BEFORE THE NEW YORK STATE SENATE FINANCE
AND ASSEMBLY WAYS AND MEANS COMMITTEES

JOINT LEGISLATIVE HEARING

In the Matter of the
2016-2017 EXECUTIVE BUDGET
ON HEALTH AND MEDICAID

Hearing Room B
Legislative Office Building
Albany, New York

January 25, 2016
9:35 a.m.

PRESIDING:

Senator Catharine M. Young
Chair, Senate Finance Committee

Assemblyman Herman D. Farrell, Jr.
Chair, Assembly Ways & Means Committee

PRESENT:

Senator Liz Krueger
Senate Finance Committee (RM)

Assemblyman Robert Oaks
Assembly Ways & Means Committee (RM)

Senator Kemp Hannon
Chair, Senate Committee on Health

Assemblyman Richard N. Gottfried
Chair, Assembly Health Committee

Senator David J. Valesky
Co-Chair, Senate Committee on Health

2016-2017 Executive Budget
Health and Medicaid
1-25-16

PRESENT: (Continued)

Senator James L. Seward
Chair, Senate Committee on Insurance

Assemblyman Kevin A. Cahill
Chair, Assembly Committee on Insurance

Senator Diane Savino

Assemblyman Michael J. Cusick

Senator Kathleen A. Marchione

Assemblyman Kevin A. Cahill

Senator Gustavo Rivera

Assemblywoman Jo Anne Simon

Assemblyman Félix W. Ortiz

Assemblyman Andrew P. Raia

Senator Roxanne Persaud

Assemblyman Andrew Goodell

Assemblyman Jeffrion L. Aubry

Assemblyman Phil Steck

Assemblyman Andrew Garbarino

Assemblyman John McDonald

Senator Martin J. Golden

Assemblywoman Aileen M. Gunther

Assemblyman Edward P. Ra

Assemblywoman Nicole Malliotakis

2016-2017 Executive Budget
Health and Medicaid
1-25-16

PRESENT: (Continued)

Assemblyman Thomas J. Abinanti

Senator John DeFrancisco

Assemblywoman Shelley Mayer

Assemblyman David Weprin

Senator Phil M. Boyle

Assemblyman Raymond Walter

Senator Susan Serino

Senator Velmanette Montgomery

Assemblywoman Latrice Walker

LIST OF SPEAKERS

2016-2017 Executive Budget
Health and Medicaid
1-25-16

LIST OF SPEAKERS, Continued

LIST OF SPEAKERS, Continued

LIST OF SPEAKERS, Continued

LIST OF SPEAKERS, Continued

CHAIRMAN FARRELL: Good morning. Today we begin the second in a series of hearings conducted by the joint fiscal committees of the Legislature regarding the Governor's proposed budget for fiscal year 2016-2017. The hearings are conducted pursuant to Article 7, Section 3 of the Constitution and Article 2, Sections 31 and 32A of the Legislative Law.

Today the Assembly Ways and Means Committee and the Senate Finance Committee will hear testimony concerning the budget proposal for health and Medicaid.

I will now introduce the members from the Assembly, and Senator Young, chair of the Senate Finance Committee, will introduce members from the Senate.

We have been joined by Assemblyman Richard Gottfried, chair of the Health Committee; Assemblyman Michael Cusick, Assemblyman McDonald, Assemblyman Steck, and Assemblyman Oaks, who will give us --

ASSEMBLYMAN OAKS: Yes, we've also been joined by Assemblyman Raia, Assemblyman

Garbarino, Assemblyman Goodell, and Assemblywoman Malliotakis.

CHAIRMAN FARRELL: Senator?

CHAIRWOMAN YOUNG: Thank you very much.

And good morning to my colleagues here at this Health Committee hearing. And also to the people who are in the audience, we welcome you. As you know, this is one of the most important areas of the State Budget and also it's the most extensive area, in many ways, of the State Budget. And it impacts so many lives across our entire state. And so we expect to have very good discussions this morning, and probably into the afternoon -- hopefully not into the evening, though. But you never know.

I'd like to welcome my colleagues Senator Kemp Hannon, Senator Jim Seward, Senator Kathy Marchione, Senator David Valesky, Senator Diane Savino, and Senator Marty Golden.

And I'd like to turn it over to my colleague Senator Liz Krueger.

SENATOR KRUEGER: Thank you very much.

I'd like to welcome our Ranking Senator Gustavo Rivera, and our newest Senator, Roxanne Persaud.

CHAIRMAN FARRELL: Before introducing the first witness, I would like to remind all of the witnesses testifying today to keep your statement within your allotted time limit so that everyone can be afforded the opportunity to speak. If we do it well, we'll be out of here by 6:30.

(Laughter.)

CHAIRMAN FARRELL: That's something we don't have to meet, that point.

We're joined today, we begin with Dr. Howard Zucker, commissioner of the New York State Department of Health.

Good morning.

COMMISSIONER ZUCKER: Good morning.

Good morning, Chairpersons Young, Farrell, Hannon and Gottfried, and distinguished members of the State Senate and Assembly. I am pleased to be here today to discuss Governor Andrew Cuomo's 2016-2017

Executive Budget as it relates to the goals of the Department of Health.

There is a great deal of good news to share with you this morning. The commitment Governor Cuomo has made to protect and improve public health is significant.

I'd like to begin by discussing the accomplishments of the State Medicaid Redesign Team, which has had extraordinary success in overhauling the largest and most expensive Medicaid program in the nation.

When Governor Cuomo established the MRT, our program cost twice the national average per recipient, yet it was consistently ranked below other states on several measures of care quality. Even worse, it was growing at an unsustainable rate of 4.3 percent annually. Today, Medicaid spending per recipient has dropped to its lowest level in 13 years, and the rate of spending growth has slowed to just 1.4 percent annually. At the same time, we have increased enrollment to 6.3 million people and improved the quality of care in

communities across the state.

More work remains to be done, and the Governor's budget provides resources to help improve the full spectrum of healthcare delivery, including increased payments to essential community providers and new payments to enhance population health improvements. These investments are balanced by savings from initiatives to eliminate fraud and abuse, improvements in benefits design, and greater pharmaceuticals controls.

The Executive Budget also provides resources to support safety net hospitals and ensure their sustainable future. Throughout the state, in urban and rural areas, safety net hospitals are facing unprecedented financial challenges. Federal and state policy changes demand quality, efficiency and value. Advances in technology and medicine are shifting health care services from hospitals to outpatient and community-based settings, and they face increased competition with larger regional health care systems and physician services. As a result, many of

these safety net hospitals are no longer financially sustainable in their current form.

Last year, with your support, we were able to provide more than $325 million of assistance to 28 safety net hospitals to support the critical role that these institutions play in protecting the health of low-income vulnerable people and serving as economic anchors of their communities. The Executive Budget provides $450 million in operating assistance to enable these hospitals to continue to deliver essential health care services while longer-term sustainable solutions are developed and implemented. Their problems weren't created overnight, they won't be solved overnight, and without this level of commitment, many would close.

The Executive Budget also continues nearly $2.5 billion of capital resources that will improve, streamline, modernize and strengthen the state’s healthcare infrastructure. We are going to great

lengths to ensure that the investments we make with these dollars permanently improve the sustainability of essential healthcare providers and the quality of services that they provide.

The Governor's budget also provides resources to help us end the AIDS epidemic in New York and also increase improved health outcomes for New Yorkers with two of the most prevalent forms of cancer.

I'm sure you recall that back in 2014, Governor Cuomo outlined his comprehensive plan to address and finally end the AIDS epidemic in New York State. I am very proud to say that we are on our way to achieving that goal, and in fact, for the first time since the epidemic began, we had no new mother-to-child transmissions of HIV. That is a significant achievement.

In December, at World AIDS Day, Governor Cuomo reaffirmed his pledge to End the Epidemic with an additional $200 million multiyear commitment of new funding toward HIV/AIDS efforts, which is in addition to the

$2.5 billion in public funding that the state currently directs toward addressing the healthcare needs of those living with the disease.

And just as the Governor committed the energy and resources of our state to fight against AIDS, he has now announced new efforts in the fight against cancer. This includes a comprehensive, statewide plan announced in the Governor's State of the State address to increase screening for breast cancer and increase awareness of prostate cancer.

Breast cancer is the most common cancer among women in New York, with 15,000 diagnoses each year. It is also the second leading cause of cancer-related death in New York women, responsible for 2,700 deaths each year.

Other than skin cancer, prostate cancer is the most common cancer among men in New York State. Each year, more than 15,000 men are diagnosed with prostate cancer, and more than 1,700 die of the disease.

The Governor’s plan will help women access the treatment they need and educate thousands of men about the risks associated with prostate cancer. The state’s investment will support the purchase and operation of mobile mammography vehicles, to be used in areas with a high number of unscreened women. The Executive Budget also provides funding to hire additional healthcare workers at cancer treatment and other healthcare facilities, to identify and reach out to patients due for breast cancer screening, and to help improve access to mammograms as well as subsequent diagnostic follow-up and treatment services.

As a result of the Governor’s initiative, more than 212,000 additional women will be screened for breast cancer by December 2020, and 25,000 men will receive peer education and outreach services, helping them make an informed decision about whether to be screened for prostate cancer. One thing we know in the medical community -- the best hopes for surviving breast cancer rests with early detection, and the Governor's plan

will no doubt save thousands of lives.

The Executive Budget provides us with a blueprint that will help us to protect and improve public health, while also taking on the monumental tasks of reforming our healthcare delivery systems. Together with all my colleagues at the Department of Health, I look forward to working with our partners in the Legislature and with all our stakeholders to take on that task and to rebuild our health care system into the finest in the nation.

Thank you. I am happy to answer your questions. And I will also ask Jason Helgerson, the director of our Medicaid team, to join us to answer the questions related to the Medicaid program. Thank you.

CHAIRMAN FARRELL: Thank you very much.

I've been joined by Assemblyman Cahill.

First to question, Assemblyman Gottfried.

ASSEMBLYMAN GOTTFRIED: Thank you,

Commissioner. Good morning.

You talked about the state's increasing efforts to invest resources in hospitals, which is certainly very important. Under the DSRIP plan and the state's SIM grant and other efforts, though, I think there is widespread understanding that if we're going to help control the cost of healthcare and improve outcomes, we need to shift more and more of our resources into primary and preventive and non-hospital care.

And so my question is, what is the state doing to increase investment in those community-based providers that are not hospitals? What percentage of DSRIP money and capital restructuring money and other programs are going to community-based providers, and what is the future of that effort?

COMMISSIONER ZUCKER: Thank you for your question.

I think as we are seeing that there is a move towards primary care -- and that is part of our model, with our Advanced Primary

Care model tying together medical issues and behavioral health -- we are moving towards more of a community-based system. We have invested in many programs dealing with the Prevention Agenda, which ties also to primary care. We have programs that are out there as we move forward with some of the investments on specific hospitals which are reaching out into the community. And also our DSRIP program, as you had mentioned before, looks at not just the hospitals but also the community.

There has been investment put in the programs dealing with everything from school-based clinics, which is an area which we also have been focused on. There is issues that we are putting money towards connecting physicians' practices, which are more in a community environment, with the hospitals. And there's money towards that through the SHIN-NY. There's also efforts made to target specific medical problems that are not necessarily hospital-based, but issues that are in the outpatient area.

Regarding DSRIP -- I guess, Jason, do you want to answer the DSRIP issue?

MEDICAID DIR. HELGERSON: Certainly.

In terms of DSRIP, I mean obviously that's a very exciting opportunity for us as a state, $7.3 billion being invested in delivery systems over the next five years. And if you look at that initiative, you see that front and center are community-based providers. Just to give you like one example of where we're going to make significant investments of resources is in terms of improving the quality of primary care and access to primary care services. So one of the requirements that every single one of the performing provider systems across the state is required to do is to help ensure that all their primary care providers meet Level 3 patients that are medical home status, or the standards that are being developed as part of Advanced Primary Care by the end of the third year of the demonstration. Which means that while we've made some significant progress and have led the nation in many ways in terms

of high-quality primary care, we will actually build upon that and almost ensure that every Medicaid member, all 6.3 million of them, will have access to some of the finest primary care in the country.

So I think at the end of the day, DSRIP is a unique opportunity. But to, you know, add to Dr. Zucker's comments, the challenge -- and you hit it right on the head, Assemblyman, which is that we have to find a way to transition from a system of healthcare that relied far too heavily on institutional providers to one that relies more on the community. But we have to do that in a way that doesn't create healthcare deserts, where a healthcare system collapses in a community faster than we have the ability to transform it.

And I think that's why you need a multipronged strategy, which is what the Governor's budget does, which not only continues to move forward with the exciting initiatives in DSRIP, but also provides this temporary assistance targeted at the

institutions that are most at risk to allow them to transform in ways that makes sure that those communities are well served.

ASSEMBLYMAN GOTTFRIED: Well, my concern is that if you ask a question about hospitals, you get an answer filled with references to hundreds of millions if not billions of dollars. And if you ask a question about community-based organizations and primary and preventive care, you get an answer about goals and standards we're going to hold them to. I'm looking for the hundreds of millions of dollars that will help build those community-based providers and enable them to function on their own two feet and do the jobs we're asking them to do.

MEDICAID DIR. HELGERSON: In terms of DSRIP, what I could do for you, Assemblyman, is add up, based on the current budgets that have been submitted by each of the PPSs. We break those budgets down by provider type, and so we could get you a breakdown of the amount of money that's going into the community-based providers. It's quite

substantial.

And so I'm happy to provide that information to you and the other members of the committee.

ASSEMBLYMAN GOTTFRIED: And just to be clear, what I'm looking for is not just the number on what share of payment for healthcare services goes to primary care providers, which is what a PPS might give you.

What I'm interested in is the state's grants to help them build their infrastructure and pay for electronic health record systems and all of those things that we give hundreds of millions of dollars to hospitals to do. I want to know what kind of comparable grant-making programs -- and how much -- for primary care providers and other community-based providers.

My second question is several years ago we shifted the administration of the drug benefit under Medicaid from a preferred drug program that negotiated on prices with drug companies on behalf of all Medicaid

recipients, and we shifted the handling of the drug benefit to each of the managed care plans so that they are responsible for their own negotiating of drug prices with drug companies.

It seems to me, kind of elementary, that if you're negotiating on behalf of 6.3 million lives, you're going to have more bargaining clout with huge drug companies than if you're negotiating on behalf of 100,000 or 200,000 covered lives.

And so my question is, does the state have statistical evidence documenting that the movement away from the preferred drug program to dispersal of the drug benefit to managed care plans, has that produced lower drug prices than would have been expected under the preferred drug program?

MEDICAID DIR. HELGERSON: Yes, Assemblyman, the answer is yes, it has. It's to the tune of somewhere between $400 million and $500 million a year in terms of lower cost.

And in terms of why that's possible,

how that's possible given the fact -- the situation you describe, I think it's important to note that these individual health plans, these insurance companies, don't actually as a rule go out and negotiate themselves. Rather, they contract with pharmacy benefit managers. Those pharmacy benefit managers tend to have much, much stronger bargaining power because they cover many more lives than are on the New York Medicaid program. You have pharmacy benefit managers who are responsible for as many as 100 million Americans in terms of drug benefit. And so with that comes significant leverage, and the plans are able to leverage that bargaining power in their discussions and contracts with the PBMs.

And what we have seen, very clearly, is that both -- I think, first and foremost, our goal with this was to increase the use of generics, and we've seen a significant increase. When this was a fee-for-service benefit with the state paying directly, we had a generic dispensing rate somewhere

around 67, I think, 68 percent. We're now at 80 percent generic dispensing, which is I think a significant accomplishment, generics being, generally speaking, cheaper than brands.

And then also what we've seen is not only have the plans been able to maintain the net prices, in fact they've actually been able to beat the fee-for-service program, previous program, pretty clearly. And in fact there's a budget initiative where we now have access to information, prices paid by the managed care organizations in the area, such as specialty drugs, and we're able to use that information to actually come up with a budget proposal to lower our reimbursement for those specialty drugs in the fee-for-service program because we have access to some of that pricing information that comes from the plans.

ASSEMBLYMAN GOTTFRIED: If you were looking at the bargaining clout of a preferred drug program today which covers, what, 100,000 or 200,000 fee-for-service

Medicaid recipients, compared to managed care, that's not a very good comparison.

Has the state compared not just on what it arguably ought to be, but what it actually was for price containment under the preferred drug program when it covered several million Medicaid recipients just before the handover to the managed care companies, and what the managed care companies were doing when they first took it over? Obviously they wouldn't be overlapping time periods, but they would be pretty close time periods. Has the state analyzed that, and could you provide us with that analysis?

MEDICAID DIR. HELGERSON: Sure. We update that analysis every year, and as I say, I think that the delta -- and I'm trying to remember what that -- but somewhere between $400 million and $500 million is the savings associated with carving the drug benefit in.

So that savings has basically remained pretty constant from when we fully implemented it. And so we always are

constantly looking at that; we want to make sure that the managed care organizations are as efficient and are achieving the kind of savings that we expected from the drug carve-in.

I think overall, if you look back to MRT Phase 1, back to the '11-'12 budget, and you look at the list of 78 initiatives we went forward with, I would argue that the drug carve-in was probably the most significant and most successful of our initiatives. It was a very complex implementation affecting millions of Medicaid recipients who switched from having a fee-for-service benefit to a managed care benefit on October 1st of 2011. And as I say, we look at it each year and the savings continues to hold.

That said, pharmacy pricing overall is a significant challenge. And I think it's probably the most significant challenge facing the healthcare system in the country right now. It's become, once again, one of the fastest-growing -- in fact, is one of the

most, you know, fastest-growing in New York Medicaid, so we have to constantly be vigilant and be looking for new strategies to help ensure that we're getting prescription drugs for individuals that are the drugs they need at the lowest price possible.

ASSEMBLYMAN GOTTFRIED: Yeah. I'd be very interested in seeing that documentation.

I've submitted several other questions to the Commissioner. We discussed this earlier. I assume we will be getting answers after the hearing. Thank you.

CHAIRMAN FARRELL: Thank you, Assemblyman.

We've been joined by Assemblywoman Simon.

Senator?

CHAIRWOMAN YOUNG: Thank you, Assemblyman.

We've been joined by Senator John DeFrancisco.

And I'd like to welcome the commissioner to the hearing today. Thank you very much for your testimony and answering

all the questions. I have a whole series of questions regarding the global cap, the minimum wage, Medicaid waiver, the Healthcare Facility Transformation Program, the Essential Plan, Health Republic, Early Intervention Program reform, breast and prostate cancer awareness campaign, the 21st-Century Workgroup, and so on.

But I'd like to defer right now to my health policy expert in New York State, first to let him ask the questions. And what he doesn't ask, we'll be able to get to, I think, eventually. So I'd like to introduce Senator Kemp Hannon, chair of the Senate Health Committee.

SENATOR HANNON: Good morning, Doctor. Good morning, Mr. Helgerson.

You've had a lot of successes this year, and of course I think it's only appropriate to mention them -- things like Ebola; turning around the entire SHIN-NY, the State Health Information network, through the good work of the department; advancing on AIDS; and to my mind, a very small but

significant thing, the first annual report out of the Health Department in decades. Very important in terms of measuring sticks. We expect an improved one next time.

As I've gone through the budget, which is noticeably short, the thing that struck me was not so much what's in there and we argue about, but what struck me was what's not in there, what we haven't done. You look at some of the programs where we've tried to deal with distressed hospitals -- upstate, downstate -- millions of dollars have gone out. But as I look at those programs, I don't see a coherent whole as to where we're going, why we're going, what we ask those recipients of the monies to do, what the changes are.

Yes, on one hand we'll ask them to do something through DSRIP. But DSRIP is only for Medicaid. And Medicaid is only maybe a third to a half of a given hospital's revenue stream. Yes, there's some other things happening by CMS for changing their billing, but that's not the whole.

So I don't know where we go unless we tie it all together with DSRIP. We have SHIP, the State Health Improvement Plan. We have the Prevention Agenda, kind of a subsidiary, but existing on its own with a separate grant from the federal government. We have value-based purchasing, one of the most esoteric, head-scratching concepts we've ever had, which has occupied many people in the healthcare community in this state. At least it's open and it's transparent, but the next thing is finding someone to explain it.

We have VBP QIP, we have QIVAPP -- these are all numbers. And there's huge amounts of money that have gone out. But where are we going? And I think in terms of money, the biggest thing that's not here is what we've already done, what we've appropriated.

Over the past three years, we've appropriated over $3 billion in construction money. Now, you had an interesting take on that for Utica; you took it back. But there's still lots there. We don't know

where it's going for Brooklyn, we don't know where it's going throughout the rest of the state. What are the themes? And if those awards are ever made, what are the conditions of those awards, what they must do? And sometimes some of those awards are viewed by the DSRIP preferred provider system as building blocks to achieving the goals of DSRIP. It's just not all there. There's nothing tying it together.

We have hospitals, we have -- we now categorize hospitals not by the percentage of money they made or losses they made, but how many days cash on hand? We have a list of about 60 hospitals in that total category, out of 300 hospitals in this state.

We're not doing well. And yes, everybody says we have to change, but we're looking for a vision as to how that change ought to be. And then when you add on a couple of other torpedoes to the bow that have not been accounted for -- where are we going with the minimum wage? This is a whole system of care that directly and indirectly

will be affected by the minimum wage. We all want people to be paid well, but where are we going to get the payment for that? And through what formulas? How do you help? You can't just adjust Medicaid. We need federal rules. Medicare is beyond us. So are the private insurers, they're beyond us. So we have a problem there.

We just had a roundtable in regard to Health Republic, and the estimates of what the healthcare system has lost is getting close to $200 million. And some of those are for hospitals that are on the watch lists. So this only aggravates it.

We finished off, by the way, that roundtable -- I was hoping DFS would be here. They've been in the past -- we finished off that with a comment from an insurance executive saying because of Health Republic's loss, the rest of the healthcare companies are going to take a loss themselves. And frankly I haven't seen any accounting for that, whether that's going to add up to some other company being in trouble or not.

But it's the things that are not here, that we haven't addressed, that are the real problems.

So I thank you very much. I'm not going to ask any more questions -- I'll be back. The ranking member says I get another 10 minutes after everybody else is gone, so I'll wait.

COMMISSIONER ZUCKER: Thank you, Senator. I think you crystallized all the challenges that we are facing in the department in those six minutes.

I recognize -- let me just comment on two parts of that. The big picture here is also what we're doing with SHIP. That's an overarching look at how to tackle these problems. And there are problems with workforce and health information technology. And I think that we are using that as the umbrella by which we can tackle many of the components there.

I recognize that there are challenges with the hospitals, both in the rural and urban areas. We are working on that, not

just with DSRIP but with other funding that we have put forth. We -- and you bring up some particular areas in general, and I recognize that and elaborate on that later. And I think that there are many other components of how we can improve the health system, but none of these are in isolation. And that's why this is taking a period of time to move forward to where we want it to be. But we are making progress on this. We are making progress.

CHAIRMAN FARRELL: Thank you.

Assemblyman Cusick.

ASSEMBLYMAN CUSICK: Thank you, Mr. Chairman.

Commissioner, thank you for being here today and testifying. Good to see you.

I just have a few questions. I know my colleagues will be asking many questions of the Medicaid issue. I'd like to just ask you, which regions of the state have seen the largest amount of Medicaid growth, would you say?

MEDICAID DIR. HELGERSON: Certainly.

I would say it's interesting, if you look at the growth in Medicaid enrollments say over the last two to three years, there's actually been more growth in the upstate region than in New York City. We can certainly get you the numbers to show that. But overall, that's been the trend, especially if you do the comparison in terms of what the historic shares have been, sort of upstate versus city.

But I do think that the growth and the change in the eligibility rules and the launch of New York State of Health, with the health insurance exchange and the promotion, we've been able to increase enrollment to individuals who maybe thought they weren't eligible before and just simply went without health insurance. We've been able to identify those individuals and get them enrolled.

So I think that one of the successes of the implementation of the Affordable Care Act in New York has been that we've really made some significant strides in reducing the

uninsured rate upstate.

ASSEMBLYMAN CUSICK: Thank you.

Also with the Medicaid and the long-term care, I know with a lot of communities throughout the state, the issue of spousal refusal is a big issue for many of us. Could you just address that issue, how it's addressed in the budget?

MEDICAID DIR. HELGERSON: Sure. In terms of spousal refusal -- or we call it now spousal support -- I think this is the 26th year that a Governor of the State of New York has proposed to eliminate spousal support.

It's a proposal that actually has been highlighted by the House Oversight Committee as being an area where New York State is out of compliance with federal law, in the sense that it's a means for which individuals who do have income, do have assets, can in essence allow a spouse to enroll in the Medicaid program.

You know, we understand full well the challenges associated with the high costs of

long-term-care services. And certainly no one wants to see someone have to, you know, divest themselves of assets in order to access basic services. But at the same time, you know, Medicaid is, as was mentioned, a huge part of our budget here in New York, and long-term care is roughly about 50 percent of the total cost.

So what our goal has been throughout the MRT period has really been to try to identify ways that we can tighten up eligibility so as to ensure that the individuals who access the program are the ones who need it the most.

ASSEMBLYMAN CUSICK: And do you know offhand how many individuals would be affected by the proposal that's put forward in this budget on spousal support?

MEDICAID DIR. HELGERSON: Off the top of my head, I don't know how many. But we can get you the detail on the fiscal notes, we can get that for you, which has all that information.

ASSEMBLYMAN CUSICK: That would be

appreciated.

I just want to shift gears for a second to one of the issues that hits many of us in our districts throughout the state is the heroin and prescription drug epidemic. I know that OASAS and other areas of the budget deal with funding in fighting these issues.

But, Commissioner, could you give us a little rundown on the Department of Health's point in this?

COMMISSIONER ZUCKER: Sure. Happy to do so.

There's a couple of issues. There's the issue of opioids, and we have been tackling this from different fronts. One of them is an education program. We need to be out there educating physicians, hospitals and others.

There's also the challenge of making sure that those who have taken opioids and are at risk -- we have pushed forward with Naloxone, which is an antidote to opioids. We have trained 85,000 first responders on this across the state. We are also putting

forth the proposal to have pharmacists be able to actually administer Naloxone if necessary. We are also working towards, as I mentioned, other education programs there. That is one component. This is a concern not only in the State of New York, but across the country.

In addition to that, there's also a whole issue of synthetic cannabinoids, which are not directly opioids, but this is a concern as well. This has been a problem that we have noticed in the state both downstate but also upstate, in the Syracuse area. The Governor has focused on this, and it was part of our Capital for a Day to look at this. We sat together with OASAS, the Office of Mental Health, as well as the State Police, in an effort to raise awareness to this, have a campaign to address it.

And we have also been working with the health practitioners to target the issue of synthetic cannabinoids. This is a concern because many users believe this is just a form of marijuana, but the fact is that

synthetic cannabinoids are a product made that works on the receptors of the body where the psychotropic part of marijuana actually works, the THC component. And it can cause many serious side effects, including death. So we are looking at that as well, and there's a commitment to that.

So on both fronts, both the opioid front but also the synthetic cannabinoid front, we're tackling that.

ASSEMBLYMAN CUSICK: Well, we appreciate the work at DOH and all the agencies in New York State. I know Staten Island has been hit very hard by the epidemic. But I know, with my colleagues, it's not just my district, but it's all over New York State. So I know it's something that we all have to work together on.

Could you just -- I see I have a couple more minutes left. Could you just give me, on I-STOP, are there any updates on the results of I-STOP to this date and where we're moving forward on implementing certain changes in I-STOP or certain areas that we

needed to just tweak a little bit?

COMMISSIONER ZUCKER: Well, we've had much success with this, and this is part of the way to tackle the issue that we're dealing with. I can get back to you on the exact numbers of where we are on that. But I am optimistic that this will help tackle the opioid problem as well.

ASSEMBLYMAN CUSICK: Okay, great.

Thank you, Mr. Chairman. Thank you, Commissioner.

CHAIRMAN FARRELL: Thank you very much.

We've been joined by Assemblyman Felix Ortiz and Assemblyman Jeff Aubry.

Senator?

CHAIRWOMAN YOUNG: Thank you, Assemblyman.

We've been joined by Senator Phil Boyle.

So I'd like to take my turn right now, to begin. First of all, I totally agree with Senator Hannon that you and the department have had many significant accomplishments

this year, and I really compliment you on that.

I also want to personally thank you because, as you know, we've had very serious issues especially related to hospitals in my Senate district, and you and the department have been phenomenal as far as being responsive and very effective. So kudos to you, and sincere thanks.

I did have some questions, and the first one was regarding the global cap. And the state is estimated to spend about $17.95 billion on Medicaid in this fiscal year. And during the budget briefings we were provided with a Medicaid Redesign Team, MRT, budget proposals chart that detailed $270 million in new Medicaid investments that are offset by $270 million in new Medicaid savings initiatives.

So aside from the chart, however, is there any other accessible public document that provides a detailed accounting of the projected $17.95 billion in Medicaid expenditures, including what is assumed to be

in the base year from prior-year MRT initiatives?

MEDICAID DIR. HELGERSON: Certainly. There's quite a bit of additional documentation. Happy to work with your office to get you all the information that you need.

We try to manage the global cap in a transparent fashion. There's a lot of moving parts, a very large and complex program. But happy to get you additional information as desired.

CHAIRWOMAN YOUNG: Look forward to getting that. Thank you, Mr. Helgerson.

During this fiscal year, the estimates show that there are emerging pressures on the global cap due to higher than expected enrollment. Is the global cap on track to remain balanced through the conclusion of this fiscal year after accounting for higher estimated deficits? And if not, is the department prepared to develop a Medicaid savings allocation plan as outlined in the statutes?

MEDICAID DIR. HELGERSON: We believe we will finish the year within the confines of the global cap, and we are not in the process of developing a Medicaid savings allocation.

CHAIRWOMAN YOUNG: So even though there's increased enrollment, you believe that you'll be able to stay within the boundaries --

MEDICAID DIR. HELGERSON: Correct. Yes, we have been successful, over the last four-plus years, of managing within the confines of the global cap, and so while this year is certainly challenging, we believe that as we proceed towards closeout for the fiscal year, that we have a path to close the year in balance.

CHAIRWOMAN YOUNG: Okay, thank you for that.

The fiscal year 2016 global cap midyear update estimates a deficit of $377 million, and this deficit is closed by decreasing funding for numerous programs, including the Vital Access Provider, the VAP

funding for financially distressed hospitals. And as you know, that's of particular interest to me.

What is the rationale and process that goes into the decision to reduce Medicaid funding for these specific programs, and what factors are considered?

MEDICAID DIR. HELGERSON: Sure. So in terms of the VAP adjustment for closing this fiscal year, I think the idea was that, as Commissioner Zucker mentioned, the state is investing significantly into facilities of varying types. And so as an effort to basically close or help to ensure that we can close, we have made a slight reduction in the available funds for the VAP program.

That said, if it turns out that we don't need to make that reduction, we have the ability to then, in essence, restore those funds and maintain the program at that current appropriation.

We've had a very successful year in terms of matching some of our state investments with federal funds, and you see

that the Governor's proposed budget for next year in essence ensures that not only do we maintain but we significantly expand upon resources available for financially challenged providers, with the funds growing to $450 million just for hospitals for next year.

So while it certainly is a challenge and we look at every dollar within the cap to see if there are ways that we can economize, even if on a temporary basis, we feel at the end of the day we have sufficient resources to meet the needs of providers while at the same time allowing us to close the year with a balanced global cap.

COMMISSIONER ZUCKER: And some of those -- and there are 28 hospitals that were in the VAPAP, which 11 of those have transitioned to the Value-Based Payment Quality Improvement Program. So we are moving forward with that. As you're aware, the VAPAP was in state funds and the Value-Based Payment QIP is included in federal funds.

CHAIRWOMAN YOUNG: Okay, thank you for that.

I wanted to switch gears to the minimum wage. And as we know, in the Executive Budget there's a proposal to increase the statewide minimum wage to $15 per hour, although no funding is identified within the Health/Medicaid budget to help entities such as nursing homes, hospitals, home care agencies and other providers that have a finite amount of existing resources to cover increased labor costs.

I've had providers come to me, nursing homes, for example, who have said that if this $15 an hour goes forward, there is no question that we will have to shut our nursing home.

So the question is, how will this be addressed in the context of the budget? And also, how many nursing homes and hospitals are currently designated as financially distressed? Because we do know that there are a significant number of hospitals and nursing homes right now in New York State

that already are under dire financial pressures. And so how are we going to deal with this issue?

COMMISSIONER ZUCKER: So there's two parts to that.

The issue of minimum wage, the Governor has proposed a multiyear phase-in for the increase in minimum wage. And we will work, as we negotiate the budget, to discuss how we move forward with that. And we recognize the impact on the workforce in general.

But I will say that we've had a track record of working on phased-in projects in the past, and including wage parity, which Jason could speak to on that as well. Regarding the nursing homes, we are looking at all the nursing homes and we recognize there have been challenges there. I think the issue in nursing homes in general is the bigger issue of how do we move forward on long-term care, aging, home care. And so it's a more complex question, not just the survival of individual nursing homes, but the

bigger picture of where we're going to move forward on that.

Jason, do you want to talk about wage parity?

MEDICAID DIR. HELGERSON: Sure. So back in Phase 1 of MRT back in the '11-'12 budget, an item that was included in that was basically to extend wage parity laws in the New York City, Long Island and Westchester Counties, where those laws existed, to a subset of home care workers that had been basically exempt from those laws. And so it was a phase-in much like the $15 wage, in that case over a three-year period. And we basically had to manage that implementation.

And so what we were able to do within the confines of the global cap was to, in essence, raise their wages and benefits, which meant we had to pay the providers more to cover those costs. But we were able to manage it over that multiyear period. And so our hope would be to adopt a similar approach here in terms of trying to manage that.

I would say also in terms of the

$15 wage, I think that in the areas that you mention, I think we collectively believe that at the end of the day we want a healthcare workforce, a healthcare system that is built on a workforce that is adequately reimbursed, that has wages that not only help them cover the cost of their own living but also help to ensure that we have a stable workforce. And I know we've got plenty of experience with regards to the fact that higher wages and benefits can actually translate into a workforce that will stay with you for the long run, that will lead to better patient outcomes. And I think those are the kind of benefits that we would hope to see from the wage as a result of its implementation within the healthcare system.

CHAIRWOMAN YOUNG: So because there aren't any funds, I believe, currently identified in this budget proposal that do what you say needs to be done, is there a way that we could get some kind of plan from the department as to how you would address the $15 minimum wage? I think that would be

helpful.

And also, does the department keep a list of distressed hospitals and nursing homes? And could we have that?

COMMISSIONER ZUCKER: We can get you that information.

CHAIRWOMAN YOUNG: That would be great, thank you.

I did want to ask about the Medicaid waiver. So the state and the Centers for Medicare and Medicaid, the CMS, reached an agreement on the federal waiver that authorizes the state to reinvest $8 billion in federal Medicaid savings into the state's healthcare delivery system over five years, and Year 2 begins on April 1st, as you know so well. The $8 billion is broken out as follows, with $6.42 billion for DSRIP, $1.08 billion for other Medicaid redesign purposes, and $500 million in IAAF funds, which is the Interim Access Assurance Funds.

Are we on target for April 1st for the Year 2 start?

COMMISSIONER ZUCKER: Yes, we are. We

are on target for this.

You want to go through the details?

MEDICAID DIR. HELGERSON: Sure. Just that so far we feel like this has been exceptionally successful. It's still early days. Just last week we had the Oversight Review Panel, which is a requirement that was established under the terms and conditions of the waiver, met for two days. And we've broken the performing provider systems within DSRIP into two cohorts. This was the second cohort; the New York City-Long Island PPSs all were in attendance. They each had an opportunity to present, so it was a good opportunity to sort of check in on where the initiative is.

And there's some amazing things that are going on. We had heard earlier -- sort of in the fall we had heard from the upstate PPSs. There's a tremendous amount of great work going on there, really significant changes to the delivery system, better care for patients going on. And we are absolutely on path to continue implementing this

initiative within the confines of the terms and conditions.

CHAIRWOMAN YOUNG: How will the second year of DSRIP be different than the first year?

MEDICAID DIR. HELGERSON: I think the way to think about this is over the five years of the initiative, the first one, two and then into also the beginning of Year 3 are really what we call the infrastructure building phase. This is where the performing provider systems -- and what a performing provider system is, it's basically a network of providers that come together in a community and they collectively agree to basically work together to improve the quality of care for the population of Medicaid and uninsured that they serve.

And so really what the first couple of years are about is launching anywhere from eight to 11 projects that they committed to in their application. It's, as I say, investing in the infrastructure, doing things such as, as I mentioned earlier, the idea

that every primary care provider would be a Level 3 patient-centered medical home. It takes investments and effort to reach that high national standard. And so those are the kinds of things that are happening.

They're also investing in things like HIT and advanced analytics so that they can actually mine their own data in more effective ways, get information into the hands of clinicians to allow them to better serve the population. And so there's a lot, a lot of work going on. This is no small task. These are organizations that never existed before. These are coalitions, in some cases, of competitors who have had to sort of set aside their somewhat natural competitive instincts to really work together for the vulnerable in the communities.

And so that's really what Years 1, 2 and 3 are. But as we get closer to that third year, it's going to be less about investing in the infrastructure and more about the outcomes. Because the way that the waiver works is that in the outyears,

Years 3, 4 and 5, more and more of the money is tied directly to improved outcomes: Did Medicaid patients actually see improvements in their health and well-being? Did we prevent individuals from going into the hospital when they didn't need to be there? That's really what happens in those outyears.

And so there's a lot of time pressure on the PPSs to get that infrastructure up and running as quickly as possible so that they are fully prepared for when money -- which is all linked to performance -- is really riding on their success of actually improving the health of their communities.

CHAIRWOMAN YOUNG: So you believe that we're on target to reduce readmissions by 25 percent by the end of Year 5? You think that's on track?

MEDICAID DIR. HELGERSON: Absolutely.

CHAIRWOMAN YOUNG: Thank you.

And also, have there been improvements -- because again, financially distressed hospitals -- have you seen improvements in Years 0 and 1 as a result of

the DSRIP actions?

MEDICAID DIR. HELGERSON: Absolutely. In fact, those IAAF funds that you mentioned as an initial source were essential to helping some of these providers get to the point where we are.

Obviously, in addition to DSRIP, there are some facilities that need additional assistance. That's where that $450 million comes in. That needs to be very targeted. But overall, we think we've made some strides. Still a lot of work to be done. There's no question that some of these institutions are going to take several years to transform. But we're very excited, there's some really exciting initiatives designed to help these institutions basically transform into things that are going to be much more sustainable, and we're very excited to get ongoing here into the second year to really start seeing some of those investments starting to be made.

CHAIRWOMAN YOUNG: Thank you.

And one final question. What

percentage amount of DSRIP funds are expected to flow beyond hospitals to downstream providers, such as nursing homes, pharmacies, clinics, or other community-based organizations? Because they need help too.

MEDICAID DIR. HELGERSON: Sure.

So that was Assemblyman Gottfried's question as well. And I don't have that number off the top of my head, but I'm happy to provide the committee with a detailed breakdown.

The thing about DSRIP, it's a very transparent initiative. So each and every quarter, each performing provider system has to provide a very detailed report to the state. And in that report is a lot of information. Those reports are all made public and posted to the website.

But what we'll be happy to do is to basically, out of those reports, sum up out of the reported budgets as well as actual expenditures, the breakdown by provider type so you can get a real specific answer to your question.

CHAIRWOMAN YOUNG: Thank you.

CHAIRMAN FARRELL: Thank you.

Assemblyman Oaks.

ASSEMBLYMAN OAKS: Yes, we've also been joined now by Assemblyman Walter.

CHAIRMAN FARRELL: Next, Assemblyman Raia.

ASSEMBLYMAN RAIA: Thank you.

Thank you for attending and taking the questions. I know it's not easy, but ...

I have two general policy areas. First off, the Executive Budget seeks to give the Department of Health authority to establish pharmacy reimbursement rates for specialty drugs using the department's data; correct? How many specialty drugs would this be applied to?

COMMISSIONER ZUCKER: Do we have numbers?

MEDICAID DIR. HELGERSON: So the proposal is that we do have information -- from a pharmacy benefit manager that many plans contract with -- that suggests that in the case of fee-for-service, as well as

generally in managed care, that we are paying prices in excess of what is already being achieved in the same marketplace. And so we're using that information to propose adjustments on a drug-by-drug basis.

Off the top of my head, I don't remember how many specific specialty drugs are to be impacted, but we can get you that analysis. Happy to do so.

ASSEMBLYMAN RAIA: That would be helpful, thank you.

So where are you obtaining the data from that you just mentioned, a specialty --

MEDICAID DIR. HELGERSON: We obtained it from a price list and pricing information that was obtained through one of the pharmacy benefit managers that's one that contracts with quite a few of our Medicaid managed care plans.

ASSEMBLYMAN RAIA: Is that information available to the Legislature or the pharmacies or the folks that might be affected?

MEDICAID DIR. HELGERSON: So there's

certain information -- some -- the challenge with drug pricing is some information is proprietary. But I believe the information that we have is available, and I'm happy to get you whatever can be made public, yes.

ASSEMBLYMAN RAIA: Thank you.

Is it possible that the new rates that we're going to be talking about could wind up paying pharmacies less than their actual costs?

MEDICAID DIR. HELGERSON: That's a good question. Certainly our goal here is not to have pharmacies lose money as a result of participating in the Medicaid program. If they do, chances are they'll exit the program.

We've enjoyed throughout Medicaid's history in New York very wide participation amongst pharmacies, and continue to do so today.

I can say that we have a mechanism in place that if a pharmacy can document to the state that the rate of reimbursement or the rate that they're -- basically, what they're

paying to acquire the drug ingredient is higher than what we're reimbursing them, there's a mechanism for them to provide that information, a 1-800 number they can call. And then once we can document that's true, we have the ability then to increase the price, not only for that pharmacy but, if we believe that that's a systematic issue, we can increase it generally so that it won't impact other pharmacies as well.

COMMISSIONER ZUCKER: Let me add one thing about the pharmacies in general. We feel as we move forward in transforming the system that the role of the pharmacist and the role of the pharmacy is critical to the success of what we're trying to do. We feel that they should be more integrally involved in some of the things that we've asked; we've seen this with flu shots. But that's just the beginning of where we're at. And I think that in some parts of the state where many people don't have the chance to get to their doctor, their doctor's much further away, the person in the healthcare system that they are

most familiar with usually is the pharmacist.

So I think that as we move forward with our plans, we are looking and reaching out to the pharmacy community and to the schools of pharmacy to address that as well.

ASSEMBLYMAN RAIA: Thank you.

My next question deals with the current level of the tobacco control funding. What is budgeted for that this year?

COMMISSIONER ZUCKER: So we continue to move forward with pushing to be as successful as we are in decreasing young people from starting to use tobacco as well as getting those who are using tobacco to stop. This is part of our Prevention Agenda, and I can get you the exact numbers of the amount of money that will be put into that program.

ASSEMBLYMAN RAIA: Is it increased over last year, or what's allocated in the budget this year, if you know?

COMMISSIONER ZUCKER: I have to check and see what we have, the exact amount.

ASSEMBLYMAN RAIA: Okay. If you could

get back to me on those numbers.

COMMISSIONER ZUCKER: We will.

ASSEMBLYMAN RAIA: Because I guess the concern is particularly in certain areas of the state, lower socioeconomic areas -- we may be making a dent in other places but certainly in our inner cities the numbers are certainly increasing.

COMMISSIONER ZUCKER: Right. And this is -- as we've been pushing, this is one of the most important things we can do in the Prevention Agenda. And clearly we know the risks of tobacco, so we would not want to have anything fall back on that initiative.

ASSEMBLYMAN RAIA: Okay, thank you.

I yield back my time.

CHAIRMAN FARRELL: Thank you.

Senator?

SENATOR KRUEGER: Thank you.

Senator Gustavo Rivera.

SENATOR RIVERA: Thank you, Senator.

And thank you both, folks, for coming.

I have a couple of questions, and I will reserve the time to go in afterwards.

There's a couple of things that -- first of all, before anything else, most of what Senator Hannon says I want to kind of echo. A lot of the concerns about what is not in the document certainly need to be discussed.

In particular, as far as the money that has been previously allocated for capital funds across the state, I do not live in Brooklyn but certainly share many of the concerns that many of my colleagues do. Certainly Senator Persaud and Senator Savino both share concerns about their constituencies in Brooklyn.

And also the concern that we all share about the impact that Health Republic has in other insurance across the state, and particularly the coverage that has already been issued, has already been done, right, how people have been cared for, and then the cost that many institutions and particular individual doctors have had to swallow, certainly we have to figure out where that's coming from.

But there's two things that you didn't

talk much about, Commissioner Zucker, that I wanted to get into. At least the initial proposed budget does include an amendment to the local contribution on Medicaid expenditures. It is something that was not mentioned in the -- it has obviously been talked a lot about, but it wasn't in your testimony this morning. I wanted to -- is that something that still is in -- it's still in the proposed budget, hasn't been changed yet? That is still going forward as it's structured in the initial budget that we got?

COMMISSIONER ZUCKER: So we -- do you want to address the New York City issue?

MEDICAID DIR. HELGERSON: Sure.

So yes, so there is a proposed change in the budget relative to New York City's contribution to the Medicaid program. And I think that the bottom line is that proposal obviously helps the state in terms of funding the state's share. The state has been picking up an increasing amount of the costs of the Medicaid program, and to a great extent to tremendous benefit particularly to

the counties, as well as the City of New York.

And I think that since the City of New York is obviously the home of over 50 percent of the total Medicaid expenditures in the state, the Governor's proposal suggests that they pick up a bit more of that expense.

But I think at the same time, what we're committed to doing is working with the city, that if there are things we could do, efficiencies that could be found that could avoid the need for that change, I think we're open to that. And open to discussions with all of you, as we move through the budget process, about that particular proposal.

SENATOR RIVERA: There's a lot of numbers that have been thrown around. What is your estimate as far as the cost to the City of New York?

MEDICAID DIR. HELGERSON: Correct. Our estimate is that for the first year I think it's about $195 million -- it could be a -- right off the top of my head, but that's

approximately it, is -- would be the cost.

But I think you also have to take into account that in a broader perspective, in terms of other enhanced federal funding and other things that are going into the city at the same time, that we think that if you look at it in totality, we believe certainly that it's affordable for the city.

SENATOR RIVERA: There's many of us that disagree with you on that --

(Laughter.)

SENATOR RIVERA: -- but that is what these conversations are for.

And just to make sure that I'm clear in my head, so explain to me again the reasoning for the proposals to change it just for the City of New York and not change it for anybody else.

MEDICAID DIR. HELGERSON: I think at the end of the day it's an analysis of ability to pay and where the costs of the program are. And I think that that, at the end of the day, is it. I mean, I think we've heard loud and clear the concerns in the city

about the change, and that's where I think that certainly you've heard from the Governor and from his office a desire to be open-dialog with them and with all of you in terms of that particular proposal as we work our way through the budget process.

And so I think we remain very interested in that discussion and talking about -- you know, we certainly do not want this to negatively affect the citizens of the City of New York.

SENATOR RIVERA: We certainly agree on that.

The second part has to do -- the second set of questions has to do with the minimum wage proposal that the Governor has put forward. Many of us are certainly thankful that the Governor has put that forward. Many of us have been fighting for a minimum wage increase for -- certainly for as many years as I've been here, and certainly many more years for folks that have been here a little bit longer.

But regarding the impact -- because

certainly Senator Young pointed to something that many of us are concerned about as far as the costs to particular organizations or institutions. I have a couple of questions about that.

Has there been an estimate on the offset from workers that, once they get the raise, they are going to transition out of Medicaid? I figure there's many workers who currently find themselves eligible for Medicaid because they have the salary that they do, but once the salary goes up, they might be off of Medicaid. Has there been a calculation about the offset of those workers coming off of Medicaid?

COMMISSIONER ZUCKER: Well, we could get back to you on exactly the details of that, of how many would move out. We have had great success with our marketplace and with people moving into our New York -- the exchange. And so we also have some numbers on that as well.

SENATOR RIVERA: Okay. And the -- I guess there are going to be continuing

conversations about what exactly the phase-in would be, the cost that it would have, and then what needs to be offset from the state.

That's all for now, but I might come back. Thank you.

CHAIRMAN FARRELL: Thank you.

ASSEMBLYMAN OAKS: Yes, we've been joined now by Assemblyman Ra.

CHAIRMAN FARRELL: Assemblywoman Malliotakis.

ASSEMBLYWOMAN MALLIOTAKIS: Thank you, Commissioner, for being here today.

I wanted to follow up on the spousal refusal questions that were asked earlier today. It's my understanding that, as the law exists, the healthy spouse can keep the family home, a car, and assets of about $113,000; is that correct? And it it's eliminated, what would the assets go down to?

MEDICAID DIR. HELGERSON: So I think there's two proposals. There's the -- eliminate that ability for a spouse to basically declare I am no longer supporting my spouse, and therefore my assets are

basically not looked at for the purposes of determining my spouse's Medicaid eligibility.

There's another proposal in the budget that does address the amount of assets that an individual can have, and what it does is it does basically adopt a floor, that's a federal floor, that in essence is designed to help ensure that, once again, like spousal support -- it's a similar proposal in the sense that it's designed to try to help ensure that the individuals who are accessing the Medicaid program are ones who really need it the most, and if there's a way for families to be able to help pay for some of those costs before they enroll in Medicaid, that we attempt to ensure that that is done to the maximum possible.

I will say about that proposal is that there are certain assets that are actually excluded from the calculation, so they would not be impacted by this change. So, for instance, the family home, up to a value of $850,000 of equity, would not be affected. Car, certain types of retirement funds are

exempt from those calculations.

So we think at the end of the day the policy is a fair one.

ASSEMBLYWOMAN MALLIOTAKIS: In previous proposals the floor would go down to like $20,000 in assets. Is that not what's being proposed this year?

MEDICAID DIR. HELGERSON: I'm trying to think -- in this particular one, I'm not sure whether we proposed it or not. I'd have to go back and look to see whether we proposed it in previous years.

But we have proposed in previous years variations on the same theme, which is in essence tightening up the eligibility rules in long-term care to try to make sure that the program is being accessed, as I said, by the people who need it the most.

What I would say is that with the baby boom generation getting closer and closer to the long-term care system, I think we just have to collectively, if you look into the future five, 10 years from now, and the people who will be sitting in this room at

that point, they will be grappling with or we will be grappling with the long-term care portion of the program growing at a rate that I fear will put tremendous strain on the New York State budget.

And that's why I think what we're trying to say now is that while any of these individual initiatives don't generate a lot of incremental savings immediately, the potential for cost avoidance down the line is quite substantial.

