NYC HEALTH+ HOSPITALS

New York City Council Hearing

Fiscal Year 2020 Executive Preliminary Budget

Committee on Hospitals

Mitchell Katz, M.D.

President and Chief Executive Officer

New York City Health + Hospitals

March 25, 2019

Good afternoon Chairperson Rivera and members of the Committee. I am Mitch Katz, M.D., President and Chief Executive Officer of the New York City Health + Hospitals ("Health + Hospitals"). Thank you for the opportunity to review the FY2020 Executive Preliminary Budget for Health + Hospitals.

It has been an amazing year at Health + Hospitals. We have made great progress executing on the Mayor's transformation plan. In line with the Mayor's plan, we are on target to achieve $757 million in revenue-generating initiatives and $430 million in expense-reducing initiatives. Through Q2 of FY 2019, patient care revenue is up $80 million versus this time last year. Driven by improved billing and better performance in our value based managed care contracts, we are just $10 million (or .5%) below the ambitious target we set for this year's budget. While we have seen a 3.8% decline in inpatient utilization, much of that decline comes in our value-based contracts. That means that, as we do a better job keeping patients healthy, they require fewer hospital visits, and we capture incentives and additional revenue from health plans. We have many important revenue initiatives just getting off the ground and we expect our EPIC electronic health record and financial system – which is coming on-line across all our hospitals this year – to significantly improve our revenue going forward.

On the expense side, we are less than $25 million (or 1%) over our budget due to important investments we have made to improve patient care and to generate revenue in the years ahead. We hired over 340 net new nurses to make sure we deliver the safest and highest quality care possible. We also invested in new staff to improve our ability to bill and collect money from insurance companies. We have offset our investments in new clinical- and revenue- generating staff by reducing the number of temporary workers in our system, eliminating consultants, and making some managerial-level staff reductions. I have made clear to our senior leadership and

administrative staff across the system that our number one priority is to invest in patient care and our front-line staff.

A year ago, at my first opportunity to appear before this Committee, we spoke about concerns around ongoing deficits and how Health + Hospitals would respond to the challenges we face. A year later, despite risks posed by the Trump Administration, Health + Hospitals maintains a balanced five-year financial plan and is well positioned for stability and success. We are investing in new sites and in our current facilities. By the end of 2021, we will have built three new one-stop-shop community health centers in Jackson Heights in Queens, Tremont in the Bronx, and Bushwick in Brooklyn. We are also investing in needed repairs and improvements, including the $52 million in planned capital investment at Metropolitan Hospital. And thanks to the Mayor and members of this Committee's generous support, we're making important improvements to Woodhull, Elmhurst, Kings, Roberto Clemente and many of our other facilities.

Building on the great work the Mayor's Get Covered initiative has done around the city, we are signing up more New Yorkers up for insurance inside of our hospitals. We have increased the number of insurance applications made by our patients by 20% to over 23,000 applications per month. This is great for our patients, who now have the security of knowing their care is covered, and it is great for Health + Hospitals, as we generate an anticipated $40 million in additional revenue this year.

We are getting better at the hard work of billing insurance companies. We have improved at every step of the process – from negotiating better rates with health plans, to more accurately documenting and coding the care we provide, to sending bills more quickly, and collecting the revenue we are owed. Our revenue cycle

efforts yielded $150 million in FY 2018. This year, we are on track to achieve over $200 million in revenue – a huge step forward.

We are also improving the patient experience and investing to make sure we better meet our patients' needs. We have hired 40 new primary care providers, streamlined our operations, and reduced our wait times - patients can now see a primary care provider within one to two weeks. We are investing to make specialty care easier to access at Health + Hospitals. This includes expanding our e-Consult system for specialty referrals, hiring new specialists, and adding new clinical services in areas like interventional cardiology, stroke care, and HIV care.

While we are headed in the right direction, we have a lot more work ahead. We need to continue to make the system as great as the people in it, and make it easier to use and more efficient to run. We need to continue to make it easier to get an appointment, to make sure our call center and customer service meets our patients' needs, and to expand eConsult to all of our specialty clinics. We need to complete our EPIC health record and financial system roll out by the end of this year and to continue our efforts to ensure managed care plans treat us fairly. We also need to deliver on key new initiatives, like opening up retail pharmacies inside our hospitals, opening new ExpressCare urgent care sites to reduce avoidable emergency room visits, and to create a more streamlined transportation system to move patients between facilities in our system.

Great risks remain due to the federal government. The President's budget would slash Health + Hospitals' revenue by billions of dollars. Health + Hospitals is already facing potential Medicaid disproportionate hospital share cuts of over $400 million in federal funds the coming year, beginning October 1, 2019, and $600

million in each of the subsequent five years. The President's budget not only maintains those cuts, but it makes the situation much worse with deeper cuts to Medicare and Medicaid. We are grateful for the past support the Council has provided in opposing these cuts and look forward to working with the Council again to advocate against these cuts.

Additionally, the Department of Homeland Security's (DHS) proposed public charge rule could impact 350,000 Health + Hospitals patients and affect the public health system financially. In the fall, we launched an aggressive advocacy campaign opposing this cruel rule, along with other City agencies, and are currently awaiting DHS's decision. The bottom line is – nothing has changed at Health + Hospitals and our patients should continue to seek care without fear at our facilities.

On the State side, the Governor and the Legislature are still negotiating the final details of the budget for the upcoming State fiscal year, which begins on April 1. We are partnering with the Greater New York Hospital Association and other hospitals in our advocacy efforts. It's still unclear how the final budget will address the pending federal DSH cuts, which are slated to begin on October 1. The bottom line is the enacted State budget must protect public and safety net hospitals that serve the most vulnerable New Yorkers.

Despite these risks, I strongly believe that this will be another great year for Health + Hospitals. We are proud to play a key role in the Mayor's Guaranteed Care Initiative. NYC Care, our new program for New Yorkers ineligible for insurance or unable to afford the options on the exchange, will begin in the Bronx this summer and will roll out to the other New York City boroughs by 2021. MetroPlus, the city's public option, is developing new partnerships with other city agencies, adopting new

outreach and enrollment-assistance strategies, and establishing new and improved member service options to better serve existing members as well as the estimated 300,000 uninsured New Yorkers who are currently eligible for coverage.

Thank you to this Committee for your tremendous support of Health + Hospitals and for making my first year back in New York so rewarding.

Testimony
New York City Council Committee on Hospitals- March 25, 2019
By Ralph Palladino, 2nd Vice President Clerical Administrative Employees, Local 1549

Clerical-Administrative Local 1549 represents 5,000 employees of the NYC H+H and Metro Plus HMO. We represent the Interpreter Title for the city and Client Navigator title in NYC H+H that can also be used for interpreting and information providing duties.

NYC H+H has always led the way in providing quality care. The system's hospitals continue to win awards for healthcare delivery. The H+H Metro Plus HMO continues to win awards at the number one HMO in the state every year. Under the leadership of Dr Katz in conjunction with union cooperation, including Local 1549 the NYC H+H has improved its' finances and patient access from the street level to the patient care rooms for patients. But much, much more needs to be done in both those and other areas. The addition of primary care and other physician staff has been good.

But the back-up, ancillary staffing remains woefully low thus impeding better healthcare delivery. Nurses and higher paid professional and managerial titles too often must perform clerical tasks as do low-wage office temps. The use of higher titles is a waste of tax dollars and the use of private temps is a threat to patient confidentiality. This continues the Bloomberg administration attack on civil service. More funding is needed to ameliorate these problems.

We therefore request:

1) Support NYC Cares

Local 1549 fully supports the Mayor's proposal for additional funding for NYC H+H through the NYC Care program. This program will allow the 600,000 undocumented immigrants and others the ability to gain access to quality healthcare when they need it.

Currently in New York City there are over 3 million immigrants, 775,000 undocumented living in the five boroughs. Like the Italian, Irish and other immigrants who came to this country legally and illegally, they work to provide services, goods and help build our city. They are tax payers contributing to the economic and social life of our city.

According to a report from Comptroller Stringer's office, "Immigrants are taxpayers: every year, immigrant New York families pay an estimated $8 billion in City and State personal income taxes and approximately $2 billion in City property taxes."

They have a human right to services that their taxes help provide. This includes services such as health care and language interpretation.

In addition we do not need to have immigrants who may be ill or carrying a disease to be discouraged from seeking care due to legal threats and/or lack of health coverage. We do not to have a pandemic or epidemic in the city because of lack of care. The most recent "epidemic' is now the measles.

At one time the city funded 33% of HHC's (now NYH+H) budget. We believe more should be done by the city, but this newly proposed program along with funding provided a couple of years ago are good starts. For years, Local 1549 has called on the city to increase its' support for our great public system. We applaud the Mayor for doing so.

2) Reach out to the state for fair share funding for NYC H+H
Medicaid Financing not meeting the cost of care

The cost of providing quality services needed by the public continues to outpace this public system's cost of care and income. It currently costs NYC H+H roughly $350 per visit by a patient to outpatient care. The Medicaid reimbursement however is roughly $200. This is a *loss*

of roughly $150 per visit per patient that the NYC H+H system must absorb. This is despite NYC H+H's low administrative overhead of just 3% (compared to private insurance that is at over 20%). Rates have not risen significantly in over 10 years.

