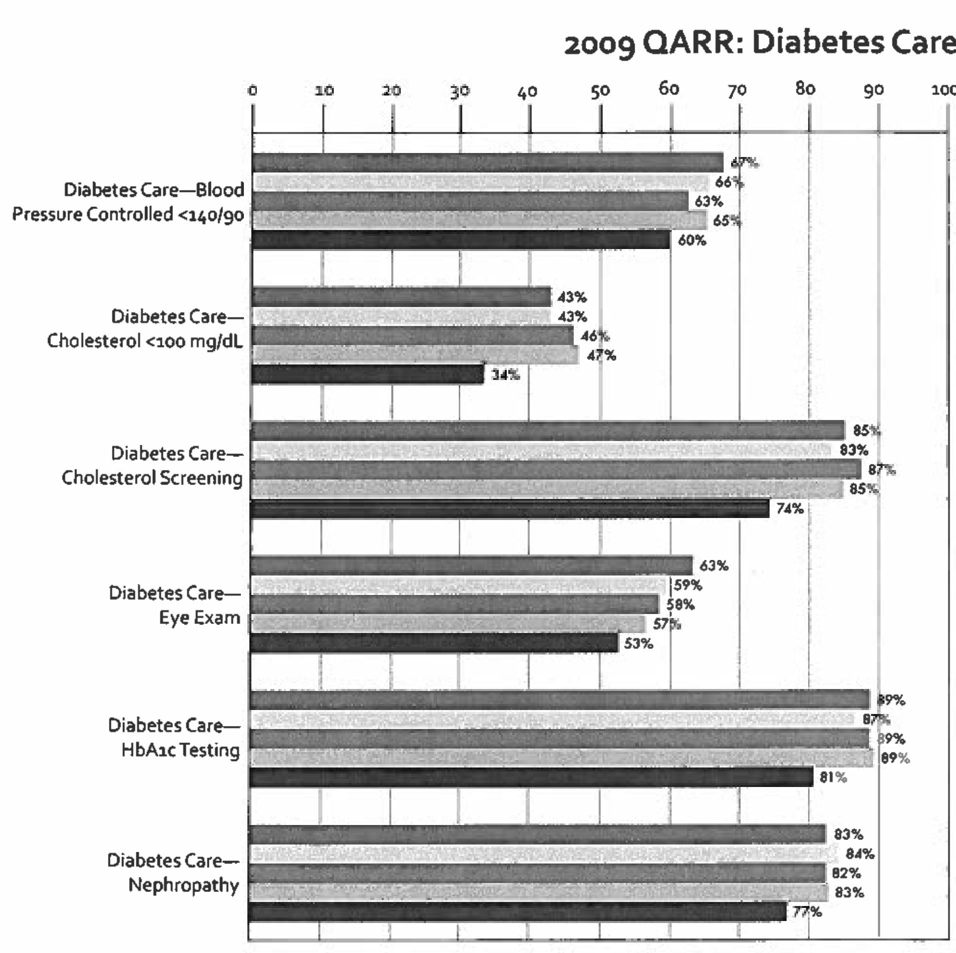
Coalition public health plans have successfully closed the gap in care quality that traditionally separated Medicaid from commercial plans. According to the most recent Quality Assurance Reporting Requirements (QARR) measures, Coalition plans exceeded statewide and nationwide benchmarks for public and commercial plans in numerous areas, including childhood immunization. Coalition plans surpassed state and national benchmarks and closely rivaled state and national commercial standards in key women's health measures, including breast cancer screening and sexually transmitted disease testing. Coalition plans also demonstrated high levels of consumer satisfaction, outdoing state and nationwide standards in measurements of overall health plan rating.



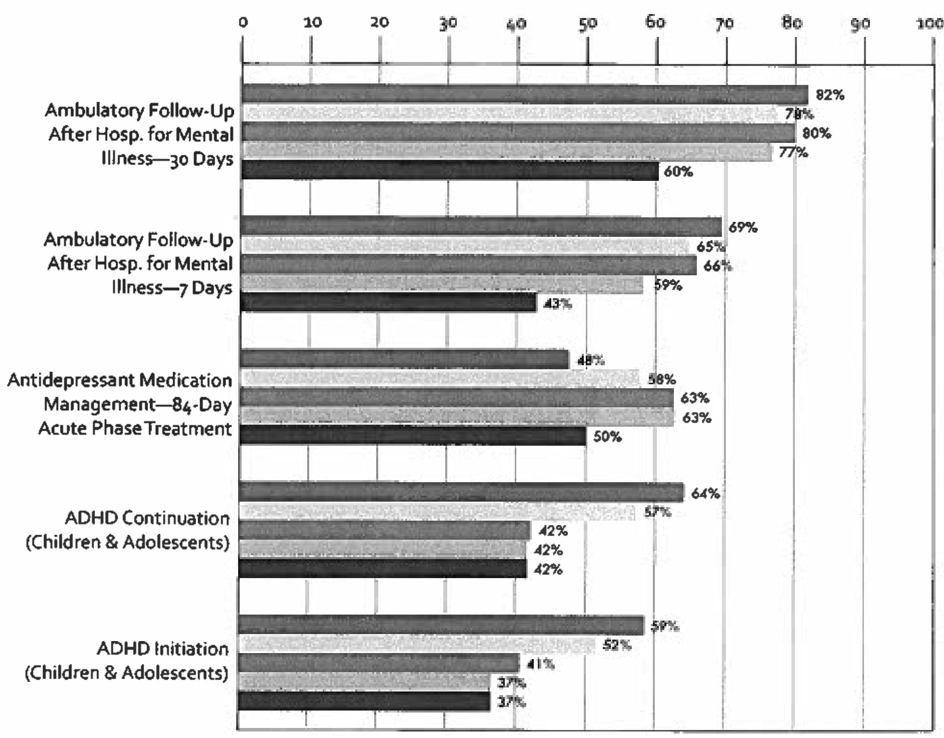
2009 QARR: Adults Living with Illness

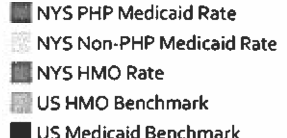


2009 QARR: Diabetes Care

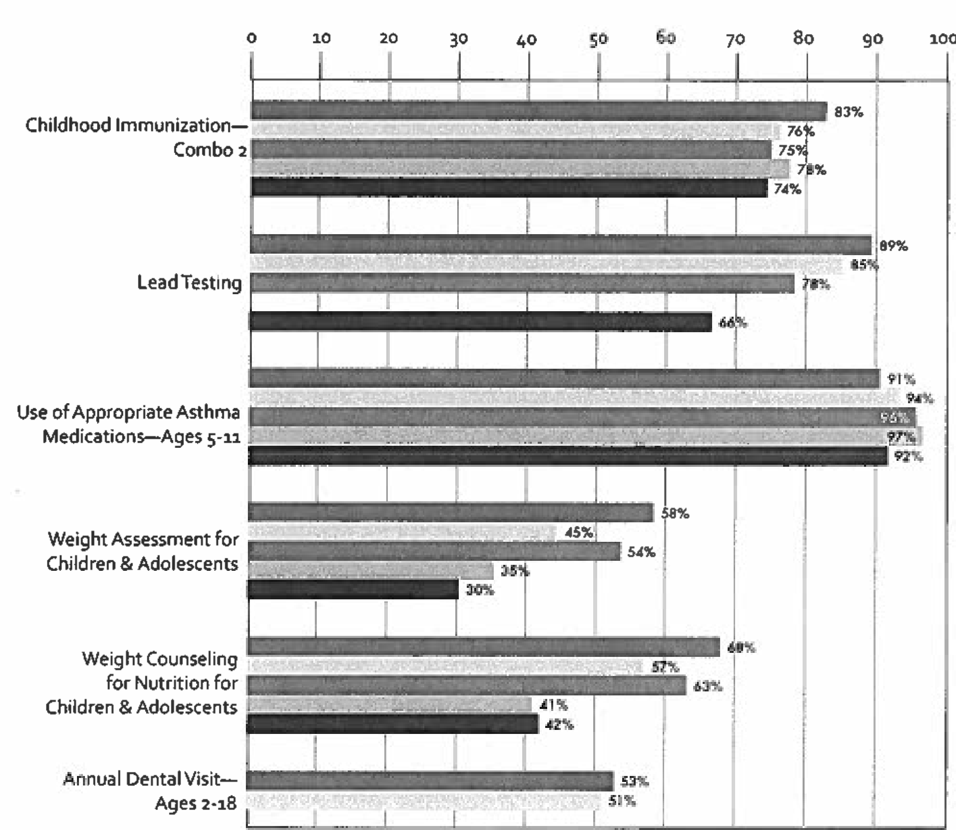


2009 QARR: Behavioral Health

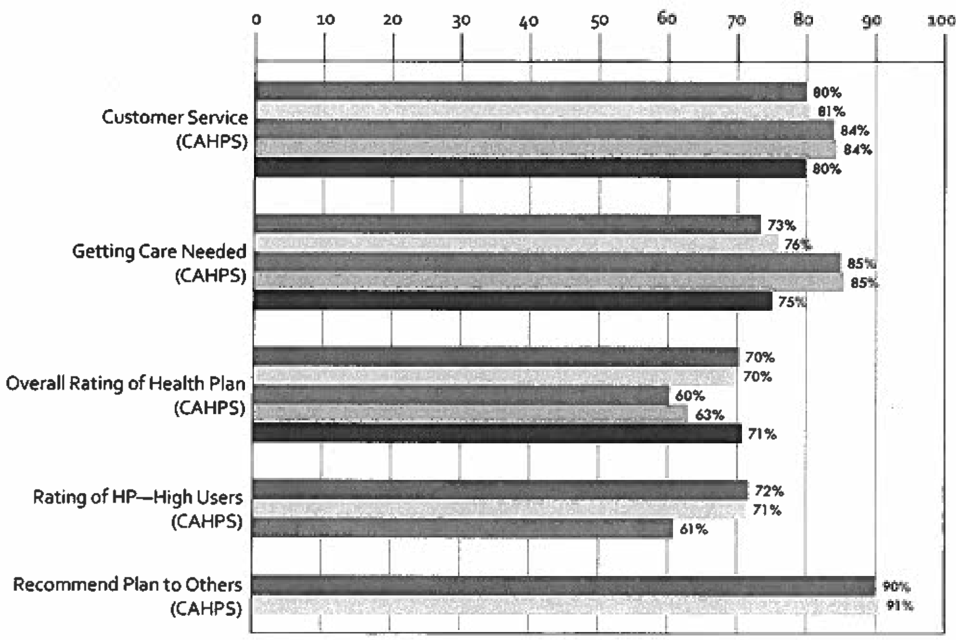


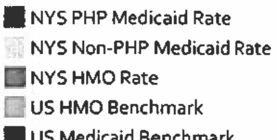


2009 QARR: Child & Adolescent Health

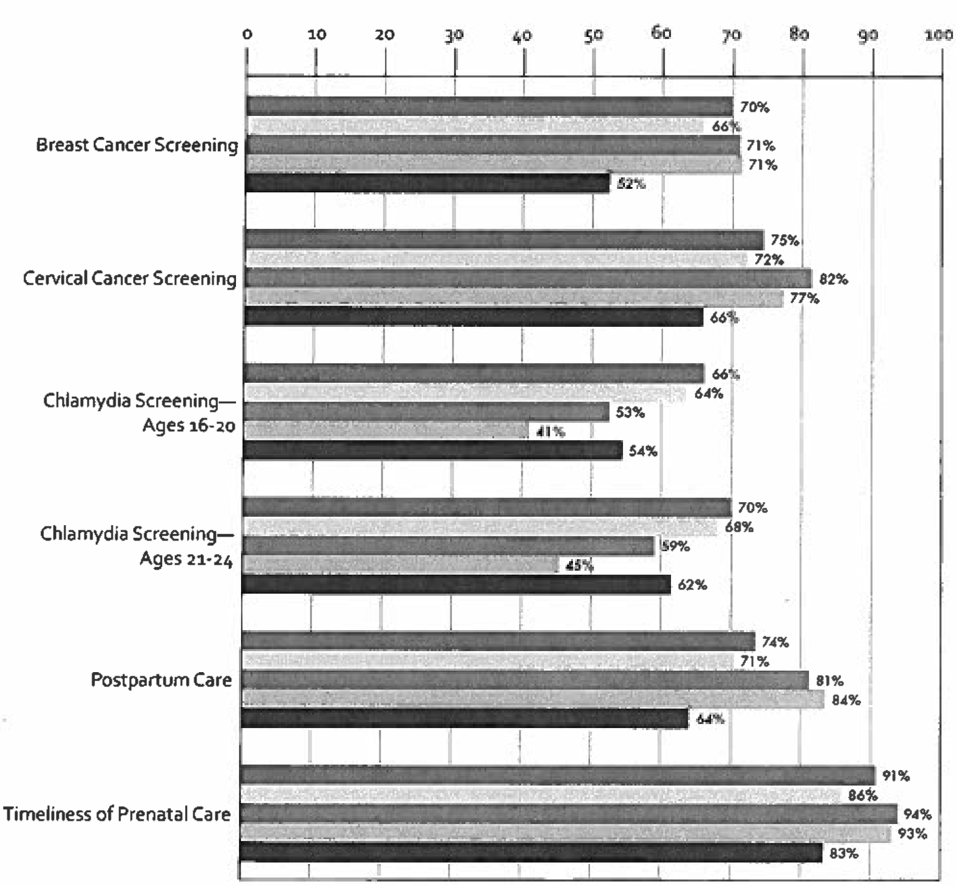


2009 QARR: Satisfaction with Care (CAHPS)





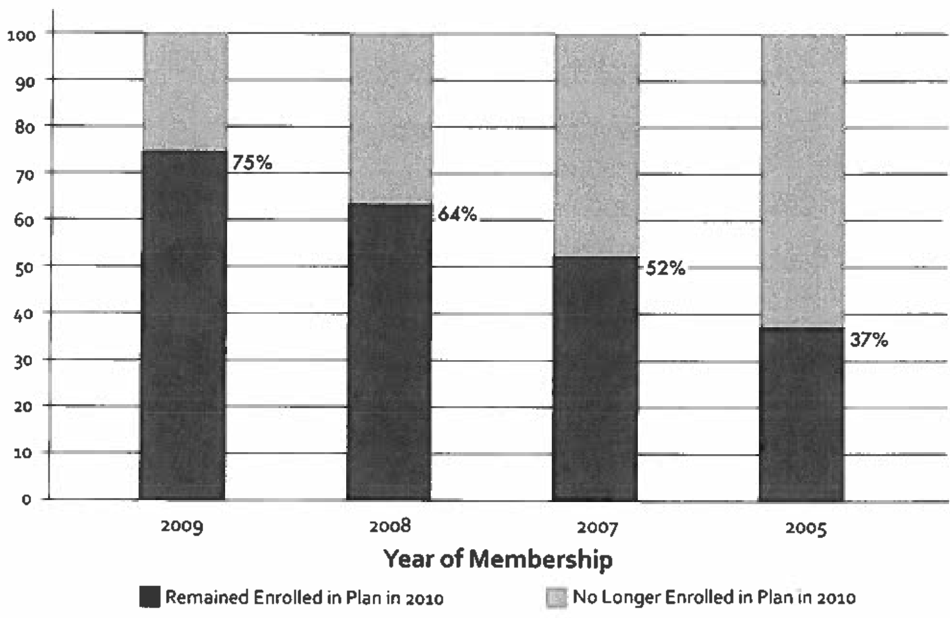
2009 QARR: Women's Health



High Member Retention

Coalition plans receive high marks in a wide range of areas of care quality and consumer satisfaction. Plans' high quality of care is also evident in their success at retaining consumers year after year.

Proportion of Medicaid Members Enrolled in PHP Plans in 2005-2009 Still Enrolled in Same Plan in 2010

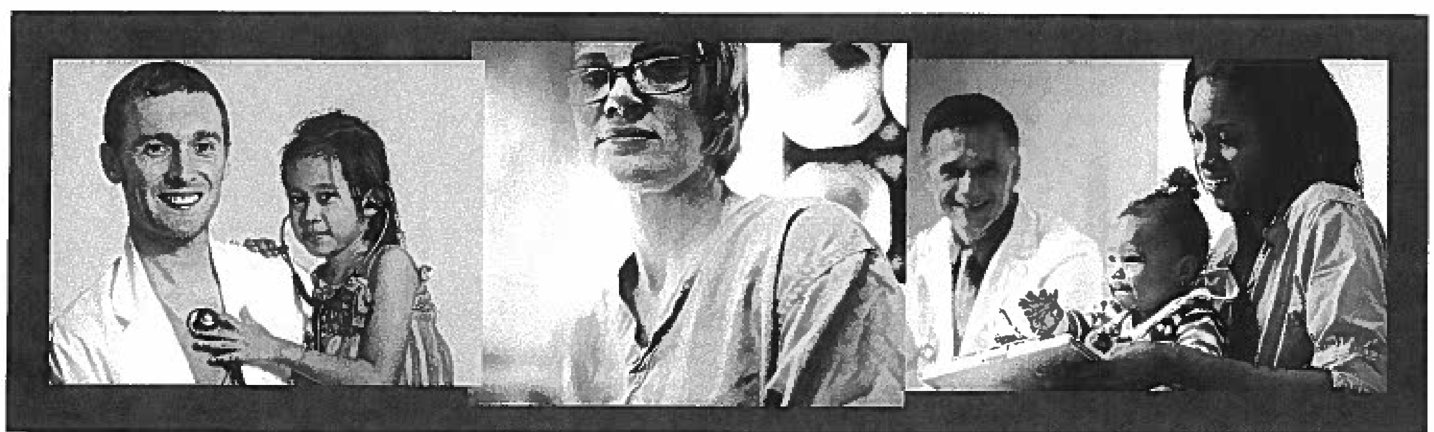


Note: Proportion reflects the share of Medicaid members enrolled as of July 1 of a given year who remain enrolled in the same plan in any program (Medicaid/FHP/CHP) on July 1, 2010.
Source: Internal analysis based on enrollment data from seven PHP plans.

Based on data obtained from Coalition plans:

- More than one-third of Medicaid members (37%) who were enrolled in these plans in 2005 were still enrolled in the same plan five years later, in 2010,
- More than half of members (52%) were retained for at least three years, from 2007 to 2010, and
- Three-quarters of members (75%) were retained for at least one full year, from 2009 to 2010.

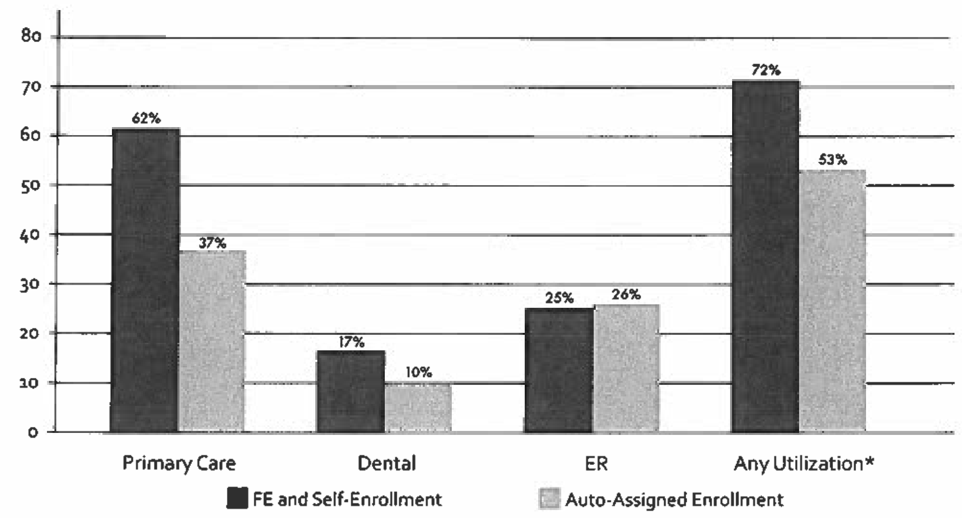
Given the historically high rates of churning in New York's public health insurance programs, Coalition plans' high rate of retention of their members over time is a groundbreaking and powerful means to achieving continuity of coverage and care in New York's health care delivery system. Stability of coverage enables patients and their doctors to develop consistent and enduring relationships, providing nothing less than the foundation of the medical home relationship—the first step in bending the cost curve.



Facilitated Enrollment—Helping to Bend the Cost Curve

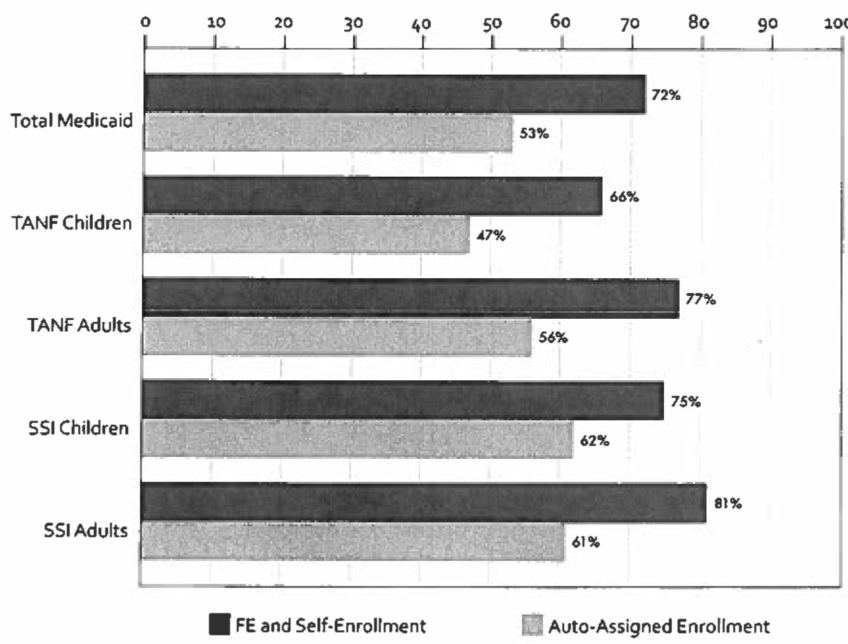
Coalition plans are consistent leaders in connecting eligible New Yorkers to insurance coverage, and in helping them keep that coverage. Coalition plans, which represent almost half of New York State Medicaid enrollees, are the backbone of the State's facilitated enrollment program. Based on data from Coalition plans, it is clear that the facilitated enrollment program does more than connect people to insurance coverage—health plan facilitated enrollers connect people to the right type of health care.

Proportion of New Medicaid Enrollees Utilizing Services in First 6 Months of Enrollment, by Enrollment Method



Note: Data reflects new Medicaid members enrolled 1/1/2009 – 5/31/2009 with six months of continuous Medicaid enrollment. Data excludes newborns and transfers. Utilization based on one or more provider visit, coded using MMCOR utilization definitions.
Source: Internal analysis based on enrollment and utilization data from five PHP plans (N=69,211).
*Does not include members who utilized pharmacy services only.

Proportion of New Medicaid Enrollees Utilizing Any Services in First 6 Months of Enrollment, by Enrollment Method*



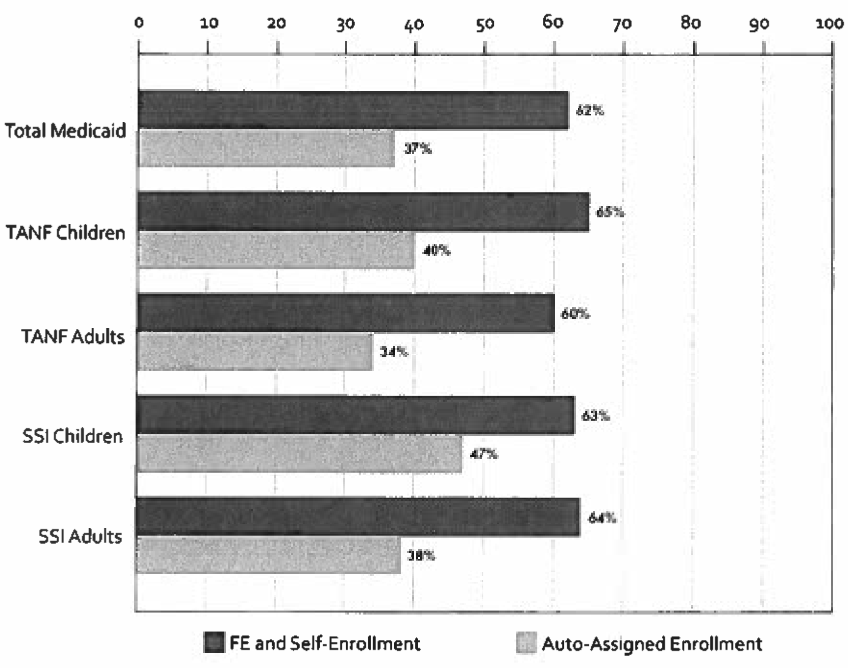
Note: Data reflects new Medicaid members enrolled 1/1/2009 – 5/31/2009 with six months of continuous Medicaid enrollment. Data excludes newborns and transfers. Utilization based on one or more provider visit, coded using MMCOR utilization definitions.
Source: Internal analysis based on enrollment and utilization data from five PHP plans (N=69,211).
*Does not include members who utilized pharmacy services only.

Overall, when compared to members who are auto-assigned to the plan, members who are enrolled through health plan facilitated enrollers are significantly more likely to use health care services within their first six months of coverage (72% vs. 53%).[1]

1 *Note: Results compare auto-enrolled members vs. members who enrolled through FE and self-enrolled members. However, the vast majority of people in the FE/self-enrolled category were enrolled with the assistance of facilitated enrollers.*

Connection to a health plan through a health plan facilitated enroller leads to the use of lower-cost care in more appropriate care settings. Members newly enrolled in Medicaid through a health plan facilitated enroller, compared to those auto-assigned, are much more likely to see their primary care provider (62% vs. 37%) and more likely to use dental care (17% vs. 10%) during the first six months of coverage.

Proportion of New Medicaid Enrollees Utilizing Primary Care Services in First 6 Months of Enrollment, by Enrollment Method



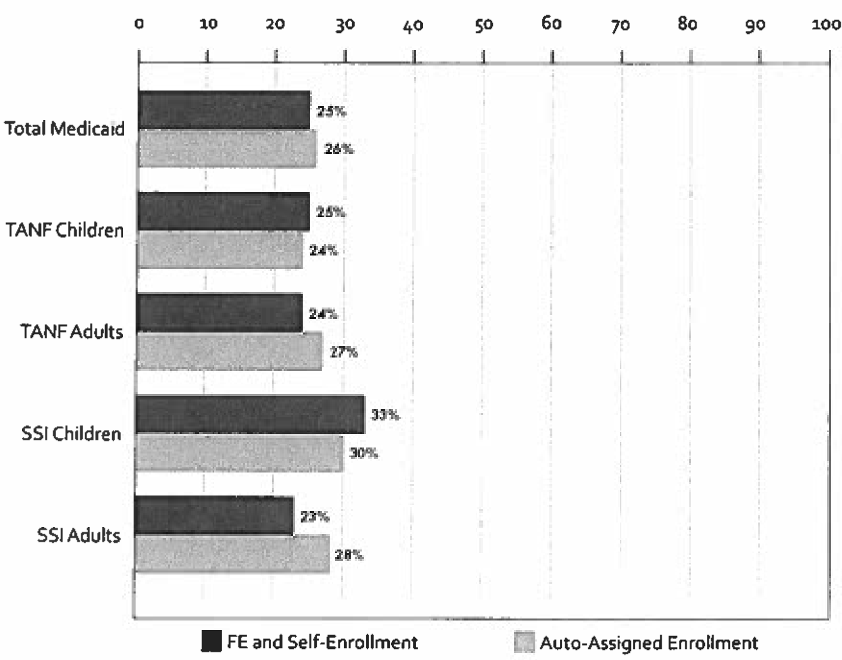
Note: Data reflects new Medicaid members enrolled 1/1/2009 – 5/31/2009 with six months of continuous Medicaid enrollment. Data excludes newborns and transfers. Utilization based on one or more provider visit, coded using MMCOR utilization definitions.
Source: Internal analysis based on enrollment and utilization data from five PHP plans (N=69,211).

Community-Based Obesity Prevention

For Coalition plans, efforts to improve members' health do not stop outside the provider office. Realizing the important role of the community in identifying and reducing childhood obesity, one Coalition plan developed a set of community-based tools to engage families and providers in building awareness around childhood obesity prevention. For providers, this plan produced a practical Pediatric Obesity Provider Toolkit, which contained attitude and behavioral assessment tools, a BMI wheel and gender-specific percentile charts. In order to promote parent involvement in BMI assessment, the plan created an attractive and engaging Height Wall Chart and a "Children's Portion Plate" tear-off sheet in Spanish and English. The plan also developed culturally sensitive community presentations to promote healthy diets and to provide nutrition information. Complementing all this, the plan organized a number of fun activities to promote healthy diets and physical activity, including a Bicycle Rodeo, walking clubs and healthy bilingual cooking classes.

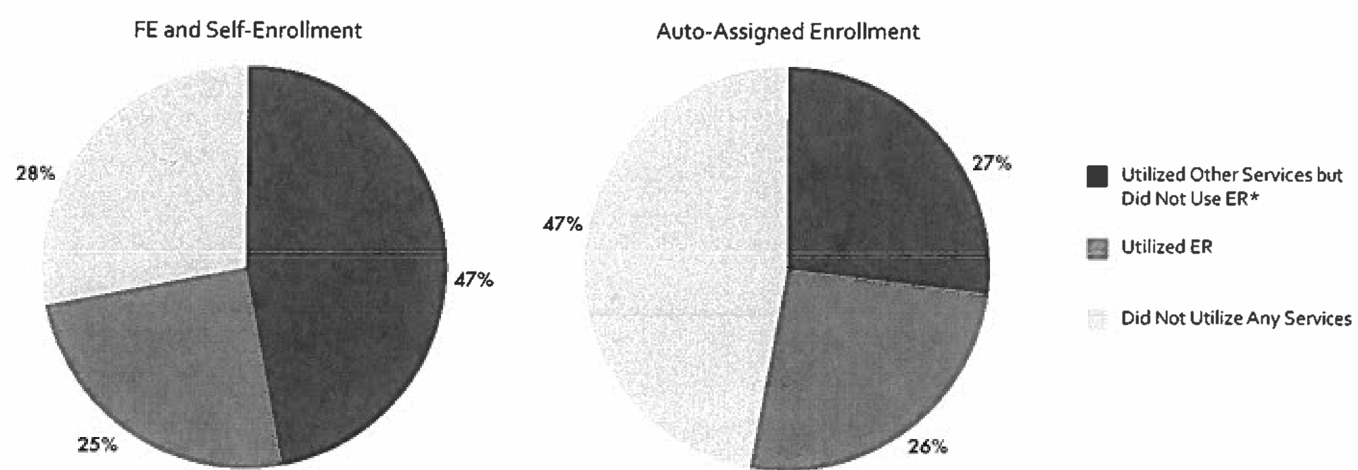
Conversely, auto-assigned health plan members are significantly more likely to use the emergency room as their only source of care—only 27% of auto-assigned members used care other than the ER, as compared to 47% of other new plan members.

Proportion of New Medicaid Enrollees Utilizing ER Services in First 6 Months of Enrollment, by Enrollment Method



Note: Data reflects new Medicaid members enrolled 1/1/2009 – 5/31/2009 with six months of continuous Medicaid enrollment. Data excludes newborns and transfers. Utilization based on one or more provider visit, coded using MMCOR utilization definitions.
Source: Internal analysis based on enrollment and utilization data from five PHP plans (N=69,211).

Proportion of New Medicaid Members Utilizing ER, Utilizing Other Services but Not ER and Not Utilizing Any Services in First 6 Months of Enrollment, FE/Self-Enrolled vs. Auto-Assigned



Note: Data reflects new Medicaid members enrolled 1/1/2009 – 5/31/2009 with six months of continuous Medicaid enrollment. Data excludes newborns and transfers. Utilization based on one or more provider visit, coded using MMCOR utilization definitions
Source: Internal analysis based on enrollment and utilization data from five PHP plans (N=69,211).
*Does not include members who utilized pharmacy services only.

New York State Coalition of Public Health Plans

PLAN	AFFILIATED ORGANIZATIONS	SERVICE AREAS
Affinity Health Plan	Primary care provider organizations with representation on the Board of Directors: Morris Heights Health Center, Charles B. Wang Health Center and Urban Health Plan	New York City and Nassau, Orange, Rockland, Suffolk and Westchester Counties
Fidelis Care New York (The New York State Catholic Health Plan)	Diocesan Bishops of the State and Ecclesiastical Province of New York and Catholic health care providers	New York City and 53 counties [3]
Healthfirst	Hospitals in all counties in which the plan operates [4]	New York City and Nassau and Suffolk Counties
Health Plus	Lutheran Medical Center	New York City and Nassau County
Hudson Health Plan	Open Door Family Medical Centers, Hudson River Community Health	Dutchess, Orange, Rockland, Sullivan, Ulster and Westchester Counties
MetroPlus Health Plan	New York City Health and Hospitals Corporation	Bronx, Kings, New York and Queens Counties
The Monroe Plan for Medical Care	Monroe Plan for Medical Care is an independent, not-for-profit managed care organization that has a contract with Excellus BlueCross BlueShield to manage their Medicaid, Child Health Plus and Family Health Plus products	Broome, Cayuga, Chemung, Chenango, Clinton, Cortland, Delaware, Essex, Franklin, Fulton, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Oneida, Onondaga, Ontario, Orleans, Oswego, Otsego, Schuyler, Seneca, Steuben, St. Lawrence, Tioga, Tompkins, Wayne and Yates Counties
Neighborhood Health Providers	Brookdale Hospital and Medical Center, Jamaica Hospital Medical Center	New York City and Suffolk County
Total Care	Syracuse Community Health Center	Cortland, Onondaga, Oswego and Tompkins Counties

For more information or to request additional copies of this report, please contact the Coalition's representative, Tony Fiori at 212.790.4582 or JoAnn Smith at 518.431.6719, of Manatt, Phelps & Phillips, LLP.

3 Albany, Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chenago, Clinton, Columbia, Cortland, Delaware, Dutchess, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Lewis, Livingston, Madison, Monroe, Montgomery, Nassau, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Schuyler, Steuben, St. Lawrence, Suffolk, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Westchester and Wyoming Counties.

4 Beth Israel Medical Center, Bronx-Lebanon Hospital Center, The Brooklyn Hospital Center, Elmhurst Hospital Center, Interfaith Medical Center, Jamaica Hospital Medical Center, Maimonides Medical Center, Montefiore Medical Center, Mount Sinai Hospital, New York Downtown Hospital, North Shore-LIJ Health System, New York City Health and Hospitals Corporation, The NuHealth System, Staten Island University Hospital, St. Barnabas Hospital, St. John's Episcopal Hospital, St. Luke's-Roosevelt Hospital Center, Stony Brook University Medical Center and SUNY Downstate Medical Center.

MRT Process

When the Association learned of Proposal 131, President Younger immediately met with the Governor's Deputy Secretary for Health to express our concerns. The civil justice system is fundamentally different from the State's Medicaid system. Accordingly, we strongly object to the fact that "medical malpractice" was a topic of discussion within the MRT's process, because the MRT lacked representatives of consumer rights and patient safety groups, the court system, and the bar.

We attempted to engage representatives of the MRT in discussions about Proposal 131, but rather than engage us, the MRT accelerated its process by submitting its recommendations to the Governor on February 23, days in advance of its March 1 target.

Proposals to diminish the rights of medical malpractice victims in New York should not be the subject of a process dominated by hospitals and other segments of the healthcare industry, promoting their own agenda. Such a process results in bad public policy and represents special-interest activities that lower citizens' respect for and trust in our government.

Conclusion

There is no question that the health care industry has long sought to limit the rights of medical malpractice victims. Under the guise of Medicaid reform, now, through the Governor's Medicaid Redesign Team—the industry seeks to achieve its goal--a dream come true.

There are obviously differences of opinion on the issue of medical malpractice, and the Bar Association is prepared to join the debate. But a serious debate needs far more time than is permitted during the budget process.

I note that the *American Journal of Obstetrics & Gynecology* published in February 2011 an article that reported that New York Presbyterian Hospital significantly lowered bad outcomes and overall malpractice costs by implementing and enforcing basic patient safety measures.

Proposals to radically re-shape our justice system should not be pushed through as part of the State budget process. This is an issue that should be considered as a separate program bill to be fully debated on its own.

We **urge opposition** to this ill-conceived proposal.

TESTIMONY
of the
CENTER FOR JUSTICE & DEMOCRACY, CENTER FOR MEDICAL CONSUMERS, CONSUMERS UNION, NEW YORK STATEWIDE SENIOR ACTION COUNCIL, NEW YORK PUBLIC INTEREST RESEARCH GROUP
before the
JOINT HEARING OF THE NEW YORK STATE SENATE FINANCE AND NEW YORK STATE ASSEMBLY WAYS & MEANS COMMITTEES
regarding the
EXECUTIVE HEALTH BUDGET 2011-12
March 3, 2011
Albany, NY

Good afternoon, my name is Blair Horner and I am the legislative director for NYPIRG. On behalf of the Center for Justice & Democracy, Center for Medical Consumers, Consumers Union, New York StateWide Senior Action Council, and NYPIRG, I offer our comments on one aspect of the governor's proposed health budget – his plan to cap the size of medical malpractice awards for non-economic damages.

This testimony has three attachments. The first is a letter our organizations sent to the Medicaid Redesign Team, the second is a recent article examining the success New York Presbyterian Hospital-Weill Cornell Medical Center has had in reducing obstetric injuries and malpractice payments and the third is a more detailed review of federal data on medical malpractice in New York State. I will refer to information during our testimony.

Our organizations may have additional comments on this issue and other proposals contained in the executive's health budget as this issue moves forward.

Overall, on behalf of the organizations, we are shocked by the Administration's proposal. The plan seeks to significantly, arbitrarily cut the malpractice payments made to grievously injured patients – most notably children with profoundly disabling injuries. We urge you to reject the Administration's proposal and to instead embrace measures that protect patients as well as reduce malpractice insurance costs for doctors and hospitals.

Evidence – Thousands of New Yorkers die each year due to negligent medical care.
Sticking with the number of hospital patient deaths due to medical mistakes reported in the national Institute of Medicine's report, *To Err is Human*, at least 3,000-7,000 New Yorkers die due to preventable harm suffered during their hospitalization. According to the CDC's estimate of 100,000 deaths due to infections in hospitals, which can be largely prevented, that represents another 7,000 New Yorkers dead because of unsafe conditions. And if you consider recent Medicare or Health Grades estimates of preventable harm, the numbers would be much larger. And remember this is hospitalized patient experience only – harm suffered in the course of outpatient care is not included in these estimates.

Evidence – Publicly available data obtained from the federal government shows no "crisis" in doctors' malpractice payments.
Presumably, the impetus for the Administration's plan is to reduce medical malpractice premiums paid by doctors. While all would agree that doctors' malpractice insurance is expensive, the claimed reason – a litigation system that's out of control – is not borne out by a review of New York State payouts. According to data reported by the federal government, medical malpractice payments in New York are quite stable. Over the years that the information has been collected, the total number of doctors making payments has remained consistent, while the number of doctors in the state has increased dramatically.

The total amount paid out as a result of malpractice litigation has increased, but at roughly the rate of inflation. See tables on page 4 in the attached letter. In addition, in the third attachment of our testimony, you will see that a detailed examination of the federal data shows that there has been little change in payouts by the type of injury. One note of caution, as you will see in some categories, the number of payouts is quite small and so one case can have a big impact. You will see in these smaller categories wild gyrations in payouts. But as you can see, overall the system is quite stable.

This data is the only publicly-available, independent, malpractice information. As a result of federal law, all malpractice payments as well as disciplinary actions taken by state medical boards and hospitals must be reported to the National Practitioner Data Bank. The specific information about an individual doctor's malpractice history is not public, but aggregate data is. Despite that legal requirement, data is not always reported and that's why we look at the data over time to examine trends. As you can see, the trend in New York is remarkably stable.

If malpractice payments are only increasing at the rate of inflation, what explains the bigger increases in doctors' malpractice premiums? The clear answer is we don't know. Our groups had urged that the MRT examine that issue *prior to embracing changes* to the malpractice system. Having seen no evidence that they did so, we can only assume that the deliberately chose not to examine this fundamental question.

Some groups are trying to argue that there is a shortage of doctors in New York State. Nothing could be further from the truth. The number of doctors practicing in New York has grown significantly and at a pace that far exceeds the growth in the state population. There are areas of the state that have seen a shrinkage in the number of doctors, but typically those are areas where there have been reductions in population or where other factors have influenced doctors' decisions about practice location. (See page 2 of the letter.) Lastly, the American Medical Association's statistics shows that New York has the second highest number of doctors in the nation (behind California) and the third highest per capita number of doctors (behind Massachusetts and Maryland). New York State's per capita number has risen dramatically over the decades.[1]

Evidence – New York hospital care is not the best in the nation.

Unfortunately, there is no publicly-available database to examine payouts made by hospitals. Therefore, we have no way of knowing if the above-referenced trend regarding doctors' malpractice payments is different, the same or inconsistent with that of hospitals. As you can see in our letter, we had urged the MRT to comprehensively examine hospitals' claims, but they apparently chose to rely on data provided by the industry itself.

In our letter we did note that the quality of New York hospitals is not nearly as good as care found in others parts of the nation. Again, there is no evidence that the MRT reviewed any independent information on the *quality of care* offered in New York hospitals.

Evidence – Obstetric care can be dramatically improved; reducing needless injuries and malpractice payments.

The last attachment is a copy of a newly-released peer-reviewed study issued by researchers examining the success of patient safety initiatives at the obstetric unit of New York Presbyterian Hospital-Weill Cornell Medical Center. The findings of their examination are startling: The aggressive focus on reducing patient harm not only improved the quality of care offered, but also led to a dramatic reduction in the hospital's malpractice payments – from a high of $50 million in 2003 to a low, unbelievably, of $250,000 in 2009!

[1] American Medical Association, "Physician Characteristics and Distribution in the US, 2011 Edition, Table 6-15.

This article was sent to the Administration in advance of the release of the MRT's report. Unfortunately, the MRT report includes virtually nothing about improving patient care. Instead, the governor's proposal focuses on merely reducing the malpractice payments made to grievously injured patients—including those treated outside of hospitals and outside the Medicaid system.

The article confirms a number of other national experiences with patient safety improvement; that when providers are serious and dedicated about preventing harm to patients they can be successful. And when harm is reduced, so are liability expenses.

Impact – A $250,000 cap on non-economic damages will reduce payments to grievously injured patients, most notably children.
The state of California has had a 35 year track record with a law that enacted a $250,000 on non-economic damages in medical malpractice cases. The results offer a guide for you on what can be expected by the law. According to an analysis by the Rand Institute for Civil Justice,[2] plaintiffs less than one year of age had awards capped 71 percent of the time, compared with 41 percent for all plaintiffs with identifiable non-fatal injuries. Injury cases with reductions of $2.5 million or more usually involved newborns and young children with very critical injuries.

In effect, the Administration's plan's savings will come from reductions in payments to the most seriously injured and those with the longest lifespan after the injury.

Solution – Reduce malpractice payments by boosting patient safety measures, not by cutting awards to grievously injured patients. Reject the governor's plan.
The Administration's proposal does not address the safety of New Yorkers at all. Its plan has chosen to be completely silent on that issue. Yet, enhancing patient safety is the best way to cut the needless injuries and deaths caused by medical negligence as well as reducing the cost of malpractice litigation.

The empirical evidence is clear. Malpractice experience in New York is stable. What is not stable is the state of patient safety.

Instead of punishing individuals who have been horribly injured by medical care, the focus of state public policy should be to embrace patient safety measures.

[2] Pace, N., Golinelli, D., Zakaras, L., "Capping Non-Economic Awards in Medical Malpractice Trials, California Jury Verdicts Under MICRA," Rand Institute for Civil Justice, 2004.

CENTER FOR JUSTICE & DEMOCRACY
CENTER FOR MEDICAL CONSUMERS
CONSUMERS UNION
NEW YORK PUBLIC INTEREST RESEARCH GROUP
NEW YORK STATEWIDE SENIOR ACTION COUNCIL
PULSE OF NEW YORK

February 15, 2011

Mr. Michael Dowling, co-chair
Mr. Dennis Rivera, co-chair
Medicaid Redesign Team
Albany, NY

Re: Analysis and recommendations on medical malpractice.

Messrs Dowling and Rivera:

We write to urge you to ignore recent requests that what has been described by some as medical malpractice "reform" be included in any recommendations that you submit to Governor Cuomo. We believe that the public interest would be better served by an executive order directing the State Insurance Department to conduct a thorough public review of the revenues and loss experiences of the medical malpractice insurance industry. Moreover, the best way to reduce medical malpractice litigation is to ensure that the state is doing all it can to protect patients from unnecessary injuries in the first place. A reduction in injuries would reduce litigation.

We respectfully suggest that there is no evidence to support the contention of many provider and professional groups that inflation in the cost of medical malpractice liability insurance has been a significant contributor to inflation in health care costs. In fact our periodic review of trends in New York's actual number of malpractice lawsuits and payouts, at least as relates to physicians, has found that the numbers of legal actions remain stable and that aggregate payouts inflate at rates consistent with inflation. Our analysis relies on data from three primary sources; the National Practitioner Data Bank, the New York State Court system and the state insurance department.

Given the apparent stability of New York's actual physician malpractice experience over the past decade or more, along with premium increases imposed by carriers over time, it is hard to understand the basis for claims by the carriers that current premium rates fail to cover their loss experience and make it impossible for them to maintain adequate reserves. To explain the gap between the evidence and apparent medical malpractice liability anecdote, we believe there must be a comprehensive and independent forensic financial audit of malpractice carriers and a detailed analysis of their underwriting, investment and business practices. This analysis should be made available to the governor, legislature and the public as the basis for future policy decisions related to physician medical malpractice in New York State.

FINDING: No compelling evidence of a litigation-caused medical malpractice crisis in New York State

The numbers of physicians licensed to practice in New York State dramatically increased.

As shown below, New York State's physician supply has been increased at a rate that far exceeds the state's population growth.

New York State's Increasing Number of Doctors 1995 – 2009 and Compared to Population Growth[1]

Year	Total number of physicians practicing in New York State	New York State population[2]
1995	51,193	18,524,104
1996	53,409	18,588,460
1997	53,409	18,656,546
1998	54,926	18,755,906
1999	55,732	18,882,725
2000	55,531	18,998,044
2001	56,995	19,088,978
2002	56,995	19,161,873
2003	59,581	19,231,191
2004	59,581	19,297,933
2005	63,427	19,330,891
2006	61,931	19,356,564
2007	65,644	19,422,777
2008	62,770	19,467,789
2009	64,818	19,541,453
Change	**+13,625 (26.61%)**	**+1,017,349 (5.49%)**

Medical malpractice lawsuits are remarkably stable over time.

As seen below, the numbers of lawsuits filed annually in the last decade has remained constant – despite the increasing number of doctors.

[1] Federation of State Medical Boards, *Annual Reports* 1995 through 2009. Federation of State Medical Boards. Summary of 2009 Board Actions, Accessible at http://www.fsmb.org/fpdc_basummaryarchive.html. The "change" row compares the amount in 1995 with the amount in 2009. Calculations by NYPIRG.

[2] Estimates for years between 2000 and 2009 are from the U.S. Census Bureau: http://www.census.gov/popest/counties/CO-EST2009-01.html Older years' numbers are from the New York State Empire State Development Corporation, "Components of Population Change, New York State 1960-2007." The "change" row compares the amount in 1995 with the amount in 2007. See: http://empire.state.ny.us/NYSDataCenter/Population_HousingEstimates.html. Calculations by NYPIRG.

