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

JOINT LEGISLATIVE HEARING

In the Matter of the
2015-2016 EXECUTIVE BUDGET
ON HEALTH AND MEDICAID

Hearing Room B
Legislative Office Building
Albany, New York

February 2, 2015
10:01 a.m.

PRESIDING:

Senator John A. DeFrancisco
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
Vice-Chair, Senate Committee on Health

2015-2016 Executive Budget
Health and Medicaid
2-2-15

PRESENT: (Continued)

Senator Diane Savino

Assemblyman Kevin A. Cahill

Senator Gustavo Rivera

Assemblywoman Ellen Jaffee
Assemblyman Andrew P. Raia
Senator John Bonacic
Assemblyman Charles Lavine
Assemblyman Andrew Goodell
Assemblyman Clifford Crouch
Senator Terrence Murphy
Assemblyman Phil Steck
Senator Elizabeth O'C. Little
Assemblyman Andrew Garbarino
Senator Simcha Felder
Assemblyman John McDonald
Senator Martin J. Golden
Assemblywoman Angela Wozniak
Assemblywoman Aileen M. Gunther
Assemblyman David Weprin
Assemblyman Edward P. Ra

2015-2016 Executive Budget
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PRESENT: (Continued)

Assemblyman Thomas J. Abinanti
Assemblywoman Shelley Mayer
Assemblywoman Earlene Hooper

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CHAIRMAN DeFRANCISCO: Thank you. I'd like to call this hearing to order.

Pursuant to the State Constitution and the Legislative Law, the fiscal committees of

the State Legislature are authorized to hold hearings on the Executive Budget proposal, which we have been doing and will be doing many times in the future.

Today's hearing will be limited to discussion of the Governor's proposed budget for health, Medicaid and the Medicaid Inspector General's office.

Following each presentation, there will be some time allowed for questions from the chairs of the fiscal committees and other legislators.

After the final question and answer period, an opportunity will be provided for members of the public to briefly express their views on the budget under discussion.

I think everybody here knows the rules. You've got a clock in front of you. Look at it every once in a while, if you would, when you're testifying; then I won't

have to interrupt you.

But the other thing is each of the Senators will be asking questions. If we run out of time for them, they'll go to the end of the line and ask whatever questions they might have.

And lastly, I would really appreciate from the witnesses that the questions, the direct questions -- and hopefully they're understandable from us -- can be answered

directly and succinctly rather than a seven-minute filibuster. Because this creates this to go longer and longer and longer.

So with that said, the Health Commissioner is unable to be here, and we will be having, from the Health Department, Jason Helgerson and Sally Dreslin.

And the people here present are Senator Hannon, the chairman of the Health Committee; David Valesky, vice chair; and Liz Krueger, ranking member.

SENATOR KRUEGER: Gustavo Rivera, ranking member of the Health Committee. And

we're also joined by Senator Diane Savino.

CHAIRMAN FARRELL: Good morning.

I've been joined by Assemblyman Gottfried and Assemblywoman Jaffee and Assemblyman Oaks, who will introduce his members.

ASSEMBLYMAN OAKS: Yes, thank you, Chairman.

We've also been joined by Assemblyman Raia, Assemblyman Garbarino, Assemblyman Ra, Assemblyman Goodell, and Assemblyman Crouch.

CHAIRMAN DeFRANCISCO: Will you be beginning?

EX. DEP. COMMISSIONER DRESLIN: Yes, I will.

CHAIRMAN DeFRANCISCO: Okay, go ahead.

EX. DEP. COMMISSIONER DRESLIN: Thank you.

Good morning, Chairmen DeFrancisco, Farrell, Hannon and Gottfried, and all of your distinguished colleagues here.

I am Sally Dreslin, executive deputy commissioner of Health. Acting Commissioner Howard Zucker was unable to attend today.

I'm pleased to be here today to discuss Governor Andrew Cuomo's Executive Budget as it relates to the mission of the Department of Health. I am joined by Jason Helgerson, Medicaid director.