ASSEMBLYWOMAN MALLIOTAKIS: The total savings of this would only be about $10 million; right?

MEDICAID DIR. HELGERSON: Right. So there's multiple initiatives, and that's why I say that the individual ones in the given fiscal are not that large.

I mean, every incremental savings is helpful because it helps to cover some other cost in the program. But you are right that, generally speaking, the proposals don't generate a lot of in-year savings. But I do think, if you think about it over the next

10, maybe even 20 years, they could be quite substantial.

ASSEMBLYWOMAN MALLIOTAKIS: See, I -- as someone who represents many seniors, I just -- I think this is really the wrong approach in terms of trying to cut and achieve savings. You're talking about 8400 people that are senior citizens, that are very vulnerable. And truly, to tell them that they need to get rid of all their assets to care for their spouse, I don't think that's the approach that the State of New York should be taking. Especially, when you have about 6.5 million people, we're talking about 8400. It's a very small population. So I would urge the Governor and the administration to reconsider that.

It's even more concerning when we're talking about this $10 million when we see that there's a budgeted $38 million that would go -- that's set aside here in this budget -- and also in last year's budget, by the way, although I don't think it has been spent because of the federal lawsuit that's

currently being reviewed by the Supreme Court.

But with President Obama's executive order, the state is now given the burden to provide $38 million to provide Medicaid for the amnesty executive order; is that correct?

MEDICAID DIR. HELGERSON: So that was the estimate from last year in terms of what we expected the potential cost to be. I think it was an outyear estimate, or the second year estimate, off the top of my head.

But yes, that the executive order signed by the President basically would have expanded access to Medicaid to additional, in essence, normally, quote, non-qualifying immigrants for Medicaid.

ASSEMBLYWOMAN MALLIOTAKIS: Why are they non-qualifying?

MEDICAID DIR. HELGERSON: So under federal law, you can be here legally in the United States but be non-qualifying for Medicaid. Usually that's because you are in some sort of a status of you're holding, you're waiting for some number of years, I

think it's like five years, before you can sign up for programs.

And so when that executive order was signed, we had to anticipate what the global cap impact was. That said, it has not gone into effect, so at the moment there has not yet been a cost associated with it.

ASSEMBLYWOMAN MALLIOTAKIS: So 100 percent of that burden, though, is being pushed onto the states, right, because the federal government does not allow these individuals to qualify for Medicaid. Is that correct?

MEDICAID DIR. HELGERSON: Yes. The thinking is that -- we're unique in that way, in the sense that it's unique in the sense that under our State Constitution, if you are a legally resident individual, even if you're non-qualifying, we had a court decision called the Aliessa court decision which basically says that you are entitled to the same treatment as any other person who's here legally.

So that's a uniqueness, and that's

because of the New York State Constitution. Whereas in other states, you are basically governed by the federal law in terms of Medicaid eligibility.

ASSEMBLYWOMAN MALLIOTAKIS: Okay, thank you.

Moving on to heroin, I share the concerns that my colleague brought up earlier. And, you know, I've read a lot about the commissioner and your efforts to bring Narcan training throughout the state, and putting it in schools and putting it in prisons as well as pharmacies, making it more available for individuals.

I think it's certainly a tool in the toolbox, and something that -- but it should be a last resort, right? We should really be more proactive in trying to stop people from using it to begin with and becoming addicted, than, you know, waiting until they're almost dead to then come with a solution.

So I was just wondering, you know, the state a couple of years ago passed legislation regarding PSAs -- which I've seen

a couple, and I think they're very good -- but also requiring education in schools. What has been the Department of Health's role specifically in doing more proactive outreach and education?

COMMISSIONER ZUCKER: Well, we are working on this issue with programs with the community, working with the counties on this, and we are also -- we tie this into our Prevention Agenda as well, to tackle drug addiction in general and to try to decrease the amount of opioid use.

I hear your concerns. As a physician, I recognize this and I've seen too many patients come in who have overdosed on narcotics and the dangers there. And I concur that this is an issue of education.

As we move forward with the transformation that we're moving into with healthcare, again, we are moving into communities and away from hospitals, and this will be some of the ways we can tackle this problem as well.

I have reached out to all the

physicians in the state about this issue as well, and will continue to do so and bring it up. And I've brought it up at some of the associations which deal with this issue, particularly anesthesiologists.

ASSEMBLYWOMAN MALLIOTAKIS: I want to just shift to inspections of facilities here in the State of New York. In 2014, it was found that 8 of only 25 clinics that perform abortions in the state had not been inspected in 12 years. Subsequent to that, I filed a FOIL request with your agency to try to get the information on inspections of facilities that conduct any type of medical procedures. It took from -- March 25th is when I initially filed. They told me it was going to come back on June 9th. I didn't get it, and they postponed it again to September. Finally I had to almost threaten a lawsuit, and December 7th they did give me the information.

I wanted to talk a little bit about the staffing and why it took so long to get those numbers for me. It just seems like

it's information that should be readily available. I mean, shouldn't the state know, you know, when their facilities are being inspected and what the results were?

COMMISSIONER ZUCKER: We can get you the issues on the numbers. I will say that all of our family planning grants do follow the Title X, the federal law -- Title X from the federal law on that. But the numbers, specific numbers I can get you.

ASSEMBLYWOMAN MALLIOTAKIS: But does the state have already a database in place keeping track of when facilities are inspected and what the result of those inspections were? Because it's -- you know, six months to put together this type of information just seems like an awfully long time. It just seems like you should have that readily available. And I was wondering if you do or not.

COMMISSIONER ZUCKER: We'll find out what the -- we do track all the information. We'll see what we can get for you.

ASSEMBLYWOMAN MALLIOTAKIS: As part of

the results that I got back, I found that 11 facilities in our state haven't received inspections in over 10 years, including one that hasn't been inspected -- it's an eye surgery center in Brooklyn, which I represent, that hasn't been inspected since 1987.

And so I'm quite curious about the facilities in this state, and if we're paying the proper attention. So what is your criteria in terms of inspection? Because I know the law itself, which I'm looking to have changed, doesn't require a set, you know, every one year, every two years, like you have tanning salons and pizzerias. We don't inspect our health facilities within a time frame, and I find that to be troublesome.

What are your thoughts?

COMMISSIONER ZUCKER: We follow -- we follow -- as I mentioned, we follow the criteria set forth by federal rules. And we also clearly always want to make sure we provide the best care, and we do inspections

as necessary.

ASSEMBLYWOMAN MALLIOTAKIS: Just shifting to Medicaid -- because I know I ran out of time. I just want to make a point. It won't be a question. But basically my concern is that we're shifting Medicaid to the city, $651 million burden over the next three years. Can you tell us what the rationale is for that?

COMMISSIONER ZUCKER: Well, the $630 million -- one key thing is that this is still more than last year, and the city will have about, what, a $185 million savings, I believe.

MEDICAID DIR. HELGERSON: Yeah, so I think the rationale, as I said, was that we thought that the proposal was balanced in the sense that the state is picking up a considerable amount of additional cost and has each and every year, as a result of the program under the global cap. And the idea was that the city, which is where more than 50 percent of the total costs are incurred, that -- and that's obviously a significant

benefit to the city -- that there was some rationale for increased contribution there phased in over time to allow the city to be able to adjust.

But obviously we're more than prepared to work with the Legislature, work with the city to see if there are alternatives to that.

ASSEMBLYWOMAN MALLIOTAKIS: Okay, thank you.

CHAIRMAN FARRELL: Thank you.

Senator?

CHAIRWOMAN YOUNG: Thank you, Assemblyman.

We've been joined by Senator Sue Serino.

SENATOR KRUEGER: And also Senator Ruth Hassell-Thompson.

CHAIRWOMAN YOUNG: Our next Senate speaker on the list is Senator Diane Savino.

SENATOR SAVINO: Thank you, Senator Young.

Thank you, Commissioner.

I want to go back to the minimum wage.

I'd say it's fair to say that when the Governor announced in December that he was going to lead the campaign to raise the minimum wage to a livable wage where a family could live in dignity, some of us were thrilled and some of us here less so. But all of us expected that at some point in his budget documents we would see funding for the employees that the state is either directly or indirectly responsible for compensating.

So to say that we were somewhat concerned when the budget came out, in the Health budget and the Human Service budget, the agencies that are directly contracted by the state to provide either home care or developmentally disabled care, human service care -- there is no allocation for them to be able to pay that minimum wage.

Now, I know you mentioned in your earlier comments, Jason, that when we did the Home Care Worker Parity Act of 2011, when it was originally enacted, there was no funding there for it. And in fact three years later, the agencies came forward and they expressed

how difficult it was for them to meet that. And as a result of that, in the 2014 budget we included another $300 million.

So I'm concerned that we think that somehow we're going to have a different outcome this time. So how are these agencies supposed to pay it? And at the end of the day, assume we do adopt the $15 minimum wage in the budget -- and we don't provide the funding for home care agencies so that home care workers are actually compensated appropriately. What kind of a message would we be sending as a state that it makes more sense to deliver pizzas for a living than to take care of the elderly or the sick?

COMMISSIONER ZUCKER: So we will -- we will, during the budget negotiation process, we will work through this and it will clearly be part of the discussion.

And as I mentioned, it is a phased-in -- the Governor has this as a phased-in period. So -- and I recognize some of the concerns that you have about this, but we will work through this during the process.

SENATOR SAVINO: There's a huge concern, Commissioner. And so we will be watching, particularly as the 30-day amendments come out, to see that there is funding there to take care of that.

So I want to jump back to an issue that Assemblywoman Malliotakis raised, about spousal refusal. As you said, every year for 26 years, this issue is included in every budget. And every year for 26 years, the Legislature bats it right back out.

But what I'm concerned about is in the 26 years that we've been playing this tennis game with this issue, what efforts has the state taken to encourage the insurance industry to create an affordable long-term-care plan? Because many people would buy it. They cannot afford it.

And in fact, earlier this year many people who did wisely purchase long-term care when it was affordable to them received a notice that their premiums are rising more than 70 percent.

So what can we do to prevent that from

happening so that patients and families can purchase a long-term-care plan that they will then be able to use to take the burden off of Medicaid?

COMMISSIONER ZUCKER: Well, I think there's two parts. One of this is the issue of education about long-term care. And I think that as we move forward with our efforts to tackle the issues of long-term care -- and as Jason mentioned, you know, the population is aging and we need to address that -- I think it does involve getting the message out to all of those about the benefits of doing it. That's one part, that was one part.

I cannot answer about the 26 years, but be happy to get some more information --

MEDICAID DIR. HELGERSON: And if I could add something too, another initiative that has come out of the last couple of years is the launch of New York Connects on a statewide basis. These are aging and disability resource centers that are now open in every county in the State of New York.

And what those are is a location where individuals and families can go when they have either themselves or a loved one who now is starting to need some help at home.

And one of the benefits there is that they provide advice, counsel, connection to services that -- and you don't have to be on Medicaid to access those services, whether that's Meals on Wheels or any one of a number of things that communities have available. Because one of the things we do know is that providing some of those low-cost services to individuals earlier on, not waiting for them to get to a situation where, because of how their apartment is set up or because of some other issue, that it leads to a fall and leads to a need for them, you know, to get on Medicaid because you need, you know, extended home care services or you need other types of services, that we can get into more of a -- even a prevention mode.

I think that's one of the benefits that those centers are going to be able to offer, is really counseling, support, and

access to services that, as I say, are far more affordable for individuals and families that really hopefully can help, you know, ensure that people are living safely at home and not needing to go through the process of divesting themselves of assets in order to access the Medicaid program.

SENATOR SAVINO: Well, there's no doubt that those are worthy considerations. But I want to repeat, again, we should be using the power of the state to force the insurance industry to create an affordable product for people. That would be the real answer for many families, if they could afford -- by the time you think about long-term care, it's too late and you can't afford it. We need to rethink this.

I want to go back to a question based on your testimony about the safety net hospitals. So there's no doubt that five years ago when the MRT was originally put together, the HHC really did not have an equal seat at the table. And as a result of it, they have not really been treated -- in

their estimation, they have not been treated as fairly, and I'm sure we're going to hear from Dr. Raju later on today about they have some proposals on reorganization of the HHC.

But one of the problems that they face, as the safety net system for New York City, is they have the disproportionate share of uninsured patients, and they don't get the same Medicaid reimbursement rate that other hospitals do, the better-situated providers.

So is there anything in this budget that's going to change the way the HHC is reimbursed?

MEDICAID DIR. HELGERSON: So in terms of -- just in terms of HHC and their role in MRT, I would say that on the Medicaid Redesign Team was Linda Gibbs, who was the deputy mayor under Mayor Bloomberg for health. And so I believe they were represented and were active partners and the city supported the MRT recommendations back in 2011, which --

SENATOR SAVINO: That was then.

MEDICAID DIR. HELGERSON: -- is now

ancient history.

SENATOR SAVINO: That was then, this is now.

MEDICAID DIR. HELGERSON: So but what I would say is that in terms of the Health and Hospital Corp. of New York City, obviously we are -- and we work very hard to assist them with cash-flow issues on what seems like a daily basis. We know about some of the financial challenges that they face. In fact, we are working with them on ideas about how we might be able to convert some funds that are at risk, what are called UPL payments, to convert those perhaps to another use that maybe -- to give them sustainability well into the future, to maybe even allow for some growth in those dollars. It would require a further amendment to our waiver, but we're working on a proposal with them on that.

I think one of the challenges that we have is that, at least in our discussions with the federal government, they've been making it very difficult for us to get a

federal approval for those payments. And the reason is that they have questioned whether or not we're paying HHC too much. And whether or not there's sufficient cost information to suggest that it's appropriate.

Now, we disagree with that approach, but that's been a back-and-forth issue for the last several years with them. You know, but at the same we absolutely agree that they are essential. We need to help them in their standard. I'm very hopeful that some of their strategies around the exchange and the use of MetroPlus is going to grow and diversify the people who utilize the system. I think they provide excellent quality of care and, you know, are the biggest Medicaid provider we have in the state, so we are absolutely committed to doing everything we can to help ensure their sustainability.

SENATOR SAVINO: Great.

And finally, I want to go back to the opioid crisis. One of the questions I have is what we're seeing now, obviously, with the heroin abuse problem is people are showing up

in the emergency room in crisis. And they're stabilized, and then they are sent home with a recommendation to go to an outpatient treatment program -- largely because our treatment protocols, I believe, and I'm sure some of you believe, are somewhat outdated. The idea that you only need an inpatient detox for alcohol or benzodiazepines sends these people back out into the street.

And once you have a person in a place where they need help, that's the best time to get them engaged in treatment. So what can the state do to begin to have a discussion with the -- I guess the treatment providers, and even the insurance companies, to change the treatment protocols to deal with this crisis?

COMMISSIONER ZUCKER: Well, one part of this is the issue of getting those who come into those facilities into a primary care setting and tying their behavioral health issues, if there are related to that, for opioid, with primary care. That will help move them forward and not have them end

up coming back in a second time and a third time after that. I think that's the first part. This is part of what our whole agenda is with the Advanced Primary Care model.

Specifically your question is insurance and coverage, is that right?

SENATOR SAVINO: Yes, because of the way people are sent back out into the street.

So again, you come into the emergency room, you have overdosed on oxy, heroin, whatever the case may be. It doesn't require an inpatient detox, so they stabilize you and then they send you home and refer you to a primary care doctor if you don't have one, they refer you to an outpatient treatment program, and then they leave it up to an individual who is addicted and incapable of making rational decisions about their care. We all know that.

So the question is, why not change the protocol so that we would require a 28-day inpatient detox or rehab to stabilize them and begin to put them on the path for treatment, instead of doing this over and

over?

COMMISSIONER ZUCKER: I hear what you're saying. So the question is about why not bring them into the hospital or have them in there.

SENATOR SAVINO: Mm-hmm.

COMMISSIONER ZUCKER: I mean, there is obviously costs associated with that. And what we need to do is strengthen the outpatient component to this, I believe. And I think that if we bring them in and we get the right people there to help put them in the right system and to follow up and to use whatever kinds of programs we have in place, and telemedicines, or have social workers and others go out there to make sure they come back in, that would be helpful.

I mean, I recognize that you say, Well, once you have them in the hospital, wouldn't it be easier just to get all those services there at that point in time. But I think there's a way to do this as an outpatient as well, assuming that they are safe to leave.

SENATOR SAVINO: And this is my final comment. I understand the cost concern, but there's an equal cost to repeat admissions to the emergency room --

COMMISSIONER ZUCKER: I agree.

SENATOR SAVINO: -- ambulance, you know, calls.

COMMISSIONER ZUCKER: I agree.

SENATOR SAVINO: So I'm not sure we're really saving money. And, you know, having worked in my previous career with people who were addicted, it is very difficult to get people to come into treatment and stay there if you send them home and expect them to be able to handle, you know, their addiction. It just doesn't happen that way.

COMMISSIONER ZUCKER: I agree.

SENATOR SAVINO: So I just think it's something that we should begin to look at, and I hope that the Department of Health will help us develop that policy.

Thank you.

COMMISSIONER ZUCKER: We will.

CHAIRMAN FARRELL: Thank you.

Assemblyman McDonald.

ASSEMBLYMAN McDONALD: (Inaudible.) It's true we're pretty much discussing all the things we may not like or are concerned about, but there are a lot of great things that are going on. And obviously it's a very large, large department, large budget. You know, the New York Connects program you mentioned is -- I can tell you, as a practicing pharmacist, has been an excellent resource to help patients get the care, because you have a lot of things going on in the community setting out there.

And I'm going to touch on a couple of different areas of interest. I will probably get into drugs at some point, as you would guess. But there's a proposal about a pilot project for retail clinics which, let's face it, they've been out there and they've been kind of working on their own in some aspects. But what I was interested in is where -- how do you account for the $5 million in savings that's attributed to it? I kind of see that as really an opportunity to actually provide

more care, which I think is known to possibly increase costs, for providing good care. But how are we accounting for savings in that aspect?

COMMISSIONER ZUCKER: Sure. So the retail clinics, these limited-service clinics, we feel will be beneficial to those who will utilize them, for several reasons. One, we feel that this will tie individuals -- we'll make sure, when they come in there, it will be tied back to their primary care provider.

We recognize there have been some concerns about the retail clinics in caring for those who are under the age of 2, so we are not going to have that as a case. We want to be sure that those individuals are tied to their pediatrician.

We will make sure these retail clinics are in areas of the state where there is no other access or a limited access to care. So that adds a definite advantage to this.

And we will also ask that the retail clinics are tied into the SHIN-NY, the State

Health Information Network, so that the information can get back to their primary care doctors or to others, and it will help improve our SHIN-NY as we move forward on that program.

So I think that this is a way to provide accessible care, and I would like to see, you know, with the next steps where we will be with that.

ASSEMBLYMAN McDONALD: Good.

Moving on to opioids, I know we've all been talking about this. And I was glad to see an expansion of the maximum four opioid prescriptions per month. I think it's -- to the managed care, anyway -- not taking a lot of savings, which is fine. It really gets to the larger issue, which is overuse and repeated use.

Recently, and I think I reached out to the department about this about two weeks ago, some reports were out there in regards to opioid overdoses in the actual, you know, coming into the ER, they're being brought back to life, they're being released back,

and in 90 percent of the cases these individuals are being given opioids again by the prescriber, because the prescriber has no idea that they had an overdose.

And, you know, my original thought was: Ah, the PMP, let's expand the PMP. And the message back was that would require a total overhaul of the PMP. And I'm sensitive to that, I understand that. But I would suggest -- this is not really -- I don't want to make this a full debate -- that between the RHIOs and all the information we have there, and the fact that prescribers truly are abiding, in most instances, by the PMP, that we find a way for the Department of Health, using all the privacy options we have, to get that information back.

It seems illogical to me that an individual who almost died that we've spent a tremendous amount of resources on to bring them back to life, to have them go right back to the prescriber and not have the prescriber take that opportunity to say, Wait a minute, we've got to take a time out, we need to move

you into treatment. It doesn't make sense to me.

COMMISSIONER ZUCKER: I hear you. And I think that you're right, that there should be some red flag that goes to the prescriber regarding this. And we will look into this. And I recognize the potential privacy issues that are involved, and we have to tackle that. But we've tackled those kind of problems before, and we will look at what can and cannot be done through the I-STOP program as well.

ASSEMBLYMAN McDONALD: Moving on to the profit cap on the health plans, and it talks about reducing the profit cap from 5 percent to 3.5 percent. So I guess the question I would probably surmise is that the plans are very profitable under the Medicaid managed care plan? Or is it they're making too much money -- I don't hear that from the CEOs that I deal with, but I'm just kind of curious. I'm not a shill for the plans, I'm just trying to understand it.

MEDICAID DIR. HELGERSON: Sure. So

that, which is an initiative that helps generate some savings within the confines of the global cap, comes out of actually an OSC recommendation from a previous OSC audit which suggested that there were certain plans that -- for-profit plans that had generated fairly substantial profits and that there would be some benefit to the taxpayer if we restricted the profit capacity from 5 percent to 3.5 percent.

So we take those OSC audits very seriously, and you'll see there's a couple of other initiatives that are directly out of the OSC audit recommendations that we're proposing to implement.

So it doesn't -- obviously doesn't -- if you don't make a profit, it does not impact you. Right? So as a result -- but there were a couple of plans, a couple of fairly large plans that generated, in the last year, a decent-sized profit. And therefore, this basically would have restricted those profits. But, yeah, that's the core of the proposal.

ASSEMBLYMAN McDONALD: So it's across the board, whether it's for-profit or nonprofit?

MEDICAID DIR. HELGERSON: It only applies to the for-profits.

ASSEMBLYMAN McDONALD: Thank you.

Moving into the drug arena for just my last couple of questions, the specialty drugs, you have an accounting for about $1.8 million in savings, I think. Is that the number?

MEDICAID DIR. HELGERSON: Yes. I could look for it, but that's about right.

ASSEMBLYMAN McDONALD: So you've kind of earmarked some drugs, whether it's three drugs or 300 drugs, that fall into that category; correct?

MEDICAID DIR. HELGERSON: Correct. So as I said, we had access to information from one of the pharmacy benefit managers relative to prices that were being paid in pharmacies here in New York State on behalf of Medicaid managed care plans. And so basically what that savings is, is it identifies some

particular drugs where both in fee-for-service, which obviously is a much smaller portion of business now -- but also a thought that we could extrapolate that result onto the remainder of the managed care plans, that we could generate what is a modest incremental savings that's associated with simply getting the lowest price possible for those particular drugs.

ASSEMBLYMAN McDONALD: I think you mentioned to Member Raia that you would be -- you have a list or you'll be able to provide a list of what those drugs are. I too would like to get a copy of that list, if possible.

I think I'm concerned -- you know, there's no such thing as a specialty drug. If you look for definitions, you won't find them. You won't find them in the Education Department. You know, there is a concern in the community -- and I say the community as the pharmacy community, but I also mean the patient community -- that what defines a specialty drug. Is it because it costs $300 or it costs $500? And then we get into that

whole discussion, which you're all intimately familiar with, which is the access issues. And then we get into limited -- you know, it's just -- it's something that I'll be continuing to monitor and pester you about as we go through the processes.

Because at the same token, you're absolutely right, the state should get the best price possible per unit for medication. But along your lines, Dr. Zucker, appropriate use of the medication and making sure that the right patient gets the medication and it's used properly is really what we all should be working for.

In regards to the generic pricing, I think there's a $26 million savings. Is that attributed to the NADAC pricing that's supposed to be effective May 1st, or is it -- it sounded like you were putting a limit in on what the generic should be. Which concerns me only for the -- if that's the case, the concern is there's been a lot of erratic behavior going on in the generic drug market.

I can tell you as a pharmacy provider and I can also say as a state legislator, we're all suffering with that. What I don't know is if you just put a limit in, like the SMAC list -- which, when challenged, has not been successful for pharmacy -- are we going to be creating another problem where we're creating access issues for our patients? Or is it the savings accounted through the NADAC price scheme?

MEDICAID DIR. HELGERSON: So the proposal -- and there is a proposal both for blockbuster brand-name medications as well as for the generic prices. And you had mentioned erratic behavior. I would say that some of the behavior is more nefarious than just simply being erratic, and there's been obviously quite a bit of coverage of some of that problematic behavior.

In terms of -- you know, for a long time generics, if anything, prices would go down. And we've actually seen some pretty substantial increases in some high-volume generics in the not-too-recent past.

And so basically the proposal is that it gives basically the commissioner the ability to impose, in essence, a cap on price increases in generics, a cap tied to the CPI-U or CPI-Urban inflation index. That can be adjusted if there are reasonable circumstances which, you know, would justify such a cap. Or, you know, if there's something like a lack of supply or a major supplier ceased production or something to that effect.

But the idea is that this would not -- none of the burden for the collection of and making sure that we were keeping those prices would fall on the pharmacy. It actually would be a direct requirement on the manufacturer to rebate the state in order to ensure that that price ceiling is not reached.

So as a result, I don't think the pharmacists should have any fear from that policy.

ASSEMBLYMAN McDONALD: Thank you.

CHAIRMAN FARRELL: Thank you.

Senator?

CHAIRWOMAN YOUNG: Thank you very much.

And our next speaker is Senator Marty Golden.

SENATOR GOLDEN: Thank you, Madam Chair.

I'm just going to go over, real quickly, some of the comments that have been brought up.

One was the long-term-care policies that have been abused by the industry over the last year or so. And if you look at spousal refusal and you look at long-term care, what we're doing is we're forcing our seniors into the best insurance plan in the nation, it's called Medicaid. And it shouldn't be happening. These are people trying to do the right thing. And unfortunately, they're not being allowed to do the right thing.

Five hundred thousand policies, a hundred thousand of those policies have gone up more than 50 percent in the last year and

a half. Think about that. It's absurd. Why would anybody want to buy a long-term-care policy in the State of New York? Why would somebody want to do the right thing? This is more of a DFS issue than it's your issue, but you two belong with DFS right now in trying to correct this imbalance so that we do have people doing the right thing here in the State of New York. It's more of a comment than a question.

Going back to some of my colleagues with the specialty drugs, there is no such thing. But we allowed the PBM to come in and make up these specialty lists, and that pharmacist that's in the pharmacy, that's at the PBM, that's at the mail order has the same degree, knows what drugs he or she can handle or can't handle, and knows the pricing structure. And if they can match the pricing structure, they should be allowed to participate.

So we need to reduce the terms and conditions to a modest number that all pharmacists, whether they be local

pharmacists or they be our large pharmacists or they be PBMs or they be the mail orders, that they have the same terms and conditions.

If you want to comment on that, you can. I believe it's arbitrary. Again, it's just a statement. But if you want to comment, you're welcome to. Okay, great.

Another comment. The Medicaid, the New York City, it's $180 million, I believe, and it's over this year coming up. But by 2020, it's up to $735 million, and that's just one issue in the City of New York -- CUNY, you look at the list, the list goes on. So I would imagine that if the City of New York were in the tax cap like the rest of the State of New York, this could not happen and the billions that are going to be clawed back by the state would actually be going back to the taxpayers in the City of New York.

Am I reading that correctly?

MEDICAID DIR. HELGERSON: Under the proposal, the city's budget contribution would increase, and that would offset the

State of New York's contribution to the program.

SENATOR GOLDEN: But if they were part of the tax cap, they would have the same commitments that the rest of the state has except for those five counties in the City of New York. They would have the same as the other counties; am I correct?

MEDICAID DIR. HELGERSON: The City of New York is exempt from the property tax cap.

SENATOR GOLDEN: Today.

MEDICAID DIR. HELGERSON: It's the only jurisdiction that is exempt.

SENATOR GOLDEN: Today.

MEDICAID DIR. HELGERSON: Correct.

SENATOR GOLDEN: But if that were to change, that could not possibly -- you could not get this outrageous clawback. This is an outrageous clawback that should be going back to the taxpayers, not to the State of New York.

This is something that should be part of a tax cap that should be statewide and that we should be the same share as the rest

of the state. Yes, no? Thank you. You guys are great.

(Laughter.)

SENATOR GOLDEN: Keep up the good work.

(Laughter.)

COMMISSIONER ZUCKER: Thank you, Senator.

SENATOR GOLDEN: The lack of funding in our life science research and biotechnology, our major competitors, that being Texas, California, Massachusetts, as we see them get IBM -- we see a whole host of companies and people that are being attracted, taken out of the state, and brought into these other states. We need to do something about that, whether it's biotech or biomed incentives or researchers grants. We didn't see that in this year's budget.

We're looking at talking to my colleagues and trying to work with our colleagues to put it into our one-house bill, trying to get some money to keep our researchers here. When you lose a

researcher, you lose a team. When you lose that team, you lose the ability to be able to discover the next life-saving drug that could actually be a plus for this great state in being able to manufacture that drug here and create the jobs and opportunities that we need.

Is there a reason we left that out, or is that an oversight?

COMMISSIONER ZUCKER: Well, I will mention that there is money put into a venture capital fund for research, part of the breast cancer initiative the Governor has proposed. So that's one area.

There's also efforts being made, we have the Genome Institute, Genome Center here in New York, which looks at many of the challenges in genetics and proteomics.

In addition to that, there is, downstate -- I'm not necessarily saying about the budget, but in general there is a lot of areas of research that are going on in the State of New York. We have some of the best scientists in the nation, and we are moving

forward with some of the --

SENATOR GOLDEN: Texas and California and Massachusetts are eating our lunch. And so is Canada and other countries around the world. And it's only because we don't put the incentives forward to be able to hold these people here and to hold these companies here and to give the incentives to researchers and for biotech and biomed, that we are losing a great opportunity.

COMMISSIONER ZUCKER: Well, as one who is a big supporter of research and recognizes the benefits that will come with research, we -- I hear your --

SENATOR GOLDEN: I'm glad you agree, sir.

Now, getting back to hospitals, the area that is ground zero for the State of New York and maybe even for the nation is Brooklyn. Some may disagree with that, but I doubt that. Brooklyn, 2 1/2 million people, the healthcare system is a disaster. In certain parts of that great county, we do see different things happening which are very,

very good, very positive. We see NYU taking over Lutheran, NYU involved with Long Island College, we see North Shore involved with Maimonides, we see great things happening in Brooklyn South, not such great things happening in Brooklyn North.

Senator Hannon did point out the capital monies that are being distributed, 3-point-something billion dollars. I know none of that money has gone to Brooklyn yet, because I do know you're looking at Brookdale, because something has to be done with Brookdale. Interfaith and some of the other hospitals that are in Brooklyn North have to be right-sized and have to be profitable, and there's a lot of work going into that.

I'd like to know what work is going into that, in the right-sizing of those hospitals. And the last part of that question is going to be about Downstate being possibly sold off to another healthcare system. And if you could comment on both of those.

COMMISSIONER ZUCKER: Sure. Sure. Thank you for the question about Brooklyn.

Let me say a couple of things about Brooklyn, because we've been looking at this for a while. Brooklyn, with it's 2.7 million people, if it were a city, it would be the fourth-largest city in the nation. And no one should have to leave Brooklyn, if they don't want to, for high-quality state-of-the-art medical care. And I know that they do, because having worked in the Bronx and in Manhattan in medicine for many years, I saw on those charts that they were coming from Brooklyn.

What we have been doing is looking at doing our due diligence, looking at the challenges, both the financial challenges of the hospital and the challenges in general in that community, to get a framework, to figure out how we move forward, what are the next steps.

SENATOR GOLDEN: Is there a schedule for that? Is there a timeline for that?

COMMISSIONER ZUCKER: Right, yes. So

we have just finished a lot of that work, and a lot of people have been involved in diligently trying to get the information to do the homework --

SENATOR GOLDEN: Can we have another roundtable with Senator Hannon, please, on this issue? Thank you.

COMMISSIONER ZUCKER: -- and I, within the coming month, would very much welcome the opportunity to sit down with the members of the Legislature who are focused on this area and to get your input and concerns -- but not just also with the Legislature, but we also -- it's important we need to reach out to the community and the people who are living in Brooklyn who -- well, obviously legislators who are there do -- but others who are accessing that care, to figure out how we move this forward. Because this is a system --

SENATOR GOLDEN: When?

COMMISSIONER ZUCKER: Now. Now meaning in the next month.

And it's a system change. And I

actually believe that when we are done and when we have developed the framework and have put into place the system for Brooklyn, it will be a model for urban healthcare --

SENATOR GOLDEN: For our nation.

COMMISSIONER ZUCKER: -- for not only New York, but for the nation. I agree that this will be a model for healthcare.

SENATOR GOLDEN: Downstate's not being sold off?

COMMISSIONER ZUCKER: Downstate Medical School is a medical school that has generated more doctors for this state than I believe any of the other medical schools in the state. And we are working with Downstate, and we need to strengthen the medical school there.

SENATOR GOLDEN: It's a great, great place, and it does great work. And it's in the central part of Brooklyn. It is full, Kings County is full; we need to keep that place open and operating.

COMMISSIONER ZUCKER: That medical school --

SENATOR GOLDEN: Last question.

COMMISSIONER ZUCKER: That medical school has put out some of the leaders in medicine --

SENATOR GOLDEN: One in three doctors come from Downstate in the State of New York.

Medicare Part C cost sharing. Doctors are complaining about the Medicare Part B cost sharing that we did in the last year's budget that was proposed last year and rejected. This would reduce the amounts that would be paid for dual eligibles -- Medicaid and Medicare eligible, for our audience -- to the amount that the Medicaid pays even if Medicare pays more. Why?

MEDICAID DIR. HELGERSON: I mean, at the end of the day the proposal is that for the service for a dually eligible individual versus the service that we would pay for somebody who's just on the Medicaid program, that the state should basically pay the same amount for those type of services.

SENATOR GOLDEN: But if Medicare pays more, wouldn't we want to take the money from

Medicare versus Medicaid?

MEDICAID DIR. HELGERSON: But the issue is that that's why it generates savings, the proposal. Because when we pay more, the taxpayer pays more. And so what we're suggesting is to adjust for those Medicare Part C crossover payments, to ensure that we don't pay more than what Medicaid would pay.

SENATOR GOLDEN: So you're suggesting that we're paying more in Medicaid versus what Medicare pays us?

MEDICAID DIR. HELGERSON: No, I'm saying that we are, in certain circumstances, paying the -- the net reimbursement the provider is receiving than what Medicaid would have paid for that service for a Medicaid-only member. So what we're saying is that we want to cap our total cost, the Medicaid cost, at what Medicaid would otherwise have paid for the service.

SENATOR GOLDEN: Can you get Senator Hannon and this body a copy of those numbers, please?

MEDICAID DIR. HELGERSON: Absolutely.

SENATOR GOLDEN: Thank you very much.

CHAIRMAN FARRELL: Thank you.

We've been joined by Assemblyman Abinanti.

And next to question, Assemblyman Garbarino.

ASSEMBLYMAN GARBARINO: Thank you, Chairman.

Assemblymember McDonald asked some questions before but I couldn't really hear some of the answers, so I'm going to just follow up.

Part of the Medicaid Redesign Team, under the budget, has $65 million in pharmacy savings. There was a ceiling on blockbuster drugs, brand-name blockbuster drugs. Do you have an idea of what some of the blockbuster drugs are that you're going to be putting the ceiling on?

MEDICAID DIR. HELGERSON: Sure. So there's been some publicity around, in the recent -- oh, I'd say last year to year and a half, there have been a number of drugs that

have come to the market that have been priced -- and these are brand-name medications new to the market -- priced in ways that have been seen by many, including ourselves, as very problematic. So the sort of poster child for this has been the hepatitis C agents, where you're talking about, for a drug such as Sovaldi, costs for the treatment of an individual ranging at about $85,000 for one set of treatments, a number of weeks.

Now, the potential benefit of Sovaldi and these new treatments for hepatitis C are potentially tremendous, in the sense that whereas the side effect profile for previous treatment regimes for hepatitis C were so problematic that it was very difficult for patients to actually go through that treatment. And the new drugs offer a tremendous amount of promise.

But the concern is that these new drugs are priced in ways that make it extremely hard for payers -- not just Medicaid, but any payer -- to be able to

maybe make them as accessible as one would like. So what this proposal -- and hepatitis C is just one, but you could look at some of the new high-cholesterol medications, you could look at some of the new drugs for the treatment of cystic fibrosis, where the pricing in our view does not tie back to anything reasonable.

And that what this would do is give the commissioner the ability to set a maximum price, following consultation with the state's actuary, looking at data provided by the manufacturer, to allow the manufacturer the opportunity to justify the price that they're asking, and then the state would then have the ability to set that maximum price and basically require a rebate, such as to ensure that the price -- the net net cost of the drug does not exceed the price ceiling.

Once again, back to the concern from Assemblyman McDonald, this policy would not fall onto pharmacists, this would simply be a relationship between the state and the pharmaceutical manufacturer.

ASSEMBLYMAN GARBARINO: Is there a concern that -- you said these drugs have tremendous benefits, possibly. Is there a concern, if you put these ceilings on the drugs, that the manufacturers just won't provide them?

MEDICAID DIR. HELGERSON: I mean, it's possible, but we believe we have the flexibility in how we administer the policy to make sure that doesn't happen.

Basically we see this as another sort of tool in the commissioner's tool belt when it comes to negotiating with manufacturers. Because as we've been looking at drug prices -- in healthcare, as I'd said previously, it's one of the major cost drivers in -- not only for Medicaid, but nationally. We went through a period of time, say for the last -- maybe up until about a year and a half, two years ago, where we actually were in a situation where many of the sort of brand-name blockbuster drugs of the past had come off-patent. Things like Lipitor and Crestor, which are high-volume

drugs, were now becoming generic, also happening in places like atypical antipsychotics had moved into the generic class, and now we've seen sort of a rebound in these drugs.

And I think probably the best example would be some of the high-cholesterol medications, which really are designed for individuals who can't tolerate the current mainline treatment for high cholesterol. The vast majority of people can tolerate and do tolerate, very effectively, drugs like Lipitor. But these drugs were designed for that subset who can't, and they're priced very, very high. And the concern is that we want to make them available to who needs them, but we also want to make sure that the price we're getting from the manufacturers is appropriate, and that's what the proposal is all about.

ASSEMBLYMAN GARBARINO: But if it doesn't work out that way and the manufacturers decide not to provide them to Medicaid patients, aren't we limiting the

access to these tremendous drugs for poor people when the people on private plans can still get them?

MEDICAID DIR. HELGERSON: There is no mandate or requirement that the state do this. There's no requirement in terms of what that price is set to. So the idea would be that it gives the state leverage, but it isn't such a policy that it is so rigid that the state couldn't, if the manufacturer absolutely, positively refused to supply the drug, that the state couldn't modify its approach.

But what we can tell you is that when we have used our leverage in the past, that leverage has been effective. For instance, in the case of the hepatitis C medications, the introduction of a second drug into the market, while the drugs aren't totally interchangeable for all genome types, they are for several of the very high-volume genome types, that that kind of competition, that kind of the state ability to make certain drugs preferred over non-preferred,

has generated savings.

So I think at the end of the day we have the potential to use this, as I said, just as another tool, but obviously we do not want to use it in a way that would restrict access.

ASSEMBLYMAN GARBARINO: I know it's lumped in with the $65 million in savings. Do you have an idea of what this specific tool could -- the other savings could be from this?

MEDICAID DIR. HELGERSON: As you can see, for that we did have a savings estimate. It looked particularly at some of the very-high-cost drugs, drugs that we believe are priced inappropriately, drugs where if we have this tool, we could apply it.

I think nationally you're hearing more and more states, other payers, beginning to raise concerns about these drug prices, wondering what the justification is. I mean, at the end of the day really all we're asking the pharmaceutical manufacturers to do is to really provide information that supports

their case as to why this drug is priced appropriately.

At the end of the day, if the state determines, based on the information provided, it's priced appropriately, then we would agree to pay that price. But we have a suspicion that when that information is provided, that the state will make a different determination, and then that would lead to a much more robust discussion with that manufacturer about what that price should be.

COMMISSIONER ZUCKER: This issue is going to grow in many ways because precision medicine and targeted drugs and pharmacogenomics is going to increase the number of medicines in the marketplace that are tailored to individuals. And I think this is something which is, as Jason mentioned, is not just a New York issue, it's a national issue, and everyone is looking at it right now.

ASSEMBLYMAN GARBARINO: Do you have an idea of how much there is in Medicaid fraud

every year, how much the state loses to Medicaid fraud?

MEDICAID DIR. HELGERSON: Well, I believe today -- I'm not sure, is today the testimony of the Office of Medicaid Inspector General? Usually they follow us. But, you know, I'm sure that Mr. Rosen can give you a detailed description.

I think that what you would see in our proposed budget is actually a new partnership between OMIG and our Medicaid managed care plans. The last four or five years, with the move through Medicaid redesign, we've been moving more and more of our populations into managed care products, billions of dollars, millions of individuals and their services moving into managed care. And we think at the end of the day that is a good strategy for preventing fraud, is that a lot of these companies have access to technology, they have access to resources above and beyond what any state agency might have that helps to prevent fraud.

But that said, we always need to be

cognizant of that as an issue. And so what this budget does propose is that a new partnership be established, plans be given actual targets for identifying fraud within their networks, and sharing information between the state agency and the plans in developing comprehensive plans, we think that will definitely help to address what fraud still remains.

ASSEMBLYMAN GARBARINO: Okay, thank you. Just to switch gears real quick, I was going to save this question for the acting superintendent of DFS, but I was told they're not coming.

The Excess Medical Malpractice Fund, there's going to be changes to that. They're cutting $25 million from last year, and they're changing the way the risk assessment is done. Looks like there's going to be a ranking based on specialty and geography.

COMMISSIONER ZUCKER: So we looked at the excess medical malpractice -- the excess liability pool, and we realized that we wanted to target this program to be more

tailored to those who would benefit the most. And those who would benefit the most are those in the high-risk specialties and in the high-risk areas or potential individuals such as high-risk obstetrics. We surely don't want to end up with no high-risk OB doctors there.

And this would move it away from those who are at lower risk who also need to have their malpractice coverage anyway. So we realized that this would be a better way to have the pool allocated, and that's why we're moving forward that way.

ASSEMBLYMAN GARBARINO: But based on the numbers that I have it looks like, under this proposal, 55 percent of physicians who currently receive coverage would be dropped from the program.

COMMISSIONER ZUCKER: Well, the physicians who are low risk would not be part of the program, and it would be shifted to those that are high risk, as I mentioned. But those people who are low risk are already -- they have malpractice coverage,

they have to. As one who's practiced in New York, I'm aware of that.

And we felt that that would be a better way of doing this than basically having this distributed across all those, add the 55 percent in, where the amount would be so minimal.

ASSEMBLYMAN GARBARINO: I understand that going after -- you know, you want to help the high risk. But, you know, there's a lot of underserved areas in the state from any -- just family physicians, there's a lot of people that aren't served by them.

So isn't there a concern that cutting the funding $25 million and doing this ranking system will cause doctors from upstate to leave where they are because they don't have access to this funding?

COMMISSIONER ZUCKER: Well, it's not so much -- I mean as --

ASSEMBLYMAN GARBARINO: Or less coverage? Sorry.

COMMISSIONER ZUCKER: When I say to areas, there could be a high risk OB doctor

in upstate New York, and that person would fall within that excess liability pool. I'm not saying there would be one specific area of the state.

And in many ways that would actually improve the situation, because it would not have that physician, who may be the only one in an area of 100, 200 miles, to suddenly leave. And so I think that what we're doing is actually to the benefit of keeping the doctors who are high-risk doctors in areas that need to be -- can serve a lot of people.

ASSEMBLYMAN GARBARINO: But --

CHAIRMAN FARRELL: Thank you. Thank you very much. We're up there with the clock tonight.

CHAIRWOMAN YOUNG: Thank you very much. Senator --

CHAIRMAN FARRELL: Just one second. We've been joined by Assemblywoman Gunther and Assemblywoman Shelley Mayer.

Yes, Senator.

CHAIRWOMAN YOUNG: And Senator Krueger has an introduction.

SENATOR KRUEGER: Senator Velmanette Montgomery has also joined us.

CHAIRWOMAN YOUNG: Thank you very much.

Our next speaker is Senator David Valesky.

SENATOR VALESKY: Thank you, Madam Chair.

Mr. Helgerson, I just wanted to follow up on your answer to Senator Young's question in regard to -- there we go. Can you hear me? -- question in regard to the DSRIP timeline. I think you had indicated to her -- you had used the phrase "investing in infrastructure" when you were talking about the transition between the DSRIP Year 1 and 2 and preparing for Year 2 and eventually into Year 3.

I have been receiving relatively frequent telephone calls from one of the hospitals in my district as it relates to the timeline for the distribution of capital grants, I think for the last three months or so, asking questions as to when those

announcements were going to be made, what have we heard about those announcements.

So can you just address the issue of the capital timeline? We're now two months away from the next DSRIP year, and I think there are a lot of questions out there that hospitals across the state have as to when those announcements are coming and why they have been delayed.

COMMISSIONER ZUCKER: So -- I'm happy to answer -- this is the largest grant the Department of Health has put forth. It has over 700 applications that have been put out there. It's a competitive grant, a competitive process, and we are moving forward with this and want to make sure that this is done with the utmost question. And so it will be soon, and that was why there's a little bit of delay.

SENATOR VALESKY: Would you anticipate that definition of "soon" being before the next fiscal year or after the start of the next year?

COMMISSIONER ZUCKER: Well, we are

moving forward quickly.

SENATOR VALESKY: Okay. I wanted to stay with the issue of capital. In the current fiscal year budget, as you both know, the Governor had proposed and the Legislature concurred with a $300 million capital allocation for a comprehensive healthcare facility in Oneida County. In this budget proposal, it appears that those dollars are being repurposed, $195 million capital fund for hospitals statewide, $5 million for purchase of mobile mammography vehicles as part of your breast cancer initiative, and $100 million for Nano Utica.

Nano Utica is an important project for the Mohawk Valley, it promises to create a number of high-paying jobs, yet it has nothing to do with healthcare.

So my question is, why the repurposing of this pot of capital money that was specific to Oneida County?

COMMISSIONER ZUCKER: Sure. Thank you, Senator.

I think the question of Oneida and the

hospital there, the Governor is committed to this project. As the budget negotiations unfold, we will look at this and -- for allocation for that. This is a hospital, Oneida is -- one of the hospitals there is strong, there's a strong system, and I recognize the need for where they're going.

But I will say that we -- as I said, the Governor is committed to this. And we would be happy to meet with the Mohawk Valley health professionals to sit down and discuss this as we move forward. And it will be part of the budget discussion.

SENATOR VALESKY: Appreciate that very much.

Just one final question in regard to that topic. So the issue of the $300 million capital appropriation for Oneida County and the $700 million appropriation for Brooklyn in the current fiscal year was, as you recall, as you both recall, the subject of much discussion among the Legislature and the Executive a number of months ago.

Is there something -- well, the

question is, the $700 million remained, the $300 million was not reappropriated. So I guess my question is, is there something that Brooklyn is doing that Oneida County is not doing that would have initiated this proposed change?

COMMISSIONER ZUCKER: So I think that as -- excellent question. I think the situation here is in Oneida, it's focused primarily on a hospital --

SENATOR VALESKY: Right.

COMMISSIONER ZUCKER: And it's strong, as I mentioned, up there.

The situation in Brooklyn is more fragile in some ways. The central part of Brooklyn healthcare system is a system, and I think that's the active word there, the system is -- needs to be restructured. And that's what we are tackling, as I mentioned before. And it requires more than just a hospital or several hospitals, it requires how do we tackle this across the whole community, we have base clinics in other areas.

In Oneida, they focused primarily on a hospital. And as I say, I'm happy to sit down and meet with the team there and sit and speak with you further about that.

So I think that that's the difference, one's a system and one's a hospital.

SENATOR VALESKY: Okay. Thank you, Commissioner. I appreciate your willingness to sit down and have further discussions.

Thank you.

CHAIRMAN FARRELL: Thank you, Senator.

We've been joined by Assemblywoman Latrice Walker.

Assemblyman Ortiz for questioning.

ASSEMBLYMAN ORTIZ: Thank you, Mr. Chairman.

Good morning, Inspector General and Commissioner.

I have a few questions. The first one has to do, Commissioner, can you comment on the status of the organ donor registry implementation, please?

COMMISSIONER ZUCKER: Sure. So this is something which we have been moving

forward with for a period of time. There is a New York State Donor Life Registry, and we've been working in a public/private partnership on this. And we have identified a New York Alliance for Donation, N-Y-A-D, or NYAD, who will lead us forward on having more of an effort to get individuals to donate organs, obviously to help many other lives.

This is now with the Comptroller, the budget proposal or the -- I should say the documents have already moved forward to OSC on that.

I know it took a little bit more time than one had originally wanted, but there are many issues involved in this, there's the issues also of privacy, and to make sure that we do this right. And so I hope this will help as we move forward with increased organ donation in the State of New York.

ASSEMBLYMAN ORTIZ: And I hope that we can continue to work together on that.

The other questions is regarding many years we opened like three centers, eating disorder centers. The eating disorder

centers was located in Rochester, Albany and New York City. Throughout the years, it sounds to me that the money has completely disappeared to trying to maintain and continue the services of eating disorders in New York State.

The Department of Health, your agency, do they have any alternative initiative, alternative plan in order to address eating disorders in New York State?

COMMISSIONER ZUCKER: I know this is something which we are interested in. The details of exactly how much and where we have that, I can get back to you on that. But I do know that this is something which we need to tackle.

It's also -- and it's an important issue, it ties back to issues of primary care, it ties back to the fact that somebody with an eating disorder should be picked up relatively early, and also works towards the issue of prevention so that the complications that would occur as a result of that condition are avoided.

ASSEMBLYMAN ORTIZ: Whatever that you can do to look into that, because I was the legislator who passed the bill about opening the three centers throughout the State of New York, and we allocated about $1.5 million. And it sounds to me that today the center in Rochester has been closed down. The center here in Albany is just trying to maneuver whether or not they can continue to be alive. And the center in New York City, at Columbia Presbyterian hospital, also is having difficulty.

So I hope that you can reevaluate, go back and please look into this very, very, very seriously.

COMMISSIONER ZUCKER: We will.

ASSEMBLYMAN ORTIZ: Because that brings me to my next issue, which we cannot talk about eating disorders without talking about obesity, the obesity epidemic that we have in the State of New York and in this country.

As you probably know, or maybe you don't know, but I've been the legislator who

has been fighting to address the obesity epidemic in New York State for many, many years, since I've been in office. As a result that obesity brings several different chronic diseases. From obesity you have diabetes, from diabetes you have cardiovascular, from cardiovascular we have kidney issues, and so on and so on and so forth. And they're partly as a result of diabetes.