New York State Office of Court Administration:
Requests for Judicial Interventions in New York, 1996 – 2008, Medical Malpractice[3]

Year	Requests for Judicial Intervention Total
1996	4,423
1997	4,460
1998	4,318
1999	4,235
2000	4,150
2001	4,338
2002	4,403
2003	4,467
2004	4,434
2005	4,270
2006	4,140
2007	4,271
2008	4,182

New York State Office of Court Administration:
Requests for Notes of Issue in New York, 1996 – 2008 Medical Malpractice[4]

Year	Requests for Notes of Issue Total
1996	2,633
1997	2,790
1998	3,044
1999	3,147
2000	3,059
2001	3,499
2002	3,182
2003	3,093
2004	2,876
2005	2,807
2006	2,901
2007	2,723
2008	2,865

The trend in the number of medical malpractice payments shows no increase over the past decade and a half. As we will discuss later, the increased in aggregate payouts appears to reflect the overall inflation rate.

We relied on publically-available information obtained from the federal government's National Practitioner Data Bank (NPDB). All states, insurers and hospitals are required to submit malpractice and disciplinary information to the NPDB. The NPDB has limitations, but it is the only publicly-available database and examining trends over time, we believe, is valid. The first chart examines the amount paid in malpractice cases and the total number of payments made.

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[3] NYPIRG submitted an e-mail request to the New York State Office of Court Administration. Data was received on June 1, 2009.
[4] NYS OCA, Ibid.

National Practitioner Data Bank:
The Total Amount Paid for Medical Malpractice in New York State 1993 – 2009[5]

Year	Total Payments Made	Total Number of Payments (rank)
1993	$515,494,950	2419 (3)
1994	$563,105,050	2419 (3)[6]
1995	$421,001,500	2010 (15)
1996	$464,228,800	2125 (13)
1997	$496,561,550	2194 (12)
1998	$546,708,850	2319 (9)
1999	$578,362,500	2371 (8)
2000	$662,860,200	2631 (2)
2001	$712,857,300	2679 (1)
2002	$668,996,350	2257 (10)
2003	$747,286,950	2390 (6)
2004	$821,477,250	2373 (7)
2005	$733,012,400	2213 (11)
2006	$822,670,650	2417 (5)
2007	$753,217,950	2026 (14)
2008	$743,567,550	1881 (16)
2009	$735,996,050	1806 (17)

As you can see, the number of payouts has remained stable for years, despite a rapidly increasing supply of doctors and growth in the general population.

National Practitioner Data Bank:
Actual medical malpractice payout compared with inflation-adjusted medical malpractice payout for years 1993 and 2009[7]

Year	Malpractice payouts
1993 *Actual* Physicians' Malpractice Payouts	$515,494,950
2009 *Projected* Malpractice Payouts adjusted for inflation with 1993 as base	*$765,348,000*
2009 *Actual* Physicians' Malpractice Payouts	$735,996,050

The amount paid out in 2009 is remarkably consistent with payouts made in 1993, when adjusted for inflation (as measured by the Consumer Price Index). The federal data makes it clear that New York's

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[5] Source: The information referenced to the National Practitioner Data Bank (NPDB) Public Use Data File was obtained through the U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Practitioner Data Banks. It was downloaded on 4/20/2010 from http://www.npdb-hipdb.hrsa.gov/.
[6] In all charts, if there is a "tie" in ranking it is listed as such. Subsequent ranks start by skipping a number. In this case, two years "tied" for third place, then we skipped to the fifth ranked year, (there is no fourth) 2006.
[7] National Practitioner Data Bank. For the "projected" category, using the 1993 actual figures as a base, the authors calculated how inflation would have increased the 1993 costs through 2009. The NPDB recommends using the inflation rate for the consumer price index. The NPDB recommends use of that adjustment index since medical malpractice payments cover a wide range of services. Inflation source: Bureau of Labor Statistics, Consumer Price Index for All Urban Consumers 1993 – 2009. Calculations by authors. Totals rounded off to the nearest dollar.

malpractice payments have remained constant for many years.

New York State has one of the highest per capita number of doctors in the nation. Only a small minority of those doctors *ever* makes a malpractice payment and an even smaller number are responsible for more than half of all payouts over the past 17 years.

As seen in the chart below, between 1992 and 2009, 4,265 doctors made three or more payments. This number represents a tiny fraction of the total number of doctors who have practiced in New York State since 1992.

That small number of doctors account for over half of the total of *all* medical malpractice payments made during that time.

National Practitioner Data Bank:
Number of Doctors Who Have Made Medical Malpractice Payments New York 1992 – 2009

Number of Payment Reports	Number of Doctors Who Made Payments	Total Number of Payments	Sum of These Payments	Percent of Total Dollars Paid Out Statewide
Total	23,263	43,559	$11,838,043,150	
1	14,626	14,626	$3,462,320,400	29.25%
2	4,372	8,744	$2,454,494,000	20.73%
3	1,940	5,820	$1,708,056,800	14.43%
4	938	3,752	$1,126,969,800	9.52%
5 through 9	1,175	7,244	$2,327,508,450	9.66%
10 or more	212	3,373	$758,693,700	6.41%

The medical malpractice system appears to be rational – the largest payments tend to go to the most catastrophic cases.
One claim of critics of New York's malpractice system is that the rewards to injured parties are random and unpredictable. Contrary to those claims, the NPDB data indicates that those patients who have suffered the most – either through permanent injuries or deaths – are the ones receiving the highest average malpractice payments.

A common-sense conclusion is that, in fact, New York's system is quite predictable – those injured the most received the largest awards. Far from being capricious the evidence suggests a system that is on average making awards that are fair.

National Practitioner Data Bank:
Patient Outcomes in Cases Involving Medical Malpractice Payments, New York 2009

Outcome	Total Value of Payments Paid (rank)	Average Payment (rank)	Number of Payments (rank)
Death	$175,903,750	$448,734.05 (4)	392 (1)
Minor Permanent Injury	$97,485,750	$317,543.15 (6)	307 (2)
Minor Temporary Injury	$34,192,000	$113,594.68 (8)	301 (3)
Major Temporary Injury	$78,058,000	$301,382.23 (7)	259 (4)
Significant Permanent Injury	$170,537,500	$679,432.27 (3)	251 (5)
Major Permanent Injury	$100,260,050	$721,295.32 (2)	139 (6)
Insignificant Injury	$3,609,500	$48,126.67 (10)	75 (7)
Quadriplegic, Brain Damage, Lifelong Care	$69,920,000	$1,319,245.28 (1)	53 (8)
Emotional Injury only	$1,182,000	$78,800 (9)	15 (9)
Cannot be determined from available records	$4,847,500	$346,250 (5)	14 (10)

FINDING: No publicly-available information on hospitals' litigation experience. However, existing reporting requirements are often ignored.

Hospital care.

As difficult as it is to get an accurate picture of the malpractice payout trends for physicians, the experience of New York's over 200 acute care hospitals is much more opaque. For one thing, unlike physician liability insurance that is provided by a limited number of carriers, hospitals use a variety of mechanisms to provide their coverage, including self-insurance, "captive" liability carriers, commercial policies, re-insurance and more. Unfortunately, there is no NPDB equivalent database for hospitals that would provide a central repository of liability experience and a better understanding of short and long-term trends.

Therefore we have no way of knowing whether the trend experienced by hospitals is any different from what we have charted for physicians. While it is hard to know the extent of the precise number of patient injuries caused by medical errors, there is evidence that there are problems with the care delivered in New York hospitals. According to the Commonwealth Fund, New York State hospitals rank below the national average in the quality of its patient care.[8]

As seen below, key patient safety measures document that New York hospital care has serious problems.

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[8] To examine the entire chart offered by the Commonwealth Fund, See: http://www.commonwealthfund.org/Charts-and-Maps/State-Scorecard-2009/DataByState/State.aspx?state=NY.

Commonwealth Fund:
New York State hospitals' performance measures compared to nation

Dimension and Indicator	Year	State Rate	All States Median	Top 5 States Average	Best State Rate	Rank	Year	State Rate	All States Median Rate	Rank	Actual Change in State Rate	Percent Change in State Rate
Avoidable Hospital Use & Costs	2009 Scorecard					50	Revised 2007 Scorecard			42	Change in Rate	
Medicare 30-Day Hospital Readmissions as a Percent of Admissions	2006/2007	**18.3**	17.5	13.8	12.9	29	2003/2004	**18.0**	17.1	29	-0.3	-1.7%
Percent of Nursing Home Residents with Hospital Readmission Within 30 Days	2006	**22.5**	20.8	14.6	13.2	35	2000	**18.3**	18.2	25	-4.1	-22.3%
Hospital Care Intensity Index, Based on Inpatient Days and Inpatient Physician Visits Among Chronically Ill Medicare Beneficiaries in the Last Two Years of Life	2005	**1.322**	0.958	0.556	0.509	50	2003	**1.338**	0.959	50	0.016	1.2%

New York hospitals too often fail to report as required by federal law.

As mentioned earlier, the NPDB requires hospitals to report actions taken against physicians. In its most recent annual report, 28 percent of New York hospitals have never reported taking an action against credentialed doctors. According to the NPDB, from September 1, 1990 through the end of 2006, 70 of the state's 245 "active" hospitals did not report any actions for the entire period.[9] This would indicate either substantial underreporting or a dereliction of the responsibility to assure that those doctors granted privileges to treat patients at that institution are competent to do so Moreover, too many hospitals fail to report to state regulators as well.

[9] National Practitioner Data Bank, Annual Report 2006, "Currently Active Registered Non-Federal Hospitals That Have Never Reported to the National Practitioner Data Bank by State, 9/1/1990 through 12/31/2006." Of the 245 New York hospitals (# of hospitals with "active" NPDB registrations), 70 (28.6%) have never reported taking an action against a physician.

New York hospitals' failure to report as required by state law.

Recent audits conducted by the State and City Comptrollers has documented serious shortcoming in the state oversight of injuries that occur in New York State hospitals. In 2000, the state committed to cut in half the number of injuries occurring in state hospitals due to substandard care.

Ten years later, the state not only has failed to achieve its goal, but the NYPORTS program that would provide the data need to determine whether patient injuries had been considerably diminished .In a recent report, the Comptroller of the City of New York found:

> We analyzed the numbers of reports hospitals submitted to the Health Department for adverse occurrences that occurred in 2004, 2005, 2006 and 2007. The reporting data was broken out by hospital and reporting category. *We found enormous reporting disparities that can only be explained by systematic underreporting of adverse occurrences.*[10]

The *New York Daily News* also found anecdotal evidence of hospitals' failures to report to NYPORTS.[11]

We suggest that the issue of medical malpractice cost as a driver of overall health care cost inflations needs to be put into proper perspective. Uwe Reinhardt, the distinguished Princeton health economist, recently had this to say: [12]

> "...We know that malpractice premiums are only a small percentage of total health spending. It is often alleged, however, that possibly as much as 15% of total personal health spending in the United States may originate in defensive medicine. Could we perhaps harvest that money through malpractice reform?
>
> Perhaps. *I am not aware of any robust empirical evidence for the claim that malpractice insurance is a major cost driver.* Instead, I am reminded of a tongue-in-cheek talk I gave some 15 years ago or so to the American Medical Association, counseling the doctors assembled there by all means to lament the malpractice problem loudly, but not so loud that God might hear them and do away with the phenomenon. Would they then cheer, I asked them, to see their revenue decline by 15 percent? I recall many blank stares.
>
> *If I had to bet, I would wager that malpractice reform might yield some small cost savings, but not a sizable amount..."*

Reinhardt is not alone among health economists and other experts in his assessment of the lack of evidence that malpractice is as a meaningful driver of costs in the nation's $2.5- 2.7 trillion health economy. Generally, the direct costs of medical malpractice (premiums, payouts etc,) are calculated as being less than 2% of the total costs. And the data churned out over the years that attempt to estimate the cost of "defensive medicine" is equivocal at best.

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[10] New York City Comptroller's testimony before the New York State Standing Committee on Health. November 2009. The testimony refers to the Comptroller's report, *The High Costs of Weak Compliance with the New York State Hospital Adverse Event Reporting and Tracking System.* Emphasis added.
[11] *New York Daily News*, series of articles during 2009.
[12] Available at: http://healthaffairs.org/blog/2009/09/14/grading-the-presidents-health-care-speech/

Estimates of the costs of substandard care, however, are supported by empirical studies that measure the direct health care dollar cost that result from errors and preventable harm. These estimates range widely, but all conclude that the cost of bad care, exclusive from any loss of productivity calculation, is in the tens of billions of dollars annually. This includes avoidable hospital readmissions, longer than anticipated hospital stays, more interventional procedures and tests, drugs and other therapy that must be employed to treat iatrogenic harms.

So we ask why isn't the focus of this debate on the cause rather than a symptom of the problem. In fact, wouldn't we all agree that all of the time and energy spent in the past on medical malpractice insurance concerns – would be better spent making patients safer? High quality, safe patient care is a win-win for everyone concerned; patients, families and caregivers, health care professionals and the health care delivery system overall.

Recommendations.

In order to reduce doctors' medical malpractice premiums, the state should ensure that it has adequate information to make policy choices and bolster state programs designed to reduce needless patient injuries.

- **Policymakers must make protecting patient safety their number one priority.** *One key measure would be the creation of a system of periodic recertification of physicians.* Both the IOM[13] and the State Health Department[14] have recommended that physicians be routinely recertified to assure that they continue to be able to practice as competent professionals. Over time, physicians may see some of their skills erode and it is difficult to keep current with the latest medical research and advances in technology. In an effort to identify these physicians *before* a patient gets harmed, a system of recertification based on competency assessment is needed.

- **Demand that an independent outside actuary conduct a forensic review of insurers' malpractice premium-setting practices, including the calculation of prudent reserves.**

- **Create a publicly available, central databank of all medical malpractice experience to provide a factual basis for State Insurance Department decisions on rates. The SID should not set rate based only on the heretofore poorly evidenced claims of carriers.**

- **Require all doctors to carry medical malpractice insurance as a condition of their continued licensure in NYS. The amount of coverage should be related to adjustment by region, specialty and previous history.**

- **Provide adequate `funding for all patient safety activities including NYPORTS and other quality and safety reporting systems that measure performance and guide improvement. In addition, the data would provide a basis on which to experience rate providers.**

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[13] National Academy of Sciences' Institute of Medicine, To Err is Human: Building A Better Health Care System, November 1999, p. 10.

[14] New York State Department of Health, Report of the New York State Advisory Committee on Physician Recredentialing: Phase One General Principles, Proposed Process, Recommendations, January 1988.

- **The state Health Department must aggressively review doctors who have more than three or more payouts in the past ten years.**

- **The state Health Department should require that hospitals in their required financial reporting provide total detailed cost analysis related to malpractice liability coverage, underwriting and loss experience.**

- **Ensure greater fairness in malpractice insurance programs.** New York should ensure that its law guaranteeing the availability of insurance to licensed doctors does not require better-performing doctors – those who are able to obtain commercial insurance – to subsidize the premiums of very high-risk physicians. It should also re-evaluate the wisdom of – and the impact on patients of – its policy to insure all of the state's physicians, including those with very poor records.

- The state must encourage and provide opportunities for patients', families and caregivers to share their first-hand experiences with, and observations of, unsafe practices in their health care encounters and to fully participate in all patient safety improvement programs and activities.

If you have any questions, please do not hesitate to contact us. Our organizations stand ready to work with the Task Force to ensure a thorough review of the state's medical malpractice system and to initiate steps to enhance patient protections.

Sincerely,

Joanne Doroshow
Center for Justice & Democracy

Blair Horner
NYPIRG

Arthur Levin
Center for Medical Consumers

Maria Alvarez
New York Statewide Senior Action Council

Chuck Bell
Consumers Union

Ilene Corina
PULSE of New York

Cc: James Introne
Jason Helgerson

PATIENT SAFETY SERIES

Effect of a comprehensive obstetric patient safety program on compensation payments and sentinel events

Amos Grunebaum, MD; Frank Chervenak, MD; Daniel Skupski, MD

Our objective was to describe a comprehensive obstetric patient safety program and its effect on reducing compensation payments and sentinel adverse events. From 2003 to 2009, we implemented a comprehensive obstetric patient safety program at our institution with multiple integrated components. To evaluate its effect on compensation payments and sentinel events, we gathered data on compensation payments and sentinel events retrospectively from 2003, when the program was initiated, through 2009. Average yearly compensation payments decreased from $27,591,610 between 2003-2006 to $2,550,136 between 2007-2009, sentinel events decreased from 5 in 2000 to none in 2008 and 2009. Instituting a comprehensive obstetric patient safety program decreased compensation payments and sentinel events resulting in immediate and significant savings.

Key words: compensation payments, medical liability, obstetric adverse outcomes, patient safety, sentinel events

Improving patient safety has become an important goal for hospitals, physicians, patients, and insurers.[1] Implementing patient safety measures and promoting an organized culture of safety, including the use of highly specialized protocols, has been shown to decrease adverse outcomes;[2-5] however, it is less clear whether decreasing adverse outcomes also reduces compensation payments and sentinel events.

Our objective is to describe comprehensive changes to our obstetric patient safety program and to report their impact on actual spent compensation payments (sum of indemnity and expenses paid) and sentinel events.

Materials and Methods

New York Presbyterian Hospital-Weill Cornell Medical Center is a tertiary academic referral center with a level 3 neonatal intensive care unit and serves as a New York State regional perinatal center. The labor and delivery unit performs about 5200 deliveries per year of which voluntary attending physicians manage approximately 25%, and 75% are managed by full-time faculty.

The New York Weill Cornell Investigation Research Board approved this report as exempt research.

Patient safety program

In 2002, we began to implement in a step-wise fashion a comprehensive and ongoing patient safety program. The date of implementation is included for each step.

Consultant Review (2002)

In 2002, as part of an obstetric initiative by our insurance carrier (MCIC Vermont, Inc, Burlington, VT), 2 independent consultants reviewed our department and assessed our institution's obstetric service. This review resulted in specific recommendations and provided a general outline for making changes and improvements in patient safety. Building on these findings, we implemented a comprehensive obstetric patient safety program.

Labor and delivery team training (2003)

Poor communication is among the most cited reasons for malpractice suits,[6] whereas improved nurse-physician communication can make labor and delivery safer.[7] Consequently, the Institute of Medicine recommended interdisciplinary team training programs for providers to incorporate proven methods of team training as a way to improve efforts and to empower every team member to speak up and intervene if an unsafe situation may be occurring.[8] Crew Resource Management (CRM) can potentially decrease medical malpractice litigation, mostly by improving communication,[9] but studies have been less clear about its effect on adverse outcomes.[10]

In 2003, several of our labor and delivery staff members including nurses, obstetricians, and anesthesiologists attended a "train the trainer" team-training course. Subsequently, all staff working on labor and delivery including clerical staff, nurses, attending obstetricians, neonatologists, anesthesiologists, and residents successfully attended a 4-hour team training session and team principles were introduced on labor and delivery. Since then, all new staff has been required to attend labor and delivery team training sessions. The CRM program is performed regularly every 2-3 months. New staff, including nurses, attending, residents, and clerical staff, are scheduled to undertake CRM at the next available time. Attending physicians are instructed that credentialing/privileges will not be

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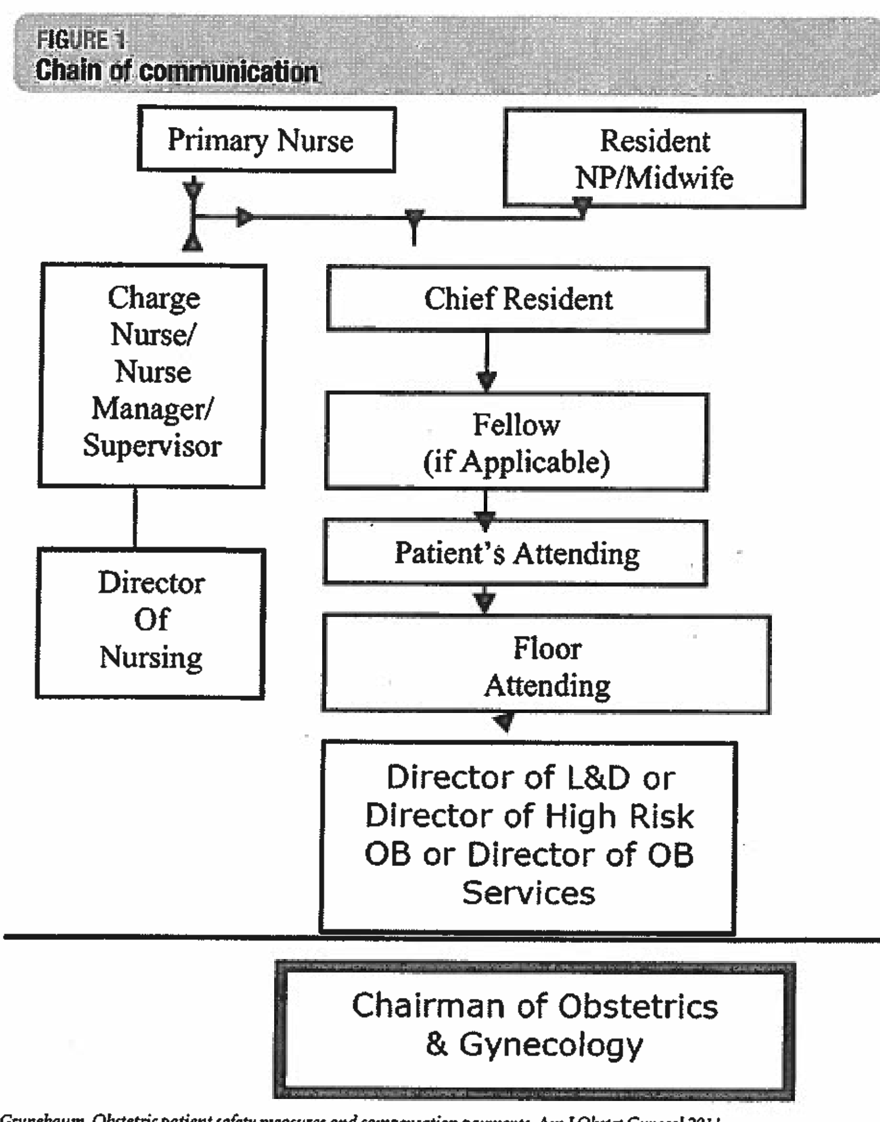
FIGURE 1
Chain of communication



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granted or renewed if CRM is not completed and nursing staff and residents are informed that they must take the CRM program within a year after employment begins.

Electronic medical record charting (2003)

Good medical record charting can help defend professional liability cases and may persuade potential plaintiffs to forego filing a suit[11] and electronic health records on labor and delivery are less likely to miss key clinical information.[12] To facilitate communication and to improve patient safety, we were among the first departments in our institution to require electronic medical record charting with Eclipsys XA (Eclipsys Corporation, Boca Raton, FL) for all patients on labor and delivery. OB Tracevue (Phillips, Andover, MA) is used for electronic fetal monitoring (EFM). All documentation occurs in these electronic formats. Paper documentation is not allowed, except when the electronic format is temporarily incapacitated.

Chain of communication for labor and delivery (2003)

Communication on labor and delivery is crucial to ensure patient safety and to provide the best care for patients and prevent errors,[13] but there are times when physician's orders and actions need to be questioned. We believed that the most effective way for staff on the labor and delivery unit to voice their concerns is to establish and promote chain-of-communication policies. In 2004, a new chief of labor and delivery was appointed and a clear chain of communication was established and supported by the departmental chairman (Figure 1). The chain of communication includes involvement of all staff beginning at the nurse and junior resident level, then up to the chief resident, the inhouse attending, the maternal-fetal medicine specialist on call, and finally the director of labor and delivery and the chairman of the department. All staff are being empowered to use the chain of communication frequently and around the clock to ensure a quick resolution to unresolved and urgent issues.

Dedicated gynecology attending on call (2004)

A gynecology attending on call schedule was established separately from the obstetric coverage. Before this change, the labor and delivery attending covered both the obstetric and gynecology services and there had been occasions when there were concurrent emergency gynecologic and obstetric cases. This situation prevented the attending from sufficiently covering both services. The added gynecology coverage allowed the labor and delivery attending to cover the labor floor exclusively.

Limitation of misoprostol to induction of labor or cervical ripening for a nonviable fetus (2004)

Misoprostol is not US Federal Drug Administration (FDA) approved for use during labor. There is evidence that misoprostol is not effective,[14] and its use is associated with an increase in hyperstimulation/tachysystole.[15]

Misoprostol has never been used at the medical center for a live fetus. After the warning from the Searle company discouraging its use in the year 2000, there was no incentive to begin using this medication at our institution, and our concern about potential adverse outcomes led us to conclude that misoprostol use

TABLE 1
Standardized protocol for induction or augmentation with oxytocin

Item	Protocol
a.	Only a premixed oxytocin solution is used
b.	The oxytocin infusion is limited to intravenous route via an infusion pump
c.	A buretrol infusion is used with a "smart pump" (a pump that comes with error reduction system and drug library capabilities)
d.	The infusion is piggybacked into the port most proximal to patient
e.	A written attending order (electronic template) is required before the start of oxytocin
f.	Before the start of oxytocin an attending must document the plan of care including indication, fetal presentation and station, cervical status, estimated fetal weight, pelvic adequacy, and fetal heart rate assessment.
g.	An attending must be available on the same floor as labor and delivery floor at all times while the patient is on oxytocin
h.	Before initiation of oxytocin a reassuring fetal heart rate must be present for a minimum of 20 minutes
i.	The oxytocin concentration is a premixed solution of 30 U per 500 mL. No individual mixing of solutions is permitted onsite.
j.	The oxytocin infusion begins at 1 mU per minute.
k.	The infusion is increased by 1 mU per minute no more frequently than every 15 minutes
l.	An attending must evaluate, document, and determine the plan of care if the oxytocin dosage reaches 20 mU per minute
m.	The maximum oxytocin dosage cannot exceed 40 mU per minute
n.	If the oxytocin infusion was discontinued for 20 minutes or less, it may be restarted at a lower rate than before discontinuation. If it was stopped for greater than 20 minutes then it should be restarted at 1 mU per minute
o.	Only a nurse can titrate oxytocin. The nurse can stop or titrate the oxytocin infusion if indicated. The doctor must be notified of this.
p.	The oxytocin infusion must be stopped or titrated for any of the following: uterine hyperstimulation/tachysystole (contractions less than 2 minutes in frequency and/or lasting longer than 90 seconds and/or more than 5 contractions in any 10 minute period); elevated uterine resting tone; nonreassuring fetal heart rate tracing; presumed uterine rupture; water intoxication
q.	The attending physician must be notified of any hyperstimulation/tachystole, abnormal fetal heart rate changes and/or stoppage or down titration of oxytocin.
r.	Terbutaline may be given if stopping oxytocin does not lead to a normalization of fetal heart rate changes in the presence of hyperstimulation
s.	Oxytocin should be discontinued as soon as a cesarean delivery is planned

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should be limited to induction of labor and cervical ripening only in the nonviable fetus.

Standardized oxytocin labor induction and stimulation protocol (2005)

A standardized protocol enables the staff to become facile in handling the myriad of problems that occur on any busy unit, quickly and efficiently.[16] In 2005, we implemented a standardized low-dose oxytocin labor induction and stimulation policy (Table 1) and a standardized order template was designed in the hospital's electronic ordering system (Eclipsys, Atlanta, GA). No other method of using intrapartum oxytocin was permitted. Highlights of this protocol included a premixed oxytocin solution, a required written attending order and note before starting the oxytocin infusion, a standardized starting dosage and increases, and a "smart pump" (a pump that comes with an error reduction system and drug library capabilities). The protocol paid special attention to tachysystole and fetal heart rate concerns. If there was tachysystole, or there were concerns about the fetal heart rate, the oxytocin infusion had to be decreased or stopped.

Premixed and safety color-coded labeled magnesium sulfate and oxytocin solutions (2005)

Magnesium sulfate is among the most dangerous solutions used on labor and delivery.[17] More recently, in addition to seizure prophylaxis and tocolysis, prevention of cerebral palsy was added as a potential indication for giving magnesium sulfate on labor and delivery.[18,19] To improve the safe use of magnesium sulfate, we implemented several changes, including the use of premixed magnesium sulfate and oxytocin solutions, color coded magnesium sulfate and oxytocin containers and intravenous lines, as well as using both with "smart pumps."

Electronic medical record templates for shoulder dystocia and operative deliveries (2005)

Both shoulder dystocia and operative deliveries are associated with an increase in

TABLE 2
Shoulder dystocia documentation template

Shoulder dystocia note
Head delivery (Spont/Forc/Vac):
Time head delivered (min/sec):
Time body delivered (min/sec):
Second stage (min):
Anterior shoulder (right/left):
Initial traction: gentle attempt at traction, assisted by maternal expulsive forces
Oxytocin stopped: yes or no
Terbutaline given: yes or no
Any/all maneuvers that apply and the order in which they were utilized.
McRoberts maneuver and by whom:
Suprapubic pressure and by whom:
Episiotomy (and by whom):
Rubin's maneuver and by whom:
Woods maneuver and by whom:
Gaskin maneuver (all fours):
Posterior arm release and by whom:
Other (maneuvers list):
No Fundal pressure after the head delivered
The arm under the symphysis at the point the head was delivered was: right OR left
Primary Care Provider(s) present:
Registered Nurse(s) present:
Pediatrician(s) present:
Others present:
Full disclosure given to patient: Yes/No

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neonatal and maternal injury and consequently litigation.[20] Making the correct diagnosis, performing the correct maneuvers, time management, prevention of traction, and documenting management and maneuvers are therefore essential.[21] We designed and implemented required templates and electronic medical charting tools for several clinical situations, including shoulder dystocia and operative delivery (Table 2).

Early identification of potential obstetric professional liability cases (2005)

Our medicolegal department met with our department and decided that early identification of adverse obstetric outcomes and potential professional liability cases and expedited reviews would be implemented. If a clear medical error was identified, we planned to approach the patient with the goal of an early settlement. Since the implementation of this program, 1 adverse outcome (an early neonatal death) was identified and quickly settled.

Obstetric patient safety nurse (2005)

As part of our patient safety efforts, our insurance carrier (MCIC Vermont, Inc) funded an obstetric patient safety nurse. The patient safety nurse is employed full-time by the hospital and is involved in staff education, team training, implementation of protocol changes on labor and delivery, obstetric emergency drills, and collection of data.

Electronic online communication whiteboard (2006)

For decades, the labor whiteboard has been the center of communications on many labor and delivery units. It usually serves as a hub for situational awareness to make all staff aware of events on labor and delivery. However, the traditional dry erasable whiteboard has many disadvantages, including limited visibility, limited access, small size, no interactivity, and inflexibility. We programmed and implemented our own proprietary online electronic whiteboard (http://www.LDTrack.com), a secure password-protected and IP address-controlled site available through any internet browser that has many interactive features, including color-coded warning labels and automatic mathematically supported updates.[22]

Recruitment of physician's assistants for labor and delivery (2006)

Newly instituted resident work hours limit the extent of resident involvement and night calls in the hospital including the labor and delivery unit. Three new obstetric physician assistants were recruited to amplify the staff and help with the workload. The physicians' assistants are assigned to labor and delivery triage and as assistants for cesarean deliveries and provide continuity and stability on the labor and delivery floor.

Electronic fetal monitor interpretation certification (2006)

Effective communication is essential when discussing and interpreting fetal heart rate and uterine activity and it requires a mutual understanding of terminology. We required that all staff involved in interpreting electronic fetal monitoring, including attendings, residents, physician assistants, and nurses, become certified in electronic fetal monitoring by National Certification Corporation (NCC), a not-for-profit organization that provides a national credentialing program for nurses, physicians, and other licensed health care professionals. In addition, all staff are required to use the National Institute of Child and Human Development

(NICHD) standardized language for fetal heart rate interpretation[23] and templates for documenting fetal heart rates based on the NICHD language were added in the electronic charting tools.

Electronic antepartum medical records (2006)

We implemented uniform antepartum medical record charting (Epic Systems Corporation) for all full-time faculty and staff patients (about 75% of all deliveries). The availability of electronic antepartum charts on a 24-hour/7 day a week basis improves availability of data, such as laboratory results and helps in improving communication among the staff.

Routine thromboembolism prophylaxis for all cesarean deliveries (2006)

Pulmonary thromboembolism is among the leading causes of maternal deaths in the United States, and most events of venous thromboembolism can be reduced with either medical or mechanical thromboprophylaxis,[24,25] and it has been suggested that a systematic reduction in maternal death rate in the United States can be expected if all women undergoing cesarean delivery receive thromboembolism prophylaxis.[5] Therefore, in addition to using pharmacologic anticoagulation prophylaxis for high-risk patients, we also implemented the routine use of intermittent lower extremity pneumatic compression devices for all cesarean deliveries.

Obstetric emergency drills (2006)

The Joint Commission recommends that obstetric departments consider periodically conducting clinical drills to help staff prepare for shoulder dystocia, conduct debriefings to evaluate team performance, and identify areas for improvement.[13] Such drills appear to improve recognition and management of shoulder dystocia and can improve physician's communication skills as well as reduce traction forces.[26,27] Drills were instituted over time for maternal cardiac arrest, shoulder dystocia, emergency cesarean section, and maternal hemorrhage. Obstetricians, anesthesiologists, neonatologists, nurses, residents, fellows, and physician assistants participate in these drills. The shoulder dystocia and maternal hemorrhage drills are performed with a maternal and fetal manikin and in small groups of 6-8 individuals so each can obtain practice in performing the necessary fetal manipulations.

The main objectives of the shoulder dystocia drill are to diagnose shoulder dystocia, prevent injury by performing the correct maneuvers, time management, prevention of traction, and teach proper documentation.

Recruitment of a laborist (2007)

Inhouse oncall attending coverage is provided on a 24-hour basis by one of the full-time faculty attendings that have obstetric privileges. To address lifestyle and patient safety concerns, Weinstein recommended a practice of having hospitalists and laborists,[28] Clark recommended a reassessment of group obstetric practice to improve patient safety,[29] and a survey showed that laborists can have a high career satisfaction.[30] In 2006, we hired a laborist to provide inhouse coverage for the labor and delivery floor for nights and weekends and therefore reduce inhouse oncall responsibilities of other physicians.

Oxytocin initiation checklist (2009)

We implemented a checklist with the most important elements of the standardized oxytocin policy. Completion of the checklist is required by nurses before initiation of oxytocin for induction or stimulation of labor.

Postpartum hemorrhage kit (2009)

We made available a single hemorrhage kit that includes the 4 most important drugs used for postpartum hemorrhage (oxytocin [Pitocin; King Pharmaceuticals, Bristol, TN], misoprostol [Methergine; Novartis Pharmaceuticals, Basel, Switzerland, Cytotec; Bristol-Myers Squibb, Skillman, NJ], carboprost [Hemabate; Pfizer, New York, NY]).

Internet based required reading assignments and testing (2009)

We created an inhouse internet-based password protected reading and testing program (http://www.InPrep.com) for protocols and other publications related to labor and delivery safety. All attendings and residents have been required to regularly read assigned literature and pass a multiple choice test related to the reading material.

Compensation payments and sentinel events

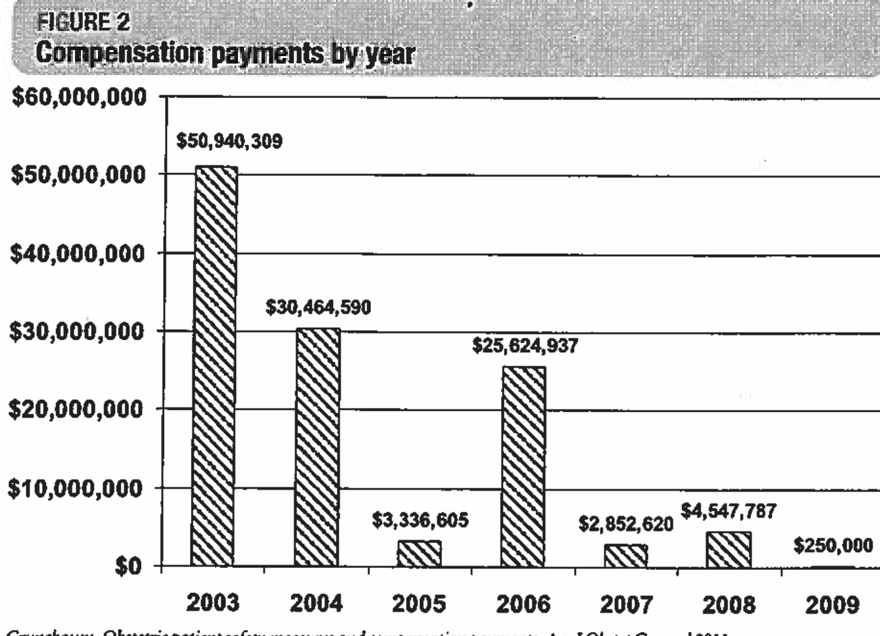
We performed a retrospective review of obstetric compensation payments from 2003 to 2009 collected by the MCIC. Obstetric compensation payments were defined as all actual payments made as a sum of indemnity paid plus medicolegal expenses paid for by the hospital for defending the case. In New York City, most professional liability suits are initiated within 2-3 years after delivery, and they are often not settled until many years later. Therefore, in addition to actual compensation payments, we also assessed new and ongoing significant professional liability suits (expected at $1,000,000 and above) and potential future professional liability suits. Data on sentinel events at our institution were evaluated from 2000 to 2009 by analyzing data obtained from a sentinel event adverse outcome database that is prospectively recorded by the hospital's quality assurance committee. Sentinel events are determined by the Medical Center according to Joint Commission standards. The Joint Commission defines a sentinel event as "... an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof ..." (http://www.jointcommission.org/SentinelEvents/). At our institution, sentinel events included maternal deaths, and serious newborn injuries, including birth asphyxia and hypoxic ischemic encephalopathy.

Results

Compensation payments

Figure 2 shows the yearly obstetric compensation payment totals paid out from 2003 to 2009. The 2009 compensation payment total constituted a 99.1% drop from the average 2003-2006 payments (from $27,591,610 to $ 250,000). The average yearly compensation payment in the 3 years from 2007 to 2009 was

FIGURE 2
Compensation payments by year



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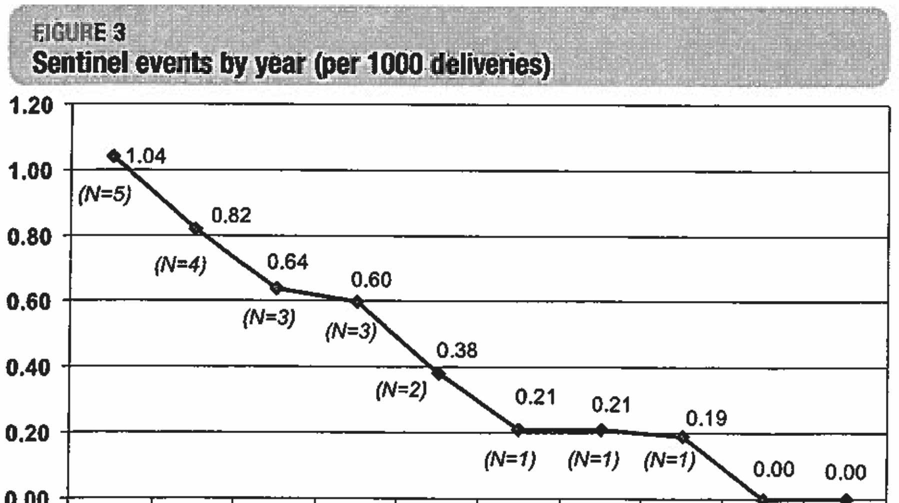
$2,550,136 as compared with an average of $27,591,610 in the previous 4 years (2003-2006), a yearly saving of $25,041,475 (total: $75,124,424) during the last 3 years.

The compensation payments between 2003 and 2008 included delivery dates before 2003. We also assessed potential future and pending professional liability suits through the early identification program. In 2006, we had 1 adverse outcome case that was identified through our program for the early identification of potential professional liability cases, and the case was settled expeditiously. In 2008 and 2009, for the first time in this decade, there was no professional liability suit initiated involving a possibly brain-damaged infant. In addition, there is currently only 1 active professional liability suit exceeding a $1 million estimated loss for an obstetric case from 2005 onward. One of the 2 other currently pending "baby damage" suits involves deliveries before 2003.

Table 3 shows the average time it takes from the event to payment. There is an average of 6.9 years (range, 0.6–17.1 years) between the event and the payment. On average, it takes 3.2 years (range, 0–10 years) between the event and the claim and another 3.7 years (range, 0.3–10.4 years) between the claim and the payment. Of all claims, 65% (26/40) were made within 3 years after the event and 49% of payments (20/41) were made within 6 years after the event.

FIGURE 3
Sentinel events by year (per 1000 deliveries)



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Sentinel events and adverse outcomes

Figure 3 shows the yearly rate of sentinel events per 1000 deliveries. There was a steady decline of sentinel events over the years of the study, from 1.04 sentinel events per 1000 deliveries in the year 2000, to no sentinel events in both 2008 and 2009. For the last 6 years, there has been no maternal death on labor and delivery (we had 1 postpartum maternal death 10 days after discharge from a cerebrovascular accident) and there has been no permanent Erb's palsy since we began shoulder dystocia drills in 2008. Since 2007 there was only 1 infant born of a total of 15,932 deliveries with the diagnosis of hypoxic ischemic encephalopathy (HIE) for an incidence of 0.6 HIE of 10,000 deliveries. Subsequently, that infant had no moderate or severe neurodevelopment impairments. In 2009 there was no infant born with HIE.

The definition of HIE included a severely depressed newborn with need for resuscitation in the delivery room, evidence of severe acidemia at birth based on cord blood gas values and early abnormal findings on neurologic examination and/or abnormal assessment of cerebral function.[32]

Comment

In 1999, the Institute of Medicine published a report challenging the prevailing wisdom that all was well with the American health care system.[8] This report called for a sweeping overhaul and stated that "higher level of care cannot be achieved by further stressing current systems of care. The current care systems

cannot do the job. Trying harder will not work. Changing systems of care will." There also have been increasing concerns about the rise in malpractice costs and its effect of availability of health care.[31]

After an external review of our obstetric service, we undertook comprehensive system changes beginning in 2003, to improve patient safety on our service. Among these patient safety changes were significant eliminations in practice variations as well as significant improvements in communication methods between staff. The main goal of these changes was to improve patient safety and decrease adverse outcomes. We did not expect a rapid and significant effect on compensation payments.

Our results show that implementing a comprehensive obstetric patient safety program not only decreases severe adverse outcomes but can also have an immediate impact on compensation payments. Beginning with the fourth year of the program, compensation payments began to drop significantly. Yearly payments for the most recent 3 years (2007-2009) averaged $2,550,136 as compared with average yearly payments of $27,591,610 for the preceding 4 years (2003-2006). The $25,041,475 yearly savings in compensation payments for the last 3 years alone dwarf the incremental cost of the patient safety program and are well above those reported by Simpson et al.[32] In our opinion the documented success of our patient safety improvement program in decreasing compensation payments for the past years understates the true long-term impact of the program on patient safety, as we expect significant savings to continue into the future.

Our neonatal intensive care unit is a center for "cool cap" treatments (treatment of infants with neonatal encephalopathy with hypothermia helmets), and it regularly treats infants with HIE.[33] Of the more than 50 infants with HIE who were treated in this program over the last 3 years, only 1 among our own 15,932 deliveries came from our institution (the only 2007 sentinel event). Our observed departmental incidence of 0.6 HIE of 10,000 deliveries in the last 3 years is well below the reported 25 of 10,000 deliveries.[34] On follow-up, this infant had no moderate or severe neurodevelopment impairments and hence for the last 3 years there are presently no known HIE brain damaged infants "in the pipeline." As the amount of compensation payments for an infant with neurodevelopment impairments can be well in excess of $10 million in New York City, the prevention of each and every 1 of these cases is crucial to minimize such payments.

TABLE 3
Yearly compensation payments and event-to-payment time

Year	Payments	Event-to-payment average (range), y
2003	$50,940,309	5.9 (1.1–10.3)
2004	$30,464,590	10.5 (3.9–17.1)
2005	$3,336,605	5.5 (1.2–9.5)
2006	$25,624,937	8.2 (4.1–13.2)
2007	$2,852,620	8.1 (5.0–12.0)
2008	$4,547,787	4.7 (0.6–14.4)
2009	$250,000	0.8
2003-2009	$117,991,848	6.9 (0.6–17.1)

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The Institute for Safe Medication Practices (ISMP) has added oxytocin to its list of high alert medications.[35] The use of oxytocin during labor has been found to be associated with malpractice claims.[36] Using oxytocin during labor may have a negative impact on the probability of successfully defending a professional liability case, and its misuse, especially its association with hyperstimulation, has been alleged to be responsible for many if not most of the adverse outcomes and professional liability litigation involving abnormal labor.[37-40]

The best defense against legal challenges involving the misuse of oxytocin is to use the drug judiciously and in accord with institutional policies.[41] However, despite reports that standardized and uniform practice patterns are known to have better outcomes than greater practice variations, medical practice continues to be characterized by wide variations that have little basis in clinical science.[16] This is especially true for oxytocin usage, which has many persistent variations even within the same institution.[42] Clark et al[41] concluded that a physiologically sound and evidence-based approach to oxytocin use is possible and explained that it may be difficult to effect change in practice when physicians so often see no untoward effects of excessive uterine activity.

It has been suggested that implementing a uniform oxytocin policy and using an oxytocin checklist may improve perinatal outcomes.[43-45] We also found that implementing a uniform oxytocin protocol and checklist helped our staff make better use of oxytocin and allowed nurses to focus on better patient care instead of following protocols that varied from physician to physician. Implementing a uniform oxytocin protocol likely contributed to our improved patient safety and prevention of adverse outcomes. Our experience supports the recommendation that: "... Malpractice loss is best avoided by reduction in adverse outcomes and the development of unambiguous practice guidelines."[5]

Many pregnant women are given misoprostol "off-label" for cervical ripening and labor induction even though this medication is not approved for use in labor and is associated with an increase in uterine hyperstimulation and resultant fetal asphyxia and uterine rupture, amniotic fluid embolism, perinatal mortality, and HIE in surviving infants.[46] Because of these concerns, we decided to limit the use of misoprostol in labor to inductions in a nonviable fetus.

Good teamwork promotes professional integrity and is essential in delivering optimal patient care,[47] and failure in communication and teamwork is often cited as a common cause of adverse events.[6,48,49,50] We found that teamwork can be further improved in labor and delivery by maintaining an electronic comprehensive communication board as the essential hub for communications among staff.

Sleep deprivation can impair safety, and establishing a laborist program has been recommended to improve safety.[28] The hiring of a laborist allowed our obstetricians to work reduced inhospital hours and likely contributed to the improved safety climate and improved outcomes at our institution.

The traditional erasable labor and delivery white board usually reflects situational awareness, the state of knowing what is going on with patients and in the unit. Unfortunately, most obstetric units still use a dry erasable white board that has severe limitations, including accessibility and space limitations. We believe that the implementation of a centralized, internet-based comprehensive electronic "white board" with automatic alarms and color-coding[18] significantly improved situational awareness and thus may have contributed in decreasing adverse outcomes and reducing compensation payments.

Historically, EFM tracings have been interpreted with wide variations among the labor and delivery staff, often leading to inconsistent decision making in response to tracing interpretation. MacEachin et al[51] showed improved communication as well as improved safety perception by the staff with the use of a common EFM language after a multidisciplinary EFM training program.

Our study is limited by its retrospective nature. There were numerous changes made over several years, so that the impact of any one change on a single outcome measure cannot be individually determined. It is possible, that because of the retrospective nature of this report, there may have been other unknown factors that contributed to the reduction of compensation payments and sentinel events.

To paraphrase Ralph Waldo Emerson (1803-1882) who said "Life is a journey not a destination," we believe that achieving patient safety on labor and delivery is a journey, not a destination.

Improving patient safety requires extensive and considerate changes, physician and staff cooperation, constant vigilance, flexibility, and rapid adaption based on new experiences and it may take considerable time to reap financial benefits in the future.