Under Governor Cuomo's leadership, New York is setting a national example of healthcare reform, reforms that are resulting in improved quality of care for our residents and cost savings for taxpayers.

We are steadily moving forward with the Delivery System Reform Incentive Payment program, also known as DSRIP. This initiative is fundamentally restructuring the health care delivery system in New York State while supporting the state's pursuit of the Triple Aim -- better health care for individuals, improved population health, and lower costs.

DSRIP will provide up to $6.4 billion in waiver funds to healthcare providers that have created performing provider systems, or

PPSs, to work toward the overarching goal of reducing avoidable hospital use by

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25 percent. Statewide, hospitals and providers have submitted proposals for 25 of these systems. The state has also received $100 million from the federal government to implement the State Health Innovation Plan, also known as SHIP, which will complement our DSRIP program and transform the way we deliver healthcare in New York State.

But while New York wisely invests federal funds to transform its healthcare system, we must also develop state programs to meet our goals. Governor Cuomo's budget calls for a $1.4 billion capital investment that will address challenges in all regions of the state, equally split between upstate and downstate. The $1.4 billion will be supplemented by Vital Access Provider funds, money to keep essential providers operating as they transition to more integrated care systems.

New York also continues to implement the recommendations of the Medicaid Redesign Team. These reforms represent the most comprehensive Medicaid reforms our state has

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ever seen. Included in this year's Executive Budget is a package of budget-neutral reforms that are worth highlighting.

Among them is the transition to managed-care plans. Our state continues to make progress towards care management for all, moving all Medicaid enrollees into these comprehensive care plans. This initiative is improving the quality of care, better coordinating care benefits and improving patient outcomes. We are moving away from fee-for-service Medicaid and redirecting our resources towards managed care. These plans address special population needs, and we are adding more plans to care for those with mental health and substance abuse issues, as well as fully integrated plans for those who are dually eligible for Medicaid and Medicare.

In addition, we plan to implement the federally supported Basic Health Plan, which was authorized under the Affordable Care Act. The Basic Health Plan is a new state health insurance option to make coverage even more

affordable for low-income individuals who do not have employer-sponsored coverage and do not qualify for Medicaid because their income is too high or because of their immigrant status. By implementing the Basic Health Plan, we will further reduce the number of uninsured in New York, resulting in savings to the state and reductions in bad debt for hospitals.

The Executive Budget also reinforces the state's commitment to putting an end to the AIDS epidemic. Governor Cuomo's three-point plan includes identifying people with HIV who are not yet diagnosed and linking them to healthcare; keeping people diagnosed with HIV in healthcare, so they remain healthy; and providing pre-exposure prophylaxis -- or PrEP -- to high-risk individuals so that they stay HIV-negative.

As part of Governor Cuomo's anti-poverty agenda, the Department of Health is committing $4.5 million to the Hunger Prevention and Nutrition Assistance Program. The addition of these funds will enable food

pantries statewide to provide an additional 2.8 million meals in the coming fiscal year.

To better care for the elderly and disabled, we must also look out for our caregivers, who provide countless hours of unpaid care to loved ones. The Executive Budget includes a $25 million investment in Alzheimer's caregiver support to provide respite services and to expand existing programs. This will give caregivers the help they need to keep their loved ones in the community for as long as they can.

We are aware that paying for these programs will require adjustments. To that end, we are proposing new efficiencies, such

as discontinuing duplicate audits of medical residents' work hours and consolidating local assistance appropriations so they better target population health needs. Taken together, readjustments proposed in the Executive Budget will save the state more than $54 million this year.

Governor Cuomo's Executive Budget reflects an unwavering commitment to

improving healthcare for all New Yorkers. And in this era of healthcare reforms, we continue to take steps that promise to enhance the quality of healthcare and improve population health while lowering costs.

To achieve these goals we must continue to work collaboratively with our partners -- the members of the Legislature, the healthcare community, and the residents of this state. Together we will continue to set the example for healthcare reform across the country.

Thank you, and I'm happy to answer any questions.