That said note that NYC H+H receives virtually NO COMPENSATION for treating undocumented immigrants. The cost and loss for uncompensated care to the NYC H+H is $1.4 billion. A lot of it is for undocumented.

Disproportionate Care (DSH) funding not fairly distributed and is ending

The federally funded Delivery System Reform Incentive Payment (DSRIP) Program allocation from the state is supposed to be provided to where the most indigent care is provided. However, this is not what the state has done. Too much of the funding is going to the private non-profit (but really for profit) sector and not enough is going to public hospitals. There have been numerous articles, in all of the major newspapers, over the past few years addressing the excessive tax dollars received by large "non-profit" hospitals that function like "for-profits," with high paid CEO's, and do not serve anywhere near the number of poor patients that NYC H+H does.

DSH funding is to be ended in a couple of years. The Trump Administration budget proposes cuts based on ending DSH while cutting Medicaid and Medicare. They propose to slash reimbursement to providers. This will cripple NYC H+H hurting patients, cutting jobs and hurting local businesses that rely on healthcare facilities being in their neighborhoods.

3) <u>The need for improvement in language services for Immigrants</u>

The influx of immigrants from all over the world using city services is great. This requires that communication efforts be enhanced. In some cases this can mean life and death. It is especially true in healthcare settings. This is critically important in communication and outreach efforts for NYC Cares.

Currently the city and NYC H+H contracts out to private vendors interpreter and language services that is done by phone. NYC H+H too often relies on non-employee volunteers or pools from employees who hold various other titles. This is providing inadequate service to those who need it. The volunteers and employees are not usually versed in medical terminology which is important. Client Navigators who perform interpreter duties are. Who does the work of pooled employees when they are called to perform this uncompensated interpreting service?

The New York Immigration Coalition has documented that the most efficient way to provide language interpretation is FACE TO FACE interpretation. This service should be performed by city employees, not private phone line employees. We hear stories from our members working in hospitals, SNAP and Medicaid about wrongful advice and interpretations being performed. The best way to have total quality control and to deliver the service is by using the Civil Service Interpreter Title throughout the city. In NYC H+H this can be done by Client Navigators.

Interpreters do face to face interpretation. They also can interpret documents and assist those who are applying for benefits with providing application filing information. <u>I refer you to the ***NY State Report on Social Services*** (chaired by then Senator Avella) that summarized the importance and need for interpreters.</u>

If the city and NYC H+H really wants to help the uninsured, especially the immigrant population then they should do it properly and in the most efficient manner. It is about peoples' health, not just figuring ways to save money.

H+H expansion is the key to making health care more accessible, especially in areas where disparities in health care exist. It is the main provider for undocumented immigrants.

Asks of the City Council

1- **Support and properly fund NYC Cares.**

2- **Demand that the NYC H+H use the Interpreter Title and/or Client Navigator title for face to face and document language interpretering rather than private contracted out and inefficient phone lines and non-employee volunteers.**

3- **Pro-actively support the Albany Rivera-Gottfried legislation for expansion of Essential Care Health Insurance for immigrants state-wide that mirrors the NYC Care in NYC.**

4- **Pro-actively advocating with the Governor and state legislature about increasing Medicaid reimbursement rates. It is also important to demand more funding and fair distribution of Disproportionate Share (DSH) Funds for NYC H+H.**

5- **Oppose President Trump's wall building and restrictions on benefits for immigrants including ridiculous work requirements.**

6- **Pro-actively oppose President Trump's proposed cuts to Medicare, Medicaid, SNAP-food stamp program vital for health, especially children and elderly, and the Affordable Care Act.**

131 West 33rd Street
Suite 610
New York, NY 10001
(212) 627-2227
www.nyic.org

The New York Immigration Coalition
Testimony on NYC FY 2020 Budget
Committee on Hospitals

Max W. Hadler, MPH, MA

March 25, 2019

Good Afternoon. My name is Max Hadler and I am the Director of Health Policy at the New York Immigration Coalition (NYIC). The NYIC is an advocacy and policy umbrella organization for more than 200 multi-ethnic, multi-racial, and multi-sector groups across the state working with immigrants and refugees. Our members serve communities that speak more than 65 languages and dialects. The NYIC Health Collaborative brings together immigrant-serving organizations from the frontlines of the battle to improve health access.

Thank you to Hospitals Committee Chair Carlina Rivera for calling this hearing and for the opportunity to testify before the committee. I'm here today to talk about Mayor de Blasio's newly announced NYC Care, a program designed to improve health care for uninsured New Yorkers, but would first like to thank Councilmember Rivera and several colleagues, including Councilmembers Levine, Ayala, and Speaker Johnson for their support of the New York City Health + Hospitals Community Proposal to fix long-standing inequities in the state's allocation of Indigent Care Pool (ICP) and Disproportionate Share Hospital (DSH) funding. This proposal, as outlined in the Councilmembers' letter to the leadership of the state Legislature, would do several things to create more equity in ICP and DSH distributions, including:

1) ending the practice of including bad debt in the allocation of ICP funds and terminate the transition collar that perpetuates a system that rewards too many hospitals that are not providing their fair share of care to Medicaid enrollees and uninsured New Yorkers, to the detriment of true safety-net providers like H+H; and
2) targeting funds toward the health care systems that serve the highest proportions of uninsured and Medicaid patients in New York City's communities.

NYC Care

There are an estimated 600,000 New Yorkers without health insurance, about half of whom are undocumented immigrants. While New York City has a strong network of providers who care for our city's residents regardless of immigration status, insurance coverage, or income, lack of health insurance has a profound effect on the ability to access care in a continuous and timely manner. NYC Care, if implemented fully and well, has a unique opportunity to direct many of these individuals to care earlier and in a way that promotes their wellbeing.

At the NYIC we value Mayor de Blasio for standing by immigrant communities with a powerful message of inclusion and taking this important step to create a program that has the opportunity to better meet the health needs of hundreds of thousands of uninsured New Yorkers. We commend his efforts to tackle the complexity of navigating the massive H+H system by providing navigation and coordination support for patients.

There are many exciting components of NYC Care, including the aforementioned navigation and coordination assistance through a primary care home assignment, a membership card and dedicated customer service line, and a clear welcoming message that encourages uninsured New Yorkers to seek care on an ongoing and preventive basis through membership in a branded program. This message is all the timelier in this moment, when the proposed radical expansion of the public charge rule has caused many immigrant families concern about seeking health services and enrolling in public benefits. NYC Care would remain outside the bounds even of the expanded public charge definition because it is exclusively funded by the city.

While we are enthusiastic about the potential of NYC Care, the details of the program have yet to be ironed out. For example, there was a strong emphasis in the Mayor's announcement on the integration of NYC Care with other city initiatives, including ThriveNYC, yet no details have since emerged about how coordination among physical and behavioral health services will improve under NYC Care. We urge the Council to provide close oversight to ensure a transparent and timely rollout process that sets the tone as H+H prepares to launch the program this summer in the Bronx. In addition, we want to underscore a few key areas of concern about current plans, including a slow ramp-up timeline that would only make the program available in all five boroughs by 2021, the need for additional funding, and the lack of inclusion of community health centers.

The mayor has proposed $25 million in FY2020 for the initial rollout of NYC Care starting in the Bronx, ramping up to $75 in FY2021 and $100 million annually at full scale. Spending funds to establish the program, including outreach and education, customer service components, and hiring additional clinical staff, is a step in the right direction; however, additional funding will be necessary if the program is to be truly successful in reaching its target population. Our understanding is that H+H currently serves significantly less than half of the estimated 600,000 total uninsured New Yorkers. Given that H+H is the sole entity that will provide services under NYC Care, additional funding to more dramatically expand capacity is necessary to meet the demands of providing care to a larger number of patients, especially if the city declines to expand the network of NYC Care beyond H+H.

This leads to another concern about the current structure of NYC Care, which will only cover services at H+H and exclude community health centers outside of H+H's network that serve as patient-centered medical homes for so many immigrant New Yorkers. We cannot underscore enough the importance of including community health centers as an integral part of the program given that they already provide high-quality care to a significant number of uninsured New Yorkers. The ActionHealthNYC pilot clearly demonstrated the integral role that community health

centers play in health access and continuity of care, and improving linkages between community health centers and H+H must continue to be a priority in trying to improve access to care for uninsured New Yorkers. It is hard to imagine a truly successful effort to guarantee comprehensive health access in New York City that does not include providers beyond H+H.

Finally, we urge the city to re-examine the current ramp-up timeline to make NYC Care available across the five boroughs by 2021. This timeline can be accelerated because of the demonstrated success of the city's own tested model – the ActionHealthNYC pilot. We already know this type of coordinated direct access program, with primary care homes and improved customer service and the feeling of being part of a program, can be successful, because we have already done it. While ActionHealthNYC functioned on a much smaller scale than NYC Care will, the goal should be to bring the program to scale sooner than the current proposal, with an appropriate level of funding. There is no need to prove the model works; there is a need to provide uninsured New Yorkers and the systems they rely on for health services with the full amount of resources they need to have better access through an already-proven model.

Thank you for the opportunity to share this testimony today.