Making significant changes on a labor and delivery unit including such features as the implementation of a standardized oxytocin protocol, electronic charting, team training, and improving situational awareness through a central communication system, should be considered by all obstetric services. As we have shown, these changes can increase patient safety, decrease sentinel events, and, as a consequence, reduce compensation payments. ■

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NEW YORK PUBLIC INTEREST RESEARCH GROUP (NYPIRG)
TESTIMONY ADDENDUM FOR EXECUTIVE'S 2011-12 HEALTH BUDGET

NPDB shows little change in malpractice payment experience, even when examining payments for causes of injuries. The NPDB allows the public to "drill deep" into its data. Researchers can examine payment patterns for injuries. The following charts show changes regarding payments that stem from injuries relating to diagnoses, medications, surgeries, obstetrics, anesthesia, IV and blood work, treatments, monitoring and equipment failures.[1]

National Practitioner Data Bank: Payments Made for Diagnosis-Related Injuries

Year	Diagnosis Related Payments	Diagnosis Related Count
1993	$143,269,550	661
1994	$177,947,650	681
1995	$136,221,750	574
1996	$171,278,000	660
1997	$201,001,000	744
1998	$221,514,150	778
1999	$217,929,550	773
2000	$228,862,050	762
2001	$262,048,150	813
2002	$247,070,850	681
2003	$245,881,800	624
2004	$290,467,250	690
2005	$260,575,750	670
2006	$302,509,750	714
2007	$269,743,500	597
2008	$290,648,750	586
2009	$305,235,050	558

National Practitioner Data Bank: Payments Made for Surgery-Related Injuries

Year	Surgery Related Payments	Surgery Related Count
1993	$115,363,550	599
1994	$101,934,150	627
1995	$94,510,500	575
1996	$101,039,550	549
1997	$103,950,300	554
1998	$120,873,900	629
1999	$127,234,650	654
2000	$153,642,800	698
2001	$170,121,550	702
2002	$143,998,750	582
2003	$153,404,100	571
2004	$169,512,500	569
2005	$163,255,550	493

[1] Data downloaded on March 2, 2011. This data is more recent than that used in the group's letter. As such, the total do not match (NPDB has updated its numbers). The difference is slightly more than 1 percent higher.

2006	$167,502,800	562
2007	$160,583,050	501
2008	$162,484,050	449
2009	$168,823,250	413

National Practitioner Data Bank: Payments Made for Anesthesia-Related Injuries

Year	Anesthesia Related Payments	Anesthesia Related Count
1993	$19,538,200	99
1994	$10,240,100	54
1995	$14,819,650	63
1996	$21,321,150	67
1997	$18,359,950	62
1998	$8,056,400	44
1999	$12,570,800	62
2000	$16,880,100	75
2001	$23,584,000	76
2002	$19,188,300	50
2003	$16,779,000	59
2004	$18,983,000	56
2005	$33,087,750	130
2006	$23,607,000	67
2007	$22,686,050	39
2008	$19,255,000	41
2009	$17,689,000	43

National Practitioner Data Bank: Payments Made for Medication-Related Injuries

Year	Medication Related Payments	Medication Related Count
1993	$14,503,050	93
1994	$19,067,000	100
1995	$6,563,000	49
1996	$12,172,800	60
1997	$14,407,300	75
1998	$14,731,500	71
1999	$22,531,500	75
2000	$16,080,500	81
2001	$17,805,750	78
2002	$16,100,050	62
2003	$14,665,500	53
2004	$17,921,250	61
2005	$13,275,750	46
2006	$20,465,350	61
2007	$16,568,500	66
2008	$18,606,500	53
2009	$23,059,000	56

National Practitioner Data Bank: Payments Made for IV and Blood-Related Injuries

Year	IV & Blood Products Related Payments	IV & Blood Products Related Count
1993	$1,217,250	7
1994	$1,265,000	8
1995	$2,030,000	5
1996	$678,750	6
1997	$876,250	3
1998	$1,452,500	2
1999	$1,131,000	5
2000	$1,310,000	9
2001	$577,500	4
2002	$1,105,000	5
2003	$985,000	5
2004	$1,342,500	4
2005	$1,026,000	7
2006	$850,000	2
2007	$30,000	2
2008	$405,000	1
2009	$12,500	1

National Practitioner Data Bank: Payments Made for Obstetrics-Related Injuries

Year	Obstretrics Related Payments	Obstretrics Related Count
1993	$121,574,500	256
1994	$141,881,550	224
1995	$75,332,050	179
1996	$77,689,500	171
1997	$77,934,800	171
1998	$87,503,350	189
1999	$108,432,800	208
2000	$116,529,350	208
2001	$119,673,750	211
2002	$86,070,000	130
2003	$121,680,750	165
2004	$171,962,750	289
2005	$150,767,750	217
2006	$141,323,750	224
2007	$128,648,750	181
2008	$115,018,750	178
2009	$124,422,500	139

National Practitioner Data Bank: Payments Made for Treatment-Related Injuries

Year	Treatment Related Payments	Treatment Related Count
1993	$92,420,750	647
1994	$106,612,300	681
1995	$63,600,450	499
1996	$73,181,150	554
1997	$72,375,700	538
1998	$89,003,950	575
1999	$82,857,650	559
2000	$117,326,150	751
2001	$113,397,800	762
2002	$150,407,850	722
2003	$179,488,000	867
2004	$120,091,250	601
2005	$90,184,300	527
2006	$112,540,000	609
2007	$128,022,800	537
2008	$114,075,250	504
2009	$132,730,250	522

National Practitioner Data Bank: Payments Made for Monitoring-Related Injuries

Year	Monitoring Related Payments	Monitoring Related Count
1993	$5,832,750	23
1994	$3,072,500	19
1995	$24,114,000	30
1996	$5,817,000	26
1997	$7,115,250	24
1998	$2,748,600	22
1999	$4,337,550	19
2000	$9,909,250	32
2001	$4,590,250	21
2002	$1,201,750	10
2003	$10,486,550	28
2004	$21,830,000	51
2005	$16,202,500	75
2006	$16,214,250	50
2007	$13,592,500	41
2008	$18,537,000	33
2009	$15,876,250	43

National Practitioner Data Bank: Payments Made for Equipment/Product-Related Injuries

Year	Equipment Product Related Payments	Equipment Product Related Count
1993	$518,300	11
1994	$260,000	3
1995	$399,500	6
1996	$204,300	9
1997	$104,000	4
1998	$15,000	2
1999	$182,500	2
2000	$87,500	1
2001	$28,750	2
2002	$232,550	10
2003	$322,500	5
2004	$1,725,000	13
2005	$605,000	13
2006	$2,461,250	11
2007	$1,208,050	10
2008	$1,951,000	12
2009	$4,567,500	10

National Practitioner Data Bank: Payments Made for Miscellaneous-Related Injuries

Year	Other Miscellaneous Payments	Other Miscellaneous Count
1993	$772,050	20
1994	$606,050	19
1995	$3,410,600	30
1996	$846,600	23
1997	$437,000	19
1998	$809,500	7
1999	$1,154,500	14
2000	$2,232,500	14
2001	$1,029,800	10
2002	$3,621,250	5
2003	$3,593,750	13
2004	$7,404,250	35
2005	$3,724,550	34
2006	$33,471,500	109
2007	$11,172,250	43
2008	$1,382,750	18
2009	$2,238,250	10

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Primary Care Development Corporation/Primary Care Coalition Testimony to Senate Finance and Assembly Ways and Means Joint Hearing on the 2011-12 Health and Medicaid Budget

March 3, 2011

Thank you Chairman DiFrancisco, Chairman Farrell and members of the Senate and the Assembly. I am Dan Lowenstein, and I am presenting testimony on behalf of the Primary Care Development Corporation and New York's Primary Care Coalition.

PCDC is a nonprofit whose mission is to increase capacity and quality of primary care in underserved communities through low cost capital financing to build and expand facilities, and technical assistance to help providers develop patient-centered approaches that strengthen their practices and improve and expand care. We are a member of the Primary Care Coalition, along with the Community Health Care Association of New York State, the American College of Physicians (NY Chapter), the NYS Academy of Family Physicians, and the NYS Area Health Education Center System.

We know that billions of dollars can be saved and we can improve health for the most underserved and sickest patients if we had a strong, effective primary care sector that truly incentivized the right care in the right place at the right time, but today we are living with the legacy of decades of primary care underinvestment and misaligned incentives. This helps to explain why New York has the highest per-capita Medicaid expenditures and the highest rate of avoidable hospitalizations in the nation. Without a strong front end on the system, consisting of primary care, we are helpless in the face of soaring costs.

We support the Medicaid Redesign Team's recommendations, which contain bold initiatives necessary to building a high-performing, patient-centered health care system for all New Yorkers. This plan recognizes the role of primary and preventive care as critical to making the system work, including:

- Expanding access to patient-centered medical homes to one million New Yorkers.
- Creating an office of Patient-Centered Primary Care Initiatives.
- Providing operational and capital resources to assist the merger and restructuring of safety net facilities, which is critical to preserve and strengthen primary care capacity.
- Providing payment incentives to support telemedicine.
- Facilitating co-located physical health, behavioral health and developmental disability services.
- Taking steps to reform the broken medical liability system.

We recognize there may not be agreement on all of the MRT's proposals, that some of these changes will indeed be challenging, and that there are other good ideas yet to be explored.

But on a whole, this is a very good package, and many of the elements fit together in ways that if pieces are removed or weakened, we will not achieve the necessary cost savings and quality improvements.

How these proposals are developed and executed of course matters a great deal. We have to make sure that the changes we make are sustainable and achieve the cost and quality gains we expect. I would like to focus on two areas that are necessary to building a sustainable foundation for Medicaid reform.

Technical assistance to expand Patient Centered Medical Homes – The Patient Centered Medical Home is a model that emphasizes coordinated, comprehensive care, including an ongoing relationship with a healthcare provider, a team approach to patient care, and the use of electronic medical records, 24/7 access to clinical advice, and e-mail and telephone consultations. PCMH has been highly effective in achieving better health outcomes, and reducing costs, particularly around hospitalizations for chronic conditions.

But most doctors and health care workers in New York that serve Medicaid patients do not operate under PCMH principles, so providing medical homes to 1 million Medicaid patients will be an enormous challenge. It's not something where you turn on the lights and you're a medical home. Often, it requires a fundamental shift in how a practice operates and how it interacts with the patient. We have found that intensive training and education of providers is critical. The Legislature should make sure that there is adequate support for technical assistance to help providers become true medical homes.

HEAL funds for primary care capital expansion – New York needs modern facilities in underserved communities for the efficient delivery of primary care. But the continuing credit crisis, layered on top of already unmet capital need in the primary health care market, may severely limit New York's ability to expand its primary care capacity as part of its overall effort to reform the healthcare system and reduce Medicaid costs.

We are very encouraged that one of the MRT recommendations is to use HEAL funds for restructuring and repurposing safety net facilities. We urge that special attention be given to ensuring that any downsizing plans include expansion of primary care in the affected communities, and that sufficient operating and capital resources be allocated to ensure successful transitions.

We also know that HEAL funds are a finite resource – once they're gone, they're gone. We should look for solutions that extend these capital resources beyond their conventional use as one-time grants. We support the use of HEAL funds for the creation of a permanent, revolving primary care capital fund that would leverage private sector capital and provide low-cost financing to build and expand facilities for years to come.

We would also like to express strong support for restoration of funding for the Center for Health Workforce Studies, which was eliminated in the Executive Budget. CHWS provides vital

information that helps policymakers determine where to put our resources to build a high-performing health system.

Conclusion

In conclusion, New York could have chosen the path several states are heading down – one of draconian cuts, pushing people out of Medicaid, and eliminating essential services.

Instead, New York is choosing to invest in and fix Medicaid to better serve its most vulnerable citizens. After listening to patients, providers and other concerned New Yorkers throughout the State, the MRT developed a package of very compelling measures that leverage federal healthcare reform, bring healthcare decisions closer to patients and their providers, and incentivize the right care at the right time in the right setting.

We urge the legislature to act on these recommendations, and keep the focus on building a strong, sustainable primary care system that will serve as the foundation of the healthcare quality improvements and cost savings we must achieve.

Thank you.

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Maternity and Early Childhood Foundation

Testimony to the Joint Legislative Budget Committee

March 3, 2011

A Positive Return on Investment!

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On behalf of our Board and the families we serve, the Maternity & Early Childhood Foundation thanks you for this opportunity to present some vital information about a cost-effective prevention program serving the needs of the most vulnerable in our state.

The Maternity & Early Childhood Foundation was founded in 1983 in response to the significant number of teenage mothers and low income single-parent families who were receiving late or no prenatal care and needed information on parenting. Our mission is to ensure a safe and healthy birth of the child and the well-being of the mother by supporting and promoting services to those pregnant and parenting women who are most in need.

The New York State Budget has long supported the Maternity and Early Childhood Foundation, Inc. (MECF). MECF is a not-for-profit agency that was started over 27 years ago through efforts of several forward-thinking individuals, including members of the New York State Legislature who realized the importance of supporting young parents at a most crucial time, the birth of a child. Research demonstrates the critical need for preventive intervention for at-risk families that begins prenatally and continues through the first three years of life.

Government and Business leaders are rightfully concerned about building the economy of New York, creating jobs, and using funds wisely. In this budget process with such a huge deficit, they want to carefully consider the return on investment. A common definition of Return on Investment (ROI) is a performance measure used to evaluate the efficiency and effectiveness of an investment. I would like to share with you some of the results of <u>your investment</u> in the Maternity and Early Childhood Foundation.

In 2009-10, the State Budget invested $1.2 million for our agency. The return for your investment included:

- 31 high-need communities received funding for services for very low income pregnant teenagers and young parents.
- Over 4800 pregnant teens, young parents and their family members were served at a cost of approximately $250 per person.
- Of them, 50% of parents were under age 21 at the time of enrollment.
- Over 50% of the parents enroll in the program pre-natally - the best time to make a positive impact on health of the baby and the mother.

Services include outreach to pregnant women who might not seek prenatal care, assistance with access to health insurance, crisis intervention, parenting skills training, information on baby safety, and support for education and employment goals. Most of the families served are living in extreme poverty with unstable housing, lack of transportation and little or no employment. The MECF

funds programs to provide a positive support, help reduce stress and give parents hope for a better future.

MECF selects funded programs through a rigorous Request for Proposal process. Funded programs serve young expectant and new parents in high need communities throughout New York State where other community services are often limited or nonexistent.

An example of a funded program is Dominican Sisters Family Health Service, Inc. located in Mott Haven in the Bronx. Mott Haven has been identified as the most distressed congressional district in the nation. All of the families are Hispanic and most do not speak English. A majority of the families live in one bedroom apartments with other families in substandard housing. Many of the mothers have a history of depression and domestic violence. Most do not have a high school education and many have only completed elementary school.

Dominican Sisters is both a center and home based program. During the operation of the center, the mothers participate in ESL, GED, parenting education, self-esteem, breast feeding, nutrition, and domestic violence classes. While the mothers are at class, the infants and toddlers play in a supervised infant/toddler room. The Director notes that since these children live with other families in crowded walk-up apartments, they don't have any experience with music or play and few opportunities for gross motor activities. Hence, this room is equipped with developmentally appropriate toys to promote gross motor, fine motor and language development. The children are screened for developmental delays and referred to Early Intervention Services if indicated. In 2009, the program served 65 children from 64 families and provided home visiting services to families in crisis. What a return on investment for those families and that distressed community!

Among other funded programs is Catholic Charities of Onondaga County. MECF funding supports the Lullaby League, the oldest consistently offered parent education course in Onondaga County. This program provides parent education classes for pregnant women and young parents. The classes focus on healthy pregnancy, baby safety and connection with community services such as WIC. At a recent class, a pregnant teen attended with her Mom, who recalled attending the classes 19 years ago. Stating that the class made all the difference to her, and enabled her to go back to school to become a physical therapist, she wanted her daughter to have the same support she received as a young scared pregnant teen. The return on investment is multigenerational for this family.

Another Mom reflected on the support she received from MOMMA'S House located in Nassau County. Prior to entering the program, she was living in a dangerous domestic violence relationship while mothering an infant. After

residing at MOMMA'S House, she went on to graduate from Russell Sage College. Her personal goal is to start a not-for-profit agency similar to MOMMA'S. She writes, "My heart is in giving back what I received while at MOMMAS – unconditional love and support. My experience there helped me to be the self-reliant woman I am today." What a return on investment!

We applaud your leadership in responding to the current economic emergency. Last year, our funding (originally eliminated in the Governor's budget) was restored at 50% or $599,000. With that funding we have already provided services to over 1200 pregnant teens, young parents and their family members at a cost of $288 per person. Compare this to the cost of one low birth weight infant ($246,000) and it is clear that services for young pregnant women make sense. We are building a strong return on investment with these families!

We recognize that the state must do business differently. We believe that we are doing just that; building a strong future for New York. While New York is facing some very serious challenges, we request that you do not forsake the future of New York by eliminating services to our most vulnerable citizens, our children and their struggling families.

Our line item was eliminated in the Governor's proposed budget and folded into the proposed local competitive grant program. The timing and priorities of this grant program are not stipulated in the budget. We hope that you will restore our line item. We strongly believe that the Return on Investment in the Maternity and Early Childhood Foundation will reap major dividends for the state in the long-term.

The support we give expectant and new parents will last a lifetime!

Thank you for your leadership during these tough times.

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Testimony of

Jo Wiederhorn

President and Chief Executive Officer

Associated Medical Schools of New York (AMSNY)

At a Joint Hearing of

The New York State Assembly

Committee on Ways and Means

And

The New York State Senate Committee on Finance

On

The Executive Health Care Budget

March 3, 2011

10:00 am

Legislative Office Building

Albany, New York

Good afternoon Chairman DeFrancisco, Chairman Farrell, Chairman Hannon, Chairman Gottfried and other distinguished members of the State Legislature. Thank you for this opportunity to testify on the Executive proposed budget for 2011-12.

My name is Jo Wiederhorn, President and Chief Executive Officer (CEO) of the Associated Medical Schools of New York (AMSNY), a consortium of the sixteen public and private medical schools in New York State. AMSNY works in partnership with its members to improve healthcare through education, advocacy, and collaboration. In 2008, the combined economic impact of New York's medical schools and primary hospital affiliates amounted to $85.6 billion annually. These institutions support almost 700,000 jobs directly and indirectly through their activities.

In my testimony today, I would like to discuss several important components of the health budget that impact medical schools. Specifically, I would like to discuss the proposed funding reductions to the State University of New York (SUNY) medical schools and their hospital affiliates; and reaffirm the value of the State's stem cell initiative and the AMSNY Diversity in Medicine/Post-Baccalaureate Programs.

Crisis Facing SUNY Medical Schools and Hospitals

New York State's public medical education system is one of the best in the country. Leaders in medical education and research have graduated from the schools or completed their residencies at their affiliated hospitals. Their affiliated hospitals are the safety net hospitals within their communities and as such treat some of the most complicated (and often rarest) medical conditions. And yet, this medical education system is facing decimation after years of draconian budget cuts to both the medical schools and their affiliated hospitals. This is a foremost concern to all members of AMSNY.

Medical Education Provided by the SUNY Schools

Let me begin by providing you with some demographics related to the four SUNY Medical Schools—Downstate Medical Center in Brooklyn, Stony Brook Medical Center,

University at Buffalo School of Medicine and Biomedical Sciences and Upstate Medical University in Syracuse.

- They provide 25% of the allopathic medical education in the State;
- They train 26% of the underrepresented minorities within the State's medical schools;
- The percentage of their student population who are NYS residents are: 76%, 77%, 73% and 82% respectively;
- Their average tuition for NYS residents is $28,000 (as compared to $48,000 at the private schools); and
- The average out-of-state tuition is $50,000 (compared to $48,000 at the private schools).

Clearly these schools take their mission to train NYS residents from all ethnic and cultural backgrounds very seriously—despite the fact that they have been continually losing State support and they could receive, on average, an additional $22,000 per student for out of state students.

Cuts in State Support

As like all SUNY campuses, the four medical schools are facing a 10% reduction in their State support. This is in addition to the 57.3 million in cuts they have received over the past 3 years.

However, these cuts cannot be taken in isolation. The medical schools are inextricably tied to their hospitals and in the FY 11-12 proposed budget, the SUNY hospitals are zeroed out. Therefore, the proposed elimination of $154 million in state support for the SUNY hospitals actually results in as much as a **30% reduction in direct State support to the SUNY medical schools and their hospitals,** while most state agencies and programs are being asked to take a 10 percent cut or less.

These proposed SUNY hospital cuts, in addition to the cuts they have received between 2007-2011,will have a lethal impact on their ability to survive. During this time frame, the magnitude of the cuts the hospitals have endured is enormous:

- Downstate: $157.1 million
- Upstate: $100.6 million
- Stony Brook: $273.6 million

As stated earlier the SUNY medical schools and hospitals are inextricably linked. They share major administrative resources i.e. human resources, physical plant, payroll, information technology, security, as well as faculty and education costs. In FY 10-11 the hospitals transferred $225 million to their academic campuses:

- Downstate: $94 million
- Upstate: $59 million
- Stony Brook: $72 million

Without that funding, the campuses could not function.

In addition, in many areas the 'hands of the hospitals and medical schools are tied.' The State negotiates salaries, benefits and pension costs....yet the academic medical centers must absorb the cost. These fixed costs continually rise, while the State continues to cut its support of the institutions, breaking a compact forged eleven years ago to provide them a modicum of support to help meet the extraordinary costs associated with supporting a public work force and providing safety net programs.

The proposed cuts will send the SUNY medical schools and hospitals into financial uncertainty and likely insolvency, upsetting the delicate balance these institutions have been able to achieve through the relatively small amount of state support they receive.

This would be devastating not only to the educational and health care systems, but also to the communities in which these institutions reside. In a 2008 study commissioned by AMSNY, it was shown that the combined economic impact (both direct and indirect) of

the SUNY academic medical centers was $20.1 billion and the number of FTEs supported through these institutions was 133,640 (both direct and indirect). Clearly these cuts would mean a loss of jobs and revenue.

For the aforementioned reasons, AMSNY requests that the Legislature continue to fund the SUNY medical schools and hospitals at their current levels.

Stem Cell Research

AMSNY would like to thank Governor Cuomo and the Legislature for continuing to fund New York's stem cell program at $44.8 million annually in the proposed SFY 2011-12 budget. New York's stem cell program has been extremely successful and continues to drive medical innovation and job creation. In its 2008 economic impact study, AMSNY estimated that for every dollar in research funding invested in medical schools, the state receives a return of $7.50.

In the spring of 2007, New York dedicated $600 million over eleven years for stem cell research, making it one of the largest government-financed stem cell programs in the country. The state's objective was to sponsor a strong research community within the state that could investigate the potential of stem cell technology to alleviate disease and improve human health. Of near equal importance was the goal of economic development – the investment in research and facilities that would create jobs, both directly and indirectly, and to fuel the local economy. The Empire State Stem Cell Board ("Board") was created and charged with making grants for basic, applied, translational, and other research and development activities to advance stem cell research throughout the state.

Funding for this program positions New York as a leader in stem cell research, and brings hope to millions of people suffering from a range of debilitating diseases. Scientists say that in the future, stem cells may be used to replace or repair damaged cells and have the potential to drastically change the treatment of conditions like Alzheimer's disease,

amyotrophic lateral sclerosis (i.e. ALS or Lou Gehrig's disease), burns, cancers, spinal cord injury, Parkinson's disease, juvenile diabetes and other conditions.

Spurs Economic Development

New York's funding commitment is critical to the State's stem cell research community given its unique nature. In addition to the derivation of stem cell lines, New York's program funds early stage research projects that have had difficulty accessing other funding sources, like the National Institutes of Health ("NIH"). New York's program also provides funding for capital and equipment to create a stem cell infrastructure.

Because of New York's funding commitment, funding has allowed the state's biomedical research and commercial sectors to grow, and has placed New York at a scientific and economic advantage over state's that do not have dedicated stem cell programs.

New York's stem cell program has been extremely successful thus far, allocating over $200 million since 2008 to support stem cell scientists in the development of new research, training, collaboration and research infrastructure. The infusion of state funds for stem cell research has been "catalytic", enabling institutions to leverage the state's investment to obtain significant amounts of external funding through federal grants and philanthropic sources.

The state's investment in these projects has created new jobs and is attracting top researchers to New York. Leading scientists and medical professionals from across the country are coming to New York because they are able to conduct cutting-edge research in the State. In doing so, these scientists are often bringing with them their National Institutes of Health ("NIH") grants and post doctoral students. Furthermore, medical schools and research laboratories are hiring new researchers to compliment the stem cell programs. The growing research infrastructure brings increased revenue for research

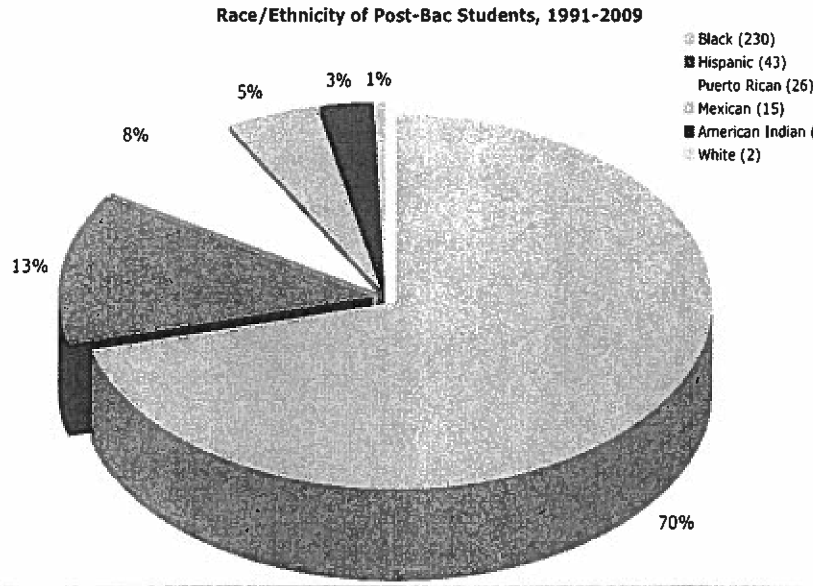
facilities and staff and the ability to train new graduate students, develop new drug therapies, and spin off clinical businesses throughout the region.

As illustrated, it is essential to preserve New York's $44.8 million annual commitment in stem cell research in order for the State to continue to be one of the strongest research communities in the world.

AMSNY Diversity in Medicine/Post-Baccalaureate Programs

AMSNY requests the Legislature maintain funding for the AMSNY Diversity in Medicine Programs at last year's level. These programs increase the number of minorities in medicine and seek to alleviate the maldistribution of health professionals in underserved areas. The diversity programs include the Post Baccalaureate Program at SUNY Buffalo School of Medicine and Biomedical Sciences; the Post Baccalaureate Masters Degree Programs at Upstate University Medical Center, Stony Brook University Medical Center and New York Medical College; the Learning Resource Center at Sophie Davis School of Biomedical Education; the Pathways to Careers in Medicine at the City College of New York and the Physician Career Enhancement Program at Staten Island University Hospital.

The outcome data illustrates the success of these programs. For example, 85 percent of students who participated in the Post-Baccalaureate (Post Bac) program at SUNY Buffalo matriculated into the referring medical school and successfully graduated from that medical school. A majority of students that participated in the Stony Brook Masters program are currently enrolled or have applied to medical school. At SUNY Upstate, all of the students that enrolled in the Medical Scholars program enrolled in medical school.



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

The success of these programs demonstrates the need to continue funding the AMSNY Diversity in Medicine programs at last year's level. Continuation of these programs will ensure that a more diverse and culturally competent workforce is developed to meet future health care needs.

Closing

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

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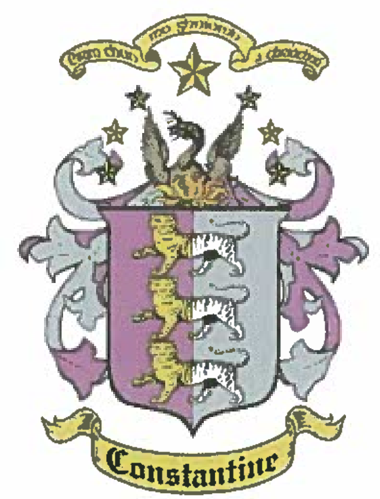

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JOINT LEGISLATIVE FISCAL COMMITTEE HEARING
EXECUTIVE BUDGET
HEALTH CARE
3 MARCH 2011
STATEMENT OF TERRY O'NEILL, DIRECTOR
THE CONSTANTINE INSTITUTE, INC.

The Constantine Institute, Inc. has been organized to promote the highest constitutional, legal, ethical and professional standards in law enforcement, to encourage innovation in public safety strategy, tactics, training and education and to foster a seamless continuum of cooperation, support and mutual respect among public safety agencies and organizations.

One of the concepts that our organization promotes is restorative justice. Restorative justice means making repair of the damage done by crime an essential goal of the criminal justice system. This generally means restitution, reconciliation or compensation to victims or making amends to the community through community service. In the case of the Spinal Cord Injury Research Program (SCIRP) created by Chapter 338 of the Laws of 1998, it quite literally puts the justice system to work to repair the terrible injuries caused to innocent people by reckless and drunken drivers. These accidents are the leading cause of spinal cord and brain injury in New York. What SCIRP does is put law enforcement officers to work generating research dollars to be invested in treatment and cure of paralysis, brain injury and other neurological injuries.

At this writing, the news of the shooting incident in Tucson, Arizona that took the lives of six people and left U.S. Representative Gabrielle Giffords with a gunshot wound to the head is no longer dominating the headlines. An injury such as Representative Giffords has sustained is very serious. No one sustains an injury like that without negative neurological consequences. This tragedy underscores the fact that it is critical that medical research toward better treatments for such brain and spinal cord injuries goes forward. New York has, in fact, invested more than $60 million in such research under the Spinal Cord Injury Research Program (SCIRP) over the past decade.

SCIRP was created in 1998 by my friend Paul Richter of Albany, a former State Trooper whose career was ended when he was shot and paralyzed near Lake Placid on September 30, 1973. With the support of many retired law enforcement officers and veterans' organizations, we were able to accomplish the extraordinary legislative feat of getting the SCIRP bill introduced, passed and enacted in the space of four months as Chapter 338 of the Laws of 1998.

The Act imposes a small surcharge on Vehicle & Traffic Law fines that goes into a fund from which grants are made to medical research facilities in our state. The statute explicitly states that these funds SHALL be applied to SCI research. In effect, the program puts the state's entire force of law enforcement officers to work, not only making our roads and highways safer and free of drunk drivers, but generating up to $8.5 million annually that goes directly into research leading to treatment and cure of spinal cord injury (SCI) paralysis, traumatic brain injury (TBI) and many other neurological conditions. As traffic accidents are the leading cause of SCI and TBI, I consider it the most extraordinary example of restorative justice I've yet seen. Moreover, TBI is at epidemic levels among our military personnel because of the enemy's weapon of choice in our current overseas conflicts, the IED. Our commitment to neurological research has brought aid, comfort and hope to tens of thousands of military families.

When Governor Paterson unveiled his austerity Executive Budget last January, he proposed terminating SCIRP and diverting its restricted revenue stream to other purposes. Paul Richter, Drs. Mark Noble of the University of Rochester Medical Center, Rajiv Ratan of the Burke Neuromedicine Institute and Sally Temple of the New York Neural Stem Cell Research Institute and many others from the medical research community joined together to put up a determined fight to prevent that, but the healthcare budget bill was the first to be subject to the governor's novel tactic for getting a budget passed. We were able to prevent a repeal of SCIRP and the statutory surcharge, however monies collected via the surcharge are no longer being directed towards funding new research projects.

Supporting advanced medical research at facilities across the state is certainly part of any comprehensive plan for nurturing the industries of the future and making New York competitive in this field in the global marketplace. The $60 million that SCIRP has invested in this research over the past decade has put New York in the vanguard of that industry by attracting impressive research talent and giving our state a good reputation for its sustained commitment to research. SCIRP grants, which are relatively small, have leveraged considerable additional support from outside New York from agencies such as NIH, DOD, the VA system as well as foundations such as the Christopher and Dana Reeve Foundation

and the Craig H. Neilsen Foundation. This has had substantial positive economic impact on our universities and research institutes.

A compelling example of the economic development impact of SCIRP is Acorda Therapeutics, Inc., one of the very few New York State biotechnology companies to bring a novel treatment all the way from development to FDA approval. Acorda was founded by a group of individuals, several of them here in New York State, to develop treatments for spinal cord injury and other neurological conditions and diseases. Funding from SCIRP was a key part of the decision to base Acorda in New York and has also been key in enabling the pursuit of novel approaches to the treatment of chronic spinal cord injury. The therapy that Acorda has brought to market is now in use by multiple individuals in New York State with multiple sclerosis or spinal cord injury. This contribution to the New York economy is considerable, particularly as the treatment sold by Acorda appears on track to be a 500 million to 1 billion dollar a year drug. In other words, a blockbuster. We need SCIRP funding to help develop the next blockbuster here in New York.

Dr. Mark Noble, who has received several SCIRP grants over the years, and his team are on track to develop new, innovative treatments that hold great promise for the treatment of chronic spinal cord injury, a condition that otherwise costs the state $300,000 a year in Medicaid costs per individual. Such treatments are also being pursued by Dr. Rajiv Ratan, head of the Burke Neuromedicine Institute in White Plains. A Center of Research Excellence (CORE) grant awarded to Drs. Ratan and Noble by SCIRP also enabled the development of a novel robotics therapy that is putting individuals with cervical spinal cord injuries back in the work force at tremendous economic savings to New York State. These are just two examples of the high-tech approaches being funded by the SCIRP to develop innovative therapies for neurological repair. Many other laboratories have received SCIRP support, which together make New York a world leader in this exciting area of bio-medical research. Loss of funding will cause a brain-drain to other states and countries, with export of talent and resources at a time when we desperately need to build our high-tech economy.

And more is at stake than just our expertise in spinal cord injury, for it is work on this injury that is the gateway to creating new treatments for traumatic brain injury (TBI), of the type suffered by Rep. Gifford, by our soldiers, by our police officers, by battered children and so many others. Because the goals in SCI repair are so clear, it is a testing ground for therapies that also target traumatic injury to the brain. Can this be true? We know it is, because Dr. Noble's team is already translating their discoveries in SCI to breakthrough treatments for TBI. The robotics therapies being pursued under Dr. Ratan's leadership also have immediate application for individuals with TBI. New York State could be the center of developing these treatments – or we can be an observer as the treatments and the financial benefits and the biotech companies move elsewhere.

I've been in Albany for a long time and I certainly appreciate the enormous fiscal problems that you have to deal with. But I ask you to consider the economic potential of SCIRP-funded research for New York's economy and future competitiveness in the global marketplace. I also ask you to consider Rep. Giffords and the tens of thousands of veterans who are coming home to us with TBI and other neurological injuries and help us get the V & T Law surcharge revenue directed back the medical research it is intended to support.

U.S. Department of Justice

Drug Enforcement Administration

Office of the Administrator

Washington, D.C. 20537

MAY 0 8 1998

Honorable Edward Griffith
Member, New York State Assembly
LOB, Room 739
Albany, New York 12248

Dear Mr. Griffith:

One of our legendary State Police heroes, retired Zone Sgt. Paul Richter, has advised me of your efforts to secure legislation that establishes a Spinal Cord Injury Research Board.

As a former Superintendent of the New York State Police, I unfortunately witnessed a number of Troopers give their lives while protecting the citizens of our state. Thankfully, the Government leaders and private citizens provided comfort to the surviving families. However, there are others who suffered serious and debilitating injuries who also have paid a tremendous price for their heroic efforts. One such individual is retired Zone Sergeant Paul Richter who was shot and critically wounded in Troop B in the early 1970's. Although it looked for a long time that Sgt. Richter might not survive, his incredible will allowed him to live. Unfortunately, the gunshot wound resulted in damage to the spinal cord. I watched Paul on a daily basis fight his way back from virtually complete paralysis to become a productive individual despite his new handicap. Despite all of this pain and suffering, he never gave up and never became bitter. Quite the opposite; he devoted his life to charitable causes often involving spinal cord regeneration.

My 34 years of service with the New York State Police was a great privilege, but it is an even greater privilege to help those who have given so much. Your generous assistance to Paul Richter and others who suffered such debilitating injuries is appreciated.

Sincerely,

Tom

Thomas A. Constantine
Administrator

SPINAL CORD SOCIETY

An International Society for cure research and treatment of spinal cord injury and related problems

Paul Richter, NYS Chapter Coordinator
24 Davis Avenue • Albany, NY 12203 • (518) 458-2141

Chairman DeFrancisco and Chairman Farrell, thank you for this opportunity to address the Joint Fiscal Committees on the continuation of the Spinal Cord Injury Research Program, which I and many of my fellow former members of the New York State Police worked so hard to create in 1998.

Troopers as first responders to scenes of traffic accidents and crimes of violence are invariably first to know that the victim is likely paralyzed or brain-injured. Creating this program gave us all a way to do something to undo the terrible damage done to innocent people who will go on to live lives diminished and often much shortened by paralysis or traumatic brain injury. We put all our brother and sister law enforcement officers to work raising the money that funds the research that SCIRP makes possible while doing their daily work of making our highways safer.

My written testimony contains documentation that SCIRP is driving advances in medical research and that it holds great promise for future economic development to benefit the state and people of New York. That is for the benefit of your budget analysts.

But recently, our investment in this program became even more personal and poignant. One of our brothers, a man known throughout the state as "Mr. State Police," Senior Investigator Jack Doyle, son of a Trooper, brother of a Trooper wantonly shot and killed on the job in 1967, died in Pulaski. Jack spent his retirement years in a wheelchair. Shortly after his retirement in 1994, he sustained a spinal cord injury in a highway accident that left him paralyzed. He succumbed, in large part, to the complications that so many SCI victims develop. I can't tell you what he endured in the last years of his life. But he was a very brave man. An exemplary New York State Trooper.

You will understand that continuation of New York's investment in the SCIRP program means a great deal to the family of the New York State Police. I hope and trust that it will mean as much to our elected representatives in the Senate and Assembly.

Thank you for your time and attention.

RETIRED NEW YORK STATE TROOPERS !!

IN SUPPORT OF SPINAL CORD INJURY RESEARCH PROGRAM (SCIRP)

We, the undersigned, urge Governor Paterson to reconsider his proposal to cut the Spinal Cord Injury Research Program (SCIRP). We support spinal cord injury research in New York State and want it to continue under the SCIRP program.

NOTE: Your address will NOT be used for ANY purpose other than to show that you are a NYS resident. This information will be kept PRIVATE and will NOT be used for solicitation purposes.

Name (Print)	Signature	Troop (Last Station) Address
ROBERT L KNAPP	[signature]	E - HORSEHEADS
RALPH J. CASSANI	[signature]	E- HENRIETTA
MICHAEL POISSON	[signature]	E - HENRIETTA
BRUNO DiMATTEO	[signature]	E- CANANDAIGUA
THOMAS BOWMAN	[signature]	A- CLARENCE
RONALD R. BROOKS	[signature]	B -RAY BROOK
Patricia Hook	[signature]	H Academy
STANLEY E. Hook	[signature]	H HEADQUARTERS
Thomas W. Winterstein	[signature]	H Headquarters
Dodi Winterstein	[signature]	H Academy & EAP
HOWARD CARRON	[signature]	B Plattsburgh

PETITION IN SUPPORT OF SPINAL CORD INJURY RESEARCH PROGRAM (SCIRP)

We, the undersigned, urge Governor Paterson to reconsider his proposal to cut the Spinal Cord Injury Research Program (SCIRP). We support spinal cord injury research in New York State and want it to continue under the SCIRP program.

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Name (Print)	Signature	Address
W J ROPELEWSKI	[signature]	G LOUDONVILLE
D P RYAN	[signature]	G LOUDONVILLE
RICHARD J KUBRICKY	[signature]	G [illegible]
ROBERT WRIGHT	[signature]	G LOUDONVILLE
Richard Carey	[signature]	G BRUNSWICK
[signature]	MARTIN F HACKEY	A BATAVIA
[signature]	FREDERICK GOLDMAN	G FONDA
PAUL R DOFTON	[signature]	C BINGHAMTON
RONN ELLIS	[signature]	C Oneonta
[signature]	[signature]	C BINGHAMTON
[signature]	J P MICILCAVAGE	C BINGHAMTON
Gayle A Mahoney	[signature]	Troop G SP Wilton

Name (Print)	Signature	Troop (Last Station) Address
KENNETH F SNYDER	[signature]	A
ROBERT BROWNING	[signature]	A.
DAVID F. VAN AKEN	[signature]	Troop "G"
WALT HORNBERGER	[signature]	" " "G+H"
DONALD J. GREELEY	[signature]	G

Name (Print)	Signature	Troop (Last Station) Address
MICHAEL E. DOWDS	[illegible]	"B" WESTPORT, N.Y
GERALD A. ROOSA	[illegible]	"D" ~~Dep~~ WATERTOWN, N.Y
JOSEPH P. MOORE	Joseph P. Moore	"C" ONEONTA, N.Y.
STEWART WINSMAN	Stewart Winsman	B WESTPORT, N.Y.

Name (Print)	Signature	Troop (Last Station) Address
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Thomas J. Kenny	[signature]	A - Batavia
FRANK B. BENOSKY	[signature]	E - CANANDAIGUA
P. J. CORR	[signature]	TROOP - K
HOWARD C. BLANDING	[signature]	TROOP A - FREDONIA
JAMES E. FARRELL	[signature]	TROOP A - FREDONIA
PATRICIA A. FARRELL	[signature]	PORTLAND, NY 14769

Name (Print)	Signature	Troop (Last Station) Address
JAMES FURPHY	James Furphy	TROOP H - ALBANY NY
DAVID R. BAKER	David R Baker	K - POUGHKEEPSIE
RONALD W. MILLER	Ronald W. Miller	A - FREDONIA
MARY E. MILLER	Mary E Miller	426 EAGLE St. DUNKIRK NY 14048
THOMAS J O'BRIEN	Thomas J. O'Brien	G - LOUDONVILLE

Name (Print)	Signature	Troop (Last Station) Address
ROBERT F. KELLY	Robert F. Kelly	TROOP A, MAIN ST. CLARENCE, N.Y.
JOHN H. KOHLAND	[illegible signature]	TROOP F MOCKINGBIRD HILL LAKE GEORGE NY
William M. Cameron		TROOP C Sidney, N.Y
William T Woods		Troop F SP Middletown
[illegible] Buckley		Troop 'C' SP Sidney
Walt [illegible]		TROOP C SP DEPOSIT
Mary Ellen Connors		Troop F Ferndale
Brian T. Connors		Troop F Ferndale

Name (Print)	Signature	Troop (Last Station) Address
ROBERT STODDART	Robert C. Stoddart	T
LLOYD A. SCHWAR	Lloyd A. Schwar	A
JOHN R LONCHER	[illegible]	T
ROBERT ARKEILPANE	R J Arkeilpane	T
TERRY SUTTON	Terry Sutton	T

Name (Print)	Signature	Troop (Last Station) Address
DAVID F. TRAUB	[signature]	"D" Lowville
EMANUEL S. FRIEDMAN	[signature]	"D" SP ONEIDA
JEFFREY L. SWEET	[signature]	T - FULTONVILLE
RICHARD J. WAGNER	[signature]	H - AVIATION - ALBANY
Ed Stewart	[signature]	D Troop - No Syracuse
Theresa Lombard	⇔ THERESA LOMBARD	Troop - "B" - Chazy
LYN R. LOBDELL	[signature]	TROOP B RAY BROOK
ROSANNA M. CLARK	[signature]	TROOP B - RAY BROOK
JAMES F. MALEY	[signature]	DIVISION HQ - TROOP H
Ronald Lombard	[signature]	TROOP B CHAZY

Name (Print)	Signature	Troop (Last Station) Address
RAYMOND S. O'BRIEN	Raymond J O'Brien	A - OLEAN NY
Timothy C Rudd	Timothy C Rudd	C - Ithaca NY
JIMMY F CARTER	James F Carter	C - SIDNEY, NY
JOHN M. COYNE	John M. Coyne	D - NEW HARTFORD, N.Y.
RW Corbeil	[illegible]	B - CHAZY
JOHN SAVINO	John Savino	B - OGDENSBURG, N.Y.
EDWARD B BROUSE	Edward B Brouse	B - OGDENSBURG
SUE RUDD	Sue Rudd	C - Ithaca
Sheri Carter	Sheri Carter	C - Sidney NY
JOANNE O'BRIEN	Joanne O'Brien	A - OLEAN, N.Y.

Name (Print)	Signature	Troop (Last Station) Address
Gregory R Snyder	Gregory R Snyder	A - Ellicottville N.Y.
Susan R. Bubbs	Susan R. Bubbs	A - Allegany NY
Rober G. Bubbs	Robert G. Bubbs	A - Allegany, NY
Mary Jo Snyder	Mary Jo Snyder	A - Ellicottville, N.Y
Niles L. Balch	Niles L Balch	D - Oneida, N.Y
Carol A Balch	Carol Balch	D - Oneida NY
Debra L. Hatch	Debra L Hatch	A - Allegany (OLEAN)

Name (Print)	Signature	Address
Michael McTustdr	[illegible]	SP Canandaigua - "E"
William F. Myers	[illegible]	SP Academy - "H"
CLAIRE MULCAHY	[illegible]	Troop NYC.
JOHN P. DUNNING	[illegible]	"F"
William T. Nuzzo	[illegible]	SP middletown - Troop F
Robert W. BURNS	[illegible]	SP - Rochester - Troop E
Paul W Kelly	[illegible]	SP N SYR TROOP D
WARREN TAYLOR	[illegible]	SP TROOP D
MATTHEW W. HOLMES JR	[illegible]	SP TROOP D
HAROLD D. HATCH	[illegible]	SP TROOP A

Name (Print)	Signature	Troop (Last Station) Address
Robert Hoagboom	Robert Hoagboom	G
Calvin V. Zier	[signature]	G
Donald E. Lawrinait	[signature]	G
James A. Nellis	[signature]	G
Richard F. Hendrick	[signature]	A.
Kenneth Gellart	[signature]	A
[signature]	Richard B. Olman	A
Eugene J. Fechter	Eugene J. Fechter	A
Joseph P. Beratta	Joseph P. Beratta	D
Leigh J. Hunt	Leigh R. Hunt	H
Edward J. Powers	[signature]	"G"
Jerry O'Leary	[signature]	F
Ann L. Hunt	Ann L. Hunt	G
Rosalie Powers	[signature]	"G"
Anthony Reppanhagan	[signature]	"G"
William F. Lair	[signature]	"G"
JB Austin	[signature]	A

Name (Print)	Signature	Troop (Last Station) Address
Anne Sebeck	Anne Sebeck	Troop C
Andrew Sebeck	Andrew Sebeck	"
Douglas S Burrell	DOUGLAS S. BURRELL	Troop C
Janet K. Burrell	Janet K Burrell	Troop C
DAVID B. Culverwell	David B. Culverwell	Troop A
ALBERT S. KUREK	[illegible]	TROOP A
Kevin D. Kailbourne	Kevin D. Kailbourne	TROOP A
Nancy S Kailbourne	Nancy S. Kailbourne	Troop A
Thomas H Mungeer	Thomas H Mungeer	TROOP F
PAUL J. BIGELOW	Paul [illegible]	Troop "A"
Bruce R Koloff	[illegible]	Troop " "
GERALD M. KIRKPATRICK	[illegible] Kirkpatrick	TROOP A
Donald Munch	Donald Munch	Troop A
TOM CONSTANTINE	[illegible]	TROOP A

Fact Sheet: Spinal Cord Injury Research Program (SCIRP)

Key Impacts

- **Attracts Additional Investment to NYS Projects:** Most SCIRP funding recipients have used the results of their scientific work to apply for additional funding from the federal government (including NIH) and private foundations. According to a recent survey of recipients who collectively received $13.8 million from SCIRP, their projects successfully leveraged $22.7 million in outside grants, implying a more than three-to-two multiplier of leveraged outside funds to state SCIRP funds.

- **High Tech Job Creation:** The $54 million awarded through SCIRP since it began in 1998 and the millions of additional leveraged dollars support hundreds of high tech jobs in New York State, including scientists and support staff in our universities, hospitals and research institutions. According to the survey referenced above, $13.8 million in SCIRP funds and $22.7 million in leveraged funds supported 160 jobs, attracted 41 individuals from out of state and generated eight patents.