CHAIRMAN DeFRANCISCO: The first questioner will be the chairman of the Health Committee, Kemp Hannon.

Oh, are you going to speak?

MEDICAID DIRECTOR HELGERSON: No, sir. Just answering questions.

CHAIRMAN DeFRANCISCO: Okay, that's

what I thought. I thought you were reinforcements.

(Laughter.)

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CHAIRMAN DeFRANCISCO: Are you ready?

SENATOR HANNON: I'm never at a loss for words.

First of all, I just wanted to commend the department for two things in the field of public health that were done this past year, and that is in regard to the reaction to Ebola and the training that was carried out there, and also in the reaction to the storm in Buffalo. I thought in terms of the public health aspects of it, they were quite well done and a reminder that there is a major emphasis in health that's other than Medicaid and other than hospitals, to the chagrin of people who are involved in that.

I'm going to think of more questions to ask, but there's a couple of broad questions I just wanted to address. And the first one is involved with a story that was in the Post this morning, and that is concerning the tax that is proposed in the budget that would be levied on everybody who has health insurance in this state, and the whole idea of that would be to finance the

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New York State exchange, Obamacare, called

State of Health.

But it was my total understanding, when the Executive Order was issued by the Governor to establish this exchange, that, and I quote from it: "The development and operation of an exchange in New York will impose no cost on the state but will be funded entirely with federal funds until January 2015, at which time the exchange will be wholly self-funded, meaning that no state or county taxpayer dollars will be used for such purposes."

This only gives raise, in my mind, of something that -- we had acquiesced in the exchange, we understand the mechanics of it, we're far better than any other state. But the costs of this, the costs of this are puzzling. The costs of this are puzzling to not only the taxpayers but to people who are subscribers and get their coverage through the exchange.

And so I wondered if you'd address why it has come about that this tax has been

proposed.

EX. DEP. COMMISSIONER DRESLIN: Thank you for your question.

The New York State of Health has been remarkably successful. Close to 2 million people have enrolled in affordable health insurance through the State of Health, and

over 80 percent reported no coverage at the time of enrollment. The department feels that we have identified a dedicated and sustainable source for funding the operations of the marketplace. We have heard the concerns. We feel that this is a dedicated and sustainable source.

MEDICAID DIRECTOR HELGERSON: Right. I'd just add that I understand the concern relative to the Executive Order. I mean, the way we view this, this is an assessment and it's an assessment that's applied against premium revenue in the health insurance marketplace. We don't see it as a tax, we just see it as a sustainable revenue source.

Now that the federal funds which have been supporting the exchange since go-live

are no longer available, we needed to do something in order to sustain it beyond, you know, the point at which federal funds are no longer available at the end of the year. And that's why we think that given the source of the revenue, through the assessment, we think it's appropriate for this purpose.

SENATOR HANNON: Needless to say, I'm going to disagree with the characterization that an assessment is not a tax.

And especially, by the way, when it's assessed on people who are getting coverage under the exchange, many of whom already

can't afford it and are going to be facing some quizzical problems when they go through the income tax season that's forthcoming.

I'm a little confused as to how many people are enrolled in the exchange, how many were enrolled during 2014 and how many have signed up so far for the open enrollment that's due to end February 15th of this year?

EX. DEP. COMMISSIONER DRESLIN: The numbers are in flux as people come on and off. We have just over 1.9 million now

enrolled in the exchange. But it is true that the numbers do rise and do ebb and do flow, and we can get back to you with more specific --

SENATOR HANNON: That 1.9 million, is that people who are covered under insurance that's offered through the exchange, or does that also include people who signed up for Medicaid?

EX. DEP. COMMISSIONER DRESLIN: It's the total number of enrollees.

SENATOR HANNON: So what would be the total that signed up for Medicaid?

MEDICAID DIRECTOR HELGERSON: It's about 1.4 million for Medicaid. So the majority, the vast majority are enrolled in Medicaid.

SENATOR HANNON: So a rough number would be 500,000 signed up for the insurance

that's subsidized?