And this is an issue that is also impacting very highly all through our children. As a result of that, your agency and the report from the Comptroller's office apparently are in agreement that one in every four children will suffer from prediabetes.

A couple of things in here. Number one, I have been through this legislation where I do believe that the same way we need to take care of the physical of our children, we need to take the mental health issue and do a better assessment within the school system at the early stage of the children's life. So therefore, the first bill was to

address that we should do a screening, a blood screening, from pre-K all the way through high school in intervals of grades, where we will be able to identify whether or not what is the potential, based on the history, the family history of the child, that this child might develop or might have diabetes, and how can we go and implement a plan of action to treat this child. That's one of the legislations that I have in place.

The second thing I would like to say, that as a result of diabetes being -- most of the time diabetes impacts more minority communities, as a result that we have so many junk food in our community, and really it's a catastrophe.

So as a result of that, I also have a question for you regarding the topical oxygen wound therapy that has been used in the Department of Defense, has been already been implemented in 19 states, in 19 states. And this is -- this is a therapy that really goes to the wound of the individual to cure diabetes. And it's very inexpensive.

Can you tell me what has been the plan of action that the agency has taken in reversing this to be out of the budget and also removed from Medicaid reimbursement?

MEDICAID DIR. HELGERSON: So we have a a panel that is actually governed by state statute now that -- in terms of a panel of outside healthcare experts that we convene to advise the department on changes to the Medicaid benefit package in terms of what are covered services and such.

That panel recommended to not cover the wound therapy that you're describing. And then as a result of that, litigation was initiated by the manufacturer of the mechanism of treatment. And so right now we are in the midst of litigation on that issue.

ASSEMBLYMAN ORTIZ: Well, let me just put this on the table, and on the record, that most of the folks who are using this, including right now they're using it at the Department of Defense, for our own veterans, and 19 states have already moved forward to implement this kind of therapy.

I hope that those advisors will revise that and go back, because this is impacting very, very heavily on the minority community.

And this is very cost-effective. You know, as we're talking about the escalating healthcare costs in our country and in our state, and as cuts have been implemented in order to save money, you know, this is another alternative that will be able to save money at the end of the day.

So, Inspector General, I hope that you can go back and have a conversation with your advisors and I hope we can come up with a positive resolution where our people, my community, who is suffering a lot from diabetes -- and I have an uncle who was taking this therapy. Over the summer we have to pay for it, and it's come to be a little expensive.

So I hope that you can put in the word for those who cannot afford, as a result that they don't have the means and the financial means to get this treatment, that you will be able to convince them that this is the right

thing to do. And we're getting a lot of letters, a lot of people visiting my office as a result of the impact that this will have in the underserved community.

Thank you, Mr. Chairman.

COMMISSIONER ZUCKER: Assemblyman, just one thing I wanted to clarify.

You had mentioned about the eating disorders, and you brought up the obesity issue. And just from the medical world, usually -- I was thinking about eating disorders, and usually anorexia is what we sort of look at as eating disorders. And so I was not thinking from the standpoint of obesity.

But I agree with you a hundred percent. We are working very hard on this issue, and we are working on this through our Prevention Agenda and across all different areas. And I agree, it needs to be tackled both in the school system, it needs to be tackled even before elementary school and particularly throughout high school as well.

ASSEMBLYMAN ORTIZ: Commissioner,

thank you for your comments.

And I would like to say, last but not least, that I have worked on this issue for my last 25 years -- which is partly the Assembly, five before this -- as an epidemiology. So I hope that you and I can work together to make sure that we can address good public policy that can -- that we can probably 10 years from now can talk about how effective this public policy, how public policy has become as a -- to help our children to be in the workforce. You know, they don't to be depending on dialysis rooms, and this kid doesn't have to be depending on a pacemaker for cardiovascular problem and neuropathy.

And I hope that this conversation will open a relationship between you and I to endure and to do the best we can for the people of the State of New York.

Thank you very much.

COMMISSIONER ZUCKER: I agree. Thanks.

CHAIRMAN FARRELL: Thank you,

Assemblyman.

We've been joined by Assemblyman Weprin.

Senator?

SENATOR YOUNG: Thank you, Assemblyman.

Our next speaker is Senator Jim Seward.

SENATOR SEWARD: Well, thank you, Madam Chair.

And I want to say good morning -- I think it's still morning, about three minutes.

(Laughter.)

SENATOR YOUNG: Two minutes over.

SENATOR SEWARD: Good morning, Commissioner and Mr. Helgerson. Thank you for being here.

I wanted to zero in on the demise of the Health Republic co-op that went belly up last fall. And I regret very much that the Department of Financial Services is not going to be with us here this morning, because it's pretty obvious that many of the decisions

made at that department have a direct impact on the delivery of healthcare here in New York State. But you are here, and I'd like to discuss this issue with you.

As Senator Hannon mentioned, we had a roundtable the first day of session on this very topic. As chair of the Insurance Committee in the Senate, I was pleased to cohost that with Senator Hannon. And we're really talking about a health plan, a co-op with over 200,000 New Yorkers who suddenly lost their health insurance coverage.

And in September of last year, of course, the Department of Financial Services directed Health Republic not to continue to write new coverage, and then of course November 30th to actually cease operation.

But in the meantime, healthcare providers continued to render service to those subscribers, and running up a total of it's estimated over $200 million in unpaid claims. I've heard estimates of hospitals alone of about $160 million, perhaps higher, and of course physicians and other medical

providers making up the balance.

So we have a serious problem here as it relates to our hospitals, many of these hospitals already in financial distress and stress. And of course with claims going unpaid to physicians and others, I think it makes it very difficult for us going forward to recruit new physicians here to New York State when we have this type of situation lingering here in the state.

There are many reasons for the demise of Health Republic. But clearly something went terribly wrong in terms of the regulatory oversight, in terms of the state regulatory function of ensuring the solvency of a health plan here in New York State.

So my question to you this morning is my reading of the Executive Budget does not show any funds to reimburse these providers for the services that were rendered to these subscribers of Health Republic. And if that is the case, two questions: Do you agree that this is a very negative and disastrous impact on healthcare providers, hospitals and

others, here in our state to have unpaid claims of this magnitude? And do you believe that funds should be identified in a final budget to cover these unpaid claims?

COMMISSIONER ZUCKER: So the department's focus on this has been very patient-centric. We have had an opportunity to have about 64,000 calls from those who were members of Health Republic or covered by Health Republic. We've had about 350,000 contacts with them, whether through email and other -- letters and other ways. We've worked very hard to make sure that those who were enrolled in Health Republic have been covered. We have 85 percent of all those who were enrolled in Health Republic now enrolled in another plan. That is close to our 90 percent that we have -- and sometimes people took a different path, and we offered them three plans and opportunities to get enrolled, and we've done everything to get them into a plan that will help meet their needs. And any small glitches in that we've also worked through as part of our team.

The issues regarding the finances here, I really need to direct that to DFS, because that's where this falls. And I would ask you to direct it to them rather than specifically to the health team.

But from the standpoint of what we're doing for the individuals who were covered, we have really moved forward diligently on that.

SENATOR SEWARD: Well, I would agree that in terms of getting the previous subscribers of Health Republic re-enrolled, that, you know, there was aggressive action taken there. And certainly, as I said earlier, I regret that DFS is not here to ask the questions regarding this issue.

However, my question to you is, your testimony related to funding for distressed hospitals and other ways of funding our hospitals. Wouldn't you agree that $200-plus million of unpaid claims is a serious financial problem for these hospitals and other providers that will have a very negative impact on the delivery of healthcare

in New York State if this issue is not dealt with?

COMMISSIONER ZUCKER: I think we should wait to see what the final outcome with those resources are. But again, that would be back to DFS.

There's a lot of challenges on hospitals, and we're trying to tackle the ones that fall within the Department of Health. And I'm happy to push forward with those that -- particularly, we've heard already some of the issues for the distressed hospitals. And what falls within the department's realm, I'm glad to move forward. But I think this sort of falls within DFS.

SENATOR SEWARD: Well, no further questions.

CHAIRMAN FARRELL: Thank you.

Assemblyman Oaks.

ASSEMBLYMAN OAKS: Thank you, Commissioner.

I wanted to touch on the exchange and the cost. I know originally the intention was to have it self-sustaining. We've had

costs in the current fiscal year, and then we have proposed ones in the upcoming one. Are we increasing, decreasing in that, or staying about the same?

COMMISSIONER ZUCKER: We've had -- from the exchange, from the standpoint of people, we have 2.7 million people now enrolled in the exchange. We have a state with only 6 percent uninsured, which is down -- basically in half or close to in half from where it was before. We have more enrolled, obviously, as Jason has mentioned, about Medicaid. We have a budget that's $575 million that is coming from the feds, federal government, I believe, and $484 million that's cost for it to run the exchange, or for the exchange.

We are making progress on that. There is also funds from the federal government. And as we are moving towards more of an Essential Health Plan, which is sort of the Basic Health Plan, we will have additional savings of probably about a half a million dollars.

ASSEMBLYMAN OAKS: So do you think going forward, then, we'll see increasing costs net to the state or --

MEDICAID DIR. HELGERSON: Yes, so I can probably answer that. Because in addition to the launching of the health insurance exchange, and the qualified health benefits, the tax subsidies that are provided to help individuals buy commercial insurance, we implemented in New York that initiative at the same time we also implemented, basically created a one-stop shop for people to access health insurance. And that includes the Medicaid program.

And if you look at the 2.7 million people who have used the exchange to date, the vast majority of those people are actually using that service to access the Medicaid program.

And what we're in the midst of doing is a multiyear takeover of the responsibility for Medicaid administration from the counties. And so your question is will the budget for that centralized function grow,

and the answer is yes, it will grow. But at the same time, the amount of money we spend at the county level for the administration of the Medicaid program will decline.

And we think at the end of the day the net cost of administering that system, that single unified system, that single, you know, one-stop shop for healthcare, will actually be less than what it cost us to administer just the Medicaid program on a county basis.

ASSEMBLYMAN OAKS: Jumping to a topic brought up before, on the executive order on immigration -- I know it's been discussed some today -- do we know the numbers that are going to be impacted by that in this fiscal year? And again, do we see that as a increasing item in the future?

MEDICAID DIR. HELGERSON: I have to go back and look at the fiscal for the executive order. I mean, I actually think it's -- as the commissioner mentioned, the creation of the Essential Plan, which was an initiative in last year's budget, generated substantial savings to the taxpayers of New York. And

the reason was that we had this population of legally resident individuals, individuals who are not here illegally but are not eligible, under federal law, for Medicaid but are, based on our Constitution, on the program.

And so we were funding those expenses to the tune of almost a billion dollars a year. And that was entirely state-only funds. And what the Essential Plan allowed us to do was -- we know the individuals who made the transition from Medicaid to the Essential Plan are different. They've got the same benefit package, same cost sharing and everything, but we were able to avail ourselves of federal funding through that program to cover the vast majority of those expenses.

So as a result, the cost of legally resident but nonqualifying, as it's referred to, immigrants to the State of New York has been substantially reduced because of that initiative.

That said, we'll get you more information about the fiscal that went into

the President's executive order, which obviously still remains stayed.

ASSEMBLYMAN OAKS: Thank you.

Also there have been comments or questions related to the Donate Life Registry. I guess I would just ask the question -- and I know you made some reference, Commissioner, to saying, you know, we're going to be making progress on that. I know we've had, you know, among the lowest donor levels or I guess registry levels in donors. Have we made any progress on those items specifically yet, or hope that we will in the state?

COMMISSIONER ZUCKER: So we have about 4 million people registered as organ donors in the state as of the 1st of this year. And as I mentioned, the award has been finalized and is now with the Comptroller, so hopefully that will help move it forward.

I think that -- and once that is awarded, then all the efforts to further outreach, to get more people registered, will happen. I know there's been a lot of

discussion about other ways to do this, and partnering with other agencies as well. And we will see what else we can tackle.

ASSEMBLYMAN OAKS: We'll look forward to that happening.

One final question, just -- I know that in last year's or the current year's fiscal budget we had enacted some provisions to help with exorbitant out-of-network costs as it related to, you know, some of those expenses with the Affordable Care Act and out-of-network.

Have we made some progress during this past year on that issue?

COMMISSIONER ZUCKER: Are you referring to our plans, the marketplace, or are you referring to in general? Some of these issues are also DFS issues we should tackle.

ASSEMBLYMAN OAKS: Okay. Well, I was looking at it from the perspective of what we had enacted. We put in the budget to make -- my understanding is to make some changes so that we could have some impact on reducing

some of those out-of-network exorbitant costs and trying to rein those in. And I was just wondering if within that we've made progress.

MEDICAID DIRECTOR HELGERSON: Yeah, I would say that I think that that question is probably best directed to the Department of Financial Services, in the sense that they were the leads on negotiating that language and they're the ones who are monitoring the implementation.

But I think that the issue that you get to, which is the concern that when individuals, for whatever reason, end up out of network, whether it's a -- you know, they have an emergency, they're picked up in an ambulance, they end up at a hospital that's not in network, and what kind of charges do they potentially face. I mean, that was the concern that we -- I know a lot of people across the healthcare system had heard, was that bills were going to be sent to these individuals that were going to be exorbitant and how could -- or their insurance companies -- and how could we prevent that.

And I think that's -- you know, DFS has really taken the lead on the enforcement of that act.

ASSEMBLYMAN OAKS: Thank you.

SENATOR YOUNG: Thank you very much, Assemblyman.

It's interesting because we've had several questions today regarding the Department of Financial Services and Health Republic and some of those other issues. I do want to point out, as chair, that they were invited to speak today to get everybody of the same page, and they're not here. Unfortunately.

Our next speaker is Senator John DeFrancisco.

SENATOR DeFRANCISCO: Good afternoon.

Doctor, don't you think it would be a great idea, in view of the obesity problem in the State of New York -- and all states -- to have a Governor's Council on Physical Fitness? What do you think?

COMMISSIONER ZUCKER: I think, as we've spoken about, I am a big fan of

physical fitness and making sure that we move forward -- I know that there was some discussion about adding some resources for that at one point, and I'd be happy to --

SENATOR DeFRANCISCO: Well, let me explain something. After our conversation, I've worked with someone from your department. I said I have no pride of authorship -- do something, put something together, and let me look at it. If it's reasonable, I'll change my bill. And so did Assemblyman Cusick.

We did it. They did it. Guess what? It got vetoed again this year. So there's a disconnect someplace.

And once again, I'm not trying to be facetious, but there used to be one when a subsequent governor by the name of Schwarzenegger was the poster child for the federal law, and I think it's time again to do it. And I'll volunteer to be the poster child, if you would like. But I would really, truly, truly need your help.

COMMISSIONER ZUCKER: And I'm happy to

work with you on this. And I do know that we need resources to move forward. And I recognize that there have been programs out there in other parts, and there was once, when I was a child, the federal physical fitness program. So thank you.

SENATOR DeFRANCISCO: Mr. Helgerson. And you've got to pay attention to this, Marty, because Marty always says that I never think about Brooklyn.

Back -- I'm sure you don't remember this letter, but you certainly remember the topic, and you did receive a copy. November 12th, a letter from Tammy Ramos, practice administrator, Hematology Oncology Associates of Brooklyn. And they list a whole slew of other -- including some from my area.

And basically -- and I'm going to read this, because I'm not an expert in this area, that the Medicaid reimbursement policy for Medicaid/Medicare dually eligible individuals was changed, and it was announced in July of 2015 that Medicaid will no longer reimburse partial Medicaid Part B coinsurance amounts

when the Medicare payment exceeds the Medicaid fee or rate for that service.

You're familiar with that?

MEDICAID DIR. HELGERSON: Yes.

SENATOR DeFRANCISCO: Was that implemented, first of all?

MEDICAID DIR. HELGERSON: I know there were some concerns about the method of implementation. But I believe yes, it has been implemented.

SENATOR DeFRANCISCO: Okay. Well, that was a bad idea.

(Laughter.)

SENATOR DeFRANCISCO: Because there's a lot of -- and this is absolutely serious. Some practices, based upon this new rule, have been estimated to lose approximately $800,000. These are medical practices. And you know what happens when they don't make money and they lose money; they don't take the patients anymore. And guess where they go? Hospitals. Which is certainly not the best setting for someone going through chemotherapy. And, secondly, it's much more

expensive.

So sometimes there's intended {sic} consequences. And later on there's going to be a speaker from the Community Oncology Alliance, and I'll send you a copy of his testimony, because it will be much more detailed than what I'm saying.

But I would really, truly -- and this is not being facetious. Please take a look at it, because we're going to end up with more expenses and we're going to end up with a much more substantial problem.

Fair enough?

(Both nodding.)

SENATOR DeFRANCISCO: Okay, I appreciate that. And lastly, just so I understand this money that's being clawed back from New York City, does it have any -- this is what I understand, that when the state capped the amount of Medicaid that the counties and the city would have to pay, that really we were picking up the balance, the new stuff. Okay?

And I heard that one of the

difficulties was that there are some areas of the state less efficient than others. In other words, the increases they don't have to pay, so we're much more generous with how we're going to deal with those funds than if we had to pay part of it.

Now, does this clawback have anything to do with that concept?

MEDICAID DIR. HELGERSON: Not particularly.

I mean, so when we implemented the -- and I think it's an initiative that doesn't -- that was part of Medicaid redesign and doesn't get enough attention is that -- and I remember full well when I arrived in January of 2011, county officials all across the state talked about how the growing burden of Medicaid was the number-one issue at the top of mind of every county executive and county legislators.

And so in the face of that -- and while the growth rate was capped, it was still rates of growth that were far in excess of what people thought they could afford.

And at the same time, we were also obviously debating the property tax cap. And so when the property tax cap was imposed, we also moved forward with basically a phase-down of the county contribution.

So now where we are is it's a dollar amount that's now historically set in terms of it, and so it's not a growing share of any county's budget.

That the proposal in this budget would do is basically ask that the City of New York contribute more -- still capped, but more -- than they would have otherwise been asked to do. Understanding full well -- and I think the rationale for that proposal, as I've stated, was that we felt that it was something that in essence is affordable for the City of New York.

There's other benefits from the Affordable Care Act, for instance, that are going to local units of government, increased federal funding and other things, that I think when you take a look in totality at what has happened, there's substantial

benefits still to the City of New York from all the actions of the Legislature and the Governor in the past.

But as we look forward to the program into the future, and we know have some growing costs under the global cap, that we felt that the city could afford to pay some additional contribution.

That said, at the end of the day, you know, it's a proposal that I know we would want to implement it in a way that would not negatively affect residents in the City of New York. And I think that's why we remain open to this conversation. If there's ways we can generate other efficiencies that aren't going to make the challenge something that can't be borne by the broad shoulders of the City of New York, then I think we're open to alternative ideas.

SENATOR DeFRANCISCO: Thank you very much.

I'll yield the rest of my time to the chairmen, in view of the fact that I know what they're going through.

CHAIRWOMAN YOUNG: Thank you, Senator

Iron Man.

(Laughter.)

CHAIRMAN FARRELL: Thank you.

Assemblyman Abinanti.

ASSEMBLYMAN ABINANTI: Thank you. Thank you, Mr. Chairman. I guess they don't want to hear from me, and I chased away the Senators.

(Laughter.)

ASSEMBLYMAN ABINANTI: I don't think we've discussed Early Intervention yet. I want to thank both of you for coming this morning, but I'd like to turn your attention to the Early Intervention changes that I'm seeing proposed in the initial budget.

As I look through Article 7, I see page after page after page of changes. Why? What's the problem? What are we trying to solve here?

COMMISSIONER ZUCKER: Well, the program has three changes. One is an administrative rate increase that's a 1 percent increase. One of the things we want to do is to get children screened

quicker and have them pulled into system before a full multidisciplinary evaluation is done. So that's something which will help get kids in quicker.

ASSEMBLYMAN ABINANTI: Help with what?

COMMISSIONER ZUCKER: Help get children into the system quick to get them screened quicker. You know, rather than having them --

ASSEMBLYMAN ABINANTI: But you're adding a screening process before the evaluation.

COMMISSIONER ZUCKER: Before a multi -- some may end up not needing the full multidisciplinary evaluation, so we're going to at least do a quick screening up-front and then do that.

ASSEMBLYMAN ABINANTI: But now you're going to be having parents go through two steps.

COMMISSIONER ZUCKER: Well, while they'd go through -- some parents may go through the screening and then the children will not need to go through the --

ASSEMBLYMAN ABINANTI: What's the difference between a screener and an evaluator?

COMMISSIONER ZUCKER: Well, the multidisciplinary evaluation is involving occupational therapy, physical therapy, and others as well. So --

ASSEMBLYMAN ABINANTI: Yeah, but if you have just one screener who's not trained in all those areas, then aren't you going to end up with the child getting maybe only one piece of the services and not the rest?

COMMISSIONER ZUCKER: Well, the initial screening will be done to look at whether they need to have more multidisciplinary --

ASSEMBLYMAN ABINANTI: Do we have screeners who are trained in all these multiple disciplinary areas -- multiply -- multiple -- in all the different areas?

COMMISSIONER ZUCKER: Well, we'll have those who will know exactly what questions to ask and to be able to at least identify whether they need to go further.

ASSEMBLYMAN ABINANTI: Is this going to be a new profession, screener?

COMMISSIONER ZUCKER: Excuse me?

ASSEMBLYMAN ABINANTI: Is this going to be a new profession? Are we going to set up a whole new --

COMMISSIONER ZUCKER: Well, we -- I will find out exactly who we would have doing the screening. But those are done probably by -- or will be done by professionals. It doesn't necessarily mean it would have to be somebody who has all OT, PT --

ASSEMBLYMAN ABINANTI: I'm sorry, the system here is terrible. I can't --

COMMISSIONER ZUCKER: It doesn't need to be someone who has OT, PT, speech and language all at one time. But the initial screening evaluation by a --

ASSEMBLYMAN ABINANTI: I'm just very concerned because what I'm hearing anecdotally is that your requirements for providing Early Intervention within a short period of time are actually being skirted because the child is touched by the system,

gets one of the many services the child needs, and now is off the list of the people who need services.

COMMISSIONER ZUCKER: Right, but some of those children may not. Some of those children will -- what has happened is that the amount of time to get that whole multidisciplinary evaluation, if it's longer, then we -- some of the kids, some of the children we would want to identify them quicker. And if it's taking a longer period of time --

ASSEMBLYMAN ABINANTI: Well, this is certainly something I'm going to want to hear from our experts in this field, then. Because I'm very concerned that this is just a way to delay the services that are going to kids rather than speed them up.

COMMISSIONER ZUCKER: Right. Well, 94, 95 percent of the children will get a thorough evaluation within 45 days period of time.

ASSEMBLYMAN ABINANTI: Okay.

And the next thing you've added in

here is they have to be screened by a standardized instrument. Are you trying to tell psychologists and all of the other people that they've been doing it wrong and now there's going to be a new -- you're going to impose on them a new way of evaluating children?

COMMISSIONER ZUCKER: We have a standard -- a screening tool that we will use, and I'll get back to you about exactly what the details of that tool are.

ASSEMBLYMAN ABINANTI: Because I'm hearing that standardized instruments are a problem in many cases. I mean, we have Blythedale Hospital, for example, and the insurance companies are trying to apply a standardized instrument, so to speak, and they've never heard of half the diseases that the kids have who are in the hospital, and therefore insurance gets denied. I'm hoping it's not going to be the same type of thing here.

COMMISSIONER ZUCKER: The other thing is we do need more occupational therapists,

physical therapists, speech and language, and so we need to bring more into the system, obviously. And so we would definitely want to have these children at least initially screened to make sure we don't -- those kids don't fall through the cracks.

ASSEMBLYMAN ABINANTI: Well, I'm understanding a lot of people are dropping out of this field because of the mess that we have with the payment. So why don't we move that. You're talking here about adding a 1 percent administrative fee. Is that on top of the existing rate, or is it part of the existing rate so that they'll get paid less for their services and more for the administration?

COMMISSIONER ZUCKER: That will be an increase. An increase.

ASSEMBLYMAN ABINANTI: It will be a 1 percent increase.

COMMISSIONER ZUCKER: I thought it was 1.7.

ASSEMBLYMAN ABINANTI: And you've allocated $400,000?

COMMISSIONER ZUCKER: I'll check on that. We'll check on that.

ASSEMBLYMAN ABINANTI: I think it's $400,000.

How many providers are in the State of New York, Early Intervention?

COMMISSIONER ZUCKER: I'd have to check on the exact number.

ASSEMBLYMAN ABINANTI: Because it sounds to me like $400,000 is -- it may be, you know, a few dollars per provider. It's not very much.

COMMISSIONER ZUCKER: Well, these are administrative fees. So if there's a group of multiple providers, then it would go to that team. Right?

ASSEMBLYMAN ABINANTI: Well, I've got to tell you, it' still not working. In Westchester County we've lost a huge number of providers. Their names are still on your list because they're still owed money from way back when, and they're not going to say they're not taking -- but they're not taking new cases.

And some of the big companies, some of the really big companies that used to do this have dropped out of Early Intervention, all because of the, quote, reform to save the people of the State of New York money. And so kids are not getting services that they should be getting. And I've got to tell you, I've said this before to both of you, and I'm still very disappointed because I don't think it's been resolved, how much money is still backlogged and has not been distributed out to the providers from when we started this program? Do we have those numbers?

COMMISSIONER ZUCKER: I'll get you the numbers. I don't have them with me.

And the claims usually come in with -- you know, most of the providers have gotten paid within about two weeks or so.

ASSEMBLYMAN ABINANTI: That's current.

COMMISSIONER ZUCKER: Currently, yeah.

ASSEMBLYMAN ABINANTI: That's current.

Now, you're talking -- one of the changes that's proposed in this budget is to require insurance companies to make payments.

Which I guess somebody's finally discovered that they're not now required to do, and really you should have discovered that before we went to the new system where you were taking all these savings on the basis of increased insurance payments, when in fact there's never been a requirement that they make these payments in the first place.

And we have been pushing for that for years. We've tried to get those changes and never could get them. I see you doing some of those now.

But has the fiscal agent been able to improve the collections from insurance companies?

COMMISSIONER ZUCKER: I think this is also a DFS question.

ASSEMBLYMAN ABINANTI: There hasn't been an improvement?

COMMISSIONER ZUCKER: We'll check. We'll check on it.

ASSEMBLYMAN ABINANTI: Okay. I'm just disappointed because you're making all of these changes but we don't have any financial

backup to show that these changes are necessary. Because there are some of us who believe that there's a problem with requiring insurance companies to pay too much.

Is there anything in the law today that limits insurance companies from putting caps on kids? Some parents don't want Early Intervention included in their insurance because they have sick kids who are going to need every penny of insurance coverage that they can get in the future, and this may be depleting their present insurance.

MEDICAID DIR. HELGERSON: In terms of lifetime caps on insurance?

ASSEMBLYMAN ABINANTI: Yes.

MEDICAID DIR. HELGERSON: I mean, the Affordable Care Act in essence banned lifetime caps on insurance.

ASSEMBLYMAN ABINANTI: But does that apply across the board or just to the -- is everything covered by the Affordable Care Act, or aren't there certain policies that are outside of that?

MEDICAID DIR. HELGERSON: I think

that's a question for DFS. But we can follow up.

ASSEMBLYMAN ABINANTI: I hope that you would.

Now, one of the other things when we're talking about Medicaid, you're talking that we have the lowest per-recipient spending in 13 years. Have you done any measurement of the quality of the service that's being provided in exchange for the cutting of the costs?

MEDICAID DIR. HELGERSON: Absolutely. So we monitor the performance in the program very rigorously. We have, in fact, been tracking performance, particularly in our Medicaid managed care products, which is now where the vast majority of our business all lies --

ASSEMBLYMAN ABINANTI: Do we have anything that shows --

MEDICAID DIR. HELGERSON: -- we've been doing that for 20 years.

ASSEMBLYMAN ABINANTI: Do you have some kind of a report or something that we

can look at?

MEDICAID DIR. HELGERSON: Absolutely. We have a report card that we can provide you that, as I say, we can go back almost 20 years to show how performance has trended --

ASSEMBLYMAN ABINANTI: I'm still hearing from parents and others -- anecdotally, again -- that they have great difficulty in finding doctors, especially for kids with special needs, who can deal with their specialty.

MEDICAID DIR. HELGERSON: Sure. I mean, I can't sit here and say that there aren't issues in certain parts of the state relatively to certain subspecialties. I mean, we have challenges, for instance, in child psychiatry that are not unique to Medicaid that are just -- there are not enough child psychiatrists in the state or nationally to meet the demand.

So there definitely are some areas of access problems. But overall, as you look at the overall statistics, I think you would see

as clearly that quality has improved even during a period of the program becoming --

ASSEMBLYMAN ABINANTI: One last question. There's a huge number of kids moving up through the system who have special needs. And we're finding that there are very few doctors who deal with adults who know anything at all about dealing with people with special needs.

Is there anything that your department is doing to get more doctors into the area who are equipped to deal with people with special needs as adults?

COMMISSIONER ZUCKER: So this is an outreach that we have made and continue to make with all of physicians. I mean, this is a special sort of a specialty that is growing, as you've mentioned.

And we continue to reach out to the community on this. And also I think a lot of this also ties to graduate medical education to get those to be more interested and to get engaged in this. It requires an understanding of what the needs are in the

community and also how they partner with others for basically a team approach to this problem. Because it's not just the doctors. I mean, as I was mentioning, we also need more of other healthcare providers -- OT, PT. But it also does involve the physicians as well. So we are doing outreach.

ASSEMBLYMAN ABINANTI: Well, thank you. I just hope that your department looks at this and finds some way to encourage doctors to get into this -- extensive training courses and whatever is necessary to get in there.

COMMISSIONER ZUCKER: I agree. I agree.

ASSEMBLYMAN ABINANTI: Thank you.

COMMISSIONER ZUCKER: Thank you.

CHAIRMAN FARRELL: Thank you.

Senator?

CHAIRWOMAN YOUNG: Thank you very much.

Our next speaker is Senator Persaud. She's left? Okay, then we would go to Senator Ruth Hassell-Thompson.

SENATOR HASSELL-THOMPSON: Thank you, Madam Chair.

Good afternoon. I didn't have an opportunity to hear your presentation, but fortunately I've had the time to sit and read it. And there are a couple of areas that I would really like to ask you to expound on a little bit.

You touch on the Executive's proposal of $200 million to help to end the HIV and AIDS epidemic. But one of the questions I need to pose is how much of that is going to be dedicated to the supportive housing units that have been developed, number one. What is the timeline for that development to occur? And supportive housing presumes that there will be trained staff. And it's almost like a follow-up to what is being said in terms of being trained for these supportive services, not -- we don't have an abundance of people that have the capacity to do that. So how much money is going to be dedicated to that?

And the last part of the question for

this question is how closely are you working with the Department of Labor to do that retraining?

COMMISSIONER ZUCKER: So thank you for the question about the Ending the AIDS Epidemic and all that we're doing.

The Governor has put forth $200 million in the multiyear plan, in addition to the monies we have already allocated for HIV/AIDS, which is $2.5 billion. And part of this is that the issues of HIV/AIDS are more than just the issue of health. There's the social determinants of health and, as you raised, about housing.

I think OTDA would be able to answer that. The monies that have put forth for the state that we are using to tackle this issue have been quite helpful in our efforts to eliminate or to bend the curve on HIV. I would direct your questions regarding the housing, the training that's needed for that issue, to OTDA and also --

SENATOR HASSELL-THOMPSON: I

wouldn't -- I would not preclude the Health Department from that training at all. And I asked the question that way very specifically, because too often the protocols require the Health Department's intervention.

And so if you preclude yourself from making the plan or being a part of that plan, it's going to lack some of the sensitivity that is necessary in order to deal with some of the population.

The supportive housing that you're doing is not just for people with HIV and AIDS, but it's also supportive housing for the homeless and those with mental illness. And so it is the Health Department's responsibility not to say that's OTDA. That is -- I think that's one of the issues that we continue to have, that there is a disconnect from agency to agency in terms of how we sit around the table and determine what the best policy and best practices are when we allow one agency to be responsible when it really should be a combination of agencies.

COMMISSIONER ZUCKER: I hear you. And I am a big believer in going across agencies on all these issues we have. And I'm glad to work with OTDA about that and also with all the other agencies on this.

I know the supportive housing issue was something which we dealt with with Medicaid issues. And Jason, did you want to comment about that?

MEDICAID DIR. HELGERSON: Sure.

So, Senator, what I would say is that as part of Medicaid redesign, dating back to the very beginning, we have made supportive housing a major component of our strategy. In fact, I remember when we were crisscrossing the state in 2011, facing the worst budget deficit in state history and a need to implement cost containment. We heard over and over again from a variety of different people across the entire state about how housing is so clearly tied to better outcomes and ultimately lower costs for so many people in the Medicaid program.

And so out of that came our supportive

housing program, our MRT supportive housing program, which we're spending $100 million a year. That's new money. And up until the Governor's announcement, really the most substantial increase in state funding for supportive housing to come from anywhere in quite a long time came from Medicaid.

We're the only program in the country that operates a program of this type. And in fact, I get more calls about this from other states than I do about almost anything else we do. And so we are fully committed to supportive housing, no question about it.

And I think the question, though, becomes, you know, when you come to workforce questions that you raised and how do you -- so we put more money into it, but how do we know we have the professionals necessary to meet the needs of the people in those settings. And anybody who goes and tours supportive housing sees the magic that happens in those sites and those locations where you have professionals working with those individuals, transforming lives as well

as health.

And I think that one of the exciting things coming out of DSRIP, out of delivery system reform, is that each of those 25 performing provider systems was asked to commit to a specific dollar amount investment in workforce. And that's workforce across the entire spectrum. And when you add up those 25 commitments, that's $450 million of commitment going in over the next five years to workforce. And each of the performing provider systems is developing their plan, but I think you're going to see a lot of non-traditional professionals, people not just doctors and others, but you're going to start seeing community health workers, you're going to start seeing other types of individuals who really are essential to success in those settings. I think there's a broader understanding and appreciation of value that housing has, and I think we just have a collective challenge of how do we make sure that these investments are used as effectively as possible.

SENATOR HASSELL-THOMPSON: Thank you. I appreciate your answer.

The other thing I just want to comment on, you addressed, fortunately, the issue of some of the blockbuster drugs and how we plan to cap those. And I'm specifically concerned about hep C, because everything that I read says that by 2020 we're going to have a cure. But it's not going to be affordable to everybody.

And I've got a deep concern that you've become very aggressive in terms of how we address that and other issues of accessibility, because we know there's going to be availability. So I just wanted to add that piece.

The other concern that I have is that we talk about the Governor's initiative along the lines of breast cancer. And interestingly enough, I just had a whole series of tests, I've been being tested every six to eight months over the last four years because they've seen something. But in the last couple of tests that were done -- all of

these are diagnostic -- they've denied, the insurance company has denied to pay for some of these tests.

And when you are doing everything that you're supposed to do in terms of preventing or early detection and, again, these become unaffordable -- and they're not just -- if they're unaffordable for me, what does that mean for somebody else who certainly has a much more limited income than mine, even though mine is limited?

(Laughter.)

SENATOR HASSELL-THOMPSON: And so I say that, you know, very honestly saying that we're trying to move in the direction where early detection becomes relevant in just secondarily to what we do. And yet if these tests are not being paid for, how do we continue to encourage that kind of participation on the part of patients?

COMMISSIONER ZUCKER: So I hear you on that. And I recognize that we all have been down this path where bills come to us and some of it's not covered.

As we move forward with this initiative, we will look and make sure that we can work with insurance companies and to make sure that things are covered.

At this point, many things are covered. But we have had conversations about what else, how to broaden this. And so I hear your concerns.

SENATOR HASSELL-THOMPSON: Thank you.

And my time is going to run out, but I just want to put this question too on your radar.

The numbers of treatment and prevention programs, I notice that you gave reports from 2015, we still have no new cases of mother-to-child transmission on HIV and AIDS. But I continue to be disturbed at the young age at which new cases of HIV are beginning to occur in communities of color. And we have not yet begun to address that issue.

COMMISSIONER ZUCKER: I hear you. And this is part of the whole initiative to End the Epidemic. We need to tackle this from

all ages, and young, all groups, and particularly those of color. We have been looking at this and I think part of this is education, a large component of things is education.

We are also looking at the issue of ending the epidemic regarding those who are incarcerated, and that's another group. We're looking at those who are over 64 years of age, that's the other end of the spectrum, because at one point we did not -- we lifted the age limit for testing, and we've allowed those over the age of 64 -- to cover for testing for them.

We've looked at some of the issues of needle exchange, which is of note. We are now less than 3 percent of HIV is a result of needle exchange, whereas originally it was over 50 percent. So that has been a big change.

The program, the Governor's initiative with the three-pronged approach, we are moving forward with that. The issues of pre-exposure prophylaxis, we have about a

thousand people that we've pulled into the program that way. And we have pulled about six -- we've had 600 people who are not virally suppressed, we've been able to have them brought back into the program for viral suppression.

So I think we're making great headway on this issue. But I do hear you that the youth are a group that we need to target, and just any -- and the thing I find about children in general, or not even just children but adolescents as well, is it's not just one area, it's the issues of other things we've spoken about. We've spoken about tobacco, we spoke about synthetic cannabinoids, we've spoken about opioids. So I think this is something which is more of a comprehensive thing we have to tackle on both HIV/AIDS and hopefully be able to tackle it for those other areas as well -- even hepatitis C that we've spoken about.

So hopefully as we move forward with our Prevention Agenda, we'll tackle all of it.

SENATOR HASSELL-THOMPSON: Thank you. Thank you.

CHAIRMAN FARRELL: Thank you.

Assemblyman Ra.

ASSEMBLYMAN RA: Thank you, Chairman.

Just a couple of questions. And there's some areas some colleagues asked questions about, but I just wanted to expand on them, one of them being limited-service clinics as proposed in this budget.

I know you mentioned earlier, you know, targeting underserved areas and that type of thing. When these clinics, you know, by whatever retail operation they're going to be are approved -- I know the budget language talks about how they'll be approved and they have to demonstrate this commitment to medically underserved areas. Will that be like a, you know, continuing evaluation? If, say, Company X, who is a commercial pharmacy, comes and says we're going to open whatever, a dozen clinics, and then they go open them and presumably they're going to have to see the same types of issues that maybe other

medical providers might see -- some areas are maybe more profitable, others aren't, trying to strike that balance -- and down the road they decide, you know, they're going to close some of them that might be in some of those underserved areas, how do we ensure that continuing commitment?

COMMISSIONER ZUCKER: Well, as we move forward with the retail clinics, the goal is to make sure that they are in these underserved areas. And in order to -- and also to encourage them to, as I mentioned before, to tie those who come into those clinics back to their primary care doctor and to use the health information system to do that.

Is your concern is that they will not be in those areas? Or is your concern that they will be there and then they'll leave, they'll close in those areas?

ASSEMBLYMAN RA: Well, I think the language here does, you know, provide that avenue that they're going to have to show some type of commitment. And presumably,

specifically they're going to say we are going to open here, here and here, which is great. But my concern I guess is making sure they stay serving those areas and whether or not this model of allowing, you know, the corporate ownership of these practices is the best way to further that, as opposed to how I know some of them have now opened where they're essentially landlords for some doctor's practice.

COMMISSIONER ZUCKER: Well, we will monitor, we will clearly monitor to be sure that they are staying open there. And if they're not, then we'll make our efforts to either -- whatever possible penalties that we can put forth.

ASSEMBLYMAN RA: Okay. Thank you.

And one other area that was touched on before, long-term care. I'm just wondering, we're starting to hear from providers of those type of services -- I mean, we're seeing this all over the medical field. But, you know, a patient comes in, you know, can have whatever, 45 days of Medicare, I think

it is, and then they would go onto Medicaid. And then, you know, the reimbursements and everything else being what they are, I guess that creates somewhat of a struggle for that facility to serve that patient.

Is there anything being looked at in that regard to, you know, find ways to ensure that these facilities can survive in this climate?

MEDICAID DIR. HELGERSON: Right. So in terms of particularly -- with regards to reimbursement rates, I mean obviously we are always looking to make sure that reimbursement rates are sufficient.

Most of these services now are provided through managed care. Managed care organizations have to be able to prove on a very regular basis, usually on a quarterly basis, that their network meets their network adequacy requirements. And if that means they have to pay above what our normal Medicaid fee-for-service rate is in order to maintain access in certain communities, they are required to do so.

And we do know that the managed care organizations do pay above fee-for-service in a variety of different settings across the state. So we have a mechanism in place that basically helps ensure that the access is sufficient.

That said, we are going through a period of transition in long-term care, both the transition to managed care, particularly upstate, which is now happening. It was accomplished already in the downstate region. We've also had in the downstate region, though, the implementation of wage parity, which has created some adjustments and some challenges.

And then also I think what you're also seeing is if you're thinking more about the nursing homes, we're going through a process of transition with them around the change from medicine's cost-based reimbursement to acuity-based rates, which is a multiyear phase-in. But the good news is that we're basically -- we've been negotiating for I think four years the universal settlement

agreement, which is a way for us to free up dollars otherwise spent on litigation and appeals, and free those dollars up to provide enhanced reimbursement to the nursing homes in a more direct fashion. That helps facilitate a quicker move to acuity-based pricing.

We had a very inequitable system of finance for a long time, and we're moving in the right direction.

So I think, you know, there are lots of things going on in long-term-care reimbursement. But, you know, I think that things will hopefully, particularly on the nursing home side with this settlement, start to calm down a bit here in the near future.

ASSEMBLYMAN RA: Thank you.

CHAIRMAN FARRELL: Thank you.

Senator?

CHAIRWOMAN YOUNG: Thank you.

Senator Kathy Marchione, please.

SENATOR MARCHIONE: Thank you.

I've noticed in the Executive proposal that there are 300 new full-time employees

associated with the phased-in takeover of the local administration of Medicaid. Can you tell me how you envision that takeover to occur, how long it will take to phase in, and are there dollar savings expected for local government?

MEDICAID DIR. HELGERSON: So certainly. So we began back in either 2011, 2012 -- I think it was 2011 -- the state takeover of Medicaid administration. It was tied directly to the implementation of New York State of Health, the health insurance exchange. It was tied to that because that gave us the system capacity to do it. Prior to that, there had been some small sort of incremental steps in particularly taking over some renewal responsibilities from counties. But with the launch of the exchange back in October of 2013, with new coverage being available January 1st of '14, the move to state takeover was launched in a robust fashion.

Dr. Zucker gave you the stats earlier -- 2.7 million people have used the

exchange. The vast majority of those people are on Medicaid. We're about getting to the point now for what's considered the -- what's called the MAGI population, or it's the modified adjusted gross income portion of the population, which is the vast majority of people who are on the program. They have a simpler definition of income. These are people who don't receive long-term-care services, so they don't have asset tests and things like that. But we're fast approaching I think it's around 50 percent of that population is now with us at the central exchange. The remaining population will continue to migrate in the years to come.

It's a six-year phase-in, so this is not a small change in the state/local government relationship. And we do believe that at the end of the day the overall system of Medicaid administration will be cheaper.

To give you a sense, before we began the state takeover, the cost on an annual basis of just administering this program at the county level was about a billion dollars

a year. So we definitely think at the end of the day this will be a more cost-effective system.

We have some important steps to occur, particularly with some further system upgrades to allow us to take on additional populations. But we think at the end of the day, after the phase-in is complete, we'll have a more cost-effective way for administering the Medicaid program.

SENATOR MARCHIONE: And do you have -- and maybe you said it and I missed it. But do you have an understanding of when the full phase-in will take place? When will it end, in what time?

MEDICAID DIR. HELGERSON: So I think we have probably, I'd say -- there's some uncertainties, but I would say probably another three, three and a half, at the most four years before it's complete.

SENATOR MARCHIONE: Okay. I also have a couple of questions relative to the breast and prostate cancer awareness campaign.

The Executive proposes a five-year,

$91 million statewide campaign to increase awareness in rates on breast cancer screening and prostate cancer, but only $5 million in appropriation authority is identified for this purpose in the Executive Budget. Which settlement funds will be used to provide additional funding for the campaign? And where can funding be found in the Executive Budget?

COMMISSIONER ZUCKER: So there was a settlement that was done prior to my time in government with -- that was an Ingenix settlement that's being involved with -- that HRI has managed on that.

SENATOR MARCHIONE: And where in the budget?

COMMISSIONER ZUCKER: Well, there's money from the legal settlement that we will be able to use those monies for the breast cancer.

SENATOR MARCHIONE: And the proposal includes a multi-million-dollar media campaign. What actions will be taken to ensure that women ages 50 to 74 -- I know

they're high-risk populations -- are targeted in this campaign?

COMMISSIONER ZUCKER: So as we move forward with this campaign, we will target all groups, all age groups. I think that we -- you know, this is a new program and we will work with all of our team to figure out the most effective way to reach all different age groups, and also relatives and friends of those who need to be screened.

There's also, as I mentioned, there's also an issue of peer educators also as part of the program, which will help reach those who are harder to reach just from a straightforward campaign. And we also have those who will help facilitate this, so that if somebody comes into the system and they're not able to navigate through that -- which is not that uncommon when you get into the healthcare system, particularly if you don't feel well -- that will help them also to get them into the system as well.

And then obviously, as part of the campaign, if we have these mammography vans,

we want to make sure that people are aware that they're there, and that's part of the campaign as well.

SENATOR MARCHIONE: And what components of the plan are linked to prostate cancer awareness? Do you know that?

COMMISSIONER ZUCKER: So we will reach out for -- also as part of the advertising campaign -- or not advertising, but a public awareness campaign, I should say, on this for prostate cancer awareness as we move forward on this. I will get back to you about exactly how much and how we'll divide up the money on it.

SENATOR MARCHIONE: And just one other question. And we've been talking a lot about doctors and retaining them here in New York State. And I can tell you personally, two out of three of my doctors, when they know what you do, you know, and they know I'm a Senator, talk about healthcare when I go in to see them. Two of them are counting the years before they can leave New York State. I think that speaks very poorly for us in

New York State.

What's the department doing to retain primary care physicians in New York?

COMMISSIONER ZUCKER: So there's different parts of this. We do have the Doctors Across New York program. That's part of it. But I think this is a comprehensive -- we have to take a comprehensive approach to this.

To get primary care doctors into areas, we're looking at how do you bring them to different parts of the state, particularly areas upstate where they may not be as quick to go just because it's an environment that they're not as familiar with if they were trained, let's say, downstate.

But we are working with schools. In order to get physicians, primary care physicians, into some of the areas, they have to be more familiar with the area. And if we can have them spend time, two, three months during residency -- or even prior to that, medical school -- but definitely during the residency program, they start to be more

familiar with the community, they may be more apt to stay.

And all the studies have shown that once someone is there for a while and they start to develop a practice there, much more feel a part of the community, they will stay there. And I think that that's one part of this.

I think there's also the whole issue of just how do we provide care. It's not just primary care doctors, but it's also nurse practitioners, it's also all of the other members of the health system which we need to target. And I think that that's something which we need to move forward on as well. In some parts of the state it may be the nurse practitioner who you're going to see on a more regular basis.

But I hear you that the doctors do leave, and I hear it not just from the role that -- the place I sit today, but I hear it from my own colleagues who I worked with for many decades as well. So I recognize that.

SENATOR MARCHIONE: Yeah, it's a -- I

think a very serious concern. And I can tell you that the doctors I'm speaking of are doctors who were brought up here, who have lived here their lives and have had their practices here, and they're the ones who are telling me, you know, 13 years and I'm gone.

So they're spending their time that they need to. But thank you for making sure we continue to look at that, because I think it's very serious in New York State. Maybe elsewhere, but definitely in our state.

COMMISSIONER ZUCKER: I think it's a big issue. We will continue to work and work with you on that.

SENATOR MARCHIONE: Thank you.

CHAIRMAN FARRELL: Thank you.

Assemblyman Cahill.

ASSEMBLYMAN CAHILL: Thank you, Mr. Chairman and Madam Chairman.

Thank you very much, Commissioner, Dr. Zucker. I'm not going to ask my questions now, in the interests of time, but I would like to ask you to commit to answering written questions in a timely

fashion on a couple of different subjects. I'll tell you now what they are.

COMMISSIONER ZUCKER: Sure.

ASSEMBLYMAN CAHILL: We want to talk about health exchange funding. We want to talk about Early Intervention, some of the matters touched on by my colleague earlier. The impact on the healthcare community of some of the proposed changes to the Excess Medical Malpractice Insurance program. And a couple more questions regarding the Medicaid retail clinics. And finally some -- just some heads-up or some up-to-date information on capital and program resources available to our community hospitals.

If it would be okay, if you would just make a commitment to a timely response to those, I'm certain we can avoid delaying this hearing any longer today.

COMMISSIONER ZUCKER: We will get you written responses to that expeditiously.

ASSEMBLYMAN CAHILL: Terrific. Thank you.

And, Mr. Chairman, I also would join

my colleagues who expressed some disappointment at the failure of the Department of Financial Services to attend this hearing.

I understand the superintendent was just nominated last week and it may very well be difficult for that individual to feel adequately prepared to attend today, but I would hope that at some future Ways and Means hearing between now and the end of this cycle that the Department of Financial Services be requested one more time to attend. There are numerous questions that need to be asked of these individuals who are responsible for a departmental budget in excess of $350 million and the fiscally most important industry, industries in the State of New York.

So I thank you, and I give back the rest of my time.

CHAIRMAN FARRELL: Thank you.

Senator?

CHAIRWOMAN YOUNG: Thank you very much.

Next would be Senator Liz Krueger.

SENATOR KRUEGER: Good afternoon, gentlemen. I'm going to try to be quick. I know you've had almost endless questions.

So probably my big one is there have been so many questions about different parts of DOH and Medicaid redesign and where we are and where we are trying to go.

Is there the equivalent of a management report -- in New York City we call it the mayor's management report. And basically it determines sort of through a list form, almost, all the different projects or big projects any given agency is working on, expectations, and then where we actually land on an actual basis.

Is there an equivalent? I mean, I know with Medicaid redesign I gave up after the 400th proposal. I used to joke there was a team working on every one of them, and I know we didn't really get all of them through.

SENATOR HANNON: There was.

SENATOR KRUEGER: There was. There really were, thank you. You heard it here.

(Laughter.)

SENATOR KRUEGER: So is there some kind of like master updating report that you both keep so that it would help us understand, you know, this has been more successful than we imagined, this hasn't been successful at all, this we're behind on, this we're still waiting to get started on? I'm curious whether there's something like that that you actually have you can make available to us.

MEDICAID DIR. HELGERSON: So at least I'd answer in terms of -- I mean, obviously the report that Senator Hannon referred to is our annual report for the Department of Health, and that provides a summary level of initiatives that cut across the entire agency.