- **Integral Part of State's Economic Development Efforts:** SCIRP established and continues to fund the Spinal Cord Injury Center of Research Excellence (SCI CORE), a first-in-the-nation collaboration between research and rehabilitation institutes from around the state seeking to discover and deliver new treatments for spinal cord injury. The central CORE facility is the Burke-Cornell Medical Research Institute (White Plains) and participating institutions include: Weill Cornell Medical College (New York City), University of Rochester Medical Center, Columbia University, Hunter College, Helen Hayes Hospital (West Haverstraw) and Acorda Therapeutics Inc (Hawthorne).

- **Helping to Develop NY's Biotechnology Industry:** Acorda Therapeutics, located in Westchester County, received FDA approval this January for a new pharmaceutical product to treat multiple sclerosis. As a member of the Spinal Cord Injury Center of Research Excellence (SCI CORE), Acorda is just one example of the New York State based biotech companies that SCIRP funding can help grow.

- **Additional Regional Beneficiaries:** Additional recipients of SCIRP funding have included: University at Buffalo, Stony Brook University, Albany Medical College, University at Albany, RPI, SUNY Upstate Medical University, NY Medical College, SUNY Downstate Medical Center, NYU Medical Center, NYU School of Medicine, Sloan Kettering, Mt. Sinai School of Medicine, College of Staten Island (CUNY)

- **Exciting New Breakthroughs:** In July 2009 with the help of SCIRP funding, University of Rochester Medical Center researchers announced breakthrough discoveries regarding the ability of the compound Brilliant Blue G (BBG) – a common food additive used in

M&Ms and Gatorade – to partially cure paralysis in rats caused by spinal cord injuries. The discovery, a milestone in spinal cord injury research, will require additional laboratory testing before human clinical trials can begin.

- **Biomedical Opportunity:** Currently spinal cord treatments are decades old and rely on stabilization with no effective therapeutics. Therapeutics developed for spinal cord injury can also be applied to traumatic brain injury and other nerve injuries. This is an open area for developing products that are desperately needed for patients, including members of the military returning home with spinal cord, brain and nerve injuries.

Background

- On September 30, 1973, New York State Police Zone Sergeant Paul Richter was shot three times during a traffic stop. One of those bullets damaged Sgt. Richter's spinal cord, paralyzing him from the neck down. Although he eventually regained enough function to walk with a cane, Sgt. Richter had to retire from the State Police and begin a new life.

- Sgt. Richter conceived the idea of a state spinal cord injury research program funded by a surcharge on motor vehicle violations. Working with the State Legislature, he made SCIRP a reality in 1998. After unanimous passage in the State Senate and Assembly, Governor Pataki signed the enacting legislation on July 14, 1998 at NYU Medical Center. The late Christopher Reeve attended the bill signing.

- The bill established the Spinal Cord Injury Research Trust Fund and designated up to $8.5 million per year (generated by a surcharge on fines for moving violations) to assist leading researchers with ongoing and new efforts to find a cure for spinal cord injuries.

- The bill created the New York State Spinal Cord Injury Research Board (SCIRB), consisting of 13 members appointed by the Governor and legislative leaders, to administer a research grants program financed by the Spinal Cord Injury Research Trust Fund. This bill was a model for legislation in other states that created similar programs, including the Roman Reed Act in California.

- The 2010-11 Executive Budget proposes to terminate the Spinal Cord Injury Research Board as of April 1, 2010, ending the program so that no new awards will be made. This termination (worth $6.7 million in FY 10-11) is part of a $14 million effort to save money on health programs deemed to be "low priority." The budget notes that existing awards will continue to be honored.

Name	location	Type of Grant	Years of funding	$$$ from SCIRB	# people supported	Grants leveraged from SCIRB	# people supported by leveraged grants
Ahmed	CUNY-Staten Island	Idea	2	$309,600	3	$0	NA
Arvanian	SUNY-Stony Brook	3 CARTs	7	$1,820,000	12	$550,000	2
Chen	Wadsworth	CART	4	$1,075,000	8	$1,612,000	4
Chesler	NYU Med	IDEA	3	$625,000	1.85	$1,848,138	3.1
Francis	SUNY-Downstate	Mentored Scientist	3	$300,000	4	$75,000	2
Francis	SUNY-Downstate	IDEA	2	$350,000	4	$12,800,000	33
Harris Warrick	Cornell (Ithaca)	postdoctoral fellowship	3	$120,000	1	$691,673	3
Helpern	NYU Med	IDEA	2	$250,000	3		
Huntley	Columbia	postdoctoral fellowship	3	$120,000	1	$0	0
Kim	NYU Med	Mentored scientist	3	$600,000	2		0
Knikou	CUNY-Staten Island	IDEA	2	$213,223	6	$249,884	5
Knikou	CUNY-Staten Island	CART	4	$1,422,066	5		
Martin	Columbia/ now CUNY		2	$264,085	4	$1,400,372	3
Martin	Columbia/ now CUNY		3	$827,667	4	$60,000	5
Martin	Columbia/ now CUNY		2	$230,000	1.5	$150,000	1.5
Mayer Proschel	Rochester	CART	4	$1,445,000	7		
Nedergaard	Univ Rochester	CART	8	$1,000,000	5	$3,000,000	8
Saha	Sloan Kettering	Mentored Scientist	3	$300,000	2	$0	0
Temple	Albany	CART	4	$760,000	3.5	$285,000	1.6
Temple	Albany	CART	4	$1,268,451	4.35		
Temple	Albany	IDEA	2	$360	1.75		
Treisman	NYU Med	IDEA	2	$354,604	1.5	$0	0
Totals				$13,655,056	85.45	$22,722,067	71.2

§ 5. Article VI of the state finance law is amended by adding a new section 99-f to read as follows:

§ 99-f. Spinal cord injury research trust fund.

1. There is hereby established in the joint custody of the state comptroller and the commissioner of taxation and finance a special revenue fund to be known as the "spinal cord injury research trust fund."
2. The fund shall consist of all monies appropriated for its purpose, all monies required by this section or any other provision of law to be paid into or credited to such fund, and monies in an amount not to exceed eight million five hundred thousand dollars collected by the mandatory surcharges imposed pursuant to subdivision one of section eighteen hundred nine of the vehicle and traffic law. Nothing contained herein shall prevent the department of health from receiving grants, gifts or bequests for the purposes of the fund as defined in this section and depositing them into the fund according to law.
3. Monies of the fund, when allocated, shall be available for administrative costs of the spinal cord injury research board established pursuant to title four of article two of the public health law and for funding spinal cord injury research projects administered by such board.
4. Monies shall be payable from the fund on the audit and warrant of the state comptroller on vouchers approved and certified by the commissioner of health.

§ 6. This act shall take effect January 1, 1999.

It is my opinion as well as many of our supporters that the mission of the Board and research program to find a cure for spina cord injury paralysis remains incomplete and leads to greater medical costs associated with these injuries. The Legislature clearly intended to fund this program $8.5M per year based on surcharges from convictions of moving traffic violations. I can assure you that the level of convictions has not precipitously dropped as such infractions occur in the millions within the state annually.

The following only scratches the surface of the many accomplishments achieved by these programs since enacted ten years ago:

- **approved funding for more than $54 million in research awards in NYS--which many recipients have leveraged to bring into NYS many more millions from NIH and private foundations.**
- **the fund has earned over $5.5 million in interest.**
- **created hundreds of good jobs in the medical research field, thereby encouraging new post grads to enter the field of sci research.**
- **creating the Spinal Cord Injury Center of Research Excellence (CORE), which is made up of researchers and support staff at eleven institutions across the state, from New York City to Buffalo.**
- **this program is a high tech job magnet - local institutes are now able to attract excellent spinal cord researchers from other states who want to move here to take advantage of this NYS funding opportunity.**
- **lest we forget that this program provides ""HOPE"" for those paralyzed by a spinal cord injury.**

Christopher Reeve's prediction "that those suffering from sci and I will stand up from our wheelchairs and walk away from them forever" did not come true in time for our great champion, but I still believe in his great dream. When that happens, New York will have been part of that tremendous effort—if we act now to prevent bureaucratic short-sightedness from killing it.

The trust fund revenues from surcharges currently supports the salaries, benefits, travel and supplies for four (4) full time state employees who are assigned to handle administrative duties of this program, it costs New York State TAXPAYERS NOTHING. The SCRIB and SCRIP are long term investments to find a cure for spinal cord injury paralysis thus reducing the taxpayer cost for care on average of $300,000 per year, multiply that by 100 patients = $30,000,000 per year. There are many thousands of such disabled people across the State of New York.

I know that my friend Christopher Reeve would join me in asking you to please, DO NOT SUPPORT the governor's proposals to terminate this one of a kind NYS Spinal Cord Injury Research Board and phase out the Spinal Cord Injury Research Program.

Respectfully submitted,

Paul Richter

Paul Richter

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Common food dye may hold promise in treating spinal cord injury

A common food additive that gives M&Ms and Gatorade their blue tint may offer promise for preventing the additional -- and serious -- secondary damage that immediately follows a traumatic injury to the spinal cord. In an article published online today in the Proceedings of the National Academy of Sciences, researchers report that the compound Brilliant Blue G (BBG) stops the cascade of molecular events that cause secondary damage to the spinal cord in the hours following a spinal cord injury, an injury known to expand the injured area in the spinal cord and permanently worsen the paralysis for patients.

This research builds on landmark laboratory

findings first reported five years ago by researchers at the University of Rochester Medical Center. In the August 2004 cover story of Nature Medicine, scientists detailed how ATP, the vital energy source that keeps our body's cells alive, quickly pours into the area surrounding a spinal cord injury shortly after it occurs, and paradoxically kills off what are otherwise healthy and uninjured cells.

This surprising discovery marked a milestone in establishing how secondary injury occurs in spinal cord patients. It also laid out a potential way to stop secondary spinal injury, by using oxidized ATP, a compound known to block ATP's effects. Rats with damaged spinal cords who received an injection of oxidized ATP were shown to recover much of their limb function, to the point of being able to walk again, ambulating effectively if not gracefully.

Now, scientists detail the clearing of yet another hurdle in moving this research closer from bench to bedside by successfully identifying a compound that could be administered systemically to achieve the same benefit. Previously, the team needed to inject a compound directly into the injured spinal cord area to achieve its results.

"While we achieved great results when oxidized ATP was injected directly into the spinal cord, this method would not be practical for use with spinal cord-injured patients," said lead researcher Maiken Nedergaard, M.D., D.M.Sc., professor of Neurosurgery and director of the Center for Translational Neuromedicine at the University of Rochester Medical Center. "First, no one wants to put a needle into a spinal cord that has just been severely injured, so we knew we needed to find another way to quickly deliver an agent that would stop ATP from killing healthy motor neurons. Second, the compound we initially used, oxidized ATP, cannot be injected into the bloodstream because of its dangerous side effects."

Nedergaard cautions that while this body of work offers a promising new way of treating spinal cord injury, it is still years away from possible application in patients. In addition, any potential treatments would only be helpful to people who have just suffered a spinal cord injury, not for patients whose injury is more than a day old. Just as clot-busting agents can help patients who have had a stroke or heart attack who get to an emergency room within a few hours, so a compound that could stem the damage from ATP might help patients who have had a spinal cord injury and are treated immediately.

Too Much of a Good Thing

While ATP is usually considered to be helpful to our bodies -- after all, it's the main source of energy for all of our body's cells ? Nedergaard was the first to uncover its darker side in the spinal cord. Immediately after a spinal cord injury occurs, ATP surges to the damaged area, at levels hundreds of times higher than normal. It is this glut of ATP that over-stimulates neurons and causes them to die from metabolic stress.

Neurons in the spinal cord are so susceptible to ATP because of a molecule known as "the death receptor." Scientists know that the receptor ? called P2X7 ? plays a role in regulating the deaths of immune cells such as macrophages, but in 2004, Nedergaard's team discovered that P2X7 also is carried in abundance by neurons in the spinal cord. P2X7 allows ATP to latch onto motor neurons and send them the flood of signals that cause their deaths, worsening the spinal cord injury and resulting paralysis.

So the team set its sights on finding a compound that not only would prevent ATP from attaching to P2X7, but could be delivered intravenously. In a fluke, Nedergaard discovered that BBG, a known P2X7R antagonist, is both structurally and functionally equivalent to the commonly used FD&C blue dye No. 1. Approved by the Food and Drug Administration as a food additive in 1982, more than 1 million pounds of this dye are consumed yearly in the U.S.; each day, the average American ingests 16 mgs. of FD&C blue dye No. 1.

"Because BBG is so similar to this commonly used blue food dye, we felt that if it had the same potency in stopping the secondary injury as oxidized ATP, but with none of its side effects, then it might be great potential treatment for cord injury," Nedergaard said.

The team was not disappointed. An intravenous injection of BBG proved to significantly reduce secondary injury in spinal cord-injured rats, who improved to the point of being able to walk, though with a limp. Rats that had not received the BBG solution never regained the ability to walk. There was one side effect: Rats who were injected

with BBG temporarily had a blue tinge to their skin.

Nedergaard's long-time collaborator on this and other projects, chair of the University of Rochester Department of Neurology Steven Goldman, M.D., Ph.D., adds, "We have no effective treatment now for patients who have an acute spinal cord injury. Our hope is that this work will lead to a practical, safe agent that can be given to patients shortly after injury, for the purpose of decreasing the secondary damage that we have to otherwise expect."

Nedergaard and Goldman believe that further laboratory testing will be needed to test the safety of BBG and related agents before human clinical trials could begin. Nonetheless, the investigators are optimistic that with sufficient study, strategies like this could yield new treatments for acute spinal cord injuries within the next several years.

Other authors from the University of Rochester Medical Center include Weiguo Peng, Maria L. Cotrina, Xiaoning Han, Hongmei Yu, Lane Bekar, Livnat Blum, Takahiro Takano, and Guo-Feng Tia.

***

The research was supported by the New York State Spinal Cord Injury program, the Miriam and Sheldon Adelson Medical Research Foundation, and grants from the National Institutes of Health.

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Retired New York trooper pioneers spinal cord injury research

Near fatal gunshot wound left him paralyzed

Retired New York Trooper and AAST Member Paul Richter

On a late-night traffic check in Lake Placid on September 30, 1973, Paul Richter was working as a New York State Police trooper when he was shot in the neck with a .22 caliber gun, leaving him paralyzed from the neck down. He has since dedicated much of his life to spinal cord injury research.

On July 14, 1998, a bill was passed realizing Richter's initiative to establish a spinal cord injury research fund. With its broad grassroots support, including a mass letter-writing campaign across the state, the bill passed unanimously in a brief nine months, becoming the first law of its kind in the nation. Major legislation typically takes three to seven years to get passed.

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Richter literally could have walked away from the devastation of spinal cord injury after regaining the ability to walk with a cane. Today he considers himself lucky.

"I couldn't turn my back on other spinal cord injury victims who aren't as fortunate as me to regain the ability to move and walk," Richter said. "My injury and extensive rehabilitation were for a reason. I can now use my situation to help find a cure."

Christopher Reeve, pictured right with Richter, was among those who helped get the bill passed to establish a spinal cord injury research fund in New York state.

Friends and connections, eventually including the late actor Christopher Reeve, paralyzed after a fall from a horse, provided invaluable support along the way to help get the bill passed, a law which provides $8.5 million a year for spinal cord injury research. The bill passed with no lobbyists – grassroots only.

In 1977 Richter joined the Spinal Cord Society, whose function is to raise money to fund research to find a cure for spinal cord injury paralysis. He is now the New York state chapter coordinator of the group, which is comprised solely of volunteers. Richter also serves on the New York State Spinal Cord Injury Research board and takes a keen interest in the research efforts that his bill makes possible, including the Center of Research Excellence.

Research money is dispensed in the form of grants, requests which are submitted to a review board administered through the New York State Department of Health.

Richter has been recognized many times for his work. On June 3 the Burke Rehabilitation Hospital and Burke Medical Research Institute in White Plains, N.Y., honored Richter as the research recipient of the Burke Award, the highest honor bestowed by Burke and its board of directors. The award is presented to an individual or group for strength in overcoming a disability for the development of science and research regarding disability, and for contributions made to the development of rehabilitation.

Thank you, Paul Richter, for your clear vision and unyielding efforts in this life-changing field.

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Same blue dye in M&Ms linked to reducing spine injury

- Story Highlights
- Researchers find way to reduce secondary damage caused by spinal injuries
- Compound BBG is similar to blue food dye used in sweets, sports drinks
- Only side effect of intravenous injection was that it turned test rats blue
- Researchers are planning to apply to the FDA for permission for human tests

(CNN) -- The same blue food dye found in M&Ms and Gatorade could be used to reduce damage caused by spine injuries, offering a better chance of recovery, according to new research.

Researchers at the University of Rochester Medical Center found that when they injected the compound Brilliant Blue G (BBG) into rats suffering spinal cord injuries, the rodents were able to walk again, albeit with a limp.

The only side effect was that the treated mice temporarily turned blue.

The results of the study, published in the "Proceedings of the National Academy of Sciences," build on research conducted by the same center five years ago.

In August 2004, scientists revealed how Adenosine triphosphate, which is known as ATP and described as the "energy currency of life," surges to the spinal cord soon after injury occurs.

Researchers found that the sudden influx of ATP killed off healthy cells, making the initial injury far worse. But when they injected oxidized ATP into the injury, it was found to block the effect of ATP, allowing the injured rats to recover and walk again.

"While we achieved great results when oxidized ATP was injected directly into the spinal cord, this method would not be practical for use with spinal cord-injured patients," said lead researcher Maiken Nedergaard, professor of Neurosurgery and director of the Center for Translational Neuromedicine at the University of Rochester Medical Center.

"First, no one wants to put a needle into a spinal cord that has just been severely injured, so we knew we needed to find another way to quickly deliver an agent that would stop ATP from killing healthy motor neurons. Second, the compound we initially used, oxidized ATP, cannot be injected into the bloodstream because of its dangerous side effects."

Back in 2004, Nedergaard's team discovered that the spinal cord was rich in a molecule called P2X7, which is also known as "the death receptor" for its ability to allow ATP to latch onto motor neurons and send the signals which eventually kill them.

Nedergaard knew that BBG could thwart the function of P2X7, and its similarity to a blue food dye approved by the Food and Drug Administration (FDA) in 1982 gave her the confidence to test it intravenously.

It worked. The rats given BBG immediately after their injury could walk again with a limp. Those that didn't receive a dose never regained their mobility.

Nedergaard told CNN that there is currently no standard treatment for patients with spinal injury when they reach the hospital emergency room.

"Right now we only treat 15 percent of the patients we receive with steroids and many hospitals question if that even works for that 15 percent; it's a very moderate benefit to only a subset of patients. So right now 85 percent of patients are untreated," she said.

Nedergaard said the research team isn't claiming that BBG can cure spinal injuries, instead that it offers a potential improvement in

patients' condition.

"Even a moderate improvement in functional performance of the patient is a big, big event for these patients," she said. "They can control their bladder. If they can just take small steps instead of sitting in a wheelchair all the time, it's a tremendous benefit for these patients," she added.

The dose must be administered immediately after the injury, before additional tissue dies as a result of the initial injury.

Researchers are currently pulling together an application to be lodged with the FDA to stage the first clinical trials of BBG on human patients.

"Our hope is that this work will lead to a practical, safe agent that can be given to patients shortly after injury, for the purpose of decreasing the secondary damage that we have to otherwise expect," said Steven Goldman, Chair of the University of Rochester Department of Neurology.

Find this article at:
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MICHAEL J. DI SCIPIO
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To: New York State Senate Finance Committee Members
and
New York State Assembly Ways and Means Committee Members

Good afternoon Senators and Assembly persons, my name is Michael Di Scipio and I am a former Albany County Sheriff's Department Corrections Officer currently residing in the Town of Colonie.

I want to thank you for giving me the opportunity to speak before you today about Governor Paterson's executive budget 2010-2011 which proposes to terminate the Spinal Cord Injury Research Board and phase out the Spinal Cord Injury Research Program.

On July 3, 1999, I had a tragic diving accident leaving me paralyzed from the chest down. Since, my life has drastically changed as well as my children's, my loved ones, and my communities. Each and every day is a struggle where I need twenty-four hour care, seven days a week, three-hundred sixty-five days a year. The daily struggles that we go through each and every day I would not wish upon any human being. That is why I have become an advocate and supporter for research in finding a cure for this devastating injury.

The New York State Spinal Cord Injury Research Board / Research Program was signed into law on July 14, 1998 by Governor George Pataki, its mission is to fund cutting edge cure directed research in New York State such as that of distinguished researcher Dr. Sally Temple. Through the hard work and dedication of Paul Richter, Christopher Reeve, Terry O'Neill, and so many others plus the sponsorship by Senator Vincent Leibell and Assemblyman Ed Griffith made this program a reality. This program raises approximately $8.5 million per year through surcharges imposed on motorists that are convicted of moving traffic violations and ***not tax dollars***. It does not contribute towards New York State's budget deficit in any way, shape or form, it is a self sustaining program. This program is so successful that it attracts world renowned researchers and their staffing to New York State.

I believe this funding can ultimately lead to a cure getting tens of thousands of New Yorkers who suffer from paralysis out of our wheelchairs to lead a normal, productive life again.

New York State needs to remain in the forefront and not fall behind with this kind of research that is why this program is so important. I am urging you today ***not to support*** Governor Paterson's budget proposals for terminating / phasing out of the Spinal Cord Injury Research Board / Research Program that will ultimately help lead to the cure we are desperately seeking.

I again thank you for this opportunity to speak here today and know that you will do the right thing.

Respectfully submitted,

/S/ Michael J. Di Scipio

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DEPARTMENT OF BIOMEDICAL GENETICS

Mark Noble, Ph.D.
Professor of Genetics, Neurology, Neurobiology and Anatomy
Director, University of Rochester Stem Cell and Regenerative Medicine Institute
Co-Director, NYS Center for Research Excellence in Spinal Cord Injury

March 3, 2010

Re: Reasons for maintaining the New York State Spinal Cord Injury Research Program (SCIRP)

The economic argument for maintaining SCIRP funding is a very strong one. This funding creates jobs, and it creates good jobs. The average grant award creates 5 or more job slots. People employed on these grants are trained for high tech jobs, and add to the skilled labor force we need to build both academic and corporate science in New York.

SCIRP funding actually brings money into New York State, and brings prestige to the state. SCIRP funding has enabled New York State researchers to attract millions of dollars in funds from the US government, from private foundations and from donors. It attracts scientists to New York to work, and these scientists also bring in external funding. Discoveries supported by SCIRP frequently are covered in newspapers around the world. Moreover, this program has enabled us to integrate the work of laboratories across the country in an effort headed here in New York State.

This funding aids biotechnology development. I am fortunate to be a founding member of the scientific advisory board of Acorda Therapeutics, one of a small number of New York State biotechnology companies with an FDA-approved drug, 4-aminopyridine. SCIRP funding to Acorda has been critical in supporting discoveries now in the developmental pipeline.

SCIRP funding also has enabled us to take people off the medical rolls and get them back to work. People like Nancy Lieberman. Nancy is a highly respected mergers specialist and acquisition/corporate law partner at Skadden Arps, one the country's largest law firms. When I met Nancy, she was in one of our New York City hospitals because of cervical spinal cord injuries. She had no use of her legs and arm movement limited literally to inches. Her doctor told her that this was all she ever would have. I told her this was wrong. She started taking 4-aminopyridine and it helped relieve her pain. She enrolled in the SCIRP-funded robotic programs at the Burke Neuromedicine Institute. And Nancy is back at work. She is creating mergers, helping businesses, earning income and paying taxes – instead of being a full-time source of medical costs.

This funding has enabled remarkable accomplishments. One of the most promising cell-based therapies for spinal cord injury was developed by our laboratories at the University of Rochester with SCIRP funding. Pharmacological agents have been discovered that greatly reduce the severity of injury, with others that may promote recovery of function after injury. The robotics therapies programs developed with SCIRP funding are revolutionizing our ideas about restoration of function. Just in the Center of Research Excellence directed by Dr. Rajiv Ratan and myself, we have set the table to attract millions of dollars in federal funding to New York; trained more than 40 young graduate students and Ph.D. post-doctoral fellows; and filed a dozen new patent applications on drugs and other therapies that can move rapidly to clinical testing and which provide a foundation for still more biotechnology development.

The ability to move people off medical care and make them productive members of society is one of the most effective means of reducing health care costs – and it is SCIRP funding that has played a major role in enabling us to begin this very process.

These are all important investments for New York State – and none of this comes out of tax dollars. The surcharges on moving violations were put in place with a law that mandates this program. .

Given the moral, legal and financial mandates of SCIRP funding for people in New York State, we can see no tenable argument to eliminate this support.

Finally, consider Paul Richter, and other officers and soldiers who can't walk because they literally took a bullet for our citizens. Walking away from them cannot be the right answer.

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March 3, 2010

Statement by Nancy A. Lieberman, Attorney and Spinal Cord Injury Quadriplegic, Regarding Funding of Spinal Cord Injury Research Board

I. Introduction

Imagine not being able to pick up a glass of water, not being able to dial 911 in an emergency, not being able to hold a pen and write, not being able to get dressed by yourself, or not being able to feed yourself! The list goes on and on--this is the world I and many other New Yorkers live in due to our paralysis.

Christmas Eve Day 2007--it was the first morning of the first day of the first vacation I had in nearly 2 years. The sky was a crisp and clear blue and the snow sparkled in the sunlight -- and - - I had a freak accident after skiing for 39 years, losing my balance, hitting a tree and hearing my neck snap. In a few split seconds I went from being an athletic 50 year old wife and mom of a 7-year-old boy who was a senior partner at a major New York law firm, practicing corporate law, to a paralyzed victim screaming for help given my plight.

From the moment I regained consciousness, one of my first thoughts was how do I get my life back? For the next 6 months I lived in 2 different hospitals, endured multiple surgeries, and received traditional physical therapy and occupational therapy. My doctors did an exemplary job in helping me to regain my general health--I could breathe without choking and I could sit in a wheelchair without my blood pressure dropping precipitously low. But, the traditional physical therapy and occupational therapy unfortunately did not do much for me -- -- there were few things that I could pick up and hold and my arm strength was minimal (really nil).

II. Results of the Research Funded by the Spinal Cord Injury Research Board (SCIRB)---My Experience

Rehabilitation doctors typically tell patients that they are likely to regain (if at all) the most use of arms and legs within the first 6 months of their injury, although substantial progress can also occur up to one year after the injury. In my case, virtually nothing came back in the first 6 months. My arms were bent in a fetal-like position, the right arm being the worst of the two. In fact, I had to have major surgery on my right arm in order to untwist my elbow and wrist.

Fortunately, Dr. Mark Noble of the University of Rochester Medical Center introduced me to Dr. Raj Ratan of the Burke Rehabilitation Institute who determined that I qualified to participate in their robotics program. This program receives substantial funding from the SCIRB research trust funds and is a true example of what its dollars can do for paralyzed people like me. I have now received robot training on both of my wrists as well as my upper arms and shoulders. There is a stunning, positive change in the strength and mobility of my arms after use of these robots. Please note that I began using these robots approximately one year after my injury and I am still using them now more than 2 years after my injury. Accordingly, the conventional wisdom noted in the prior paragraph is NOT TRUE-- with the new technology and intellectual

property developed as a direct result of SCIRB, a therapy has been developed at the Burke Rehabilitation Institute which enables spinal cord patients like myself to regain the use and strength of their arms in a way never thought to be possible. I am living proof of this.

What does this mean? It means that I have been able to go back to work at my law firm and function as a productive member of society. Because I am now able to fully work, I am able to earn a good living and gladly pay taxes to New York State. Imagine now what this would mean to the thousands of New Yorkers unhappily stuck living in nursing homes as well as to New York State which spends many millions of dollars a year on Medicaid to support these people. Perhaps many of those in nursing homes could return and become productive salary earning New Yorkers, no longer receiving such government aid, and living happier lives.

On a more detailed level, since participating in the Burke robotics program, I am now able to do the following which are really significant to the day-to-day functioning of a lawyer: flip the pages of a contract, answer my telephone at work, dial in to a conference call with my clients, flip the pages of the New York corporation law statute, turn a knob and push open the door of a conference room, pull open the drawer of my desk at work, lift a pile of papers on my desk, pick up a glass of water and drink while in a meeting (instead of being miserable because I am afraid of dropping the glass and embarrassing myself in front of my colleagues).

Please note that I have not mentioned a renewed ability to write and that is because I have not yet been able to use a hand robot. I can write using a very painful plastic device crafted by a traditional occupational therapist. If SCIRB funding is eliminated, my fear is that the Burke robotics program for paralyzed people like myself could be eliminated and I will not be able to use a hand robot and hopefully write naturally without using a painful device. I personally worry that my profound and tremendous progress will come to a grinding halt.

Additionally, I would like to briefly mention the significance of the SCIRB funding to Dr. Mark Noble's work at the University of Rochester Medical Center. A mutual friend asked Dr. Noble to visit me while I was still in the hospital. He described the stem cell research he and his team were working on, which I later learned received funding from the SCIRB research trust fund. Although not versed in science, I clearly understood the significance of Dr. Noble and his team's work when a friend happened to send me an article published by an MIT magazine (thankfully written in plain English) that summarized a scholarly article published by Dr. Noble's team. Unbelievably, they have used certain stem cells to enable rats with severed spinal cords to develop new nerve cells and eventually walk again! Our own New York State researchers are literally ushering in a new golden age of scientific discovery which has received substantial underwriting from the SCIRB research trust fund.

One major problem I have noted in my cross country search for therapies is that most seemingly cutting-edge research facilities dealing with spinal cord research and patient therapy are astoundingly unaware of the research and therapies produced at other facilities. Conversely, the nature of the SCIRB funding process has uniquely fostered a collaborative atmosphere. New York State researchers are open with each other, share their intellectual capital, and work together to integrate their various therapies in a manner that speeds delivery of real and functional therapy from the laboratory to the patient. My experiences and conversations with Dr. Noble, Drs. Proschel (two Rochester researchers with the same last name), Dr. Ratan, Dr.Volpe

(of Burke), Dr. Edwards (of Burke) and Dr. Cortes (of Burke) make it abundantly clear that their collaborative efforts have borne fruit (in the robotics program) and will continue to bear fruit (in future robotics and stem cell research).

III. The Statute Creating the Spinal Cord Injury Research Board and the Spinal Cord Injury Research Trust Fund

As an attorney trained to read and interpret statutes, I was impressed by the clarity of the statutory provisions creating the SCIRB and its related research trust fund. Many times, laws may be drafted in an ambiguous manner, or, unfortunately, there are contradictory and confusing provisions. Here, the draftsman is to be complemented for the simple, direct and easy to understand text of this law.

There are 2 core provisions of the law that must be considered. First, the provisions which define what actually constitute research trust funds. In relevant part, it states "The fund ***shall*** consist of..... all monies ***required*** by this section or any other provision of law to be paid into or credited to such fund and monies in an amount not to exceed $8,500,000 collected by the ***mandatory*** surcharges imposed pursuant to....the vehicle and traffic law." Second, the provision which states, "***Notwithstanding any inconsistent provisions of law to the contrary***, effective April 1, 1999, an amount not to exceed $8,500,000 ***shall*** be annually transferred from the general fund out of the ***mandatory*** surcharges collected pursuant to...the vehicle and traffic law to the spinal cord injury research trust fund held by the state comptroller pursuant to...the state finance law which monies ***shall*** then be deposited to the credit of the spinal cord injury research trust fund pursuant to...the state finance law."

When read together, both sections appear to unequivocally indicate that the Spinal Cord Injury Research Trust Fund shall annually be funded by mandatory speeding ticket surcharges (which are not taxes) in an amount not to exceed $8,500,000. The statute speaks in terms of "shall" fund not "may" fund, "mandatory surcharges" not "discretionary surcharges." Funding for continued spinal cord injury research under this law should be automatic based on its plain language. It would seem to me that the statute creates a system in which the State collects surcharges when speeding tickets are issued and these funds are to go directly to spinal cord research as directed by the SCIRB. The fact that surcharges are monies and taxes are monies does not mean that a surcharge is a tax, which can be diverted to fund the general state budget; they are two different "animals" that should not be confused. Or, to state it another way, cats and dogs are both animals but they aren't the same thing and should not be treated indistinguishably.

IV. Closing

I am grateful for the opportunity to have shared with you my personal story, the tangible benefits that have resulted for me due to the Spinal Cord Injury Research Trust Fund, and my interpretation of the law under consideration. If I can be of any assistance to you or you have any questions to ask me, please feel free to call me during working hours at 212-735-2050 or on my cell phone at 917-862-2500. Thank you very much.

Testimony, NYS Senate
Thursday, March 3 2011
New York State Spinal Cord Injury Research Program (SCIRP)

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I thank Senator DeFrancisco and Assemblyman Farrell for the opportunity to speak today.

My name is Natalia Lowry, I am with the New York Neural Stem Cell Institute, an independent non-profit research center focused on regenerative therapies for nervous system repair, including spinal cord injury.

Spinal cord injury is a complex medical problem; it is more complex than putting a man on the moon. It is the challenge of this century. It can't be done by one discipline; we need to bring together the most creative people in different fields - stem cell researchers, electric and chemical engineers, robotics experts and clinicians - to solve this multi-faceted problem.

The SCIRP is unique in funding inter-disciplinary projects and as a result, it is achieving highly creative solutions. If this program is eliminated it will turn back a decade of hard work and investment that NYS has made to become a world leader in biomedical and nanoscience research. SCIRP has put NYS on the map for spinal cord injury research; we don't want to lose this strong strategic position.

The success of SCIRP has made it an effective investment – this money is largely spent locally, boosting the NYS economy, and it has generated a substantial return in out-of-state dollars. For example, Dr Joseph Francis from SUNY Downstate medical center received $650,000 in SCIRP grants and used these to develop a successful 12.8 million dollar DARPA (Defense Advanced Research Projects Agency) contract.

The SCIRP program has led to hundreds of high tech research jobs and is a magnet that brings researchers into the state. It has generated numerous patents that are being developed towards therapies for spinal cord injured patients. SCIRP funding feeds local biotech. And just as the space program produced unexpected benefits, we see the same from SCIRP. For example, Acorda Therapeutics, a Hawthorn NY company founded to cure spinal cord injury received SCIRP funding. Last January they received FDA approval for Ampyra for multiple sclerosis patients, estimated to be a $1 billion per year drug. If the SCIRP is terminated, this valuable pipeline stretching from research to biotech will dry up.

For our work, SCIRP funding helped us establish a research institute in Rensselaer NY, where now 40 scientists are working to find high-tech solutions to nervous system repair. It has funded creative work that helped Dr. Sally Temple, our Scientific Director; achieve the recognition of a MacArthur award in 2008, which brings national attention to our work and to NYS biomedical research. It enabled us and Rensselaer Polytechnic Institute scientists to discover a nanodelivered candidate drug for spinal cord injury. Now we need to complete laboratory studies to move this promising finding towards human clinical trials, and without SCIRP we don't know if we will be able to do it. The rocket won't get off the launching pad.

Current treatments for spinal cord injury are 20 years old. Research is needed to create revolutionary new therapies. Over the past few years there have been huge technological advances. You see these every day in the computing technologies that have advanced all aspects of our lives. That same level of technological breakthrough has occurred in the medical research world. We are in the best position we have ever been in to produce new therapies for spinal cord injured patients. Yet to do this, we need investment in research.

On behalf of the community of spinal cord injury researchers, I urge you to ensure that surcharge revenue that this Legislature directed by its 1998 enactment creating SCIRP be appropriated **as the law requires** to the Spinal Cord Injury Research Fund, to ensure that this unique, valuable, nationally respected and sorely needed research program moves forward as it has for over twelve years now.

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Testimony on the SFY 2011-12 *Executive Budget*

Health/Medicaid

March 3, 2011

Presented by
Kate Breslin, President and CEO
Schuyler Center for Analysis and Advocacy

for Analysis and Advocacy

Shaping New York State public policy
for people in need since 1872

Testimony for the Joint Legislative Budget Hearing
Health/Medicaid
March 3, 2011

Presented by
Kate Breslin, President and CEO
Schuyler Center for Analysis and Advocacy

Introduction

My name is Kate Breslin and I am President and CEO of the Schuyler Center for Analysis and Advocacy (SCAA). Since 1872, the Schuyler Center has served as a voice for social and economic justice and policies that work for children, people living in poverty, and persons who are chronically ill and disabled in New York State. We take part in a number of coalitions and serve on the Steering Committees of Medicaid Matters New York and Health Care for All New York.

Thank you for this opportunity to testify.

Overview

Especially in this challenging fiscal environment, the essence of everything that we do with health care should aim for fundamental structural improvements in the manner in which health services are delivered to New Yorkers, whether the payer is New York State or another payer. If effectively organized and appropriately provided in a timely manner—the right setting at the right time and the right price—health care services can be more accessible, of better quality, and more cost effective for everyone. Our system must ensure that the most vulnerable people in our state are protected ***and*** that the system is sustainable over the long-term.

The state has several roles and responsibilities in this endeavor—regulator, planner, policy setter, payer, and capital investor.

SCAA is still working to understand the implications of the proposals approved by the Medicaid Redesign Team (MRT) last week. Our comments below reflect our understanding of the intent of certain proposals and our analysis of potential implications.

The Good

SCAA applauds the Governor and Medicaid Director for initiating a conversation about how to make Medicaid, and ultimately New York's entire health care system, work better. Done thoughtfully, Medicaid redesign is an opportunity to change and improve the whole system, since improvements to Medicaid have the potential to bring improvements to our entire health care delivery system and vice versa. This endeavor needs to always consider New York's most vulnerable residents and must aim, not just to solve short term problems, but build the health care delivery system that will most effectively and efficiently meet the needs of New Yorkers in the future.

Despite the budget deficit and the limited time available to develop a budget proposal, the *Executive Budget* does not propose across the board cuts to Medicaid. Across the board reductions tend to hurt the most vulnerable safety net providers, programs, and communities the hardest. Further, neither the *Executive Budget* nor the MRT moved forward with wholesale elimination of so-called "optional" benefits, which also would tend to hurt the most vulnerable. And, while other states have sought to reduce Medicaid rolls, New York's proposals do not seek to eliminate whole categories of very needy people from essential health care services through Medicaid.

There are several components of the MRT recommendations that we support in concept. These include:

Establishment of a Public Health Service Corps. There is widespread recognition that there is a shortage of various types of medical providers in underserved communities across New York State. The Corps, as described, together with a fully funded and better functioning Doctors Across New York program, could help alleviate the shortages. It will be essential to engage in planning for immediate, medium-term and long-term needs.

Expand Patient-Centered Medical Homes. Evidence shows that medical homes can yield better patient health outcomes and lower costs by ensuring provision of timely and appropriate primary and preventive health care, and, in turn, reducing expensive emergency room visits and avoidable hospitalizations. Safety net providers need up-front investment and ongoing support, as well as regulatory reform, to implement the medical home model in a comprehensive way.

Implement Health Homes for high cost, high need enrollees. New York has an opportunity to draw down enhanced federal funding that will support health homes that aim to improve coordination, care and outcomes for high need patients.

Develop an automated exchange/Medicaid eligibility system. This proposal aims to improve efficiency in the Medicaid and Child Health Plus eligibility process and ultimately build in the Health Insurance Exchange required in health care reform. It would develop a vertically integrated insurance eligibility system for Medicaid and Child Health Plus and the Exchange. In the context of federal health care reform, New York State must create a Health Insurance Exchange and has received an Early Innovator Grant to help design and implement the information technology (IT) infrastructure needed to operate that Exchange.

Enrollment and retention simplification. This proposal would implement several initiatives designed to increase enrollment and retention in Medicaid, Child Health Plus and Family Health Plus—renewal for two-year periods, targeted outreach via phone or electronically, eliminating the need to present certain original documents. This will help to reduce churning and administrative costs and keep eligible people covered.

SCAA also supports efforts to revise rates to improve the delivery of culturally competent care and address racial and ethnic disparities in care and outcomes; improve housing access to improve health; maximize access to peer services; create a dedicated Office of Primary Care; expand the Family Planning Benefits Program, and increase coverage of tobacco cessation.

Areas of Concern

First we would like to comment on the composition and process of the MRT. The composition of the MRT was disappointing in that it included no Medicaid consumers and only one community- and consumer-oriented voice. Medicaid Redesign was described on the Governor's website as open process that encouraged and facilitated the public's involvement. And many did participate—presenting testimony at the public hearings and submitting comments electronically. The ambitious public process was intended to elicit thoughtful recommendations and comments from communities around the state. Yet, most MRT members did not attend these public hearings. Less than 24 hours before the final meeting, MRT members received a 240-page document including about 50 recommendations calculated to shave billions of dollars from the Medicaid program. It is difficult to comprehend how any member could have thoroughly understood what they were asked to vote on when the question was unexpectedly called at the meeting.

As mentioned earlier, SCAA is still working to understand the implications of the proposals approved by the MRT last week. Our comments below reflect our understanding of the intent of certain proposals and our analysis of potential implications. Below are areas of concern.

The *Executive Budget* eliminates funding ($392,000) for the Center for Health Workforce Studies. Several of the MRT proposals note shortages of professionals—primary care providers, practitioners trained in palliative care, the need for mental health practitioners—yet at the same time, the *Executive Budget* eliminates funding for the state-funded entity that engages in health workforce analysis, the Center for Health Workforce Studies. This cut jeopardizes the remainder of their foundation and institutional support and it is unclear if the program will survive. The loss of funding will drastically reduce the state's ability to understand a critical component of health care at the same time a massive redesign of the Medicaid system is being proposed. Several of the major proposals being advanced necessitate the need for information about the health care workforce in order for effective planning and implementation. These include the creation of the patient-centered primary care initiative and accountable care organizations, expanding the scope of practice for some mid-level professionals and development of a Public Health Service Corps. We respectfully request restoration of this funding.

Rejection of the proposal to improve accountability of the Bad Debt and Charity Care Pool. One of the proposals initially under consideration by the MRT would have improved accountability for funds in the hospital indigent care pool. The pool should aim to cover losses incurred when providers care for uninsured patients to make sure that anyone who needs care can get it. The current methodology for this pool is not based on actual costs of providing care for uninsured patients. This reform-minded proposal was removed from the list in the final days. This is real money that should be spent in the most effective way possible.

Reduce fee-for-service dental payments. Access to high-quality dental care is already a problem, due in part to low reimbursement rates for dentists in the Medicaid program. The difficulties Medicaid patients experience in finding providers for dental services will only worsen if payments are further reduced. Even though the rate on children's procedures is left untouched by this proposal, there will be fewer dentists who take Medicaid and a dearth of

dentists to provide services to children. A January 2011 report "Active Dentists in New York" by the Center for Health Workforce Studies at SUNY Albany found that "A majority of New York dentists (54%) do not treat Medicaid patients."

Increase co-payment amounts for Medicaid Fee-for-Service and Family Health Plus; require copayments for Child Health Plus. New York's public health insurance programs are designed to serve low-income and vulnerable populations and must remain affordable to low-income New Yorkers. Research suggests that cost sharing may inhibit enrollees from seeking necessary and cost-effective preventive and other care.

Global Cap on Medicaid expenditures. One of the late additions to the MRT recommendations was a commitment to limiting total Medicaid spending to no greater than 4% of annual growth, including a 2% across the board reduction on reimbursement. We are concerned about a hard cap on Medicaid expenditures and reiterate our concerns that across the board reductions tend to hurt the most vulnerable safety net providers, programs, and communities the hardest.

Ensure that every Medicaid member is enrolled in care management. Improved access, better coordination, and continuity of care are important goals. This proposal would, over three years, expand managed care enrollment to our most vulnerable populations, including disabled children and children in foster care. Moving a vulnerable child or other individual to managed care does not guarantee improved coordination of care and can, in fact, bring new problems. Extreme care and consideration must go into every detail of this proposal and an essential component must be active consumer engagement in planning, implementation and ongoing monitoring.

The Future

If we don't change how we plan for improving care delivery, we will never have a system that produces better outcomes or cost savings. As we move forward with health care reform, New York must increase its access to effective primary health care, community-based health care, mental health care, and home-based care. Children's mental health care and early intervention must be prioritized. If New York wants to control costs, we need to plan for and build the right health care infrastructure—coordinating workforce and education; payment mechanisms; capital/bricks and mortar to ultimately improve access to the most effective types of care, particularly when the alternatives are overuse of emergency care and costly specialists.

The Schuyler Center for Analysis and Advocacy urges policymakers to consider proposals with a long-range plan in mind and make strategic decisions designed to strengthen the system and reject proposals that simply weaken the system and the people who it is supposed to help. SCAA requests that policymakers measure their vision for a stronger, better, more effective system against the following questions.

Are the most vulnerable and needy patients protected?

Are we supporting and planning for the training, education and systems of payment to ensure that we have the right health care workers to care for New Yorkers now and in the future?

Are public expenditures accountable and transparent and is the data available to communities? A good system—one that encourages, facilitates and results in desired outcomes—should be understandable to those involved in administering, implementing and benefitting from the policy. Public funds should be distributed based on real need, real services provided and real costs.

Are the correct planning and regulatory incentives in place to build the systems of care for the future? Regulatory, administrative, and financing processes should be streamlined and improved for the types of facilities, organizations and professions that New York's residents need not only now, but ten years from now and beyond. This includes making it easier and faster for certain facilities and professions to be licensed, registered and certified to provide the types of care that are most needed and effective.

In addition, New York's planning and regulatory functions must become better integrated with decisions about Medicaid financing. When a hospital goes to the newly created Public Health and Health Planning Council (PHHPC) with a plan to double the capacity of its emergency room, shouldn't the PHHPC and DOH staff inquire as to whether there has been a doubling in the number of emergencies in the area or whether there is some other reason that the hospital must expand—insufficient access to high quality primary care, a lack of coordinated care management for persons with psychiatric disabilities, or some other answer?

Does the system facilitate and reward collaboration that ensures that the needs of the most vulnerable and highest cost patients are met?

Do managed care contracts ensure accountability and establish incentives that ensure the best possible care and coordination for the hardest to serve?

Is there rational program integrity that does not compromise the safety net or demonize consumers?

How is the system set up so that local communities have a role in assessing and planning for their own health care infrastructure needs?

The Centers for Medicare and Medicaid Services (CMS) aspires to the "Triple Aim"—better care for individuals, better health for populations and lower per capita costs without harm to patients. At the heart of this is integrated care that meets the patient and their family where and how it works best for them. We need to force a Copernican Revolution of sorts—a system of people and payments and infrastructure that puts the patient, the consumer, at the center, with everything else working fluidly in an integrated fashion around them. It doesn't need to cost more; it does need to be thoughtfully and holistically organized and responsive.

Thank you. We appreciate the opportunity to testify and look forward to continuing to work with you to build a strong New York that cares for its most vulnerable residents.

Kate Breslin
President and CEO
Schuyler Center for Analysis and Advocacy
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CONNECTING STUDENTS TO CAREERS, PROFESSIONALS

TO COMMUNITIES, AND COMMUNITIES TO BETTER HEALTH.

Testimony

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

March 3, 2011

By

Mary J. Sienkiewicz, MBA
Director
New York State
Area Health Education Center System

Mary Mitchell, MPA
Executive Director
Manhattan-Staten Island
Area Health Education Center

My name is Mary Sienkiewicz. I am the Director for the New York State Area Health Education Center (AHEC) System. I am here with Mary Mitchell, Executive Director, Manhattan-State Island AHEC.

Thank you for the opportunity to provide testimony on the value of the State of New York's longstanding partnership with the New York State AHEC System. **We are here today to respectfully request level funding of $2.5 million (restoration of a $300,000 cut as proposed in the FY 2011-12 Executive Budget) in order to sustain a successful statewide, community-based AHEC infrastructure to implement statewide health workforce priorities.**

As citizens, we understand that New York State is in crisis. As stewards of public funds, we also understand the value of the New York State AHEC System. Our community-based health workforce programs result in the sons and daughters of New Yorkers becoming health professionals at hospitals, clinics and private practices and providing care to residents in underserved rural and urban areas.