Committee on Hospitals
Testimony of Jerry Wesley

Get Healthier Care Together
"Healthifying Care At Work"

Institute of Value-Based-Healthcare Credentialing Inc.

jwesley@healthiercaretogether.com (B) 718-889-1028 (F) 718-744-0927

Greetings Committee Chair and Fellow Committee Members on Hospitals:

Thank you for the opportunity to testify today. I am Jerry Wesley, A Transformation Futurist and Founder of **Get Healthier Care Together Inc.** - a 501 C (3) shared service corporation.

Get Healthier Care Together Inc. is also an approved NYC vendor in all the of the following areas:

HHS Accelerator Information Vault

Welcome: Faye A Brown, Get Healthier Care Together, Inc

Summary of Applications

Provider Status: Approved	**Expiration:** 05/03/2021
Current Application	
Application	**Status**
Business Application	Approved
Academic Supports	Approved
Capacity Building	Approved
Caregiver Support	Approved
Case Management	Approved
Community Engagement	Approved
Conflict Resolution/Mediation	Approved
Discharge/Re-Entry	Approved
Disease Control	Approved
Emergency Preparedness and Response	Approved
Health Education and Supports	Approved
Home Attendant Services	Approved
Job Placement Services	Approved
Job/Vocational Training	Approved
Life Skills	Approved
Mental Health Services	Approved
Outreach	Approved
Parenting Services	Approved
Preventive Services	Approved
Work Readiness	Approved
Facility Management	Approved

I am also the Founder of The Institute of Value-Based Health Care Credentialing Inc. a 501 C (4), and the only value-based care training institute in the five Boroughs of NYC, dedicated to upgrading the health training landscape in underserved communities.

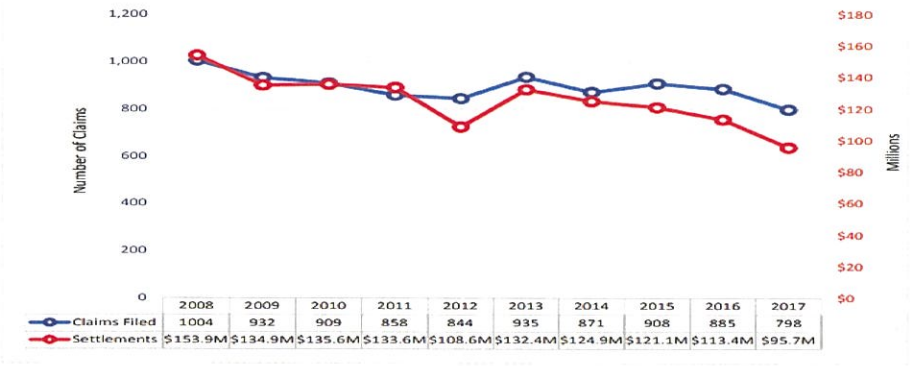
I am here today, seeking budgetary funding in the amount $1.5 Million dollars to train hospital staff in resolving underlying and systemic causes of preventable harm and wrongful deaths that are occurring at NYC H+H, either through

- Poor care coordination
- hospital-acquired conditions,
- misdiagnosis,
- wrong surgeries,
- surgical site infections
- medication errors,
- medical errors,
- in-hospital falls,
- and other preventable harmful conditions.

On March 9, 2019, a NY Post article reported that 468 wrongful preventable deaths has occurred at NYC H+H since 2014, with more than 400 cases pending.

According to NYC Comptroller's Office, between 2014 and 2017, the average annual amount **that was wasted on malpractice cost** at NYC H+H , was $113,775,000.00 a year. The $1.5 million dollars we are seeking to prevent this waste (About $374.00 per day, per hospital) is less than 1.4% of this amount . Since 2008, NYC H+H , **has wasted over $1 billion dollars in malpractice cost**.

Chart 14
HH Claims Filed and Settled
FYs 2008-2017



	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Claims Filed	1004	932	909	858	844	935	871	908	885	798
Settlements	$153.9M	$134.9M	$135.6M	$133.6M	$108.6M	$132.4M	$124.9M	$121.1M	$113.4M	$95.7M

Notably, the number of medical malpractice claims filed against H+H's acute care hospitals[9] decreased by 94 claims to 465 claims in FY 2017 from 559 claims filed in FY 2016, or a decrease of 17 percent.

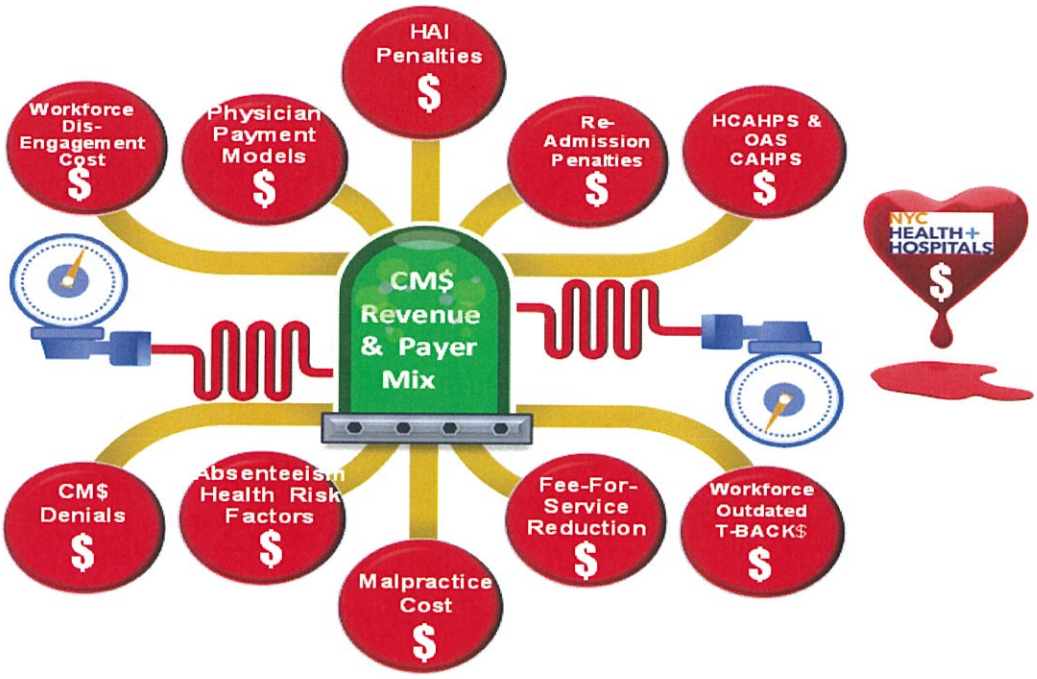
The $1.5 million dollars we are seeking will be used to implement **"CareHealthfully™ Best Practices For Reducing and Eliminating Preventable Harm"** at all NYC H+H hospitals.

Our **"CareHealthfully™** intervention is a healthifying cure for:

- The outcome health of patients and families who entrust NYC H+H with their health and lives.

- Upgrading hospital star ratings from one-star to 3-5 stars over a 2-3 year period

- Reducing and eliminating burnout of an overburdened and understaffed workforce.
- Helping restore the fiscal health of NYC H+H who continue to bleed health care dollars internally , from every organizational organ that generates revenue.



While the article covered a number of incidents in the past, it left out more recent deaths that has occurred since Dr. Mitchell Katz has been President and CEO.

An on-going contributing factor of preventable harm and wrongful deaths is that 10 out of 11 NYC H+H hospitals, have been labeled with an unhealthy one-star rating for 11 consecutive years with no public redress.

The Centers for Medicare & Medicaid Services (**CMS**) five (5) star hospital rating system has labeled the following hospitals with a one-star rating:

- Bellevue Hospital Center;
- Coney Island Hospital;
- Elmhurst Hospital Center;
- Harlem Hospital Center;
- Jacobi Medical Center;
- Kings County Hospital Center;
- Lincoln Medical & Mental Health Center;
- North Central Bronx; '
- Queens Hospital Center; and
- Woodhull Medical and Mental Health Center.

The only recent 2 star Hospital in NYC H+H system is Metropolitan Hospital Center located in Manhattan.

This alarming factor that has been ignored for years, should concern us all because, a one star hospital rating is synonymous with low value low quality care, services, health and outcomes that can lead to preventable harm and wrongful deaths.

In this budget cycle, we are asking the Committee on Hospitals to join us in using your influence and connections to secure the $1.5 million dollar we are requesting, to make sure that we as a city and as community, no longer ignore the problem that preventable harm and wrongful deaths are inflicting on our community and no longer ignore the opportunity that is staring all of us right in the face to eliminate preventable harm and wrongful deaths now and for generations to come.

Thank you for privilege of your time and your prompt response.

New York City Anti-Violence Project
116 Nassau Street, 3rd Floor
New York, New York 10038
212.714.1184 *voice* | 212.714.2627 *fax*
212.714.1141 *24-hour hotline*

Shay Huffman, Social Work Intern
community@avp.org

Good afternoon Chair Rivera, Council Members, and staff of the Committee on Hospitals. My name is Shay Huffman and I am a second-year social work intern at The New York City Anti-Violence Project. First, thank you for your advocacy for the TGNCNB community and its health needs.

I am here in support of the funding request by the *TGNCNB Solutions Coalition.* And let me tell you why I believe it is so vital.

I am a proud New Yorker, and I think of our City as a progressive, 21st century town. But, as I testified last week before the Health Committee, the realities of our transgender, gender non-conforming and non-binary community members contrast markedly with this notion.