MEDICAID DIRECTOR HELGERSON: That's correct, for the --

SENATOR HANNON: And all of that may not be subsidized, some of that may be paid

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for by the individual.

MEDICAID DIRECTOR HELGERSON: That's correct. Subsidies go up to 400 percent of federal poverty. Now, the vast majority of those who signed up for QHPs did qualify for tax credits to help subsidize their insurance, but there is a cohort who have incomes in excess of 400 percent and therefore are buying health insurance at the stated premium rate.

SENATOR HANNON: Let me switch topics entirely to your favorite topic, which is called DSRIP, which is based upon the success of the MRT, which was the Medicaid Redesign Team. And now you propose to follow the dictums of Washington and have a whole new program going on.

That's due to kick in by the time this budget is effective. You're proposing 22, 25 new entities throughout the state that would be combinations of healthcare providers and physicians, et cetera, anybody who provides healthcare under Medicaid. Do you believe that this can be achieved without

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dislocation? All I've heard in the past two months is this is very fast, very quick, we're not sure we know what we're doing.

Comment?

MEDICAID DIRECTOR HELGERSON: Sure. So yes, we acknowledge that there's some nervousness out there. I would also say I think there's a lot of excitement out across the state in terms of what DSRIP potentially means. Obviously it's a significant investment, about $6.9 billion invested over five years to transform how healthcare is delivered.

Our goal with DSRIP has always been -- and this is not just our goal, but the federal government's goal -- is to try to bring providers together to really work together as a team and be held accountable for improving health outcomes for Medicaid members in ways that's never been tried before.

And it is a heavy lift for providers. These performing provider systems, of which there's 25, range in size from a few hundred

providers up to thousands, thousands of providers.

And so it is no small task for them to organize themselves and now to move forward in implementing somewhere in the range of 10 to 11 initiatives each that are designed to

improve health outcomes.

But we feel very good about where we are. We are on path to implement what we call Year 1, which is when the projects get launched, in April of 2015. We're in the final stages of reviewing the applications, or our independent assessor is. And so we are on path to implement.

But the good news also on this in terms of nervousness is that the performing provider systems aren't really held accountable for results until Years 3, 4 and 5, so they do have a couple of years with which to cement their relationships, build the infrastructure necessary for success.

So we think that when you look at it over the full five years, there is ample time for these new groupings of providers to come

together and be successful.

SENATOR HANNON: Thanks.

Mr. Chairman, I'm going to let you move on. I'm going to come back at the end, and I have a lot of other topics I'd like to talk about, but I'm sure that my colleagues have a lot of topics they would like to talk about.

CHAIRMAN FARRELL: Thank you.

Mr. Gottfried, chairman.

ASSEMBLYMAN GOTTFRIED: Thank you.

Good morning. I have a few questions

about how some of the numbers in the budget were derived and what if any basis there is for some of those numbers.

In particular, and maybe these are just examples, the HPNAP number, the Food Bank and related programs, there's an increase, which is good. But the number of people taking advantage of these programs is about double what it was before the start of the Great Recession.

In Medicaid we're reducing reimbursement to AWP minus 24 percent rather

than AWP minus 17. I don't know what the basis is for picking 24 as the number, as opposed to 16 or 22.3 or some other number.

There are I think about 10 grant programs in the budget that are, as was proposed last year, being put into one bucket, with the total then being reduced by 15 percent. I'm wondering whether that 15 percent number is based on some calculation or analysis or just pulled out of the air. And if there is an analysis, how can you come up with such a number if you haven't predetermined what each of the 10 programs is going to get? And if you have determined that, I think we'd like to know that.

Is it fair to assume that if Commissioner Zucker, Ms. Dreslin, were to

call you after your testimony and say that he'd like you to email him the material for answering those questions and providing that analysis, that you could send that to him this afternoon?

EX. DEP. COMMISSIONER DRESLIN: I'm

sorry, I didn't understand the question.