Through nine community-based centers, the New York State AHEC System sustained record levels of outreach last year, training nearly 41,000 students (K-12 and post-secondary students; medical, nursing and other health professions students; and health professionals of all disciplines) throughout the state. AHEC strategies increase the number of students from underserved areas and underrepresented and disadvantaged backgrounds who enter health careers. Research shows that these students are more likely to choose primary care and practice in their community of origin or similar communities.

The New York State AHEC System's multifaceted recruitment, training and retention strategies are solutions to current health workforce shortages and the New York State Department of Labor forecasts that health care sector jobs will grow at rates more than five times that of all other occupations.

The $2.5 million in state funding to the New York State AHEC System this year will purchase a $7.2 million workforce development initiative (through leveraged federal, local, community and private foundation funding) invested in training programs and services resulting in better jobs and better health care for New Yorkers in medically underserved communities. Federal funds are only available to AHEC if they are leveraged with matching state and community funds.

Each year, the New York State AHEC System works with over 1,000 partners (academic institutions, elementary/secondary schools, hospitals, health care systems and clinics, and community organizations, government agencies and businesses), making all of New York State a campus.

The Manhattan-Staten Island AHEC is proud to be a member of the New York State AHEC System; a system that is developing the health care workforce that is critical to improved health care access and economic development in underserved communities across the state; a system that increases diversity and distribution of health care professionals where they are needed most.

In New York City, the Manhattan-Staten Island Area Health Education Center represents a pipeline that works. The MSI AHEC conducts a broad range of health profession education and exposure programs targeting minority youth from middle school through the collegiate level, and beyond. MSI AHEC has established credibility and leadership in developing strategic collaborations with

community health centers, health related organizations, academic institutions and health professions schools to deliver effective programs.

We know that MSI AHEC has positively impacted the lives of more than 600 students in the short time of its existence, through its cadre of high quality health career exposure programs. All of these students were either underrepresented minority, educationally disadvantaged, or first generation college attendees. Many of our former students are currently enrolled in college or health professions school. Others are already working as health care providers in underserved communities in the MSI area. For example, Elisha Medina-Gallagher, a Summer Health Internship Program (SHIP) 2005 Alumni, is a MSI AHEC Board member, and works as the Fellowship and Faculty Development Coordinator in the Brookdale Department of Geriatrics and Palliative Medicine of the Hertzberg Palliative Care Institute at The Mount Sinai School of Medicine. Danah Wilkins began her medical career path in the MSI AHEC SHIP of 2008 when she was a junior, and again as a senior in high school. She then participated in the College Admissions Guidance Program and MedPrep Program for which MSI AHEC has the primary recruitment responsibility. Danah is now a pre-med student attending college. Participants like Elisha and Dana report that early exposure through their participation in AHEC programs prepared them for success as a health professional.

Further, the NY Metro AHECs are engaged in the delivery of a Community Health Experience Program for 2nd year medical students. This successful collaboration with the New York College of Osteopathic Medicine (NYCOM) has operated over the past 5 years. NYCOM students who participated in this program have indicated that they have chosen to pursue primary care directly as a result of the exposure to medically underserved areas received in this program. Beatrice Desir, a 2010 participant of this program is now a 3rd year medical student on her way to becoming an OB/GYN physician in a health profession shortage area of NYC.

The strength of MSI AHEC programs was most recently acknowledged by the National AHEC Organization through the award of a $100,000 nationally competitive contract funded by the Health Resources Services Administration to implement a Collegiate Heath Service Corps which focuses on preparing undergraduate students to become primary care providers in medically underserved areas. Leveraging these kinds of funds is only possible through continued NYS funding.

The New York State AHEC System has demonstrated success in developing the state's health workforce. We respectfully request level funding of $2.5 million to sustain a successful statewide, community-based AHEC infrastructure to implement health workforce priorities.

In closing, it simply comes down to this:

If you are supportive of the economic strength of New York's health care sector employment, then, you must be supportive of the New York State AHEC System.

If you are concerned about a culturally competent primary care workforce, reflective of the communities it serves, then, you must be concerned about the New York State AHEC System.

If you are committed to improved health outcomes for the constituents you represent, then, you must be committed to the New York State AHEC System.

Thank you for this opportunity today and your continuing support.

A NEW YORK STATE AHEC SYSTEM SPECIAL REPORT

ahecfocus on:

NYS Area Health Education Center System

2011-12 Funding Request to New York State
$2.5 million

As citizens, we understand that New York State is in crisis. As stewards of public funds, we also understand the value of the New York State Area Health Education Center (AHEC) System. Our community-based health workforce programs result in the sons and daughters of New Yorkers becoming health professionals at hospitals, clinics and private practices and providing care to residents in underserved areas across the state.

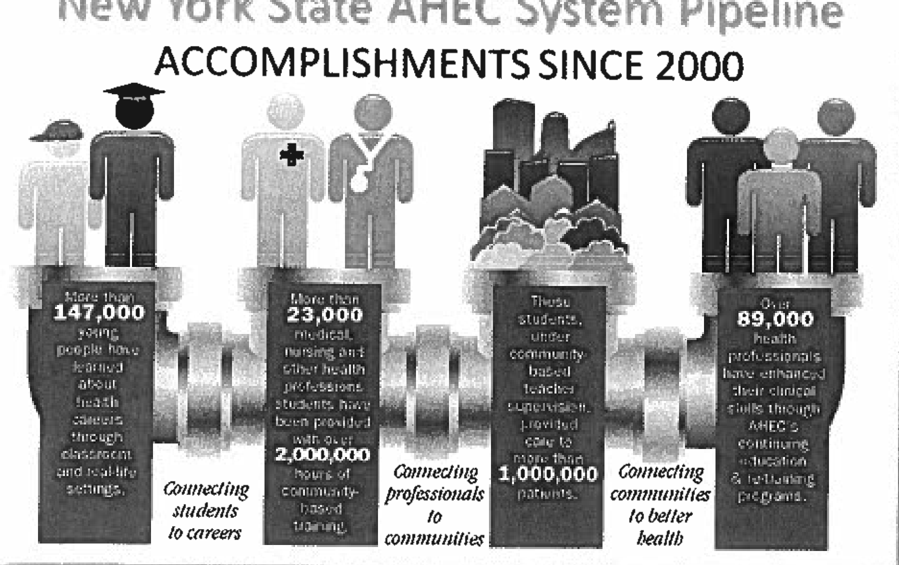
The New York State AHEC System builds skills and fills jobs through creation of a more diverse health workforce that contributes to local economies in rural and urban areas in New York State. AHECs assure that each community has enough practitioners in the right categories, particularly in primary care to improve access and quality. **AHEC strategies keep skills and talents in the state, promoting economic recovery and sustainability while improving the well-being of all New Yorkers.**

Community-based AHECs build partnerships between the health workforce supply side (secondary and post-secondary schools) and demand side (health care employers and communities). AHEC's goal is to train health care providers who live in underserved communities to provide care where they live. They have insight to improve the health of New Yorkers while also contributing to the economic health of urban and rural communities in the state.

The New York State AHEC System's multifaceted recruitment, training and retention strategies are solutions to current health workforce shortages and New York State Department of Labor forecasts that health care sector jobs will grow at rates more than five times that of all other occupations.

New York State AHEC System health workforce recruitment, training and retention strategies via nine community-based AHECs:

- ►Develop clinical training opportunities for future health professionals in medically underserved areas; recruit faculty committed to working with them
- ►Encourage young people, especially from underrepresented and disadvantaged backgrounds, to pursue health careers
- ►Provide continuing education and professional support to practitioners, develop career ladders and promote workforce re-entry programs



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"Connecting students to careers, professionals to communities, and communities to better health."

The State of New York's longstanding partnership in the New York State AHEC System's work is a fiscally sound investment in the State's present and future.

The New York State AHEC System provides results that impact the health of New Yorkers and the economy of New York. Federal funds are only available to AHEC if they are leveraged with matching state and community funds.

The $20 million in state funding to the New York State AHEC System since 2000 purchased a $74 million workforce development initiative (through leveraged federal, local, community and private foundation funding) invested in training programs, services and jobs in medically underserved rural and urban communities.

The New York State AHEC System sustained record levels of outreach last year, training nearly 41,000 students throughout the state.

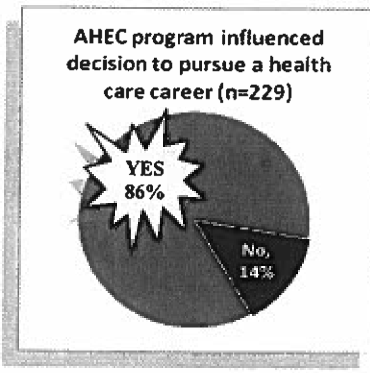
►Nearly 1,900 medical, nursing and other health professions students were provided with community-based training in rural and urban sites.
►Nearly 16,000 health professionals attended continuing education, distance learning and web-based programs.
►Nearly 23,000 K-12 and post-secondary students learned about health careers through classroom and real-life settings, with a greater emphasis placed on multi-contact, sequential learning opportunities.

Making all of New York State a Campus

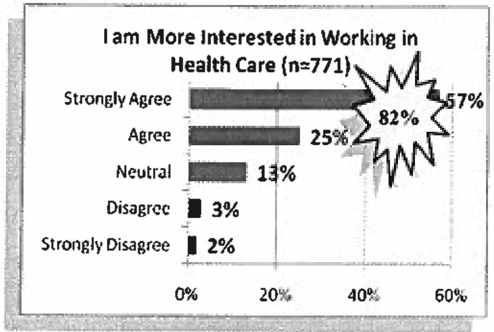
Each year, the New York State AHEC System works with over 1,000 partners (academic institutions, elementary and secondary schools, hospitals/health care systems, and community organizations, government agencies, businesses and professional organizations) to support training, pipeline and/or continuing education and re-training programs.

New York State AHEC System Outcomes

AHECs across New York State have success stories about young people working as nurses, therapists, social workers and doctors in underserved areas.



Students indicate that their participation in an AHEC program influenced their decision to pursue a health care career.



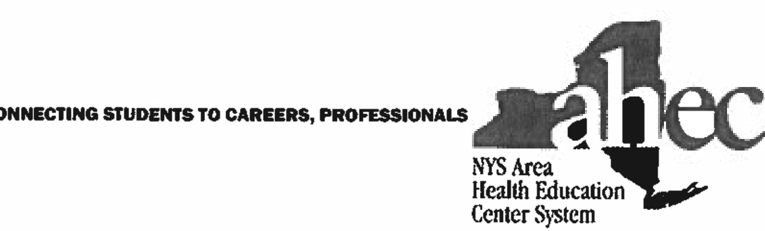
Adults whose jobs have been eliminated, or who need new skills to keep pace with advancing technologies, or are simply seeking a new career, have benefited from AHEC workforce training and retraining programs.

Health professions students in AHEC's SEARCH (Student/Resident Experiences and Rotations in Community Health) Program indicating probability of practicing in New York State, practicing in an underserved area, and practicing in a rural area increased from pre to post community clinical experience/rotation. Nearly all students agreed or strongly agreed that "Based on this experience I am now considering working in a medically underserved area."

02-21-11

Mission: "To enhance access to quality health care and improve health care outcomes by addressing the health workforce needs of medically disadvantaged communities and populations through partnerships between the institutions that train health professionals and the communities that need them most"

New York State AHEC System Statewide Office, UB Family Medicine, Inc., 462 Grider St., Buffalo, NY 14215
www.buffalo.ahec.edu



TO COMMUNITIES, AND COMMUNITIES TO BETTER HEALTH.

New York State AHEC System
2011-12 Funding Request to New York State
$2.5 million

1) As citizens, we understand that New York State is in crisis. As stewards of public funds, we also understand the value of the New York State Area Health Education Center (AHEC) System. Our community-based health workforce programs result in the sons and daughters of New Yorkers becoming health professionals at hospitals, clinics and private practices and providing care to residents in underserved areas across the state.

2) The New York State AHEC System sustained record levels of outreach last year, training nearly 41,000 students (K-12 and post-secondary students; medical, nursing and other health professions students; and health professionals of all disciplines) throughout the state.

3) The New York State AHEC System's multifaceted recruitment, training and retention strategies are solutions to current health workforce shortages and the New York State Department of Labor forecasts that health care sector jobs will grow at rates more than five times that of all other occupations.

4) The $2.5 million in state funding to the New York State AHEC System this year will purchase a $7.2 million work force development initiative (through leveraged federal, local, community and private foundation funding) invested in training programs and services resulting in better jobs and better health care for New Yorkers in medically underserved rural and urban communities. Federal funds are only available to AHEC if they are leveraged with matching state and community funds.

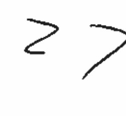
5) The New York State AHEC System has demonstrated success in developing the state's health workforce. Rather than reduce or eliminate funding to the New York State AHEC System, we propose that New York build on its successful statewide, community-based AHEC infrastructure to implement statewide health workforce priorities.

Mission: "To enhance access to quality health care and improve health care outcomes by addressing the health workforce needs of medically disadvantaged communities and populations through partnerships between the institutions that train health professionals and the communities that need them most"

Leadership for the New York State AHEC System is provided by community-based centers, the Statewide Office at the University at Buffalo and regional offices at Upstate Medical University, Albany Medical College and The Institute for Family Health.

(716) 898-4699 **Fax (716) 898-3536** **www.ahec.buffalo.edu**

New York State AHEC System Statewide Office University at Buffalo Department of Family Medicine 462 Grider Street Buffalo, NY 14215



Joint Legislative Budget Committee Hearing on Medicaid & Health
Family Planning Advocates of New York State
March 3, 2011

Testimony of Tracey M. Brooks, President and CEO

Family Planning Advocates of New York State (FPA) represents the state's family planning providers – including eleven Planned Parenthood affiliates, hospital- and non-hospital-based family planning centers and a wide range of other health, community and social service organizations. Providing vital health care services to the ever-increasing numbers of uninsured and underinsured, our family planning clinic members operate 250 sites across the state serving more than 400,000 New Yorkers each year with high quality, cost-effective health care.

Family planning services are critical to the health and well-being of the women and families of New York State. Family planning centers provide a place where women can obtain a wide range of preventive health services such as routine gynecological exams; screening for breast and cervical cancers, high blood pressure, anemia, and diabetes; health education; screening and treatment for sexually transmitted infections; pregnancy testing; prenatal care or referral; and contraceptive care. For many women, family planning health care *is* their primary care. More than six in 10 patients receiving care at family planning centers consider it their primary source of health care.

Investing in family planning is a cost effective public health strategy that saves the state money by preventing costlier health problems.

Consider the following:

- ✓ For every **$1** spent on family planning services in New York, **$4** in Medicaid costs are *saved.*
- ✓ For everyone one of those Medicaid dollars New York spend on family planning, the federal government reimburses the state 90 cents – a **90/10 match.**
- ✓ By preventing unintended pregnancies and subsequent births, it is estimated that the services provided at family planning centers in **New York saved $261,546,000 in public funds in 2008.**

The benefits of investing in family planning extend far and wide, and are a key strategy for fostering healthier communities and bolstering our economy.

A PRECARIOUS POSITION

Certainly no one would question that these are challenging times. As the state struggles to make ends meet, so do New York's families and family planning providers. A 2009 study conducted by the Guttmacher Institute found that 64% of women agree with the following "with the economy the way it is, I can't afford to have a baby right now." The same study also found that nearly one in four women reported having putt off a gynecological or birth control visit to save money in the past year.

Family planning providers are also making tough choices. Prior to the conversion to the new Ambulatory Payment Group (APG) methodology in July of 2010, family planning providers' Medicaid rates had been frozen since 1995 at 1992 levels. More than a decade of underfunding, exacerbated by the financial crisis, decreases in philanthropic giving, restrictions on lending, and a series of budget reductions that began in 2008, has required providers to operate more effectively and efficiently. These challenges have been intensified by providers having to meet the growing needs of uninsured and

underinsured needing to access health care as a result of the downturn in the economy. Providers have conducted multiple rounds of staff reductions, frozen salaries, instituted furloughs and reduced benefits. They have consolidated health care centers, adjusted hours of operation and in some instances closed centers thereby limiting access to preventive care in those communities. The majority of family planning providers are in a place where there is nowhere else to cut without significantly jeopardizing access to health care services.

These economic realities are compounded by the proposed elimination of federal funds for Title X and Planned Parenthood. Recently, the House of Representatives passed a Continuing Resolution (CR) for FY 2010/11 that would defund Title X. This critical program, instituted in 1970, supports basic primary and preventive health care, including annual exams, lifesaving cancer screenings, contraception, and testing and treatment for sexually transmitted infections (STIs) for low-income women and men. New York receives $10 million in Title X funding which supports 49 family planning providers whose services reach more than 410,000 patients every year. This funding accounts for 20% of the state's family planning grant. The loss of this program would be a tremendous blow to New York's family planning grant.

Equally concerning is the unprecedented move by the House to deny all federal funding, including Medicaid, to Planned Parenthood. New York's 68 Planned Parenthood health centers represent less than 30% of the family planning centers in the state. However, these clinics serve more than 54% of the total family planning patients in New York. Should the effort to defund Planned Parenthood be successful, it would result in the complete destabilization of the state's family planning network.

HARNESSING THE OPPORTUNITIES, MINIMIZING UNINTENDED CONSEQUENCES

FPA believes that times of great challenge offer great opportunity to think innovatively and address long-term systemic inefficiencies within our health care system. Governor Cuomo's creation of the Medicaid Redesign Team presents an ideal opportunity for finding strategic cost savings while protecting the core family planning services New Yorkers depend on. However, we believe the success of this effort will hinge on our ability to strike a delicate balance to ensure that these proposals do not inadvertently result in further destabilization of safety-net providers. We believe a continued partnership between family planning providers and the state can preserve this delicate balance.

"Nearly one in four women report having putt off a gynecological or birth control visit to save money in the past year."

Guttmacher Institute 2009

In this vein there are a number of proposals in the package approved by the Medicaid Redesign Team that will directly impact family planning providers. Although the details of these proposals are still being developed, FPA is prepared to work directly with the Department of Health to ensure that access to family planning services is preserved.

Transitioning Family Planning Grant Funds Into Medicaid

The MRT proposal of particular interest to FPA will cut $10 million from the family planning grant and shift those funds to the Medicaid rate reimbursement for family planning providers. This proposal will convert a portion of the family planning grant, which is 80% state funds, to Medicaid reimbursement, which will receive 90% funding from the federal government. An increase in Medicaid reimbursement for family planning providers is a welcome infusion of funds. However, FPA has significant concerns about how this proposal will be implemented. The increase of the reimbursement rate will only impact claims that are billed under the APG system. Consequently, it is not clear how the loss of family planning grant funds will impact providers that see a high percentage of uninsured patients or those that bill through Medicaid Managed Care plans. FPA is working with the Department of Health to ensure that the clinics that do not see a high volume of APG eligible claims are not adversely impacted by the

transfer of family planning grant funds. In addition, the potential loss of federal Title X funding from the family planning grant is greatly concerning. Should this program be defunded, the family planning grant would be reduced by nearly half. Clearly this would have a devastating impact on access to family planning services in New York.

Elimination of Workforce Recruitment & Retention

The MRT proposal that eliminates the workforce recruitment and retention funds for diagnostic and treatment centers (D&TC) argues that the loss of funds for providers will be mitigated by the APG payment system. The APG payment methodology was proposed in 2007 as a way to increase reimbursement for the provision of outpatient primary and preventive care through the investment of $50 million into the system. At the time of the proposal it was anticipated that with full investment, the financial situation of family planning providers would greatly improve. A variety of factors, at the state and federal level, have delayed both the implementation and the full investment of APGs. This delay has made it impossible to determine whether the intended impact of APGs is being actualized. Given this uncertainty, FPA believes the proposal to cut workforce recruitment and retention funds for D&TCs will cause family planning providers to lose ground. While FPA can appreciate the desire to eliminate duplicative funding streams, we urge the legislature in concert with the Department of Health to delay this cut until there is a full investment in the APG system.

Across the Board Reduction in Medicaid Reimbursement

Over the course of the past three years, FPA has engaged in a continued effort to partner with the state to find strategic cost savings in the delivery of family planning services. FPA has come to the budget table and negotiated in good faith to reduce non-core funding streams in order to preserve core family planning funding and mitigate proposed budget cuts. Unfortunately, the transfer of $10 million in funding from the family planning grant eliminates FPA's ability to offset across the board cuts that would impact the provision of core family planning services. This is particularly concerning since one of the MRT proposals contains an across the board reduction in Medicaid reimbursement for providers. This two percent reduction will be an additional loss in funds that will weaken an already fragile health care provider system. FPA is troubled by the effect this across the board cut could have on providers who are already losing funding from the family planning grant and who have not seen the full benefit from the newly enacted APG system. In light of the investment of $10 million of family planning grant funds into Medicaid, and given that that the majority of services provided by family planning centers are eligible for a 90/10 match from the federal government, we ask family planning providers to be carved out of this 2% across the board reduction.

Transition from Waiver to State Plan Amendment

FPA sees great opportunities in the MRT proposal that would convert the current Medicaid waiver for the Family Planning Benefit Program (FPBP) into a State Plan service. Implemented more than eight years ago, FPBP provides comprehensive family planning services with the 90/10 federal matching rate. In addition to its cost-effectiveness, FPBP plays an essential role in providing coverage to a broad range of individuals who would otherwise be unable to access these critical services. This principal is furthered by the MRT proposal to automatically enroll post-partum pregnant women into the program. FPA applauds this proposal, as it is a natural extension of New York's leadership role in proving needed health care services to vulnerable communities. FPA is committed to working with the Department of Health in crafting the state plan amendment to ensure that women, men and children can continue to benefit from the confidential and comprehensive services provided through FPBP.

We have weathered much together these past few years and FPA has valued the partnership it has developed with the legislature to preserve core services in the face of these dire economic times. FPA sees the redesign of the Medicaid system as a great opportunity to build on this partnership as we embark on a new era health care delivery in the Medicaid program.

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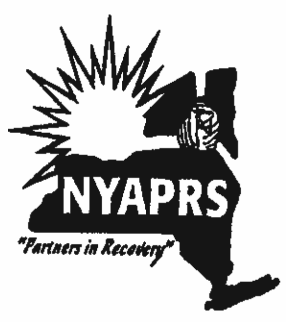


Testimony Before the NYS Legislative Joint Fiscal Committees

Health/Medicaid Budget Hearing March 3, 2011

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
President Douglas 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

I'd like to thank the chairs and members of the respective 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 100 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, Buffalo, Carmel, New York City, Syracuse, Westport and White Plains.

You may have seen our members out in great evidence last February 15th. Throughout that day, the Capitol was filled with over 800 orange-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 advance policies promoting their recovery, rehabilitation and rights.

State mental health policy is a very personal matter for our NYAPRS community. Many of our members, our board members, our staff and I 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 thousands of New Yorkers with psychiatric disabilities and their supporters that we represent.

Our community greets this year's Executive budget and MRT proposals with the following reactions and recommendations.

Support Prop 93: Regional Managed Behavioral Health Care Coordination Initiative

New Yorkers with mental health, substance use and medical conditions require more active, engaging and better coordinated care that both promotes their health and recovery and reduces costly and avoidable ER and hospital stays. They make up a high percentage of that group of Medicaid beneficiaries who use 15 times the amount of Medicaid services than the average beneficiary, typically due to poor service engagement and coordination and a lack of persistent active follow up, resulting in tremendous overuse of emergency room and inpatient facilities.

They also comprise 70% of a group involved in an estimated $800 million in frequent hospital readmissions deemed "avoidable" by the Health Department.

While many of those visits are to treat medical conditions, a majority of these individuals are not well engaged by health plans and medical practitioners, preferring to 'come into care' offered by behavioral health services.

In an unprecedented demonstration of unity and shared focus, NYAPRS and 40 other statewide and regional behavioral health advocacy groups have agreed to support a specialized form of managed care to improve care coordination, integration, effectiveness and affordability.

We are pleased and grateful that the Governor's Medicaid Redesign Team has given its support to this OMH/OASAS backed proposal to utilize specialty behavioral health organizations in administrative service capacities to provide care coordination and improvement for our behavioral health systems of care and to link those to critical health, housing and local support services.

BHOs have considerable experience with our consumer, family and provider communities and can demonstrate impressive outcomes in other states like Pennsylvania, Washington and Massachusetts in fostering the kinds of active, person-centered recovery and peer support services these groups require and respond best to.

Under this proposal, BHOs will operate regionally for the next two years, improving care and creating savings from lessened ER and hospital care.

The state will have to move very quickly to construct contractual expectations for the BHOs. The consumers, families and providers who worked so hard for this proposal have a great deal at stake here. **We urge the legislature to assure in budget language that these groups are afforded appropriate input into a transparent procurement process that guarantees strong consumer rights and choice protections, grievance and appeal processes and incentives for recovery and peer approaches.**

Eventually, this will evolve into a fully integrated managed behavioral and physical health design like Special Needs Plans.

I find it necessary to point out that our community worked strenuously against proposals to turn our services to health plan management because we found that the illness and office-based style they've long used with 'the worried well' wouldn't apply and work well with our more seriously challenged communities.

In that same spirit, NYAPRS is very concerned about proposals by hospital-led networks to take over the Special Needs Plans 3 years from now. We wonder how possible it will be for hospitals to sufficiently reinvent themselves to assume a leadership role for the recovery-focused system we will need at that time.

Recommendation: On behalf of NYAPRS and as a Steering Committee member of Medicaid Matters, we support the Regional Managed Behavioral Health Care Coordination Initiative

Support Prop 89: Health Home for High-Cost, High-Need Enrollees

Health homes represent new federally incentivized service re-configurations that the BHO coordinated model will rely on. Health homes are service networks that are specialized to offer enhanced primary care, home health and behavioral health care for individuals with serious, ongoing medical and/or behavioral health conditions.

These programs support coordinated discharge planning and home care services, engage with members for referrals to additional health service programs, and eliminate unnecessary services. They minimize gaps in care and control costs, improving the healthcare experience for patients. They are well documented to reduce state and local costs of care for the highest need members.

Health home services include comprehensive care management, care coordination and health promotion and comprehensive transitional care, including appropriate follow-up, from inpatient to other settings, patient and family support; referral to community and social support services, and use of health information technology and electronic health records to link services and assure improved care.

NYAPRS has strongly supported this proposal and urges the legislature to assure that:

- **Behavioral health providers are afforded considerable opportunities to operate the homes, as well as to be network members of all plans.** There are numerous examples of successful models where behavioral health providers are most suited to engaging this group and overseeing their care, in tandem with primary care partners or embedded medical services.
- **Consumer and family-run organizations are part of the mainstream delivery of services, as a means of enhancing access to recovery and resiliency-oriented services.** Good examples of the role these groups can have in improving and assuring the success of the health homes include:
    - Peer and family support specialists serve on treatment teams in New Mexico
    - Peers in Washington staff mobile crisis teams, operate a Crisis Triage/Living Room facility called the Recovery Response Center and a Recovery Support Line.
    - Peers in New York are demonstrating considerable success in helping to find, engage, enroll and support 'at risk' hard to find individuals with complex needs in NY's Chronic Illness Demonstration Program.
- **Health Homes should strong support person-centered and driven care.** A variety of studies have demonstrated that consumers who actively participate in their own care are more engaged, like and stick with the providers and the treatments and demonstrate improved outcomes.

Support Prop 1058: Maximizing Peer Services

We greatly appreciate that this emphasis on strong use of peer services in the BHO and health home environments is one that's advanced as one of the MRT recommendations. One of the most promising, effective and affordable innovations in modern mental health care are peer-run services, which are run by individuals with psychiatric disabilities who are trained to provide quality support and service to their peers. Peer-run services have been in development for the past three decades and recommended time and again in important national reports including the 2003 Presidential Mental Health Commissions and the 1999 Surgeon General's Report on Mental Health.

Peer run services are developing an impressive body of evidence around their capacity to help "high cost high needs" individuals with mental health and related conditions to improve their engagement and participation in treatment, health care outcomes and diminished use of avoidable and costly emergency and inpatient services.

Recommendations:

- **New York should require managed health and behavioral healthcare organizations and the emerging health homes to contractually include such peer services in their benefit packages.**
- **New York should carefully consider Medicaid reimbursement for peer services, in consultation with leading peer groups like the Coalition to Promote the Integrity of Peer Support in New York State.**

Oppose Prop 11, 15 Elements to Restrict Open Access to Medications Increased Oversight for Medicaid Mental Health Medications

For tens of thousands of New Yorkers, a disruption in access to the appropriate psychiatric medication results in relapses that are costly in terms of both human suffering and avoidable emergency and inpatient care. A the same time, prescribing practices that don't use evidence based medications or that use too many drugs simultaneously (polypharmacy) are demonstrating harmful effects (e.g. frequent connections to metabolic syndrome, diabetes, etc) and costing too much.

NYAPRS continues to advocate for unrestricted access to such medications to protect patient choice and care and we oppose the proposal to eliminate fee-for-service reimbursement for pharmacy and their 'carve in' into managed care plans.

At the same time, we urge an expansion in programs like the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES), which will play a vital role in effective health home driven care. PSYCKES improves psychotropic prescribing practices by red-flagging costly and health-threatening use or overuse (too many for too long) of such powerful medications, as well as increased use of electronic prescribing best practices to reduce avoidable errors.

Recommendations:

- **New York should continue to promote unrestricted access to protected classes of medications like mental health drugs to protect patient choice and care by rejecting proposals to:**
    - **eliminate vital 'prescriber prevails' protections.**
    - **carve in pharmacy into Medicaid managed care plans.**
- **In order to improve the management of psychiatric prescription drugs and to avoid excessive Medicaid spending, the State should expand the PSYCKES quality improvement program to all community- and hospital-based mental health providers in New York State and further enhance electronic prescribing best practices that will reduce medication errors.**

Support Prop 137: Disregard Retirement Assets for the Medicaid Buy-In

NYAPRS strongly backs this proposal to increase enrollment into the state's Medicaid Buy-In program that extends Medicaid for working New Yorkers with disabilities by allowing "working disabled individuals to accumulate modest savings for retirement without losing eligibility" by:

- raising "the resource standard... from the current Medicaid resource standard of $13,800 for a household of one and $20,100 for a household of two to $20,000 and $30,000, respectively" and
- by seeking to "disregard Individual Retirement Accounts (IRAs) as a resource in determining eligibility for MBI-WPD. Individual Retirement Accounts include IRAs, Keogh Plans and other individually owned retirement plans."

Opening up eligibility into the Buy-In will expand access to the workforce for thousands of New Yorkers with disabilities in ways that will advance their dignity and recoveries while saving New York millions. A May 2006 Mathematica study on the Buy-In found that states could realize Medicaid savings on Medicaid Buy-In enrollees, finding that "on average, Buy-In participants cost Medicaid $984 per-

member per-month (PMPM) in 2000, almost 40 percent lower than the cost of other Medicaid enrollees with disabilities.

Support Prop 196: Supportive Housing Interagency Workgroup

This proposal "would create a supportive housing interagency work group to create between 5000 and 10,000 housing opportunities for persons at risk of nursing home placements, most notably assisted living, assisted living residences, special needs assisted living residences, and the OMH supportive housing initiative.

Support Prop 55: Increase Coverage of Tobacco Cessation Counseling

NYAPRS strongly supports expanding existing tobacco cessation counseling coverage in Medicaid to include all women (not only pregnant women) and men, especially given the extraordinary high rates of smoking on our community and the very high linkages to COPD and other smoking related conditions.

Support Prop 990: Incentives for Efforts to Address Health Disparities

NYAPRS strongly supports this initiative to establish reimbursement rates to support providers' efforts to offer culturally competence and undertake measures to address health disparities based on race, ethnicity, gender, age, disability, sexual orientation, and gender expression, especially given the extraordinarily disproportionate representation of people of color in the "high cost high needs" groups, as well as in our homeless shelters and prison and jail systems.

Thank you for this opportunity to share our community's concerns and recommendations.

Z 9

Testimony of
Coalition for the Homeless

presented by

Shelly Nortz,
Deputy Executive Director for Policy

before the
Fiscal Committees of the NYS Legislature

on
The 2011-2012 Executive Budget Proposal for Health

March 3, 2011

146 Washington Avenue Albany NY 12210 www.coalitionforthehomeless.org 518-436-5612 fax 518-436-5615

Good Afternoon. Thank you, Senator DeFrancisco and Assemblyman Farrell for holding this important hearing and inviting me to share some insights with you regarding the Executive Budget proposal for Health. My name is Shelly Nortz and I serve as the Deputy Executive Director for Policy with Coalition for the Homeless where I have been a public policy specialist for the last 24 years.

The deepening problem of homelessness in our state is not without serious implications for the health of our population and the costs of our healthcare system. These considerations should inform the choices made in negotiating the health budget.

Record Homelessness

Let me start by sharing just a few fundamental facts:

- In 2010, more than 113,000 different men, women and children – an all time record - were admitted to the New York City shelter system, and nearly 43,000 of them were children.

- Eighty-five percent of the homeless population in New York State is in New York City, where income inequality – a key factor in the economics of homelessness - has reached an unprecedented extreme.

- The number of families turned away from shelter in the City has skyrocketed since 2007 from 1,052 families per month to 1,855 families per month.

- Shelter demand among unaccompanied homeless women has also been rising unabated in recent years and now stands at a record exceeding 2,600 per night in New York City.

- Every night, 38,000 men, women and children bed down in the municipal shelters – among them, 9,700 families and 15,000 children.

- Every month this winter new shelters have been opened to accommodate the growing demand among men and women – with not a little prodding from our staff and the State. We are relieved that we have not seen the kind of chaotic admissions and over-night placements that posed such serious problem last winter.

- The fact that many homeless people suffer with multiple chronic illnesses and consume large amounts of costly medical services has been well documented, and more recent studies demonstrate that housing instability is a variable that can be changed to help address both the health and housing status of such individuals.

- And, these stark facts say it all: People without homes die 30 years earlier than people with homes. In New York the leading causes of death among homeless people are heart disease and cancer – cancer deaths at twice the rate of those in the general population.

Further, despite incremental efforts to build affordable and supportive housing, the current effort is clearly not sufficient to compensate for the loss of hundreds of thousands of affordable units due to deregulation and market forces.

Nor are current efforts able to keep up with a rising demand from new households and an un-abating need for housing with supports for populations that are no longer locked away in institutions, but left to find their way with the most meager of resources in a period of intractable unemployment. It is my assessment that the pace of special needs housing development has been cut by half since the early 1990's, and is insufficient to keep

up with the need deriving from of a population of 19.5 million people – our population has grown by more than 1.55 million individuals in the last couple of decades.

So - things are not good for homeless New Yorkers, especially those with psychiatric impairments and other disabilities, and families. Therefore, we want to underscore some critical recommendations that were submitted to but not voted upon by the Medicaid Redesign Team and urge the Legislature to include them in the budget:

Maximize participation in federal disability benefits and housing for high cost homeless people with disabilities

Coalition for the Homeless asks that a small $1 million general fund program be established to help homeless people with disabilities obtain Federal disability and veterans benefits as well as stable housing modeled on our own small **Client Advocacy Program**. Such an investment literally can pay for itself in interim assistance recoveries paid to the state from the retroactive benefits awarded to the recipient. This is one way the Social Services budget could also help with Medicaid Redesign – the more people with disabilities and unstable housing we can get into Federal disability benefits, Medicaid, and housing, the more taxpayer funds can be saved by cutting down on preventable hospital readmissions and unmanaged chronic illnesses that often become acute and very costly for those without a home.

Maximize participation in Medicaid by Eliminating "Hospital Medicaid" and replacing it with Medicaid Managed Care/Behavioral Carve-out/Health Home/Special Needs Plan Enrollment On the Spot

Coalition for the Homeless recommends that New York take full advantage of the Affordable Care Act authority to establish presumptive Medicaid eligibility when people without insurance are hospitalized. Under current practices, the hospital bills of such people are often paid under what is called "hospital Medicaid" – a device that allows hospitals to be paid with an open-and-shut Medicaid transaction that does not supply the patient with a Medicaid card that could be used to obtain prescriptions or follow up care. This contributes to the revolving door of preventable hospital readmissions and must be changed. By enrolling people in Medicaid/managed care on-the-spot, this approach helps with continuity and follow-up care and also would "lock" in the Medicaid benefit for 6 months so that people will not lose their Medicaid when they lose their cash assistance or housing.

Include recipients with no address in MAMC and any behavioral carve-out rates.

A technical but vital issue arises when speaking of enrolling homeless people in any kind of capitated system: in the past, while the mental health Special Needs Plans were out to bid, the rate tables upon which the bids were to be based segregated out exempt and excluded groups, including those with no address. If homeless people are to be served in fact by any of the care management structures, their utilization data has to be included in the rates. They were the most expensive group, the last time we looked, so if their data are not included, we think they will be effectively excluded, whether exempt or not.

Continue the homeless exemption to allow homeless people continuity of care with treating providers including healthcare for the homeless centers.

Coalition for the Homeless agrees that the care of homeless people should be better coordinated and enriched, but at least a limited exemption from mandatory managed care must be maintained for two reasons. First, there are at least 14 federal healthcare for the homeless grantees in New York serving over 91,000 patients in a great variety of settings including shelter-based clinics. One such provider counts six in ten of its patients as a Fee for Service Medicaid patient, and forty percent of its revenue from that source. The ability of homeless people to access these services in their shelters and neighborhoods where their shelters are located is of critical importance, and we therefore ask that the homeless exemption remain. At the same time, as medical homes are being established, it may make some sense to include these clinics on the front

lines, particularly for chronically homeless people whose housing stability will be significantly aided by access to this care and support.

Establish Housing Vouchers for 2000 high cost mentally ill Medicaid recipients with unstable housing
Coalition for the Homeless believes that a sort of triage approach to helping the highest cost patients with unstable housing is supported by the research. We think the provision of immediate housing to the highest cost patients can be effected while also saving the state funds - $1200 per person per year - that can then be reinvested in housing more such individuals.

I want to mention just a couple of additional MRT issues that have a bearing on our clients.

New York/New York IV
We note with appreciation that a fourth New York/New York Agreement is contemplated. A workgroup recommended by the MRT is expected to address by September the specifics of how to build 5,000 to 10,000 supportive housing units. Coalition for the Homeless recommends that the plan, in addition to the laudable plan to provide supportive housing for those seeking to avoid or leave Nursing Home placements, also ramp up the production of housing for homeless people with disabilities. It is of critical importance to build more of this housing more quickly, because the current pace of production is not keeping up with the need, and the shelter numbers continue to rise at great public expense. A supportive housing unit built in 2011 will be less costly than one built in 2013 or 2015, and it will put more people to work sooner as well. Coalition for the Homeless asks that NY/NY IV include 4,000 units per year for the first three years to provide supportive housing for homeless people with disabilities.

Behavioral Carve-out/Special Needs Plan
Coalition for the Homeless is hopeful that an HHC Special Needs Plan/Health Homes plan may be the right solution for New York City and is eager to join in discussions about how homeless people may best be served in such a system. It will be important for HHC to adopt new approaches that emphasize recovery, rehabilitation, and housing if this plan is to succeed.

Exempt homeless people from co-payments
Coalition for the Homeless is concerned about the impact of the co-payment proposal for our clients. For people who cannot afford the subway, and who suffer with chronic illnesses in need of primary care, it makes no sense to erect such a barrier to healthcare. We ask that homeless people be exempt from co-pays.

Un-Freeze Homeless Housing
I want to mention just one item from the broader budget discussion that impacts the health budget, and that is the Office of Mental Health housing budget. It is our understanding that DOB is holding back on some homeless housing at OMH that would not save any real money this year but would in future years when the units are slated to come on line. At a time of record homelessness, we ask that the Legislature assure that all homeless housing pipelines remain open, not frozen.

Further, we urge that future budget balance be achieved in part through extension of the surcharge on high-income earners, not freezing housing investments that generate jobs and taxes. None of us can afford to blow a $5 billion hole in the budget for next year when we have such extreme income inequality and record homelessness.

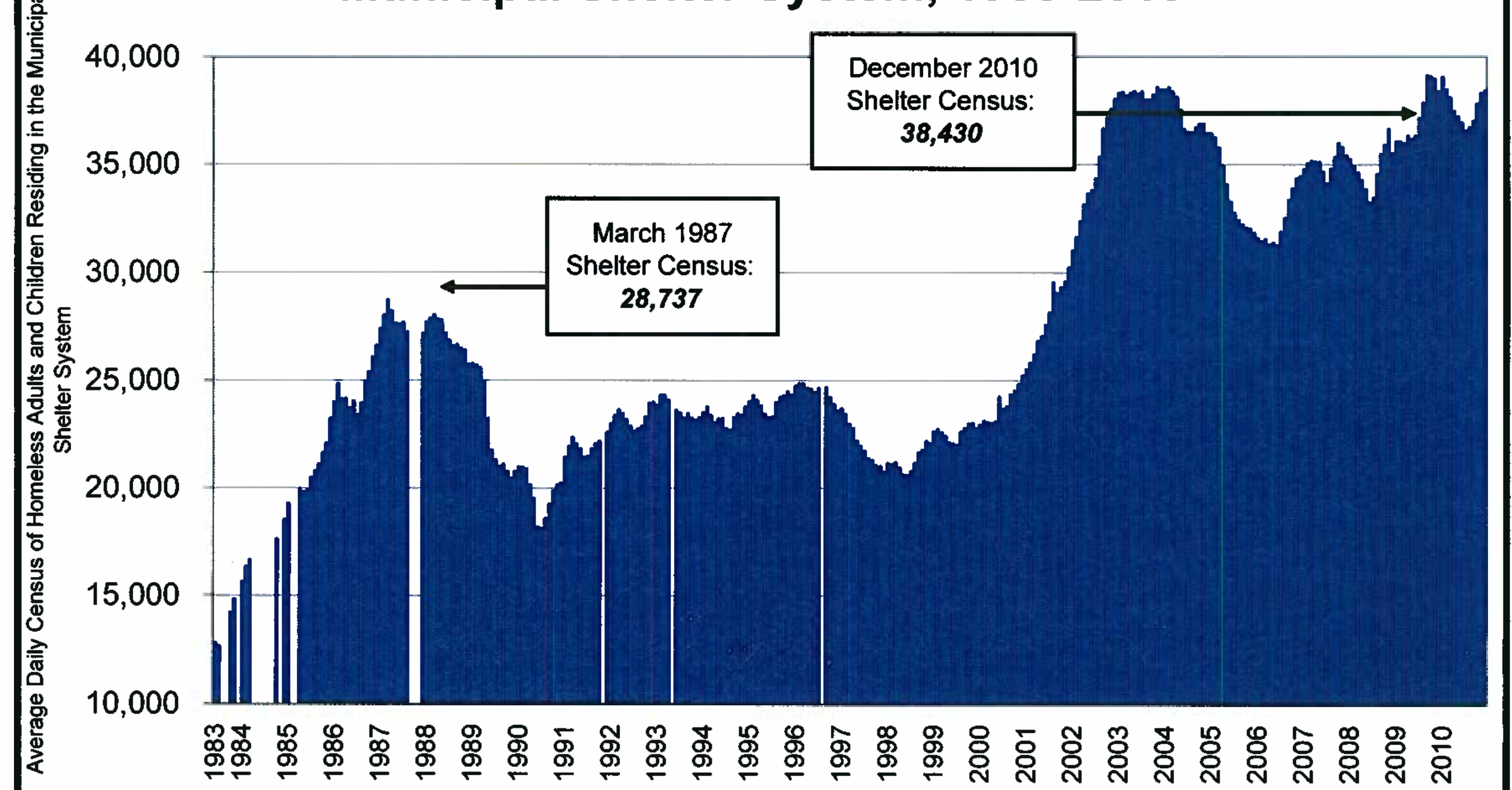
Conclusion
Thank you for your interest, I will be most pleased to answer any questions you may have either now or in the coming days and weeks.

coalition for the homeless

Homelessness in New York City

Updated January 2011

Chart 1



Source: New York City Department of Homeless Services and Human Resources Administration, shelter census reports

Prepared by Patrick Markee, Coalition for the Homeless, 212-776-2004

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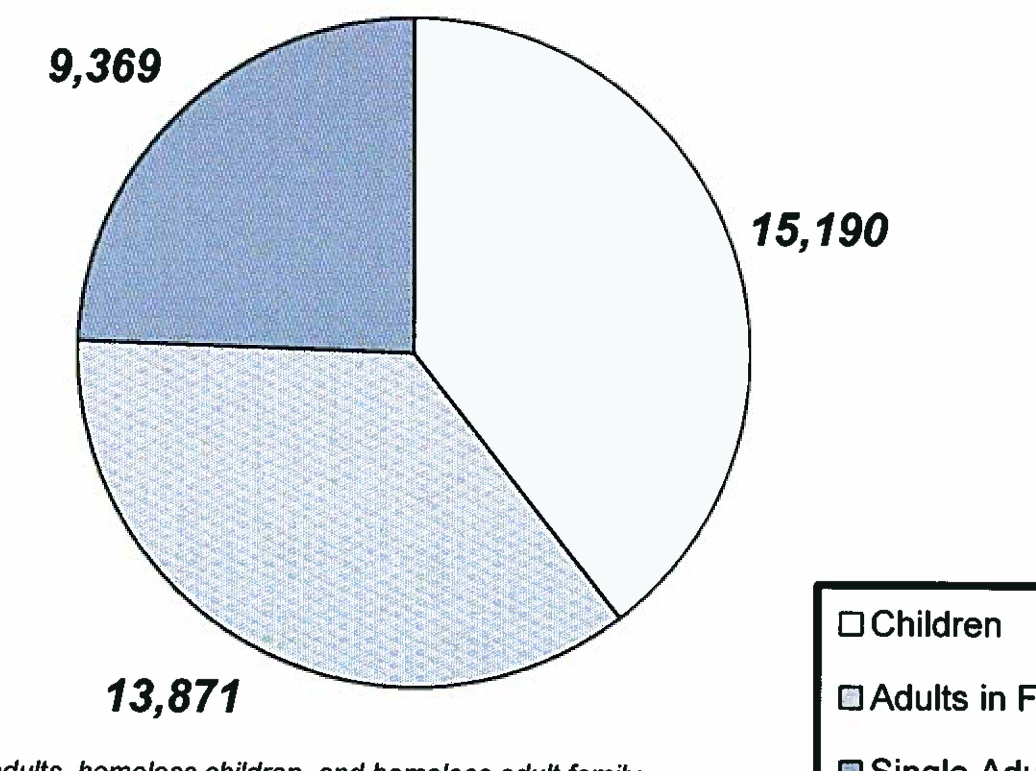
Homelessness in New York City

Updated January 2011

Chart 2

New York City: Census of Homeless People in the Municipal Shelter System, December 2010

Total NYC Municipal Shelter Population: ***38,430***



Note: Number of homeless single adults, homeless children, and homeless adult family members, residing in the municipal shelter system.