In my internship at AVP, I have had the opportunity to research issues related to their health care. I have also had the honor and privilege of meeting with, listening to, and sharing stories of community members around their experiences in accessing care. The information I've gleaned, the narratives I've heard - reveal numbers and challenges that fall FAR short of what we **would** and **should** expect and desire from a progressive city:

- Seeking care at hospitals where intake forms do not even include an option for their gender identities ("Other")
- Being refused medical care
- Sitting in Emergency rooms that give little consideration of their needs and rights regarding privacy
- Encountering physicians who are not culturally competent in their health care needs.

During one interview a community member shared with me that, even in a supposedly progressive hospital, they had a physician who was freaked out by their identity and would not touch them.

In another, the person shared how each prospective encounter became a trade-off: their mental and emotional well-being in exchange for medical care. **It was that stressful!**

The term "gender minority stressors" is used to capture the experiences and expectations of rejection, discrimination, and non-affirmation that result from stigmatized social status. A stigma based on a person's gender identity.

Gender minority stress is real! Its impacts are real! It often causes people to delay care, or

worse - forego it, which further compromises overall health. It increases the likelihood of substance use and abuse, suicidal ideation, and suicide attempts.

Not surprisingly, research indicates strong correlations between gender minority stress and anxiety and depression. And if a person is a member of more than one marginalized community – i.e., a person of color, a woman, an immigrant, the impacts are compounded.

I would urge H and H to collaborate with community members and leaders in assessing needs, tracking concerns, and developing initiatives.

Chair Rivera, Council Members and Committee staff, I respectfully submit that, these are all strong indications of why we need the budget items in our ask.

Good afternoon, Chair Rivera, and Council Members and staff of the Committee on Hospitals. My name is Cecilia Gentili. I identify as a transgender woman, Latina and I would like to talk about a budget proposal related to health that would be vital for transgender, gender non-conforming, and non-binary, or TGNCNB people.

First, I want to thank you for your advocacy for the TGNCNB community and its health needs.

Last year after feeling unwell for a couple of hours, my partner took me to the hospital. We suspected I was having a urinary tract infection (UTI).
After getting to the registration part where my identity as trans had not place to be reflected I chose to write "transgender woman" to give the medical workers (triage nurse) a better understanding of who I was. They did not understand it and, we had a 20 minutes argument talking about my genitals. During that very uncomfortable time I was repeatedly ask about my menstrual cycle and because my insurance and ID is changed to female they were not able to understand that as a transgender woman I don't have one.
Let me all remind you that while this was happening I was in extreme pain and having to use the restroom every 5 minutes.
After they understood my situation I was sent to see a doctor who after checking the results from my test confirmed I had a UTI but when I ask if she should check my genitals to rule out other issues responded: "I don't want you to feel uncomfortable"
I believe she was feeling uncomfortable.
My insurance paid a lot of money for this terrible interaction and I had a co-payment of $250 dollars for this anguish too.

Health should not be a privilege of cis folks.
We as transgender, gender non-conforming and non-binary people deserve to get respectful treatment and services like everyone else.

We are here to propose solutions.

- TGNCNB Community Outreach Worker

We believe there should be five Community Outreach Workers, one per borough, so that each outreach worker can become familiar with the TGNCNB communities of each borough, and also have a chance of having enough workers to plausibly meet the needs of TGNCNB people citywide.

- TGNCNB Health Care Technical Assistance

Funding should be allocated for community Outreach Workers that can advocate with health care institutions where failings occurred to bring in TA for health care staff that need the extra education—and the TA will provide the education

- Media Campaign

Funding should be provided to advertise the existence of Community Outreach Workers, and how they will work with the community to address issues in the broader health care system

Thank you, Chair Rivera, Council Members and committee staff. I'm happy to answer any questions you have.

New York City Anti-Violence Project
116 Nassau Street, 3rd Floor
New York, New York 10038
212.714.1184 *voice* | 212.714.2627 *fax*
212.714.1141 *24-hour hotline*

Good afternoon councilwoman Rivera, fellow members of the committee.

My name is Elaine Rita Mendus. I'm a community member at the New York City Anti-Violence Project, as well as a youth counselor at the Ali Forney Center. Both of these organizations work to support the growth and success of members of the queer community, especially the transgender and gender non-conforming community in the New York City area.

I am here to advocate on behalf of the establishment of the health outreach worker program for transgender health.

As a woman who began transition outside of the New York City area, I can say that healthcare here is better than other state, but, not perfect. I started my transition in small town Pennsylvania, and I had to "prove" my dysphoria was real. Many physicians still require this performance as they do not operate through informed consent access to hormone therapy.

Currently, word of mouth between community members is the best tool that many of us think we have to find affirming providers. It is not enough. When I was homeless in 2015, I was told to go to one of two clinics for my hormone therapy. Later on, when I was pursuing surgery, I was informed that only breast and vaginal surgery were available. Insurance coverage later on allowed for facial feminization surgery to be covered, something which I am looking forward to next week. The point of this story isn't that I'm getting my face done. The point is that I was lucky enough to ask the right person where to find the treatment.

Luck should not be involved with treatment, though. I am not the first transgender woman to suffer from facial dysphoria, nor will I be the last. If I did not ask the right person at the right time, I might very well be stuck with this same face for years.

We don't settle for such low standards with other conditions. Why is New York City resting on its laurels with regards to transgender health? What is celebrated as good and acceptable would be a scandal if it were the same low-effort put forward for a condition.

Funding the health outreach worker program would be an important step. That said, it is necessary that the city commits to a strong awareness campaign. Without that, this program will be doomed to fail. I trust that both lawmakers and transgender citizens alike would hate to see this become a failure.

Thank you for your time. I trust the right decision will be made.

Elaine Rita Mendus
e.r.mendus@gmail.com

New York City Anti-Violence Project
116 Nassau Street, 3rd Floor
New York, New York 10038
212.714.1184 *voice* | 212.714.2627 *fax*
212.714.1141 *24-hour hotline*

Thank you councilmember Rivera, and the rest of the committee, for having us here today.

My name is Briana Silberberg, I am a community organizer at the NYC Anti-Violence Project, and with Andrea a sitting member of the steering committee of the TGNC Solutions Coalition.

I want to make clear to you today how necessary and important the requests and recommendations that the Solutions Coalition has come to present are. Providing outreach workers, technical assistance, and a media campaign to advertise the outreach workers and the services they provide are a dire need of NYC's trans community.

When I was beginning my transition a few years ago I was both overwhelmed and befuddled by the options ahead of me to get gender affirming hormone replacement therapy.

Community word of mouth was really the only resource available to me, and the people around me were telling me to go to Callen-Lorde and I would be okay. So you can imagine my bright-faced disappointment when I braved the trip to the clinic that I thought would change my life when I was told that they were at overcapacity, and that I would actually not be able to get treatment there. They then suggested I try to go to Apicha, who let me sign up for an orientation another two months away, before scheduling my first appointment another three months down the line.

All of this could have been easily avoided if outreach workers were available to the community, and if they were advertised appropriately. The overcapacity at both Callen-Lorde and Apicha, which led to such (frankly speaking) dangerous delays in my receiving care would be way less of a problem if patients actually knew they had other options. We need to help people navigate the places they can go to get care aside from the big name clinics, and these recommendations that Andrea has presented to you could go a long way towards vastly improving this untenable status quo. I know from working with community that my story is painfully similar to those of a great many folks, most of whom only know of the two clinics I named as options for informed consent care, despite the many other sites available that could help.

Thank you so much for your time and I wish you all the best.

Briana Silberberg
Community Organizer
The NYC Anti-Violence Project
bsilberberg@avp.org
(212)-714-1184

New York City Anti-Violence Project
116 Nassau Street, 3rd Floor
New York, New York 10038
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212.714.1141 *24-hour hotline*

Good evening to Committee Chair Carlina Rivera, to the council members on the Committee on Hospitals, and to all present tonight. My name is Anastasia Wythe. I am a 25-year-old transgender woman who lives in Brooklyn, and I work as a journalist on LGBTQ issues for The Daily Dot. I have first-hand experience with emergency medical care here in New York City, which I will share to give the committee a better insight into what it's like to navigate an ER room as a transgender woman.

On Valentine's Day, my throat closed up during an allergy attack, and my coworking space's hosts called 911. An FDNY ambulance responded and took me to the Lenox Hill Greenwich Village hospital, and I was discharged several hours later. However, there were several issues with the emergency visit that I would like to address.

First, during my ambulance ride, one paramedic that supervised my initial onboarding made a joke about "male-female" and "female-male" transgender people. When I arrived at the hospital, a receptionist received my insurance info—which has my then-legal name on it—and, after inputting my information, immediately asked me if I was menstruating. This is impossible for me, as I am transgender. Because the hospital registered me under my legal name, nurses would check up on me by saying my legal name and entering into the room. I would have to correct them each time, letting them know my name is actually Ana, and explaining that I am a trans woman. This would become tiring and stressful on a day where I needed to recover.

I believe these experiences are a microcosm for greater issues that are present for transgender emergency care patients. If both the FDNY and hospital staff were given the proper training they needed for sensitivity toward TGNC patients, I believe these uncomfortable moments would have been avoided. I would like to thank the Committee on Hospitals for your time and for listening to my story, and I hope it proves helpful in finalizing the city's budget.