ASSEMBLYMAN GOTTFRIED: If the commissioner were to say to you, I'd like to know the analysis that the HPNAP number's based on, and the AWP minus 24 and the bucket number, the minus 15 percent -- if he were to call you and say "Do we have an analysis for what was put in the budget?" And if so, if he were to say "Could you email it to me or find someone in the department who could email it to me this afternoon," would your answer be yes or no?

EX. DEP. COMMISSIONER DRESLIN: Yes, there's been analysis over the previous months in the development of the budget, the resources that are available and the programs that we fund. And there has -- yes.

ASSEMBLYMAN GOTTFRIED: Okay. And if he said "Could you find the person in the department who has that on their computer and send it to me this afternoon," you would say "Of course," yes?

EX. DEP. COMMISSIONER DRESLIN: Of course we could provide supporting

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information for how decisions were made.

ASSEMBLYMAN GOTTFRIED: Okay. Would you instead send it to me this afternoon?

ASSEMBLYMAN RAIA: I'd like to see it too.

EX. DEP. COMMISSIONER DRESLIN: We've provided it --

ASSEMBLYMAN GOTTFRIED: I'll send it to Andy.

Could you do that this afternoon?

EX. DEP. COMMISSIONER DRESLIN: It perhaps is -- there was great deal of information that has already been provided to the Legislature and combined in the letter that the Senate sent with over a hundred --

ASSEMBLYMAN GOTTFRIED: No, that's not what I'm asking. I'm not asking for a letter, I'm not asking what went to somebody else.

I'm asking, the analysis that you have in a computer in the department that you could email to the commissioner this afternoon, could you -- would you email that to me this afternoon?

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EX. DEP. COMMISSIONER DRESLIN: Yes.

ASSEMBLYMAN GOTTFRIED: Yes. Okay, please do.

And by the way, I don't mean to be

annoying about the "this afternoon" part, but sometimes when we don't specify a time and we say we really need it right away because we're working on the budget, we get it like the last day or two of March. So it would really be good if you could send it to me this afternoon.

The $1.4 billion in money for hospitals, two questions. Where would I find the criteria that will be used for spending that enormous chunk of taxpayer money? And will any of it go to community health centers, or is it only for hospitals?

EX. DEP. COMMISSIONER DRESLIN: So the $1.4 billion in the Executive Budget is split evenly between upstate and downstate. There will be criteria --

ASSEMBLYMAN GOTTFRIED: Could you talk a little closer into the microphone?

EX. DEP. COMMISSIONER DRESLIN: I'm

sorry. The $1.4 billion included in the Executive Budget will be split evenly between upstate and downstate. Community health centers, community health providers and primary care providers are an integral part of the transformations that are happening in healthcare today.

ASSEMBLYMAN GOTTFRIED: Yes, community health centers are a very important part of the system. Will they be any part of the

$1.4 billion?

EX. DEP. COMMISSIONER DRESLIN: They will have opportunities, yes, to receive funding from the $1.4 billion.

ASSEMBLYMAN GOTTFRIED: Some of the 1.4 will be for community health centers?

EX. DEP. COMMISSIONER DRESLIN: They will have access to that, yes.

ASSEMBLYMAN GOTTFRIED: And on the question of what the criteria will be, where can I find that?

MEDICAID DIRECTOR HELGERSON: Okay. So in terms of -- we're happy to provide greater detail. I would say the 1.4 could be

split sort of into sort of three buckets.

Bucket No. 1 would be $700 million that's been set aside to address needs specifically in Central and Eastern Brooklyn. I think it's been well publicized we have significant problems in terms of both financially stressed providers and just a lack of access to high-quality care in that particular part of the state, and so money is set aside.

Now, in terms of that funding and what the right solution is for that part of Brooklyn, we definitely see that federally qualified health centers or other providers in the community can and should be part of a comprehensive solution. This funding is set

aside to help be part of funding that solution. So I would say that in the case of that pool of funds, definitely there are opportunities for partnerships that would include the federally qualified health centers.

In terms of the $300 million, which is designated -- these are capital funds

designated for upstate. Specifically, they're identified for Oneida County.