Source: New York City Department of Homeless Services, shelter census reports

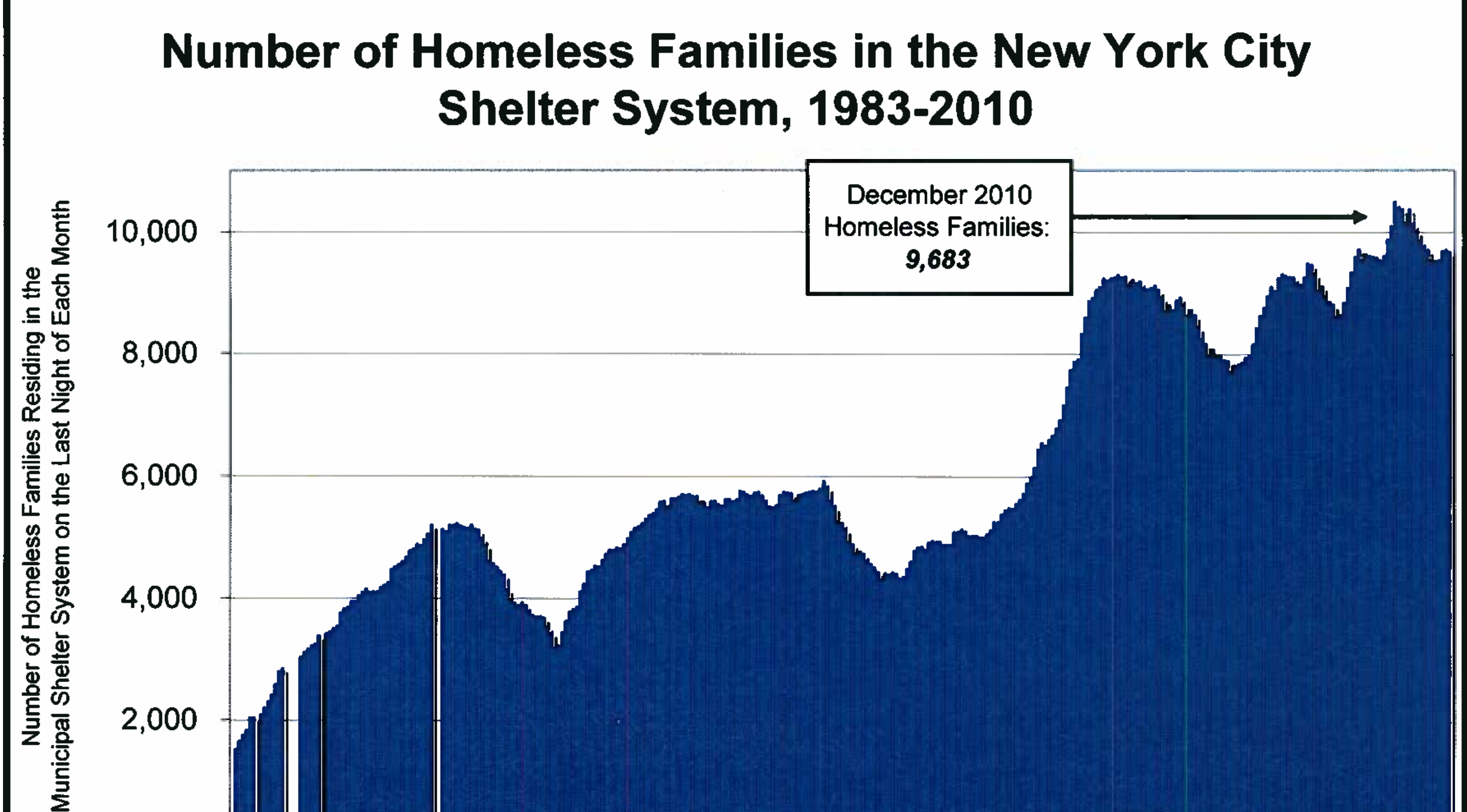
Prepared by Patrick Markee, Coalition for the Homeless, 212-776-2004

coalition for the homeless

Homelessness in New York City

Updated January 2011

Chart 3



Source: New York City Department of Homeless Services and Human Resources Administration, shelter census reports

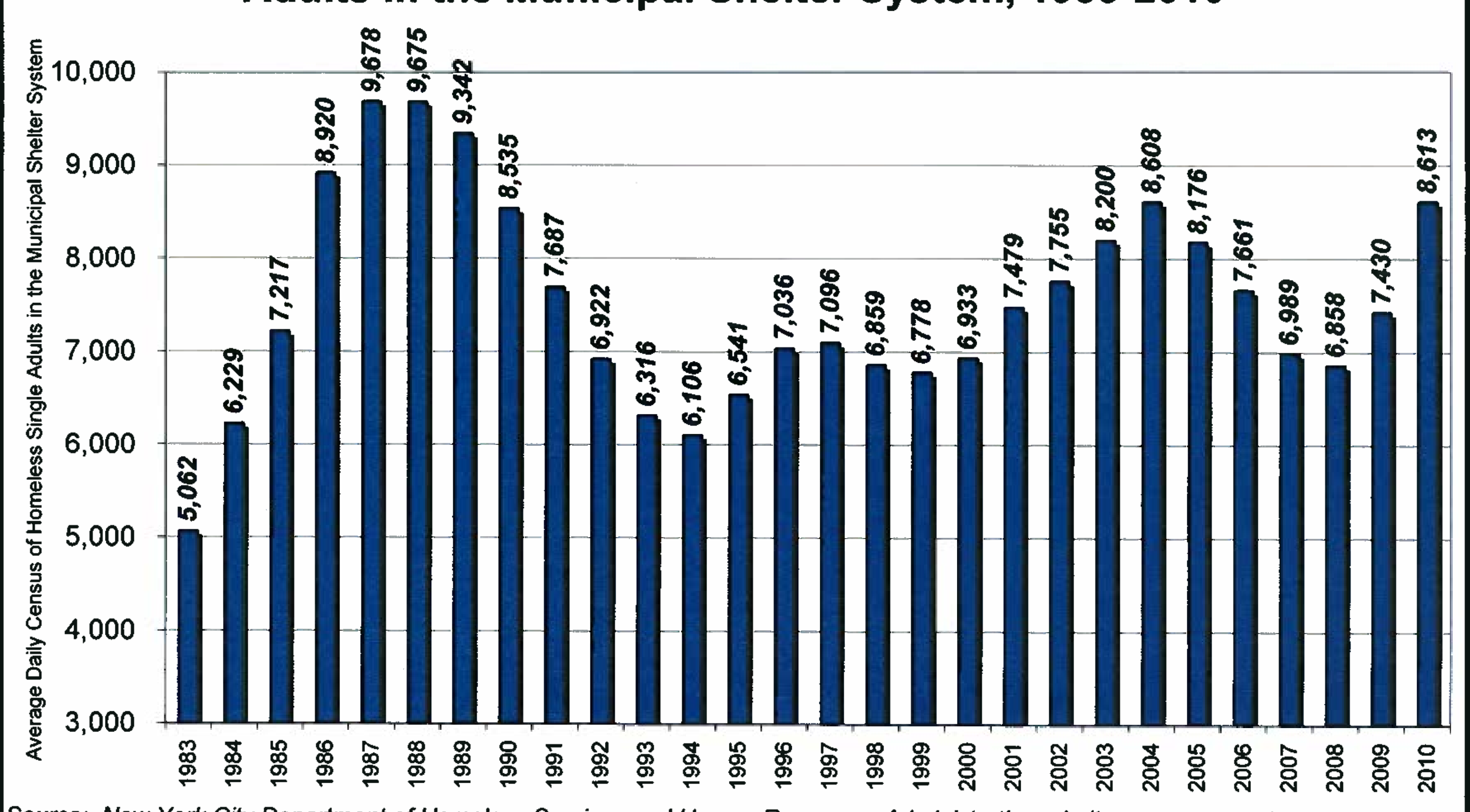
Prepared by Patrick Markee, Coalition for the Homeless, 212-776-2004

coalition for the homeless

Homelessness in New York City

Updated January 2011

Chart 4



Homelessness in New York City

Updated January 2011

Chart 5

New York City: Average Daily Census of Homeless Single Adults in the Municipal Shelter System, 2000-2010

Average Number of Homeless Single Adults in the Municipal Shelter System Each Month

9,500
9,000
8,500
8,000
7,500
7,000
6,500
6,000

JAN 2000
JUN 2000
NOV 2000
APR 2001
SEP 2001
FEB 2002
JUL 2002
DEC 2002
MAY 2003
OCT 2003
MAR 2004
AUG 2004
JAN 2005
JUN 2005
NOV 2005
APR 2006
SEP 2006
FEB 2007
JUL 2007
DEC 2007
MAY 2008
OCT 2008
MAR 2009
AUG 2009
JAN 2010
JUN 2010
NOV 2010

Source: New York City Department of Homeless Services, shelter census reports
Prepared by Patrick Markee, Coalition for the Homeless, 212-776-2004

Homelessness in New York City

Updated January 2011

Chart 6

New York City: Average Daily Census of Homeless Single Women in the Municipal Shelter System, 1983-2011

Source: New York City Department of Homeless Services and Human Resources Administration, shelter census reports

Prepared by Patrick Markee, Coalition for the Homeless, 212-776-2004

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Homelessness in New York City

Updated January 2011

Chart 7

Source: NYC Department of Homeless Services, Critical Activities Reports

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Homelessness in New York City

Updated January 2011

Chart 8

This map shows where new Coalition clients came from by zip code in 2010. The concentration is indicated by the shades of green, with yellow representing the lowest concentration, and dark green representing the highest concentration of 100 or more.

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Joint Legislative Budget Hearing on Health

March 3, 2011
Albany, NY

Prepared by:

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Introduction

Thank you for the opportunity to testify on the health portion of the Executive Budget proposal. My name is Cathy Roberts and I am a Senior Paralegal in the Albany office of the Empire Justice Center. Empire Justice is a statewide legal services organization with offices in Albany, Rochester, White Plains and Central Islip (Long Island). We provide support and training to legal services and other community-based organizations, undertake policy research and analysis, and engage in legislative and administrative advocacy. We also represent low-income individuals, as well as classes of New Yorkers, in a wide range of poverty law areas, including access to health care. We also serve on the steering committee of Medicaid Matters New York, a coalition of over 130 consumer advocacy groups across the state.

As New York continues to grapple with the aftermath of the recession, it is essential that we do not forget that there are many among us that are still in its epicenter. There continues to be little evidence that prospects are improving for low income and low skilled New Yorkers. Indeed, most signs tell us just the opposite. Unemployment in New York remains high, averaging 810,000 in 2010, which is 90% higher than in 2007. The recession drove New York's poverty rate up to 15.8% in 2009 with pockets of much higher poverty in many areas of the state.

It is against this backdrop of increased poverty and persistent unemployment that we make our comments about the Health budget. While the Medicaid program is an inevitable target in the push to achieve savings, it is also a lifeline for unemployed and low-income New Yorkers, as well as a jobs engine in many of our communities. Growth in the Medicaid program is not a bad thing in and of itself if the program can help bridge access to more affordable private health insurance under federal health care reform, if we can get the support we need from the federal government and if Medicaid spending can slow the ballooning costs of health care generally.

In the testimony below, we comment first on the proposals that have emerged from the Medicaid Redesign Team (MRT), which are reflected in the Governor's 30 day amendments. We then turn to proposed changes to the EPIC program for New York's seniors.

The Medicaid Redesign Team

The Process. We want to begin by commending Commissioner Shah, Medicaid Director Helgerson, and the extraordinary staff of the New York State Health Department for the extensive analysis and herculean organizing effort that underlies the MRT process. The MRT's regional meetings, well-publicized website, and live discussions have encouraged input from many sectors. The Empire Justice Center joined many other consumer advocacy groups in submitting proposals for improving the efficiency of the Medicaid program and were pleased to see some of those ideas reflected in the package presented to the MRT members.

We have several fundamental concerns about the MRT process, however. First, MRT members were precluded from considering revenue options that might have avoided the need for some of the most painful cuts in the package. **To help mitigate the need for deep cuts in Medicaid and other benefits, Empire Justice Center strongly supports the efforts of the**

GrowingTogetherNY Campaign[1], which is advancing a series of revenue options, including the continuation of the temporary personal income tax surcharge.

Second, consumer input in the process was marginalized. Only one of 27 seats went to a consumer group – the coalition Medicaid Matters New York (MMNY) - and not one of the State's 4.6 million Medicaid beneficiaries was appointed. Although providers, insurers and labor unions clearly have a strong interest in changes to the Medicaid program, so do consumers. We were very disappointed to see the Medicaid consumer perspective minimized to this extent. We urge that should a similar process be used in the future, that a set percentage, perhaps 15-20%, of seats be devoted to consumer representatives.

The events of last week only served to underscore these imbalances in representation. When the Team assembled for the first of two days of discussion on a new package of proposals, a vote was demanded. While clearly many members of the team were aware of the change in plans and had been briefed on the extensive new material, MMNY was taken by surprise. Lara Kassel, the group's coordinator and the MRT representative, was forced to abstain from voting, as she was in no position to approve a new package. She had just emerged from five hours in meetings with the MMNY steering committee to score the old package. Legislative representatives also abstained. Yet the proposal that emerged was characterized as a consensus product. From a consumer perspective, this deviation from the process and lack of uniform briefing and input raises serious concerns about the ability of the Team to produce recommendations that represent adequate input from all appointees.

The Proposals. Clearly, the MRT process has resulted in wide input and serious analysis of numerous ideas for improving the efficiency of the Medicaid program. Despite the frustration we experienced with the process, we were also gratified to see that the package approved by the majority did not include some of the proposals originally put before the MRT members for scoring that were of serious concern. There were several proposals that would have had a detrimental effect on Medicaid consumers (and in some cases, would have resulted in loss of federal benefits), including elimination of education and outreach for Medicare Part D, elimination of Medicaid payment for adult dentures, elimination of targeted case management, and elimination of funding for health plan facilitated enrollment.

We found many proposals within the package to be creative efforts to increase efficiency without decreasing the quality of care or access to services. At the same time, we strongly oppose several proposals that cut deeply into access to care and promise little in return by way of savings. Finally, we urge reconsideration of several proposals that would dramatically expand managed care, in order to ensure appropriate consumer protections.

MRT PROPOSALS WE SUPPORT:

We applaud the Governor for including the following MRT proposals in his 30 day amendments, all of which address significant barriers to accessing health care services for low income New Yorkers, and many of which move our state forward in implementation of federal

[1] More details available at: http://www.abetterchoiceforny.org/

health care reform. New York's leadership in providing quality health care in its public health insurance programs has been rewarded with an Early Innovator Grant that will help the state develop the technology necessary to support these proposals.

- Automatic recertification for the aged and disabled (proposal #133)
- Development of an automated eligibility process (proposal #150)
- A series of additional enrollment and retention improvements (two year renewal, data transfers, phone outreach, use of tax forms, reduction in documentation) (proposal #1029)
- A supportive housing initiative to avoid nursing home placement (proposal #196)
- Authorization for Accountable Care Organizations (proposal #243)
- Health Homes for high need enrollees (proposal #89)
- Expansion of Patient Centered Medicaid Homes (proposal #70)
- Exploration of mechanisms to address health disparities, including higher reimbursement rates (proposal #990)
- Support for Peer Services (proposal #1058)

MRT PROPOSALS WE OPPOSE:

- *Increases in co-payments* (proposal #104) - People who rely on Medicaid fee-for-service and Family Health Plus would see increased co-payments for many services and also new co-payments for many rehabilitative services. Items to be subjected to co-payments include eye glasses, eye exams, dental services, audiology, physician services, nurse practitioner services, occupational therapy, physical therapy and speech therapy. The annual cap on co-payments would also be increased. Some children and nursing home residents would be exempt.

  A recent study published by the Robert Wood Johnson Foundation concluded that cost-sharing increases may not be an effective means of achieving savings since most people are healthy and their service use reductions only result in very modest savings. The study found that patients do not accurately discriminate between essential and nonessential services when responding to cost-sharing; many will go without essential, preventive drugs. Cost-sharing increases are thus associated with adverse health outcomes, particularly among vulnerable populations like the elderly and chronically ill.[2]

- *Reduction in dental rates* (proposal #17) – This proposal reduces the rates paid to Medicaid providers of dental care outside of managed care. Not all managed care plans cover dental services, particularly upstate. If rates are decreased, access to fee for service dental services for Medicaid enrollees will become even more problematic.

  Although research has increasingly recognized the importance of dental care and coverage to overall health and well-being, adult dental benefits are often one of the first targets of

[2] Shwartz, K., "Cost-Sharing: Effect on Spending and Outcomes Report," Robert Wood Johnson Foundation, December, 2010.

Medicaid reductions. The experience in Massachusetts is instructive. When Massachusetts reduced dental benefits for adults in 2002, some private dentists stopped serving MassHealth patients altogether. Lack of remaining capacity among dental safety net providers led to serious untreated dental conditions, which in some cases exacerbated other chronic or disabling health conditions. Overall, the state achieved minimal savings from the benefit reduction compared to overall program spending, and some costs were shifted to other areas including the state's Uncompensated Care Pool.[3]

- *Reductions in payments for Medicare Part B* (proposal #164) – Under this proposal, Medicaid would no longer pay physicians Medicare Part B coinsurance for non-Medicaid services and would limit payment to clinics to the Medicaid rate. This proposal will shrink the number of providers willing to care for Medicare patients who are poor enough to qualify for Medicaid (dual eligibles). Dual eligibles already face barriers to access due to complex billing and provider shortages and should not be targeted for further reductions. Savings associated with this proposal will be offset if this fragile population goes without the primary and preventive care available in clinics and doctors' offices.

- *Restrictions in access to prescription drugs* (proposals # 15, 43, 48, 80) - Under these proposals the "prescriber prevails" protection that allows a doctor's choice of drug to be honored will be stripped from the program and the Medicaid coverage that "wraps around" Medicare Part D will be eliminated and anti-depressants, atypical anti-psychotics, anti-retrovirals and immune-suppressants will be subject to prior authorization. Patients may be required to "fail first" on a sub-optimal drug before they are permitted to obtain the treatment their doctor believes is medically necessary. This, in turn, may have consequences for public health and health costs if failure to benefit from a drug results in hospitalization, drug resistance or non-adherence.

- *Restricting access to long-term care services* - Proposals 2, 18, 1116, 4652 are likely to shift long term care usage from community settings to institutional settings through instituting an eight hour cap on personal care hours and tightening eligibility budgeting by eliminating spousal refusal and applying a transfer penalty to community long term care services. These proposals run counter to the U.S. Supreme Court's decision in Olmstead, requiring that individuals with disabilities receive health care services in the most integrated setting.

  In addition, the elimination of spousal refusal and application of transfer penalties are likely to violate maintenance of effort (MOE) requirements in the Affordable Care Act , unless the proposal is implemented very carefully. Any proposal restricting eligibility for Medicaid has to fit an exception to the MOE requirements that can be triggered if the State certifies that it has a budget deficit. Even then, changes may be made only for certain groups. *New York cannot eliminate spousal refusal or impose penalties on transfers of assets for individuals with disabilities under age 65 or persons age 65 and older whose income is less than 133% of FPL.* See Sections 2001(gg) and 2101(b) of the Affordable Care

[3] Pryor, C. & Monopoli, M., "*Eliminating Adult Dental Coverage in Medicaid: An Analysis of the Massachusetts Experience*," Kaiser Commission on Medicaid and the Uninsured, September 2005. Massachusetts took the route of eliminating preventive dental services, rather than reducing the reimbursement rate. The effect on provider capacity and access to care, however, is likely to be similar.

Act. Implementation of restrictions on spousal refusal thus becomes complex, and administratively costly.

Even if for those groups that could be subjected to the change, we urge a graduated approach to restricting spousal refusal, one that would limit its use to couples with income and assets below the spousal impoverishment levels. This approach would codify the longstanding practice of many counties, which have long used the spousal impoverishment standards as a guide in prioritizing which "refusing spouses" to pursue for support. Any other approach forces lower-income couples into institutional care or divorce, since federal law requires states to preserve spousal refusal for nursing home applicants (42 U.S.C. §1396r-5(c)(3).

- *Global cap* (proposal #4651) – We oppose a flat cap on increases in Medicaid spending without a better understanding of how New York would achieve the savings that would be necessary to counterbalance natural growth in difficult economic times. Such drastic measures should not be considered in the absence of full debate on revenue proposals.

MRT PROPOSALS WE URGE YOU TO RECONSIDER:

The package approved by the majority of MRT members includes a huge expansion in New York's Medicaid managed care program. Proposal #1458 adds personal care and pharmacy services to the managed care benefit package. The proposal also mandates enrollment for all currently exempt populations. These changes are to be accomplished over a three year period, with the expectation of realizing significant savings even in the short term.

Several other proposals (#s 70, 89, 90, 141, 1032, 1427, 1451) are aimed at moving remaining long term care services into a managed environment by applying provider specific caps and other payment changes in the fee for service environment, while expanding authorizations of managed long term care providers (to include Consumer Directed Care and to qualify as health homes) and then mandating enrollment in managed care for users of home care (60 hours or more). An innovative approach is taken with regard to behavioral health services under a proposal to explore the use of behavioral health organizations that appears to include the flexibility for considering a special needs plans approach to mental health needs (proposal #93).

Oversight and enforcement of plan responsibilities must be strengthened in the traditional managed care environment if plan responsibilities are to be enlarged on the scale envisioned in the MRT proposals. While some managed care plans have done a good job of engaging their members and holding down costs by expanding access to primary and preventive care, not all plans have been as successful. Adding new services and populations with more complex needs to the plans' responsibilities will increase the risks to consumers. While proposal #1458 picks up on some important consumer protections, crucial elements, such as enforcement mechanisms and more transparent contract negotiations with plans, are missing. The proposals transitioning long term care recipients into managed care do not discuss oversight or patient protections, although mention is made of creating a workgroup to aide in implementation of the shift.

Empire Justice subscribes to the principles for consumer protections in Medicaid managed care that were submitted to the MRT by Medicaid Matters, and favorably received by NYSDOH and Medicaid Director Helgerson. These principles include the following:

- Consumer and provider education to minimize auto-assignment and care disruptions
- Full, clear disclosure of plan policies and options, including comparisons of provider networks
- Consistent and accessible notices
- Language assistance services, including translation of important documents
- Clear and responsive grievance and appeals processes
- Appropriate staffing at the NYSDOH to monitor quality and compliance
- Consumer rights to enforce health plan contractual obligations

It is also imperative that the MRT workgroups addressing the expansion in Medicaid managed care include strong consumer representation and that development of the contractual provisions which define the plans' obligations become more transparent. We urge expansion of the role of the Medicaid Managed Care Advisory Review Panel (MMCARP) to take on these roles.

In summary, the process of developing the package that the majority of MRT members have approved has been far from perfect. However, as indicated above, we are supportive of many of the components of the plan and are hopeful that the next phase of the process may yield more opportunity for meaningful legislative input as the proposals are fleshed out in the 30 day amendments. Through that process, we urge you to reject the deep cuts to consumer access, and insist upon meaningful and ongoing consumer involvement. We ask for your support in insisting that consumer representatives have a meaningful role in the MRT subgroups envisioned in proposal #1451, so that the voices of those who use the system can be reflected in its redesign and implementation.

Other Health Budget Proposals

Support Dry Appropriation for Community Health Advocates Program

We encourage continued funding for the Community Health Advocates (CHA) consumer assistance program through the $5 million dry appropriation in the Governor's proposed budget. That appropriation will allow the State to direct up to $5 million in federal funds to an existing network of community-based organizations that currently provide much needed assistance in accessing health care and insurance coverage. The CHA network is currently funded by $2.2 million in federal dollars allocated to the State under the federal Affordable Care Act. These funds are available to continue funding for consumer assistance programs for the next three years at no cost to the State. Support for the dry appropriation will simply allow the State to continue providing the services – again – without any State or local dollars.

CHA is a network of 25 community-based organizations (CBOs) serving New Yorkers in need of assistance with health care or insurance coverage, including three specialist agencies that serve

as legal back-up for the CBOs, providing training and technical assistance to CBO staff and taking referrals for more complex cases challenging eligibility or service denials. The Empire Justice Center serves as a specialist agency for the CBOs located outside of New York City and has been actively engaged in creating the new upstate network. The Legal Aid Society and the Medicare Rights Center also serve as specialist agencies.

CHA CBOs are located throughout the state in the communities where those in need of the services live and work. Building on the trust and experience that only local organizations can provide, CHA CBOs offer assistance in a linguistically diverse and culturally sensitive manner, helping consumers access insurance coverage and use it effectively so that the cost of their health care can be well managed and not become an additional drain on scarce State resources. We ask that you approve the Executive's proposed dry appropriation that will keep this vital program going by channeling federal funding through to CHA as soon as it is available.

Restore cuts to EPIC

We join our colleagues in the advocacy community in opposing the Executive's proposal to drastically reduce the EPIC program. We support the state's ongoing initiatives to aggressively maximize federal payments under Medicare Part D and the Low Income Subsidy so that New York is not picking up costs that should be borne by the federal government, and would urge further steps in that direction.

Service providers from all over the state tell us that seniors often sign up for EPIC because they've reached a point in their life where they can't afford to continue taking their medication. Also, seniors who cannot navigate the Part D enrollment system on their own greatly benefit from EPIC's facilitated enrollment model, where EPIC enrolls the senior into the most compatible Part D plan. The Executive proposal will remove these critical safety net protections for our most vulnerable senior population.

Under the Executive proposal, EPIC's only remaining function would be to help with cost sharing during the Medicare Part D coverage gap (also known as the "donut hole"). All of these other benefits that EPIC currently provides would be eliminated:

- Helping seniors enroll in a Part D plan
- Paying for Part D premiums (up to "benchmark")
- Covering the annual Part D deductible
- Assisting with Part D co-pays during the initial coverage limit
- Providing emergency temporary coverage for Part D drugs when plan denies payment
- Providing drug coverage for individuals waiting to get into Medicare Part D
- Acting as secondary payor for people with other "creditable" drug coverage, such as retiree or union drug coverage (as well as Part D)

The cost savings achieved in the Executive proposal will not be shifted to the federal government. Instead, many EPIC seniors will have to pay higher out of pocket costs for their prescription drugs.

According to EPIC's own statistics[4], fewer than one-third of EPIC seniors reached the Part D coverage gap in the 2008-2009 program year. The remaining two-thirds never reached the coverage gap because they fell into one of these 4 groups:

1. They had drug coverage other than Part D
2. They had no other drug coverage and weren't eligible for Part D yet
3. They had Part D with the Low Income Subsidy (no donut hole applies)
4. They had Part D, no Low Income Subsidy, and their total drug costs never reached the coverage gap limit

These 4 groups, totaling approximately 200,000 seniors, who comprise more than two-thirds of the EPIC population, would be completely cut out of the EPIC program under the Executive budget proposal. As a result, EPIC seniors who are not yet eligible for Part D and EPIC seniors with Part D who aren't poor enough to qualify for LIS will likely be the hardest hit:

- EPIC seniors waiting to get into Medicare will have to pay the entire cost of their prescription drugs.
- EPIC seniors with Part D and incomes above 150% of the federal poverty level will have to begin paying their own monthly Part D premium, the annual deductible, and the full Part D co-pay amount during the initial coverage limit, rather than the $20 maximum per drug they currently pay. These additional costs could run anywhere from a few hundred to several thousand dollars per year, depending on the senior's individual circumstances and drug utilization.

While some seniors may be able to absorb these additional costs, there are many who simply cannot. And for chronically ill seniors who wind up having to cut back on or stop taking medications because they can't afford them, the consequences (including increased hospitalizations and need for long term care assistance) are potentially far more costly in the long run.[5]

There are better alternatives which can still achieve cost savings by redirecting these costs to the federal Part D Low Income Subsidy program, rather than onto our vulnerable senior population. The federal Low Income Subsidy for Medicare Part D provides cost-sharing protection by eliminating annual deductibles, monthly premiums and the donut hole. We recommend that instead of cutting EPIC services, the EPIC program instead focus its efforts on maximizing Part D

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[4] EPIC Annual Report to the Governor & Legislature, October 2008 to September 2009, available at http://www.health.state.ny.us/health_care/epic/annual_report/2008_2009/docs/annual_report_2008-2009.pdf

[5] August 2009 New England Health Care Institute Research Brief: *Thinking Outside the Pillbox,* available at *http://www.nehi.net/publications/44/thinking_outside_the_pillbox_a_systemwide_approach_to_improving_patient_medication_adherence_for_chronic_disease;* AND *Despite Programs, Medication Unaffordable for Many Stroke Survivors,* Medscape Medical News, February 23, 2011, available at http://www.medscape.com/viewarticle/737901

and Low Income Subsidy enrollment. There are additional steps that could be taken to streamline the process for enrolling EPIC seniors into the Low Income Subsidy.

In addition, New York should consider expanding its Medicare Savings Program (MSP) income eligibility levels in order to help more seniors qualify for MSP. Participation in an MSP means automatic enrollment in the Low Income Subsidy, which, as explained above, effectively replaces many of the benefits EPIC currently provides. Cost incurred by expanding two of the MSPs, QMB and SLMB, would be reduced by a 50% federal share. There is no state cost associated with expanding the third MSP, QI-1, which is paid for 100% by federal funds.

We look forward to the opportunity to explore these proposals in more detail with legislators and staff in the coming weeks.

Conclusion

Once again, we appreciate the opportunity share our recommendations and look forward to working with you over the course of the next month as the budget is negotiated.

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Thank you Committee Members for allowing me the opportunity to provide testimony on the Executive Budget Proposal for Health and Medicaid. I am honored to be a voice for New Yorkers affected by chronic disease as both the leader of a patient advocacy organization and as a patient myself. I hope you are listening. 29 years ago I was a senior at Colgate University. My life was full of dreams and promise, my future was bright. As a language major I dreamt of going off to Europe, falling in love with a Prince, and living the life of a romance novel character. Instead I woke up in a hospital bed following emergency abdominal surgery, my first brush with death and a diagnosis of lupus. From that point on, my life took on a new direction.

Systemic Lupus Erythematosus is a chronic inflammatory disease in which the immune system actually attacks the body's own tissues and organs. It is more prevalent in women and disproportionately affects people of color, especially African Americans, Hispanics, Asians, and Native Americans. Lupus affects mostly young Americans in the prime of their lives, and is a leading cause of kidney disease, stroke and premature cardiovascular disease in young women and there is no known cause or cure. Lupus is an unpredictable disease in which symptoms come and go and complications can arise suddenly. 1 in 4 persons with lupus is disabled and receives their medical care through Medicare or Medicaid.

Due to the complex nature of lupus no two cases are alike and treatment is highly individualized; effectively treating patients like me is like balancing on a pinhead. Patients and their physicians need open access to all medications in order to maintain consistent disease management. My treatment regimen is tailor-made and during my last life-threatening flare my doctor made the compassionate decision to add an off-label immunosuppressant drug to my current treatment cocktail. This medication has allowed me the ability to function when I could barely think, walk or raise my arms above my head and had spent months in bone gnawing, soul wrenching pain going from physician to physician begging for help. Believe me it is a desperate place to be.

I have 8 autoimmune disorders and presently take 30 medications daily. Four of these drugs are brand immunosuppressants because the generic versions when attempted did not have the same therapeutic effect and actually caused my conditions to worsen. As a matter of fact, I almost died and it was 2 years before my health was somewhat stable again. It has taken me over 2 decades to become an empowered and informed patient and to find the right health professionals to treat my complicated medical picture. I choose who the members of my treatment team are and am comfortable in knowing that they make the best treatment

decisions based on my past history especially regarding effectiveness and side effect tolerability. The Medicaid Redesign Team's Proposal Number 15 takes away my choices and that is simply unacceptable to me. I want the most appropriate and stable medical care to be accessible to me and I want my personal physicians making those treatment decisions, not state officials.

On behalf of all New Yorkers suffering the devastating effects of chronic disease who are struggling to face yet another day filled with pain, limitations, and frustration, I passionately implore Committee Members to consider the negative impact Medicaid Redesign Team Proposal 15 will have on New Yorkers. Patients want to choose the members of their medical treatment team. NYS Officials do not belong on any patient's team. Nothing should come between a patient and their physician; this relationship is crucial in attaining the most optimum medical care. Treating physicians familiar with a patient's history should make treatment decisions. Prescribing physicians should have the final say period.

Due to my strong conviction in opposing Proposal 15 I have collaborated with numerous patient and professional societies throughout the state in a grassroots campaign to develop the following Memorandum of Support.

The undersigned New York State organizations applaud the New York State Medicaid Redesign Team (MRT) in reviewing, prioritizing, and consolidating the proposals it received from stakeholders across the state; resulting in the recommendation of 79 of these proposals. We strongly support initiatives that can improve our health care system and be cost efficient while still preserving health professionals' rights to make treatment decisions in the best interest of their patients. We believe it is imperative that the determination of appropriate medical treatment is best accomplished by open communication between the health care provider and patient and that this relationship remains intact. We are concerned with several of the proposals directed at altering the prescription medication benefit provisions that will jeopardize the provider/patient relationship and negatively impact Medicaid beneficiaries' access to lifesaving and life-enhancing medications.

There are two proposals on this list that could significantly affect patient quality and access to medicine that we are urging New York State Officials to:

> ***Reject*** **proposal #11** that would eliminate the fee-for-service Medicaid drug program and carve the drug benefit into managed care.

***Reject* proposal #15** that would eliminate "Prescriber Prevails" allowing the State Medicaid Director to make final determinations regarding prior authorizations of non-preferred brand drugs, and require prior authorization for currently protected classes of drugs (antipsychotics, antidepressants, anti-retroviral drugs, and immunosuppressants), and eliminate the Medicare Part D coverage wrap for dual eligibles for the same drugs.

Restricting Access to Medicines Harms Patients – Preserve the Protected Classes

- Establishing administrative barriers, such as prior authorization requirements, can discourage health professionals from prescribing the most appropriate medication for their patients. Delaying patient access to medicines denies care. Patients and their providers need open access to all medications in order to maintain consistent disease management. Disrupting continuity of care can result in detrimental life threatening consequences to the individuals who are the most vulnerable and can actually lead to more medical complications and higher health care costs.

- Basing decisions for inclusion on a formulary or preferred drug list on cost rather than clinical considerations, ignores important variations that can exist among patients in terms of safety, efficacy, and tolerability in drug classes. New scientific research shows there are gender, racial, and ethnic differences in responses to treatments, and limiting access will greatly widen already existing health disparities.

- Individuals with Psychiatric Disabilities – including individuals with schizophrenia, bipolar disorder or major depression and those with autoimmune disease such as lupus, rheumatoid arthritis, crohn's disease, scleroderma, sjögren's syndrome, multiple sclerosis, psoriasis – require individually tailored treatments. Many of these individuals have multiple co-morbid conditions that require unencumbered access to the full array of treatments. Individuals with complex care needs (e.g., mental health and multiple chronic conditions) require unique strategies to manage their care.

- Medications for mental illness vary greatly in their effectiveness in treating specific symptoms or disorders or in their side effects. HIV /AIDS treatment can be very complicated given severe side effects and interactions with other medications. Individuals with complicated multi-system diseases and organ transplants take a multitude of medications to stabilize and treat their conditions. Not all individuals receive the same

therapeutic effect or benefit from non-brand medications. Limiting the number of brand name prescriptions to 5 per month causes an interruption in stability of treatment, increases medical costs in the long run and increases the prescriber/provider workload.

- Individual response to any given treatment is not equal. Psychotropic medications often require weeks to fully take effect and abruptly discontinuing one medication without proper clinical guidance can have serious consequences. Immunosuppressant drugs are not always equivalent; what is tolerable for one individual may not be in the next. There is no single medication that individuals respond to—again treatment is highly individualized and no two people are alike. Transplant patients are particularly vulnerable and rely on their immunosuppressive medications to maintain the life of their organ. Their immune systems are sensitive and response to drug therapies differs from patient to patient. Once stabilized, any change in drug therapy can have adverse affects resulting in multiple complications – not the least of which may be rejection.

- Individuals with multiple chronic conditions are extremely complex and may require multiple medications for each of their chronic conditions. Health providers know best what therapies they intend to use to balance the various therapeutic and safety concerns in these complex patients. Many diseases are limited in treatment choices. The entire patient picture needs to be considered including: unique bio-chemical needs, individual compliance, side effect tolerability, and limited heterogeneity. There are over 100 Autoimmune Diseases and 50% of them have never had a drug specifically developed for the condition, therefore few therapeutic choices exist for these individuals. Lupus for example, has not had a new treatment in over 50 years; most therapies being prescribed are off-label.

- There is ample evidence that new medications which often cost more than older treatments–can offer some therapeutic advantages over conventional medicines. For example, older immunosuppressant therapies attacked a patient's entire immune system; causing detrimental side effects, while newer targeted therapies target a particular cell or biomarker making the treatment much more efficient and safer. Simply put, access to newer medications matters to patients in these protected classes.

- Eliminating the state funded Part D wrap around for dual eligible patients may expose thousands of New Yorkers to significant financial burden and may discourage them from considering transplantation as a treatment option. Transplantation not only gives a

dramatically improved quality of life, but it also saves healthcare dollars over the long term. The cost of dialysis for one patient per year is $71,000. The cost in the first year of transplantation is approximately $107,000 with subsequent years estimated at $18,000 - $20,000.

- The determination of the most appropriate medication for a particular individual with mental illness; HIV/AIDS; multi-system autoimmune diseases; or the recipient of an organ donation/transplant must be made on the basis of patient acceptability, prior individual drug response and side-effect profile, and long-term treatment planning – not on cost. Many of these individuals already face difficulties in their daily lives and do not need another roadblock to further complicate their medical care.

Elimination of Patient Protections

The prescriber prevails language was originally included in the law to ensure that the prescriber, who is acutely aware of their patients' needs, is able to make the ultimate decision about which drug therapy is best for his/her patient. It is imperative that this relationship between individual and prescriber remain intact. Only health care professionals familiar with a patient's personal medical history and uniqueness should be making these treatment decisions. The Medicaid system should facilitate this process not establish more obstacles for providers and patients to overcome. Limiting access to vital life-saving medications will disrupt continuity of care and result in driving up the cost of Medicaid in the long run by increasing the number of unnecessary hospitalizations and emergency room visits. Since the vast majority of Medicaid enrollees in New York State are children, blind/disabled, and elderly; and more than 50% are people of color, any limitations to treatment will disproportionately affect access to vital health care for the most vulnerable populations.

For the above reasons we urge New York State Officials to reject proposals 11 and 15. The undersigned New York State organizations strongly believe it is imperative that these safeguards remain in place to make certain that health professionals continue to be empowered to provide the best possible care to patients, and that patients' access to lifesaving and life-improving medicines is protected.

Lupus Foundation of Mid & Northern NY
National Kidney Foundation of NENY
Mental Health Association of New York State

Latino Commission on AIDS
National Kidney Foundation of Central NY
New York State Rheumatology Society
New York State Osteopathic Medical Society
Hispanic Mental Health Professionals
Lupus Alliance of America, Hudson Valley Affiliate
Lupus Alliance of America, Long Island/Queens Affiliate
Lupus Alliance of America, NY Southern Tier Affiliate
Lupus Alliance of America, Upstate NY Affiliate
The SLE Lupus Foundation
Lupus Foundation of Genesee Valley NY, Inc.
Scleroderma Foundation / Tri-State Inc., Chapter
Global Healthy Living Foundation
Hispanic Federation
Hispanic AIDS Forum, Inc.
Sjögren's Syndrome Foundation
South Bronx Mental Health Council
Promesa, Inc.
National Hemophilia Foundation
AIDS-Related Community Services
Epilepsy Foundation of Northeastern New York
National Alliance on Mental Illness Queens/Nassau
Southern Tier AIDS Program
New York Multiple Sclerosis Coalition Action Network
New York City –Southern New York Chapter
Long Island Chapter
Upstate New York Chapter
AIDS Care Rochester
National Alliance on Mental Illness-New York State
International Institute for Human Empowerment, Inc.

Thank you very much.

Kathleen A. Arntsen, Patient Advocate
March 3, 2011

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/Medicaid

March 3, 2011

Thank you for the opportunity to testify today. My name is Leah Farrell and I am the Policy Analyst for 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 10 counties in New York State and offices in Rochester, Corning, Geneva, and Albany, CDR represents the concerns of thousands of people with disabilities.

The disability rights community has been calling for redesign of Medicaid in New York for more than a decade. No one understands the impact of this system better because we see it first hand. It not only wastes taxpayer money, but steals our freedom by needlessly forcing some seniors and people with disabilities into nursing facilities and institutions. In fact, according to the latest report from Thomson Reuters, based on CMS figures, New York spends more per capita on nursing facility placement than any other state.

When the Governor announced the Medicaid Redesign Team (MRT), although others criticized it, we supported the approach. Many of us around the state participated in the MRT public forums. We repeatedly explained how Medicaid's system for providing long term services and supports could be redesigned to promote independence and integration, foster compliance with the Supreme Court's *Olmstead*[1] decision, and control costs. We provided the research and fiscal analysis to back up our suggestions which would save New York $1 billion over five years by shifting people from institutional to community based settings, maximizing the use of consumer directed services, and taking advantage of federal initiatives that promote rebalancing of the long term care system.

Part of our proposed savings can be achieved by implementing the Community First Choice Option (CFC), one of the new federal initiatives. Because of the hard work of disability rights advocates and the strong support of Senator Schumer, the Affordable Care Act included a provision that would allow states to provide community-based attendant services as an alternative to expensive institutional placement while giving the states an extra six percent in federal funding. I'll say it again, an additional six percent federal match with no sunset. Conservatively, we estimate that implementation of CFC would save New York at least $90 million a year.

Another proposal involves taking advantage of the Nursing Home Transition and Diversion (NHTD) Medicaid waiver. This is an existing program and does not require any additional

[1] *Olmstead v. L.C.* 527 U.S. 581 (1999)

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resources or infrastructure from the State. If the State transitioned only 10% of the Medicaid-eligible individuals living in nursing facilities who have expressed a desire to return to community-based living, according to CMS figures, even factoring in a 1% disenrollment rate, New York State would save $6.3M in the first year and $127.15M in the non-federal share over five years. Too often, people are placed in a nursing facility immediately following a hospital stay and struggle to leave this costly setting later to return to the community. By implementing an expedited enrollment process in the NHTD waiver and diverting just 10% of the Medicaid-funded nursing facility admissions, New York State would save $6.2M in the non-federal share during the first year and $125.25M in the non-federal share over five years. We gave the Administration specific recommendations for improving the NHTD waiver and reducing unnecessary red tape in order to take full advantage of the model's potential savings, yet we still have not seen any movement.

These are only a few of the recommendations that we submitted to the MRT. A copy of our report is attached to this testimony and an accompanying fiscal analysis is available upon request.

Although we had been told that every idea would be compiled, none of our proposals were included in the materials presented to the MRT. Perhaps the administration did not expect ideas to come from regular New Yorkers, particularly those with disabilities. Even so, $90 million in savings should have caught someone's attention.

In the world of public relations, often times, the nuances of a proposal get lost. I want you to really understand what was voted through:

- An elderly middle-class woman will be forced to divorce her husband in order to receive care in the community - or be pulled from her home to receive institutional care in a nursing home. (#18: Eliminate Spousal and Parental Refusal)

- A man with Multiple Sclerosis who may finally be on an effective medication regimen will have to "fail first" on different medication, resulting in potentially serious health risks and increased hospitalizations. His physician will no longer be able to insist his specialized medication is covered. (#15: Limit Access to Prescription Drugs)

- A newly disabled person with a Traumatic Brain Injury will only be able to get the therapies necessary to relearn walking, speaking, and self-care at a maximum of 20 sessions a year—that is less than one session every other week. This proposal could create a hindrance to people maximizing their independence by using therapies to reach a higher level of functioning. (#34: Establish Utilization Limits for PT, OT, and Speech Therapy/Pathology)

- A woman with a spinal cord injury will suddenly find out, because of a decision made by the health Commissioner, that she will not get the services and supports she needs to stay in the community. (#4652: Personal Care Utilization Limits)

- By increasing co-pays, a person living on SSI will put off health care that they feel they can "get away with" until their health deteriorates to a point that they require more costly care. This is well documented. People with disabilities on fixed, low incomes,

cannot incur additional co-pay expenses and instead would forgo necessary care, such as skipping a doctor's visit or cutting pills in half. (#104: Increase Enrollee Copayment Amounts for MA FFS and FHP; Require Copayments for CHP)

- A blind man will not get adequate assistance doing simple tasks like laundry or vacuuming to ensure his home is clean and safe. Or an elderly woman with diabetes may skip a meal because she cannot get assistance with preparation of adequate nutritional meals in order to prevent health complications. (#4652: Limit Personal Care Level I to 8 hours a week)
- Most alarming, there is a mandate that nearly 20,000 seniors and people with disabilities who need long term care must enroll in Managed Long Term Care (MLTC) plans; a system with a built-in financial incentive to serve those people that do *not* have significant disabilities. (#5 and #90: Mandatory enrollments in Managed Long Term Care) Currently, one in three Managed Long Term Care plan members file complaints, while fewer than half of the complaints (41.5%) are resolved satisfactorily from the consumer's point of view[2]. In addition, there are few younger people with significant disabilities served in the existing MLTC programs[3]. Finally, the vast majority of all current enrollees live in New York City (92%)[4]. Why, then, is managed long term care the State's solution to redesigning Medicaid, given this as the starting point? There is a concern that MLTC will not result in promised savings, but will only pull money out of direct services.

It's not at all clear that these proposals are "penny wise," but they are most certainly pound foolish. It is understandable that the State hopes that managed care will provide cost savings. It offers the budgetary convenience of a per enrollee "capitation" payment (i.e. insurance premium) and transfers certain financial risks to managed care organizations (MCOs) which act like HMO insurance companies. Unfortunately, in the absence of carefully crafted health care quality standards and meaningful enforcement of those standards by the State, the profit-making priorities of the MCO threaten to overwhelm their health care function to the detriment of New Yorkers.

One of the more concerning components to the MRT package is the across the board cut because, in the end, it appears it is not across all sectors. The draft bill language states, "...be subject to a uniform two percent reduction and such reduction shall be applied, to the extent practicable, in equal amounts during the fiscal year, provided, however, that an alternative method may be considered at the discretion of commissioner of health and the director of budget based upon consultation with the health care industry." Health care industry, i.e. not consumers. Imposing a cap at a time of economic downturn and a rise in the senior demographic is very concerning. On top of that, there are still over $500 million in unspecified cuts necessary to reach this stated target with no publically disclosed details. Crain's reported that the Administration has given control over services to providers and included a "gain-

[2] *Managed Long Term Care (MLTC) Plan Member Satisfaction Survey Report.* Prepared on behalf of the New York State Department of Health. IPRO, October 22, 2007

[3] ***An Overview of Medicaid Log-Term Care Programs in New York: Medicaid Managed Long-Term Care.*** United Hospital Fund Medicaid Institute. Prepared by Alene Hokenstad and Meghan Shineman of the United Hospital Fund and Roger Auerbach of Auerbach Consulting, Inc. April 2009.

[4] Ibid

sharing arrangement" if actual spending is lower than his global target[5]. This creates a system where provider networks and managed care entities will be financially rewarded for restricting access to services.

There is a clear institutional bias at play here. While we may not always agree with the New York State Association of Health Care Providers, they rightfully noted that approximately 33% of the Medicaid cuts target home care, despite the fact that community-based long term care is the most cost-effective model. And community-based care accounts for just 12% percent of Medicaid long term care spending on seniors and people with physical disabilities.

In just the few hours we have had to review the actual language in the legislation, it is clear that all of the identified stakeholders on the MRT got something out of the process. Because we need to achieve savings in a closed system, the offset for these "gives" will be cuts to services for people with disabilities, with the brunt of the cuts hitting people who have the most significant disabilities.

According to the draft Article VII language, regarding changes to the personal care program, "the commissioner is authorized to adopt standards for the provision and management of services available under this paragraph for individuals whose need for such services exceeds a specified level to be determined by the commissioner." This gives the Administration complete authority to cut services in the personal care program without public comment or discourse and it clearly targets people with the most significant disabilities. Reducing access to services for seniors and people with disabilities is NOT the only way to reform the Medicaid system and save the state money. The ideas presented by the disability rights community - including implementation of the Community First Choice Option - provide opportunities for the State to bring needed reform to Medicaid long term care and generate long term savings. Research shows that states are containing Medicaid costs using the approaches we are proposing

Finally, it is important to recognize that the right to live and receive services in the most integrated setting has been affirmed by the Supreme Court in the *Olmstead* decision. An increase in home care is a step in the right direction; a fact to be applauded, not deplored. New York State has already been found non-compliant with this important civil rights decision. Disturbingly, the issue of supporting people in the most integrated setting has not been publicly acknowledged in this process. The disability rights community has worked to show the state that we can achieve both goals: contain costs and comply with *Olmstead.* We ask you to support our civil rights and do what is right for the state.

Again, I have attached our proposals that reduce New York State spending <u>and</u> promote the independence and integration of seniors and people with disabilities and I strongly urge this Legislature to review them. Thank you.

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[5] *NY Medicaid panel makes surprise move.* Crain's New York Business. Barbara Benson. February 24, 2011

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Proposals to reduce New York State spending and promote the independence and integration of seniors and people with disabilities

January 7, 2011

"We have the highest [Medicaid] rate in the nation, and that's just not sustainable...I want to bring in the people who are actually doing business with the State and say, 'Guys, we can't afford it anymore. We have to reduce the amount we spend on Medicaid. Let's redesign the program together, otherwise, I'm just going to have to cut off the top, and that's not the best way to do it.'"