Ana Whyte
ana.wythe@gmail.com

Bowen
Public
Affairs
Consulting

Testimony before the New York City Council Committee on Hospitals
Carlina Rivera, Chair
March 25, 2019

My name is Andrea Bowen, Principal of Bowen Public Affairs Consulting. I'm a transgender woman, and a coordinator of the transgender, gender non-conforming, and non-binary, or TGNCNB, Solutions Coalition, which advocates for community-based economic justice and anti-violence strategies to support TGNCNB New Yorkers. Thank you Chair Rivera, Council members and staff of the Committee on Hospitals, for giving me the opportunity to speak today.

I am joined by community members, policy experts, and allies to present to you the need for three major funding items we would like to see you take up within an initiative for the City's FY20 budget. These are funding items that would go toward the Health and Hospitals Corporation (H+H), and because of your committee's support of TGNCNB health needs, we wanted to present them to you.

To summarize—and there are longer explanations in a factsheet attached to my testimony—we seek **five TGNCNB Community Outreach Workers, at a cost of $471,250.** H+H has been hiring for *three* Community Outreach Workers for the remainder of FY19 that will support TGNCNB people in finding affirming care, and we want to see this program extended into FY20, and expanded to *five* Community Outreach Workers, for better coverage across the City. We seek **TGNCNB Health Care Technical Assistance funds at $59,400.** Our

community has spoken extensively, and will explain in this hearing, about specific failures in the health care system. Funding should be provided immediately to address these concerns. H+H should use this funding to contract with TGNCNB community organizations with experience in providing such support. The TA providers and Community Outreach Workers can work together to catalogue problems currently identified in the system, and those that appear in the future. Community Outreach Workers can advocate with health care institutions where the failings occurred to bring in TA for health care staff that need the extra education—and the TA will provide the education. Finally, five outreach workers and a cadre of TA providers will only have so much reach: there must be funding for a **media campaign, at a cost of $691,900,** to advertise these services and actions to the TGNCNB community.

As you heard in last fall's TGNCNB health hearing, and as you'll hear today, our community can't wait for action: we can pinpoint problem areas across the health care system, and with each incident of mistreatment toward TGNCNB people, with each botched surgery or incident of medical providers laughing at community members, we lose trust of the health care system we so desperately need. TA providers, community members, and Community Outreach workers can pinpoint failings here and now, and make the system more responsive to us. With the funding we propose, the City can use media to direct people to Community Outreach workers, have Community Outreach Workers guide people to the right care, and TA providers reinforce previously-received trainings and ensure that health care providers truly understand community needs.

Thank you Chair Rivera, Council Members and committee staff. I'm happy to answer any questions you have, and you can contact me at andy@bowenpublicaffairs.com.

The Transgender, Gender Non-Conforming, and Non-Binary (TGNCNB) Solutions Coalition, comprised of several TGNCNB-serving and led organizations in NYC, seeks FY20 Budget funding, and legislative action, for a comprehensive vision for improving the TGNCNB community's access to health care services.

Our vision: our community members can pinpoint failings of the health care system, and we need to address them immediately. We propose to do this with continuation of funding for a cadre of Community Outreach Workers focusing on TGNCNB healthcare needs, technical assistance for health care providers on TGNCNB health care needs, and marketing of health care services, especially Community Outreach Workers, so that our community members can learn about health care services both through Community Outreach Workers and through a larger ad campaign.

These services can be provided and funded by the Health and Hospitals Corporation (H+H), though they should be delivered across public and private health care systems. Tables outlining cost assumptions are on the flip side of this one-pager.

TGNCNB Community Outreach Workers: $471,250, baselined.

H+H has created three LGBTQ Community Outreach Workers, to be funded through the end of FY19. We are excited about the creation of these positions. However, simply going across Brooklyn to support people in need is challenging enough. Thus, we believe there should be five Community Outreach Workers, one per borough, so that each outreach worker can become familiar with the TGNCNB communities of each borough, and also have a chance of having enough workers to plausibly meet the needs of TGNCNB people citywide. Finally, while the Community Outreach Workers are currently called LGBTQ Community Outreach Workers, we see that the TGNCNB community's experience with poor healthcare access is so deeply felt that these staff should be named *TGNCNB* Community Outreach Workers to signal that they are specifically knowledgeable about and working for TGNCNB communities.

TGNCNB Health Care Technical Assistance: $59,400

Our community has spoken extensively about specific failures in the health care system. Specific instances of mistreatment were mentioned in the City Council hearing on TGNCNB health care needs in late 2018, and are an ongoing subject of discussion with community organizers. Funding should be provided immediately to address these concerns. H+H should use this funding to contract with TGNCNB community organizations with experience in providing such support. The TA providers and Community Outreach Workers can work together to catalogue problems currently identified in the system, and those that appear in the future. Community Outreach Workers can advocate with health care institutions where the failings occurred to bring in TA for health care staff that need the extra education—and the TA will provide the education.

Media Campaign: $691,900

The Community Outreach Workers' reach will not immediately impact all TGNCNB community workers. Nevertheless, community members should be aware of the services provided by the City. Thus, funding should be provided to advertise the existence of Community Outreach Workers, and how they will work with the community to address issues in the broader health care system. Precedent for such an ad campaign includes the NYC Unity Project MTA ad campaign and advertisements for HIV/AIDS prophylaxis medications. Furthermore, such an ad campaign doesn't just give important information to TGNCNB people—it educates all people in NYC about TGNCNB life.

Legislation Creating a TGNCNB Advisory Council

We seek legislation to create a TGNCNB Advisory Council, comprised of TGNCNB community members, that can work with H+H staff in overseeing and advising on ways to address needs for systemic change across NYC's health care system.

COST BREAKDOWNS OF BUDGET ITEMS

HEALTH OUTREACH WORKERS

Base salary	$50,000
fringe (45%)	$22,500
5 workers	$362,500
Administrative cost (10%)	$36,250
TOTAL	**$471,250**

TECHNICAL ASSISTANCE

Cost of one day TA session (inclusive of lesson preparation and a day of training)	$1,500.00
Number of TA providers per session	2
estimated number of TA sessions a year	18
subtotal (base cost * # of providers * sessions)	$54,000
Administrative cost (10%)	$5,400
TOTAL	**$59,400**

MEDIA CAMPAIGN

Printing of subway/bus ads and palm cards	$70,000
Placement of subway/bus ads	$538,000
Creating/planning ad campaign, graphic design work	$83,900
TOTAL	**$691,900**

CHCANYS DEFINING NEW DIRECTIONS
Community Health Care Association of New York State www.chcanys.org

COMMUNITY HEALTH CENTER FQHC QUALITY

Testimony from the Community Health Care Association of New York State
Committee on Hospitals: Preliminary Budget Hearing
Council Chambers, City Hall, New York, NY
March 25, 2019

The Community Health Care Association of New York State (CHCANYS) is pleased to submit this written testimony to the City Council's Committee on Hospitals Preliminary Budget Hearing.

CHCANYS is New York State's Primary Care Association for federally qualified health centers (FQHCs), also known as community health centers. CHCANYS operates as an advocate and voice for the 70 community health centers that operate over 800 sites across the State. In New York City, there are over 500 FQHC sites serving 1.3 million patients, or one in seven New Yorkers annually. In 2015, NYC Health + Hospitals formed Gotham Health, Inc. which now operates many health center sites throughout the city.

FQHCs are non-profit, community run health centers located in medically underserved areas that provide high-quality, cost effective primary care to anyone seeking it, regardless of insurance coverage, immigration status, or ability to pay. Each FQHC is governed by a consumer-majority board of directors who seek to identify and prioritize the services most needed by their communities. Indeed, FQHCs offer unique benefits to all communities, particularly those who have been underserved and are low income, including a model of patient-centered care that is demonstrably associated with improved outcomes and reduced costs.

FQHCs are designed to be fully integrated patient-centered medical homes, providing mental health, oral health and health promotion/disease prevention services as required components of a comprehensive primary care setting. The provision of service to all, regardless of immigration status or ability to pay, has been the hallmark of the FQHC model for fifty years. FQHCs across the city, including Gotham Health, create a reliable network of primary care throughout New York City.

Across the State, Medicaid and Medicare account for approximately 53% of annual emergency department (ED) visits.[i] Meanwhile, research has shown that many visits to hospital emergency departments are non-urgent or preventable and could have been treated or avoided through timely primary care.[ii] FQHCs are the bedrock of the NYC primary care safety net, providing access to effective primary care, especially among populations that are most likely to present at the ED with a non-urgent or avoidable condition. In fact, FQHC availability has shown to reduce ED utilization among populations most likely to appear in an ED with a non-urgent condition, including low-income individuals, Medicaid beneficiaries, and the uninsured.[iii]

FQHCs serve all individuals regardless of ability to pay for services or insurance status and allow for payment for services to be determined based on ability to pay and a sliding fee scale. Through provision of enabling services that enhance access to care, including transportation to and from visits, language assistance, comprehensive case management, and extended hours, FQHCs have become a trusted

provider in their communities. Approximately 14% of New York City health center patients are uninsured, and 370,000 are best served in a language other than English. While proposed changes to public charge have threatened immigrants' sense of security and/or willingness to sign up for public benefits, health centers have maintained their status as a communal safe space for all, even when they stand to lose as much as $100M in annual Medicaid revenue as a result of the proposed rule.[iv]

CHCANYS applauds the Mayor's efforts to expand access to health care to 600,000 New Yorkers without insurance coverage through the NYC Care initiative. However, by limiting FQHC participation in the NYC Cares program to Gotham sites, we are concerned that the mayor has overlooked the larger existing network of FQHC providers that have relationships with the kinds of patients the NYC Cares is looking to serve. NYC's FQHCs leverage their strong community relationships to provide comprehensive case management and refer out to support services across the city as needed, even in hard to reach areas.