Within Medicaid redesign, we have our project management work papers that summarize the status of all of our projects, all of the ones that have yet to be fully implemented, and that's available on the website. So you can see -- and we update those on a monthly

basis -- you can see the current status of every single one of the MRT initiatives. And this is the sixth phase of MRT, so there's -- each of the phases has its own plan and you see where we are with each of those projects.

And that's been an important tenet of Medicaid redesign from the beginning, was to be very transparent about -- I think one of the first things we heard, whether it was Assemblyman Gottfried or Senator Hannon, when we started in MRT, was that that was a feeling about the Health Department, was that a budget would pass and initiatives would be included and then the question is, well, how is the department doing in implementing it. And we were very sensitive to that and have tried to be very transparent in terms of how we're implementing.

COMMISSIONER ZUCKER: And regarding other parts of the department, yes, we keep a close tab on this, we -- obviously regularly, and I keep a tab on all of the different major projects that are moving forward.

The deputy commissioners also have --

know the major items that we are tackling, and we are kept up-to-date -- or I'm kept up-to-date on that regularly, probably every other week.

SENATOR KRUEGER: And that's also on a website, as the MRT --

COMMISSIONER ZUCKER: On the website we have -- the major programs we do have on the website. And any new changes in those programs, particularly the ones that are very active at this point in time, are put onto the website. If there are areas of some of those programs where there may be additional concerns, then we do usually put out a "frequently asked questions" on that topic because I realize that otherwise that we're going to have a lot of calls about that anyway, so I thought that's the effective way of doing that.

SENATOR KRUEGER: And going back to the MRTs, where it's online -- because I haven't had a chance to take a look, and I will -- does it actually break down, you know, we expected we would save X amount of

money by doing this, we expected we would have better health outcomes for this subpopulation, and actually does that level of evaluation of where we are?

MEDICAID DIR. HELGERSON: So what we do is for -- particularly for the ones for which there is a fiscal implication, so that it requires -- you know, you can look at claims data, counter data -- we have within Salient, which is the system that we use, a New York company, that's a data mining tool, we have established what are called bookmarks that you can actually go into this tool and you can literally -- and the data is refreshed every week, so you can actually go in and see how these initiatives are doing.

So we report out, usually I think on a quarterly basis, how we're doing on each of the initiatives dating back to the beginning of MRT.

We also provide the Legislature with a detailed report of all of those initiatives and what the savings estimates are in an updated fashion.

So we do -- and we go back and look at those initiatives, even things that we implemented, you know, four years ago, to see how they're doing. It was relative to the question that was asked about how we're doing relatively to the carve-in of the drug benefit, which is a big question because that's one of the bigger ones. So we do do that.

The document that is on the website at the moment is the project implementation plan. So it shows all of the key steps, milestones for each and every project. And what you can see is that it tracks the times and dates of each milestone being implemented, so you can go back and see how many times the schedule was adjusted or things were delayed. And so you can see full well when each of those steps was implemented. It gives you a flavor to the degree to which it was implemented on time.

SENATOR KRUEGER: Thank you.

We are, particularly when it comes to insurance and Medicaid, and I think any

number of other issues in health, we simply can function or not function based on what the federal government does for us or to us. If I were to say what are the three most important things the federal government could do to help you with your mission, what would those three things be?

COMMISSIONER ZUCKER: Well, one, always resources.

MEDICAID DIR. HELGERSON: I was going to say, more money?

COMMISSIONER ZUCKER: More money is always a good one.

Collaboration on some of the projects that we are moving forward on would be helpful. And we do get that at least on some of the public health issues with CDC. So those are two big ones.

And to hear our concerns about specific areas or -- when we reach out to the federal government on particular areas, sometimes we don't hear back from them as frequently as we would like to.

SENATOR KRUEGER: We have a number of

outstanding waivers we're still waiting to hear from them on. Any expectation of hearing something --

MEDICAID DIR. HELGERSON: Sure. So we have a lot of irons in the fire with the federal government at any given time with regards to the New York Medicaid program. I bet right now somewhere -- we probably have, between state plan amendments and waiver amendments, probably somewhere in the range of 120, 130 requests pending with the federal government.

And I think one of the challenges we have is dealing with the CMS system and their ability, from a resource standpoint, to sort of keep up with the rate of change.

One of the more challenging things has been, for our Medicaid managed care plans, the federal government made a decision about a year and a half ago to begin sending all of our Medicaid managed care rate updates, rate packages, through their Office of the Actuary, an office that was built simply to assist the Medicare program, never for the

roughly 46, 47 states that operate Medicaid managed care plans, to also review all of our rate packages, of which we have multiple ones in any given year. And so that has been a challenge trying to get that approved.

But, you know, to a great extent, I mean, I think our relations with CMS relative to Medicaid are in a better position relative to the OPWDD challenges. That was a low point in our relationship. But I think things have improved lately, and so they're trying hard. I think part of their problem is just a lack of resources, particularly resources with the right subject knowledge in some of these areas.

So there still is a bunch of things that are still pending with the federal government, and I think it's just one of those things we just collectively struggle with on a day in, day out basis.

SENATOR KRUEGER: Thank you. Thank you.

CHAIRWOMAN YOUNG: Thank you, Senator.

Assemblyman?

CHAIRMAN FARRELL: Thank you.

Assemblyman Goodell.

ASSEMBLYMAN GOODELL: Thank you.

Thank you, Commissioner, and you as well, for being here.

The Governor proposed a 15 percent cap on outside income for all legislators, even though there's currently state law that prohibits any outside employment that would conflict with our legislative duties.

My question to you is three parts. First, what are you paid as the board president for Health Research, Inc.? What are you paid total in outside income? And do you believe there should be a 15 percent cap on all outside income for executive branch employees?

COMMISSIONER ZUCKER: So I -- on the HRI, that amount is -- I have to take a look back. It's probably about 50 or 60,000 on that.

And I sit on one board outside.

And that -- and I can't answer your question on what I think, because I haven't

looked at the data close enough on that.

ASSEMBLYMAN GOODELL: We've been asked from time to time to pass legislation on minimum staffing levels for nurses and nursing homes and hospitals, and we're told that the staffing ratios are too low now. Do you believe that the staffing ratios for nurses are too low? And is there any funding in this budget to increase funding for nursing homes or hospitals to address that?

COMMISSIONER ZUCKER: So I think the question about nursing in general, there's two parts. There's nursing homes and there's nurses in the hospitals, in general and staffing ratios.

I think the issue of staffing ratios, the bigger issue is really, in general, how do we provide care to patients who are in the hospitals. Not -- not all care necessarily will require the level of skill of a nurse, and that's why we've been looking at other -- those who can assist nurses as well. I think this is a challenge that we have been faced with for a period of time.

I think that we are moving forward with looking at also, in nursing homes in general, what kind of aides. And then there's also the issue of home care and nurses. So we have been looking at how can we get aides who work in homes to provide some of the services that nurses were doing, including injections or medicines that would probably keep that person at home rather than have them have to go into a nursing home or into some kind of other assistive care facility.

So I think that this issue of nurses in general is a little bit more of a -- a little more complex than we would mention.

ASSEMBLYMAN GOODELL: And I take it there's no specific funding allocation in this budget to address any of those issues?

COMMISSIONER ZUCKER: Well, we did -- I can't comment specifically on the nursing ratio, but I could look back into that. But, you know, the budget addresses a lot of these issues in just general in provided care, not just the -- you know, I don't think we should

just turn to the one part for nurses because there's so much else involved in the health delivery system in general.

ASSEMBLYMAN GOODELL: I had a few questions on the health exchange.

When the Legislature first approved this, we were told a couple of things. One was that it would be self-sufficient. And secondly, that it was necessary, in order to qualify for federal financial support. Of course, the second characteristic of the federal financial support, the Supreme Court said it didn't matter whether you had a state exchange or a federal exchange.

This budget, as I understand it, includes $58.7 million specifically for the exchange, an additional $229 million, I think, that relates to the Medicaid portion. And I believe you said the overall cost for the exchange right now, including the Medicaid side, is in the range of $575 million.

My question is if we eliminated the state exchange and let the federal government

pick it up, would we be saving in the range of a half-billion or would we still be incurring a significant portion of those costs?

MEDICAID DIR. HELGERSON: I mean, the significant portion of the cost is associated with Medicaid. And at the end of the day, the IT system that was built to facilitate the implementation of the Affordable Care Act actually is used more by Medicaid recipients than it is by individuals who are qualifying for the qualified health plans through the exchange, the commercial insurance.

So if we were to simply hand the responsibility of the exchange back to the federal government, then we would face a choice of do we hand the responsibility of Medicaid eligibility back to the local units of government. And our view is to do so would increase the total cost for Medicaid administration for taxpayers and do it in an environment where the new system we have, the eligibility system we have that we built for the exchange, processes those applications in

a much more timely and efficient fashion than the system that the counties historically have struggled with, which is the WMS system, which I think is around 45 years old. So any computer system 45 years old has its challenges.

So I think at the end of the day, even if the state were to decide that it no longer made sense to operate the exchange, quote, unquote, it still would be in the state taxpayers' best interest to continue to move forward with the implementation of state takeover, which is in essence really, to a great extent, mandate relief for local units of government and I think at the end of the day creates a much more patient-friendly way to access the programs.

ASSEMBLYMAN GOODELL: I see that we've included a $43.2 million increase in the budget to provide financial assistance for individuals who are in the exchange with an income between 138 and 200 percent of poverty, if I'm correct.

My concern is that when you cross the

threshold and you earn a dollar more than 200 percent, then at that point all your copays and your deductibles jump; right?

MEDICAID DIR. HELGERSON: So I think what you're referring to is the state share of the -- or portion of the state share for what's called the Essential Plan.

ASSEMBLYMAN GOODELL: Yes.

MEDICAID DIR. HELGERSON: And so this is previously known as the Basic Health Plan, under federal law, but renamed the Essential Plan here in New York. But this is a product really targeted for two populations. One is the individuals who have incomes between 138 and 200 percent of federal poverty. And then also, as I've mentioned, also targets those immigrants who are here legally in the State of New York but are nonqualifying for Medicaid who are switching from state-only Medicaid to the Essential Plan. Those are the individuals -- roughly half of the people are that immigrant group, the other half are those individuals with 138 to 200 percent of federal poverty.

So the vast majority of the cost for those individuals is picked up by the federal government. And that's a very cost-effective program, very low cost sharing.

But, you know, in the sense of if you now go over 200 percent and now where you are -- you're either one of two place's insurance. You're either on the exchange choosing one of these qualified health plans, or you are in a commercial product, probably through your employer, where the cost sharing can vary.

I can say that in the case of the exchange you still have mechanisms in place for those 200 percent up to 400 percent to have pretty substantial tax credits to cap your premiums as a percent of your total income. And there's other mechanisms for offsetting cost sharing. But there is what's a bit of a cliff effect, meaning that individuals who go a dollar above do see an increase, but not as much of an increase as you would have experienced prior to the Affordable Care Act.

But I think there is always that issue of how you have it so that it's a reasonable increase as people's income rises. We're very hopeful the Essential Plan actually -- one of the populations of the Affordable Care Act most challenged was those with that income, between 138 and 200. Even with substantial tax credits, still far too many of those folks finding it unaffordable. The Essential Plan makes it more affordable.

ASSEMBLYMAN GOODELL: I am very concerned because, as you can appreciate, when you cross that threshold you lose eligibility for childcare, you lose eligibility for this particular program, the essential care program. The increase makes it almost impossible for many people to accept a raise or, you know, move out of that category.

So I'm very interested in your ideas on how we can address that fiscal cliff, if you will.

MEDICAID DIR. HELGERSON: Sure. And the way you're thinking about it is a good

one in the sense that individuals, families in these circumstances, they're looking at it from a holistic standpoint, not just a program-specific standpoint, which we tend to, in government, look at it just from the programs that we administer.

And I think the issue is that -- but what I can say is the Affordable Care Act made the situation far better in the sense that it used to be that the minute you were no longer income eligible for Medicaid, it was about as steep of a cliff as one could imagine, because insurance in the individual market, health insurance, commercial insurance, was almost completely unaffordable. Very few people were buying it. And so unless you had something through your employer, you would simply go without.

And so the ACA has made that -- you know, resolved that issue to a great extent. But if you dive in deeper and look at the interplay between the programs, I'm sure you'll still see some cliffs that I think none of us would like to see.

ASSEMBLYMAN GOODELL: Thank you.

CHAIRMAN FARRELL: Thank you.

Senator?

CHAIRWOMAN YOUNG: Thank you, Assemblyman Goodell.

The next speaker is Senator Kemp Hannon.

SENATOR HANNON: Thank you for hanging in there.

I was thinking, as I'm looking at you as individuals testifying and the experts behind you, part of the problem we have in trying to get decent health policy is that we now have to negotiate, as a Finance Committee and as a Ways and Means Committee, with the Budget Office. Which nowhere near has the understanding or comprehension as to what actually occurs when you try to put these things in the field.

But I want to just focus on the big numbers. I talked about it before, the capital restructuring program, $1.2 billion that we have not allocated. Brooklyn, $700 million. Oneida, even repurposed,

$300 million, with the 195 now going scattered to the winds. Transitional funding, behavioral health: $10 million unallocated. Essential healthcare provider monies: $355 million unallocated.

And then we have had a fair amount of money in base VAP, behavioral health VAP, VAPAP, VBP QIP -- we could have Jeopardy games based on what you know in these things. And we also happen to have an ongoing DASNY restructuring fund that's replenished to the tune of $19 million a year.

My whole point is, where are we going with this? What is our vision for this? What is the direction? What will the healthcare system look like when we finish with DSRIP?

I was very dismayed to get an invitation to go to a Healthcare Vision in New York invitation for February 9th, but it's put on by United Health and the Health Foundation, not by the State of New York. Not by the department. Who's doing our visioning? That's the problem.

There's been a lot of very good people in your department who really try to help when there are hospitals in need, and they are in need. I talked about the 60-plus that are over the number of days we count to have cash on hand. They still need a structure to go through. And so much of it is still related to Brooklyn. I'm concerned about it as much as anybody because, if that doesn't succeed, the rest of the healthcare system doesn't succeed.

I think a couple of months ago, Mr. Helgerson, you were on stage and someone was challenging what you were doing, and you were talking about $100 million a month towards healthcare in eastern Brooklyn. I think that was -- I'm not making that up, it was a pretty big meeting of hundreds of people.

We need to resolve this. We need to be on a path, because we can't keep doing it. How much are we propping up? And even some of the things we're doing upstate, we're propping people up in the little hospitals.

Very significant, $4 million or $5 million. I think people in those regions would be surprised it goes to be that much.

So the other part of it is the vision, supportive housing -- it's been there with MRT, it's actually grown. I think there's $250 million someplace in the budget -- and I don't know if it's in the Health budget. It might be in DHCR.

But how is that directly related to healthcare? How is it indirectly related to healthcare? Are there going to be qualifications? Are there going to be tests so that we can avoid readmissions by the people we put in the supportive housing? I don't know that there's been enough thought to all of that. Not easy. I once chaired the Housing Committee, it's a -- it's actually more complicated than health.

A couple of just things as I finish. Naloxone. We've given you the power, Commissioner, to do a standing order. It's not been issued. The commissioner of health for New York City has issued a standing

order. It's available in New York City. I see the other day that CVS says they'll make it available. I presume you gave CVS a standing order.

I would urge two things: One, you issue the standing order, and second, we begin a program to have interventions so the kids who get revived two or three times, we have something to go after them saying, We want to talk to you, we don't want you just to go home, we want to have referral, we want to -- something that has to be saying to them, No, you can't go on forever. Because the history is after a few revivals, they die. And we don't want that to happen.

So I urge you about the standing order.

Transplants, I must have talked myself blue in the face, to you and many members of the administration. That organization that won the RFP still does not have a contract. I would ask for -- let's find out where it is. Did it leave DOH legal?

COMMISSIONER ZUCKER: It did.

SENATOR HANNON: Is it at AG or OSC? Let's nail it down and talk to them further.

The last time I have to say is given the lack of DFS here, and given the major amount of implications, its failures, its nonachievements have resulted -- and I'm asking, maybe are you willing to take on regulation of these health plans? Maybe that's what we ought to do and move it from DFS. I mean, you regulate some health plans as it is, the Medicaid managed care plans, so it's not as if this is a new talent you'd have to employ. And maybe we can get it done a lot more efficiently.

Because at the end of the day, the health of the health plans like Health Republic and the rest of the exchange, and the health plans who are participating in Medicaid managed care, and the rest of the health plans who are doing commercial health, is very essential to the whole healthcare system. And unless we get this brought a vision also, we're not going to be doing a good service to the people of New York State.

I thank you for your patience.

COMMISSIONER ZUCKER: Thank you.

Let me respond to a couple of the targeted issues and then the bigger picture.

With regards to the organ donation, that has left DOH. It's with the Office of the State Comptroller, so it's at OSC.

Regarding the regulation of health plans, I think there's a bigger question as to where we should be going on that and perhaps, maybe as we move forward and see what happens with DFS's investigation, we can address that at that point in time.

We do have -- 500 CVS pharmacies have signed on with the naloxone issue. In addition to that, Duane Reade and some of the other pharmacies also have partnered with us to work on that. And also independent pharmacies -- there are about 1700, I guess, 1600 -- 1600 independent pharmacies. And we have been working with them as well on this issue. And also, as I mentioned earlier, the possibility of having those pharmacists administer naloxone.

But I do hear the concern about if someone goes in, as the Senator mentioned, and they come back out and then they go back into the system, how do we target that?

The housing issue, I'll turn to Jason in a second. But in the bigger picture of where are we going, I hear you, but this is a complex issue of -- there's a lot of moving parts on this. There are issues of everything from the hospitals and transition from hospitals into outpatient care. There are issues of support for the hospitals, particularly -- whether it's in urban areas or rural areas, there's a lot of challenged facilities out there. And I think part of this is a result of the fact that we are moving from hospital-centric kind of care to an outpatient kind of care, and with that comes a lot of challenges that we face.

We are moving from a state where there have been one in 20 people over 65 to a state that's one in 7. So that brings up the whole issues of long-term care, rehab medicine -- even though rehab medicine could be in those

younger, but it's something that we have to address -- and nursing homes. So that is another area.

And so we have to step back. And as Senator Krueger said, you know, when you asked me like, sort of, are you looking at these things -- yeah, we do. We sit back and we've looked at them. We actually had a retreat to sort of address this: Where are we going as a state? How are we going to make healthcare better for everyone? And in a lot of ways this is where I feel that this is what it is to be in public service, to do what you can to help improve the lives of those in the state.

And you raised a lot of issues here, and they all overlap. And that's the challenge, is that these are not in isolation. And as the Assemblyman and the Senator said earlier about not working across agencies, it is important to work across agencies and also important for us to work within our agency on these issues.

I recognize that this is a big

challenge, and I do recognize that that is a lot of money going out there. The challenge here is that this is an investment we have to put in there, because if you just keep putting little -- filling up little holes, then you can just continue to fill up little holes. And so I think somebody's going to have to just make the big investment. That's what we're looking at. That's what the Governor has asked us to do, is just sort of fix it all and make the system better. And it does require a lot of collaboration and challenges.

But as you know, the Chinese word for like "crisis" and "opportunity" are the same. And I guess Assemblyman Gottfried's not here, but I know he's excellent on Chinese characters. But the thing is, that's where we're at. We're at an issue of -- you know, there are crises there, but there are great opportunities. And I think that we will be able to move this forward.

And I do believe that five years from now we're going to look back and say, we have

fixed the system. There was a lot of changes that had to be made, and there was a lot of tough decisions and a lot of unsettling situations, but I think that we'll look back and we'll be pleased about that.

DSRIP is an example of where we're going, and Jason has been -- you know, has shown me some of the targets of where we've gotten. And I think that will move things forward too. We're also -- as you mentioned, a value-based payment system is something which is really new and novel, and as a result of that there's a lot of changes that take place. But I am confident that we will get there and that all New Yorkers will be better for that in the long run.

But I hear you and I recognize that there's a lot of money involved in this.

But, Jason, do you want to talk about the housing?

MEDICAID DIR. HELGERSON: Just on the housing, you know, we've been operating the supportive housing program in MRT for -- this is going to be our fourth year. I mean,

we have a very strict definition of what our money can be used for, in the sense of it can be used for capital, it can be used for operational subsidy, it can be used for rent. However, what we say is that in order for a project to receive any funding through MRT, they have to specifically target high-needs Medicaid members, meaning individuals who meet, in essence, the health home definition of eligibility, in order for -- and so whatever the project is, whether it's a new building, whether it's rental subsidies, it has to meet those definitions.

So we stuck to that, and -- but, you know, we don't -- we're not housing experts. We rely on the other state and local agencies across the state to assist us in terms of making sure our dollars are the most effectively used possible. But we have a very clear definition of who we use those funds for.

And what we're also doing is in the midst of a very detailed evaluation, where we're going to track the results of each and

every individual who has a Medicaid program who benefits from our housing. And the reason we're doing that is because we believe at the end of the day it will show that we generate net savings. And we want that data so we can prove to the federal government that's exactly what we're doing, and to hopefully get them to agree to match our $100 million a year investment so we can turn it into $200 million.

SENATOR HANNON: And I'd like access to your bookmarks for Salient, okay?

MEDICAID DIR. HELGERSON: Sounds good.

CHAIRMAN FARRELL: Thank you, Senator.

To close, Assemblyman Walter.

ASSEMBLYMAN WALTER: Lucky me. No, lucky you guys.

(Laughter.)

ASSEMBLYMAN WALTER: All right, so a couple of things. The Medical Marijuana Program, how are we doing? Have you consistent growth in certified doctors and patients? Do we have any anticipated revenue in the budget, of what level? And then is

there anything planned in the budget or going forward to address those who can't afford to access the program?

COMMISSIONER ZUCKER: So I am very pleased with how the program is going. It is the first to mention that we had 18 months to do this. It was the fastest that any medical marijuana program came on board. We started in the beginning of January, January 7th the dispensaries opened. By the end of this week, we'll have probably about 16 of the dispensaries, close to the 20 that we had promised by the end of January. We have over 350 patients enrolled, we have close to 300 doctors enrolled. And that was, you know, last week, so there may be more as the numbers come in.

We've reached out to all the physicians in the state about this. And regarding also for those who can't afford, we have looked at ways -- and this works with the dispensaries -- of whether there are ways to help to subsidize those who cannot afford this.

I think that our program is moving forward nicely, and I'm optimistic to see where it is. I will gladly fill you in as we move forward and give reports back to the Legislature on that.

ASSEMBLYMAN WALTER: Is there anything in the budget that you've anticipated as far as revenue, do you know --

COMMISSIONER ZUCKER: Well, we had money that was put in originally, and I'm not sure where we are on the additional funds for that.

ASSEMBLYMAN WALTER: Okay. A couple of other topics here.

Can you clarify which settlement funds will be used for breast cancer? And are these funds already announced, or is it new settlement money?

COMMISSIONER ZUCKER: So the settlement fund was from Ingenix, and I'd have to get you more details about that.

ASSEMBLYMAN WALTER: Okay. Then finally, the Governor's office agreed to include the requirement that DOH establish a

clinical advisory council with expertise in individuals with disabilities in the 2014-2015 budget, but DOH hasn't convened this, says the budget language doesn't require them to.

With all of the DOH Medicaid changes, including moving to managed care, and decisions made by DOH, without consulting with OPWDD, that have negatively impacted those with developmental disabilities, with any disabilities, would it be a good idea to convene this advisory council to assist and educate DOH staff on the impact to people with disabilities?

MEDICAID DIR. HELGERSON: So in terms of -- it's been a tumultuous couple of years for providers in the OPWDD system, driven to a great extent based on some of the fallout from the financial issues we've had with the federal government relative to the historic ways in which providers were paid and the CMS mandate that that methodology change.

And so we worked very closely with our colleagues at OPWDD as well as with affected

providers and the other stakeholders to help work through the issues. I know that's created a lot of angst, particularly amongst the providers within that system. And in my perfect world, we would not have spent the last 18 months to two years, it seems, working on these what are really fee-for-service changes and rather really use this as a time to prepare for the real future, which is managed care, which is value-based payment, which is really trying to give providers more flexibility in terms of how they provide services to this complex population.

But we've been sort of stuck because of CMS requirements to negotiate and work to implement this new fee-for-service rate structure.

So -- but what I would say is that we have been in regular contact and consulted on a very regular basis with affected stakeholders in all of this. I hear you about that task force, and in fact maybe we can go back and look into that and see what

we can do. But I definitely feel like we have been engaged with the affected parties, and understanding that it's created challenges, no question about it.

ASSEMBLYMAN WALTER: Well, I mean if there's an existing advisory board that's there that was promised in the budget language, it would make sense, then, that you would follow through through that process.

MEDICAID DIR. HELGERSON: Right. I mean, the challenge here is that Kerry Delaney has an advisory group, we have had an advisory group, so there's multiple groups here. But I agree with you, we can look at that language again and see the extent to which maybe we can consolidate some of those efforts under that one group.

ASSEMBLYMAN WALTER: Thank you.

CHAIRMAN FARRELL: Thank you very much.

Senator?

CHAIRWOMAN YOUNG: Thank you. I want to thank Commissioner Zucker and Director Helgerson. It's been four hours and 12

minutes of testimony, and I think what that means is that you are among the most popular, sought after individuals in New York State government.

(Laughter.)

CHAIRWOMAN YOUNG: So congratulations on that, and look forward to continuing to work with both of you.

COMMISSIONER ZUCKER: Thank you very much.

CHAIRMAN FARRELL: Thank you very much.

CHAIRWOMAN YOUNG: Thank you.

CHAIRMAN FARRELL: (Inaudible.)

(Laughter.)

(Pause.)

CHAIRMAN FARRELL: New York State Office of the Medicaid Inspector General, Dennis Rosen, inspector general.

MEDICAID IG ROSEN: Good afternoon, Chairman Farrell, Chairwoman Young, and Senator Hannon is probably here somewhere. I appreciate the opportunity to discuss the activities and initiatives of the Office of

the Medicaid Inspector General as they relate to the 2016-2017 Executive Budget.

OMIG is nationally recognized for its commitment to protecting the integrity of New York State's Medicaid program. It has done so through its investigative work and partnerships with other law enforcement agencies, innovative auditing techniques, and proactive outreach and compliance initiatives, all of which have resulted in billions of dollars in cash recoveries and cost savings. As such, OMIG plays a vital role in ensuring that Medicaid recipients throughout the state have access to New York's high-quality, cost-effective healthcare delivery system.

OMIG pursues recoveries where overpayments have been made. Even more important, in my view, are OMIG's efforts to prevent, up front, improper costs and billings to the Medicaid program. As we all know, it is far more cost-effective to prevent improper payments in the first place, as opposed to chasing dollars after they have

been paid.

OMIG's cost-avoidance initiatives for 2015 delivered savings of more than $1.1 billion through September. These results are on track to exceed 2014's cost-avoidance results of $1.8 billion. Each of OMIG's cost-avoidance initiatives has its own comprehensive methodology for accurately calculating Medicaid program dollars that are saved.

For example, OMIG uses pre-payment program edits that we build into the Medicaid billing system that deny improper provider claims. Another area of cost savings is where OMIG has had an intervention with a provider, we will subsequently compare billing patterns prior to the intervention with those after, to determine the cost savings attributable to the modifications in the provider's operations that were a result of our involvement.

In addition to cost avoidance, identifying and recovering dollars that have actually been paid because of fraud, waste or

abuse in the Medicaid program is a core OMIG function. OMIG's 2015 preliminary audit results through September show more than 1,700 audits initiated and over 725 audits finalized. Cash recoveries for this nine-month period, including audits, third-party liability, and investigations, total approximately $250 million. That's cash for the state. That's the state's share.

Moreover, holding accountable those who intentionally defraud the system is priority number one. To this end, OMIG works independently and in collaboration with partners at all levels, including local, state and federal law enforcement, provider organizations, and health plan special investigation units, SIUs. These collaborative efforts have become more effective as the healthcare delivery system continues its shift from a predominantly fee-for-service model to a managed-care approach.

One example of this is OMIG's Managed

Care Investigation Unit. The unit investigates complaints received from managed care organizations, MCOs, relating to network provider fraud, and works with their SIUs to develop comprehensive investigative plans. OMIG conducts quarterly statewide meetings with all of the SIUs at which it shares recent case referrals from SIUs to identify suspicious trends across plans, coordinate next steps, and provide additional information to enhance program integrity and drive results. OMIG has created a database that is accessible to OMIG investigators, consisting of contact information for SIU staff in all managed-care plans. Preliminary data for 2015 show that as a result of OMIG's work with the SIUs, referrals from MCOs to OMIG totaled 344, up from 273 referrals in 2014.

Also as part of its managed care focus, OMIG continues to generate results through its reviews of managed long-term care plans, the MLTCs. These MLTC audits focus on enrollee eligibility for long-term care, and

whether the plans are meeting the service needs of enrollees based on their plans of care. OMIG has engaged 26 MLTC plans for audit, and has reviewed enrollment eligibility criteria and related care plans for more than 4,900 enrollees.

In addition, OMIG, in concert with the Department of Health and the Office for the Aging, developed and implemented last year New York's first-ever certification process for social adult day care providers, SADCs. This will play an important role in the state's oversight of managed long-term care organizations and their relationships with the SADCs.

Additionally, OMIG has played a critical role in many collaborative law enforcement actions that have resulted in the prosecution of major fraud schemes, enrollment fraud arrests, and drug diversion cases.

One example of this resulted in the indictment of 23 defendants who were involved in a $7 million Medicaid fraud scheme in

Brooklyn. Last March, OMIG, along with the Brooklyn district attorney, the United States Health and Human Services Office of the Inspector General, and the New York City Human Resources Administration, announced charges against nine physicians and 14 other individuals pursuant to a 199-count indictment. The defendants lured homeless people and individuals from low-income areas to medical clinics, where they received unnecessary tests in exchange for free shoes. OMIG provided Russian-speaking staff, data collection and analysis, and intelligence gathering in the course of the investigation.

We have also been very involved in drug diversion cases. For example, we assisted the Suffolk County DA's office investigation of Ingrid Gordon-Patterson, a nurse practitioner based in Suffolk County. In a one-year period, she wrote more than 1,200 prescriptions of Oxycodone for patients who had no medical need for this highly addictive drug. OMIG’s assistance included surveillance, data-mining services, and

reviewing documentation from MCOs. On June 29th, Gordon-Patterson was convicted on five counts, which included criminal sale of a controlled substance, and on August 25th she was sentenced to nine to 19 years in prison.

Thus far our 2015 statistics regarding enforcement activity are robust. Preliminary numbers through September indicate that OMIG opened more than 2,700 investigations, completed more than 2,900, and referred 926 cases to law enforcement and other agencies. In addition, during the same nine-month period OMIG excluded 844 providers from the Medicaid program. This exceeds the 822 provider exclusions for all of 2014.

OMIG also places great emphasis on provider outreach and education, particularly focusing on providers having proactive compliance programs that will prevent or, when necessary, detect and address abusive practices. We offer compliance webinars, guidance materials, self-assessment tools, presentations, and a dedicated compliance

email address and phone number. OMIG's oversight activities and educational efforts increase provider accountability and contribute to improved quality of care.

In 2015, OMIG issued more than 30 compliance-related guidance materials and conducted over 20 educational presentations and webinars. The compliance section of the OMIG website had 36,000 visits to compliance webinars, 25,000 visits to compliance publications, and 40,000 visits to compliance resources and FAQs. Many of our webinars are accredited for legal, accounting or compliance continuing-education credits. In 2016, 206 participants have already received credits, largely because last November OMIG created and posted on its website a nine-part series on New York's mandatory compliance program obligation for providers, as well as a webinar detailing the 2015 compliance program certification process.

We at OMIG appreciate this opportunity to speak with you about our Medicaid program integrity activities, and we believe that our

provider education and outreach programs, our investigative efforts, and our success in identifying cost savings and recovering inappropriate Medicaid payments play a vital role in preventing and detecting Medicaid fraud and abuse while promoting the delivery of high-quality care to millions of New Yorkers.

Thank you. I am happy to address any questions you may have -- although I did tell my wife I'd try to be home for dinner.

(Laughter.)

CHAIRMAN FARRELL: Thank you very much.

Assemblyman Garbarino.

ASSEMBLYMAN GARBARINO: Thank you very much, Chairman.

A quick question. You said over the nine-month period in 2015 --

MEDICAID IG ROSEN: Sorry, I'm getting an echo and it's -- my old ears are having trouble.

ASSEMBLYMAN GARBARINO: Sorry. Through investigations in 2015, just that

first nine-month period, your department found $250 million in Medicaid fraud; is that correct?

MEDICAID IG ROSEN: I'm -- I'm having trouble hearing you, I'm sorry. Could you switch to another microphone?

ASSEMBLYMAN GARBARINO: Better?

MEDICAID IG ROSEN: Yeah.

ASSEMBLYMAN GARBARINO: In your testimony you said that there was $250 million in Medicaid fraud that your department found in 2015.

MEDICAID IG ROSEN: Yeah, for the first nine months we recovered $250 million in cash recoveries. That's state share. The total recoveries would be about twice that.

ASSEMBLYMAN GARBARINO: Does your office have any estimate about how much additional fraud there is out there, how much we haven't gotten yet?

MEDICAID IG ROSEN: Again, because it's hard for me to hear, you want me to estimate how much money was stolen that we didn't get?

ASSEMBLYMAN GARBARINO: Yes. Do you have an idea?

MEDICAID IG ROSEN: I think that's impossible to do. There are different estimates. Some people say there's 10 percent fraud in the system, some people say 30 percent. But I don't think there's any legitimate way to guess how much money is being stolen.

That's one reason why -- you would have seen it emphasized -- in addition to obviously going full steam and trying to get cash recoveries and doing investigations relating to things like drug diversion, one of the things we've been emphasizing more so is cost avoidance, where I gave you some examples.

Another example would be before a bill is paid, we'll find a third-party insurer, through our data mining, who should be responsible for that bill and not the state or Medicaid.

But I cannot give you with any credibility an accurate guess as to how much

money is out there in addition to the money we bring in.

If your question is are we bringing in everything that's being stolen, the answer is no.

ASSEMBLYMAN GARBARINO: Is there a way -- I mean, there's a lot in this budget, there's some cuts to some programs that the state pays for under Medicaid. I'm just wondering if instead of cutting programs that help people, if we gave your office additional funds -- I believe your current budget is around 43, 44 million; is that correct?

MEDICAID IG ROSEN: I'm still having trouble hearing you. I'm going to come up there and listen to you.

(Laughter; cross-talk.)

(Medicaid IG Rosen ascends the dais and sits next to Assemblyman Garbarino.)

ASSEMBLYMAN GARBARINO: Well, the question is instead of cutting certain programs under the budget that are being proposed, would it be better to increase the

funding to your office to help with inspectors? Currently I believe you have a $44 million budget?

MEDICAID IG ROSEN: No, we're at about -- am I on? Yes. For '15-'16 we're at about 55 or just below 55. In the proposed budget, we'd be cut about $2 million, it would be about a 4.2 cut to, as I recall, I think it's 52.7 million. More than half of that money is federal share. It's about a $21 million state share in the proposed budget.

ASSEMBLYMAN GARBARINO: Okay. Will those losses in this year's budget affect recovery?

MEDICAID IG ROSEN: I can't say that it necessarily will, because there's a few directions that we've been going in. One is a better use of technology.

One of the things that really impressed me when I came to the agency in late March of last year was the technology that has been put in place in the last couple of years and the technology that I think

we're going to be bringing on board in the next year or two. The kind of data mining that the agency can do is really fantastic now. And it's more a question of how current can we get in terms of the technology out there rather than how many people necessarily are sitting at desks at the agency.

Also there's a real tropism toward being more efficient in how we conduct our business. You know, the administration has placed a great emphasis on something you've probably heard about, the Lean Program, where agencies now are emulating what private industry does, which is you have what are called Kaizens, you get your folks together for two or three days, you break down a particular process.

Like, let's say, doing audits, we want to make audits more efficient. We've had -- for one or two different kinds of audits we've had Lean events where people will spend maybe a couple of days in a room putting up on the walls all the aspects of the audit and looking for the bottlenecks, why does it take

longer to get this out.

And some of those kinds of initiatives have had really, really real-world effective results that have increased our efficiency. So I think in the past, you know, when money was less scarce, there was less incentive for agencies to do that. That has been a real push in this administration: Be more efficient, run your operation like a business, and go towards the best technology you can go to and have people learn how to use it.

For example, we've got a wonderful bit of technology called the Provider Audit Documentation System. One of the things I had to learn was about 300 acronyms when I took this job nine months ago. And it's a wonderful piece of software. And when we work with counties now when they're doing their own investigations, one of the things we do is teach them how to use it. And we work with them. And it's been a wonderful improvement for the counties and a great help to our relationship.

So that's where the challenge is, I think, and not so much whether I've got a few more or a few less people.

ASSEMBLYMAN GARBARINO: So the counties are still active, even though their contribution is capped? Are they still an active partner in fighting fraud?

MEDICAID IG ROSEN: Yes. We have some counties that do a terrific job. And in fact, Onondaga County's been so great that we've been meeting with them to talk to them about some of what they've been doing because we're interested in some of their techniques.

There's more to be done with the county demo projects and other kinds of collaboration. But for example, the counties used to just be able to do transportation, DME, durable medical equipment, and pharmacy, and we've trained them now -- and it's quite an effort on the agency part to do that statewide, but we've trained them now where they can also look and audit assisted-living plans and also long-term healthcare.

So those efforts I think are very good

in terms of the results that we get from that collaboration. And our partnership with the counties has been very rewarding. At least one of the things I'm most proud of with the agency is we've worked very well with the counties on issues like drug diversion. I mentioned the Suffolk County case just as an example. There have been lots of others.

And also what we've been doing, and again sometimes in some collaboration with the counties, we'll go into pharmacies and we'll look at their inventories and we'll match that against their -- the company that's -- the company records of the wholesaler who's selling them. And we want to see if it matches up.

For example, we caught one pharmacist who was buying drugs from people just so he could sell them -- almost like some guy in the street, except this was a pharmacy. But they would buy them cheaply, you know, some of the more dangerous drugs, people who had prescriptions, they would come to him, and he was known as somebody who will buy pills from

you and then resell them.

And again, that partnership with the counties has been very, very helpful in that respect.

ASSEMBLYMAN GARBARINO: I have one final question. I commend your work with the counties. I'm from Suffolk County, so I've seen what you've done.

My concern is, though, about the cuts that are in Medicaid now, which you don't have anything to do with. But do you think if your office received more funding we could get more back in fraud? I'd rather go after the people doing Medicaid fraud than cutting -- you know, getting rid of spousal refusal or getting rid of, you know, anything -- the pharmacy or capping prices that go to pharmacies.

MEDICAID IG ROSEN: I think there's nothing wrong with having more resources, obviously. Obviously. But I think the challenge for state government -- and I went through this when I came to Albany six years ago, to the State Liquor Authority, where I

really saw it there -- the challenge with state government is to use what you've got effectively before you go around asking for more.

And that's what we're in the process of doing. And I think people at the agency are starting to step up and give it their best shot in that way. And then let's see where that takes us, and you and I could have this conversation perhaps a year from now and we'll see where we are.

ASSEMBLYMAN GARBARINO: That's good. Thank you very much.

CHAIRWOMAN YOUNG: Thank you.

MEDICAID IG ROSEN: I'm going to go back. I think it was just the mic, but -- if not, I'll be visiting here again.

(Laughter; Medicaid IG Rosen returned to the speaker's table.)

CHAIRWOMAN YOUNG: He may be back.

Well, first of all I'd like to welcome Inspector General Rosen. And I apologize if there are technical difficulties; we'll look into addressing those.

I have to say I'd also like to welcome you as an honorary member of the State Legislature. I think this is a first in New York State history, but I think it shows a lot about you as a take-charge kind of person, and that's what we need in the Office of Medicaid Inspector General. So thank you for that.

I also want to thank you for your testimony, because it did contain details and statistics, which we always appreciate because that cuts down on some of the questioning that we have to do.

I may have one or two questions in a moment, but at this time I'd like to turn it over to Senator Hannon.

SENATOR HANNON: Yes, thanks, Mr. Medicaid Inspector General. Not like "Commissioner" or anything like that.

You raise the question of what you had done in Suffolk on the surveillance and convicted somebody on five counts who wrote more -- in a one-year period, you say she wrote more than 1200 prescriptions.

MEDICAID IG ROSEN: I'm still having a little bit of trouble, so if you don't mind, I'm going to --

(Laughter; cross-talk.)

CHAIRWOMAN YOUNG: Come on back.

SENATOR HANNON: Sit next to the guy with the scarf.

(Laughter.)

SENATOR HANNON: Here, right here.

MEDICAID IG ROSEN: Thank you. Sorry about this.

SENATOR KRUEGER: That's okay.

MEDICAID IG ROSEN: When the other folks were sitting there, I could hear you perfectly.

SENATOR HANNON: The question is this lady was caught writing more than 1200 prescriptions of Oxycontin in a one-year period. Was this before or after I-STOP? Because we now have I-STOP, where everybody's controlled substances have to be recorded.

MEDICAID IG ROSEN: This went back to '13-'14, if I recall correctly.

But I can tell you we're taking a real

close look. And I-STOP I'm not sure is always working in other situations. And we're really looking at that.

SENATOR HANNON: Because that's exactly what we'd want to do. There's been people suggesting we take a better look at I-STOP. There's the other balance in regard to you get it too much of a prosecutorial tool, that physicians will try to avoid using it entirely.

But the point is it's a rich database that's been reported that it has caught many people doctor-shopping and it has curtailed some prescriptions. So I ask to be kept abreast of your look-see into that whole situation.

MEDICAID IG ROSEN: We'll do that. It's a terrific tool, and we use it very, very much.

But for example, I know we're looking at a situation right now where it looks like somebody got a ton of prescriptions from different pharmacists within one plan, and we're looking at whether or not I-STOP should

have prevented that.

So that, yeah, we will keep you apprised of our progress.

We also do a lot of in terms of the -- just to go off on a little bit of a tangent, but I think it's something, based on all your comments, that you folks are interested in. We also have a restricted recipient program where if somebody does have a history, for the state's protection, for their own protection, they've got to go to one provider for whatever -- one pharmacy, for example, one primary care, so you don't get somebody basically taking the one prescription and going to 15 pharmacies.

So that's been very effective too. And we've beefed that up I'd say in the last year or two.

SENATOR HANNON: It's good to put that on the record. Thank you.

MEDICAID IG ROSEN: You're welcome.

I think I may just stay here, if that's all right.

(Laughter.)

CHAIRWOMAN YOUNG: Sure, stay.

Any more Assembly?

Okay. Senator Krueger.

SENATOR KRUEGER: Thank you.

It's a follow-up question, I think, to Senator Hannon's. So the state has not yet set up the prescriber's electronic mandate requirement for all prescriptions, but it's scheduled to go in I think in March of 2016, so that all prescribing will have to go through an electronic system.

SENATOR HANNON: Unless there's a waiver.

SENATOR KRUEGER: Unless there's a waiver, thank you.

So I guess it's a twofold question. On the one hand I hear from mostly doctors in individual practice that they're not really going to be set up to be able to use this system. Perhaps institutional doctors -- hospital-based, clinic-based -- will, but they're concerned they won't be. So I have a concern whether the state is rushing forward.

On the other hand, I want to hear your

perspective on is this going to be another tool that helps you make sure that prescriptions are being written appropriately through the Medicaid system.

MEDICAID IG ROSEN: Yeah, I think this is a very, very important tool.

And people have certainly had enough notice that it's coming so that I don't know -- I won't say now what our attitude will be when people make a case for special circumstances and ask for some sort of break. But I know this is very, very important to us. And I think the industry is at a point where I don't think it's an overbearing, overly burdensome challenge -- again, given the notice that's been out for them to meet this requirement by March.

But this will be a very powerful tool. And this will deal with some of those drug diversion issues and some of these opioid issues, it really will. So I think it's very important.

SENATOR KRUEGER: Thank you.

And in your testimony you talk about

the enormous amount of money that's saved by actually preventing it from ever going out the wrong door in the first place. I just want to reemphasize that kind of story doesn't always sort of get told, but that's the critical story, that what you are doing is preventing us from seeing the kind of Medicaid fraud we would otherwise have.

Just as a follow-up, so I don't take a third question, is it your experience, now that you've moved to OMIG from SLA, that the majority of that fraud that you are stopping from ever happening, or catching, is really on the provider end or the participant end?

MEDICAID IG ROSEN: Oh, I think the bigger dollars are on the provider end. We've had -- I mean, we go after recipient cases. And again, for example, we worked last year with law enforcement and we found a couple in Roslyn Heights who were on Medicaid who lived in a house that was worth about a million and a half dollars and were living a very nice lifestyle.

So that we do do those cases, and we

do make recoveries where we can. But the big dollars are at the provider end.

SENATOR KRUEGER: Thank you. Thank you for your work.

MEDICAID IG ROSEN: Thank you.

CHAIRMAN FARRELL: Thank you.

CHAIRWOMAN YOUNG: Thank you. I did have one question.

So, Inspector General, can you update us on the DSRIP and value-based payment compliance initiatives, and how are things going on working with the Department of Health?

MEDICAID IG ROSEN: Again, I was having trouble on the microphone.

But you basically want to know how we see our role?

CHAIRWOMAN YOUNG: Mm-hmm.

MEDICAID IG ROSEN: The comment that I enjoyed the most today, as I sat there and my sciatica was acting up in my left leg -- but the thing that totally took my mind off of that was Senator Hannon's comment. And here's a guy who, you know, I know from my

10 months now at the agency, and I've done a ton of reading, I've talked to tons of people, people in the industry. Here's a guy, nobody is more respected for his knowledge and his understanding of the industry, and he sat here about -- was it a couple of days ago or three or four hours ago? It seems -- I've lost track.

But he sat here and said he's still trying to get his arms around value-based payments. And I am too, and I think we all are. And I've been to meetings with the federal authorities, like CMS and HHS, and they're still wrestling with it.

And one of the challenges that I have to face, as the guy who's leading OMIG now, is figure out exactly, you know, what the metrics are and how you enforce the metrics. And that's a real challenge, but obviously it's very, very worthwhile. In the end, the goal is fantastic. But right now it's the Holy Grail, it's almost mythical.

And I watched your hearings; months ago you were talking about value-based

payments. And in terms of trying to get my -- as the new guy, trying to get my arms around something concrete, it was very, very difficult for me to walk away with concrete take-aways.

With respect to DSRIP, what we've done is -- how do you like looking at my back?

SENATOR RIVERA: It's cool.

MEDICAID IG ROSEN: It's all right?

With respect to DSRIP, our role will change as it unfolds more. But initially what we did was -- and again, this was something the agency ramped up to before I came, so it's not that I would take credit for it. But the agency did a really good job about getting out there and explaining to the leads of these networks -- you know, you've got these performing provider systems, and then there's a performing provider system lead. And that's usually a big hospital, though there are new co's that I'm not quite sure what they are. But usually it's a big hospital system, for example.

And our folks were very good at

getting out and explaining to them that they need to have a good compliance program, good internal controls, good checks and balances for that $7.4 billion that's going to be coming through -- not just in their own house, because a lot of them do that already, as large providers, but also throughout their PPS network, which could have hundreds of providers. And I think the agency did a really good job of that.

It also did a lot to check out and verify the attestations that these PPS leads were submitting as to who's in and who's out of their system. So we did a pretty good job on that.

And a lot of those hits that I talk about -- and one of the things I'm proudest about are those hits on the website, on the compliance and education materials. And one of the biggest areas has been the DSRIP-related stuff. We've got a document we put up in tandem with DOH, we've got FAQs on the website.

You know, when I was at the SLA, I did

record enforcement. We had the highest recoveries ever. A wholesaler, in 80 years, had never had their license suspended in New York State. There were suspensions.

But before I did any of that, I spent at least the first year really making sure I went all over the place telling people these are what the rules are, this is where we are now, this is where we're going to be going forward. And everybody had a chance to clean things up if they wanted to, and then we came along with the tough enforcement. And I think there's a real obligation to do that on a regulating agency before you -- you know, before you break the door down and come barging in.

And that's what we've done with DSRIP. So we've tried to really help people proactively set themselves up so that the money won't be misspent and everybody embarrassed. Because the concept is fantastic. And if it works, it's going to be wonderful.

CHAIRWOMAN YOUNG: Thank you for that

frank answer. And I do want to say I hope your sciatica feels better soon, and hopefully your testimony before us was less painful.

(Laughter.)

CHAIRWOMAN YOUNG: So get better, and thank you for joining us.

MEDICAID IG ROSEN: Thank you very much.

CHAIRMAN FARRELL: Thank you very much.

We may have started a new pattern here. We'll give you an option, on the bench or on the table.

(Laughter.)

CHAIRMAN FARRELL: Health Care Association of New York State, HANYS, Dennis Whalen, president.

MR. WHALEN: Good afternoon, Chairman Young, Chairman Farrell, Health Committee Chairman Hannon, and committee members.

Our comprehensive written testimony has been filed, so I am simply going to summarize our key points and talk to you for

a few minutes about the larger dynamics underway in healthcare and why they are important as you consider what should be done in the final budget.

The hospitals and health systems across New York State have fully embraced the work of transformation. They're investing in growing the abilities of their clinical staff, their healthcare workers, and bringing advanced technologies to patient care, restructuring their services, that expands both their ability to provide more complex care as well as to increase their capacity to provide primary care and wellness services.

In a typical year, 8.5 million patients are treated in our hospital and health system emergency rooms, 2.2 million patients are admitted to the hospitals, and more than 53 million outpatient visits take place in their clinics and offices.

They remain the 24/7, 365 ever-ready point of response for medical and other emergencies, from outbreaks of a new disease, to the heart attack or car accident, to the

organ transplant or the mass disaster.

Our hospitals and health systems are also among the largest employers in every region of this state, providing a total of more than 770,000 jobs. They generate $138 billion a year in economic activity, which accounts for more than 10 percent of the state's entire gross domestic product. And they provide billions of dollars of free and subsidized care each year.

The decisions you will make as you negotiate and craft this budget will impact the ability of every hospital and health system to continue their important work, and it will determine how quickly and how effectively healthcare transforms in New York and whether our system remains stable and durable as these changes take place.

I've described the Governor's proposed budget as a work in progress. While it contains positive recommendations, it fails to address significant fiscal issues that already exist or which may occur in the upcoming fiscal year. Importantly -- and

this is a point that many of you have talked about this morning -- and to emphasize this as a context, health providers in this state are awaiting more than $3 billion that has been previously proposed, negotiated, appropriated, yet is still not out the door. Nearly half of that, $1.2 billion, is from the 2014-2015 final budget.