- Governor-elect Andrew Cuomo speaking at the Roswell Park Cancer Institute, October 25, 2010

The disability rights community could not agree more. To this end, the New York Association on Independent Living (NYAIL) and the Center for Disability Rights (CDR) offer the following action plan for both immediate and long term savings in New York's Medicaid program. NYAIL is a membership organization of Independent Living Centers (ILCs) across New York State which works to improve the quality of life and safeguard the civil rights of people with disabilities. ILCs are community-based not-for-profit organizations which are controlled by and largely staffed by people with disabilities. ILCs are cross-disability providers of services and advocacy to people of all ages. CDR is a statewide organization providing services and advocacy devoted to the integration, independence and civil rights of all people with all disabilities. CDR is a member of NYAIL, as well as a leader in the disability rights movement through its support of ADAPT, a national, grassroots, disability rights network devoted to eliminating Medicaid's institutional bias.

The Independent Living Center network has served as the voice of the disability rights movement in New York since its inception more than two decades ago. ILCs help the state advance policies of community integration and move people with disabilities from institutions and other segregated settings to the community, as required by the Americans with Disabilities Act and the *Olmstead*[1] decision. Major successes of the ILC network's advocacy include the creation of the Most Integrated Setting Coordinating Council (MISCC), the state Medicaid Buy-In for Working People with Disabilities program, the Nursing Home Transition and Diversion (NHTD) Medicaid waiver program, and the NHTD waiver housing subsidy.

ILCs have been transitioning and diverting people from institutions for more than 20 years and have played a critical role in implementing the Nursing Home Transition and Diversion waiver program, with five ILCs serving as the Regional Resource Development Centers (RRDC) for the waiver, and many others providing waiver services. Data collected by VESID has shown that ILC transition and diversion efforts have saved the state more than $110 million per year in institutionalization costs, including Medicaid and other state funds.[2] In addition, NYAIL and ILCs are helping the state rebalance the long term care system through the federal Money Follows the Person Rebalancing Demonstration (MFP). NYAIL is working to increase accessible, affordable, integrated housing for seniors and people with disabilities, while ILCs are identifying and assisting individuals in nursing facilities who wish to live in the community.

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[1] *Olmstead v. L.C.* [527 U.S. 581 (1999)]

[2] *NYS Independent Living Centers Deinstitutionalization Cost Savings*, October 2001-September 2009 Statewide Report, VESID

A significant reason that New York's long term care system is so expensive is that it remains unnecessarily biased towards institutional care, at a time when other states have reduced Medicaid costs by "rebalancing" their Medicaid programs. Statistics to support this are provided in the recommendations.

Ample opportunity for reform exists. There is a large population of New Yorkers, both current users and those at risk of needing long term care, who want to live in the community. Consider the following statistics:

- According to the state's 2010 3rd quarter report on the Center for Medicare and Medicaid Services (CMS) Minimum Data Set (Q1A), there are currently 22,248 New Yorkers living in nursing facilities that indicated they wish to return to the community.
- According to the AARP Policy Institute, 89% of Americans over age 50 want to remain in their own homes as long as they can.[3]
- Through an analysis of federal data from the Department of Health and Human Services, National Public Radio's Investigative Unit found that young people ages 31 to 64 now make up 14 percent of the nursing home population, an increase of 10 percent in 10 years.[4]

As importantly, rebalancing the long term care system will help meet the state's legal obligation to provide its citizens with assistance in the most integrated setting under both the federal Americans with Disabilities Act and the 1999 *Olmstead* ruling by the U.S. Supreme Court. In 2010, the state has already been found to be non-compliant with *Olmstead* by the *Disability Advocates Inc. v. Paterson*[5] ruling. Clearly, the state should be designing its system into compliance, rather than having federal judges order changes in the long term care system. Importantly, these efforts will also result in more than $1 Billion structural savings in the state's Medicaid program over five years.

Proposed Policy Change	Associated FY 2011-2012 MA Non-Federal Share Savings
Shift people from institutions to community-based settings:	
1. Increase transitions on the NHTD waiver	$6.31 M
2. Divert people from nursing facility placement using the NHTD waiver	$6.21 M
Take advantage of the Federal health reform initiatives that support community-based programs:	
3. Implement the Community First Choice option	$7.85 M
4. Authorize the State Balancing Incentive Program	$4.02 M
Transition from a medical-model to a consumer directed model of care:	
5. Shift people from CHHAs to Consumer Directed Personal Assistance Program	$4.46 M
6. Shift people from personal care assistance to CDPAP	$1.93 M
7. Expand pool of direct care workers	$11.48 M
8. Increase use of assistive technology to increase independence	$1.74 M
Total Medicaid Non-Federal Share Savings	**$44.00 M**
Total Medicaid Non- Federal Share Savings Over 5 Years	**$1.009 Billion**

[3] *Providing More Long-Term Support and Services at Home: Why it's critical for health reform.* AARP Public Policy Institute, Fact Sheet, 2009.

[4] *A New Nursing Home Population: The Young. National Public Radio,* http://www.npr.org/2010/12/09/131912529/a-new-nursing-home-population-the-young, December 9, 2010

[5] 653 F. Supp. 2d 184 (EDNY 2009)

SHIFT PEOPLE FROM INSTITUTIONS TO COMMUNITY-BASED SETTINGS

National research has demonstrated that states which shift from using institutional care, including nursing facilities, to community-based models of care are leveling out their long term care costs, while states that are not making this transition are continuing to see their long term care costs escalate. According to a recent study in *Health Affairs*, "It seems apparent that states offering noninstitutional LTC services as an alternative to institutionalization are not only complying with the *Olmstead* decision and meeting the demands of their citizens with disabilities, but are also potentially saving money."[6]

Unfortunately, state policy makers in New York have not recognized this potential. Instead of supporting the shift toward community-based services, over the past several years these services, particularly the state's Personal Care program, have been criticized in New York State as exorbitant "Cadillac care". In budget presentations, Department of Health staff repeatedly point out that New York State spends more on personal care than any other state. However, when comparing state Medicaid spending, one cannot analyze New York's personal care program in a vacuum. In New York, the personal care program serves people who are nursing facility eligible. In other states, these people would receive long term services and supports through a Medicaid waiver program. Consequently, when analyzing the spending for the Personal Care program, we must evaluate it in the context of combined spending for both personal care and Aged and Disabled (A/D) waivers.

The most current 2009 data from Thomson-Reuters (formerly Medstat) paints a picture of New York State's long term care system that is drastically different than the view espoused by DOH. New York State does not spend the most for these services, and is a distant fourth in spending for this population. In fact, New York spends $123 *less* per capita than the top-ranked Washington, D.C. Alaska and Minnesota also significantly surpass New York. Additionally, DOH has often noted that the spending in the personal care program has gone up as the number of people in the program has declined. In New York City, advocates have recognized that Managed Long Term Care programs have cherry-picked those individuals with low care needs, leaving people with the highest care needs in the State Plan personal care program.

Not only are these attacks on personal care unsubstantiated and misleading, they have distracted state policy makers from the real problem in New York State's system for providing long term services and supports: the institutional bias and an overreliance on nursing facilities. Moreover, by not addressing the institutional bias and making across the board cuts to home and community based services, New York State will just further lock itself into an expensive and unsustainable system.

While NYS has made some efforts to rebalance the long term care system since the 1999 U.S. Supreme Court *Olmstead* decision, when comparing the progress other states have made, New York has notably slow rebalancing outcomes and has continued to increase institutional spending. Based on data from Thomson-Reuters, New York ranks 35th in long term care rebalancing efforts to increase community-based services (including personal care, home health, and A/D waivers); the state only raised its percentage of community-based spending by 7.43 percentage points since 2000. Conversely, New Mexico gained 55.6 percentage points, rising to number one in balancing efforts and transforming its long term care system to serve people in the community. Since 2000, New Mexico reduced its institutional per capita spending to a mere $29.72 per person, the lowest in the nation.

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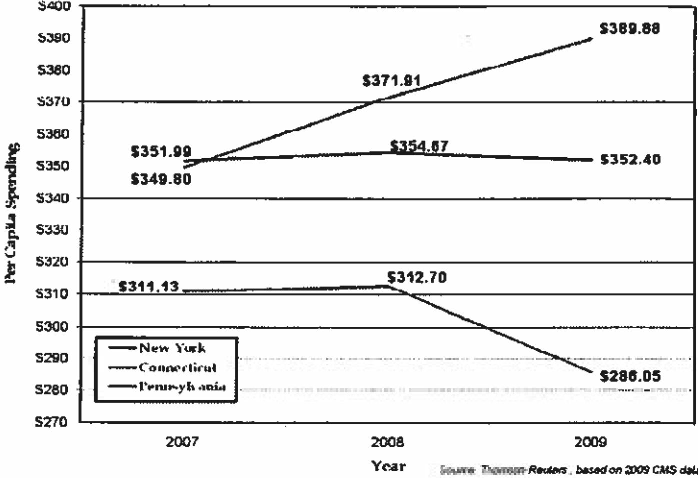
[6] *Do Noninstitutional Long-Term Care Services Reduce Medicaid Spending? Home and community-based services help people with disabilities stay in their homes while reducing long-term care spending.* H. Stephen Kaye, Mitchell P. LaPlante, and Charlene Harrington. *Health Affairs* 28, No. 1, Jan/Feb 2009.



The failure to address the institutional bias in New York is most clear when comparing per capita spending on nursing facilities. In 2007, only three states had per capita spending of more than $300, and New York ranked second at $349.80 per capita, just after Connecticut. Over the last three years, the spending in these three states has moved in very different trajectories. New York State has increased per capita spending on nursing facilities by about $20 each year, exceeding Connecticut's spending in 2008 to now have the highest per capita spending on nursing facilities. Since 2007, Connecticut has leveled its spending on nursing facilities, while Pennsylvania (ranked third) has undertaken substantial rebalancing efforts and significantly decreased per capita nursing facility spending. Based on these data, it is clear that New York State has not committed to reducing institutionalization, complying with the *Olmstead* decision, and rebalancing its system of long term services and supports.

We propose that New York State implement specific policy changes that will contain Medicaid spending for long term services and supports. While the largest savings will develop over years, even with an analysis that uses conservative projections, New York State can achieve significant savings in FY 2011.

The following two recommendations would entail a **policy change** within the Department of Health, which has historically been over reliant on facility placement, to shift people toward more cost-effective community-based services using the Nursing Home Transition and Diversion (NHTD) Waiver. Because of previous advocacy efforts by the disability community and Independent Living Centers, these recommendations do not require additional budgetary or legislative action and the new administration has the authority to implement them immediately.

1. **Increase utilization of the Nursing Home Transition and Diversion (NHTD) Medicaid Waiver to transition people from nursing facility placement to community living, for a potential first year savings of $6.3 million in the non-federal share.**

According to the state's 2010 3rd quarter report on the Center for Medicare and Medicaid Services (CMS) Minimum Data Set (Q1A), there are currently 22,248 New Yorkers living in nursing facilities that have indicated they wish to return to the community. Only California has more nursing facility residents who have indicated they wish to return to the community. That amounts to $406 million the state could be saving annually by de-institutionalizing this population. In fact, the savings could be more substantial. Studies indicate that this percentage is significantly understated and that a large percentage of people who would like to return to the community is undercounted in the report. In fact, under the state's Money Follows the Person Outreach Program, about 8% of people with limited assistance needs who are listed in the MDS data as not wanting to return to the community, have expressed a desire to return to community living after being contacted by the program. Even this modest percentage has the potential to additionally save more than $123 million each year, raising the potential annual savings to $529 million.

Unfortunately, despite the potential for significant savings, the state's original estimates for Nursing Home Transition and Diversion Waiver enrollment have not been met. The Department of Health estimated there would be 5,000 enrollees by the end of the third year of waiver implementation, in August 2010, but as of December 2010, waiver enrollment was just 674 individuals. While DOH has worked to implement the waiver, overly bureaucratic processes have slowed progress. Department staff – at times – has micro-managed the program resulting in an overly regulated and overly bureaucratic process that simply does not need to exist. DOH has contracted with nine Regional Resource Development Centers to administer the NHTD waiver. An effective strategy to increase waiver enrollment would include utilizing the RRDCs more effectively and allowing them to exercise the level of discretion intended when the program was created. By streamlining state government and reducing the unnecessary bureaucracy, the NHTD waiver has the clear potential to help the state achieve significant cost savings.

The NHTD waiver is too small and too new to have good data to effectively demonstrate its own cost savings, but the cost saving potential is very similar to the state's experience with the Traumatic Brain Injury (TBI) waiver. The TBI waiver's track record is a strong indicator of NHTD's potential for significant savings. The TBI waiver is becoming even more comparable, as the population of younger people in nursing facilities continues to rise. Reversing this trend has the potential to generate significant long-term savings, as over time these individuals have a greater opportunity to develop improved independent living skills and more extensive informal supports.

We use the TBI waiver's savings as a model and conservatively assume only 85% of these savings. If only 10% of the Medicaid-eligible individuals who have expressed a desire to return to community-based living were transitioned to the waiver (112 participants per month), New York State would save $6.3 million in the first year, even factoring in a 1% disenrollment rate. This proposal would save $127.15 million over five years. (*Additional detail on this calculation and the calculations below will be available upon request.*)

2. **Establish an expedited enrollment process for the NHTD and TBI waivers to divert people from nursing facility placement, for a potential annual savings of $6.2 million in the non-federal share.**

   Too often, people are placed in a nursing facility immediately following a hospital stay, and are unable to leave this costly setting later to return to the community. The lengthy and difficult enrollment process for waiver services contributes to nursing facility placement at hospital discharge. This has also slowed enrollments and limited the savings potential of the waiver. The Health Department should create an expedited enrollment process that allows seniors and people with disabilities to immediately return home from a hospital stay.

   This approach would promote the goal of individual independence and help people return home with more cost-effective community-based services by reinforcing an attitude of self-reliance rather than promoting dependence on services. (*Specific details on the expedited enrollment proposal are available in a separate paper.*) Although the Department of Health recently created an interim service coordination option as well as a revised initial service plan to hopefully address some of the barriers that have resulted in slowed enrollment, this approach still has the potential to easily bottleneck enrollment. Our proposal would more effectively address barriers to enrollment.

   By implementing our recommendations for an expedited enrollment process and diverting just 10% of 13,187 Medicaid-funded nursing facility admissions (only 110 admissions per month), New York State would save $6.2 million in the non-federal share during the first year while promoting the

independence and integration of these individuals by avoiding long-term institutionalization. Over five years, this proposal would save $125.25 million.

TAKE ADVANTAGE OF FEDERAL HEALTH REFORM INITIATIVES PROMOTING REBALANCING

There are significant long term care reform initiatives in the *Patient Protection and Affordable Care Act* that would help New York State rebalance its long term care system and pay for community-based services: The Community First Choice Option (CFC), the State Balancing Incentive Payments Program (BIPP), and the extension of the Money Follows the Person Rebalancing Demonstration (MFP) (Pub. L. No. 111-148). Each offers an incentive for additional federal matching funds to the state's efforts to increase independence, save state Medicaid dollars, and serve people where they choose to live – in their own homes in the community.

3. **Implement the Community First Choice Option (CFC) and shift people from the traditional personal care program into the CFC state plan program, to realize $4.5 million of savings in the non-federal share during the first year, with the potential to save New York more than $391 million over five years.**

The ***Community First Choice Option*** allows states to create a community-based state plan service for people who are at an institutional level of care. There is a substantial financial incentive for creating a program that closely parallels New York's existing Personal Care option. Expenditures under the CFC option receive an additional six percentage points of the federal medical assistance percentage (FMAP). New York State could realize significant savings by drawing down these additional federal dollars through seamlessly shifting nursing facility eligible people in the existing personal care program to the CFC Option.

According to United Hospital Fund, 65 percent of the people enrolled in the state's Personal Care Program are at the nursing facility level of care.[7] We conservatively estimate that because these individuals have the most significant assistance needs, they would account for 85% of the expenditures in the program. Based on 2009 spending data from Thomson-Reuters, New York spent $2.7 billion on personal care services. The additional 6 percent FMAP available through implementing the Community First Choice Option on the $2.3 billion spent for nursing facility eligible individuals would result in nearly $139 million of additional FMAP to New York State on an annual basis. The savings potential to New York is significant, but the CFC option would require the state to make an incremental increase in the eligibility and services of the program, which would partially offset our savings projections, as described below.

As determined in the *Rodriguez*[8] decision, the Personal Care program does not provide safety monitoring as a discrete service. The CFC option would require the state to provide services to people who require this type of support, but don't need hands-on assistance. This small population is already served in New York State nursing facilities. They can be identified using the Minimum Data Set (MDS) Active Resident Information Report from the CMS website. Report G2b indicates that 1.5% of nursing facility residents require no setup or physical help from staff with bathing, the activity of daily living that is most likely to require hands on assistance. The percentage of people who meet this criteria in the community would not likely be different that that in the resident report.

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[7] *An Overview of Medicaid Long-Term Care Programs in New York.* Prepared by Alene Hokenstad, Meghan Shineman, and Roger Auerback. Medicaid Institute at United Hospital Fund. April 2009.
[8] *Rodriguez v. City of New York*, 197 F.3d 611 (2nd Cir., Oct. 6, 1999)

We assume in our calculations that the cost of serving this population under the CFC Option would reduce the potential state savings. Because factors such as the range of care needs, cost, and the potential impact of the "woodwork effect" are already factored into New York's spending on the Personal Care Program, our projections anticipate increased Medicaid spending on Personal Care Services for nursing facility eligible individuals by this same percentage (1.5%). This small percentage increase seems reasonable. Although implementing the CFC expands the available services, the expanded population is already served by Home and Community Support Services (HCSS) in three of the state's waiver programs (NHTD, Traumatic Brain Injury [TBI], and Long Term Home Health Care Program [LTHHCP]). We estimate that adding services for this population would increase state spending by $15 million annually.

The CFC Option would also expand services to individuals who are Intermediate Care Facility (ICF) eligible as well. According to the Commission on Quality Care/Office of the Advocate for Persons with Disabilities, there are 4,000 people on the waiting list for services through the Office for Persons with Developmental Disabilities (OPWDD). All of these individuals are not ICF eligible or currently in need of services as families often add their names to waiting lists long before services are needed. Assuming that 85% of the individuals are ICF eligible and 90% of those actually need services, there would be 3,060 people who would need to be served.

Because this population generally lives with family and is at school or another program during the day, they would not require as many hours of assistance as is typically provided in the personal care program. Assuming that an average individual would need a couple of hours in the evening and some additional hours on the weekend, we anticipate that people would be authorized for 25 hours per week. Using the PCA rate, that would increase state spending by $37 million annually.

New York would eliminate HCSS as a waiver service because that assistance would now be available under the State Plan, and the state would receive additional funding from the enhanced FMAP under the CFC Option. In-home assistance accounts for the bulk of the cost in serving waiver enrolled individuals, and New York would be able to draw down the enhanced 6 percent FMAP on all of these services, further increasing the savings associated with our earlier recommendations to facilitate expedited enrollment in these waivers. Transitioning all people receiving HCSS services under the waivers to the CFC option would generate an additional $4.8 million in the enhanced FMAP funding annually.

The implementation of the CFC Option would also allow New York to move toward a more cost-effective model for providing assistance in the community. Because the CFC Option serves people with all types of disabilities, it could be the first step in developing a consolidated service system and allow the state to eliminate costly, redundant and confusing state bureaucracies. The addition of this level of service has the potential to provide a more cost-effective option for serving individuals with developmental and intellectual disabilities.

Implementation of the CFC Option should also address a critical need in community living: medication administration. According to the recent proposal by PHI,[9] the state should create "medication aides" to address the issue of medication administration – a service not currently covered in traditional personal care. Rather than modify the existing Personal Care or Certified Home Health Aide programs, however, the state should incorporate this health-related task in the

[9] *A Home and Community-Based Service System Reform Blueprint*. Rick Surpin. PHI and Independence Care System, November 2010.

CFC option, which would further promote the use of this service and increase the state's ability to draw down the additional federal funds.

Although many of the recommendations above could be implemented administratively, the CFC Option will also require legislative action, including it in the state budget and amending the Nurse Practices Act to allow for the incorporation of consumer direction in the new service option.

Ultimately, the state's long term care system would evolve into a three-tiered system. Personal Care Aide services would provide in-home assistance with activities of daily living (ADLs) to people who are not at the nursing facility level of care. Consumers who are nursing facility eligible and need basic in-home supports would receive assistance through the CFC program. Finally, those with additional needs (such as home modifications and structured day program services) would be able to get these auxiliary services through the HCBS waivers. (*See chart to the right.*)

How New York's Long Term Care System Could Incorporate the Community First Choice Option

Program	People Served
HCBS Waiver Services	Individuals at or above the nursing facility level of care who need assistance with the activities of daily living and instrumental activities of daily living as well as more intensive supports like home modifications and independent living skills training
Community First Choice Option	Individuals at or above the nursing facility level of care who need assistance with the activities of daily living and instrumental activities of daily living
Personal Care Program	Individuals below the nursing facility level of care who need assistance with the activities of daily living

Finally, it is well-understood that New York's current long term care system is dominated by diagnostic "silos". The CFC Option, because it is based on functional need and not diagnosis, has the potential to be the first step in rationalizing the state's service delivery system across disability categories and state agencies. This would not only eliminate gaps in the service systems and simplify navigating the long term care system, it could generate millions of dollars in savings through the elimination of duplicative state bureaucracies. CMS is expected to release the rules shortly and the state can implement the CFC option as of October 2011. The base proposal would save the state $4.5 million during the first year. Over five years, it would generate over $332 million is savings.

4. **Take advantage of the State Balancing Incentive Payments Program to access $12 million in additional Medicaid funds; use Money Follows the Person incentives to continue these rebalancing efforts.**

New York State is eligible to participate in the ***State Balancing Incentive Payments Program***. This program offers an additional two percentage points of the federal medical assistance percentage (FMAP) to states with less than 50% of total Medicaid long term care expenditures on community-based services. In order to receive the additional funds, the state must make a proposed budget that details the State's plan to expand and diversify medical assistance for non-institutionally-based long-term services and supports, and exceed 50% spending on community-based services by October 1, 2015. The state will receive an additional 2% FMAP for the community-based expenditures used for the rebalancing, for expanding programs like personal care, the Consumer Directed Personal Assistance Program (CDPAP), and waiver programs.

To participate in this program, states must propose budget plans for three initiatives: (1) "establishment of a 'no wrong door—single point of entry system,'" (2) conflict free case management, and (3) uniform assessment instruments to determine eligibility for community-based

services. New York is already on the path to implementing these programs and would not have to invest significant resources to participate in the rebalancing program to draw down the additional FMAP.

DOH recently de-funded the NY Connects program, which had been implemented by the New York State Office for the Aging through the Area Agencies on Aging. Some have proposed this program serve as New York's single point of entry. Rather than fund an entire new system, we propose that the state use a "no wrong door" approach, for the purpose of participation in the balancing incentive payments program, by utilizing its extensive network of Independent Living Centers along with local Area Agencies on Aging, to provide information on long term care services to seniors and people with disabilities. New York State can capitalize on the service planning component of the Medicaid waivers and CFC Option to meet the requirement for conflict free case management. Finally, the state has contracted with InterRAI to develop a comprehensive uniform assessment tool to assess functional need which would meet the requirement for uniform assessment instruments. Not only is the state eligible to participate in the State Balancing Incentive Program, but to do so would require no significant additional resources because the state has the ability to or has already begun implementing these initiatives.

LTC in NYS	Expenditure	Percentage	Community v. Institution
Personal Care	$2.721 B	14%	47%
All HCBS Waivers	$4.854 B	24%	
Certified Home Health	$1.775 B	9%	
Nursing Facilities	$7.618 B	38%	53%
ICF-MR	$3.112 B	15%	
Total	$20.080 B	100%	100%

Based on 2009 CMS data analyzed by Steve Gold, presented at the New York Association on Independent Living Olmstead Conference, October 2010

New York State is eligible for this enhanced FMAP until its long term care spending shifts by three percent toward the community. Factoring in a reduced growth rate in total long term care spending - to account for needed budgetary reductions - New York State can expect to achieve a savings of $12M in total long term care spending over three years by rebalancing the system toward community-based options. It is actually to the state's benefit, where possible, to avoid significant cuts to Medicaid long term care at this time in order to draw down additional federal dollars through the enhanced 2% match.

Under the *Patient Protection and Affordable Care Act*, the Money Follows the Person Rebalancing Demonstration Program (MFP), scheduled to end in 2011, was extended for five years, with an additional annual appropriation of $450 million for each FY 2012-2016. Although states are required to spend the additional FMAP available through this program on rebalancing initiatives, and thus there are no cost savings generated directly by this program, MFP was specifically designed to support these rebalancing initiatives.

DOH's MFP workgroup, which advises the state on the program's implementation, has strongly recommended continuing and expanding two critical elements of the project:

1) activities intended to increase affordable, accessible and integrated housing for seniors and people with disabilities, and 2) outreach to individuals in nursing facilities who may wish to live and receive services in the community. Both of these initiatives are critical to the state's rebalancing efforts.

In 2005, the Independent Living Centers and disability rights community worked closely with DOH on the state's initial MFP application to CMS, identifying the lack of affordable, accessible and integrated housing as the primary barrier to successful Nursing Home Transition and Diversion. The

advocate group also identified providing residents who might choose to leave a nursing facility with information about transitioning to community living, on a peer to peer basis, as a promising way to identify transitions that could generate the most significant savings through enrollment in the NHTD waiver.

Independent Living Centers play a major role in both of these initiatives. In fact, New York's MFP program has become a national model of collaboration by a state with the Independent Living Center community. According to a report produced by CMS in association with Ascellon that examines the relationship between Centers for Independent Living (CILs) and MFP,

> *"CILs are key partners in the MFP Demonstration in the five states included in this report [including New York]. Keys to a successful relationship between project staff and CILs are learning about each other's philosophy and developing a process that supports choice and independence while recognizing and preparing for the risks that might accompany the consumer's choices."*[10]

More generally, another recent study funded by CMS supports the critical role of ILCs in helping states comply with federal law and save costs:

> *"Centers for Independent Living continue to demonstrate value in assisting individuals with disabilities of all ages to gain needed skills and obtain needed supports to live independently in integrated community settings. Centers have proven to be effective partners in helping government comply with the Americans with Disabilities Act and save money by supporting individuals with disabilities to live in less-costly community settings."*[11]

The state should direct additional resources from the increased FMAP available through MFP for rebalancing activities to ILCs during the five year MFP extension. These funds should be used to continue and expand the existing initiatives, which have been implemented in partnership with ILCs, to increase affordable, accessible and integrated housing for seniors and people with disabilities and to provide outreach to individuals in nursing facilities who may wish to live in the community

TRANSITION FROM A MEDICAL-MODEL TO A CONSUMER DIRECTED MODEL OF CARE

Not all home and community-based services are alike or equally cost-effective. A person may receive long-term services and supports in the community from a medical model agency or through a consumer directed program. Medical model services were developed during a time when disability was seen as a medical condition requiring medical intervention. In contrast, consumer directed programs evolved because seniors, people with disabilities, and their families wanted to assert more direct control over the services they received.

In a consumer directed program, *consumers* (or family members), as opposed to an agency, manage the services and are empowered to hire, direct, and dismiss their attendants in accordance with their plan of care. This results in lower costs to the state through reduced reimbursements, because consumers take on the administrative roles (i.e., scheduling) that an agency nurse or case manager is typically responsible for. In addition, aides can perform skilled tasks that under an agency model are performed by expensive medical personnel.

[10] *Exploring the Relationship between the Money Follows the Person (MFP) Program and the Centers for Independent Living (CILs), Final Report.* Robert Mollica, Rhonda Simms, and Sheila Scott. Prepared by the Centers for Medicare and Medicaid and Ascellon. Contract No. GS 10F 00244S, Task No. HHSM-500-2007-00262G. April 30, 2010.

[11] *Independent Living Centers: Experienced Local Partners for Medicaid Home and Community Based-Services.* Center for State Health Policy, Auerbach and Claypool, June 2008.

Studies have proven that consumer directed services result in higher satisfaction among consumers. According to a report by the National Council on Disability, "Studies of consumer direction indicate positive outcomes in terms of consumer satisfaction, quality of life, and perceived empowerment. There is no evidence that consumer direction compromises safety—in fact, the opposite appears to be true. Individuals who have participated in consumer directed systems express strong preference for consumer direction and satisfaction with their care."[12] The state should offer consumers real choice in long term care and promote programs, like consumer direction, that produce higher levels of satisfaction and reduce costs.

5. **Implement a plan to shift some people currently receiving long term services through the Certified Home Health Agency (CHHA) program to the less costly Consumer Directed Personal Assistance Program, for a potential first-year savings of $4.5 million in the non-federal share.**

The Consumer Directed Personal Assistance Program (CDPAP) is the most cost-effective model for assistance in the home because the per-hour rate for CDPAP is less costly than other home care services. As previously mentioned, cost savings results from reducing or eliminating the nurse/case manager role in scheduling, training and supervising the direct care worker. Additional dramatic savings accrue under CDPAP by allowing direct care workers to perform skilled tasks which otherwise would be performed by expensive medical personnel.

New York State relies significantly on agency-controlled home care, ranking number one in Certified Home Health Agency (CHHA) care per capita spending at $90.85 in 2009. Certified Home Health care accounts for 14.75% of the state's Medicaid long term care spending for aged and physically disabled individuals. In other states, CHHA services account for a far smaller percentage of long term care spending. For example, Certified Home Health care in Washington State is just 2.04% of spending. Compared to Certified Home Health Agency care, CDPAP reduces Medicaid spending by $9.52 for every hour of service. The state can realize significant savings by better utilizing CDPAP instead of CHHA services.

We recommend the state initiate efforts targeting the CHHA population receiving long term services. Because CHHA services are not authorized through the Local Departments of Social Services (LDSS), the Department of Health can identify usage for each county, including consumers who are the long term, high cost users of CHHA services. The LDSS could meet with these consumers and assess whether they would be appropriate for CDPAP, paying particular attention to whether the consumer has a "self-directing other" (such as a family member) who could manage the services if the consumer cannot do this for him or herself. The State should direct counties to meet specific transition targets based on these usage reports.

Using a conservative assumption of 5 hours of service per day and shifting approximately 1,000 people over one year from Certified Home Health care to CDPAP, the state would reduce Medicaid spending by approximately $8.9 million (a savings in the non-federal share of $4.5 million) during the first year of implementation.

Assuming that the state pursues the CFC Option as a way to secure the enhanced FMAP, this proposal would generate additional savings. In addition to saving money because people are being served in a more cost-effective model, were CDPAP incorporated into the CFC Option, the state would receive an additional $1.11 million in the first year. This amount would increase in each year

[12] *Consumer directed health care: how well does it work?* National Council on Disability, October 2004.

as more people transition into the program, resulting in an additional $22.36 million is savings over five years.

The Independent Living Center and disability rights community successfully advocated in the 2009-2010 state budget for a change in state law to expand participation in CDPAP.[13] The amended statute requires counties to set CDPAP enrollment targets and develop annual implementation plans, with the goal of increased consistency in approved service levels across the state. It also provided funding to implement a peer based program of education and outreach to eligible individuals, and training for discharge planners, local Departments of Social Services, and others. As a result, DOH issued an RFP and is currently negotiating a contract with the Consumer Directed Personal Assistance Association of New York State to implement the program in 2011. As counties identify consumers in CHHAs who could be effectively served at a lower cost in CDPAP, the counties could refer these consumers to the new program to assist with the transition. This proposal requires no additional funding and can be implemented administratively through the Department of Health.

6. **Implement a plan to shift some people currently receiving Personal Care Services to the less costly Consumer Directed Personal Assistance Program, for a potential annual savings of $1.9 million in the non-federal share.**

   CDPAP is less costly than traditional Personal Care services because the state reduced the allowable direct care and training costs as well as the allowable percentage for administrative costs. Although these savings are not as dramatic as transitioning individuals from CHHAs, they are still significant. More importantly, the process necessary to realize these savings requires no additional staff or infrastructure and dovetails into existing work done by the LDSSs. People who receive personal care – in both traditional personal care and the consumer directed program – are required to be reassessed every six months for the service. During this already routine assessment, the local Departments of Social Services could assess for CDPAP eligibility and refer consumers to CDPAP.

   Because many staff in the local Departments of Social Services are more comfortable with the traditional medical model programs, implementing this proposal would require a strong policy commitment from Albany. To assure local implementation of this initiative, the Department of Health should set aggressive targets for each county. On average, CDPAP is 6.89% cheaper than traditional personal care with a per hour Medicaid savings of $1.46. By shifting about 2,000 people from Personal Care to CDPAP, at an average of 7 hours of service per day, in the first year the state would reduce Medicaid spending by about $3.9 million (a savings in the non-federal share of $1.9 million). Over five years, this proposal saves $38.85 million in non-federal share spending.

7. **Expand the pool of direct care workers in the Consumer Directed Personal Assistance Program to match the federal rules for paid family caregivers, which would promote the use of this cost-effective service, for a potential annual savings of $11.48 million in the non-federal share.**

   The relationship between an attendant and the consumer is essential to the success of the any home care service, but the ability to select who comes into your home is a critical component to the success of the Consumer Directed Personal Assistance Program. To increase the savings generated by using CDPAP, the state should implement policies which would promote its use. Because of the type of assistance that is being provided, individuals with disabilities, particularly seniors, often prefer having a family member serve in this role. In addition, family members often choose to

[13] Social Services Law § 365-f

institutionalize a senior who would otherwise live with them, because they do not want to have strangers providing services in their homes.

Federal regulations state that personal attendants cannot be a family member who is "legally responsible" for the care of an individual (42 C.F.R. § 440.167). This has been interpreted to include spouses and legal guardians (parents) of minors. However, New York State is currently much more restrictive than the federal regulations and prohibits additional members of the consumer's family from working as an attendant, including a daughter, son, daughter-in-law or son-in-law (18 NYCRR § 504.14(h)(2)). Based on vigorous advocacy last year, proposed regulations for CDPAP were recently issued, and include this expansion of eligible workers (18 NYCRR § 504.28). Final regulations are expected to be adopted by the end of CY 2010. We strongly support the inclusion of the expanded definition of eligible workers in the final regulations.

Changing this regulation would allow a large nursing facility population to transition to the community. For example, a daughter or daughter-in-law of an elderly woman in a nursing home could leave her current job and be paid to provide her relative with care at home. Concerns have previously been raised about paying people who might otherwise provide informal support, however Departments of Social Services still control authorizations and balance the availability of informal supports with paid care. Departments of Social Services are gatekeepers for authorization of hours and are the front line defense against fraud or abuse. By amending the state regulations to expand the definition of personal attendant, we estimate that 1% of the Medicaid-funded nursing facility population over 65 years could transition into the community and the state would save $22.9 million annually in institutionalization costs during the first year ($11.48 million in the non-federal share).

This proposal, combined with implementation of the CFC Option, would generate additional savings from the enhanced FMAP. The state would receive an additional $2.23 million in the first year. This amount would increase in each year as more people transition into the program, resulting in an additional $36.20 million is savings over five years.

This change would also address a critical shortage of home care workers that has stalled efforts to shift toward a community-based model of long term services and supports. Previous efforts in New York State to address the shortage of direct care workers have focused primarily on making the job more desirable to workers by providing improved benefits or a career ladder. While these efforts have had some impact, the efforts target the same pool of workers and have a limited effect in bringing in additional workforce. Our proposal significantly expands the pool of workers available and encourages additional workers who would not otherwise be attendants to provide these critical services, addressing a significant barrier to increasing cost-effective community-based services and reducing the state's Medicaid spending.

8. **Better utilize assistive technology to reduce personal care spending, for a potential first year savings of $1.74 million in the non-federal share.**

While there are options for obtaining assistive technologies (AT) under the NHTD and TBI waivers and through vocational rehabilitation services, the Department of Health has generally overlooked assistive technology as a potential method of cost savings. Increasing use of tele-health has been proposed in policy discussions about the use of technology, but meeting more basic needs of individuals who want to live independently has been ignored. Technology, however, has the possibility of significantly reducing long term care costs. According to a study in the *American Journal of Public Health*, "The multivariate models show a strong and consistent relation between equipment

use and hours of help—the use of equipment was associated with fewer hours of help, after control for other factors."[14]

For example, people who require 24-hour or overnight home care because they are unable to get out of bed independently to open the door for the morning attendant, could potentially receive reduced hours if they were provided with assistive technology to allow them to open the door. We recommend that the Department of Health instruct local Departments of Social Services to assess consumers who receive a high number of service hours as to whether assistive technology could reduce the hours of service necessary. The Departments of Social Services would refer these consumers to the NHTD waiver for service coordination and assistive technology. Assuming that the state provides such assistive technology to only 12 people a month from across the state, reducing their need for personal care by 8 hours a day (an overnight shift), and factoring in a 1% disenrollment projection, the state would reduce Medicaid spending by $1.74 million in the non-federal share in the first year.

PROJECTED SAVINGS OVER FIVE YEARS

While immediate one-year reductions in Medicaid spending are the first priority, the new administration must consider ways to contain costs over the longer term as well. By implementing our proposals, the state can fundamentally restructure its long term care system, comply with the *Olmstead* decision which requires the state to serve individuals in the most integrated settings, take advantage of additional federal funding, and change the trajectory of New York's long term care spending.

Projected Savings in State-Share Medicaid Over Five Years

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Recommendation 1	$6.31 M	$17.01 M	$26.51 M	$34.93 M	$42.39 M	$127.15 M
Recommendation 2	$6.21 M	$16.77 M	$26.12 M	$34.40 M	$41.75 M	$125.25 M
Recommendation 3	$7.85 M	$66.09 M	$102.85 M	$106.03 M	$108.57 M	$391.39 M
Recommendation 4	$4.02 M	$4.10 M	$4.19 M	$0 M	$0 M	$12.31 M
Recommendation 5	$4.46 M	$12.04 M	$18.75 M	$24.71 M	$29.98 M	$89.94 M
Recommendation 6	$1.93 M	$5.20 M	$8.10 M	$10.67 M	$12.95 M	$38.85 M
Recommendation 7	$11.48 M	$28.56 M	$40.78 M	$49.52 M	$55.77 M	$186.11 M
Recommendation 8	$1.74 M	$5.02 M	$7.96 M	$10.58 M	$12.93 M	$38.23 M
Total	$44.00 M	$154.79 M	$235.26 M	$270.84 M	$304.34 M	**1,009.23 M**

If the proposed pace of enrollment in the NHTD waiver is maintained over the next five years, the state will reduce Medicaid spending by $254.3 million through transitions from nursing facilities ($127.15 million non-federal share) and by $250.5 million through diversions ($125.25 million non-federal share).

Implementing the Community First Choice Option would address a number of critical issues in the state's system for providing long term services and supports, including the need for assistance with medication administration, while saving New York more than $391 million over five years, with FMAP savings continuing into the future.

Calculating CFC Savings

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
PCA/HCSS to CFC	$4.51 M	$57.54 M	$90.26 M	$90.26 M	$90.26 M	**$332.83 M**
Impact of CFC on Rec 5	$1.11 M	$2.99 M	$4.66 M	$6.14 M	$7.46 M	**$22.36 M**
Impact of CFC on Rec 7	$2.23 M	$5.56 M	$7.93 M	$9.63 M	$10.85 M	**$36.20 M**
Total	**$7.85 M**	**$66.09 M**	**$102.85 M**	**$106.03 M**	**$108.57 M**	**$391.39 M**

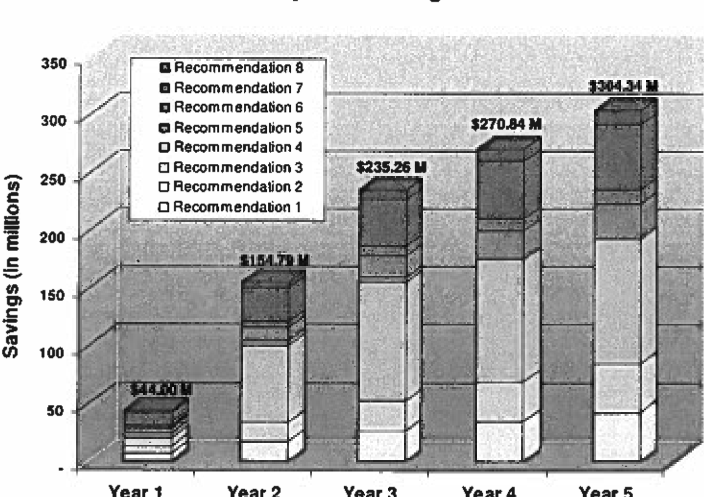
As New York rebalances the long term care system, we should shift away from a medical model of service provision that is over-reliant on expensive medical professionals to perform tasks that family

[14] "Does Assistive Technology Substitute for Personal Assistance Among the Disabled Elderly?" *American Journal of Public Health.* Helen Hoenig, MD, Donald H. Taylor, Jr, PhD, and Frank A. Sloan, PhD. 2003 February; 93(2): 330-337.

members have always performed and that paid attendants should be able to perform as well. This will help the state comply with the ADA and the *Olmstead* decision and reduce Medicaid costs. If the state encouraged the transition of 1,000 people annually from Certified Home Health programs to the Consumer Directed Personal Assistance Program, by the end of the fifth year Medicaid spending would be reduced by $179.8 million ($89.94 million non-federal share). Similarly, by shifting 2,000 people annually from traditional personal care to consumer directed services, the state could realize a reduction in Medicaid spending of $77.7 million ($38.85 million non-federal share).

As proposed above, a regulatory change in the consumer directed program could also yield significant savings. If the state expands the pool of direct care workers to be aligned with federal regulations, over the next five years the State would reduce Medicaid spending by $372.2 million ($186.11 million non-federal share). Finally, by providing assistive technology options to consumers who would benefit and who currently receive high hours of personal care, New York State could realize a reduction in Medicaid spending of $76.5 million ($38.23 million non-federal share).

Total Projected Savings Over Five Years



If these policy recommendations are implemented today, by the end of the fifth year, **New York State would reduce its Medicaid spending by more than $1.009 Billion.**

CONCLUSION

In New York today, a "perfect storm" of economic, policy and legal issues threaten its ship of state:

- Annual budget deficits approaching $10B;
- A long term care system out of balance both with what New Yorkers want, and what New York taxpayers can afford;
- Increased federal efforts by both the Department of Justice (DOJ) and the courts demanding that States comply with the Americans with Disabilities Act and the U.S. Supreme Court's *Olmstead* decision (now 10 years old), which further threaten state solvency without preemptive action.

In the face of this storm, with these recommendations, the disability community is prepared to stand shoulder to shoulder with Governor Andrew Cuomo to pursue aggressive efforts to balance the state budget, while advancing our established legal rights.

Detailed plans for each proposal that outline specific steps necessary for the State to achieve projected savings, as well as copies of supportive research identified in this paper, are available upon request. For additional information, please contact Bruce Darling, President/CEO, Center for Disability Rights (BDarling@cdrnys.org; ph. 585-546-7510) or Melanie Shaw, Executive Director, New York Association on Independent Living (MShaw@ilny.org; ph. 518-465-4650).

REMARKS OF SCOTT AMRHEIN
PRESIDENT, CONTINUING CARE LEADERSHIP COALITION
JOINT LEGISLATIVE PUBLIC HEARING
ON THE SFY 2011-12 EXECUTIVE BUDGET PROPOSAL
MARCH 3, 2011

Good afternoon. My name is Scott Amrhein, and I am President of the Continuing Care Leadership Coalition (CCLC). CCLC represents more than 100 not-for-profit and public long term care providers in the New York metropolitan area and beyond. CCLC's members are leaders and innovators in the delivery of skilled nursing care, home health care, adult day health care, respite and hospice care, rehabilitation and sub-acute care, senior housing and assisted living, and continuing care services to special populations.

My goal today is to leave you with two key takeaways. The first is that our long term care system - while delivering some of the best quality care in the nation - is incredibly fragile, and if we do not take extreme care to keep the system strong while pursuing budget savings and reform, the consequences will be dire not only for seniors and the disabled, but also for our economy and for the ability of our health care system overall to operate efficiently and effectively. The second is that, notwithstanding the adoption of reform and budget savings recommendations by the Medicaid Redesign Team, our work - and your work - is far from over. There are critical details to be worked out as the MRT reforms are implemented. And there are important steps yet to be taken that were not included among the 79 recommendations of the MRT.

This testimony will begin by reviewing a number of important facts about the long term care system in New York and conclude with our recommendations of five essential actions to ensure a stable long term care system that works for New York.

Setting the Record Straight: Vital Facts About Long Term Care in New York

New York's Nursing Homes and Home Care Programs Are Essential to the Efficient Operation of New York's Health Care System.

Real patient-centered care means helping patients progress as quickly as possible through the care continuum, moving efficiently from the hospital to post-hospital inpatient settings and then to home, and, when possible, directly from the hospital to home with necessary supports.

- New York's nursing homes currently take in more than 238,000 hospital discharges annually, a 100% increase over the past ten years.

- New York's home care programs absorb an additional 300,000 hospital discharges each year, a 73% increase over the last ten years.

We need a strong, stable long term care sector to make efficient, effective, patient-centered care possible in New York.

New York's Long Term Care Providers Are a Vital Contributor to the Health of the State's Economy.

Just this week it was reported in a national study that nursing home investment in New York generates more jobs and economic activity than in any other state.

- 141,151 people are directly employed in the nursing home sector in New York, significantly more than in California, where that total is 117,090, and Florida, where the total is 95,007.

- When additional external jobs generated by nursing homes are taken into account, the total number of jobs generated by the nursing home sector in New York rises to 197,414, more than in California, where the total is 179,300, and Florida, where the total is 145,114.

- In total, as an economic sector, nursing homes contribute $21.35 billion in economic activity in New York, compared with $17.86 billion in California and $11.63 billion in Florida.

Long Term Care Organizations Have Piloted Many of the Models that Hold the Greatest Promise in Caring for Difficult-to-Manage High Cost Populations.

For years in New York, the long term care sector has been in the vanguard of creating and demonstrating the effectiveness of innovative models for caring for high-cost, fragile, and complex Medicaid beneficiaries. The following are among the most important of these vital long term care-sponsored programs.

- *Program of All-Inclusive Care for the Elderly (PACE).* New York was one of the first States to step forward in the mid-1980s to pilot this program, which keeps frail elders in the community, and which seamlessly serves a population that is dually eligible for Medicaid and Medicare. New York has continued its leadership in this area with the advent of the Medicaid Advantage Plus program, designed to also integrate acute and long term care services.

- *Long Term Home Health Care Program.* In the 1970s, New York obtained a Federal waiver to create a "nursing home without walls" program, under which payments are capped at 75% of the average nursing home rate, and through which individuals in the community, who would otherwise be living in a nursing home, receive coordinated care and services across the State.

- *Managed Long Term Care.* Since 1997, NY has been a leader in developing Managed Long Term Care programs, which effectively serve as health "homes" for at-risk Medicaid beneficiaries, arranging and paying for health and social services, including home care and primary care, to help these beneficiaries remain in the community.

- *Adult Day Health Care (ADHC).* NY has long supported this essential program, which allows older and disabled individuals to live in the community and to go as needed to an ADHC center, where they can get the medical care and

supervisions that they need to remain independent. This program also provides family caregivers with important respite from their daily routine of caring for their loved ones at home.

- *Telemedicine for Care Monitoring.* NY has been a leader in testing models to finance and use technology to assist clinicians in remotely monitoring patients' health as a means of enabling patients to remain at home and identifying health status changes that can be effectively managed with timely interventions.

Long Term Care Spending is *Not* What is Driving Cost Growth in the Medicaid Program.