To summarize, health centers are an existing network of providers with strong ties to the communities they serve. These bonds to the communities make it possible for FQHCs to engage even the hardest to reach patients in all corners of NYC. In the city's effort to expand access to coverage and care for all New Yorkers, CHCANYS urges the Council to engage FQHCs and leverage their existing relationships with community providers – including social support services, specialty care and hospital-based services. In the effort to ensure that neither immigration nor insurance status determines health status in New York City, we urge the Council to look beyond the walls of the public hospital system and to support collaborations among trusted community-based organizations, including FQHCs.

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[i] Goins S, Conroy MB. Statistical Brief #8. *New York State All Payer Emergency Room Visits, 2013.* New York State Department of Health Office of Quality and Patient Safety Division of Information and Statistics. March 2015. https://www.health.ny.gov/statistics/sparcs/sb/docs/sb8.pdf

[ii] McWilliams A, et al. *Cost analysis of the use of EDs for primary care services in Charlotte, North Carolina.* N C Med J. 2011;72(4):265-71.

[iii] Laiteerapong N, et al. Health care utilization and receipt of preventive care for patients seen at FQHCs compared to other sites of primary care. Health Serv Res. 2014;49(5):1498-1518.

[iv] CHCANYS testimony before the New York City Council Committees on General Welfare, Immigration, and Health. Oversight Hearing: The Impact of the Proposed "Public Charge" Rule on NYC. November 15, 2018. http://www.chcanys.org/clientuploads/2018%20Policy/FINAL_Public_Charge_NYC_Hearing_WRITTEN_Testimony_11.15.2018_PDF.pdf

New York State NURSES ASSOCIATION One strong, united voice for nurses and patients

New York City Council Budget and Oversight Hearings
Fiscal Year 2020 Preliminary Budget

NYSNA Testimony to the Committee on Hospitals
March 25, 2019

Presented by Judith Cutchin, RN
President, NYC Health + Hospitals and Mayorals Executive Council
New York State Nurses Association

The New York State Nurses Association represents more than 42,000 registered nurses and is the largest union representing registered nurses in New York State. NYSNA is also represents more than 8,500 public sector nurses employed at the NYC Health + Hospitals system and various Mayoral agencies.

As a union representing registered nurses, we advocate universal, equal, high quality health care for all New Yorkers regardless of ability to pay.

NYSNA strongly supports funding that will allow nurses and other direct care health workers to provide the highest quality care for our patients, equality of health care services for all New Yorkers and communities, in accordance with professional standards, with guaranteed minimum staffing ratios, and under safe and fair working conditions.

1. NYC Health + Hospitals is the backbone of the NY City area health care system

The public Health + Hospitals system is the core of the broader city-area acute care hospital system. Though Health + Hospitals operates about 20% of the total city-wide in-patient hospital beds, it provides a disproportionate share of out-patient clinic services, psychiatric services, Level I trauma capacity, and other specialized types of care that are vital to the entire NY city health care system.

In addition, Health + Hospitals provides an outsized and widely disproportionate share of services to uninsured and underinsured patient populations and communities. The public system thus accounts for about 20% of hospital capacity, but it provides about 50% of uninsured patient acute care discharges and emergency room visits, and even higher (60%-70%) rates of out-patient, ambulatory and primary care services to the uninsured.

The Health + Hospitals system also plays a key role in allowing the private medical center systems (NY Presbyterian, Mount Sinai, NYU and Northwell) to generate huge operating and total profits, which

have ranged from $600-$900 million annually. The existence of the Health + Hospitals system has allowed these private hospitals to focus their operations on the most profitable types of services (cancer, joint disease and surgery, cardiac, transplant, etc.), further padding their profits. This is accomplished by shedding costly and unprofitable services (psychiatric, obstetrics, emergency, trauma, etc.) and populations (uninsured and underinsured patients, and low income communities) and shifting the financial burden of providing this care to the public hospital system.

In the final analysis, the very high profits being generated by the major private sector hospital systems are only possible because of the existence of the Health + Hospitals system. These private sector hospitals thrive through a symbiotic relationship that essentially relies on the exploitation of the public sector system.

2. NYC Health + Hospitals must be funded equitably

Given the dynamic between the private and the public hospital systems in NY City, it is critical that the public system is provided with the resources it needs to fulfill its critical assigned role within the broader health care delivery system.

The quality of care provided by the Health + Hospitals system is must be noted is as good as or better than that provided by major private hospital systems.

The objective metrics relating to patient outcomes in the Health + Hospitals system (mortality, hospital acquired infections, patient falls, incidence of bed sores, etc.) are equal or comparable to those of the private systems.

In addition, the Health + Hospitals system is not, contrary to certain ideological narratives, equally efficient in terms of labor costs and total costs. The costs of providing care in the Health + Hospitals system are in line with or superior to those of the private sector when analyzed in comparison to the volume and types of services provided.

The public hospital system, however, is not fairly reimbursed for the services it provides (because it provides a disproportionate share of poorly reimbursed or inherently expensive services – Level I trauma and psychiatric services, for example – and cares for disproportionate numbers of uninsured and underinsured patients). This results in an apparently higher cost of services relative to the income produced and feeds the false narrative that the public system is less efficient than the private system.

As the public system continues to labor under the financial pressure of ongoing operating deficits and calls to reduce costs, however, there are real impacts on its patients and the communities that it serves. Cost cutting initiatives are demanded to compensate for the operating deficits caused by unfair reimbursement and inadequate resources. This creates a further downward pressure on the quality of care and scope of services offered.

Because the public system disproportionately serves poorer patients and communities, this results in the increasing prevalence of a two-tiered system of care in which poorer and working class patients and communities receive lower levels of services than those provided by the private sector hospitals to their more affluent patient population.

The City of New York must not permit a two-tiered health care system to operate in NY City in which immigrants, people of color, lower income workers, and other New Yorkers receive fewer services, reduced access and lower quality of care than that received by others who have more wealth.

The City of New York must work to adequately and fairly fund the Health + Hospitals system, ensure that all New Yorkers have equal and equitable health care, and assert its authority to fairly allocate resources to all communities.

3. NYC Care and NYC Public Option

In January of 2019, the Mayor announced a new initiative to provide health care coverage to all uninsured NY City residents. The Mayor's proposal, which would provide direct access or health insurance to the approximately 600,000 city residents who currently are uninsured, relies upon Health + Hospitals as its core element.

Under the Mayor's proposal the NYC Health + Hospitals system, which is already the largest source of health care for uninsured and Medicaid patients in the city, would serve as the source of direct care services to this population.

In addition, the MetroPlus health insurance program, which is affiliated with the NYC H+H hospital system and currently offers coverage on the ACA private insurance exchange in New York and operates Medicaid managed care and other types of health insurance services, would serve as a "public option" insurer for part of the remaining uninsured population.

The FY2020 Preliminary Budget allocates $25 million for NYC H+H in FY2020 to begin implementation of this new health coverage, and projects $75 million in FY2021, $100 million in FY2022 and $100 million in each year thereafter. The Preliminary Budget also proposes to increase enrollment in MetroPlus, though no specific funding is allocated and there is no clear explanation as to how this will be accomplished.

NYSNA is a strong supporter of universal, single payer health coverage and has been a long-standing major supporter of the NY Health Act legislation currently pending in the state legislature (A5248/S3577).

NYSNA strongly supports the Mayor's "NYC Care" initiative as a necessary transitional step to provide health care coverage for city residents who remain uninsured under the current ACA health care structure while the struggle to implement universal health care coverage at the national or state level is carried to its conclusion.

NYSNA believes that the NYC Health + Hospitals system is the backbone of the city health care system, and is already providing about 20% of total hospital, ambulatory, health clinic and emergency care for NY city residents.

NYC Health + Hospitals already provides the bulk of such services as Level I Emergency trauma capacity, psychiatric and mental health care, maternity and delivery care, and other critical services that are too expensive and/or poorly reimbursed to interest private sector providers.

In addition, NYC Health + Hospitals also disproportionately cares for uninsured and underinsured patient populations and communities. The public hospital system's in-patient discharges, emergency room visits and out-patient visits are generally more 65%-70% covered by Medicaid and uninsured. The NYC Health + Hospitals primary care clinic system's scope and extension dwarfs those of the private hospitals and more than 50% of the patients seen in those clinics are uninsured.

Given its existing role in the broader health care system, it is no accident that NYC Health + Hospitals loses about $1 billion a year in its operations. The public system assumes the task of providing the bulk of poorly compensated services to New Yorkers who cannot pay the costs of their care, while the private hospitals focus on the wealthier patient populations and the most profitable services. We thus have a symbiotic relationship in which the private sector is able to make money precisely because the public sector is there to absorb the social costs of caring for the patients and communities that they seek to avoid.