In his Executive Budget the Governor proposes ambitious, multiyear, visionary agendas and plans for key areas of policy and infrastructure, but healthcare is not among them. We recognize that multiyear reform is taking place for Medicaid via the federal waiver, but the overall task is much broader and diverse. And when undertaking complex and challenging change over a several-year period, there is great value in predictability of investment, just as there is in a common understanding of the roadmap of where we are going and how to get there.

In regard to specific recommendations in the Executive Budget, the Governor's budget proposes $195 million in capital

dollars, but in doing so reduces healthcare capital $100 million on a year-to-year basis and eliminates $300 million in funding that was promised last year for healthcare upstate in Oneida County.

Importantly, over the last week, we understand that meetings with the elected representatives in Oneida County, the Governor's office, and the Department of Health have been productive, and that a commitment has been to provide funding to Oneida County. We support the restoration of the previously promised capital funding for healthcare upstate, as well as the critically needed new $195 million.

While some have characterized the need for capital only as a means of fueling and permitting partnerships where large systems consolidate with smaller institutions, the need is more complex than that. Capital dollars are needed to allow those institutions who face special challenges, such as being in a rural area or serving as a critical-access hospital, to transform their

operations. It enables hospitals that are seeking a partner to stabilize their balance sheets, to go into that partnership on an equal footing. It does enable stronger hospitals and health systems to enter into partnerships without weakening their own balance sheets. And it will enable hospitals that remain independent to do so, including as they transform themselves using new models of care.

We are concerned about a number of issues that are not addressed in the Executive Budget. Healthcare providers are awaiting more than $3 billion in outstanding state commitments, as I mentioned. No provision is included in this budget that would increase the timeliness with which dollars get out the door and critically needed funds are distributed.

Hospitals and health systems across the state will face a $570 million impact at the point of full implementation of a minimum wage increase that's proposed in the Executive Budget. There's no perspective

included in the budget to mitigate the impact of this increased minimum wage, and it's important to note that the necessary actions to do so should be implemented in a manner that holds harmless the Medicaid global cap.

The amount due to hospitals throughout the state as the result of nonpayment for services resulting from the collapse of Health Republic is approximately $200 million. Similarly, there's no provision in the budget to pay those providers for the care that they have provided to their patients.

And separately we note that in recent past sessions, discussions have occurred regarding potential legislation that would have enormous financial impact on hospitals and health systems, including imbalanced medical malpractice proposals and mandatory nurse staffing ratios.

As you review the Executive Budget and develop your own one-house budgets, I ask that you consider both the current state of healthcare and the best pathway to achieve

the goals to which we all aspire. It's important, I think, to understand our starting point, and I just want to offer a few facts about the current state of healthcare in New York.

Our hospitals and health systems are fragile. Hospitals in New York State have the second-worst operating margins in the United States, and they are far below the national average. Nearly three-quarters of the hospitals are in fair or poor financial condition -- as you've heard this morning, 28 hospitals are receiving special funding to ensure that they can continue to stay open -- and many are rushing to meet that eligibility criteria.

Our healthcare infrastructure in New York is the sixth oldest in the nation. And it's important to remember that over the next 10 years, $27 billion in federal cuts will be undertaken in New York, further destabilizing our institutions.

Therefore, the challenge is how to reconcile the current state with our goals so

that we can chart the right path forward. We look forward to working with you over the next nine weeks to craft a budget that will enable our hospitals and health systems to continue their transformation in a way that protects access to care and offers a degree of stability in the midst of intense change.

Thank you, and I'd be happy to answer any of your questions.

CHAIRMAN FARRELL: Thank you.

Questions?

CHAIRWOMAN YOUNG: Thank you, President.

So Senator Gustavo Rivera has a question first. Or more, maybe.

SENATOR RIVERA: Thank you, Chairwoman.

And just -- to Dennis, thank you. And you know if you have some issues down there, you can always cop a squat over here. You're good. We saved it for you.

I have a couple of questions regarding -- I just went through your -- by the way, I also thank you for just giving us

the highlights and letting us ask questions. That's always most efficient.

Particularly I'm concerned about how you folks view the increase, the $15 minimum wage increase. And obviously that's something many of us, as I said earlier, have been fighting for just across all different job classes across the State of New York. You have a sense that it will have a serious impact on your particular industry, so I wanted to ask particularly two questions.

First, explain to me, as far as the estimates, you include not only the salary itself, right, which will be done in a phased-in fashion, and we've still got to figure out exactly what that is, as the folks from the Health Department said this morning. But you include not just a salary but also what you call compression, spillover, et cetera. I want you to explain that to me and why you think that it was important to include that in the calculation.

MR. WHALEN: Sure. I should say that we've done this estimate in cooperation with

the nursing home associations and the home care associations. And the total impact for that group of the full rollout of minimum wage is $2.9 billion at full implementation.

SENATOR RIVERA: Full implementation. So we're talking between 2016 and 2022, I think it is?

MR. WHALEN: Right. Right. Yeah, you've got a differential roll-in with New York City and then rest of state.

And the estimate has three components. So the first is the direct wage impact of moving individuals who are below $15 to the $15 level.

And then there's the compression factor. And when you talk to labor experts, that occurs when a lower band of salaried employees moves up and bumps into the next higher band. So those with increased responsibilities above those who you are now increasing to $15, you'd have to do some commensurate change in their salary level to reflect their level of responsibility.

And the third component is what you

might call indirect, but it's as your salary changes, so does your employer's obligation for Social Security, workers' comp, and a whole series of other areas where you are contributing on behalf of your employee.

And we're happy to share this methodology, and our numbers as well, as to how that impact rolls out differentially on the geography across the set of years.

SENATOR RIVERA: I would certainly appreciate it, because I want to --

MR. WHALEN: I think Year 1, you know, it's roughly, depending on what you do about compression, it's a $50 to $100 million impact on the hospital side.

SENATOR RIVERA: And does your estimate -- did it include just Medicaid costs or you included non-Medicaid costs as well?

MR. WHALEN: You know, the issue of whether or not Medicaid is used as a tool to somehow compensate or mitigate this cost of wage needs to be approached carefully, because of the difference around the state in

the proportion of patients that are Medicaid.

So there are some institutions, particularly downstate in urban areas, where there's a very high percentage of patients that are Medicaid, and you can do some adjustment. As you move to areas that have more Medicare, as opposed to Medicaid, you would have to do such an adjustment on the Medicaid side that I think you could possibly run into disallowance problems in Washington because you'd be paying for the same service at a fairly radically different level.

SENATOR RIVERA: And lastly, since I asked the folks from the Health Department this morning -- and you obviously have the experts that's crunched all these numbers -- have you folks calculated whether there would be some costs that would be offset by workers transitioning from Medicaid eligible to non-Medicaid eligible as their salaries go up?

MR. WHALEN: I don't think we have factored that particular item in. But we can certainly look at it.

SENATOR RIVERA: Okay. Thank you.

CHAIRWOMAN YOUNG: Senator Hannon.

SENATOR HANNON: Mr. Whalen, right along the theme that Senator Rivera has raised, if you tried to channel money to healthcare providers by the Medicaid system, you run into the third rail of violating federal rules, because upstate, with far less of Medicaid paying in an institution, you'd have to raise it even more. Contrasted with downstate, you'd raise less, but then you'd have two systems. That's verboten.

But if you started to then look at whatever the different formulas that might be available to give money to hospitals, nursing homes, home healthcare -- trend factors, grants, et cetera -- then you probably are starting to run afoul of the global cap that the state has made a mantra not to violate.

So I just don't know, is there some other path that we could do this with?

MR. WHALEN: Well, that's why we've emphasized the need to do -- whatever is done to address this problem, to be neutral to the

Medicaid global cap. Otherwise, you are correct, you would run right into that.

So taking a look at the array of things where revenue is even moved outside of hospitals, whether that's various assessments or taxes on gross receipts -- there are lots of things that occur that, if those were changed, could result in a revenue flow to hospitals that might be able to be accomplished without presenting a global cap problem. Or to simply do it as neutral to the global cap even if it involved Medicaid.

So you would have to temporarily or for this purpose increase the global cap.

SENATOR HANNON: But it would need some type of adjustment to the existing systems.

MR. WHALEN: That's right. That's right.

SENATOR HANNON: Thank you.

CHAIRWOMAN YOUNG: Thank you, Senator Hannon.

Senator Savino.

SENATOR SAVINO: Thank you, Senator

Young.

So I'm just going to follow up on the questions that -- you answered some of the questions I had when Senator Rivera posed them to you. So let me make sure I understand this.

You're not necessarily opposed to the concept of raising the minimum wage for workers if the state fully funds it.

MR. WHALEN: That's correct.

SENATOR SAVINO: Okay. And I think what I heard you say was that you would prefer that we fully funded it as opposed to raising the Medicaid cap; is that also correct?

MR. WHALEN: No, that if any portion of Medicaid is used to mitigate those costs, it should be done in a way that does not negatively impact the global cap. So we don't want to use up global cap room for this purpose.

SENATOR SAVINO: Right. And the figures that you gave us about the full cost, which would not just be the minimum wage

workers now, but potential wage compression -- is that fully funded to the $15 or is that this year's cost? For the first step. Because remember, this is a multiyear implementation.

MR. WHALEN: This year's cost -- again, depending on what you do with the compression issue -- would be, for hospitals, between 50 million and 100 million.

Over the full implementation for hospitals, that cost is 570 million. And if you add in hospitals, nursing homes, and home care agencies, that's $2.9 billion. But again, that's at full implementation.

SENATOR SAVINO: Full implementation.

MR. WHALEN: So 15 everywhere in the state.

SENATOR SAVINO: Right. And on the compression thing, because I heard that raised at the minimum wage hearing that Senator Martins and I had about a month ago, whenever -- the minimum wage has gone up three times now in the past couple of years. We had three separate increments. Every time

the minimum wage goes up, do you also then raise the wages of other workers who are above minimum wage?

MR. WHALEN: To the degree that it bumps into that salary band above that and it's required to do so, yes. Because you wouldn't want to have people with disparate responsibilities being paid the same.

SENATOR SAVINO: So you have a $9 an hour minimum wage individual now. And what would the next salary band be that would be affected by it? Because we're talking about potentially a 60 percent pay raise over full implementation at the lower end; correct?

MR. WHALEN: Yes.

SENATOR SAVINO: So do you have like -- how many workers would be in the next band that would be slightly above it? If you know. If you don't know, that's okay.

MR. WHALEN: Yeah, I don't. We've worked with labor experts, and I'm sure they can put something together for you.

SENATOR SAVINO: The majority of the employees that are affected by this, aren't

they unionized, though?

MR. WHALEN: You know, it depends where they are in the state, whether their facilities are unionized or not. Typically these people most affected would be, you know, physical and corrective therapy assistants, medical transcribers, orderlies, housekeeping staff. Folks like that.

SENATOR SAVINO: But for those who are covered by a collective bargaining agreement, wouldn't those, you know, wage compression issues be the subject of negotiation with their union?

MR. WHALEN: I don't know. I can't answer that question. It's a good question.

SENATOR SAVINO: They probably are.

MR. WHALEN: But, you know, again I think the argument would simply be that, you know, you have individuals with different levels of responsibility. You know, it's like what happens in the state. Individuals get raised, so you have to have the supervisor, you know, raised a commensurate amount.

SENATOR SAVINO: Okay. But most importantly, you're not opposed in concept; it's just how do we pay for it.

MR. WHALEN: Correct.

SENATOR SAVINO: Thank you.

CHAIRWOMAN YOUNG: Thank you, Senator Savino.

Senator Krueger.

SENATOR KRUEGER: Thank you.

So in your testimony you go over how much capital money hospitals are owed and we're behind on. I guess -- I'm sure there's lots and lots of detail somewhere of where we're behind and by how much. But I know, speaking for Manhattan where I represent, everybody keeps changing what they're planning on doing. They are moving to more ambulatory care, they're closing beds.

Is it reasonable to say the state ought to reevaluate how it's made its capital commitments in light of what seems to be a very fairly dramatic change in the patterns of in-bed hospitals versus ambulatory care centers?

MR. WHALEN: So, Senator Krueger, the first point I'd make is that these dollars on the capital side are not exclusively available to hospitals. They're available to, you know, nursing homes, clinics and other parts of the system.

Secondly, the RFAs for these dollars spoke exactly to the point that you're raising, that transformation is needed. In some cases it was asking for how a more sustainable, different way of delivering care would be provided going forward.

And, you know, there are -- you know, the biggest chunks of this are the $1.2 billion that was appropriated in '14-'15 to help transform through capital assistance programs. Then there's the $700 million for Brooklyn. There's the $300 million for Oneida County. There's a 355, approximately, chunk for what were called the essential providers.

So I think it speaks exactly to the kind of issue that you've outlined, which is take where you are now, understand where we

need to be, and what do you need assistance with, going forward, to get to the new place.

SENATOR KRUEGER: And since you lined out those items -- I know Brooklyn's got its own set of issues still -- are there actually proposals in the pipeline and it's the state agencies that have failed to say, Yes, you've checked all the boxes, here we're going to DASNY to help bond for this?

MR. WHALEN: The $1.2 million --

SENATOR KRUEGER: Billion.

MR. WHALEN: -- 1.2 billion has been in with applications for quite some time. You know, our understanding is that the Health Department has completed its review of those.

For the essential provider RFP, similarly, those have been out, the responses have been filed. We understand that the department is finished or close to being finished with the review of those applications.

For Brooklyn and Oneida, no offering has yet been outlined or requested for

purposes of spending those dollars.

SENATOR KRUEGER: I hear your frustration. There was a quote somewhere in a paper today, I think, or perhaps a blog, that many of New York State's capital plans are more aspirational than actually getting done. So I think for the sake of healthcare, we want these projects to actually have real bricks and mortar sooner than later.

MR. WHALEN: And everybody's struggled. The dollars are not aspirational, they're real. They're real and sitting there unavailable.

SENATOR KRUEGER: Thank you.

CHAIRWOMAN YOUNG: Thank you, President Whalen. And I want to welcome you also and thank you for your testimony.

As you know, the topic of hospitals is very important to me and my district, and I want to thank you for all the information that you've given today and also the information you've given in the past.

I think you're right on the money, so to speak, as far as the fiscal stresses that

our hospitals are under right now across the entire state, particularly regarding capital and operating funds, and how do you transform yourself moving forward so that you can have the high-quality delivery system that our residents in New York State need and deserve to have.

I was hoping you could just comment a little bit further on the state of rural hospitals and what you see in the future for them.

MR. WHALEN: You know, I think the -- as you know, Senator, there have been a series of hospitals that serve rural communities that have had difficulties over the past couple of years. Some of those have involved partnerships that didn't work out. Some of those have been the struggle to transform the services moving to a substantially more -- a set of more outpatient-type services, but then community concerns being raised about obstetrical care or trauma care or other things.

And I think part of the frustration

is -- and it speaks to this issue of understanding where we want to go -- is that it seems we're almost solving these issues on an ad hoc basis each time there's a crisis, instead of thinking in a more principled way beforehand of what set of services and what sorts of configuration could be put together that serves communities where, because of geographic challenge and sometimes there's a weather factor in that -- in other words, easier to travel distances in summer months and tougher to travel distances in winter months -- you know, what are the models? How do we build telehealth, telemedicine, you know, into this set of services? What types of arrangements do we need between hospitals? We've done this in areas such as stroke, where we have hub-and-spoke model designations by the Department of Health, and prearranged protocols about transfer of patients and other things.

And I think you need some thinking about that sort of clarity in terms of the models and how they would be supported.

Instead of solving these on a crisis basis, where a community tends to get very upset because they don't understand that there's been some thinking, that there's a preset of choices on a menu for how you can put services together that will meet the needs of communities in rural areas, and couple those with reimbursement or other supports so that these remain going, healthy concerns -- instead of just hoping that you're close enough to a large system that can come in and partner and solve your problems that way.

You know, it doesn't really. Certainly systems come in and, you know, lots of affiliations are underway in New York that sort of mirror that model. But even there, systems are going to be taking a look at the level of services that are needed -- you know, how do I attract physicians, nurses and other healthcare personnel into these areas if it's going to be a worry on a year-to-year basis whether or not the structure that's there will truly be supportive.

CHAIRWOMAN YOUNG: Right on target.

So thank you very much.

CHAIRMAN FARRELL: Thank you.

MR. WHALEN: Thank you.

CHAIRMAN FARRELL: Kenneth Raske, president, Greater New York Hospital Association.

MR. RASKE: Thank you very much.

I'm Ken Raske, and joining me is David Rich, our executive vice president of the Greater New York Hospital Association.

And first let me say to Madam Chairman and Mr. Chairman, I want to thank publicly the workers who toiled over the last 48 hours down in the downstate area on a horrendous snowstorm, and the dedication of the hardworking staff, nursing staff, allied professionals, physicians, to make sure that the patients were accommodated and taken care of in the best possible fashion. So my heartfelt thanks to all of them. Much appreciated by everybody in the healthcare community.

Now, with respect to the subject matter at hand of this hearing, I want to hit

five subjects in plain talk. And they are the capital issue as it relates to distressed hospitals, Health Republic, the minimum wage straightforward, med-mal, and the nurse staffing.

We begin by dealing with the troubled institutions. Yes, you have 28 of these institutions listed here; you all know who they are. Some may or may not be in your various districts. But you certainly have colleagues that represent them.

And the fact of the matter is if you take a look at what's going on currently, there is no good way out. On the one hand, you can continue with your subsidies and life support. Up to $400 million now; could be increasing substantially in the future. Or you can let them fail. So what happens when you let them fail? Well, you know what happens then. Your communities go up in arms -- justifiably so -- local elected officials, state officials, federal officials, everybody gets involved. And you have basically chaos. So there's your two

choices. Pick one.

Well, maybe you have a third one. And that third one is a proposal which we have made to the executive branch throughout the fall, and that is to create an incentive program for healthcare systems, large ones -- you all know who they are -- to adopt and adapt these facilities to the new world. It doesn't mean to cross-subsidize them, it means to adopt and adapt to the new environment, to make sure that their communities are served properly.

And when I made this presentation to the Executive, I said I think that $500 million will be necessary to do that for one year, but you're going to need a five-year commitment. That's $2.5 billion over the string of years. This way -- and if you think about it, it's only like a short-term investment, even though five years might seem like a long time. But on the track that you're on right now, you're never going to get out of it unless you take one of those two possibilities -- continue

subsidization, or failure. So this way you can eventually wean yourself off the subsidy, not have the chaos at the local level, and have a healthcare system that best serves New Yorkers. So that's our idea.

I want to thank the Governor for putting in the budget a placeholder of $195 million. And I would like the Legislature to add to that to make it a more robust sum and then, more importantly, the future commitment to do it year in and year out until we have satisfied the needs of these various communities. So that's our idea on capital.

Health Republic, again, plain talk. Health Republic, you heard, is about $190 million into the hospitals. I don't know exactly how much it is into physicians and home healthcare agencies, but it's obviously a significant amount of money.

We have proposed -- and this is something that has been proposed before -- that we have a guaranty fund or an assessment that is placed on the remaining insurance

companies.

So what do we get when we say something like that? Well, we'll get the insurance companies coming back and saying, Hell, no, we won't do that. And I say to them, that's baloney. That is nothing more than crocodile tears on this particular subject. So let me explain to you why.

In 49 other jurisdictions across the United States, you have guaranty funds for health insurers. Guess who doesn't have one? Well, that's why we're here today. And why not? I don't know. I can't explain it. But we need it. You have it for property and casualty companies in New York, but you don't have it for health insurers.

So when the insurers say to me, Well, this is going to be a tax, I say to you most of these insurers in New York now are national companies, aren't they? Aren't they? Aetna. United. The list goes on. And what do these companies do? They didn't complain in New Jersey, they didn't complain in Pennsylvania, California, or Illinois.

They're complaining here. Now, I submit that they are not credible on that particular subject.

So take stock of what is important for New York as we frame a solution to Health Republic.

Minimum wage. Senator, you asked the question. Here's where I'm coming from on the minimum wage. I believe it's a moral mandate. I really believe that. I know how hard it is to make a living. I understand that. You pay 9, 10, 11, $12 an hour to somebody that is in home healthcare or nursing homes, what have you, across the state? It's hard, and we ask a lot of them.

I also have an obligation to my healthcare partner, 1199 SEIU. This issue is important to them, so therefore it is important to me.

Now, the problem with it clearly is, well, how do you finance it? That's number one. And then once you solve that particular problem, then you have to clearly exclude it from the calculation of the cap. Otherwise

it becomes a screwy calculation -- you give on the one hand, then you take it back through the cap, so it doesn't make any sense. So the logic there seems pretty clear; right?

On med-mal, we have the highest med-mal costs in the United States. Ladies and gentlemen, I submit we do have the worst doctors and hospitals in the United States. Wouldn't you think we would if we have the highest cost? Well, we don't. By most metrics, we have the finest hospitals and the finest doctors in the United States.

So what's wrong? Maybe we have the worst tort laws in the United States. That, I submit, is the issue. We need to change it, and we need to change it this year, because the erosion factor is astronomical.

Finally, with your indulgence, nurse staffing is an important issue to the Greater New York Hospital Association. We know that legislation has gone through the Assembly Health Committee already and is slated for future consideration with the Assembly. I

assume that that future consideration will also be made in the Senate. It's an important issue to me. Nurses are the backbone of the healthcare system.

But I also submit that staffing ratios, staffing ratios do not work. And they simply do not work because in each individual institution, you have a different configuration of services. And in addition to the point that was made earlier by a number of you, the healthcare system is evolving into an ambulatory component. More and more material medical care is being given on an ambulatory basis.

So as a result, the idea of fixed ratios doesn't work. What does work? Local consideration. This past year we've had a number of major academic health centers in New York have negotiations with NYSNA, the New York State Nurses Association. They came to a successful conclusion. They were not only about wages and benefits; they were, in point of fact, about staffing.

And these decisions should be made on

a case by case, local determination basis, and that's where we come from on this matter.

In conclusion, it's been my privilege to be the president of the Greater New York Hospital Association for a long time. I'm dedicated to the healthcare and well-being of the people of this state. And I believe, I firmly believe that the New York State Legislature as a body has been a major reason why the great successes have been made in healthcare in this state over the years. You've done a marvelous job. It doesn't mean that we agree, but you've done a terrific job, and we don't take that job lightly. So, ladies and gentlemen, I want to thank you on behalf of my people, the healthcare providers of New York State and New York City.

Thank you.

CHAIRMAN FARRELL: Thank you. Thank you very much, Ken.

CHAIRWOMAN YOUNG: Thank you very much, President Raske. I don't think that, because of your comprehensiveness, there are any questions. So thank you for your

testimony today.

MR. RASKE: I'm sorry.

(Laughter.)

CHAIRWOMAN YOUNG: No, be proud.

(Cross-talk.)

CHAIRMAN FARRELL: Ken. Ken. Ken. Just one question.

MR. RASKE: Oh, I'm sorry, forgive me.

CHAIRMAN FARRELL: No, I just want to know, who's here longer, you or me?

MR. RASKE: I beg your pardon?

CHAIRMAN FARRELL: Which one of us is here longer, you or me?

MR. RASKE: I think (pointing).

(Laughter.)

CHAIRMAN FARRELL: No.

MR. RASKE: No?

(Laughter.)

MR. RASKE: We're supposed to get a reward for that. Thank you.

CHAIRMAN FARRELL: Just checking. Thanks, Ken.

Laura Haight, vice president, public policy, New York State Association of Health

Care Providers.

MS. HAIGHT: Good afternoon. How are you today?

CHAIRMAN FARRELL: I was good when I started.

(Laughter.)

MS. HAIGHT: I'm joined today by Bader Reynolds, current board member and past chair of HCP, and she is the executive vice president for CareGivers, which provides home care services throughout upstate New York.

HCP is a trade association representing approximately 350 offices of licensed home care service agencies, certified home health agencies, long-term home healthcare programs, and health-related organizations throughout New York State. On behalf of the HCP board of directors and members, thank you for the opportunity to testify today.

I'm going to summarize from my written comments in order to stay on top of the time.

We all recognize the importance of home care. Home and community-based care is

seen as a central component for new models of healthcare delivery aimed at achieving the state's triple aims of improving care, improving health, and reducing costs within the Medicaid system. Home care is the patient-preferred option, enabling disabled, chronically ill and elderly New Yorkers to remain with their families and be cared for with dignity in the comfort of their own homes.

As a growing percentage of New Yorkers age in place in their homes and communities, long-term home care will become increasingly important to support those with chronic conditions and functional limitations.

Despite the widespread recognition that home care saves money by keeping New Yorkers out of more costly healthcare settings, the Governor's proposed 2016-2017 budget continues a years-long pattern of disinvestment in home care. Not only does this budget fail to alleviate the very real financial pressures home care providers across the state are currently experiencing,

it includes a significant minimum wage increase with no funding to support it.

Since home care agencies will likely be the most impacted by the Governor's proposed budget, I'd like to begin by explaining the unique position of licensed home care service agencies. The acronym is LHCSA. LHCSAs make up the majority of HCP's membership. LHCSAs employ the vast majority of home care aides in New York. However, although most of the services LHCSAs provide are funded through Medicaid, LHCSAs cannot be directly reimbursed from Medicaid. This has important implications. It means that LHCSAs are not eligible for funding from the various MRT programs intended to assist providers during this transformation, including support for distressed safety net providers.

Home care is facing a perfect storm of challenges, and this is before the minimum wage increase. Mandatory wage and benefit costs for home care agencies in New York have dramatically increased over the past three years, while reimbursement for these services

is woefully inadequate. It was alarming to hear Commissioner Zucker and Medicaid Director Helgerson testify earlier today that the 2011 home care worker wage parity law would be a model for the state to follow when phasing in the proposed minimum wage increase. Wage parity rates are now $14.09 in New York City -- this is $10 in base pay plus $4.09 in supplemental wages and/or benefits -- and they'll be going up to $13.22 in Nassau, Suffolk and Westchester counties in March, a $1.72 increase over the previous year.

While the law was well intentioned, the promised increases in reimbursement have not materialized. To date, only $35 million in QIVAPP funds have been distributed to home care agencies, and eligibility has been severely limited. Even for those providers that ultimately receive QIVAPP awards, the funds will not come close to covering the additional cost of compliance with the wage parity law. No such assistance has been offered to agencies in Westchester, Nassau

and Suffolk, which also have to comply with the wage parity law.

Moving forward, particularly as the state transitions into Medicaid managed care, it is imperative that home care providers be fully compensated for the cost of complying with state and federal wage and benefit mandates, and that this money comes through in advance and not years later. We're dealing with statewide minimum wage increases, mandatory health insurance coverage under ACA, double-digit increases in workers' comp rates, new federal overtime payment requirements -- all within a very complicated transition into managed care which has been fraught with problems which I have addressed in our written testimony but will not go into any further now.

Critical funding promised from the state to reimburse or at least partially offset home care costs have yet to be seen by home care providers. Most recently, as an example, the federal Fair Labor Standards Act rule was revised to require higher overtime

payment, and that went into effect October 13th. Home care agencies have still not seen the emergency funds promised by the state to reimburse them for the additional costs of compliance.

This has had an impact. We've come here before, many years, saying the continued cuts are going to have an impact in the care that we provide, and as an example of just how vulnerable this industry is to wage increases, I'm going to go into a little bit more detail on the FLSA.

In addition, there's funding that's provided through the budget that we're not sure if it gets down to providers. We want to make sure that there's more transparency and that providers actually do get the funds that are sent to managed care that are intended to help us with workforce recruitment and retention.

Home care agencies in New York employ over 200,000 home health and personal care aides who provide more than 300 million hours of care a year to New York's frailest

citizens. Our workforce is our major investment, and thus we are especially sensitive to changes in labor requirements. Because we're mostly government-funded, we can't simply raise our rates when the costs go up.

So going back to the federal overtime increase, it was a relatively modest increase compared to what we're looking at with the minimum wage increase. It changed the way overtime is compensated from time and a half of minimum wage to time and a half of the base pay. And yet without the funding, the home care industry -- that's already in crisis -- simply could not absorb these additional costs and have been forced to take measures to reduce their overtime hours that in some cases they know are not in the best interests of either their clients or their workers. Agencies have had to limit their home care workers' hours, assign multiple aides to cases. Many are not accepting any new live-in cases. And in areas where there are staffing shortages, some agencies have

been unable to guarantee that they can meet clients' requests.

The impact of the minimum wage increase will be especially significant for New York's home care industry, where more than 90 percent of the workforce earns less than $15 an hour.

HCP, together with HANYS and other organizations, have worked together on these estimates and find that at a minimum these will cost, at $15 an hour, $1.7 billion more annually once phased in for the home care industry alone. And this doesn't even anticipate expected increases in home care utilization.

There will be immediate and significant Medicaid cost implications in this coming fiscal year, particularly in New York City, where most of our hours are served and where average wages are below $12 an hour for home care workers. Most of these hours are Medicaid-funded.

So we're working on that estimate on Year 1 impacts, but you can be sure that they

will be significant for the home care industry, including the compression factor, which will kick in even at that first-year level.

I'm running out of time, so I just want to make sure that Bader has an opportunity to speak. I just want to bring to your attention that while we're talking about the Health Republic collapse, the HHH Choices Health Plan, an MLTC in Westchester, also filed for bankruptcy this year, leaving home care providers with more than $13.7 million in outstanding claims. And this has to be taken up by this Legislature, because there are going to be more collapses in the future and we must make sure that providers are made whole in these circumstances.

The home care industry needs additional resources to help us through these healthcare transitions, in particular with healthcare IT.

And in conclusion, while this proposal includes grand and ambitious proposals to

invest in vital infrastructure for New York, like our roads and bridges, the home care industry also needs infrastructure investment. If home and community-based care is to be the bridge to the future of New York's healthcare delivery system, we need to invest in it today.

Thank you, and I'll turn this over to Bader.

MS. REYNOLDS: Thank you, distinguished members. I represent the geographic areas of Western New York, Finger Lakes, Central New York, the North County and the Mohawk Valley region. We are a multi-site licensed home healthcare agency, and we provide services to well over a thousand clients in these communities and employ upwards of 700 field and in-office staff.

I wanted to speak to the minimum wage issue. You have a great support of the issues pertaining to that. But I do want to mention that much of our work, although it may not be totally Medicaid-driven, the

Medicaid rate, the process of calculating a Medicaid rate -- which precludes having any cost of living and a cap on labor and other types of adjustments, to date -- actually is the model for other negotiated rates with health insurance plans and sets a base for what our private pay rates must be.

So regardless of our mix and our models, everything is driven by this Medicaid rate and we do obviously need to address those concerns in order for us to be able to address minimum wage concerns and other cost-related factors.

And I just want to mention that we have other incentives and other types of costs pertaining to travel and other pay that will be impacted through this compression point that has been spoken about. Everything that we provide for our staff, including the consideration of merit raises, going forward may become obsolete if agencies are not able to manage the base wage that is out there.

Thank you for the opportunity.

CHAIRMAN FARRELL: Questions?

CHAIRWOMAN YOUNG: Senator Hannon.

SENATOR HANNON: You mentioned a figure of 1.9 billion?

MS. HAIGHT: 1.7, correct.

SENATOR HANNON: 1.7. That's a cost to home healthcare agencies?

MS. HAIGHT: Additional cost.

SENATOR HANNON: Because of the federal overtime rule?

MS. HAIGHT: No, no, because -- that's because of the -- that would be the additional cost of the proposed minimum wage increase if it went up to $15 an hour today.

SENATOR HANNON: And over what period of time?

MS. HAIGHT: That would be at the $15 point, so that would be if today the rate was $15 an hour, that's what the additional cost would be.

SENATOR HANNON: Okay.

MS. HAIGHT: We estimate it will be higher, obviously, you know, once we factor in the expected increase in usage of home care services.

SENATOR HANNON: And what is the cost on an annual basis of the federal overtime rule?

MS. HAIGHT: The Department of Health is working on a rate-setting process now. They haven't identified that yet. They're going to be putting out a survey, Mercer is going to be doing a survey to get a better sense from home care providers as to what that cost is.

SENATOR HANNON: Thank you.

MS. HAIGHT: But I will say that obviously, you know, we're talking about a difference between -- a significantly higher impact from the minimum wage proposal.

SENATOR HANNON: Well, in the meantime, is it possible that home healthcare agencies are going to move people into nursing homes? Because if they've added 24-hour care without having to pay overtime after 13 hours, but now they have to pay a full 24 hours, they're going to move them into nursing homes.

MS. HAIGHT: Well, so far we're still

not paying at 24 hours unless it's 24-hour care. Most live-in cases are paid at less than that, 13 hours, provided they have a certain amount of sleep and breaks during the day for meals and so forth.

But even so, I don't -- we can't really answer that question as to how many people might be moving into nursing homes at this stage.

SENATOR HANNON: Thank you.

CHAIRWOMAN YOUNG: Senator Savino.

SENATOR SAVINO: Thank you.

I don't have to ask you about your position on the minimum wage; we had that conversation in the hallway before, and I share your concerns about it.

I'm just confused on the overtime issue. So prior to this federal ruling, home care workers were not entitled to collect overtime after 40 hours a week?

MS. HAIGHT: They were -- we actually rely heavily, our industry in the past has relied very heavily on overtime hours. So there's been a major restructuring that's

happened in the past year just to deal with this very small increase.

When you think about the number of hours we supply, you know, 300 million hours a year, and the very narrow margin -- and many of our agencies are operating underwater right now in terms of our reimbursements -- the very narrow margin that we operate under -- our agencies, you know, saw what was coming, they saw that the government had not adjusted rates, that the plans were not going to be increasing their rates and they knew that they had to make these adjustments to be able to stay in business and maintain their weekly payroll obligations.

So whereas we might have had, in the past, one worker doing 60 hours, you know, a week for one client, we would have to break that up now to two or three workers. Now, in some cases that's fine, you know, you can achieve efficiencies, but in some cases that's detrimental, particularly for patients, for instance, who have Alzheimer's or dementias who have particularly, you know,

challenging situations where change can be very disruptive and traumatic.

So that's when we can't answer about how the impacts ultimately have gone in terms of where some families have had to make difficult choices. But for many of our agencies, we've had to change our staffing. Eighty percent of our agencies surveyed reported that they are not taking any new live-in cases. And where are these people going? You know, I don't know the answers to those questions.

But I actually had, in my, you know, hyperventilating trying to get through too many words in too little time, somehow omitted from my testimony the important point that we do support our workers. We realize that they are the heart and soul of the care that we provide, that they're dedicated, they work hard, it's difficult work, it's challenging conditions. We totally support the need to provide fair wages for our workers.

The challenge is, you know, we have to

pay them in real money. And that isn't coming.

SENATOR SAVINO: Right. We totally agree on that.

You didn't mention it in your testimony, but it is in your written testimony, about the high cost of workers' compensation cases and the rate of workers' compensation injuries that are occurring in the home care industry. Can you explain -- how is that happening? What's happening there that's not happening maybe in hospitals or -- and what can we do to address that?

MS. HAIGHT: I'm very glad that we have Bader here, because she's actually done some tremendous things within her agency to reduce workplace injuries.

But you have to realize that it's not a controlled setting. It's not like a hospital or nursing home. People are going to homes, they're tripping over things, there's dogs, there's any number of -- you name it, I'm sure Bader can tell us a story about that.

The workers' comp rates increased by 35 to 40 percent two years ago, and another 25 to 30 percent just this year. So our workers' comp rates are among the highest of any industry. And again, that sort of falls into this whole category of unreimbursed expenses which we definitely need to have.

Part of that is the high rate of injury. You know, you're talking lifting people who are heavy and -- why doesn't Bader answer that question.

MS. REYNOLDS: Well, it is not a controlled environment, as Laura said. So we are not able to insist on some of the things that we can have in an infrastructure in a facility. While we do evaluate for safety and we do try to encourage and not put our employees in harm's way, there are circumstances that we sometimes can't control for in a home setting.

And it is the client's right to refuse or request certain things be done, and then we have to make demonstrations as to whether or not we can safely provide those home care

services in their home, or maybe they do need to go to a higher level of care or a different setting that could be more costly.

SENATOR SAVINO: Thank you.

CHAIRMAN FARRELL: Thank you.

CHAIRWOMAN YOUNG: Thank you very much.

MS. REYNOLDS: Thank you.

CHAIRMAN FARRELL: Medical Society, State of New York, Joseph Maldonado, M.D., president; Elizabeth Dears, chief legislative counsel.

MS. DEARS: Good afternoon, Chairwoman, Chairman. It's a pleasure to be here.

Regrettably, Dr. Maldonado cannot join us today. But on his behalf, and on behalf of the solo, small group, large group, and employed physicians across New York, I thank you for the opportunity to present our reaction to the budget.

Regrettably, today I must express great concern with regard to a number of the provisions included in the proposed budget

that exacerbate the already challenging practice environment that physicians face. Physicians, while endeavoring to transform their practices, confront certain market forces threatening their very viability and contend with increasing costs associated with many of the federal and state mandates.

The costs of running a practice continue to rise steadily, while Medicare and commercial payers continuously reduce our reimbursement. Exacerbating the situation for many physicians is the significant financial losses that they have incurred as a result of the demise of Health Republic.

While we have a number of newly insured and have seen an increase in Medicaid beneficiaries, coverage being offered is less robust, with many plans narrowing their networks who are dropping scores of physicians who have historically served this population, thereby impeding access to care.

So with regard to the budget, as Senator Seward mentioned and many others have discussed already, the budget fails to

include a guaranty fund or other pool of monies to assure that physicians and other providers can be reimbursed for the services that they did provide to the enrollees of Health Republic throughout its demise this fall.

In Westchester County, for instance, we have five physician practices who have lost more than $12 million. And while we're getting more information on the aggregate nut that physicians are bearing in terms of arrears, I think we can safely say and guesstimate that it's around the $100 million level.

We urge, consequently, that the Legislature work with the Governor to identify a funding source to make physicians and other providers who served this population whole.

The budget also would cut an appropriation for the Excess Medical Liability Insurance Program by $25 million. As a result of this cut -- currently there are 23,000 -- roughly -- physicians who are

covered under the Excess program; they receive an additional layer of $1 million in coverage over and above their primary layer of coverage. Fifty-five percent of physicians would be dropped from the Excess program if this cut were to be implemented.

Physicians who are neither neurologists, general surgeons or OB-GYNs -- so everyone else -- north and west of Greene County will be dropped from this program. That's every cardiologist, including cardiologists in Olean, New York, anesthesiologists in Syracuse, New York, and every primary care physician in the North Country will be dropped.

In Kings and Queens County, all primary care physicians will be dropped, as will all ophthalmologists and anesthesiologists. We have an interesting circumstance in the first territory, which includes New York County, Westchester, Sullivan, Orange, and Rockland counties. There, you have 2108 internists, but there's only funding for 527. How exactly will that

funding and coverage be allocated amongst those internists in Territory 1? How will those physicians who will be dropped by this initiative be protected?

We have to recall that it was first implemented in the mid-'80s because judgments and settlements pierced the primary layers of coverage afforded and purchased by physicians. Nothing has changed; in fact, the situation has been exacerbated over the years. If anything, proposals that are currently being discussed in the Legislature that would increase our liability exposure are going to further exacerbate this problem.

If we are going to continue to attract the best and the brightest to the State of New York, as the commissioner says he wants to do, we need to restore funding for the Excess program.

We're also concerned by a proposal that would allow retail clinics to be established in New York without CON review for public need. This proposal specifically will allow publicly traded, for-profit

entities to directly own healthcare clinics in communities that are already saturated with healthcare providers. Under this proposal, it's not necessarily limited to establishing these clinics in underserved communities.

We're also concerned by sweeping changes to New York's workers' comp program that will discourage physicians from participating in the program in the future.

And lastly, I would like to also encourage action to reduce the medical liability premium burdens shouldered by physicians in New York State. We're among the highest in the country. And as Mr. Raske noted, medical liability payments far and away exceed every other state in the nation by more than twice the second-highest state.

We need comprehensive reform to reduce these costs, and we encourage you to reject measures that on their own would expand the cost burden associated with medical liability for physicians.

Thank you very much for your time.

CHAIRMAN FARRELL: Thank you.

Questions?

CHAIRWOMAN YOUNG: Questions?

Thank you very much.

CHAIRMAN FARRELL: Thank you.

New York State Health Facilities Association, Stephen Hanse. Did I pronounce that correctly?

As we get closer to the end, which is about 7 o'clock, would the people come down and be next? Ami Schnauber, you're next, with James Clyne.

MR. HANSE: Good afternoon.

CHAIRMAN FARRELL: Good afternoon.

MR. HANSE: My name is Stephen Hanse, and I have the privilege of serving as vice president and counsel for the New York State health facilities association and the New York State Center for Assisted Living.

Joining me today is Deanna Stephenson, the director of managed programs for the New York State Health Facilities Association and the New York State Center for Assisted Living.

NYSHFA and NYSCAL members and their 70,000 employees provide essential long-term care to over 44,000 elderly, frail, and physically challenged women, men and children at over 350 skilled nursing and assisted living facilities throughout New York State.

As we sit here today, New York's long-term care and assisted living providers face significant challenges as a result of the state's transition to managed long term care, recent state budget constraints, and certain initiatives proposed in the 2016-2017 Executive Budget.

Over the past nine years, funding cuts to New York's long-term healthcare sector have exceeded $1.7 billion. Initiatives implemented by the MRT have resulted in approximately $700 million in cuts over the past three fiscal years, and the potential for additional federal Medicare cuts only exacerbates New York's already fragile long-term-care finances. For example, at $48.43 per patient per day, New York unfortunately has the nation's second largest

shortfall between Medicaid payment rates and the cost of providing necessary care.

As providers enter into their eighth year without a trend factor for inflation, New York's long-term-care facilities have worked hard to endure these past budget cuts, and this is demonstrated by the fact that nursing home spending is often below the Medicaid global spending cap enacted under the MRT. Recognizing these constraints, it is very important to note that the 2014-2015 enacted budget eliminated the MRT-imposed 2 percent across-the-board provider rate cut for nursing homes which was effective April 1, 2014. This initiative would have restored $280 million to long-term-care providers throughout New York State over the past two fiscal years. However, the state has yet to enact the approved restoration of these needed monies.

With these issues and constraints serving as a backdrop, we would like to briefly address three areas of concern with regard to the 2016-2017 Executive Budget.

First, the impact of the proposed minimum wage increase on long-term care and assisted living providers; Deanna will discuss issues concerning the state's transition to Long Term Managed Care; and finally, I'll raise three issues that NYSHFA/NYSCAL respectfully request be included within the 2016-2017 enacted budget.

Turning first to the minimum wage, first I would like to thank Senator Young, Senator Hannon, Senator Rivera, Senator Savino and the committee in general for the recognition of the impact that the state's minimum wage has on New York's healthcare providers.

You may be familiar with the assertion that "a rising tide lifts all boats" with regard to increasing the minimum wage. Certain economists view this assertion as true for those businesses and employers who are able to pass the increased labor costs through in higher prices for their products or services to the end consumer. However, this assertion is not true for the state's

Medicaid providers who provide essential long-term care to New York's most frail and infirm individuals.

This is true because there is one major problem. As you've heard today, providers of long-term care and the patients we serve are almost completely dependent on government programs for the payment of necessary care. As such, while other boats may be lifted with the tide, New York's skilled nursing and assisted living providers are not able to pass through the increased labor costs of an increase in the minimum wage as a consequence of being tethered to the "anchor" of Medicaid, if you will.

It has been said that to care for those who once cared for us is one of life's highest honors. Nowhere is this more evident than in New York State's nursing homes. Our residents are often discharged from hospital settings needing extensive care and rehabilitation. In addition to stroke patients, ventilator-dependent residents, cancer patients, dementia patients, TBI

patients and other high-acuity patients, a majority of our residents need considerable assistance with their activities of daily living.

Caring for our residents is a challenging privilege that requires training, expertise, patience and resources. Presently, 76 percent of all nursing home residents throughout the State of New York rely on Medicaid to pay for their care. Another 13 percent of our residents rely on Medicare to pay for their care. Consequently, nursing home and assisted living providers face a unique and difficult position. First, we cannot simply raise the price of our services to reflect higher labor costs due to an increase in the minimum wage. Second, we do not have the ability to change the makeup of our patient mix or shift costs to other residents. And third, we are not willing or able to reduce the needed services or the quality of the care we provide.

Working collaboratively with other statewide associations representing nursing

homes, hospitals and home care providers, and utilizing the best currently available data, NYSHFA conservatively estimates the Executive's minimum wage proposal would increase costs for skilled nursing providers by $600 million, and more than $50 million annually for assisted living providers. These figures were established employing a methodology that you had earlier with regard to direct impacts, wage compression and indirect labor costs.

Given the significant costs associated with the proposed minimum wage increase from $9 to $15 per hour, coupled with the unique inability of skilled nursing and assisted living providers to raise the price of our services to absorb any mandated increase, it is vital that the state fully fund the increased labor costs resulting from the implementation of any minimum wage increase.

Quite simply, the proposed minimum wage increase places skilled nursing providers in a uniquely detrimental situation. We are dependent upon state and

federal funding for payments of almost 90 percent of our residents. These payments already do not meet the cost of providing care at the state's current minimum wage level.

As other states have done when increasing the minimum wage, New York must financially acknowledge the unique nature of skilled nursing and assisted living providers and fully fund this increase in a manner that does not impact the Medicaid global cap, to ensure the continuation of access to high-quality, long-term care.

I will now turn the mic over to Deanna Stephenson.

MS. STEPHENSON: Good afternoon, everyone.

CHAIRMAN FARRELL: Good afternoon.

MS. STEPHENSON: In regards to managed long term care, I want to talk about three distinct pieces today. The first one I want to discuss is the extension of the nursing home benchmark rate.

In 2015, the state established a

benchmark rate that would be paid by managed long term care plans to contracted skilled nursing facilities for a three-year period. Generally speaking, the benchmark rate is the current fee-for-service Medicaid rate and is set to sunset in 2018. In establishing the benchmark rate, the state acknowledged that it will assess the impact of its long-term managed care policies and consider extending the benchmark rate beyond that three-year requirement.

The benchmark rate provides vital rate stabilization and has secured the capital rate component necessary to fund needed facility renovations in order to optimize our residents' care. As such, the benchmark rate has served to provide a level of certainty to providers that will be necessary for the program to continue beyond the rate's sunset date.

A stabilized Medicaid benchmark rate will also add to a provider's ability to commit to the Fully Integrated Duals Advantage, which is our FIDA initiative,

which coordinates resident care between the state and federal governments.

Secondly, health plan solvency. Stabilizing resident care rates through the benchmark rate not only benefits providers and the residents we serve, but it also benefits managed care plans by ensuring that premiums will be sufficient to serve our most vulnerable population.

At the start of the state's transition to managed long term care, there were approximately 45 managed long term care providers. Throughout 2015, we witnessed the failure, reformation and collaboration of many of these plans. Earlier in 2015, as you had heard before, HHH Choices Health Plan filed for bankruptcy, leaving behind creditors including nursing home providers. One example is we had a provider that is standing and waiting for a $500,000 payment.

Consequently, increased scrutiny by the state as to the financial health of long term managed care plans is needed to protect both consumers and providers.

Lastly, eligibility determinations. It is the state's policy that individuals not enrolled in a MCO or newly eligible individuals in need of nursing home care will need to obtain eligibility through their local social service district. Under the state's policy, local districts have 45 days at present from the date of a completed Medicaid application to determine eligibility. To date, there are numerous documented reports of counties failing to meet the required timeline of those 45 days, therefore jeopardizing necessary payments for nursing home care. If these extended eligibility time frames continue, the goals that you heard this morning from Jason of the state's long term managed care initiative will not be achieved, as enrollment numbers will be greatly reduced.

At this point I'm going to turn it back to Stephen.

MR. HANSE: In the interests of time, I'm going to summarize very quickly on the last remaining items.

One is the one that the New York State Senate has included in their one-house budget with regard to the return on equity, something that was taken away in the MRT from proprietary nursing homes. We respectfully ask for the Legislature to include that in the 2016-2017 enacted budget.

Secondly, we would respectfully request that the Legislature include an increase through the SSI rate for adult care facilities. New York has not increased the state portion of the Supplemental Security Income rate for low-income elderly and disabled individuals in adult care facilities in eight years. The current $40 per day is clearly insufficient to provide room, board, meals, activities, case management, supervision and medication assistance for our SSI residents.

And lastly, the issue we would like also included within the 2016-2017 budget will be an Assisted Living Program rate increase. Assisted living facility Medicaid rates under the ALP program are based on 1992

costs, receiving only minimum inflationary trend adjustments through 2007. And since 2007, like skilled nursing facilities, assisted living providers have not received any inflationary trend factor adjustments to their rates.

Thank you very much for your consideration.

CHAIRMAN FARRELL: Questions?

CHAIRWOMAN YOUNG: Senator Krueger has a question.

SENATOR KRUEGER: Thank you.

Just a clarification. In the beginning of your testimony you talk about your facilities on average receiving $50 a day per patient from Medicaid?

MR. HANSE: No. What that is, there's a national study that goes through all the states in terms of the cost to care for a Medicaid resident. And right now the amount that we are reimbursed, nursing home providers throughout New York State are reimbursed, falls $48 short of the full amount necessary to care for those residents.

SENATOR KRUEGER: So you would agree that in New York State Medicaid is paying more like a minimum average of $300 a day; in certain parts of the state, close to $400 a day?

MR. HANSE: The average, to the best of my knowledge, New York State's actually down towards $200. In some places it's well below that. But the average for New York State, when you take all the Medicaid rates, you know, from Montauk to Buffalo in terms of what is that state average, it falls $48 short of the provision of care for that resident.

SENATOR KRUEGER: Even though most states don't cover nearly as much long-term care under its Medicaid program as we do?

MR. HANSE: That was a decision of the Department of Health in terms of the population that is covered.

SENATOR KRUEGER: Because I was looking up the states' charts. And I suggest you double-check, because I think their numbers for nursing homes are around the 320

to 380 mark. I didn't see any regions where it's falling below --

MR. HANSE: In terms of the Medicaid reimbursement? I would not say upstate, that's absolutely not true. And even downstate I think the average is well below that.

SENATOR KRUEGER: So take a look at their charts, because I think we're working off some different numbers. And I think --

MR. HANSE: Sure. No, and I'd be happy to get you --

SENATOR KRUEGER: We can agree and disagree, but I think New York State ends up paying more towards long-term care in our Medicaid program than anywhere by a pretty hefty amount.

MR. HANSE: That may be accurate, but I still think for the provision of care, Senator, that there is a full shortfall. I mean, that is an accurate number. And I will get you that report.

SENATOR KRUEGER: Thank you.