As the table included in my testimony below illustrates, over the last ten years, long term care costs have grown at a fraction of the rate of cost growth in the Medicaid program overall. According to the Division of the Budget's own numbers, the real cost growth in the Medicaid program has been the result of enrolment increases, utilization growth, and the State takeover of the local Medicaid share. Key facts about long term care spending growth include the following:

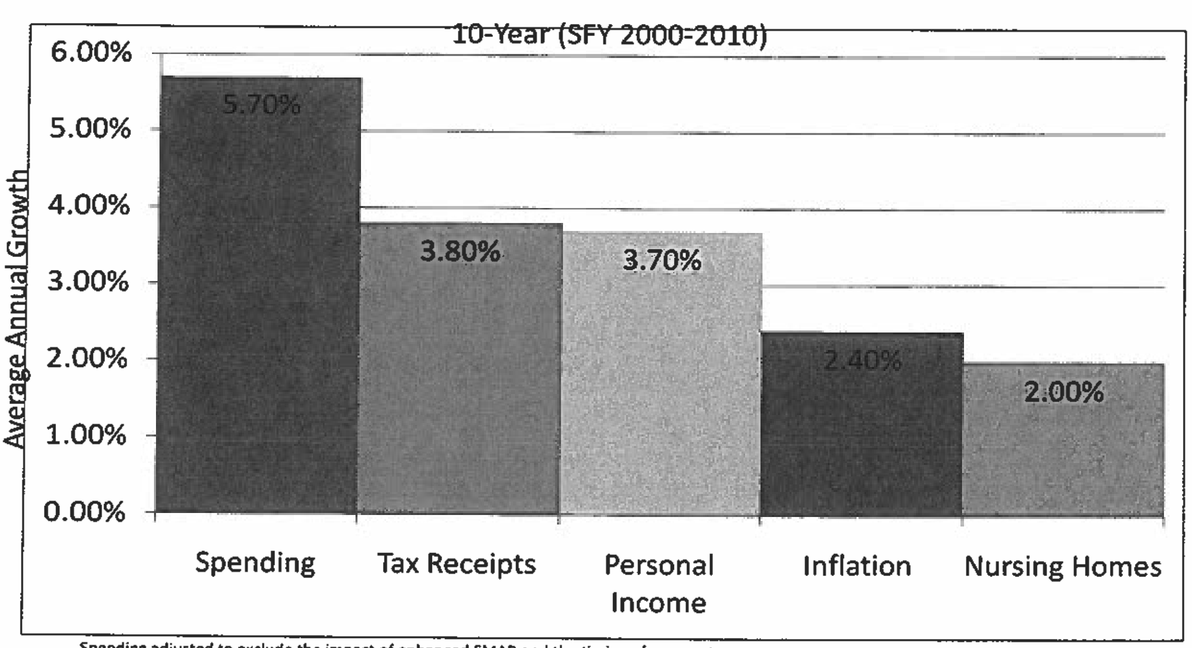
- Nursing home bed capacity has actually declined by more than 3000 beds (3%) since the year 2000.

- The average annual rate of growth for long term care programs since 2000 has been less than half that of the Medicaid program overall (3% vs. 6%).

- The home care sector's share of total State Medicaid spending remains flat; it is exactly the same as it was ten years ago (14%).

- The nursing home sector's share of total State Medicaid spending has actually fallen by 8 percentage points; it has declined from 24% in 2001 to 16% in 2011.

Nursing Home Growth is NOT the Driver of Medicaid Spending Growth in New York State



Spending adjusted to exclude the impact of enhanced FMAP and the timing of payments

Source for nursing home (skilled nursing facility) annual Medicaid growth statistics: "Medicaid in New York: Current Roles, Recent Experience, and Implications of Federal Reform," p.16, Table 1. Medicaid Institute at United Hospital Fund, December 2010. Growth is for the 10 year FFY period 2000-09.

After Nine Rounds of Budget Cuts, New York's Long Term Care Providers Are in Critical Financial Condition

Since April, 2007, New York's nursing homes and home health providers have sustained over $1.5 billion in Medicaid cuts. As a result, the financial status of many of our State's long term care service delivery providers has reached critical condition.

- The shortfall between what it costs to provide nursing home care for a Medicaid beneficiary in New York and the payment received for providing this care has climbed to the unprecedented - and unsustainable - level of $47.95 per patient day[1] in 2010.

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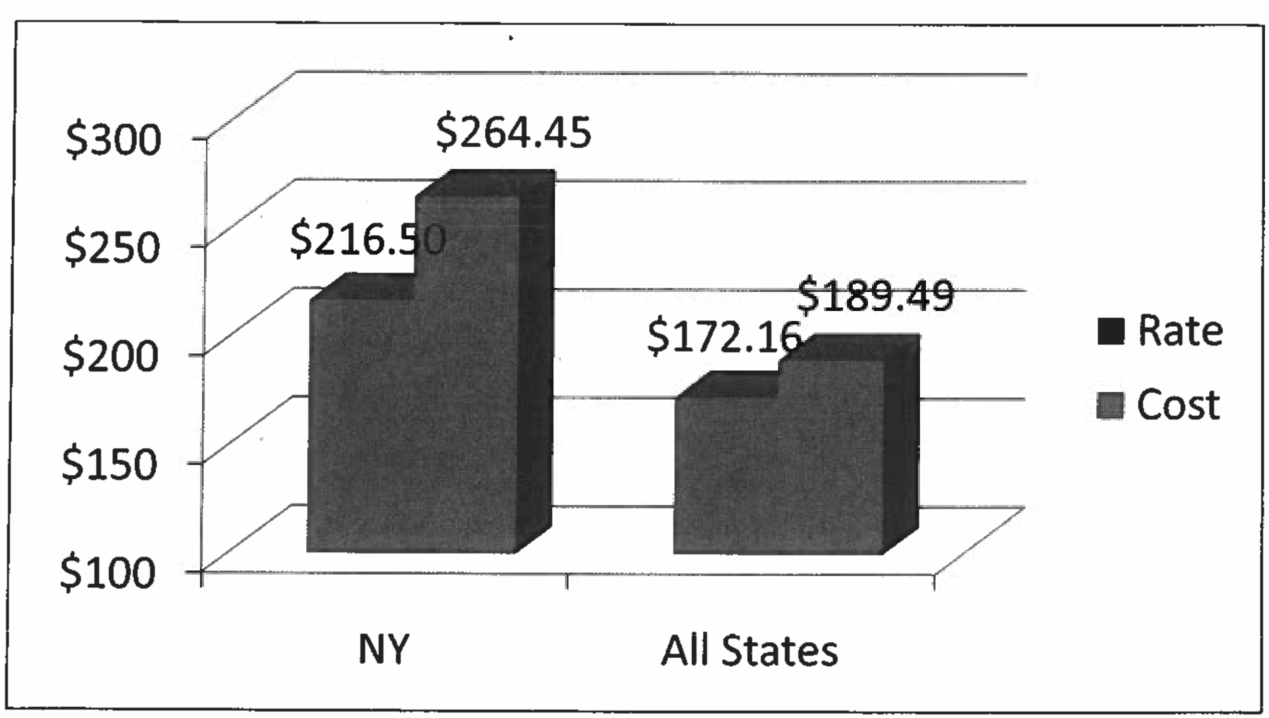
[1] Data Source: A Report on Shortfalls in Medicaid Funding for Nursing Home Care, Eljay LLC, December 2010

- In 2009, almost 50% of all nursing homes lost money on operations, while close to 70% of not-for-profit homes lost money on operations[2].

- For the latest year for which data are publically available, 62% of CHHAs and 81% of LTHHCPs lost money on operations[3].

The following tables illustrate the unsustainable financial position in which our State's nursing homes and home health providers find themselves.

Shortfall: Medicaid Rates vs. Cost for Nursing Homes in 2010



Data Source: A Report on Shortfalls in Medicaid Funding for Nursing Home Care, Eljay LLC, December 2010

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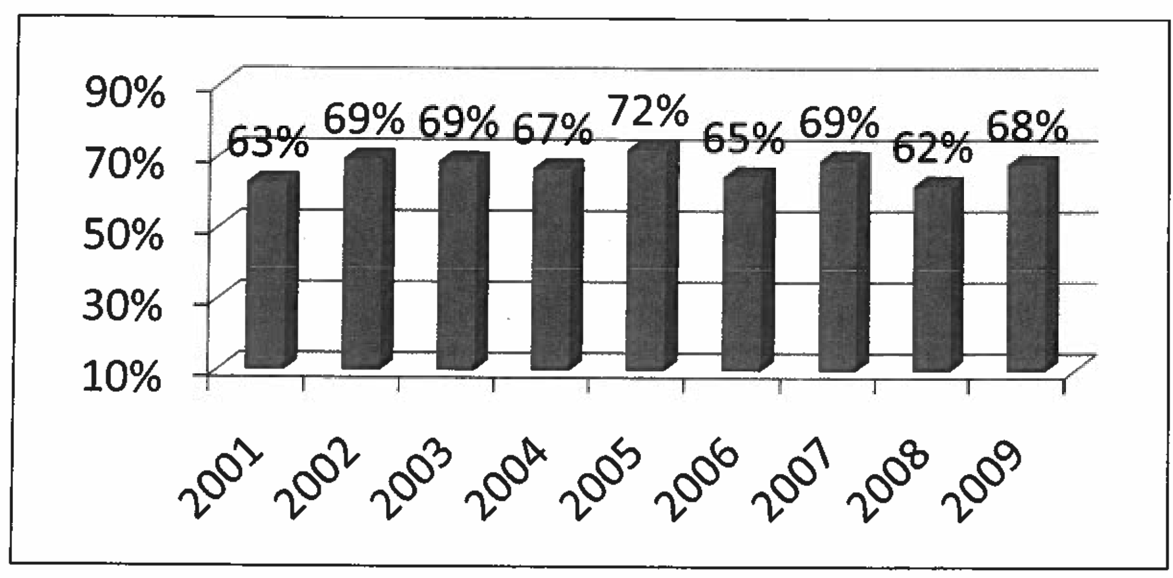
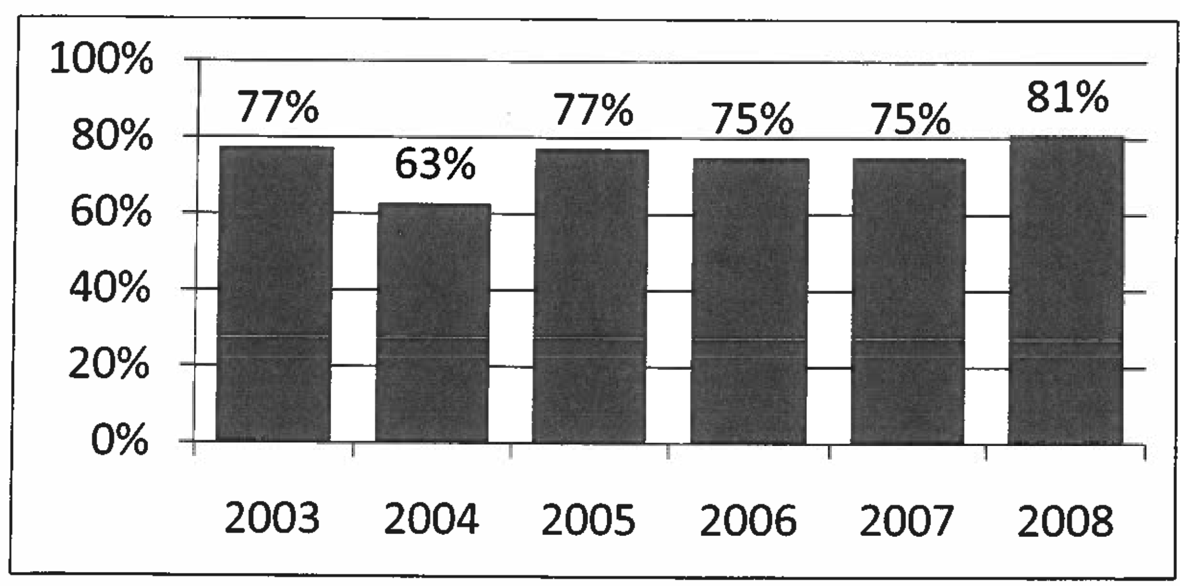
[2] Nearly 70% of not-for-profit facilities lost money on operations between 2001 - 2008.
[3] Per 2008 CHHA and LTHHCP Cost Reports.

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



Data Source: 2001 to 2009 Residential Health Care Facility (RHCF - 4) Cost Reports

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



Data Source: 2003 to 2008 LTHHCP Cost Reports

Essential Actions to Ensure a Stable Long Term Care System That Works for New York

As I said at the beginning of this testimony, there is a great deal of work to be done to ensure a strong, effective, and stable long term care system, both in the context of the recommendations adopted last week by the Medicaid Redesign Team and independent of the MRT process.

The following are what we deem to be essential actions in this regard:

1. **We must minimize the effect of across-the-board cuts to long term care providers, who are at disproportionate financial risk when Medicaid payments are cut.**

   One of the provisions at the core of the recommendations adopted by the MRT is the proposal to establish a "global spending cap" on Medicaid expenditures. Embedded in this plan is a call to reduce State share spending across the sectors by 2%. Achieving these savings in the form of rate cuts is disproportionately damaging to nursing homes - for which Medicaid is the primary payer (at 76% of all paid days of care on average in New York) - and it is also highly damaging for certified home health providers - for which Medicaid is the source of 55% of all patient revenues - and Long Term Home Health Care Programs - for which Medicaid is the source of 80% of all patient revenues.

   When payment cuts are used as the means for achieving State Medicaid savings, the result is that providers must be cut by slightly more than twice the amount of the savings target, due to the effect of the Federal Medicaid matching amount (FMAP). In the case of the MRT across-the-board savings targets, it would take $143 million in cuts to nursing homes, and $200 million in cuts to home health providers, to get the targeted savings of $69 million and $97 million respectively from the nursing home and home health sectors. We strongly urge that everything possible be done to reduce the effect of the targeted across-the-board cuts to nursing homes and home health providers.

2. **We must ensure that long term care services are protected if additional budget actions are considered during the upcoming fiscal year.**

A second component of the global spending cap in the MRT plan is the assumption that the health provider community, working together in the context of a Voluntary Health Care Industry Cost Containment Initiative, will achieve unspecified Medicaid health system savings of $640 million. If this target is not met, the global spending cap provision grants the Department of Health authority to take actions - which may include utilization controls and rate reductions - to make up any savings shortfalls. In light of the particular vulnerability of long term care sector providers to Medicaid rate cuts, we strongly urge the Legislature to weigh in and make it your priority to protect the nursing home and home health communities from mid-year cuts that could jeopardize vital organizations and programs that New York seniors and disabled citizens depend upon.

3. **We must protect proven care delivery models, such as CHHA services, LTHHCP services, and the medical model Adult Day Health Care program.**

One of the MRT proposals (proposal #90), which would require mandatory enrollment of Medicaid recipients age 21 and older in need of community-based long term care services into Managed Long Term Care (MLTC) plans, contained specific language envisioning the elimination of existing programs that are successfully coordinating care for the high-cost, medically fragile population, such Long Term Home Health Care Programs (LTHHCPs) and Certified Home Health Agencies (CHHAs) By inference, this proposal seems to also put New York's Adult Day Health Care program model at risk.

These programs are successfully coordinating and providing care for patients with complex long term care needs, and are essential to helping the State provide high-quality, community-based long term care in local communities. Eliminating these programs - and the services that are helping sustain medically complex long term care patients in their communities - will result in *catastrophic consequences for patients and their family caregivers*. It is vital that the Legislature ensure that Medicaid beneficiaries continue to have access to the services offered by CHHAs, LTHHCPs, and Adult Day Health Care Programs.

4. **We must identify and enact important savings strategies and reforms that were not included among the MRT's recommendations.**

CCLC recommended several actions - some of which had significant potential budget savings associated with them - which were not ultimately included among the MRT's final recommendations. We would urge the Legislature to work with the Executive to ensure that the following additional actions are taken, and that savings from these actions be used to offset other actions with a more direct impact on provider bottom lines.

- *Participate in the Balancing Incentive Payments Program.* New York should ensure that it meets the threshold for, and seeks recognition under, the ACA's Balancing Incentive Payments Program. Under this program, states that effectively expand the delivery of care via home and community based services are eligible for additional federal matching (FMAP) payments on their home and community based services. State applications are due in mid-summer 2011 and the program funding is expected to be available effective October 1, 2011. Potential enhanced State revenues under this initiative could exceed $100 million in SFY 2011-12.

- *Launch a Statewide Program to Encourage Nursing Home Mortgage Refinancing.* New York should develop and implement a program to facilitate the refinancing of capital debt of long term care facilities (to include potential assistance with refinancing fees and related costs), which will reduce the State's expenses over time related to pass-through payment of nursing home capital costs.

- *Maximize Federal Payment for Veterans' Long Term Care Services.* New York should establish a program to encourage veterans with disabilities that are 70% or more service connected to utilize State Veterans Homes for needed institutional long term care services, as payment for such services are fully paid at Federal expense.

5. **We must ensure payment stability for New York's nursing homes while resolving the issues of nursing home rebasing and future nursing home payment reform.**

   For more than three years, nursing homes in New York have been unable to plan their operating budgets with any degree of certainty as the implementation of nursing home rebasing has time and again been delayed, and as questions have loomed about the form of a future payment model for nursing home services. The fact that these questions remain unresolved only complicates the predicament of nursing homes as they evaluate how to manage their finances in the year ahead. In our view, the best way to guarantee maximum financial stability for New York's nursing homes in the face of the known shared sacrifice called for under the MRT plan would be for the State to 1) indemnify nursing facilities that would lose money under rebasing from retroactive exposure as a result of the rebasing implementation delays; 2) find a means to fully compensate nursing facilities that were told to anticipate specific funding increases under rebasing; and 3) defer the implementation of a new price-based reimbursement model to avoid creating additional redistribution-driven losses, which for many facilities would prove impossible to absorb on top of the deficit-reduction-driven cuts that are now before the Legislature. Resolving these issues is critical, and should receive the full priority of the Legislature and the Executive in the days and weeks ahead.

I appreciate the opportunity to provide these perspectives and recommendations today. CCLC looks forward to working with each of you as a partner in ensuring that essential long term care services remain strong and available to our State's elderly and disabled as the demand for these services grows in the years ahead.

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TESTIMONY OF GEORGE GRESHAM
President, 1199 SEIU United Healthcare Workers East

Presented To The Joint NY State Assembly Ways & Means
And Senate Finance Committees
Public Hearing On Healthcare and Medicaid
March 3, 2011

We'd like to thank the Committee Chairs for allowing us to present this testimony today. 1199 SEIU United Healthcare Workers East is the largest union representing healthcare workers in New York with 275,000 members in the state. Our members work in hospitals, nursing homes, home care services, ambulatory care facilities, primary care clinics, and a variety of other health-related areas in every region of New York State. Our members are frontline healthcare workers -- nurses, nursing aides, maintenance and environmental staff, technicians, lab workers, and virtually every other occupation found in the healthcare system. In addition to our direct workforce, when our members' spouses, partners, children and retirees are included, we represent over 1 million people, or more than 5% of the population of New York State, as consumers of healthcare services. We believe this gives us a distinctive view of the healthcare system as it relates to our members, middle-class and working families, and the communities where they live and work..

Last week, the Medicaid Redesign Team proposed groundbreaking industry-wide savings and reforms to Medicaid that will protect patient care while improving healthcare delivery in our state. All industry stakeholders -- including labor, business, non-profit institutions, government and consumer advocacy groups – came together to find innovative ways to dramatically reduce Medicaid spending while improving the quality of care and making it more patient-centered.

This is an enormous feat and was only possible through real compromise around the common purpose of helping to reduce the $10 billion budget deficit. We are proud that working people were able to play a role in this process and participate in finding solutions. While this plan certainly results in pain, we feel that it is a shared sacrifice throughout the industry and for that we applaud and thank every team member.

Though the Medicaid Redesign Plan contains significant spending reductions, the cornerstone of the agreement is a commitment from health care providers to collectively improve quality and reduce costs to help New York stay within a Medicaid spending limit of $52.8 billion – an estimated *2% reduction* from current year spending. In total, the agreement would cut Medicaid spending by $2.3 billion in the next fiscal year.

The plan also includes much needed homecare, pharmaceutical, and medical malpractice reforms that will lower costs, make the Medicaid program more efficient and improve quality healthcare for all New Yorkers.

In the area of home health and community-based care, the reforms contained in the plan will ensure that state funding for homecare is spent on the direct provision of services and require all Medicaid labor subcontractors to meet basic wage and benefit standards already in place at

responsible providers. 1199 SEIU has been fighting for a living wage for home care workers in this sector for over 10 years and these reforms will bring economic justice that is long overdue. The measures will also improve the quality of care by reducing turnover and ensuring the availability of a trained, stable workforce to meet the needs of a growing aging population.

Other important benefits of these reforms include:

- An increase in care coordination and management for homecare beneficiaries with complex needs, implemented in a way that will prevents disruption for clients and maintain standards for their caregivers.

- A check on runaway spending by certain Certified Home Health Agencies that have led to a dramatic increase in per-recipient spending in recent years.

There is no question that cuts have consequences and our members have experienced this pain first-hand with the recent closures of four New York City hospitals – Mary Immaculate and St. John's Hospitals in Queens and St. Vincent's and North General Hospitals in Manhattan. In addition, dozens of nursing homes across the state including several in inner-city Buffalo have been forced to close their doors.

These closures have had a traumatic impact on our workers and the communities they served.

The Medicaid Redesign Team Plan includes a safety net pool to assist struggling institutions as they merge or restructure in order to keep their doors open and continue serving their communities. This fund will be critical in helping to protect and preserve vital healthcare institutions that mostly serve low-income families and communities of color.

We urge the Legislature to adopt the Medicaid Redesign Team Plan in its entirety. The proposals contained in this historic effort represent a comprehensive overhaul of the healthcare system that remains true to the original purpose and mission of the Medicaid program – delivering quality care to our most vulnerable citizens.

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Housing Works' Testimony Before the Joint Legislative Public Hearing on the 2011 – 2012 Executive Budget Proposal on Health/Medicaid

March 3, 2011

Submitted by:
Charles King, President and CEO
Housing Works, Inc.

Please find attached Housing Works' comments on the recommendations submitted by the Medicaid Redesign Taskforce (MRT) to the Governor, Housing Works' earlier recommendations submitted the MRT, and a new recommendation that Housing Works has made to the MRT and would like the legislature to consider as well.

Housing Works' analysis looks at 35 of the MRT recommendations that most directly impact on people with HIV and persons most at risk of HIV, including homeless people with mental illness and/or chronic chemical dependence, as well as the overall well-being of the community-based AIDS prevention and service delivery system. In our analysis, there are three recommendations that we oppose and ask the legislature to reject. There are 21 that we support, though we would like to see seven of these proposals strengthened. Finally, there are 11 proposals that we believe the Legislature should reshape to ensure that they are focused on the best healthcare outcomes as well as monetary savings.

In summary, Housing Works opposes reduction in fee-for-service dental payments as this will further limit access to quality dental care for low-income New Yorkers, who often have severe dental needs that impact on other health issues. We also oppose more restrictive criteria for payment for enteral formula as this will have a negative impact on the elderly and others with chronic conditions who do not have access to, or are unable to prepare nutritionally appropriate meals. Finally, we oppose any increase in co-pays on the most vulnerable Medicaid recipients as this will be a strong barrier to care if recipients

are compelled to pay and will effectively serve as a rate cut to providers who can least afford it.

Housing Works wholeheartedly supports use of APGs to reimburse for HIV testing, in as much as it will result in more testing even if select HIV clinics receive a slightly lower rate. We also fully support:

- Increased coverage of tobacco cessation counseling,
- Expansion of SBIRT for alcohol and drug addiction beyond the emergency room setting,
- Requiring provision of patient centered palliative care,
- The development of an automated exchange/Medicaid eligibility system,
- The development of innovative telemedicine applications with payment incentives, expanded hospice care,
- The development of an office in DOH for patient-centered primary care initiatives,
- The establishment of reimbursement rates to support efforts to address health disparities,
- Enrollment and retention simplification,
- The maximization of peer services, and
- The change in the Family Planning Benefit Program as a State Plan Service.

Housing Works supports the elimination of the case mix adjustment for AIDS nursing services in CHHA and LTHHCP Programs as well as the development and implementation of a uniform assessment tool, but our support is contingent in both cases on inclusion in the tool of an adequate assessment of behavioral health needs that are not currently captured in the existing Medicare tool. Likewise, Housing Works supports the establishment of a Public Health Services Corps, but we believe it needs to explicitly favor marginalized diseases, such as HIV and addiction, and marginalized populations, including homeless people and persons who are addicted. Housing Works also supports the proposal to streamline the managed care enrollment eligibility process, but only if there is adequate education about all options, including education regarding the SNPs, and the right for certain populations to opt-out or to later change plans.

Housing Works supports the Supportive Housing Initiative, but we urge the legislature to insist that this initiative incorporate housing for people with HIV that have not progressed to AIDS and housing for other homeless people with chronic conditions who are not eligible for nursing home placement or who are currently in nursing homes. In fact, passage of state-wide legislation to expand housing for homeless people with HIV, in order to reduce the medical costs for persons with AIDS who receive state housing assistance, was one of Housing Works' initial recommendations.

Housing Works initially recommended and strongly supports facilitating co-located physical health, behavioral health and developmental disability services.

The need to meet completely separate physical plan requirements and needs assessments for each licensed service currently makes co-location all but impossible.

Housing Works initially recommended and supports the health home model for high-cost, high-need enrollees and urges that the budget include language that would allow HIV SNPs to expand their service population to include these enrollees and that they be eligible to function as health homes. Similarly, Housing Works initially recommended and supports initiatives to integrate and manage care for dual eligibles, and would hope that the HIV SNPs would be permitted to develop a PACE-like model of care for people with co-occurring chronic conditions as a part of this effort.

Housing Works has concerns that it believes the legislature should address with the following proposals:

<u>Elimination of Direct Marketing By Medicaid Managed Care Plans</u> – Housing Works recommends that HIV SNPs be exempt from this proposal. Otherwise, persons who do not know they are HIV+ at the time of enrollment or who are auto-assigned will not be aware of the option to enroll in a plan designed specifically for their chronic condition.

<u>Bundle Pharmacy into MMC</u> – Housing Works supports this concept in principle. We are concerned, however, that the rate-setting methodology, particularly for

the HIV SNPs, will not take into account HIV ARVs nor will it incorporate the latest research which supports, as both a care and preventative measure, the early initiation of treatment using ARVs for people in the earlier stages of HIV-infection.

Consolidate all pharmacy fee-for-service proposals into a comprehensive reform package – Because of the number of proposals included in this proposed reform package, the Legislature should carefully examine the implications of the combination of proposals. For example, Housing Works, almost alone in the AIDS community, has supported inclusion of ARVs in the PDL program, but with a strong "provider prevails" provision. One proposal rolls ARVs into the PDL. Another eliminates "provider prevails". And a third seems to require pre-authorization of ARVs. Eliminating "provider prevails" provisions and requiring pre-authorization of ARV's should both be strongly resisted by the Legislature.

Limit opioids to a four prescription fill limit every 30 days – While this proposal generally makes sense, initiation of pain management may require more frequent dose adjustments. This should be taken into account in developing by-pass provisions.

Establish behavioral health organizations to manage carved-out behavioral health services – As contemplated by OMH, this proposal would divide the state into regions with a single behavioral health organization in each region. This precludes patient choice and codifies a particular model of managed behavioral

health care, even if the BHOs are intended as a temporary arrangement. Instead, and in keeping with the concept of health home, the legislation should encourage a variety of demonstration models that can inform the development of new models of integrated care.

Reform Medical Malpractice and Patient Safety – It is not clear that this proposal will lead to improved patient safety through changed clinical practice as opposed to simply capping damages.

Explore Models to Implement Accountable Care Organizations – Housing Works encourages the Legislature to articulate the role of community-based care so that ACOs are not simply the appendage of large health institutions, and community-based care an after-thought.

Expanding Managed Care to All Currently Exempt Populations – In the implementation of the HIV SNPs, the Legislature and DOH established a solid set of standards for what had to be available in each county to mandate enrollment in managed care. These standards should be applied with all currently exempt populations in every country, rather than establishing deadlines for mandated enrollment into systems that do not have essential services available or do not meet other criteria, including choice of provider and accessibility.

Expanded Managed Addiction Treatment – As currently structured, managed addiction treatment does not take into account Harm Reduction as an

appropriate treatment methodology. Housing Works has submitted a new proposal, below, that if integrated, would allow for the incorporation of Harm Reduction.

Global Spending Cap on Medicaid Expenditures – Giving the DOH unilateral authority to reduce rates or eliminate or limit services is highly problematic and should be carefully vetted by the Legislature. Moreover, this provision seems to count on an improving economy. If that proves not to be the case, there needs to be a better contingency plan than simply cutting existing services or rates.

Housing Works' New Proposal –

Allow Medicaid to reimburse for needle exchange services and harm reduction therapy

Active drug users are often out of care due to behavior and practice associated with their chaotic life style. They are heavy users of emergency room and impatient care. The Federal government just certified needle exchange as a "drug treatment". The state should explore using Medicaid to reimburse needle exchange and harm reduction therapy. These interventions are proven to reduce HIV and Hep C transmission. In addition, they dramatically reduce drug overdose and frequently serve as a gateway into abstinence therapy and into coordinated health care

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Housing Works' Recommendations for Medicaid Restructuring

Housing Works strongly supports restructuring New York's Medicaid-funded services in order to achieve significantly improved health outcomes for low-income New Yorkers with special needs. Among those with special needs are: people living with HIV; people living with hepatitis C; the homeless; and people who suffer from chronic mental illness and/or chronic chemical dependence. In many, if not most, instances, people in these populations overlap and live with multiple chronic conditions, each of which is potentially severely debilitating. The proper reorganization of services for these New Yorkers would not only dramatically improve health outcomes but also significantly lower costs.

Restructuring Medicaid-funded services, however, will not fully achieve the desired savings for people with chronic conditions who are homeless without also prioritizing the provision of stable housing. Our recommendations on housing can and should be implemented immediately. These recommendations can be implemented in part through new investment, but they can also be implemented through strategic re-prioritization of existing resources.

Mandating homeless people into mainstream managed care is not a solution for people who are homeless. Many homeless people are *already* in managed care plans—since Medicaid has no way to know their housing status, they are simply auto-assigned to a plan. In these cases, homeless people often do not even know who their primary care provider is, and their transient living circumstances may mean that they live far away from that provider or from areas where their managed care plan offers services. In these cases, managed care becomes a *barrier* to health care access. While it is true that the managed care plans absorb the increase in emergency room and in-patient visits that are a byproduct of misguided auto-assignments, the lack of easy, direct health care access drives up the use of carved out services. The lack of access also results in much poorer health care outcomes than could be achieved otherwise.

We offer specific recommendations that would build on existing Special Needs Plans to meet the managed care needs of homeless people. We have divided our recommendations into three categories: Housing, Immediate Medical Restructuring, and Long-Term Medicaid Restructuring.

Housing Recommendations

1. **Change the definition of HIV illness.** New York is the only state in the nation that offers as an entitlement an enhanced shelter allowance for extremely low-income people with HIV illness. This stream of funding has been used to pay for rental assistance as well as a portion of the operating costs for a wide range of supportive housing programs for persons with HIV who

also have severe medical, mental health and addiction issues. However, the definition of "HIV illness" has not been changed since the program was created in the 1992, and relying on out-dated science, limits this benefit to people with a clinical diagnosis of AIDS or other advanced HIV disease.

Housing Works recommends that the Department of Health change the definition of "HIV illness" to "HIV infection". The total estimated incremental annual cost to the State and localities respectively to meet immediate housing need (including supportive housing for persons who need it) for approximately 3,100 PLWHA in New York City would be $17 million and $17 million. The savings estimated from getting people into care are conservatively estimated at $46.5 million, far outweighing the cost of providing housing. Additional savings in lifetime medical costs through prevention of new HIV infections can be conservatively estimated at $37 million, clearing demonstrating the overwhelming benefits of this investment.

2. **Pass NYS "HASA for All."** A second limitation on the NYS enhanced shelter allowance is that the language is fairly permissive as applied to the local social service districts. As a consequence, most counties do not make this benefit available. NYS HASA for All legislation would require every social service district to set up a mechanism to make this resource available. The total estimated incremental annual cost to the State and localities to meet unmet need (including the staff and mechanisms to administer the program) for approximately 3,300 PLWHA in the balance of NYS respectively would be $24 million and $24 million. The savings estimated from getting people into care are conservatively estimated at approximately $50 million, outweighing the cost of providing housing. Additional savings in lifetime medical costs through prevention of new HIV infections can be conservatively estimated at $40 million, clearing demonstrating the overwhelming benefits of this investment.

3. **Pass the "30% Rent Cap" for people with HIV.** Almost all subsidized housing in NYS caps tenant rents at 30% of their income in order to comply with HUD regulation and governing Federal law. In fact, most supportive housing for people with AIDS must also comply with the 30% rent cap. However, the NYS OTDA requires that persons with AIDS who use the shelter allowance as an open market rental subsidy and receive disability or other income from any source be budgeted at a rent level that reduces their discretionary income to the level of the public assistance grant. This policy has two pernicious impacts. First, it causes tenants to fall behind in rent leading to frequent evictions, which often lead people to fall out of health care. Second, it leads more sophisticated and stable tenants to opt for supportive housing, in order to reduce their rent burden. This clogs up the supportive housing system, keeping people who genuinely need supportive housing to maintain their health care homeless.

   The incremental cost of the rent cap would be $10 million to the state and $10 million to the localities. While it is difficult to calculate the direct benefits in reduced Medicaid costs, we

estimate the savings conservatively to be $22.5 million in the cost of care and $16 million in prevention of new infections.

4. **Reprioritize eligibility for existing low-income housing resources to homeless people living with chronic conditions.** New York has a vast array of housing for low income people, including Section 8 programs, housing authorities, and even a variety of supportive housing programs funded through a variety of federal and State funding streams. Over the last several decades, the priority for much of these housing has shifted to the chronically homeless on the one extreme and low income working families and even lower middle class families on the other. If New York is seriously committed to bringing down the cost of treating chronically ill homeless people, it needs to make it a laser-like focus to prioritize housing homeless people with multiple chronic conditions, using a "housing first" model. This must explicitly include prioritizing people who are chronically chemically dependent.

Immediate Medicaid Restructuring

1. **Consolidate and streamline licensure processes for co-located services for persons with multiple chronic conditions.** For people with multiple chronic conditions, "one-stop shopping" is the best way to ensure access to coordinated care. However, inconsistent and complicated regulations governing different licensing agencies make co-located services all but impossible. Each licensing agency has its own Certificate of Need Process that has its own detailed space and physical plant requirements, requirements around space segregation, intensive needs assessments, separate operational plans, policies and procedures manuals and segregated charts, as well as restrictions on shared staff.

   Housing Works recommends that an approved Art. 28, Article 31, OASAS or OMRDD provider who seeks to add co-located services governed by OMH, OASAS and/or OMRDD, would submit a single simplified CON application to the respective agencies for a desk review to be conducted by each agency within 60 days. If the applicant certified that the space licensed under the existing CON generally met the requirements of the other licensing agencies, there would be no further review of space or physical plant. The applicant could meet the requirement of demonstrated need simply by showing that the provider is already serving persons in need of the additional services in its existing program.

   The simplified CON application would contain the existing operational plan and policies and procedures manual amended to describe the additional services the applicant intended to provide. Shared allocation of administrative and appropriately credentialed program staff would not be a barrier to approval by any agency. Rate methodology and reimbursement

would remain the same as the current structure until the State develops and receives Federal approval for a capitated rate for a bundle of these services.

We further recommend that providers of behavioral health services who seek to provide primary care be permitted to submit a simplified CON application for an Art. 28 "part-time clinic" in order to facilitate co-location.

2. **Streamline the DOH CON application process and eliminate the need for CON applications for all but major changes in operations.** As it stands, even the smallest changes in a licensed Art. 28 facility, including termination of a service, require submission of a CON application. This process is costly to providers, inhibits development of appropriate services, and serves little useful purpose to the State.

Long-Term Medicaid Restructuring

1. **Expand the populations served by the HIV Special Needs Plans to include non-HIV populations, including persons with hepatitis C and homeless people.** Mainstream plans have not demonstrated the capacity to manage successfully the health of people with multiple chronic conditions. Moreover, the alternative of behavioral health organizations is an unproven model, and it is not clear how these BHOs would interact with health maintenance organizations. At the very least, the state should not look to BHOs as the only solution. On the other hand, the SNPs have clearly shown the capacity to serve people with multiple chronic conditions, including mental illness and chronic chemical dependence as well as HIV and hepatitis C. SNPs now serve more than 10,000 people. A study relying on data through 2008 showed that the SNPs reduced costs by 15% for its enrollees. We estimate that the same percentage savings could be achieved by enrollment of homeless people in these programs.

2. **Provide the SNPs with a restructured capitated rate that includes all behavioral health services, long-term care, community case management, and, for people living with HIV, AIDS Adult Day Health Care.** The members of the AIDS Day Services Association, which launched Amida Care, one of the three SNPs, have attempted for years to persuade the State to support the development of a PACE-like model for people living with multiple co-morbidities, including HIV. We believe that this model leads to the best possible integrated care, positive health outcomes and reduced costs.

3. **Apply for a Federal Waiver on behalf of the SNPs allowing them to service dual Medicaid and Medicare populations in a jointly funded capitation, with Medicaid sharing in any cost savings.** As people with multiple chronic conditions age, they become ineligible for managed care solutions that are practiced in the state. A waiver allowing dual-eligible persons to enroll in

a jointly funded capitation program would expand the health benefits and savings of these programs.

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Housing Works' Comments on the Proposals Submitted to and Adopted by the Medicaid Redesign Team on February 24, 2011.
(In addition, Housing Works has one **NEW** proposal for submission based on action taken yesterday by the Federal Government.)

Associated page numbers are from the 2011-02-24_staff_draft_proposals_with_descriptions.pdf

PROPOSAL NUMBER	PAGE NUMBER	PROPOSAL DESCRIPTION	HOUSING WORKS' COMMENTS
#10	9	Eliminate Direct Marketing of Medicaid Recipients by Medicaid Managed Care Plans	Special Needs Plans should be exempted. A high percentage of people with HIV do not understand the benefits of a SNP option or do not know that they are HIV positive when they choose a managed care plan and therefore have no reason to consider a SNP. Moreover, SNPs cannot participate in auto-assignment. It is inconsistent to say that people with HIV can opt out of a mainstream plan for a SNP at any point but not give the SNPs the ability to market their services. Also, if the goal is to expand to SNPs to include other currently non-mandated populations for medical home, the SNPS would have to be able to market to these populations.
#11	11	Bundle Pharmacy into MMC	The rate for this benefit would have to be separately calculated for SNPs unless HIV medications remain carved out. Otherwise this will have a very bad impact on SNP viability. Moreover, any capitation should take into account the fact that the only generic ARVs are older drugs that are less effective and have greater side effects. It should also take into account increasing evidence that earlier initiation of ARVs, including immediately upon HIV infection, has significant health benefits as well as a strong prevention effect. Any effort to calculate this benefit based on disease progression would be counter-productive.
#15	18	Consolidate all pharmacy fee-for-service proposals into a comprehensive reform package.	It is not clear if this proposal would bring ARVs and other AIDS medications into the PDL. While Housing Works, alone among AIDS organizations has supported this in the past, we strongly oppose folding in HIV/AIDS medications into the PDL without a "provider prevails" provision. Also, we strongly oppose prior authorization for ARVs. It is not clear what the benefit of prior authorization is for ARVs and what reason there would be to decline authorization. If the state's current standards, which are out of sync with the Federal standard, were used, this could deprive people from seeking early treatment and be a disincentive to early testing. Any pre-authorization requirement would have a negative impact on use of ARVs for either pre- or post-exposure prophylaxis.
Attachment #15K	42	Limit opioids to a four prescription fill limit every thirty days.	While this proposal is probably manageable, initiation of pain management, particularly for chronic pain, may require frequent dose adjustments and/or changes in drugs or

			drug combinations. The first 30 days of therapy may require more frequent prescriptions for opioids. This should be taken into account in developing by-pass provisions.
#17	47	Reduce fee-for-service dental payment on select procedures	Housing Works **opposes** this proposal as it will limit dental access for Medicaid recipients, particularly in places where no dental clinics exist or where Art. 28 clinics are oversubscribed.
#18	49	Eliminate spousal refusal.	This proposal may have the unintended consequence of driving up the cost of the AIDS drug assistance program if spouses or parents cannot afford the cost of HIV/AIDS medications, or may result in people living with HIV not receiving care.
#24	54	Payment for Enteral Formula with Medical Necessity Criteria	Housing Works **opposes** this proposal as it will have a negative impact on people with advanced HIV or AIDS, especially those with concurrent conditions such as renal failure and cancer. Many of these people are not capable of preparing or may not have the resources to purchase foods necessary for a special diet. Requiring persons to be underweight to receive this benefit would negatively impact health outcomes for these people.
#37	70	Eliminate Case Mix Adj for AIDS Nursing Svcs in CHHA and LTHHCP Programs	Housing Works **supports** this proposal. As an alternative, the assessment tool should capture behavioral health needs that might make home health care more expensive, requiring better-trained workers or more hours of care. (See comment on #69)
#41	72	Establish the Public Health Services Corps	Housing Works **supports** this proposal. However, incentives for persons trained in HIV and/or community medicine must be a part of this proposal and have not been included in the proposal as written. Professionals often avoid certain disease classes, including HIV and addiction, and often avoid classes of people including those who are homeless and active drug users.
#49	76	Reimburse Art 28 clinics for HIV counseling/testing using APGs	Housing Works **supports** this proposal. These rates maintain the ability to bill for a counseling-only visit for someone who elects not to take an HIV test. The HIV test is still billed separately from other billing if there is an additional clinical matter. Rapid testing has been included and has been expanded to allow billing by all providers. While this proposal will result in a slight decrease in payments per test, it has the potential to dramatically increase the number of people who receive counseling and who receive testing.
#55	80	Increase coverage of tobacco cessation counseling	Housing Works **supports** this proposal.
#69	92	Develop and Implement a Uniform Assessment Tool (UAT) for LTC	While Housing Works **supports** this proposal, we are concerned that this assessment adequately accounts for the varying needs of people living with HIV and other chronic conditions such as mental illness, chronic chemical dependence, and homelessness. We propose that HIV service providers, such as AIDS Adult Day Health Care, be

			included in the development of this assessment tool and participate in beta testing and piloting it.
#83	101	Expand SBIRT for alcohol/drug to hospital clinic, DTC and office settings.	Housing Works **supports** this proposal.
#89	103	Implement Health Home for High-Cost, High-Need Enrollees	Housing Works **supports** this proposal.
#93	110	Establish behavioral health organizations to manage carved-out behavioral health services	This proposal should be rewritten to allow a variety of demonstration models for managing behavioral health. Reliance on a single BHO for each region will likely negatively impact the ability to develop new models of integrated care, including the development of new co-location and other PACE-like models.
#101	114	Develop Initiatives to Integrate and Manage Care for Dual Eligibles	Housing Works **supports** this proposal and recommends that the SNPs be incorporated into this planning and that PACE-like models be a key component for people with multiple chronic conditions.
#104	121	Increase Enrollee Copayment Amounts for Medicaid Fee-for-Service and Family Health Plus; Require Copayments for Child Health Plus	Housing Works **opposes** this proposal. Where providers follow the law and don't require payment for patients who cannot afford the co-pay, this is simply a reduction in rates in disguise. Where providers attempt to collect, the co-pays are a barrier to basic and necessary care that, if not provided, will lead to more expensive treatment.
#109	125	Require Hospitals and Nursing Homes to provide Patient Centered Palliative Care	Housing Works **supports** this proposal.
#131	134	Reform Medical Malpractice and Patient Safety	Housing Works supports malpractice reform that focuses on improvement of patient safety. It is not clear that this proposal as written, will accomplish this since at least initially the savings come through caps in damages as opposed to changing clinical practice.
#150	156	Develop an Automated Exchange/Medicaid Eligibility System	Housing Works **supports** this proposal.
#153	159	Develop innovative telemedicine applications by reducing regulatory barriers and providing payment incentives	Housing Works **supports** this proposal.
#196	169	Supportive Housing Initiative	Housing Works **supports** this proposal but urges that the initiative consider the full range of populations with chronic conditions in need of supportive housing, not just to avert nursing home stays, but to ensure medical and psychosocial stability and adherence to treatment as well as prevention of disease transmission. There is clearly documented evidence particularly with people with HIV, but also with other homeless and chronically ill populations that housing is a cost-effective intervention that achieves treatment adherence and significantly reduces costs while improving health outcomes. There is compelling evidence that housing of people who are HIV positive and those at

			highest risk dramatically reduces transmission of HIV as well.
#209	173	Expand Hospice	Housing Works **supports** this proposal.
#217	175	Create an office for development of patient-centered primary care initiatives	Housing Works **supports** this proposal.
#243	177	Explore Models to Implement Accountable Care Organizations (ACOs)	Housing Works has concerns about the role of community based providers and other community-based groups of providers in the ACO scheme, including their ability to operate or have a significant voice in the operation of ACOs rather than functioning as a subsidiary partner to a hospital or network of hospitals.
#990	186	Explore the Establishment of Reimbursement Rates to Support Efforts to Address Health Disparities	Housing Works **supports** this proposal.
#1021	188	Facilitating Co-Located physical health, behavioral health and developmental disability services	Housing Works **supports** this proposal.
#1029	190	Enrollment and Retention Simplification	Housing Works **supports** this proposal.
#1058	195	Maximize Peer Services	Housing Works **supports** this proposal.
#1451	206	Establish various MRT workgroups	Housing Works **supports** this proposal.
#1458	208	Care Management Population and Benefit Expansion, Access to Services, and Consumer Rights	Housing Works has concerns that people will be mandated into managed care without a clear understanding of their rights and without the services available. For example, thousands of homeless New Yorkers, are already enrolled and even auto-assigned to a plan with even knowing their right to dis-enroll. Mainstream plans rarely provide them the services they need, apparently willing to accept the ultimately higher costs of care as a "cost of doing business" without regard for the negative health outcomes. The State needs to establish upfront the essential elements any plan must have in place to identify and meet the needs of these discrete populations, including, where appropriate, special needs plans. And the state must ensure that there are sufficient plans that meet those requirements before it mandates managed care enrollment. For example, it would be wholly inappropriate to mandate enrollment of people with HIV in managed care in parts of the state where this would exacerbate a lack of choice in providers or where there are no HIV/AIDS special needs plans.
#1458 Attachment 3	216	Streamline Managed Care Enrollment Eligibility Process	Housing Works **supports** this proposal in principle but has concerns about the education new enrollees will receive to understand their options, including the option to opt for a special needs plan or to opt out of managed care altogether if they meet the criteria to do so, particularly in light of the elimination of managed care plan marketing funds.
#4647	223	Expand Managed Addiction Treatment	Housing Works would support this proposal if Harm Reduction approaches to addiction

		Program (MATS)	treatment were incorporated into it. **(See Housing Works' new proposal below.)** Further, Housing Works has concerns about how MATS would integrate with other Health Homes for patients it enrolls.
#4648	226	Family Planning Benefit Program as a State Plan Service	Housing Works **supports** this proposal.
#4651	229	Global Spending Cap on Medicaid Expenditures	Housing Works supports the development of a two-year budget for Medicaid. However, we have strong concerns with the rest of this proposal because of the authority it gives DOH to unilaterally cut funding for services during the budget period as well as the fluctuations that enrollment can generate against such a global cap. As it is, the proposed 2% across-the-board reduction unfairly hits programs that have not seen rate increases in years as well as programs that have had the benefit of year after year trend factors. This wholesale approach to cost reduction gives little reason to believe that future unilateral cuts will be any more fairly allocated or any less subject to the influence of New York's health care power brokers than they have been in the past.
		NEW PROPOSAL: **Allow Medicaid to Reimburse for Needle Exchange Services and Harm Reduction Therapy**	**Active drug users are often out of care due to behavior and practice associated with their chaotic life style. They are heavy users of emergency room and impatient care. The Federal government just certified needle exchange as a "drug treatment". The state should explore using Medicaid to reimburse needle exchange and harm reduction therapy. These interventions are proven to reduce HIV and Hep C transmission. In addition, they dramatically reduce drug overdose and frequently serve as a gateway into abstinence therapy and into coordinated health care.**

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