Given this dynamic, we believe that the Preliminary Budget does not provide sufficient funding to maintain the existing services provided by NYC Health + Hospitals. We urge the council to provide additional funding that Health + Hospitals will be need to implement the Mayor's ambitious new NYC Care plan.

4. Establish a Planning Body to Coordinate the Implementation of NYC Care

Beyond the additional funding for NYC Health + Hospitals that will be necessary to provide universal health coverage for 600,000 uninsured New York City residents, we also believe that implementing the NYC Care program will require a high level of coordination and planning.

The NYC Care program will require NYC Health + Hospitals and the city to:

- Assess local community health needs throughout the city;
- Identify the geographic, racial, ethnic/cultural, and income/social composition of the 600,000 city residents who make up the uninsured population;
- Determine the scope of the health care needs of the uninsured;
- Analyze the scope and types of services that will needed to meet their needs;
- Analyze and determine the geographic dispersion of the target population and the existing services available in those areas;
- Create a specific plan to meet the needs of the uninsured population;
- Identify and develop needed health care services sites;
- Identify, develop and put in place the necessary staffing of physicians, physician assistants, nurse practitioners, registered nurses, supportive care giver personnel, non-care giver personnel and administrative personnel;
- Analyze and identify the costs of setting up the necessary primary, ambulatory and clinical services; and,
- Analyze and identify available resources to provide the desired services.

We also believe that the City and the NYC Health + Hospitals system should not be left to bear the full responsibility for providing universal coverage.

The private hospitals, and the large and very profitable academic and specialty medical centers in particular need to make resources available for this project. The private sector hospitals should either contribute financially or in the form of direct care to the target uninsured population, rather than relying entirely on the tax payers to assume the costs of implementation.

In order to effectively implement a city-wide universal health coverage program, there will need to be a centralized body to create a plan, coordinate public and private efforts to implement the plan, and with some official power to direct and guide the process.

NYSNA thus urges the Council to include in the budget provisions for a City-Wide health planning commission or administrative body to oversee the implementation of the NYC Care program.

5. Oppose the proposed Cuts in State Medicaid Funding

NYSNA is deeply concerned about the health care cuts that were proposed in the state FY2020 Executive Budget in Albany.

The cuts in hospital and other health care provider funding being proposed in the state budget exceed $1 billion in state funds. In addition, when matching federal funds that will be lost are included, the total cost to health care providers state-wide rises to about $1.5 billion. In addition, many of the cuts are target at or will disproportionately impact New York City hospitals and providers.

These cuts include the following:

- $138 million reduction in state Indigent Care Pool (ICP) funding, totaling $275 million when federal matching aid is eliminated, and all targeted specifically at downstate hospitals;
- $180 million in Medicaid reimbursement rates, totaling $360 million state wide when federal matching aid is eliminated;
- $220 million in revoked Medicaid rate increases for hospitals (2%) and nursing homes (1.5%) that were implemented in November of 2018;
- $59 million in state reimbursements for NY City local public health programs.

Though it appears that a consensus is forming in Albany to drop these proposed cuts to health care funding, it is imperative that these cuts be stopped.

NYSNA strongly opposes the proposed state health care cuts and strongly urges the City Council as a body and individual council members to do their utmost to persuade the state legislature to reject the proposed cuts in Medicaid and ICP funding.

6. Support the "NYC Health + Hospitals Community Plan" to fix Inequities in Indigent Care Pool (ICP) Funding

The Federal Disproportionate Share Hospital (DSH) program currently allocates about $1.8 billion to New York to provide support to hospitals that provide health care to "disproportionate" shares of Medicaid and uninsured patients. New York State, some county governments, and New York City contribute an equal matching share (50%/50%) to provide hospitals with a total of $3.6 billion in funds to compensate for the care of the uninsured and Medicaid patients (for whom Medicaid reimburses provides less than the cost of care).

About $1.135 billion of the total DSH pool is distributed through what is known as the Indigent Care Pool (ICP), which uses various formulas to distribute the money to private hospitals.

These funds are intended to compensate safety-net hospitals for the losses associated with higher rates of Medicaid and uninsured patient populations and correspondingly lower rates of privately insured patients.

The basic premise of the DSH/ICP funding program is that Medicaid reimbursement rates are set below actual costs in most instances and that uninsured patients are not reimbursed at all, putting these hospitals in a precarious financial situation. The DSH funds are intended to redress this imbalance by providing extra support to offset these losses and allow safety net institutions to continue to operate and provide vital care to poor communities.

The current state methodology for distributing the DSH and ICP funds does not target this funding to those hospitals with the highest rates of Medicaid and uninsured patients. Instead, it distributes the money more broadly to all hospitals, using formulas that continue to incorporate bad debt, and consequently distributing significant portions of this finite pool of funding to hospitals that do not need the funds (because they are highly profitable) or do not deserve the funds (because they serve a proportionately low share of Medicaid and uninsured patients).

The DSH and ICP funds also continue to consider "bad debt" in the distribution of funds to hospitals, even though this "bad debt" is not considered "charity care" and is no longer allowed by federal law to be included in determining allocations of federal DSH money. New York was supposed to have phased out the inclusion of bad debt more than five years ago, but has maintained a "transition collar" to phase it out so slowly that it will take decades to eliminate.

The net effect is that the DSH and ICP money is not distributed fairly and targeted to those true safety-net hospitals with the highest rates of Medicaid and uninsured patients. Money from the pools is still being given to highly profitable hospitals that treat relative low numbers of uninsured and Medicaid patients. Instead of being allocated to safety-net hospitals, much of the money in the fund goes to richer hospitals that neither need nor deserve the funding.

The NYC Health + Hospitals system and numerous community and patient advocacy groups, including NYSNA, have helped to formulate and support the "NYC Health + Hospitals Community Proposal" to fix the inequities in the ICP and DSH pools.

NYSNA strongly supports this proposal, which is being included in State Senate budget proposals and as stand-alone legislation in the Assembly (A6677) and which would:

- Leverage $300 million in additional federal money for "Enhanced Safety Net Hospitals" as reimbursements in the state Medicaid program;
- Eliminate the "transition collar" in the ICP pool without harming rural and urban safety net hospitals;
- Distribute more DSH and ICP money to hospitals with high levels of indigent, uninsured and Medicaid patients; and,
- Reduce payments to hospitals with low levels of uninsured and Medicaid patients;

NYSNA strongly urges the Council as a body and individual council members to call upon legislators to include the "NYC Health + Hospitals Community" plan in the state budget or to enact A6677 as stand-alone legislation.

7. NYSNA Supports Minimum Safe Staffing Standards in Hospitals and Other Health Care Facilities

In presenting the state Executive Budget, Governor Cuomo announced that he was directing the Department of Health to conduct a study that will examine ways to implement staffing enhancements to improve patient safety and the quality of care in our hospitals and nursing homes.

In addition, there is pending legislation that would set minimum safe staffing ratios that all hospitals and nursing homes would have to adhere to pending in the legislature (A2954/S1032).

NYSNA and a range of other labor and community advocates strongly support expanding mandatory safe staffing ratios to ensure that hospital and nursing home patients have enough registered nurses, licensed practical nurses, nurse's aides, patient care technicians, and other direct patient care workers and professionals who are part of an inter-disciplinary team to deliver safe high quality patient care.

We believe that minimum staffing ratios covering registered nurses, licensed practical nurses, nursing aides, patient care technicians and other members of the inter-disciplinary team of direct care staff will be found to be the most effective approach to improving patient safety and the working conditions of direct care workers.

This conclusion is supported by a well-established body of research and the actual experiences of New York, California and other jurisdictions that have successfully implemented minimum staffing ratios.

Setting a floor on the number of patients that registered nurses, licensed practical nurses, nursing aides, patient care technicians and other direct care staff can be assigned to care for is safer to patients, safer for direct care workers and in the end more cost effective than short-sighted management efforts to cut corners and pinch pennies by skimping on patient care.

New York has already established safe staffing standards for certain types of patients by statute and regulation. New York's approach to safe staffing standards was a correct response to documented

patient safety concerns for certain types of units. With the intensification of patient acuity throughout hospitals and nursing homes, it is now time to expand the application of staffing standards to every patient care unit in furtherance of safe patient care and to be consistent with New York's long standing approach to regulating hospital and nursing home staffing.

Research shows that the more patients assigned to a nurse and other direct care staff, the worse the quality of care that is received by those patients. Poor staffing increases patient mortality rates, reduces patient health outcomes, increases the incidence of co-morbidities, complications and length of stay, reduces patient ratings of their care experience, lengthens patient recovery times, and leads to higher rates of readmission and unnecessary health care utilization.

Poor staffing also negatively affects the working conditions of direct care workers and the experience of patients. Inadequate staffing increases wait times for care, is a trigger for workplace violence and assaults on patient care staff, leads to increased workplace injuries and illness, depresses workplace morale and leads to higher rates of staff burnout and turnover.

The adverse effects of poor staffing also have serious costs and financial consequences for bottom lines of hospitals, nursing home and other health care providers. High rates of turnover of direct care staff pose a huge and increasing cost for employers in the form of direct recruitment and training costs and indirectly in the form of lost experience and productivity. Unnecessary patient admissions and readmissions impose significant costs on the health care system and result in reduced provider reimbursement and other monetary penalties under current federal and state policy. Poor staffing is a major contributing factor in assaults and work-related injuries, leading to increased labor back-fill and employee health care costs to employers. Poor staffing also increases liability costs for malpractice and patient harm lawsuits. Poor patient care outcomes also impose a macro-economic cost in the form of lost work time, decreased quality of life and higher total health costs in the broader economy.