CHAIRWOMAN YOUNG: Thank you.

CHAIRMAN FARRELL: Thank you.

CHAIRWOMAN YOUNG: Thank you for your input.

CHAIRMAN FARRELL: LeadingAge New York, Ami Schnauber, vice president, advocacy and public policy, with James W. Clyne, Jr., president and CEO.

Next will be Community Health Care Association.

MS. SCHNAUBER: So thank you for having me. We don't have Jim Clyne with us today, it will just be me. And I appreciate this opportunity to present testimony on the health and Medicaid components of this year's budget.

My name is Ami Schnauber. I represent LeadingAge New York, and we represent nonprofit aging services providers, long term and post acute care providers, all the way from independent senior housing to home care, assisted living, managed long term care, nursing homes, continuing care retirement communities and other retirement communities.

So we have an interesting perspective,

since we represent the entire continuum, and we've found that a lot of our members also represent an entire continuum of providers on a campus setting.

And I would say the biggest challenge we have is that there hasn't been a lot of thought into what we're going to do with long-term care. I can tell you that by 2025 you will see -- I'm not reading all my testimony, don't worry about that. By 2025, the state's population -- 18 percent of the state's population will be in their eighties.

Unfortunately, this budget, in past experience, has not provided any real investment in long-term care.

And if you look on page 3 of your testimony, you will see an answer to the question that Assemblyman Gottfried asked of Jason Helgerson today, and the commissioner, which was: How much of the DSRIP money is going to non-acute care providers? So how much of that money is going to anyone other than a physician or a hospital? And you will see from that pie chart that it is a very

small fraction. It's on page 3 of the testimony.

The fact is the money is not trickling down. Trickle-down economics is not working for long-term-care providers, I'll tell you that.

This budget doesn't improve that situation. You may recall that last year you included residential healthcare facilities in the Essential Healthcare Provider Grant Program. However, when it was ultimately implemented by the Department of Health, they limited it to hospitals and hospital-based nursing homes and said that nursing homes were not included because they were not hospitals.

We then looked at the Nonprofit Infrastructure Capital Investment Grant Program that you also enacted, and in this case nursing homes were also excluded because we are hospitals, because Article 28 hospitals include general hospitals and nursing homes.

So if you say hospitals, it includes

us, but if you say general hospitals, it does not. So in both cases, they excluded us.

So we're again at a point where none of this investment, whether it's from IT or any infrastructure, is really going to long-term care. And the fact is we're not going to prepared. We have E-Prescribing, someone talked about the I-STOP provisions a little bit earlier with OMIG. We still have providers who are struggling to meet that March 27th deadline because they simply don't have the resources to put these IT systems in place that are required.

The great news this year is that the department has decided that the waivers could go beyond just the physicians and it could actually be for settings. So many of our members are looking into that. But the reality is that if we don't find resources for long-term-care providers, we're not going to move in the direction that we want to.

And so what we're asking for is $100 million in funding that would specifically be directed to long-term

post-acute care providers. Because if you don't line it out for us, it is clear that our members are not going to get it.

The other place of significant concern for long-term-care providers is the Medicaid rates for managed long term care. They are woefully inadequate. We are now working on two-year-old rates. As Jason Helgerson said, there's a whole number of rates that are waiting on CMS approval. But what it has meant over these last couple of years is all these additional mandates and these new populations that are going into managed long term care are simply not accounted for in the rate.

And as you will also see, we included a couple of other charts on page 5 and page 6, in which we see that the aggregate premium margin of managed long term care plans has plummeted from a positive 3 percent in 2012 to a negative 4 percent for the fourth quarter of 2014.

So, you know, once these rates get approved through CMS, we still have a lot of

ground to cover because we've been negative for so long. And I would say that if we can't start turning that picture around, the plan of putting all these folks into managed long term care and transforming the long term care system is just not going to happen. We have too many plans who are in the negative, and they're not going to be able to survive.

And I think that, you know, you have a situation where if -- you might want some consolidation, but no two providers who are in the negative are going to be in the positive by merging. So I think that we have a real issue that we're asking for the Legislature to address. We are actually asking for you to reject the Governor's $22 million in cuts to managed long term care plans. And in addition, we're asking for an increase of $90 million to help sustain the managed long term care plans.

The other proposal impacting managed long term care plans, adult day healthcare and nursing homes relates to the transportation carve-out. You may recall

that this is a provision that the Governor included last year for managed long term care. He is now -- and you saw fit to include statutory language that would ensure that managed long term care could be carved out of the state operator for transportation.

We would like to see it reestablished in this budget. We would like to also include adult day healthcare and nursing home rates. I think that what the Executive is failing to understand is the amount of care that it takes for these plans and providers to transport individuals.

These are people with very high acuity levels. They're people who would be qualified for nursing home level of care. And just getting them from their home onto a van and to where they need to get takes a lot of work. Sometimes it includes shoveling their sidewalk. And so we're just concerned about what that would mean in terms of time for them to get to their programs.

The other thing I would say is that we have a whole number of managed long term care

providers and other providers who have spent significant money over the last year or two to put transportation fleets together, and now they're being told that those won't be funded any longer. We think that's the wrong direction.

You'll see that my testimony includes pieces on minimum wage and the Fair Labor Standards Act. You heard from the Hospital Association, NYSHFA and HCP. We worked on those numbers together. It's a significant impact. You know, our providers would love to pay increased rates to their staff, but when 70 percent of your income comes from Medicaid, there's no way you can do that without an increase in Medicaid funding. So we would ask that any increase that you put there, you fund.

But I'd also say that we're in very dangerous territory when you have certain workers getting higher minimum wage, because our members are going to have to compete for those workers anyway. So we're going to have areas of the state where you can get $15 by

working at fast food but you'll only be able to make $10 an hour caring for somebody. Those are very hands-on jobs, it's a lot of hard work. It's hard to imagine how you're going to get quality workers under those conditions.

The other -- the final areas I would like to talk about are two components of aging services that I think are important for the state to consider, is adult care facilities, assisted living program, and independent senior housing. The fact is, if we can keep these people in the community and in these settings longer, we're going to be able to keep them from moving to a nursing home level of care at a much higher cost to Medicaid.

We know that in some parts of the state, because the SSI rate is so low -- the last increase was eight years ago -- we have areas of the state where the adult care facilities are prepared to close down. And in some counties they're the only ACF. That will mean that those individuals will have to

go to a nursing home because there's nowhere else they can go. We have to find a way to invest in these settings.

The other thing I would mention is a resident advisor program that we would like to see Medicaid fund. Senator Young is I'm sure very familiar with the "Smartments" that are in Jamestown, in her district. And what we've found is that these apartments provide a great platform for care.

And if we can keep people in independent senior housing and provide some very light touch services, we know that we can keep them from going to Medicaid. Many of these individuals, if they're on SSI, if they're in low-income housing, they truly are one event from being a high Medicaid user. There's significant savings if we can keep them in independent senior housing. But the only way we're going to do that is if we increase funding for independent housing.

There's a great program in Syracuse where Christopher Communities is working with a PACE program, and they collocate some

services. Again, this is a huge benefit to the community. It's keeping people in independent housing and keeping them from going to nursing homes.

So if we can replicate the Smartments that are in Jamestown, or if we can be replicating the program that Christopher Communities is offering in Syracuse, we are going to keep people in the community longer at great savings to Medicaid.

CHAIRWOMAN YOUNG: Thank you, Vice President Schnauber.

MS. SCHNAUBER: You're welcome.

CHAIRWOMAN YOUNG: No questions. So we appreciate your participation today.

MS. SCHNAUBER: Okay. Thanks.

CHAIRWOMAN YOUNG: Thank you.

Our next speaker is Beverly Grossman, senior policy advisor from Community Health Care Association of New York State.

Welcome.

MS. GROSSMAN: They lost my testimony. Let's hope that's not personal. You got it? Okay. So I'm going to go ahead? Thank you.

CHAIRWOMAN YOUNG: Go ahead.

MS. GROSSMAN: Thank you for the opportunity to provide testimony today on the Governor's 2016-2017 budget proposal.

My name is Beverly Grossman, and I am the senior policy director of Community Health Care Association of New York State, CHCANYS. We are the state's primary care association for federally qualified health centers. We serve as the voice of community health centers and as leading providers of primary care in New York State.

We work closely with more than 60 federally qualified health centers, FQHCs, that operate over 600 sites statewide and serve more than 1.8 million patients annually. We're not-for-profit community-run health centers located in medically underserved areas that provide high-quality, cost-effective primary care to anyone seeking it, regardless of their insurance status or ability to pay.

The most pressing issue currently affecting FQHCs is a $54.4 million funding

deficit in our indigent care reimbursement. The Diagnostic and Treatment Center Uncompensated Care Pool, D&TC UCP, has historically been comprised of $54.4 million in state funding, with an equal federal match, totaling $108 million. Although this funding does not fully reimburse FQHCs for the cost of providing care for the uninsured, it is essential to ensuring that FQHCs are able to do so, a cornerstone of our mandate.

While we are pleased that the Executive Budget includes the state share of $54.4 million, the authorization for the federal match expired in 2014. Today, FQHCs still have not received more than half of their 2015 indigent care funding. The Department of Health requested the federal match to be reauthorized and extended, but we have yet to get an approval.

FQHCs are already beginning to feel the effect of not receiving the full 2015 indigent care funding amount, and have begun reducing staff, delaying expansion plans, limiting clinic hours, and making plans to

reduce care such as oral and behavioral health services, canceling OB and women's health services, and so on.

Nearly 25 percent of health centers that receive indigent care funds are experiencing operational deficits and will continue to do so if they do not receive 2015 federal match dollars.

In order to address this critical funding deficit, we urge the Legislature to include $54.4 million in contingency funding to fill the gap created by the loss of federal dollars, to ensure that FQHCs are able to continue to provide high-quality community-based primary care to all New Yorkers.

New York's stated priority is to transform the healthcare system by providing access to high-quality coordinated care through the integration of primary care and other community-based care. However, downstream community providers have yet to receive any meaningful funding under DSRIP compared to the total percentage of

dollars available to PPS leads.

Furthermore, in last year's budget non-hospital community-based healthcare providers received less than 4 percent of the nearly $1.7 billion in new healthcare funding. New York State is relying on the work of community-based healthcare providers to transform the state's healthcare delivery system, yet has not made the equitable investment in the sector to support this work.

The state should make the following investments in community healthcare providers to support their integral role in transformative initiatives: Allocate 25 percent of the $195 million in healthcare facility transformation funding to community healthcare providers.

CHCANYS is pleased that the Governor's Executive Budget proposes restructuring $200 million of the Healthcare Facility Transformation Program appropriated in last year's budget and making $195 million of that available to healthcare providers for

facility transformation. The inclusion of this funding is a heartening first step, although the funding must be available to all types of providers participating in the transformation efforts, not just hospitals and acute-care settings.

Additionally, CHCANYS requests that a minimum of 25 percent of the $195 million, or approximately $49 million, be allocated solely to community healthcare providers in order to ensure that community healthcare providers have equitable access to these funds.

We also ask the Legislature to create an Essential Community Healthcare Provider Pool. Last year's budget included $355 million for an Essential Healthcare Provider Fund to support provider transformation initiatives. However, community healthcare providers had no access to this money, despite their essential role in the state's transformation initiatives.

CHCANYS requests a new $88.5 million funding pool, the Essential Community

Healthcare Provider Fund, be established and made available solely for community healthcare providers. This pool would have the same purpose as the pool in last year's budget, to support capital and working capital needs of community healthcare providers in the furtherance of healthcare transformation.

In addition to the above funding requests, CHCANYS also asks you to add $20 million to the Community Healthcare Revolving Capital Fund and ensure that last year's previously appropriated $19.5 million are sent out in a timely manner; fully restore funding for health centers serving migrant and seasonal farmworkers to previous fiscal years; support Doctors Across New York; and provide additional support for school-based health centers to account for the upcoming transition to managed care.

In conclusion, CHCANYS supports New York's healthcare transformation efforts and is pleased the state has recognized the importance of expanding access to

comprehensive community-based care. However, meaningful, sustainable delivery system transformation will only be achieved if the state provides appropriate financial investment directly to the community healthcare providers whose work is at the center of this reimagined care delivery system. CHCANYS stands ready to work with the Governor and the Legislature to support New York's ambitious healthcare agenda.

I thank you for the opportunity to present, and I'm happy to answer any questions.

CHAIRMAN FARRELL: Thank you very much.

Questions?

CHAIRWOMAN YOUNG: Senator Rivera.

SENATOR RIVERA: Hello. I just have a quick one.

On page 2, where you were talking about the FQHCs that are currently -- I'm just going to quote here: "FQHCs are currently experiencing a $54.4 million deficit in addition to the prospect of

additional costs due to numerous factors."

So the transition to value-based payment, closure of Health Republic, and proposed minimum wage increase, that refers to future deficits, not the $54.4 million?

MS. GROSSMAN: So the $54.4 million is the federal match has yet to be approved by CMS for our indigent care dollars. So it started -- we flagged it in 2013, it expired in 2014. So last year we only received half the dollars that we anticipated receiving for indigent care. And so far it hasn't been reauthorized, so we will have a -- you know, if it's not reauthorized, it will be 50 percent going forward.

SENATOR RIVERA: So the other factors that you mentioned are -- would be on top of this, is what you're saying.

MS. GROSSMAN: Exactly. There's, you know, what we call hidden cuts. So we have the indigent care funding, we have other things like minimum wage, Health Republic, all these things compounded. And at the same time, what new dollars were out there last

year weren't available to us. Even though the rhetoric is, you know, we're the cornerstone of rightsizing and reimagining healthcare delivery in New York.

SENATOR RIVERA: Thank you.

CHAIRWOMAN YOUNG: Thank you. No other questions.

MS. GROSSMAN: Thank you.

CHAIRMAN FARRELL: Thank you very much.

Next, Steve Sanders, Agencies for Children's Therapy Services.

Good afternoon, Steve.

MR. SANDERS: Good afternoon. You're still here. I don't just mean today; you're still here.

(Laughter.)

MR. SANDERS: Which is heartening.

Good afternoon, ladies and gentlemen. Chairman Hannon, Chairman Farrell -- and I can't help but observe, Chairwoman Young, I believe that you are the first woman in the history of the State of New York to serve as the chair of either the Assembly or Senate's

fiscal committees. And that's quite a milestone; I congratulate you. It's terrific.

CHAIRWOMAN YOUNG: Thank you very much, Steve. Always good to see you.

MR. SANDERS: I'm here again this afternoon to talk about Early Intervention. I'm the executive director of the Agencies for Children's Therapy Services. ACTS' members provide about 60 percent of the Early Intervention services statewide.

The Governor has essentially made proposals in three areas of Early Intervention. The first area is of tremendous concern, and I want to address most of my remarks towards those proposals, in which the commissioner earlier today had an interesting exchange with Assemblyman Abinanti.

One set of proposals that the Governor, through the Department of Health, has made deals with changing the method and the circumstances that toddlers and infants will be evaluated for eligibility into the

Early Intervention program. What the Governor basically wants to do is to set up a new layer of bureaucracy. He wants to do pre-evaluations before the evaluations. He calls it prescreening.

The commissioner, in his exchange with Assemblyman Abinanti, insisted that that will somehow speed the process along, that kids will somehow get evaluated more quickly, get referred more expeditiously, and receive their services on a more timely basis.

The best I can say about those remarks is that the commissioner is wrong. It doesn't even make sense -- even if you don't really understand the process, it doesn't really make sense to a layperson to hear that a new layer of bureaucracy to evaluate a child is somehow going to get that child into services which that youngster desperately needs more quickly. Doesn't make any sense. The commissioner's wrong.

There are two other things about that proposal that are very troubling. Not only does the commissioner want to have

prescreening of infants and toddlers in some cases before they will get evaluated and then services will begin, the Governor also proposes that in some cases evaluations are not necessary at all, that you can just take a youngster's prior medical condition and take the records that are associated with that prior medical condition -- which in some cases may have nothing to do with a disability -- and use those records as a substitute for evaluations.

Well, I have real serious concerns about that, because those medical records and those observations by some health professionals who are not trained to identify and really target developmental disabilities very often will miss symptoms that only qualified evaluators are able to discern and then to make recommendations about services.

So using a set of medical records as a proxy for determining eligibility is a real problem.

The third thing in this part of the Governor's proposal which is very troubling

is that the Governor takes out altogether -- he eliminates multidisciplinary evaluations.

In other words, evaluations right now for a child who is suspected of having a learning delay or a developmental disability is done on an across-the-board basis: Speech, occupational therapy, the variety of delays a youngster can have. That's multidisciplinary.

For some reason unknown to me, the Governor brackets out "multidisciplinary" and just says when it's appropriate, an evaluation will take place. Well, I think that is almost ensuring that this youngster or many youngsters are not going to be able to receive all of the services that are appropriate to that youngster.

Why would the Governor do this? Well, you know, the fewer kids who get referred to Early Intervention, the less money that the state and the counties have to pay. That's the wrong prescription. That's the wrong way to go.

Every study that has been done about

Early Intervention makes the same conclusion, which is that when these very young kids, age zero or even one or two months to 3, receives Early Intervention, that eliminates more costs that will be incurred by school districts and preschool special education and school-aged special education, far more expensive modalities of services. Those expensive services are not needed, in some cases, or at least the disability is lessened or remediated through Early Intervention, saving the state money.

Early Intervention is not a cost driver, it is a cost saver. And when we try to skimp on providing adequate resources for Early Intervention, we pay the price later. More importantly, these youngsters and their families pay the price with a lifetime of more complicated disabilities than they might otherwise have had were it not for the fact that they did not get the Early Intervention they needed.

Let me quickly mention the two other areas that the Governor does, I think, make

constructive recommendations. He does recommend a 1 percent increase in the administrative cost for processing Early Intervention claims for agencies. This doesn't make up for 20 percent cuts over the last four or five years, it doesn't make up for the fact that there's been no increase for Early Intervention in well over a decade, but it's a start. And I'm pleased at least to see the needle going in the right direction with respect to that.

One other area that I think is important to note, the Governor makes some changes in the Insurance Law which would require that commercial companies adjudicate the claims faster, hopefully pay more of the Early Intervention claim.

Currently and historically, this percentage has never changed: Commercial insurance pays 2 percent of the $600 million which is claimed in Early Intervention every year. Let me repeat that. Commercial insurance pays 2 percent of the $600 million in Early Intervention claims that are made

each year by the nearly 70,000 youngsters in early intervention. That is shameful. It's shocking.

And I'm pleased that the Governor is trying to take steps this year to have commercial insurance not only adjudicate the claims faster, because it takes far too long with far too much bureaucracy in determining whether a claim will be honored, but they pay far too little. And anything that we can do to help ensure the commercial insurance companies are paying their fair share not only saves the state money, but it also is the right balance. It still preserves the autonomy for private insurers, but it also has the right balance of autonomy and I think responsibility.

So to conclude, I would say to you that the Governor's proposals to amend the Public Health Law are wrong. This Legislature considered similar proposals in 2013; you rejected them for the right reasons. They didn't get better with three years of age. They were wrong in 2013,

they're wrong in 2016. I hope you'll reject them again.

And his proposals to amend the Insurance Law I think are things you should seriously consider, because commercial insurance needs to be stepping up to the plate and honoring a much higher percentage of those claims.

I thank you very, very much for your time, and your consideration always.

CHAIRMAN FARRELL: Thank you very much, Steve.

Questions, Senator?

CHAIRWOMAN YOUNG: Yes. Senator Krueger.

SENATOR KRUEGER: Haven't seen you in the hood for a while, Assemblymember. Nice to see you.

MR. SANDERS: Good to see you again, Senator.

SENATOR KRUEGER: Two quick questions because of the time frame of the day.

I agree with you, it's unbelievably disturbing to hear that private insurance is

only paying 2 percent of the cost. Any number of topics came up today where we were disappointed the Division of Financial Services wasn't here. Do you think insurance companies are actually violating state law or the policies that they have written?

MR. SANDERS: To the best of my knowledge, they are not. They have an obligation in law to honor what is -- the provisions in their particular policies. I think the problem is that their policies are so weak in Early Intervention, there's very little in their policies that they ever really have to pay.

Absent the Legislature making a stronger statement that Early Intervention has to be a covered policy, absent that insertion in the law, it's been my experience -- with apologies to some very, very good insurance companies; I know there are some -- but it's my experience that they are very, very good about avoiding their responsibilities, not just in Early Intervention but in other areas, in paying

claims that really they -- they're accepting premiums, they're accepting a lot of money for these policies, they're not so good in paying out when it comes time to pay out.

Are they violating the law? I can't say that they are. But certainly I would be in favor of a stronger statement in law that they have to fully cover Early Intervention.

SENATOR KRUEGER: I agree with you. Thank you.

And I think a follow-up to a much earlier question by one of my colleagues, I think to the Department of Health, concerned that providers of early intervention services have dropped out but still appear on lists because they're not removed from the lists.

MR. SANDERS: Yes.

SENATOR KRUEGER: Can you talk briefly about whether you agree with that, that we have a much smaller universe of people participating?

MR. SANDERS: That is an accurate statement. There are a number of Early Intervention service providers who in the

last three years in particular have left the program but -- in other words, they're not accepting any more cases, or very few cases. But because in some instances they are still owed money from the services that they provided in 2014, '13, they are not withdrawing officially from the program. They're no longer providing services because it has become so very, very complicated and so very, very expensive for agencies or individual providers to do the work the counties used to do.

You have to remember that prior to 2013, counties were billed for the services and counties paid the providers up front, and then the counties had to collect from Medicaid or commercial insurance or other sources.

That all changed in 2013. Now it is the responsibility, pretty much, of the providers and the agencies to go chase the insurance companies, to go chase Medicaid, to go chase the other parties in order to be able to be reimbursed. It isn't just that it

is more difficult, it is tremendously time-consuming. And a lot of providers simply no longer have the time to be billers, accountants, and also service providers. They signed up to be service providers, and now they're told that half of their time has to be spent chasing down those people who have responsibility to pay them.

The fiscal agent was brought into play in 2013. In some areas they've done a good job in helping to expedite this morass. But it has still fallen largely on the providers to try to be paid for services that they have provided, and it's just too time consuming and a lot of them have left the system. And it's a pity.

SENATOR KRUEGER: Thank you for your testimony.

CHAIRMAN FARRELL: Thank you.

Further questions? Mr. Abinanti.

ASSEMBLYMAN ABINANTI: Thank you, Mr. Chairman.

Thank you, Mr. Sanders.

First, I don't know if the questions

I'm going to ask are within your area of expertise; forgive me if they're not. But there are some things in this Article 7 that I'm trying to understand, and frankly I didn't get much assistance from the commissioner this morning. But perhaps you can help me.

I see in here one place there's something that says a "family-directed assessment." It says "If consented to by the family, in order to identify the family's resources, priorities and concerns and the supports necessary to enhance the family's capacity to meet the developmental needs of the child, the family assessment shall be voluntary" -- but basically what it looks like -- I mean, from one point of view you can look at this and say this is great because we're going to assess what the family needs and we're going to provide more.

From the other way, you can look at this and say this is violative of the approach that Governor Mario Cuomo took, which said it doesn't matter what your family

resources are, we're going to bring the state's resources to help each and every child.

Do you read this the way I do, that this is an attempt to cut back and say your family is richer than some others and therefore you're going to have the responsibility to take care of this child and we're not going to give you the services you need?

MR. SANDERS: Well, I certainly hope not. I'm frankly somewhat baffled at that language as well, because state law currently -- and federal law, IDEA -- guarantees that a family that has a child that is in need of Early Intervention, not because the family says so but because that child has been evaluated, there has been what is called an individual family service plan, an IFSP, that has been developed and that IFSP has the participation of the county that the child resides in, so county officials are involved in that, the development of that IFSP; the evaluator is involved with

development of the IFSP; the family can have representation on that committee. And once the IFSP is developed and identifies the services which that youngster needs, federal and current state law provide that those services will be given to that child at no cost.

Now, I'm not sure where the Governor is going with this language, which is one of the reasons why my recommendation and advice is that the changes in the Public Health Law that the Governor has made, almost all of which we've seen before that have been rejected, ought to be rejected again.

There are certain things in this program that are simply not broke, and the Governor ought not try to fix that which is not broke. One of the things that is not broken is the parents guarantee and ability to have their child evaluated by an evaluator of their choice, based on an approved list. And once their child is evaluated, then the process kicks into motion.

We ought not be placing impediments

between the family and services. And the prescreening places impediments. I'm sure that the commissioner could, if he were here, could cite one or two examples of, well, if we have prescreening, I can show you how that will speed things up. And I bet he's right, there might be one or two cases where you could posit an example where that could happen.

But in the main, if we are now placing a new bureaucracy, a new layer of responsibility between when the child is actually diagnosed or evaluated and services begin, it's going to delay services. And every clinician and every medical study that has been done -- and I know you're aware of many of them, I know each of you are -- every one of those studies indicate that the cognitive development of that child, that child's brain, is such that if services are not brought to bear at a particular age, if you wait literally weeks or months longer than you might otherwise have waited, the synapses have closed, there are certain

disabilities that are much harder to remediate even if you wait a few months at that age, when a child is six months old, eight months old, nine months old.

So time is of the essence. Time is very much of the essence. And anything that will slow down that process is dangerous and wrong.

ASSEMBLYMAN ABINANTI: Okay, there's another section in here that talks about a healthcare clearinghouse. It says providers shall enroll, on the request of the department or the department's fiscal agent, with one or more healthcare clearinghouses.

I can't find in here a definition of -- maybe you know what a healthcare clearinghouse is and what -- what is this about?

MR. SANDERS: This is something that has been done on a voluntary basis whereby there are services that are provided or organizations that exist that will help to expedite the claims. And you go through that clearinghouse, and they help -- actually,

they help the fiscal agent to expedite the claims, they try to sort out --

ASSEMBLYMAN ABINANTI: But who pays for this? The providers will have to pay for this?

MR. SANDERS: No, the providers generally -- no. To my experience, the providers do not pay for this at all, no.

ASSEMBLYMAN ABINANTI: Who pays for them?

MR. SANDERS: I presume the state does.

ASSEMBLYMAN ABINANTI: That's not clear in here, okay.

MR. SANDERS: Assemblyman Abinanti, if you find a number of references that are not explicit, then your reading is no different from my reading.

I don't worry about the clearinghouse because I've seen it in operation on a voluntary basis. And at worst it's benign; it may actually in some instances be a helpful tool.

ASSEMBLYMAN ABINANTI: But shouldn't

that be what the fiscal agent is doing? Shouldn't they also be a clearinghouse?

MR. SANDERS: Well, you know, I'll tell you something. When this Legislature approved a fiscal agent back in 2012, to go into effect in 2013, it was your expectation and our expectation, the providers, that the fiscal agent in fact was going to operate in such a manner that you submitted your claim to the fiscal agent, the fiscal agent then acted as an intermediary between the provider and the insurer to make sure that the provider got paid.

It hasn't turned out that way.

ASSEMBLYMAN ABINANTI: So then instead of requiring the fiscal agent to do this work, we're now adding another layer in here by some private companies that are healthcare clearinghouses.

MR. SANDERS: Well, if you ask my opinion, I think that it is a task that the fiscal agent should have been doing. I don't think it was ever part of their contract to do that particular work.

And an honest answer to your question is I don't know who funds the clearinghouse other than it is not my understanding that that is a cost that has been absorbed by providers.

ASSEMBLYMAN ABINANTI: And lastly, do we have any numbers out there of how much money is still left over owing to providers that they haven't caught up yet? Is there any number out there?

MR. SANDERS: The Public Consulting Group, which is the fiscal agent, puts out reports periodically. I believe that their last report, which goes back just a few months, indicated that there wasn't -- if recollection serves, there wasn't more than 14 -- 12 or $14 million that was still outstanding. Which isn't bad, you know, when you talk about a $600 million annual claiming in Early Intervention.

But one of the things that the commissioner said that was very misleading, in answer to one of your questions, Assemblyman, is that he said, well, you know,

providers get paid on average now every two weeks or so -- their claim. Their claim is paid about every two weeks.

That just isn't accurate. There are some claims that are paid very quickly. Claims that go to Medicaid tend to be paid rather quickly. Claims that bypass Medicaid or even commercial insurance, if the family is not insured, that goes directly to an escrow fund that is funded by the counties and ultimately the state -- they share it about 50/50 -- those claims get paid pretty quickly also.

The claims that go to commercial insurance can still take weeks and weeks and weeks -- indeed, months and months and months -- even before they're adjudicated. And in most cases, they pay very little of the claim anyhow. It takes them a long time to adjudicate the claim, and they pay very little.

That's one of the reasons why I think that the Governor's recommendations to bolster the Insurance Law are good

recommendations. It will help -- I think it will help to expedite the claims, and I think it will help to get insurance to be paying their fair share.

ASSEMBLYMAN ABINANTI: But the whole claim is awaiting the insurance company's yes or no.

MR. SANDERS: That's correct. Once your claim --

ASSEMBLYMAN ABINANTI: Just for 2 percent.

MR. SANDERS: -- goes to commercial insurance, even if they're only going to pay a small part of it, none of it gets paid until the payer of first resort, commercial insurance, decides whether they're going to pay and how much they're going to pay.

So consequently, you've hit the nail on the head. You have a claim of a thousand dollars, of which that commercial insurance company is only going to pay 50 bucks -- the other 950 gets held in limbo until the commercial insurer decides that they're only going to pay 50 bucks or less.

CHAIRMAN FARRELL: Thank you. Thank you very much.

MR. SANDERS: I thank you all once again.

CHAIRWOMAN YOUNG: Thank you, Assemblyman.

CHAIRMAN FARRELL: Home Care Association of New York State, Joanne Cunningham, president.

MS. CUNNINGHAM: Good afternoon.

CHAIRMAN FARRELL: Good afternoon.

MS. CUNNINGHAM: I'm Joanne Cunningham. I'm the president of the Home Care Association of New York State. We represent around 400 not-for-profit, public and proprietary home care agencies from the tip of Long Island to Buffalo to the North Country. Our members are certified home health agencies, long term home healthcare programs, licensed home care agencies, and managed long term care plans and hospices.

First I want to say thank you very much for having me and listening to the Home Care Association's concerns and thoughts

about the Executive Budget proposal, and also some of our ideas for how to preserve, protect, sustain and really bolster the home care community across the state.

I also want to say thank you to so many of you who raised questions and concerns already about some of the issues that we in the home care sector care deeply about.

I have prepared written testimony for you. I'm not going to read it. And I've also given you two reports. One is our 2016 financial condition report. This is a report that the home care association provides every year. We use cost report data as well as survey data to take a look at really the state of the home care industry across the state.

What I'm going to do today is talk a little bit about some of the highlights in our financial condition report and then talk about some of the concerns we have in the budget, and then share some ideas.

First, if you read the report -- and I'm sure that you and your staff will take a

look at it -- nearly half of the home care agencies, providers in the state, are looking at reducing staff or doing other kinds of cuts in order to continue their operations.

About 70 percent of certified home health agencies and long term home healthcare programs have negative operating margins -- that's almost three-quarters. And this is a similar trend that we've seen year after year.

About half of home care agencies have had to borrow money, using lines of credit, in order to maintain operations and keep their doors open. And we've seen that trend accelerating over the past few years.

On the managed long term care side, and you've heard some of this in prior testimony, about 63 percent of MLTCs -- and those are managed long term care plans, so those are the plans providing long-term care for the Medicaid population -- 63 percent of MLTCs had negative premium incomes in 2014. And this is also a trend that is worsening from last year to this year.

A couple of other data points. On average, less than half of Medicaid claims are paid to home care providers within the dictates of the state's prompt-pay law. So agencies' Medicaid revenue is in effect in their accounts receivable for an average of about 72 days. And one of the reasons we're seeing that is also something that you heard in prior testimony, the fact that the MLTC rates haven't been kept up-to-date, and they're struggling on the rate side, so in effect they're not passing the money down to providers.

The rest of the data points in the report are all showing worsening financial condition trends. And one of the things we really worry about is what that means for providers as they try to participate in some of the new models that we're seeing the state obviously propose, and the federal government as well.

So given those data points that spell a real fragile nature for the home care community in our state, as well as MLTCs,

it's daunting to think that these providers are expected to step up and continue to participate in a system that increasingly is relying on them. And we all hear over and over really the description of how we need a robust home and community-based provider network in order to achieve all of the state's policy goals. We heard that in prior testimony from the community health centers.

Support and infrastructure investment for home care and MLTCs is urgently needed in this budget in order to secure and sustain delivery system reform. Yet how is the Executive's budget proposal responding to this? Of the executive's priority or signature budget proposals, nearly all of them target non-healthcare for investment. So it's rather ironic that what we're looking at is investment, needed investment in other sectors, yet none of it is focused on the home care side.

You've talked a lot about and heard a lot of testimony about the effect of the minimum wage increase. This is deeply

concerning for the home care field. We have estimated that it's going to be about a $1.7 billion hit on the home care community. And that's direct costs, indirect costs, benefits, and that ripple effect.

We've devised this estimate using data from cost reports as well as other data sources, and we're working together with HANYS and the other provider organizations -- LeadingAge, the nursing homes -- to present a unified front. But if you think about it, the home care number, at $1.7 billion, is much larger than the hospital and nursing home number together, which is $1.1 billion.

Last year the adopted budget included over $2 billion in new investment funding, largely for the state's hospitals and institutional sector. This support was on top of the $7 billion-plus provided to the hospital sector through DSRIP. And the LeadingAge testimony that had the pie chart, that is a very telling visual that really shows you the lack of investment that is focused on anything other than really the

hospital sector. The home care sector is in desperate need for that investment.

We urge the Legislature to ensure that healthcare investments in this year's budget include home and community providers and that any new investments under existing programs be amended to fully apply to the home care sector.

A final document that we've given you is a document that looks like this (showing) that articulates two asks that the home care sector has. The first ask is to fix the state's reimbursement laws and levels to cover and reimburse needed services. And we've outlined exactly where that investment needs to occur, but it needs to be placed in adequate rates on the episodic side of the home care provider rate system, as well as in the MLTC rates.

We need to ensure that the payments and the rate calculations include workforce costs. We've already talked a lot about the need for workforce investment. We have the impact of a new mandate that's coming along,

technology, HIT -- you've heard from other presenters today about the lack of HIT for any of the non-institutional provider sector.

We need to make sure that workforce costs are incorporated in the payment methodology, and we need to make sure -- and this really links with prior testimony also -- that the long-antiquated State Insurance Law that covers home care is modernized. We have a State Insurance Law that outlines the home care coverage that hasn't been changed since the '70s. We need to modernize that benefit.

Our second fix really focuses on how do you support and really support the home care infrastructure and operations. And we can do that through fast-tracking regulatory changes. We have been trying to work with the Health Department for a number of years to think about how we change a regulatory structure that is linked to a fee-for-service system that doesn't exist anymore. We need to be quicker, more nimble at making regulatory changes in a managed care, in a

DSRIP, in a value-based environment. And that will help home care providers compete, that will allow them to participate more fully in integrated systems.

We also have to harness home care in public health areas. Home care can be critical in sepsis, fall prevention, all kinds of innovations that are really focused on the public health side. We need to harness home care to do more in those areas. And we'll see savings in state dollars, undoubtedly, if we do that.

We also, and I mentioned this briefly, need a proactive HIT policy, a heath information policy for home care. We don't have that now. We need to put some infrastructure dollars in and have a state policy so that our home care providers are connected to these integrated models.

We have to fund the Hospital Home Care Physician Program that Senator Hannon was a champion of last year. We need to improve home care quality through innovations. And we need to authorize any kind of innovative

new demonstration payment methodologies.

In closing, I just want to say again thank you for your support of home care in the past. We need to do more. If we expect this system to be part of, a critical part of an integrated healthcare system, we need to invest in this system so that we can maximize its potential. And the state is relying on us, so we need the help and support.

Thank you very much for your time, and I'd be happy to take any questions.

CHAIRMAN FARRELL: Thank you very much.

Any questions? Senator?

CHAIRWOMAN YOUNG: No questions. So thank you so much.

MS. CUNNINGHAM: Thank you.

CHAIRMAN FARRELL: Thank you.

CHAIRWOMAN YOUNG: Oh, I'm sorry, Senator Hannon does have a question.

SENATOR HANNON: I just would like to follow up on each of those points later on in a meeting. I think they're enormously significant, and some of them {inaudible}, so

I {inaudible}.

MS. CUNNINGHAM: We'd be happy to, and we have budget language all ready to go, and we'd be happy to sit with you. Thank you very much. Thanks.

CHAIRMAN FARRELL: New York Health Plan Association, Paul Macielak.

The next one will be James Lytle, counsel, Managed Long Term Care & PACE Plans.

Good afternoon.

MR. MACIELAK: Good afternoon, Assemblyman. I'd like to thank the Senators and Assemblymen for the opportunity to appear. The hour's late; I'll keep it short.

As it regards health plans, there's some good news in the budget and some bad news. On the good news front, there's no new taxes. Good news, no new taxes, no tax increases. There's no exchange tax, unlike last year. The Governor had proposed an exchange tax which you were able to defeat. It doesn't exist in this budget. There's no guaranty fund or solvency tax.

Now, I want to make clear that the

Health Plan Association strongly opposes a guaranty fund. I would take exception to statements from the representative of the Greater New York Hospital Association, who talked about the crocodile tears of the health plans in opposing a guaranty fund. I'd say that's a bunch of bunk. I would hope he would get his facts straight when he'd be making public statements.

He indicated that you should all believe that in New York for-profit plans make up the vast majority of the plans in the state. That's wrong. The vast majority of health plans in this state are nonprofit. Whether they're plans like Affinity, MetroPlus, Healthfirst, Emblem, CDPHP, Independent Health, HealthNow, the vast majority are nonprofit. They would all have to pay this tax.

He also made the statement that everybody's got a guaranty fund, so why should anybody object to it. I would say the reason we object is because no one else in this country has HCRA taxes to the tune of

$5 billion. That's a tax on health insurance, it makes it less affordable. It's about 5 percent of your premium are existing taxes today.

A chunk of that $5 billion flows to those Greater New York hospitals -- bad debt and surety monies, GME monies. And so if people want to look for funds, we'd say look for existing state funds.

A lot of talk today about programs like VAPAP, VAP, QIVAPP, healthcare facility restructuring funds. All of those are all state dollars to take care of distressed hospitals. We can say you can find in the budget existing state funds to take care of the Health Republic situation.

One other entity of good news in the budget is pharmacy transparency. I think it's a good first step. It requires drug companies to file information with the state about how much they spend on research and development versus things like admin, marketing and profit.

We think it's good, but it only

applies to the Medicaid program. And we would ask that it also be disclosed to consumers and businesses in the state because pharmacy spending is the biggest cost driver in healthcare premiums and directly affects affordability.

Certainly the media attention on something like Turing Pharmaceuticals that had the 5,000 percent increase in price for an existing drug by a hedge fund I think brought a lot of attention to the question of what components go into pharmaceutical pricing. But I'd also point out companies like Pfizer have increased their drug prices on their like 100 top-priced drugs by up to 20 percent for the coming year.

So our view would be what's good for the goose is good for the gander. And if it's going to be that kind of disclosure for the Medicaid program, also apply it to consumers and businesses in the state in the commercial market.

On the bad news front. In spite of the Health Republic closing, we're

disappointed that the Governor did not put in any rate reform proposals.

Prior approval. The current law of the state setting commercial insurance rates is a failed state policy. We say you should repeal it, replace it with an objective standard like the medical loss ratio.

We also think that DFS should be required to have actuarial certification of rates. Health plans submit their rates, they have to be actuarially certified. We should get back a rate decision from DFS that likewise is actuarially validated and certified.

Political price suppression of rates threatens the state health exchange. Health Republic closed, other health plans have suffered losses in the last two to three years. All have had their rate applications cut by DFS on a subjective basis. Sustainability of health plans that give consumers access and choice is dependent on rate reform.

In terms of the Health Republic

scenario, providers lost money, health plans have lost money. There were a number of health plans that were supposed to receive money from Health Republic under a risk adjustment methodology. They're not going to see any of that money. So that is not reflected in prior years' rates, it's going to have to be applied for in future rates. That likewise goes to premium affordability.

So we say please look to existing state resources, and we would suggest looking at state settlements. The Governor's fiscal plan identifies and makes the statement that settlement money should be spent as one-shots. They're one-time monies that should be used to fix one-time problems. So we've looked and we've seen that even in the Assembly's Yellow Book, that of the bank settlements there are still, I think, $2 million {sic} of bank settlement monies that have been unallocated. So we think that would be one source that you could look at.

Secondly, recently there was an announcement of a tobacco settlement of

$550 million, of which the state is supposed to get about half of that. So that doesn't exist on any of these allotment lists. We would say that's $275 million that could be available to help pay providers and plans who have suffered losses as a result of the Health Republic closure.

I'd like to turn my attention to the Early Intervention proposals. Early Intervention is really -- the proposals that are in the budget really are just an old chestnut seeking to shift state/county costs onto insurance premiums, so that consumers and business now have to pay for it as opposed to the state or the counties.

Historically, EI really is not a medical issue that would be covered by health insurance. It really is a developmental program that was structured within the Education Department, the education statutes of the state. And what we've been dealing for a number of years with is trying to fit a square peg into a round hole.

The managed care rules which exist

today look to be undercut by these budget proposals. They seek to do a cost shift by eliminating traditional managed care tools on network credentialing on, network development, use of medical necessity, prior authorization of services, sites of services -- all rules that apply to all providers except, as would be proposed now, EI providers. They would be the exception to the rule. All other providers have to follow these rules except for EI.

Now, I know there was some testimony given prior to my appearing that talked about prompt pay and number of violations and delays in payment. I think if you go back to DFS, you will find that there are no EI prompt pay violations. There are no claims that have not been adequately addressed within the law for EI claims by insurance companies.

We get certain rules in terms of 45 days to process a written claim, a paper claim; 30 days for electronic. And providers have to submit clean claims. Now, EI

providers are new to this system, so they're new to actually billing and insurance forms, following state procedures. So we're seeing a lot of garbage in, garbage out. That explains a good part of the payment delays that providers are seeing. It's not because plans aren't paying, but because they're not getting a clean claim for them to process and to pay.

Another point that I want to raise in that regard is that a lot of these claims are for self-insured plans. And those are not regulated by the state. Plans like the Empire Plan, a lot of school districts, a lot of hospitals -- self-insured. They are not subject to these rules. They don't cover EI services at all, but they get lumped into this overall number.

A final point, because I know I'm out of time here, is that the Medicaid managed care cuts lack a balance and are really used to just balance the global cap. They disproportionately fall in Medicaid managed care plans. There are no other sectors that

take the level of hits that Medicaid managed care plans do in this budget. We would ask for some kind of a balance in terms of your approach to it.

You've heard a lot of testimony about managed long term care plan rates being inadequate. The same application exists for some of the managed care plans as well in the general field who are suffering losses. So you have a profit tax that's been proposed by the Governor; that money is just taken and used at the global cap, as opposed to being maybe reinvested or used for some of those plans that are suffering losses.

So basically we've got a budget by the Executive that has some good components. We'd look to you, the Legislature, to improve on that budget and solve some of the issues.

Thank you very much. Any questions?

CHAIRMAN FARRELL: Thank you. Questions?

MR. MACIELAK: Thank you very much.

CHAIRWOMAN YOUNG: Thank you, Paul.

CHAIRMAN FARRELL: Thank you.

Next, James Lytle, New York Coalition of Managed Long Term Care & PACE Plans.

MR. LYTLE: Thank you very much. My name is Jim --

CHAIRMAN FARRELL: Excuse me. Did you give us paper? We didn't get any paper.

MR. LYTLE: Yes. We have testimony for both the Coalition of Managed Long Term Care Plans and the Coalition of Public Health Plans. I apologize for that. I will make sure -- we understood it was delivered earlier today. And in light of that, I'll be even briefer in my testimony.

My name is Jim Lytle. I represent two coalitions of managed care plans who are devoted to the Medicaid managed care program. Both, as Mr. Macielak referenced -- we represent the not-for-profit component of his association, in part. All of the plans in our two coalitions are not-for-profit, provider-related, provider-sponsored plans. In the New York State Coalition of Public Health Plans there are eight plans, 3 million enrollees; they include plans such as

Fidelis, Healthfirst, MetroPlus, and they represent two-thirds of the total enrollment in the state in these not-for-profit, provider-sponsored plans.

On the managed long term care side, we represent 21 plans, over 111,000 enrollees -- again, more than two-thirds of the total enrollment.

Just by way of background, managed care plans in our coalition and in the one in the Health Plan Association have been the centerpiece of the Medicaid strategy in New York State for over 30 years, across five administrations, to a point where virtually every New Yorker who's a Medicaid recipient is enrolled in a managed care plan. In context, we're talking about a $20 billion expenditure on mainstream managed care plans and about $5 billion on the managed long term care side.

I should emphasize that these dollars reside in the plans only momentarily and are quickly paid in claims to providers, paid to help provide support to members who are

trying to navigate the complicated healthcare system, and paid to help invest in the care management and managed care that is the whole purpose of these programs.

I would just highlight a few issues in the budget for your consideration. I would echo some of what Mr. Macielak said -- frustratingly, from our perspective, many of the largest concerns we have in the budget are on the administrative side, steps that the Governor and the administration are proposing to take without your endorsement or support, including the profit cap that Mr. Macielak referenced.

It's particularly frustrating from the standpoint of a not-for-profit plan whose only surplus is not coming from shareholder investments but from whatever money it happens to make on premiums paid to be used for investments in new programs, in new plans, in information technology to assist in the delivery of these services. A proposal on the administrative side will limit the amount of surplus the plans are able to

retain.

We also would support a number of the proposals the Governor advanced to control the ever-escalating cost of pharmacy benefits, in particular an emphasis on tailoring the prescriber-prevails policy to those drugs that are the most sensitive and vulnerable ones in the behavioral health arena, but allowing plans to manage the prescription drug benefit in an appropriate way that is based on the medical experience and based on outcomes and results.

The Governor has proposed to carve out the transportation benefit from managed long term care plans as he did last year. Particularly our upstate plans, who regard the transportation benefit they provide to their enrollees in managed long term care as an integral part of what they do not only to get the enrollee from place to place, including to doctors' offices or to other programs that they need to attend, but to help look in on the individual and to provide other support in addition to the

transportation benefit itself.

The Governor has also proposed statutorily to change the eligibility standard for managed long term care back to what it used to be, that only people who are nursing-home-eligible would be entitled to enroll in managed long term care. We have no particular opposition to that; that used to be the standard. The vast majority of enrollees within managed long term care plans across the state meet that standard.

The only trick is, which is my next point, it's important that rates to the managed long term care plans are adequate and are determined on a timely basis, and we have struggled with that for many years with the department.

You've heard this -- and I'm happy to say there was a time where the provider associations I think at times testified about their concerns about managed long term care, their worries about the program, in some cases their opposition to the program. Now I'm delighted to hear the provider

associations are echoing our concerns about the adequacy of the rates being paid to the managed long term care plans, and we appreciate that.

The last point I'd make actually gets back to the mainstream program. Many of our plans who are providing Medicaid managed care on the mainstream program are seeing a significant amount of their enrollment occur through the state's exchange, the New York State of Health. From the very get-go, we have asked that the New York State of Health make it possible for someone who is enrolling in the Medicaid program through the New York State of Health to designate who their primary care provider is. The challenges faced by plans -- who don't have that information after the person is enrolled in the plan -- to follow up with the enrollee to find out who the PCP should be has been extremely difficult and has resulted in a significant barrier to the successful transition of individuals into that program. It's been on the list of things, of system

improvements, for what has otherwise been a successful launch of New York State of Health, for which the folks running that program deserve a great deal of credit. But it's important that we make it easier for Medicaid enrollees to access coverage through the New York State of Health and be able to designate, right at that time, who they would like to select as their primary care provider.

With that, I'll answer any questions, and I'll make sure that the testimony finds its way to the right spot.

CHAIRMAN FARRELL: Thank you.

Any questions?

SENATOR KRUEGER: Thank you very much.

MR. LYTLE: Sure.

CHAIRMAN FARRELL: Thank you very much.

Julie Hart, director of government relations, American Cancer Society.

Good afternoon.

MS. HART: Good afternoon. Thank you

for the opportunity to testify today. My name is Julie Hart. I'm the government relations director for the American Cancer Society Cancer Action Network. We're the advocacy affiliate of the American Cancer Society. I appreciate the opportunity, especially at this late hour, to testify.

My written testimony is in front of you; I'm just going to highlight a couple of key points for you.

On the first page you'll see the numbers in terms of how cancer takes its toll on New Yorkers. Cancer is the second leading killer of New Yorkers. Approximately 110,000 New Yorkers will hear this year from their doctor that they have cancer. In addition, approximately 35,000 New Yorkers will lose their battle to cancer this year. And as you can see by the chart, cancer takes a tremendous toll on New York State residents.

Towards that end, we're excited about a number of recommendations that are included in the Executive Budget. We are very supportive of the Governor's proposal to

increase screenings for breast cancer and for prostate cancer. That proposal includes mammography vans, patient navigators, a public awareness campaign, and also extended hours to make mammography available. We do believe that this will help make screenings more readily available. We strongly support this, and we encourage the Legislature to support this also.

Related to this announcement is the state's current Cancer Services Program. This program provides screenings to low-income uninsured New Yorkers. They can get breast, cervical, and colorectal screenings at no cost. In the past fiscal year, approximately 30,000 New Yorkers were able to receive a screening that they otherwise would not have if it wasn't for this program. And this is critically important, because early screening can save a life. Particularly if you look at colorectal screenings, if you look at polyps, not only can you detect that, you can actually prevent cancer before it occurs in that case.

The funding in the Executive Budget proposal is maintained at approximately $25.3 million, and we encourage that to be maintained in the final budget.

In addition to screening -- there's a great emphasis on screening in the budget. We would like to see the same emphasis actually placed on prevention activities. So towards that end, one of the issues that was brought up earlier today was tobacco and smoking rates. The state's Tobacco Control Program in the Executive Budget is proposed at $39.3 million. This is the same as in previous years.

There's really three big things that lawmakers can do, three big policy interventions that will help in terms of reducing smoking rates and reducing the toll that tobacco takes on New Yorkers. There's a number of policy interventions that can have a small impact, but there's three that can have a really large impact, and to your credit, New York does a lot of things right.

We have the highest cigarette tax in

the nation, we have one of the strongest Clean Indoor Acts that -- you know, many followed in our footsteps once it was passed. Where we don't meet the bar is when it comes to tobacco control funding. Our Tobacco Control Program is not adequately funded. Currently, approximately 28,000 New Yorkers lose their lives each year to smoking. We've made some progress, but we still have about 73,000 high school kids who are still smoking.

In addition to that, you can see on page 4 there's a chart that shows the smoking rates in New York State. So approximately 60.6 percent of adults are smoking; however, there's huge discrepancies. So you'll see with lower income levels, and you'll also see with those with poor mental health, that the rates can be in the high 20s, can be in the 30s percent. So there's pockets of New Yorkers that we're still not reaching at this point.

The CDC says that we should fund this program at $203 million, so we're falling far

short at $39.3 million. I know that going from 39 to 203 isn't practical. We are recommending an increase to $52 million this year, and each year we'd like to see a little bit more. We think at $52 million we can start to make a dent in those populations where we're not being able to make that same -- have the same impact right now.

In addition to tobacco, another area that can have an impact on cancer which many people don't think of is obesity. This is an area where people don't often make the obesity and cancer connection. However, obesity is a major risk factor for several types of cancers. Right now in New York State 8.9 million adults are either overweight or obese. That's the populations of numerous states put together, just in New York State.

In addition, approximately one-third of kids are considered overweight or obese. Obesity rates are also higher in Hispanic populations, black populations, and low-income populations. It will certainly

take a multipronged approach to start reducing those obesity rates.

One of the areas where we can see some improvement is trying to improve access to healthy foods. It's hard for people to eat healthy if they don't have healthy foods available in their neighborhood -- for children and families, if they don't have a local grocery store, if they don't have a corner store that has healthy foods available.

In 2009 the state created what was called the Healthy Food and Healthy Communities Fund. It's a public-private partnership that provides grants and loans to either renovate or locate a supermarket or a mobile market, whatever will work for that particular community. That was started with $10 million in state capital funds. The funding has now been depleted. Because of the public-private partnership, the funds actually lasted a number of years. They were able to immediately get $20 million privately, and then from that point they were

able to fund 20 projects statewide.

If you look on page 6, you'll actually see a map so you can see where those projects have been funded. So in those communities, we're actually starting to make a dent. So previously they didn't have a healthy food outlet; now they do in those communities.

But you'll also notice there's a lot of communities that did not receive funding, and certainly those are not the only food deserts across New York State. So since funding is now depleted for this program, we'd like to see $15 million dedicated to the Healthy Food and Healthy Communities Fund.

In addition, we're also asking for $3 million for a healthy corner store/healthy bodega-type initiative, because those smaller types of outlets, where they may need the funding for it, not necessarily renovating or locating, but it may be a market that's in existence, whether it's in an urban area or a rural area, where they may need retrofits, they may need refrigeration, they may need some technical assistance. So those are

smaller amounts, so we would like to see $3 million dedicated towards that.

We think both of these initiatives will go a long way to improving access to healthy foods, and certainly as a first step to combating obesity.

So thank you. And with that, I'm open to any questions.

CHAIRMAN FARRELL: Questions?

Yes, Assemblyman.

ASSEMBLYMAN RAIA: Hi. Thank you.

Just for the record, I'd like to mention that the commissioner didn't even answer my question as far as how much money was in the budget this year for tobacco control funding.

It is my understanding, however, you did mention we have -- New York State has the highest tobacco tax.

MS. HART: Correct.

ASSEMBLYMAN RAIA: But it's also my understanding that only 1.9 percent of that tax actually goes into tobacco control-funding programs. Is that correct?

MS. HART: Yeah, from tobacco revenues. From the tax and also from the master settlement agreement, we take in about $2.6 billion, but only $39.3 million actually goes to help New Yorkers quit smoking and to keep kids from getting a deadly addiction.

ASSEMBLYMAN RAIA: The rest of it goes where, the General Fund?

MS. HART: Correct.

ASSEMBLYMAN RAIA: Okay. Thank you.

CHAIRMAN FARRELL: Questions?

Thank you very much.

SENATOR KRUEGER: Thank you.

CHAIRWOMAN YOUNG: Thank you.

CHAIRMAN FARRELL: Community Oncology Alliance, Ted Okon and Maryann Roefaro. How close did I get it?

Next will be Empire State Association. If you move down, you can speed it up. We've got a lot to go.

MR. OKON: Good afternoon, although I guess I should say good evening.

CHAIRMAN FARRELL: Good afternoon. I messed up your name?

MR. OKON: We thank you for the opportunity to share our views on the adverse impact Medicaid payment cuts will have on patients with cancer in New York State who are covered under Medicare and also eligible for Medicaid. I am the executive director of the Community Oncology Alliance, a nonprofit organization dedicated to serving patients and providers in the community oncology setting, where close to 70 percent of Americans with cancer are treated.

After my initial remarks on this critical issue, I will hand over this testimony over to Maryann Roefaro, who is the chief executive officer of a large community oncology practice in New York that serves patients with cancer in the greater Syracuse area.

Recent changes to the State of New York's Medicaid reimbursement policy for patients dually eligible for Medicare and Medicaid will hurt community oncology practices and the patients with cancer they serve. Specifically, we are concerned with

the budget-cutting policy that Medicaid is now no longer reimbursing partial Medicare Part B coinsurance amounts when the Medicare payment exceeds the Medicaid fee for that service.

Medicare covers 80 percent of the reimbursement rates it sets for cancer care, with patients responsible for the remaining 20 percent. For those individuals covered by Medicare, who are also eligible for Medicaid, it is Medicaid that is supposed to cover the 20 percent coinsurance. That is the issue -- although New York Medicaid relented in not cutting payments for the 20 percent Medicare coinsurance for cancer drugs, it is now substantially cutting payments for the administration of chemotherapy and other vital services provided to the most vulnerable patients with cancer; that is, seniors and those disabled individuals covered by Medicare.

As background on this issue, community oncology practices like Maryann's have faced many devastating payment cuts at both the

state and federal levels, such as the automatic Medicare budget sequestration cut in 2013. These cuts have slowly pushed more practices to close or to be acquired by hospitals, consolidating the cancer care delivery system significantly. Over the last eight years, nearly 40 percent of New York State's community oncology practices have closed clinics or have been acquired by hospitals.

The problem is that as community oncology practices close, patients have to go to hospital for care they could be receiving in the community setting. Patients that have been receiving treatment from the same practice -- in some cases for years -- face dangerous gaps in their care when they are displaced to the hospital setting.

Furthermore, many studies have demonstrated that hospital-based cancer care is 153 percent more expensive than in the community setting.

The consolidation of cancer care in New York State and across the country is

already creating stresses on the nation's cancer care delivery system, with patients being displaced and costs increasing as cancer care is absorbed into large hospital systems.

Now, New York Medicaid is adding to the stresses by paying a fraction of the 20 percent Medicare coinsurance for dual-eligible individuals. As it is, community oncology practices are reimbursed by Medicare for just 57 percent of the costs related to chemotherapy administration and related critical services. Additionally, many other services are not reimbursed at all, including psychological counseling, care coordination, supportive care, telephone support, and financial counseling.

Community oncology practices simply cannot absorb additional payment cuts. They either have to send patients to hospitals or eventually close or merge into large hospital systems, in which case all patients end up being billed under the more expensive hospital setting. Taxpayers end up paying

the price when that happens.

Representatives from community oncology practices across New York State -- from Long Island, Queens, Brooklyn, Syracuse, Albany and beyond -- are here today to say that this Medicaid policy change is extremely shortsighted. While it may save money in the short run, there is no question that costs for cancer care to New York State Medicaid and the federal Medicare program will go up dramatically.

Tragically, it is the most vulnerable patients -- seniors and those with disabilities -- who get caught in the policy cross hairs. And when I get too caught up in the policy, it is my wife, who is a full-time oncology nurse, who reminds me what cancer care is about: People battling a dreaded disease.

Recently, President Obama and Vice President Biden launched a moonshot to cure cancer. We commend them for that and know that New York oncologists have and will continue to contribute greatly to that

effort. But as we prepare for the battle tomorrow, we cannot forget the Americans, especially the most vulnerable New Yorkers, facing misguided public policy that threatens their cancer treatment today.

I now will hand this testimony over to Maryann Roefaro, of Hematology-Oncology Associates of Central New York.

MS. ROEFARO: Thank you, Ted.

I'm very grateful for this opportunity to speak with you today.

As Ted said, I run a large independent private oncology practice in Central New York. It's been providing services since 1982, serving people of greater Syracuse area. We had 5,000 new patients last year and served 17,000 visits.

We have a team of 16 specialists in our practice and four clinic locations in the area of oncology, hematology, and radiation oncology, as well as a plethora of professional clinical staff, of advanced practical care nurses, nurse practitioners, physician assistants, specialized oncology

nurses, and ancillary professionals. We have a doctor of physical therapy who also does our cancer rehabilitation program.

Our mission is simple -- it's to provide the highest level of quality care in a healing environment for the mind, body, and spirit of those patients dealing with cancer and blood disorders. Our goal is to offer the highest-level, state-of-the-art technology, care, and treatments while meeting the emotional needs of our patients and their families.

In taking care of the whole patient, we provide an array of clinical cancer diagnostic and treatment services in a highly coordinated and efficient manner -- and I often say that it takes a village to take care of these people. We have 270 employees to serve these patients. Our services include the administration of chemotherapy, biologicals, related cancer drugs, diagnostic imaging, psychosocial services, and nutritional counseling. We do support groups for families and caregivers, provide

radiation therapy and specialty drug pharmacy treatments.

We are extremely concerned with the payment cuts that Medicaid is now implementing for our patients dually covered by Medicare and Medicaid. As Ted has described, our practice has felt the brunt of these cuts after cuts after cuts to cancer care, including the blunt ax of the Medicare sequestration cut. These types of cuts have real impact on the cancer care system in each of your districts. For example, our practice alone had to close a smaller satellite office a few years ago. And just recently, a few months ago, we had to close a satellite in Rome, New York, which is actually quite rural and is feeling the effects of us not being there, and they need to drive now into East Syracuse.

It's been very difficult to absorb all of the cuts that have come our way in the recent years. The most recent Medicaid cuts are truly unsustainable. Community oncology practices with small populations of patients

who only have Medicaid coverage accept losses in order to provide care to the needy. However, for many of us, dual-eligible Medicare and Medicaid patients represent a large part -- upwards of 30 percent -- of the Medicare population we serve, and this new policy will hurt tremendously. For four of the practices joining me today in this room, losses from just this new Medicaid policy are estimated to be over $235,000 a year. And although that doesn't sound like much to you, with a budget of billions of dollars, it means a lot to us and it will have an incredible impact on our ability to render cancer care to the people of New York.

The services impacted by these cuts are critical to patient care and safety. For example, skilled nurses that administer chemo and care for patients while they receive treatment will fall under these cuts. They are essential to patient care, monitoring for dangerous complications and ensuring good treatment outcomes. In the short term, these cuts will cause practices like ours to cut

back skilled nursing and similar key oncology administrative services -- which is a very shortsighted way to achieve any quick savings -- or, in the end, being forced to send these patients to hospitals for treatment because we can no longer take care of them and sustain the losses. The problem in our case is that the hospital simply cannot even absorb this number of patients -- there's about 980 of them alone in our practice.

I underscore what Ted related from my vantage point of running an oncology practice and keeping it viable. As a businessperson, I totally understand that it's about budgets and finances. However, fundamentally it's about people, people I watch every day fighting terrible, often devastating disease. I watch them struggle with treatment, their own finances, and simply putting one foot in front of another just to fight their disease. These Medicaid cuts will have devastating impacts on the most vulnerable of these patients.

If you don't believe me, look at recent studies documenting that patients who are dual-eligible for Medicare and Medicaid face significant disparities in outcomes of quality cancer care. They are diagnosed at more advanced stages of disease, have lower five-year survival rates, receive lower quality of care, and have poorer outcomes than people with insurance from other sources.

I call your attention to a recently published study by the University of California-Davis, which we have referred to in our testimony. As an example, cancer patients in California who are dual-eligible for Medicare and Medicaid had the lowest proportions of recommended treatment of breast cancer with radiotherapy and of colon cancer along with chemotherapy. In short, dual-eligible patients end up being treated like second-class citizens, and this simply is not right.

If these Medicaid cuts being implemented now are not bad enough, New York

Medicaid has indicated that the cuts will retroactive from July of 2015. And this means that we'll be required to refund -- and yes, I underscore the word "refund" -- portions of reimbursements that we have been provided since July. Not only will this be devastating, it will be a big fat mess in our practice management systems for billing.

We met with New York Medicaid last December; they listened to the facts we provided. But they said they are unable to do anything, and we implore the Senate and the Assembly to help us in this dire situation. We're not just asking to stop additional payment cuts to mandate Medicaid to work, but also to work with practices across the state. Community oncology practices like ours have been leading the way in real payment reform, with national insurance companies like Aetna, UnitedHealthcare, and even Medicare reducing costs. Just recently, our practice received accreditation as an Oncology Medical Home from the Commission on Cancer. This is very

exciting and something that we're very proud of -- and so should you, because there are only nine of these practices in the United States, and we are the only practice in New York State that has achieved this. And so we hope that you are proud also.

Given the special nature of cancer care, the devastating impact of the disease, and the vulnerable dual-eligible population involved, we ask for a carve-out of cancer care services from these Medicaid cuts, including the suspension of the retroactive payments back to Medicaid. This will actually end up saving the state money, as well as Medicare, by keeping cancer care from migrating further into a more expensive hospital setting. This way our practice can work with New York Medicaid in devising innovative solutions that provide quality, efficient cancer care to these dual-eligible individuals.

Please, please let us work together for our patients, the New Yorkers you represent, not to mindlessly cut cancer care

to the most vulnerable but to improve it for generations to come.

Thank you for listening, and I know it's -- we're out of time, but we'd be happy to answer any questions.

CHAIRMAN FARRELL: Thank you very much.

Questions?

CHAIRWOMAN YOUNG: Thank you.

Senator DeFrancisco.

SENATOR DEFRANCISCO: Not so much a question, but I want to thank you both for being here. You weren't here in the morning when I talked to the health commissioner and the head of the Medicaid department and told them that I would send a copy of your testimony to them because you'd be able to elaborate on this issue much more than I can.

But the point is, if we are closing satellite offices, where for people sick with cancer that they have to travel many, many miles to get to your facility now, and if we keep this up and if facilities like yours close, both of yours close and all throughout

the state -- even in Brooklyn, as I told Marty Golden, and they close -- then it means hospital care. And how shortsighted is it, to spend -- when that cost is 153 percent of the cost that you provide. It's just shortsighted foolishness and long-term big damage.

So thank you. I know I've talked to Senator Hannon about this issue already, and hopefully we can generate the support and change some minds during this budget process, because it's an essential issue. And I thank you for coming again.

MR. OKON: Thank you, Senator. Thank you all.

MS. ROEFARO: Thank you very much, Senator.

CHAIRWOMAN YOUNG: Senator Hannon.

SENATOR HANNON: Yeah, I just want to say that Senator DeFrancisco had said that, and you can tell -- he can tell -- he's really determined, because he came back just for your testimony.

This is an issue that we tried to

solve, not to go along with the administration's proposal last budget. And they kept on making us pay for it and pay for it. They had a total of 40 million, they cut it in half, we ultimately didn't have the last 20 million.

So we understand the issue, we're going to try to fight for it here and make sure that it does not remain, because we do believe, as Senator DeFrancisco said, it's counterproductive.

MR. OKON: Thank you, Senator.

MS. ROEFARO: Thank you very much.

MR. OKON: I just want to say that there's a tremendous amount going on in oncology payment reform that's happening across the country, as Maryann said. So we're ready to work with basically Medicaid in terms of transforming the Medicaid payment for oncology services.

SENATOR HANNON: And given your sophistication, I would get ahead of it. I would have proposals, I would make it to Medicaid, because I've read some of the stuff

that CMS has tried to do, especially with private physicians and what's going on with oncology drugs in their offices. So if you get ahead of it you can have it, probably, the most reasonable and sane you can get it.

MR. OKON: Thank you. We've provided Medicaid with a lot of the information on these alternative payment models.

SENATOR HANNON: Thanks.

MR. OKON: Thank you very much.

MS. ROEFARO: Thank you very much.

CHAIRMAN FARRELL: Thank you.

Empire State Association of Assisted Living, James Kane. Next it will be the Pharmacist Society.

MR. KANE: Good afternoon.

CHAIRWOMAN YOUNG: Good afternoon.

CHAIRMAN FARRELL: Good afternoon.

MR. KANE: My name is Jim Kane, and I am the past president and current treasurer of the Empire State Association of Assisted Living, commonly known as ESAAL.

Thank you for the opportunity to testify today. I will limit my testimony to

one critical area for our low-income seniors and disabled individuals on SSI: The urgent need for an immediate increase in the SSI rate, which is currently only $41 per resident per day.

ESAAL is the only association that exclusively represents the assisted living provider network, serving more than 275 licensed facilities and more than 23,000 seniors and disabled individuals throughout New York. While ESAAL represents the entire assisted living industry, my testimony today is focusing on those facilities that provide housing and care for our low-income SSI seniors and disabled individuals.

Currently, adult care facilities are paid $41 per day and we provide housing and a wide array of care and services to low-income seniors and disabled individuals on SSI, including three meals a day, housekeeping, activities, supervision, case management, medication assistance and hands-on personal care. And let me repeat that number, it's $41 per day in total for these people. It's

approximately the same amount that you would pay for a quick night out at the movies. You know, we probably pay more than that to house a dog in this day and age. So it's really a shame that we're at this level.

I would have to believe that everyone would agree that $41 -- excuse me, I have a bit of a cold today -- I have to believe everyone would agree that $41 per day is grossly insufficient to adequately house and properly care for a needy individual. I doubt if anyone could find a decent hotel room for that price.

The last time the state increased its share of the SSI rate was nine years ago, in 2007, and the last increase before that was 17 years earlier. That is one rate increase in approximately 25 years for our industry. With one rate increase in two decades and no state COLA, the SSI rate has fallen far behind the costs of providing care and services to our seniors.

Currently there are approximately 250 ACFs that house and care for seniors and

disabled individuals on SSI. Many of these ACFs only accept a certain number of SSI residents at any one time because it is impossible to meet facility costs solely on that rate. Indeed, a significant number of ACFs that cater solely to this low-income population have been forced to close their doors and move their residents out of their homes. Approximately 10 facilities voluntarily closed over the past two years, mostly because of financial hardship.

I can also speak from personal experience here as well. In addition to my role with the Empire State Association, I also own and operate a small family-owned company. We started in the early 1970s, and at our peak we had 14 SSI facilities across upstate New York serving approximately 500 low-income seniors and disabled individuals. Over the past few years, we have closed six of our 14 facilities due to financial losses, so we now have eight remaining facilities serving approximately 350 residents.

Over the past two years, we have closed three SSI facilities, resulting in 88 low-income residents having to leave their homes with us and having to move to other settings, mostly including the far more costly skilled nursing facility. And while it has been painful to have to close our facilities and move our residents, the part that is so unbelievably frustrating is the last part -- watching our residents move into nursing home beds prematurely at a far greater cost to the state.

For every displaced SSI resident upstate who ends up in a nursing home, the daily cost of housing and caring for the state increases dramatically from approximately $41 per day to somewhere in the neighborhood of $150 to $250 a day. Indeed, in December 2014 an SSI facility closed in Syracuse, and eight of the remaining 14 SSI residents moved into higher levels of care, resulting in the state paying approximately $325,000 more annually to house and care for just those eight low-income seniors.

The simple reality is that SSI beds are, by far, the best bargain the state has to care for low-income seniors. Nursing home beds are the most dramatic cost comparison, generally costing four to five times the $40 per day for an SSI bed. But even home care agencies and adult day programs charge the state far more than $40 per day, and that is for just a few hours of services each day, as opposed to the 24 hours of housing and care that comes with an SSI-funded adult home bed.

And it is important to note that most of the residents that we are talking about must live in a 24-hour supervised environment. They cannot live alone and receive services sporadically from those other programs in a safe manner.

And yet the state is allowing this bargain to slip away just as the state's senior population is going to increase dramatically. More and more ACFs that cater only to this low-income population are closing. And many ACFs that have reserved some capacity for SSI residents in the past

are setting aside fewer and fewer slots for this low-income population. Absent an increase in the SSI rate, there will eventually be no SSI beds in this state, and nowhere for these low-income seniors and disabled individuals to live.

In my view, it is absolutely imperative that the state increase the SSI rate this year. ESAAL is respectfully asking the Legislature to increase the SSI rate by $7.50 per day in this year's state budget. This modest increase of $7.50 per day will help make up for the fact that our rate has been frozen for the last nine years, and help stem the financial losses that many SSI facilities are incurring right now.

However, I need to be crystal-clear that this modest rate increase will not do anything to offset the proposed minimum wage increase to $15 an hour the Governor recently proposed. Like so many other small businesses, the proposed minimum wage hike to $15 an hour would simply devastate our SSI facilities, and we would need a dramatically

higher rate increase to avoid closure of our SSI facilities.

For my facilities in upstate New York, the direct impact of the minimum wage increase to $10.75 within this next year would be $495,000 a year. And I might add, the impact once we've reached the entire $15 an hour would be $1.7 million annually. And just to put that in perspective, I employ approximately 155 employees, and I house 359 residents. My total payroll right now is $3.2 million, and this rate increase would represent over a 60 percent increase in just our labor costs.

Without substantial funding from the state to offset these higher costs, there is no doubt that I will have to close all eight of my facilities -- and the same is true of many of assisted living facilities throughout the state. ESAAL is currently studying the impact of the proposed minimum wage increase for the assisted living industry, and preliminary estimates indicate that the total impact to our industry would be over

$170 million per year. And that's just for the direct labor costs.

In addition, I must point out two additional funding requests the Governor made in his Executive Budget that I believe further justify an SSI rate increase as a matter of basic fairness.

First, the Governor has proposed $38 million in the OMH budget for ongoing compliance with a federal court settlement called the O'Toole settlement, in which he voluntarily agreed to attempt to move a few thousand SSI residents out of 23 adult homes in New York City and into supported housing. Over the past three years, the Governor has requested and received over $84 million in appropriations from the Legislature for compliance with this federal court settlement. However, according to a most recent report to the federal judge, the Executive has moved only 110 SSI residents into supported housing to date. I want repeat those numbers one more time: $84 million appropriated over the past three

years, and only 110 SSI residents have moved into supported housing so far. And just like last year, the Governor is now asking for an additional $38 million for this initiative, on top of the $84 million you have already appropriated.

Our modest SSI rate increase of $7.50 per day would also cost approximately $38 million annually, but unlike the O'Toole appropriation, it would impact approximately 13,000 SSI residents statewide, not just a few hundred in New York City. In addition, our modest rate increase would actually help save Medicaid dollars by helping avoid costly nursing home placements. By contrast, the O'Toole appropriation drives additional Medicaid spending because, once the SSI residents are moved out of their adult home into supported housing, they need extensive wraparound services to replace the 24/7 care, services, and assistance they currently receive in the adult home.

And second, the Governor has proposed approximately $640 million in spending to

help combat the homeless problem in the state. Of course we do not take any issue with the state increasing funding to help the homeless, but if the state is going to spend $640 million to develop new housing for the homeless, we respectfully ask for a fraction of that amount -- approximately 6 percent -- to help save the existing SSI homes and beds of our low-income seniors and disabled individuals.

Thank you again for the opportunity to testify today, and I'd be happy to answer any questions.

CHAIRWOMAN YOUNG: Thank you. I don't believe there are any questions, so thank you very much for your testimony. We appreciate it.

So it's almost 5:30, and we've been at it here for nearly eight hours and we still have about 17 speakers left in the queue. So here's an idea. If everyone could please cooperate -- instead of just reading your testimony, please submit your testimony and all members of the committee will take it

very seriously, we'll review it. But if the remaining speakers could just cover the top five things that they wish to highlight -- not read the testimony, but actually do it that way -- that might allow us to get out of here before 1 o'clock in the morning. So we appreciate that.

Next, we have the Pharmacists Society of New York State, and after that in the queue we have the Chain Pharmacy Association of New York State. So if the Chain Pharmacy Association could be ready to go, on the starting blocks, that'd be great. Thank you.

And from the Pharmacists Society of New York State we have Roger Paganelli, president, and Kathy Febraio, executive director. So thank you so much for being here today.

MR. PAGANELLI: Thank you. Good evening and thank you, Senator Young and all the distinguished members here today.

You introduced me, so I do have the condensed version of our testimony here today, and therefore I will be brief.

My name is Roger Paganelli. I am a third-generation pharmacist and pharmacy owner in the Bronx. I currently serve, as you stated, as the president of the Pharmacists Society of the State of New York. With me is Kathy Febraio, our executive director. You have our written testimony before you, and in consideration of your time and that of the witnesses coming up after us, I'll keep the remarks as brief as I can.

Firstly, we'd like to thank you for all your support that you've shown to community pharmacy, both independent and chain, in previous budget decisions and votes for the legislation important to us.

Today I want to share our concerns about another risky Medicaid initiative to replace the existing fee-for-service Medicaid reimbursement formula for so-called specialty drugs with a method that would pay pharmacies based on a cost basis to be determined by the Department of Health.

Some key points that I need to make: There is no such thing as a specialty drug.

"Specialty" is an arbitrary term used by unregulated business entities such as the PBMs, or pharmacy benefit managers, for their own financial advantage. Another point I'd like to make is that the term "specialty drug" is not supported nor defined by any federal or state agencies.

The published brand-name drug benchmarks, AWP and WAC, which refer to average wholesale price and wholesale acquisition cost, are widely used in pharmacy contracts to define drug costs both for purchase and for reimbursement purposes. AWP and WAC are adjusted when drug prices increase or decrease. They're reliable, transparent, published benchmarks understood by everyone in the industry.

Replacing these established benchmarks with a ceiling price determined by DOH would constitute an irresponsible public policy. A state agency is ill-equipped to set prices for prescription drugs. Doing so would result in significant risk for patient harm while destabilizing community pharmacies --

again, both the independent and the chain pharmacies. Given our knowledge of the costs that pharmacies incur when purchasing their inventories, we have no confidence that payment levels under the new paradigm would be either realistic or responsible if this initiative was to be implemented.

I'm going to make two quick points before I close up, and that is I understand earlier that Jason Helgerson mentioned a process that was in place with respect to brand-name drugs for appeals in the event that we were underpaid at the pharmacy level. I'll go on the record stating that no such process exists. It does not exist, and I challenge it.

The second point I would like to make before I close is if the DOH is focusing efforts on cost savings of a few million dollars, why would they leave $95 million in rebates to them uncollected?

So in closing, I will say that due to market forces, pharmacies currently survive on razor-thin margins and further cuts would

certainly impact the ability for us to care for our patients, the citizens of New York, whom we are determined to serve. On behalf of the most vulnerable patients covered under Medicaid fee-for-service and the 25,000-plus pharmacists practicing in this great state, we urge the Legislature to reject this deeply flawed Medicaid budget proposal. We need your help.

Thank you very much.

CHAIRWOMAN YOUNG: Thank you very much.

CHAIRMAN FARRELL: Thank you.

MS. FEBRAIO: I'm Kathy Febraio, the executive director of the Pharmacists Society. Prior to joining the Pharmacists Society I was an advocate for the Early Intervention Program, and I have to say that parallels between the budget's Medicaid fee-for-service reimbursement proposal and the shift to a state fiscal agent are chilling.

The proposal will take a predictable payment system and turn it on its head. It

relies on the Department of Health to gather data, analyze it, and report results to key stakeholders with little or no transparency. It asks you to give up your authority to hold the department accountable on a critical state program. And, as Roger pointed out, all for several million dollars -- while $95 million of rebates remain on the table.

The result in the EI program has been devastating to both the providers and the patients in the system. Please don't let the Department of Health create another system that forces providers with direct patient contact out of a program that serves the state's most vulnerable.

Thank you.

CHAIRMAN FARRELL: Thank you very much.

CHAIRWOMAN YOUNG: Thank you.

Yes, Senator Hannon.

SENATOR HANNON: Yes, okay. Mr. Paganelli, you made some statement about an appeals bill. I'm reading from a Pharmacists Society press release dated

December 21, 2015, that talks about the Pharmacists Society and the Chain Pharmacy Association worked to successfully pass a MAC Appeal bill signed into law by Governor Cuomo. I'm sure that's what the people were referring to. I don't know why you are -- do you have some explanation of that?

MR. PAGANELLI: The MAC appeal bill refers only to generic drugs. What is on the table today, and what was discussed earlier -- and I was not here, that was information that was shared with me -- was referring to brand-name drugs in the Medicaid program.

SENATOR HANNON: I don't know what -- I don't know what they were referring to. I'm just telling you that I'm sure that they were -- they thought they would be referring to this bill that you and the chain pharmacies had praised.

MS. FEBRAIO: The bill does not apply to the Medicaid program.

SENATOR HANNON: It just talks about all therapeutically equivalent drugs. Okay?

I thought it covered all the drugs that were sold by a pharmacy.

MR. PAGANELLI: Generic drugs only.

SENATOR HANNON: All right. But I simply think that if there's more to be done, you might phrase it in that context instead of just saying they don't -- you don't know what they're talking about. Okay? Thank you.

MR. PAGANELLI: Thank you.

CHAIRMAN FARRELL: Thank you.

CHAIRWOMAN YOUNG: Thank you.

CHAIRMAN FARRELL: Chain Pharmacy Association of New York State, Mike Duteau. I chewed that up.

MR. DUTEAU: Good evening.

(Discussion off the record.)

MR. DUTEAU: Honorable Chairwoman Young and Chairmen Farrell and Hannon, Senator Valesky and other distinguished members of the committee, my name is Mike Duteau. I am a pharmacist, vice president of business development for Kinney Drugs, and president of the Chain Pharmacy Association

of New York State.

We would like to thank you for your strong past support of community pharmacy and our patients, and for the opportunity to testify today regarding the proposed state budget.

Specific to the state budget, the Chain Pharmacy Association has focused on two issues: Protecting patient access to critical pharmacy care by ensuring adequate payment to pharmacies; secondly, strengthening the role that pharmacists can play in improving patient health outcomes while reducing costs.

Both issues are referenced extensively in my written testimony. For the purposes of this hearing, I will briefly focus only on the first issue.

The State Department of Health is seeking broad authority in the Executive Budget to set reimbursement rates for community pharmacies for an undefined and undisclosed list of specialty drugs as designated by Medicaid. The proposal would

cut community pharmacy reimbursement by $3.7 million.

While this number seems relatively small compared to previous Department of Health budget cuts related to Medicaid fee-for-service, the department has made clear its intent to use this methodology whenever it deems appropriate, and that it plans to migrate this proposal into Medicaid managed care.

Without question, the impact of this on community pharmacies could be pharmacy closures and job losses leading to patient access issues, especially in our low-income, rural, and underserved areas. This proposal has numerous flaws and is extremely concerning.

The data that the department would use is not readily available to pharmacies, to the Legislature, or to the public. Using this data, the department would identify the lowest reimbursement paid by managed care plans, below cost in many instances, and reimburse pharmacies in their network for

specialty drugs, setting that rate as a ceiling for what Medicaid would pay.

While contractual agreements legally prohibit me or PBMs from discussing specific reimbursement rates, I can share with you that it is becoming increasingly more common for my company to lose $1,000 or more on each Medicaid managed care hepatitis C prescription. I think it's obvious that that is not sustainable, and unfortunately we have been turning patients away.

Furthermore, while the department has stated that they will initially only apply this short list of drugs to the specialty segment, it's pretty obvious that over time they could significantly expand that list of what they consider to be specialty drugs if given broad authority.

I am also a member of the New York State Board of Pharmacy, and there is no such legal definition of a specialty drug or even a specialty pharmacy. Therefore, this proposal could be applied to any or all drugs. That outcome would be catastrophic

for community pharmacy and all of the patients we could no longer afford to care for.

If enacted, this cut could jeopardize patient access to essential medications because it directly targets these patients with the most serious and often life-threatening diseases who still remain in the fee-for-service program. This could include drugs to fight cancer, multiple sclerosis, cystic fibrosis, mental illness, HIV and others.

New York State already has one of the lowest Medicaid pharmacy reimbursement rates in the entire country. We have just learned that the Department of Health once again failed to collect almost $95 million in drug rebates. From a dollar-amount perspective alone, fixing this issue should be a bigger priority than implementing this flawed reimbursement proposal.

Finally, we respectfully ask that the Senate and the Assembly firmly reject the proposal, the proposed Medicaid cut to

pharmacy reimbursement, in the final state budget in order to protect pharmacy care in New York.

And again, I thank you for all of your long-standing and unwavering support of community pharmacy and all of those patients that we serve. Thank you.

CHAIRMAN FARRELL: Thank you.

CHAIRWOMAN YOUNG: Thank you.

CHAIRMAN FARRELL: Questions?

CHAIRWOMAN YOUNG: No questions.

Thank you so much.

MR. DUTEAU: Thank you.

CHAIRMAN FARRELL: Thank you.

Susan Zimet, executive director, Hunger Action Network.

MS. ZIMET: Hi, everyone, and thank you.

First, I just want to tell you how impressed I am that you're still here -- it's 5:30, and I know you started at 9:30. I've come to these hearings before and they've been pretty sparse at this time, so I'm incredibly impressed. And it's good to see a

lot of you.

I'm going to be pretty quick because I know you've been here for a long time, and you could read this. And there's really about three things that I really -- four things that I wanted to just top-line and talk about.

I started at Hunger Action Network -- after 20 years of being in local government -- last year. And it was exactly at this time, so last year I started by coming here and testifying last year -- but I didn't really know what I was talking about because it was all new to me.

But what I have learned in this past year, which we all know, is the level of poverty and hunger in New York State and how really devastating it is and how many kids are living in poverty, how many kids are using free or reduced-cost milk programs.

What's also happening right now, though, is there are new sectors that are growing every single day, and those sectors are -- we have more seniors now than

ever before that are actually going hungry. We have veterans, more than ever before, that are actually going hungry. We have college students, we have food pantries opening up on college campuses -- in New Paltz, where I lived for 30 years, at SUNY New Paltz they opened, in the Christian Student Association, a food pantry to help the kids who can't afford to pay for their tuition, their housing, and their food.

So we have a lot of new sectors that are growing. And with some of these new sectors, specifically the veterans and specifically the seniors, these people are very, very, very proud, and they're not the kinds of people who are used to going into a pantry and asking for help. And so the way we approach hunger now is really a little bit different than the way it just used to be. Way back when, the emergency food pantries were just that; they were emergency food pantries. They weren't like the supermarket that helped the working poor, the veterans, the seniors, the parents with children who

have to go in and supplement so they can get food on the table through the entire year.

And so the pantries and food banks are really under a really great threat in terms of pressure that they have, of the demand since the recession, and it's just not easing. HPNAP funding has been pretty much flat for a number of years, and what's happening now is that all the food banks want to do nutritious food -- they are very, very into that, they support it, they want local food, they want local farm food -- but the more that they have to buy healthier food, the more costly it is. So the more nutritious food they have to buy, the low-sodium food they have to buy, the more expensive it is. So they get less food for the same amount of money.

So the demand is greater, they're getting less food for the money because they're buying better food, and so it's ending up where people are now, when they go to the food banks and pantries, are being rationed or they're being turned away, and

every food bank or pantry tries not to turn anybody away.

So when I started last year, I had found out that the New York City Food Bank had basically done an analysis where they looked at the number of people who are in poverty since the recession, the cost of food, and then what it would take to basically put everything even, and they came up with $51 million. That in order to basically meet the needs of New York State, HPNAP has three pantry bags a day for three days for everybody in the family. So in order for a food bank to meet the standards that New York State sets, they calculated we would need $51 million.

And that's the number they said that we need to basically feed the people of New York. Sure, that's a hefty increase from $34.5 million. But at the end of the day, ultimately a budget reflects who a government is, a voucher reflects who we are as a people. And letting kids go to bed hungry, letting veterans go to bed hungry, letting

senior citizens not know when their next meal is coming is not who I think we want to be as New York State. If it takes $51 million, it takes $51 million. And we know that there's money there.

Last year -- you know, after you did the budget last year -- there was an article in the Legislative Gazette that talked about dark money, about $2.6 billion that was approved but not allocated. And so I read that and sort of said, you know what, let's try and see if we can get $16.5 million to help make sure people are getting fed.

And Assemblyman Crespo stepped up to the plate and helped, he did a sign-on letter, Senator Bonacic did a sign-on letter, a number of you actually signed the letter asking the Governor to come up with $16.5 million. Unfortunately, we sort of thought we would get the money, but we didn't. But we were praying we would get it in this year's budget. And this year we didn't, it's just $34.5 million again this year.

And so we're really hoping that you could consider asking the Governor to do an amendment to really raise it to the $51.5 million, the $51 million to make sure that people get fed.

In the Anti-Hunger Task Force report, one of the recommendations is to have $51 million given towards HPNAP. So it is in the Anti-Hunger Task Force report, it just didn't get embedded into this budget. So that's just number one. Really, any help you could do -- I mean, we just don't want to have people being hungry. We understand we want to solve the problems, and that's the most important thing is solving the problems and doing legislation to take people out of poverty. But while we as government try to solve the problem, we should make sure that our kids aren't going to bed hungry and that, you know, we just owe it to the kids of our state and to the people of our state.

Number two is -- and I know Senator Kemp Hannon I think knows about this -- I've been working very closely with Long Island

Cares, the food bank down on Long Island, and they created this very innovative pilot program where they actually go out to the veterans and they go out to events where veterans are gathering and they go out there and they bring the food to the veterans, because they know the veterans are too proud to walk into a pantry. So they actually created a program to take it to the veterans, they've created a program to take it to the seniors, and they're being very, very innovative in what they're doing. And they're getting calls from all over the country asking people how they did this so they could replicate it.

So one of the things that I know that the Long Island Cares food bank is talking to their representatives -- I know they talked with Senator Flanagan, I know they talk with people in the Assembly -- and other food banks are asking for a million dollars to be set aside for a competitive program where they figure out ways to service people who are hungry that just don't go into your

normal food banks or pantries, so to come up with some creative ways to make sure we're getting the people who need to be fed fed.

The third thing is single-payer health insurance. Most people who go into food banks or food pantries -- you know, the three biggest issues that they pay their bills on, first it's their house, they want to keep a roof over their head; second, it's their utility bills, so they can stay warm in their house; and then it's healthcare. And when they get done paying those, they usually don't have money left to pay for food, which forces them into a pantry, and that's happening more and more. So any way we can help to alleviate the burden of single-payer healthcare {sic}.

And just to wrap up real quick, there was also just one thing. If you look at the Governor's Anti-Poverty Agenda -- and let me just say I think it's phenomenal that everybody is focusing on poverty and hunger and that we're making it an issue. We're thrilled that the Governor incorporated the

Anti-Hunger Task Force report into his policy book for the State of the State. We're thrilled about that, we're thrilled about his Anti-Poverty Agenda. But in the Anti-Poverty agenda there is one particular thing that I have, it's in there and it explains it a little bit more.

There's the Empire State Poverty Initiative, which the Governor is looking to basically do for about $500,000 each for 10 selected cities, for a total of like $5 million. And talking to some anti-poverty people, it's come to our attention that the Community Action Program is federally mandated to do studies every three years. And basically the belief is that that $500,000 is going to go for grants for these cities to do assessments. And so what we understand is Community Action does do these assessments, and they're obligated to do it, and they can fine-tune the targeted 10 cities for about 75,000, not 500,000.

And they could be put under contract -- they already are with the federal

government, they are the federal anti-poverty arm for the past 50 years. By potentially freeing up this money, we could then reinvest it into housing, into hunger, into other things. So that's just the one thing in the Anti-Poverty Agenda that we should look at closer, because that could free up possibly like 4 or 5 -- $4.5 million. And so that was something that came to our attention when some of the poverty people were reviewing everything.

And we can get into that in more detail, but I've taken up enough time. So I want to thank you very much, and again, I want to applaud you for all being here.

Thank you.

CHAIRMAN FARRELL: Thank you very much.

Questions?

CHAIRWOMAN YOUNG: Senator Valesky.

SENATOR VALESKY: Not so much a question, Susan. I just want to thank you for your testimony.

Just to follow up on your last point.

You probably know in the City of Syracuse, one out of every two children are born into poverty. So the Governor's anti-poverty initiative was welcome news, certainly for those of us in Syracuse and across the state. And I'd be very interested in following up with you on the research that you have found in regard to Community Action Program, so we can stretch those dollars.

MS. ZIMET: Thanks. And I will just say very quickly about Syracuse -- when I first came in, there was a snowstorm, as usual. But when I first came in, one of the first phone calls I got was from Syracuse, from public radio, because this -- Joe Burke from New York City had just released something about, you know, "After the Bell" or whatever, and actually in Syracuse your superintendent in -- someplace in Syracuse, that they're doing an amazing job of getting like 80 to 90 percent of the kids getting fed in the school. So I actually want to follow up --

SENATOR VALESKY: Great.

MS. ZIMET: -- with, you know, in Syracuse to find out what they're doing and how we can sort of replicate that, because the most important thing is making sure kids get fed --

SENATOR VALESKY: That's right.

MS. ZIMET: -- so they can learn and they can have a chance at life and not end up dropping out of schools. So I'd love to talk to you more about this.

SENATOR VALESKY: Thank you.

MS. ZIMET: Okay. Great, thank you.

Any other questions?

CHAIRMAN FARRELL: Senator?

MS. ZIMET: Hi, Liz.

SENATOR KRUEGER: Thank you.

In your testimony you reference a draft of the Governor's Hunger Task Force Report. Is there an actual report out yet or a draft out?

MS. ZIMET: Yes and no.

SENATOR KRUEGER: Okay.

MS. ZIMET: I've been asking for a while, you know, about the Anti-Hunger Task

Force Report. We've been waiting to see it. We thought it was going to come out around Thanksgiving, and then I was told that it would come out before the State of the State.

What ended up happening is the Governor incorporated a bunch of it into his State of the State policy book. Page 169 is where it starts in the policy book. So he talks about implementing the recommendations of the Anti-Hunger Task Force. He's talked about, you know, raising the 150 percent community eligibility, which is phenomenal, because it'll get about 750,000 more families, you know, eligible for SNAP. He talked about creating possibly a cabinet-level Hunger Task Force, policy task force. And he talked about the 250,000, I think, Farm-to-School. So that was in his book. And he said they're adopting the recommendations.

I have since gotten -- but it's not for public distribution, because it was a draft and it's not mine to distribute -- but I did get a copy of the 34 recommendations.

It started out at 25, but I think it's now 34. And what the draft shows -- what this chart shows is all of the recommendations and what's in progress and what has not started yet.

So I'd be more than happy to come up and meet with you and show it to you, but I just can't release it because it's not my document to release.

SENATOR KRUEGER: Thank you.

MS. ZIMET: You're welcome.

CHAIRMAN FARRELL: Thank you.

MS. ZIMET: Okay, thank you.

CHAIRMAN FARRELL: New York Chiropractic Council, Dr. Bryan Ludwig, Albany district president.

DR. LUDWIG: Thank you for having me here to testify today.

I testified in 2014 before the workers' compensation fee schedule hearing. I want to thank you for having that hearing. It was instrumental in worker's comp's board --

CHAIRMAN FARRELL: We did it just for

you.

DR. LUDWIG: Huh?

CHAIRMAN FARRELL: Nothing. Keep going. I said, you did it just for us.

DR. LUDWIG: So yeah, that fee schedule is no longer going to be put into effect. We appreciate that. And we also want to thank you for proclaiming September as Chiropractic Health Month.

We would like to draw your attention to some pending legislation. Again, we have the medical partnership bill -- we feel that that would be instrumental in changing the culture of healthcare in New York State.

As I sit here and I listen -- I've listened to other years when I've testified -- we keep hearing about how there's more and more ill people and there's increased costs with that and if it's not handled at the local level, then it goes to the hospital level and there's increased costs there.

But what about just having fewer sick New Yorkers? You know, that would lower the

cost for a lot of different things. In the past I gave some testimony on Blue Cross/Blue Shield of Chicago and how they reduced costs and things like that, and we can get into that more if you have some questions on how they reduced pharmaceutical costs by about 80 percent. I wonder how big the Medicaid budget is on just pharmaceutical costs -- it's a funny question, but I know we know that answer.

As a chiropractor, we start to think -- and I'm looking at things that are promoted as health and healthy. And to me, that is the major issue, is that those things are not healthy that are usually promoted as that. A quick fix of treating a symptom, not finding what was causing the symptom, leads to chronic illness, wasteful spending on healthcare, and it just spirals and spirals.

Chiropractic can help New Yorkers achieve true health. We do it safely, naturally, and in the process can save the health care system lots of money. So if you want to spend less on prescription drugs and

needless surgery, if your goal is to have fewer heroin addicts among young New Yorkers, then you've got to reach the person before they become an addict, before they become sick, before they become diseased. You must put and keep them on the road to good health.

So how do you do that? Well, we've heard some people today talk about good nutrition. Smoking cessation. All great starts. A place that we keep going -- and I keep saying this is not health -- detecting an illness early is not preventing it. You first have to bring the person to be healthy before you can -- if you do that, then they're not going to be sick and you're going to lower your costs that way.

So we focus on the chiropractic, and the Chiropractic Council focuses on how the body works as a whole -- without drugs, without surgery. So before early intervention, before detection, before screening, we don't pollute or modify the body chemically merely to mask symptoms, we help the body return to normal function.

So it's like if you're driving down in your car and you're going through the tunnel and you're listening to your radio, all of a sudden you can't hear the radio. Well, maybe the message to your radio isn't getting there. You don't need a new radio. You don't need to cut it out, you don't need to inject more electricity to it. You just need to get the message there.

So that's what we do. We get the message there, from the brain to the body and the body back up to the brain.

So a case in point, Medicaid, chiropractic care could substantially help many Medicaid-eligible New Yorkers, but we're unfunded. So I have Medicaid people coming to me and they're paying out of pocket for preventive care. A hundred percent. Why?

I could have read the whole testimony, but I kept it to five minutes.

CHAIRMAN FARRELL: Thank you.

CHAIRWOMAN YOUNG: Thank you very much.

Any questions? Okay, thank you.

CHAIRMAN FARRELL: Renée Nogales, MPA, Nurse-Family Partnership.

MS. NOGALES: Good evening, Chairman Hannon, Chairwoman Young, Chairman Farrell, and other committee members. My name is Renée Nogales, I'm with the national office of Nurse-Family Partnership.

And I want to start out by thanking the Legislature for your support over the past five years for this program, without which we definitely wouldn't be where we are today.

This year we ask you to support $5 million in funding to support NFP, and in addition to this request we're asking that you also support maintaining the COPS funding, Community Optional Preventive Services, which is an important funding source for NFP, and also to support funding for other home visiting programs, including $4.5 million for Healthy Families, $3 million for Parents as Teachers, and $1.5 million for the Parent-Child Home Program.

But I'm here to talk about

Nurse-Family Partnership today. Many of you are already very familiar with this program, which is one of the largest and most extensively studied community health programs that transforms the lives of Medicaid-eligible women who are pregnant with their first child. They get partnered with nurses early in pregnancy, and the nurses work with them until their child is 2 years old, to help them set goals for themselves, help them build their self-confidence, and help them achieve milestones. And we really believe that these nurses are helping reduce poverty, one mother at a time.

The Nurse-Family Partnership is backed by decades of research which show documented reductions in the use of public programs like Medicaid and food stamps, reductions in child maltreatment, better pregnancy outcomes, better language development for the children, and also better academic performance for the children.

In over 38 years of ongoing research and development, which is continuing to

today, it's really showing positive results both with the mothers and the children, which really shows that NFP is a dual-generations strategy. For example, we see a 35 percent reduction in pregnancy-induced hypertension, a 67 percent reduction in behavioral and intellectual problems by the time the child is six, and a 59 percent reduction in arrests when the children are age 15.

So there's a lot more details on the data in the program in my written testimony, including some client stories at the end. I hope you'll take an opportunity to read them, but I just want to wrap up by reading one very brief story.

This is from a former NFP participant in New York City named Donna Freeman. "I learned about NFP from a caseworker at my shelter. I'm usually pretty open-minded, so I thought I'd give this a try. My nurse Joanne helped me in so many ways. She gave me confidence as a mother, helped me create a real relationship with my daughter, taught me what it means to be nurturing. I would never

have thought about reading to her, or teaching her to play with crayons -- but now Zaira is 5 years old, and she's so smart and she loves to write. She's doing really well in kindergarten.

"I felt like NFP was my family -- extended family, better than my real family in some ways. Raising a child is stressful, especially when they get sick -- that baby messes with your mood. You can feel really alone. But I always had someone to talk to, and the right someone, because Joanne is a nurse and she knew what to tell me. She was always positive and helpful, she taught me everything I needed to know. And I always felt heard with her. Plus Joanne built up my self-esteem, not just as a mother but as a human being -- now I know I'm worth a lot.

"I'm working as a police officer in DHS now" -- which is the New York City Department of Homeless Services -- "and it's very challenging, but I use all the lessons I learned from NFP about patience and compassion every day."

I get so inspired when I have a chance to meet these families, so I hope you'll enjoy the other stories. I just want to thank you all again for your continued support, and I can answer any questions if you have them.

CHAIRMAN FARRELL: Thank you very much.

Questions? Thank you.

MS. NOGALES: Thank you.

CHAIRMAN FARRELL: Kim Atkins, board chairman, Family Planning Advocates of New York State.

MR. ATKINS: Thank you for the opportunity to testify today. My name is Kim Atkins, and I am the board chair of Family Planning Advocates of New York State, as well as the CEO of Planned Parenthood Mohawk Hudson.

Family Planning Advocates represents New York's family planning provider network, including Planned Parenthoods, the hospital-based, county-based, and freestanding family planning centers that collectively represent

an integral part of New York's health care safety net. Family planning centers provide vital primary and preventive care services that include full reproductive care; testing, treatment, and counseling for STDs including HIV; breast and cervical cancer screening; family planning that often includes basic primary care for women.

In 2010, more than six in 10 women obtaining care at a family planning center considered it their usual source of care. For four in 10, it was their only source of care.

Despite a continual decline in unintended pregnancy, New York remains one of three states with the highest unintended pregnancy rates in the nation. And in the absence of publicly funded family planning services, the rate of unintended pregnancy and abortion in New York would be 32 percent higher.

By redoubling efforts to advance access to family planning services, we can improve the health of our communities, better

positioning individuals to explore and achieve their educational, economic, and family aspirations.

With that in mind, Family Planning Advocates asks the Legislature to allocate an additional $2.4 million in funding for the Family Planning Grant to bolster the ability of grantees to continue providing these critical health services and connecting individuals to health coverage. This request reflects the $750,000 in funding the Assembly has added in the last several budget cycles, and an additional $1.65 million, adjusted for inflation, which was reduced in the 2013-2014 enacted budget.