NYSNA strongly supports the expansion and establishment of enforceable staffing ratios beyond where they already exist to all areas of hospitals and nursing homes, applicable to nurses and to other direct care workers, as a necessary measure to ensure the health and safety of patients and workers.

We strongly urge the Council to enact a resolution in support of the pending legislation to enact minimum safe staffing standards to maintain the working conditions of direct care nurses and other caregivers and to provide safe care to our patients.

Testimony
New York City Council Committee on Hospitals- March 25, 2019
By Ralph Palladino, 2nd Vice President Clerical Administrative Employees, Local 1549

Clerical-Administrative Local 1549 represents 5,000 employees of the NYC H+H and Metro Plus HMO. We represent the Interpreter Title for the city and Client Navigator title in NYC H+H that can also be used for interpreting and information providing duties.

NYC H+H has always led the way in providing quality care. The system's hospitals continue to win awards for healthcare delivery. The H+H Metro Plus HMO continues to win awards at the number one HMO in the state every year. Under the leadership of Dr Katz in conjunction with union cooperation, including Local 1549 the NYC H+H has improved its' finances and patient access from the street level to the patient care rooms for patients. But much, much more needs to be done in both those and other areas. The addition of primary care and other physician staff has been good.

But the back-up, ancillary staffing remains woefully low thus impeding better healthcare delivery. Nurses and higher paid professional and managerial titles too often must perform clerical tasks as do low-wage office temps. The use of higher titles is a waste of tax dollars and the use of private temps is a threat to patient confidentiality. This continues the Bloomberg administration attack on civil service. More funding is needed to ameliorate these problems.

We therefore request:

1) Support NYC Cares

Local 1549 fully supports the Mayor's proposal for additional funding for NYC H+H through the NYC Care program. This program will allow the 600,000 undocumented immigrants and others the ability to gain access to quality healthcare when they need it.

Currently in New York City there are over 3 million immigrants, 775,000 undocumented living in the five boroughs. Like the Italian, Irish and other immigrants who came to this country legally and illegally, they work to provide services, goods and help build our city. They are tax payers contributing to the economic and social life of our city.

According to a report from Comptroller Stringer's office, "Immigrants are taxpayers: every year, immigrant New York families pay an estimated $8 billion in City and State personal income taxes and approximately $2 billion in City property taxes."

They have a human right to services that their taxes help provide. This includes services such as health care and language interpretation.

In addition we do not need to have immigrants who may be ill or carrying a disease to be discouraged from seeking care due to legal threats and/or lack of health coverage. We do not to have a pandemic or epidemic in the city because of lack of care. The most recent "epidemic' is now the measles.

At one time the city funded 33% of HHC's (now NYH+H) budget. We believe more should be done by the city, but this newly proposed program along with funding provided a couple of years ago are good starts. For years, Local 1549 has called on the city to increase its' support for our great public system. We applaud the Mayor for doing so.

2) Reach out to the state for fair share funding for NYC H+H
Medicaid Financing not meeting the cost of care

The cost of providing quality services needed by the public continues to outpace this public system's cost of care and income. It currently costs NYC H+H roughly $350 per visit by a patient to outpatient care. The Medicaid reimbursement however is roughly $200. This is a *loss*

of roughly $150 per visit per patient that the NYC H+H system must absorb. This is despite NYC H+H's low administrative overhead of just 3% (compared to private insurance that is at over 20%). Rates have not risen significantly in over 10 years.

That said note that NYC H+H receives virtually NO COMPENSATION for treating undocumented immigrants. The cost and loss for uncompensated care to the NYC H+H is $1.4 billion. A lot of it is for undocumented.

Disproportionate Care (DSH) funding not fairly distributed and is ending

The federally funded Delivery System Reform Incentive Payment (DSRIP) Program allocation from the state is supposed to be provided to where the most indigent care is provided. However, this is not what the state has done. Too much of the funding is going to the private non-profit (but really for profit) sector and not enough is going to public hospitals. There have been numerous articles, in all of the major newspapers, over the past few years addressing the excessive tax dollars received by large "non-profit" hospitals that function like "for-profits," with high paid CEO's, and do not serve anywhere near the number of poor patients that NYC H+H does.

DSH funding is to be ended in a couple of years. The Trump Administration budget proposes cuts based on ending DSH while cutting Medicaid and Medicare. They propose to slash reimbursement to providers. This will cripple NYC H+H hurting patients, cutting jobs and hurting local businesses that rely on healthcare facilities being in their neighborhoods.

3) <u>The need for improvement in language services for Immigrants</u>

The influx of immigrants from all over the world using city services is great. This requires that communication efforts be enhanced. In some cases this can mean life and death. It is especially true in healthcare settings. This is critically important in communication and outreach efforts for NYC Cares.

Currently the city and NYC H+H contracts out to private vendors interpreter and language services that is done by phone. NYC H+H too often relies on non-employee volunteers or pools from employees who hold various other titles. This is providing inadequate service to those who need it. The volunteers and employees are not usually versed in medical terminology which is important. Client Navigators who perform interpreter duties are. Who does the work of pooled employees when they are called to perform this uncompensated interpreting service?

The New York Immigration Coalition has documented that the most efficient way to provide language interpretation is FACE TO FACE interpretation. This service should be performed by city employees, not private phone line employees. We hear stories from our members working in hospitals, SNAP and Medicaid about wrongful advice and interpretations being performed. The best way to have total quality control and to deliver the service is by using the Civil Service Interpreter Title throughout the city. In NYC H+H this can be done by Client Navigators.

Interpreters do face to face interpretation. They also can interpret documents and assist those who are applying for benefits with providing application filing information. <u>I refer you to the ***NY State Report on Social Services*** (chaired by then Senator Avella) that summarized the importance and need for interpreters.</u>

If the city and NYC H+H really wants to help the uninsured, especially the immigrant population then they should do it properly and in the most efficient manner. It is about peoples' health, not just figuring ways to save money.

H+H expansion is the key to making health care more accessible, especially in areas where disparities in health care exist. It is the main provider for undocumented immigrants.

Asks of the City Council

1- **Support and properly fund NYC Cares.**

2- **Demand that the NYC H+H use the Interpreter Title and/or Client Navigator title for face to face and document language interpretering rather than private contracted out and inefficient phone lines and non-employee volunteers.**

3- **Pro-actively support the Albany Rivera-Gottfried legislation for expansion of Essential Care Health Insurance for immigrants state-wide that mirrors the NYC Care in NYC.**

4- **Pro-actively advocating with the Governor and state legislature about increasing Medicaid reimbursement rates. It is also important to demand more funding and fair distribution of Disproportionate Share (DSH) Funds for NYC H+H.**

5- **Oppose President Trump's wall building and restrictions on benefits for immigrants including ridiculous work requirements.**

6- **Pro-actively oppose President Trump's proposed cuts to Medicare, Medicaid, SNAP-food stamp program vital for health, especially children and elderly, and the Affordable Care Act.**

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☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Briana Silberberg

Address: 116 Nassau St NY NY 10038

I represent: NYC Anti-Violence Project

Address: 116 Nassau St NY NY 10038

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Name: Shay Huffman

Address: 116 Nassau St NY NY 10038

I represent: NYC Anti-Violence Project

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Name: Ana Whyte

Address: 116 Nassau St NY NY 10038

I represent: NYC Anti-Violence Project

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Name: Elaine Merdus

Address: 116 Nassau St

I represent: NYC Anti-Violence Project

Address: _____

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Name: Esmeralda Mattos

Address: _____

I represent: community member

Address: _____

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Date: 3/25/19

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Name: MAX HADLER

Address: _____

I represent: NEW YORK IMMIGRATION COALITION

Address: _____

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(PLEASE PRINT)

Name: John Ullberg

Address: _____

I represent: N.Y.C. Health + Hospitals

Address: _____

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Name: Leon Bell

Address: 131 W 33rd St. NY NY

I represent: NYSNA

Address: 131 W 33rd St NY NY

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(PLEASE PRINT)

Name: Addrea Bowen

Address: 147 S Oxford St Brooklyn NY

I represent: Bowen Public Affairs

Address: same

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(PLEASE PRINT)

Name: Cecilia Gentili

Address: _____

I represent: Trans Equity Consulting

Address: _____

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☐ in favor ☐ in opposition

Date: 3.25.19

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Name: Patsy Yang

Address: _____

I represent: NYC. Health + Hospitals

Address: _____

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Date: 3.25.19

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Name: Mitchell Katz, M.D.

Address: _____

I represent: NYC Health + Hospitals

Address: _____

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Date: 3.25.19

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Name: Matthew Siegler

Address: _____

I represent: N.Y.C. Health + Hospitals

Address: _____

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Date: _____

(PLEASE PRINT)

Name: Ralph Palladino

Address: _____

I represent: Vice President, Local 1549

Address: DC 37

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☐ in favor ☐ in opposition

Date: 3/25/2019

(PLEASE PRINT)

Name: JERRY WESLEY

Address: 127 E 38th Street Ground Floor

I represent: GET HEALTHIER CARE TOGETHER INC

Address: 127 E 38th Street Ground Fl Brooklyn NY 11203

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