The cost savings achieved through publicly funded family planning services are simply undeniable. By assisting clients in avoiding unintended pregnancies, reproductive cancers, and STIs, New York's publicly funded family planning centers saved $605 million in public funds in 2010.

As the state continues to implement innovative approaches to improving health and

reducing costs, doubling down on effective programs like family planning is a strategic investment in the future health and economic stability of the state.

We'd also like to urge the Legislature to restore COLA funding that was cut in the Governor's budget. So the funding level contained within the enacted 2015-2016 budget -- a $2.3 million reduction in COLA funding absolutely hinders the family planning providers from hiring the kind of qualified healthcare professionals -- especially in this time of healthcare reform, when there's a lot of change going on. And we need to pay our providers what they're worth and also handle the increasing costs of healthcare benefits and other things that are impacting the delivery of service.

So I understand the COLA budget is a formula, but it's really important to acknowledge that not everybody's affected by the CPI in the same way and that it's important to have quality healthcare providers providing services.

And finally, I'd like to just make a case for transformation funding for safety net community health care providers, one of which is family planning providers, but also community health centers and other behavioral health providers in the community. As we collectively move towards the high-quality, coordinated health care delivery system that emphasizes the right care being delivered at the right time and in the right location, it is imperative that access to vital services be ensured within communities across the state.

Community health care providers, including family planning agencies, are essential partners in these efforts. Many of these providers are small agencies with lean operating budgets challenged by years of stagnant or reduced funding pools and increased costs of operation. Engagement in transformation initiatives necessitates resources not currently present within these agencies or flowing from the Performing Provider System lead agencies or

state-designated funding streams that support capital or working capital needs. The state's dependence on the community-based health care provider network for the successful transformation of the delivery system must be matched with reasonable investment in this provider network.

So in concert with other community health providers, we recommend that a minimum of 25 percent of the $195 million Healthcare Facility Transformation Program funding be allocated to community health care providers including family planning, behavioral health, and home health agencies, as well as FQHCs. This amount reflects the goal of DSRIP to reduce avoidable hospitalizations by 25 percent.

And, too, the establishment of a new funding pool in the amount of $88.5 million entitled "The Essential Community Healthcare Provider Fund." This funding should be solely available to community health care providers, and the purpose is in direct alignment with the funding pool in last

year's budget — to support the capital and working capital needs of these providers.

With that, I just want to acknowledge that we are thankful for the continued funding of the Comprehensive Adolescent Pregnancy Prevention Grant at current level, and welcome the Governor's funding commitment for a statewide plan to increase the state's breast screening rate by 10 percent over the next five years.

Thank you.

CHAIRMAN FARRELL: Thank you.

Questions? Have a good evening.

MR. ATKINS: Thank you.

CHAIRWOMAN YOUNG: Thank you.

CHAIRMAN FARRELL: Linda Wagner and Frank Kruppa, New York State Association of County Health Officials.

Yes, good evening.

MR. KRUPPA: Good evening. My name is Frank Kruppa, and I'm the public health director and mental health commissioner of Tompkins County. I also serve as vice president of the County Health Officials of

New York, a statewide association also known as NYSACHO. With me is Linda Wagner, our executive director. And Dr. Sherlita Amler from Westchester County sends her regards; she was unable to attend.

The work of local health departments has been very visible over the last year, dealing with emerging communicable diseases such as Ebola, Legionnaire's Disease, and now Zika disease, among others. Most of our work, however, is much less visible, and our time is spent touching almost all of the issues you've heard presented by other speakers today. And we serve as the foundation of health in our local communities.

We are requesting your help and support to reinforce that foundation by making a change to the state aid formula in Article 6, Section 605 of the Public Health Law. Article 6 provides a base grant to local health departments, either a flat amount of $500,000 for smaller partial service counties or $650,000 for more

populous counties. Since the population of New York City, Nassau and Suffolk counties is so much larger, their base grant is a per-capita amount of 65 cents per person. This amount is higher than the flat base grant would be, but 65 cents per person is a low per-capita rate.

With the base grant, 100 percent of allowed local expenses for core public health activities can be reimbursed. Beyond that base grant, local expenditures can be reimbursed at a 36 percent rate.

So we're asking your support in making changes to Article 6 state aid in two ways. First, we're requesting an increase to the base grant from $500,000 to $550,000 for partial service counties. Also, an increase from $650,000 to $750,000 for full-service counties and provide $1.30 for every resident in the larger counties and in New York City.

This rate would be more equitable for the city, Nassau and Suffolk counties, and it would add Westchester, Erie, and Monroe counties to the higher per capita base rate.

Our second request is that you provide local health departments with an increase of 2 percent, from 36 percent to 38 percent, in the Article 6 state aid reimbursement rate. These increases will help us achieve the goals that we've been asked to address, including DSRIP, among many others. And we seek your support in helping us reinforce the foundation of local county health departments.

Thank you, and I'd be happy to answer any questions.

CHAIRWOMAN YOUNG: Any questions?

SENATOR HANNON: Good. Got the point. Thank you.

CHAIRWOMAN YOUNG: Yes. Very effective.

SENATOR HANNON: Good stuff.

CHAIRMAN FARRELL: Thank you very much.

Kathleen Callan, assistant director, New York State Area Health Education Center System.

MS. CALLAN: Hi, there. My name is

Kathleen Callan. I'm the assistant director of the New York State Area Health Education Center System, which we refer to as AHEC. So glad to be with you tonight. Several of you are AHEC supporters and champions, and we are so thankful for your support.

I'm here today relieved that we are put in the budget for level funding this year. There's no cuts. There's no buckets. There's no consolidation. This is a great day for us. I don't mean to -- I know, and you were so supportive, and we want to say thank you to the legislature last year for turning back the buckets and the cuts. The state funding helps our nine centers and our three regional offices prepare the next generation of health professionals that are going to work in our underserved communities.

We are about one-third funded by the state. That serves as the match to our federal funding, that's another third. And then the last third of our funding is other grants that you'll hear about throughout my testimony, things that we get on our own that

the state and federal funding helps sustain.

I want you to know, though, that it wouldn't be fair to say that we have adequate funding, and we can't turn back all the primary care shortages in New York State that we're facing and that you are all well aware of in both rural and urban areas.

We are focused on grow-our-own programs, taking middle school, high school, college students, even some career-change professionals, and turning them to the opportunities, the many opportunities that are in the medical professions and the health-related professions.

You've heard all today about the many transformation programs going on in New York State: DSRIP, PHIP, SHIP. None of these are possible without adequate staffing. And we are involved in many of the PPSs, and we are a consistent voice in those PPSs and with the Department of Health, reminding them that we need to think about the future health professionals that are coming up and we need to invest in that.

Just trying to summarize here. Okay. So on the next page and in our annual report which you have in front of you, you can see that we worked with nearly 13,000 elementary and middle school/high school students, we worked with college students, we worked with medical students, nursing students, health profession students who are going through their rotations, exposing them to an underserved community and also recruiting those students and supporting those students from the underserved communities to help the overall diversity of New York State.

We continue to do continuing education programs that you can see listed here, and we also collect short-term, intermediate, and long-term impacts, and you can see that as well.

I guess the best way to talk about AHEC is to talk to our students. I invite you all on February 3rd -- we have an open house in 711A, some of our students will be coming there and talking to you about their experiences, about the mentorships that AHEC

offers, about the exposure that they got to health careers that they had never considered, and their commitment to working in underserved communities.

Thank you so much for your support.

CHAIRWOMAN YOUNG: Questions?

CHAIRMAN FARRELL: Thank you very much.

Leslie Grubler, founding director of the United New York Intervention Providers and Parents and Partners.

And after that is Daniel Lowenstein, Bryan O'Malley next, and then Amy Lowenstein. If you get close to the table, we'll move faster.

MS. GRUBLER: Good evening. My name is Leslie Grubler from the United New York Intervention Providers and Parents as Partners. I know, it's a mouthful. Thank you all for being here this evening, I so appreciate you staying.

The testimony -- it's not by accident that I have this statement on the cover. Dr. King was a fighter for liberation, not

unlike our families and our providers, and UNYEIP represents not only the families but also the independent contractors, all the folks who are on the front lines in treating children of Early Intervention, those zero to three.

I'm going to be very brief and just address the points that were in the EI reforms of the Executive's budget. The first point is the screenings. Screenings are just that. They don't tend to tell everything, they're not comprehensive, they don't give us all the data, and they could very well mislead. And that's an important component if they're being added mandatorily to the process. We may actually end up spending more rather than less.

The second piece is -- there were questions about the family-directed evaluations, and the question of resources or the exploration of resources of a family. You should know that these types of evaluations are already done in New York City, and they're done basically to determine

whether there's appropriate support in the family. That is, if there's caregivers, if mom and dad work, if they have individuals who are supporting them -- grandparents, extended families, et cetera.

We have never found it in New York City to be problematic. I'm not sure what the Executive's perspective is here. I am a little bit concerned about the wording, because resources can be looked at from a financial perspective as well. So I think perhaps in reevaluating the paperwork, either we change that word or we just delete the entire idea.

The medical records component as being used to determine eligibility -- we know that typically medical records are written by physicians. Not every physician has a bent on developmental disorders or developmental delays. They're not able to prescribe and they don't know what type of treatment to recommend.

Think of yourselves, those of you who may have gone to physical therapy. Could

your physician, your general practitioner tell you exactly what exercises to do to relieve your pain or distress, et cetera? Likely not. But your physical therapist could, not unlike something a speech-language pathologist like myself could do, or an occupational therapist as well. So we have to be mindful of that.

The language in the reforms reflects a 1 percent increase in the administrative function. That would mean that none of the hands-on providers typically would have the opportunity to partake of that unless they were an independent contractor. The 1 percent is 1 percent of the administrative costs. If we consider that to be 20 percent of the rate, that would come to about 10 to 16 cents per session, or a per annum increase of about $344 a year.

If you take a look at the testimony, I've included some charts in the back that reflect that since 1993, the inception of the program, there's been a cost of living increase of 64.58 percent. The next chart

reflects -- or I should say the previous chart -- what the decreases in rate were, anywhere between 15 and 20 percent as well.

So it's just important to note that while that 1 percent is helpful, it's 1 percent of administrative costs, which is significantly less. It probably could pay for a cup of coffee at Dunkin' Donuts, I think. Maybe every day.

So Early Intervention families, they've been unknowingly sacrificed by a system that has not only dismissed the vulnerability of the children's conditions but has dismissed the evidence-based practice that supports and enables their children's progress.

There are questions as to waiting lists. Yes, they still occur. Those questions as to whether the lists the Early Intervention DOH department has are accurate, we know that they are not. We've known that for three years, and those lists have still not been made accurate. I'm not quite sure what is taking all of the time in ensuring

that they are accurate.

A couple of other comments on prompt pay and what I call "prompt say." The prompt-pay provisions, which I indicate on Chapter 4, are great. However, the 90 days must start from the time of authorizations, because service coordinators do not process that before -- on a timely basis, and the 90 days is then ticking away.

"Prompt say," again, is also very good. However, presently the SFA has no capacity to update data in NYEIS. They must refer this change to the provider, who then must relay the information to the service coordinator. So if we're going to make change happen and if we really want to make this system efficient, then we need to go all the way.

My last comment, and that's on the last pages, is that I think we need to recognize that the system, and I'm speaking of the NYEIS system, is a dinosaur system. And still to this day, almost three years after the inception of the fiscal agent,

there are insurmountable inefficiencies. If we want to attract good providers back into the system, then we need to really look at rebranding, rebranding the DOH and the Early Intervention program so that it is again meaningful to the children that we service.

And that's really all that I have to say today. Any questions at all?

CHAIRMAN FARRELL: Thank you very much.

SENATOR KRUEGER: Thank you.

CHAIRMAN FARRELL: Questions? Yes.

ASSEMBLYMAN ABINANTI: Just one question.

You said "tracked back into the system." My understanding is a lot of providers have left the system because of the process. Can you just very briefly tell us your experience, how many have left, and why?

MS. GRUBLER: Yeah, 45 percent of providers since 2013 have left the system. And that's what is in fact yielding the waiting lists that we have.

So here we know that Early

Intervention will help our children, will perhaps take them from disability to ability, and we're dismissing that. And it's not something that we can dismiss. And as I said on the cover here, our lives begin to end when we become silent about things that matter. Our children matter. Our most vulnerable children matter. And we have to start making them a priority.

Thank you.

CHAIRMAN FARRELL: Thank you.

Daniel Lowenstein, senior director of public affairs, Primary Care Development Corporation.

MR. LOWENSTEIN: Okay. Thank you very much, chairpeople, vice chairs, and ranking members, members of the Legislature.

I'm going to take less than 10 minutes -- I'm going to probably take less than five, which is only slightly less than your average primary care visit.

(Laughter.)

MR. LOWENSTEIN: We're trying to change that.

As was said, I am the senior director of public affairs for PCDC, the Primary Care Development Corporation. We are a nonprofit that works to expand access to primary care in underserved communities.

We provide affordable capital to expand primary care, we provide expert technical assistance to change the primary care model, and we provide advocacy to really support policies and funding that support and sustain the primary care sector. Overall, we have had investments of about $670 million in primary care projects that have provided access to primary care to 860,000 new patients. We have trained thousands of workers and hundreds of organizations, including 200 patient-centered medical homes that have been recently transformed.

Primary care really is the linchpin of healthcare delivery and payment reform because of its proven ability to improve health while lowering costs. And we do support the New York State agenda, DSRIP, the State Health Innovation Plan, value-based

payments, which are really working to transform the system. Primary care is at the heart of that system, but it must be funded and there must be strong policies that support it.

Right now, about 5 to 8 percent of total spending is on primary care -- this despite the fact that more people use primary care than any other healthcare service.

Here's our priorities. Number one, capital for community-based healthcare providers, who were largely left out of the funding last year and in previous years. We are asking for $20 million for the Community Healthcare Revolving Capital Fund which, we are very grateful was supported last year in the budget -- there was $19.5 million. We think that that can be utilized very quickly, and we're looking for another 20. We're looking for 25 percent of the Healthcare Facilities Transformation Program to be targeted to community-based healthcare providers, and 25 percent of the Essential Healthcare Provider appropriation also for

community-based providers.

Number two, to restore and increase funding for PCDC to $600,000. We're very grateful to the Legislature, which has restored it over the last number of years. We use it to really help the primary care sectors and individual providers in this increasingly complex environment.

Number three, provide $54.4 million in contingency funds to make up for the potential lost funding in the Diagnostic and Treatment Center Uncompensated Care pool. This is the item that the Community Health Care Association of New York State advocated for. We fully support the request; it is important to the stability of the sector.

Number four, we support the language regulating retail clinics to ensure greater integration with primary care.

And number five, just regarding the minimum wage, we know that front-line workers work directly with patients, work in our communities, are absolutely essential to this transformed model. They are the ones who are

going to be coordinating the care, they are the ones who are going to take the higher costs out of the system.

A recent report by PCDC and 1199 SEIU found that about three-quarters of providers were having trouble retaining these types of staff, and that about half of those -- the reason for that half was insufficient salary. We also know that this money is not something that they have hanging around. These providers have to be funded in order to support these essential workers in the healthcare system.

Thank you.

CHAIRMAN FARRELL: Thank you very much.

Questions? Yes.

SENATOR KRUEGER: Thank you. Hi.

MR. LOWENSTEIN: Senator Krueger.

SENATOR KRUEGER: Very quickly. Your definition of a retail care center, is that what we call an urgent care and emergency care center?

MR. LOWENSTEIN: No. Urgent care is a

different definition, to our understanding. This is retail within the confines of a retail establishment. So it's more like a CVS with a clinic.

SENATOR KRUEGER: Got it. Okay.

CHAIRWOMAN YOUNG: Senator Valesky has a question.

SENATOR KRUEGER: I have one more, I'm sorry.

CHAIRWOMAN YOUNG: Oh, I'm sorry.

SENATOR KRUEGER: Sorry, Senator Valesky.

And the integration of primary care with alcohol and substance abuse. I thought when they moved to Article 28, that was their intention. That's what they were going to do, provide primary care at the site they were also providing substance abuse treatment. That's not the case?

MR. LOWENSTEIN: My understanding is that the integration is -- what this provision in the budget does is it gives them access to a DASNY financing pool for alcohol and substance abuse providers that

they -- to make sure that even though they are going to have an Article 28 also, they can still have access to that pool of money. Which is fully within -- and we completely support that.

SENATOR KRUEGER: Thank you.

CHAIRWOMAN YOUNG: Thank you.

CHAIRMAN FARRELL: Thank you.

CHAIRWOMAN YOUNG: Senator Valesky.

SENATOR VALESKY: Thank you, Madam Chair.

Thank you, Dan. Very, very quickly, just one point.

Both HANYS and the Iroquois Healthcare Alliance in their presentation earlier today in regards to access to primary care -- both referred to the Doctors Across New York program. I noticed in your testimony and your five points that you don't speak to that program. Do you have a thought on Doctors Across New York in terms of --

MR. LOWENSTEIN: It was more of a matter of -- yes, we fully support it. Very much so, yeah.

SENATOR VALESKY: It just didn't make the cut in terms of the top five.

MR. LOWENSTEIN: Yes. Yes.

SENATOR VALESKY: Okay. Thank you.

CHAIRWOMAN YOUNG: Thank you.

CHAIRMAN FARRELL: Thank you.

MR. LOWENSTEIN: Thank you.

CHAIRMAN FARRELL: Bryan O'Malley, executive director, Consumer Directed Personal Assistance Association of New York State.

MR. O'MALLEY: Hi, good evening.

I'm going to try and be brief. We have a number of programs that would help mitigate costs and strengthen protections, but I do want to focus on just three primary ones this evening.

I do thank you for taking the time to hear from us. For those who don't know, the Consumer Directed Personal Assistance Association of New York State represents nearly 15,000 New Yorkers with disabilities and chronic health needs who use the Consumer Directed Personal Assistance Program where

they can recruit, hire, supervise, and if necessary terminate their own workers. These workers can be anyone except a spouse or parent -- and actually, that latter one will change in April, due to legislation passed last year.

Our consumers employ approximately 30,000 workers across the state. It's one of the fastest growing areas of the home care industry, which, in and of itself, is one of the fastest growing sectors of the current economy.

Overall, from our perspective, there's actually very little to like about this budget. The largest problem with it is the fact that the Governor, as you've already heard, has proposed dramatic increases in the minimum wage without honoring the state's obligation to fund those increases through the Medicaid program.

To be clear, our program is a hundred percent Medicaid. We do not exist outside of the world of Medicaid. We cannot raise the cost of a t-shirt, we cannot raise the cost

of a hamburger, we cannot buttress these costs in a private-pay marketplace. If the minimum wage increase is not funded, then the program goes out of business.

This hits hardest in the Southern Tier and Central New York, where there's about $4 million to $5 million of unaccounted-for costs, and in New York City, where there's about $30 million of unaccounted-for costs. This is in Year 1 only.

These costs are truly layered on top of a system that has already degraded reimbursement to a point where fiscal intermediaries -- those are the providers -- cannot add one penny to the cost of providing direct services. In an ironic twist, many of my members have commented that they could dramatically increase their reimbursement by doing such things as purchasing company cars or increasing expense accounts.

However, as good stewards of taxpayer dollars committed to the services they provide, this is not the course of action they choose. In fact, most of my members

have about an 8 to 12 percent administrative cost, with 88 to 92 percent of each dollar going to providing direct services.

The fact that the direct care costs are insufficient has led to what is already an all-time low in funding for these organizations, with the average funding being less today than it was in 2006, not adjusting for inflation. There is no more fat to trim, there's no more efficiencies to find. The failure to fund this minimum wage increase and adequately fund this program is causing the entire program to collapse upon itself.

CDPA is not worried that one or two FIs will have to close their doors. We're discussing the potential wholesale collapse of an industry. FIs in New York City -- I'm sorry, this is the problem with jumping around in your testimony.

CDPA is integral to the state's efforts to achieve the Triple Aim. Delivering high quality services for less money with higher consumer satisfaction, CDPA allows the state to lower costs. It is

estimated that we saved the state Medicaid program over $50 million just last year. That's expected to grow exponentially this year, as the program has increased by 40 percent in the last year due to managed care.

The budget undermines all of that by ignoring a simple financial truth, that services cannot be delivered if the money is not there to pay for them.

The Governor noted that the failure to pay a minimum wage, that is a living wage, amounted to nothing more than a subsidy for employers. He stressed that it costs $6,800 per year in public subsidies to keep a McDonald's or Burger King employee at the current minimum wage. What he fails to note is that the current worker in the Medicaid system who receives a minimum wage, because that is what the state's inadequate reimbursement allows, also costs the state $6,800 per year in public subsidies.

What he fails to mention is that the accomplishment of his global cap and reining

in Medicaid growth has come on the back of the working poor, often single mothers. These workers do back-breaking work and cannot afford to put food on the table for their family or heat their home without benefits and subsidies from TANF, HEAP, and other social safety nets. In other words, while the Governor decries McDonald's and Burger King for using public benefits to lower their bottom line, his Medicaid program is doing just that.

Last year Governor Cuomo, acknowledging the distinct differences in CDPA from other traditional services, committed to fully funding the program's costs incurred as a result of the new federal rules that require full overtime to be paid, as well as travel costs. He committed to doing this in consumer directed because he acknowledged that we have no control over who consumers hire and how long they schedule them for.

other traditional services, committed to fully funding the program's costs incurred as a result of the new federal rules that require full overtime to be paid as well as travel costs. He committed to doing this in consumer directed because he acknowledged that we have no control over where consumers hire -- over who consumers hire and how long they schedule them for.

He promised $20 million to fund

overtime last year. His ultimate solution of

34 cents an hour would deliver $10 million to this program, a 50 percent cut. He has proposed that same number on an annualized basis this year, meaning that this year's proposal is a 50 percent cut from what was promised and passed in the budget last year for overtime and travel in consumer directed.

This is an enormous problem that again threatens the stability of this program. Many workers have subsidized inadequate wages by working 60 or 70 hours a week, and they cannot afford to take these pay cuts.

Finally, I want to promote the certification of fiscal intermediaries. This is legislation sponsored by Senator Hannon and Assemblyman Gottfried that the Legislature passed unanimously last year. For some reason, it was vetoed by the Governor -- he purported that it had outrageous fiscal costs but was very important. Despite his feeling that it was important, the Legislature's obvious feeling that it was important, and any number of organizations that felt it was important, he

did not include it in his budget.

We feel it is imperative that the Legislature again address this issue and put it in the budget this year to make sure that fiscal intermediaries operating in consumer directed are not merely operating scofflaw home care programs and are in fact running a consumer directed personal assistance program.

With that, I am available for questions and will be in to see all of you.

Thank you.

CHAIRMAN FARRELL: Questions? Any questions?

CHAIRWOMAN YOUNG: Senator Krueger.

SENATOR KRUEGER: Thank you.

So I know we made you skip around, but is there a definition of a scofflaw program versus an approved program?

MR. O'MALLEY: So in consumer directed we would argue that many agencies, traditional licensed agencies, are merely taking what were their personal care aides and putting them into a now consumer directed

case where that consumer's not hiring -- for instance, we had one worker call who said she was brought in to work for two different consumers who she never met prior to the day she went in. She is now doing nursing tasks, which is well outside the scope of what a PCA can do. The agency is still scheduling her, not the consumers. In fact, one consumer will not even allow her to touch them, which makes you wonder what they're billing Medicaid for.

But, you know, this is what we're talking about in terms of scofflaws. It's individuals acting outside their scope of what they're allowed to do.

SENATOR KRUEGER: So if I understand it right, consumer directed is a lower cost reimbursement. So why would an agency in the home care business create a fake consumer districted subsidiary or within their --

MR. O'MALLEY: Largely, managed care companies are increasingly driving more and more individuals to consumer directed. More and more individuals are identifying consumer

directed as a means in which -- as a platform they want pursue. And particularly downstate, consumer directed is not subject to the wage parity laws, and so agencies can get out of paying their workers wage parity in wage parity counties.

SENATOR KRUEGER: I knew there was something like that there. Thank you very much.

MR. O'MALLEY: Thank you very much.

CHAIRMAN FARRELL: Thank you.

CHAIRWOMAN YOUNG: Thank you.

CHAIRMAN FARRELL: Empire Justice Center, Amy Lowenstein, senior attorney.

MS. LOWENSTEIN: Good evening. Thank you for staying so late. And thank you for the opportunity to testify.

I've shortened -- first of all, don't worry, it's large print. It's not as big as it looks. I just want to touch on a few points I know some of my colleagues at Schuyler Center, Medicaid Matters, and Healthcare for All New York will also touch on in more detail, and then I want to just go

into a little more detail on some things that I don't believe anybody has addressed, or at least from a consumer perspective.

So Empire Justice Center is a statewide legal assistance organization with offices in four cities, including Albany. We focus on issues that affect low-income families, and healthcare and access to healthcare is one of our critical programs. My testimony details the work we've done in the area of healthcare over the years, in the committees and workgroups we're on. I will not get into that.

So the first thing I want to talk about is our request to expand the Community Health Advocates program and support that program. We appreciate the Governor's continued support for Community Health Advocates, also called CHA -- this is the one-H CHA, not the two-H CHHA -- through a $2.35 million allocation in the Executive Budget. But we're still seeking from the Legislature, once again, additional funds for CHA to bring it to its current annualized

budget of $4 million. This will allow the program to continue providing the same level of services, and without this investment CHA is going to face a 25 percent reduction across the board.

So, quickly, Community Health Advocates is a statewide network of community based organizations, including chambers of commerce, that assist individuals and small employers so that they're able to effectively use the health insurance that they have now attained.

We also do help people who don't have insurance, who are finding themselves with bills, figuring out how they can get coverage for those bills. And that's briefly it, I'm not going to get into any more detail on that. But the requests we're making --

SENATOR HANNON: I don't have your printed testimony.

CHAIRMAN FARRELL: No, you're getting it in a minute.

SENATOR HANNON: Okay. All right.

I'm reading something that says

Schuyler Center --

CHAIRMAN FARRELL: Yeah, I know.

SENATOR HANNON: -- and that's funny, you don't look like Bridget.

MS. LOWENSTEIN: Some of it's similar.

I don't think that's going to help you.

(Laughter.)

CHAIRMAN FARRELL: I jumped ahead.

MS. LOWENSTEIN: Okay, so once you have it -- I won't reference it until you have it.

CHAIRMAN FARRELL: I already had it.

SENATOR KRUEGER: You're fine.

MS. LOWENSTEIN: Okay.

CHAIRMAN FARRELL: I'm the one that's having problems.

SENATOR HANNON: I didn't know it was you.

CHAIRMAN FARRELL: I was reading backwards.

MS. LOWENSTEIN: So anyways, just to sum up, we're seeking an investment -- last year the Legislature, the Assembly put in

$500,000 for CHA, to bring it to $3 million. We're asking for 1.5 million, because our budget has now been annualized to $4 million.

Quickly, to touch on a few issues, we ask that the Legislature ensure that sick and disabled children, New Yorkers with disabilities, and seniors continue to have access to medically necessary care by preserving spousal and parental refusal in the Medicaid program.

We also ask that the prescriber-prevails provisions in fee-for-service Medicaid and Medicaid Managed Care be preserved as well, so that providers who are really working with people with multiple conditions are able to make the choices about what is best for their patients.

Quickly, there are some proposed changes to MLTC, putting in a nursing home-level care requirement. We are asking the Legislature to consider this cautiously, because if this means a smaller number of people going onto MLTC, it means more people going back to the local districts to get

their care. And already we're hearing from local districts that they're having trouble meeting the home care needs of people over whom they still retain responsibility.

Like our colleagues in the provider community, we're concerned about the cross-claim issue between Medicaid and Medicare. Last year it was done for Part B so that the amount of the coinsurance that Medicaid would pay was reduced. We've seen the impact on our clients. I have one story in here, and we don't want to see it happening even further, because what it means is people will lose access to providers, providers won't want to see people who are dually eligible. I mean -- not all of them, of course.

So I wanted to get into a little more detail, but I promise not too much. We're calling, along with our colleagues at Medicaid Matters, Schuyler Center, and Healthcare for All New York, for an expansion of the Essential Program to cover all immigrants who are permanently residing under color of law. The Basic Health Program has

been renamed the Essential Plan, and it launched on January 1st. We think of it as a huge step forward in making health insurance much more affordable for people who are just above the Medicaid income threshold.

But while it promises affordable health insurance to many low-income New Yorkers, there is a subset of people who are permanently residing under color of law, including people who are deferred action for childhood arrival, who are left out of the Essential Plan. These individuals are eligible for Medicaid but, once their income goes above the Medicaid level, they basically have a health insurance cliff. They are not allowed to enroll in the Essential Plan, they're not allowed to enroll in any marketplace products, there are no affordable health insurance options for them because of certain federal rules.

So what we're asking -- instead of having insurance, people forgo treatment or they seek out care only in emergencies, and they wind up using the, quote, unquote,

charity care system in hospitals. So we're asking the Legislature to ensure access to -- this population.

The Community Service Society is going to come up with a study -- and they have a study, it's going to be published very shortly, like in the next week -- that says it's about 5,500 people who are affected, and that the cost to the state would be $10.3 million and it would create basically a state-funded Essential Plan.

Something that came up very briefly in the beginning of this long day was the reduction in the spousal impoverishment resource allowance, and I don't think anyone really touched on it. But basically, 20 years ago New York State set the resource allowance at just below $75,000. That amount has never been adjusted, and this year what is being proposed is reducing that amount by $50,000. So these are the resources that a community spouse of somebody who is in a nursing home, a waiver program, or managed long term care -- these are the resources

that they are able to keep. Those who benefit from spousal impoverishment are usually on fixed incomes, and they're using their income and spending down their resources to pay the cost of their living expenses, including their own medical bills. It helps stave off their need to rely on Medicaid.

So I don't know if you have my testimony, but if you look on page 7, I actually put in a chart -- this is courtesy of New York Legal Assistance Group -- but there's a formula under federal law for how you figure out what resources can be retained by the well or community spouse, and it's the federal minimum allowance or whatever the state sets -- so that's just below 75,000, in New York -- or one-half of the couple's combined assets, up to $119,000, whichever is higher. So already in New York we have a situation where people who have more resources get to have a higher resource limit than people with lower resources.

This morning it was said that the

reason for this proposal is to ensure that the people who need it most are the only ones getting access to the spousal impoverishment protections. This will do the opposite. People who have the lower resources will actually be able to keep less, while people with higher resources will be able to retain the same amounts they can currently.

So we are actually asking for New York to up its spousal resource allowance to the federal maximum, which would put everybody on the same level. And I couldn't find updated data in time, but in an AARP study of states in 2010, there were 18 states that used the federal maximum.

Okay, the last thing I want to -- two quick things I want to touch on is addressing barriers to care that we're seeing in home care, and we've moved to managed long term care and Medicaid Managed Care as the primary source for obtaining home care. However, we as a legal office have seen a huge amount of people having trouble accessing care. There's an aide shortage upstate. We hear

from local districts and managed care plans and they just can't fill hours that they've approved. We have fair hearing decisions saying that the plans or the local district have to comply with the number of hours they've approved, and we're still not able to get the care in.

We are also concerned that managed care plans are discouraging people with higher needs from enrolling by offering insufficient number of hours, requiring people to have a backup from a family member, telling them that their needs are too high before actually assessing them, and telling them that they don't provide 24-hour care, which is not permissible.

We've also seen widespread, across-the-board reductions in hours by some plans, and when those cases are taken to hearing, they are almost always overturned.

So we have some recommendations. My colleague Lara Kassel is actually going to touch on those in order to address that.

The last thing I want to quickly say

is -- and I'm not going to go into detail -- we have been looking at fair hearing decisions and talking to clients, and we think the four-year experiment on a physical therapy, occupational therapy, and speech therapy cap of 20 visits has failed. We have people who are forgoing -- who are unable to get the physical therapy they need after surgeries, after accidents, people who -- we have a client who uses maintenance therapy. She uses up her 20 visits every year, she basically deteriorates, and then she has to start up all over again.

And so we're asking the Legislature to reconsider that and repeal the cap.

Thank you.

CHAIRMAN FARRELL: Thank you very much.

Any questions? One question.

ASSEMBLYMAN ABINANTI: Does the 20-visit cap, does that apply to people with developmental disabilities as well? Or is this just --

MS. LOWENSTEIN: There are some -- I

don't know the exceptions off the top of my head. It depends on where they're getting the services, so there are some clinics where it doesn't apply. And it doesn't apply to people who have TBIs.

But it applies to, you know, anybody who's getting physical therapy, occupational therapy, or speech therapy in an outpatient setting other than sort of clinics that have certain licenses.

ASSEMBLYMAN ABINANTI: So you might have somebody with autism or something like that, does it apply to them?

MS. LOWENSTEIN: Sorry?

ASSEMBLYMAN ABINANTI: Does it apply to people, let's say, with autism or something like that?

MS. LOWENSTEIN: Well, it doesn't apply to children, for starters.

ASSEMBLYMAN ABINANTI: Right.

MS. LOWENSTEIN: I think that the waiver programs have -- and this is something that my colleagues who do the waiver programs know a little better than me, so I'm going to

admit to not being great on this one. That there are certain clinic environments where it can be done for people who are in waiver programs.

ASSEMBLYMAN ABINANTI: Because I thought our statute was a monetary, not a visit cap. And I'm --

MS. LOWENSTEIN: No, our statute is a visit cap. So the hearing officers will say there's no doubt that you need this physical therapy, however, you already had 20. And, I mean, there's hundreds of fair hearing decisions like this.

ASSEMBLYMAN ABINANTI: Okay. Thank you.

CHAIRMAN FARRELL: Thank you.

MS. LOWENSTEIN: And I can get you additional information on that as well, on who's covered and who's not.

ASSEMBLYMAN ABINANTI: I think it's relevant, because the Governor -- I mean, the proposal was for insurance companies to pick up more on Early Intervention, for example. That seems to be contrary to this concept

here of you want people to get better. Or to maintain at a level where they can function.

MS. LOWENSTEIN: Right. It is. I mean, the Early Intervention, it wouldn't apply -- our statute doesn't apply to children. So they are sort of --

ASSEMBLYMAN ABINANTI: I'm just saying consistency -- in one place we're trying to get insurance companies to cover more, and here we don't seem to be caring at all whether they cover at this end.

MS. LOWENSTEIN: Right. Yes.

ASSEMBLYMAN ABINANTI: Okay. Thank you.

MS. LOWENSTEIN: And in a commercial setting, you can actually get far more.

ASSEMBLYMAN ABINANTI: Thank you.

CHAIRMAN FARRELL: Thank you very much.

Now we'll get the real Bridget Walsh, Schuyler Center.

(Laughter.)

MS. WALSH: Thank you.

SENATOR KRUEGER: Are you the real

Bridget Walsh?

MS. WALSH: Yeah.

Thank you very much for the opportunity to comment today on the Executive Budget.

The Schuyler Center is a 144-year-old statewide, nonprofit organization dedicated to providing policy analysis and advocacy in support of public systems that meet the needs of disenfranchised populations and people living in poverty. The Schuyler Center often works in areas that fall between multiple systems, including physical and mental health; child welfare; human services, and early childhood development.

You have our testimony before you, and you can see that we commented today on a wide variety of topics in the budget, including maternal infant home visiting, investment in community-based health infrastructure, the impact of the minimum wage on health providers, funding for community health advocates, and funding for the transition of adult home residents to community-based

settings.

I'm just going to touch briefly on a couple of items today. The first is that the Executive Budget includes $5 million in funding for communities to repair, upgrade, and purchase fluoridation equipment. This investment fulfills a promise that was made last year of a $10 million fluoridation equipment fund, and we appreciate the support of the Legislature last year for that appropriation and seek your support again this year.

In October, the New York State Health Department released a set of RFAs for the first round of that funding, and the opportunity remains open for communities through February 29th of this year. We understand from talking to some communities that applications are coming in, and we're looking forward to an announcement releasing the grant awards for that first round of funding.

Community water fluoridation is, far and away, the single most cost-effective way

to improve oral health, especially for children in poverty. The Governor's proposal is a smart, cost-saving public health investment. In fact, in a study that was done by the New York State Department of Health, it was shown that low-income children on Medicaid in less fluoridated counties of New York needed one-third more fillings, root canals, and tooth extractions than those living in counties where the water was optimally fluoridated.

But as beneficial as community water fluoridation is, there's large areas of the state where residents do not have access to this benefit. Outside of New York City, fewer than 50 percent of New York residents on community water systems receive fluoridated water. A recent study modeling practices in New York to prevent oral disease found that raising the share of children outside of New York City who have access to fluoridated water has the potential to save the Medicaid program $27 million over 10 years by reducing the need for fillings

and dental treatment.

So, once again, we ask your support for the funding for this appropriation this year.

And I also want to lend our support for the increase in funding to the county health departments. As you heard a few minutes ago, the Executive Budget maintains the existing base grant and state aid percentage for Article 6 funding to local county health departments. Without a change in the formula, local public health will continue to experience reduced capabilities.

As New York State aims to reduce health care costs and improve outcomes in part by focusing on community-based initiatives and prevention, strengthening local public health capacity with an increase in Article 6 funding is a step in the right direction.

Finally, I just want to touch on children's behavioral health services. As a result of a long planning process to better meet the needs of children with significant

behavioral health issues, the budget includes funding for six new Medicaid services for children. And we know that the state will be submitting a State Plan Amendment to CMS to approve this change.

And while the funding is welcome, children's behavioral health care system suffers from a history of underinvestment and a lack of integration with primary care. Children's behavioral health providers are preparing for a transition to managed care and developing the infrastructure necessary for children's health homes. These endeavors require attention and preinvestment that is at least commensurate with the state's investment in the adult-serving system.

We're urging you to support the increase for these new services, but would welcome additional discussion on the further investment for children's behavioral health infrastructure.

And we thank you very much and are available to discuss any of the items that are in our testimony.

CHAIRMAN FARRELL: Thank you very much. Questions?

CHAIRWOMAN YOUNG: No questions. Thank you so much.

CHAIRMAN FARRELL: Thank you very much.

Lara Kassel, coordinator, Medicaid Matters New York.

MS. KASSEL: Good evening.

CHAIRMAN FARRELL: Good evening.

MS. KASSEL: Thanks very much for being here at this late hour. I appreciate it.

CHAIRMAN FARRELL: Thank you for being here.

MS. KASSEL: As Amy Lowenstein indicated, several of us from the community consumer perspective got together a little while ago and we decided who would touch on what topics, and so some of us are glossing over some topics and focusing on others to kind of tag --

SENATOR KRUEGER: Could you pull your mic up to your --

MS. KASSEL: Sure.

So some of us are -- okay -- we're kind of tag-teaming each other on issues.

So Medicaid Matters, as some of you know, is the statewide coalition representing the interests of Medicaid beneficiaries. While there are lots of other interests, as is demonstrated by the fact that we're here until the evening, there are lots of other interests related to how Medicaid debates and how Medicaid budgeting and policy making impacts on the industry and on managed care plans, et cetera. We are the statewide voice that has come together to represent the interests of real people.

In recent years, as you might imagine, we have focused our energies on advocating around the initiatives of the Medicaid Redesign Team, beginning in 2011, and in the last year or so -- year to two years -- we have been focusing our attention on the state's initiatives related to payment and delivery system reform, namely the Delivery System Reform Incentive Payment Program, or

DSRIP, as well as, more recently, value-based payment, which is the state's move to have 80 to 90 percent of all payment, beginning with Medicaid, be paid on a value basis rather than paying for volume.

So we as a consumer community have been very involved in these discussions. We sit on any number of workgroups, and our goal in all of this is to bring voices to the table when it comes to debating these topics and creating new initiatives, bringing voices to the table that represent the interests of real people.

So I'm just going to touch on a few initiatives in the Governor's budget this year. First, changes to managed long term care. There are two in particular I'd like to bring to your attention.

One that would change the eligibility criteria from 120 days or more, needing 120 days or more to needing nursing home level of care. And while the numbers may be low as far as how many people that could impact, our concern is that the local social service

districts may not have the capacity to take on the volume of people who could be impacted by this eligibility change.

And so I think a keen eye needs to be focused on what will happen to the people who will be impacted by the eligibility change, and in particular what their needs are, because it's likely they're still high-need people and we want to make sure that their services are provided.

In addition, there's a change to managed long term care as it relates to the transportation benefit. The Governor proposes to take the transportation benefit out of managed long term care, and that may be fine, but we have heard reports, mostly on an anecdotal basis, that the transportation vendor that the state has used over, I think, a couple of years now to administer the transportation benefit has not worked well for everyone. And so we would want to make sure that we pay attention, pay careful attention to the vendor that provides the transportation benefit and make sure that

people continue to have access to that benefit.

As Amy pointed out, there are a number of consumer protections that we believe really ought to be built into managed care. Many of these are not new. There are things that we have brought to the table before that we believe would go a long way to make sure that people are protected in managed care and managed long term care. So now is a good time to -- a good opportunity to raise those again.

For instance, we would encourage establishing a high-needs community rate cell to counteract the financial incentive to place people in nursing homes. We would encourage strengthening the community-based long-term-care workforce and addressing workforce shortages in some areas by ensuring adequate wages and benefits. We would urge providing the necessary funding to pay for the new overtime and travel requirements of the Fair Labor Standards Act, which includes providing managed-care capitation rates that

are sufficient to account for increased costs.

And last but certainly not least, there is a significant amount that we believe could be done in the area of oversight, oversight and accountability. We would urge you to consider requiring managed care plans to report on any reductions in home care hours and any new placements in nursing homes. We think it's also incumbent on the Department of Health to publish detailed and specific data on grievances, appeals -- both internal and external -- complaints to the Department of Health, and fair hearings, because that would give us a better glimpse into access issues as it relates to reductions in hours and placement in nursing homes.

And we think that airing that kind of information would help give better insight into what's actually happening in the program as relates to access. And we believe that managed care organizations should be held accountable for the Governor's own goals of

the Olmstead Plan, which would require that all people be served in the most integrated setting possible.

We join other people who have testified today in opposing the elimination of prescriber prevails. Amy spoke about the elimination of the spousal -- and others, many others as well -- spoke about the elimination of the spousal and parental refusal.

We also align ourselves with groups who support the Community Health Advocate program. Amy spoke about -- Amy and others, and I know Health Care for All New York as well will talk about the expansion of the Essential Plan to cover income-eligible immigrants.

My testimony also speaks to the minimum wage impact, which many other groups spoke about today. And while we are a coalition that represents the interests of people, we believe that making sure that the providers who serve people, particularly safety net providers, have all of the

resources available to them to continue to do the work that they do while also employing a workforce that deserves the higher wages.

And last but not least, I want to touch on something that we at Medicaid Matters have been working on, in particular for the last few years as relates to Medicaid redesign, and that is making sure that community-based safety net providers have access to the same types of funding -- in particular capital, IT, and infrastructure.

There are billions and billions of dollars that have been appropriated in previous years -- also appropriated in this year's proposed budget -- for large institutions, namely hospitals, and we believe that community-based safety net providers ought to have access to that funding as well. Not doing that is really antithetical to the state's own goals in Medicaid redesign and systems transformation, and we would urge you to make sure community safety net providers have access to those funding pools as well.

And in addition, community-based organizations which are nonmedical, non-Medicaid providers, but human-service-type providers, will have a pretty significant role to play in all of this health system transformation work.

The state has spent a lot of time, through many different workgroups and many different discussions, highlighting the need for more focus on social determinants of health. And it is the human service organizations that provide food security, vocational training, et cetera, that really are going to be the community-based organizations that lend to helping us reach the good outcomes that are inherent in DSRIP and value-based payment.

And without making sure that CBOs have support and technical assistance to participate in all of this, we're afraid that they won't be able to continue to do the work that they have a long history of doing -- and that they ought to be able to do that work in order to contribute to the overall goals.

So I'll leave it at that and trust that we will have many more opportunities as the budget process continues.

CHAIRWOMAN YOUNG: Questions?

CHAIRMAN FARRELL: Thank you very much.

CHAIRWOMAN YOUNG: No questions. But thank you for being a trooper. Lots of good information.

ASSEMBLYMAN ABINANTI: And you did it all without taking a breath.

MS. KASSEL: Thank you.

SENATOR KRUEGER: Thank you, Lara.

CHAIRMAN FARRELL: Adam Prizio, manager of government affairs, Center for Disability Rights.

(No response.)

CHAIRMAN FARRELL: Is he here? Going once. He may come back.

Bob Cohen, policy director for Citizen Action of New York, Health Care for All New York.

MR. COHEN: Good evening.

In respect of the fact that it's a

little after 7 o'clock, and a fair amount of what I was going to say has been said by my colleagues, I will be quite brief.

And I do want to say in -- by way of introduction that if I gloss over things, and talk about one or two other things, that it doesn't mean that I don't care about those other things. But I want to be respectful of all of your time.

If people don't know, Healthcare for All New York is a large coalition -- over 170 organizations -- of consumer organizations with an interest in healthcare reform. We're the ACA folks and work on many, many other issues concerning consumer access to quality affordable healthcare.

So I'm just going to really breeze through a number of quick things and reiterate what some of my colleagues have said very recently. And just for your information, my organization, Citizen Action of New York, is a member of the steering committee of Healthcare for All New York, as is the Empire Justice Center -- Amy

Lowenstein just spoke -- and Bridget Walsh of the Schuyler Center for Analysis and Advocacy is also a member of our steering committee. So we share views on many issues.

So just to briefly reiterate, our entire coalition supports the $4 million allocation that Amy talked about for Community Health Advocates. It's an incredibly important program that fills in a gap that is not covered by navigators, the folks that are trained to enroll people in health insurance. My organization has about nine navigators, and I can say that we don't have the expertise or the capacity to deal with post-enrollment issues, and that's why CHA is incredibly important.

As we have more folks enrolled in health insurance, it stands to reason that there's going to be more people who have not had health insurance that need to be assisted to use their health insurance effectively.

I'm not going to again repeat what Amy said -- she covered it very well about our desire to have $10.3 million for, as she

described it, essentially a state funded essential plan for DACA immigrants -- only to add that we believe this is also a profoundly important moral case that these folks be covered.

One thing that I'm going to talk about that I believe has not been mentioned by other speakers is we believe that there needs to be -- we're requesting a small amount -- and incidentally, I'm on page 4 of my testimony -- $2 million to fund community-based organizations and small business serving groups to reach the remaining uninsured through outreach activities.

As we say in our testimony, there's still about 8 percent of New Yorkers that are uninsured. We've obviously done a great job collectively in enrolling people, but as we get into where we are now, which is Year 3 of the Affordable Care Act and New York State of Health's active operations, it's getting harder and harder to reach certain folks. And we believe one way to address that would

be to have a small but effective grant program that would address situations where navigators either can't or don't have the time to reach certain communities such as rural New Yorkers and people whose first language is not English.

And I just want to -- actually, I have two things to say in conclusion, really quickly. Our entire coalition shares our colleagues' view that the Legislature should once again reject the Governor's proposals to eliminate spousal refusal and to repeal prescriber prevails. We know you've been doing that the last few years, we praise you for doing that, and we trust and hope you'll do it again.

And I just want to make one last statement. And I'm quite frankly using my hat as Citizen Action of New York, it doesn't necessarily represent our entire coalition -- not because our coalition has rejected this position, but because we haven't discussed it in our coalition. Obviously many providers have talked earlier today about the impact of

an increased minimum wage on their operations. It's certainly not something we're going to deny is true. But from an equity standpoint, it seems to us that the most rational approach would be to provide the adequate funding so these agencies -- at the risk of saying the obvious, the state should provide, in our opinion, the funding these agencies need to pay adequate wages rather than continue to have employees that are dependent on public assistance who are on their staff.

Thank you.

SENATOR KRUEGER: Thank you.

CHAIRMAN FARRELL: Thank you.

Henry Garrido, executive director, DC 37.

MR. GARRIDO: Good evening. I want to thank you all for your leadership and for sticking around. Long day. But I like to think that you left the best for last. So if I can have a moment of your time, I will, respectfully, not go through my testimony, but actually I just want to take a moment to

highlight some of the most important, more salient points that you see, in respect of your time and that of everybody else's.

I'm Henry Garrido. I'm the executive director of District Council 37, the largest municipal union in New York City. We represent about 18,000 workers in the hospital system and about 4,000 in the Department of Health and Mental Hygiene. And I won't mince any words here today. Quite frankly, we need your help. The workers need your help.

Over the next few years, the Health and Hospitals will be facing $1.2 billion in deficits. Now, I'm usually skeptical of announced deficits because I believe that numbers are used to lie repeatedly. But this time, we've actually looked at these numbers and found them to be accurate and true. And despite last week's announcement by the city that it would pour in an additional $337 million to try to eliminate the deficit, the honest truth is that with the changes in the healthcare law and the industry, the

Health and Hospitals system could not and would not survive without your help.

And what we are asking for, quite simply, is equity, is fairness. You cannot have 80 percent of the uninsured patients in the Borough of Brooklyn be serviced by a hospital system that continues to be underfunded.

So first I want to take your attention to the indigent care part. Whereas $3.5 billion of distribution of funding goes from the state to distribute it throughout the state, our Health and Hospitals only receives $96 million of that, despite covering 50 percent of the patients in the emergency rooms. That is unfair, and it's inequitable. It needs to stop.

Now, we're not begrudging any voluntary hospitals for the work that they do. I think they do a great job sometimes. But the fact is that the hospital system continues to provide 40 percent for the mental {sic} care in New York City and throughout the state. Ninety-six million

dollars is just simply good enough, and we need your help to try to make our system more equitable.

Second, safety net definition and DSH funding. As you know, things are changing continuously in New York State in terms of funding. But we need a formula that better reflects and follows the patient. So I want to thank Senator Hannon for his leadership and great work and education in this process, particularly on the Vital Access Funds that we need in New York. I think that definitely, if there's a place where you underscore the kind of inequity we're looking it, this is one.

And as you know, the state is going through a major reform through DSRIP. And we've been in consultation with our sisters and brothers and with the Health and Hospitals program, and we would like to be part of the major reforms that One City Health is continuing to do. But the fact is the funding still remains inadequate, $800 million short. And their expectation is

that you have to train 10 percent of the city's workforce and the workforce throughout.

So that, combined with a $400 million shortfall committed, we believe creates a structural financial deficit for the Health and Hospitals System that's providing the majority of care for the patients.

So I want to thank you for listening today and for the long hearing and, again, for your great work. But New York City helps you, and so do we. Thank you.

CHAIRMAN FARRELL: Thank you very much.

Questions?

SENATOR KRUEGER: Thank you.

CHAIRMAN FARRELL: Thank you.

We will adjourn until tomorrow at 10 a.m. Not 9:30, but 10:00.

(Whereupon, at 7:11 p.m., the budget hearing concluded.)