The reason for that is there's a very unique opportunity for a system that has come together after multiple years and has inherited a very old physical plant. And they have a proposal that they came to us with, a suggestion about how they might be able to take capacity out of the system and basically replace antiquated capacity with the kind of capacity the community really needs, so that it can have sustainable healthcare. So that's the second part.

The third part is $400 million that's set aside really to assist particularly rural hospitals in upstate that are in communities where there has not been a lot of reinvestment, where we have had, you know, a lack of particularly opportunities to deal with sort of legacy debt issues. And a lot of these facilities are ones that we think that with -- obviously, because of their

size, modest investments can actually help ensure their long-term sustainability.

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There's been quite a few stories about rural hospitals in particular that have been financially stressed and have been basically at risk of going out of business, and so we'd like to use those $400 million to really potentially do some significant restructuring there.

The last thing I would say is that this additional money comes on top of what's already been allocated by the Legislature and the Governor, which is $1.2 billion. And there's an application that is due -- applications are due for that money on February 20th. So by addressing specifically in a targeted fashion places like Central and Eastern Brooklyn, we in essence free up monies that would have probably otherwise gone to that community to be available for other projects, including ones that would be led by federally qualified health centers, particularly as they work as part of performing provider systems across the state.

ASSEMBLYMAN GOTTFRIED: Of course if money that was going to go to Central

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Brooklyn out of the existing pot of money instead comes out of this new pot of money, then the new pot of money is really

benefiting someplace other than Central Brooklyn. Even though they might look at this and say, Oh, good, we're getting 700 million, actually it's -- almost all of it is money you were going to get anyway, and it's really somebody else that's going to benefit by the money being freed up.

MEDICAID DIRECTOR HELGERSON: I mean, the issue is it's a zero-sum game. When we put in -- or we ask the performing provider system to tell us what they -- to estimate what their capital needs were, we did this back when they submitted their planning grant applications. And we got a total ask of about $3 billion -- a big chunk of which, over a billion, was specifically requested for Brooklyn.

So we've known about the significant capital needs for that part of the state. And I think the decision here was to target that very directly, so that meant that a

disproportionate share of what had already been allocated, the $1.2 billion, would not be required to simply address challenges in Brooklyn.

So I think at the end of the day we have, between both what was already allocated and what the Governor has proposed, you know, about $2.6 billion. Now, that's about $400 million less than the $3 billion

requested. But we do think that within the borrowing constraints and other financial constraints that presented to the Governor in this budget, we have an opportunity to go a long way towards meeting the capital needs of healthcare providers across the state.

ASSEMBLYMAN GOTTFRIED: Okay, where would I find the criteria for how this $1.4 billion is going to be spent? And when I find them, are they going to be the sort of criteria that are kind of soft and fluffy and ultimately can justify any grant the commissioner chooses to make, or will they be more precise and arithmetic? And where will I find them?

MEDICAID DIRECTOR HELGERSON: Right. So the criteria, the language that's included in the budget clearly gives the commissioner discretion to make allocations. That said, staff currently are in the process of developing criteria and an application process. And as that's developed, we're more than happy to share that with you and the Legislature more generally.

ASSEMBLYMAN GOTTFRIED: Will that be sometime early in the budget process or after the budget is done?

MEDICAID DIRECTOR HELGERSON: I anticipate that we would be able to complete that task before the budget process is over.

CHAIRMAN FARRELL: Richard --

ASSEMBLYMAN GOTTFRIED: Okay. All right, I'll come back.

CHAIRMAN FARRELL: Come back, yes.

ASSEMBLYMAN GOTTFRIED: Okay.

CHAIRMAN FARRELL: Thank you.

We've been joined by Assemblyman Lavine and Assemblywoman Shelley Mayer.

Senator?

CHAIRMAN DeFRANCISCO: Senators Felder, Bonacic and Little are now with us.

CHAIRMAN FARRELL: And also Assemblywoman Gunther.

CHAIRMAN DeFRANCISCO: The next questioner is Senator Valesky.

SENATOR VALESKY: Thank you, Mr. Chairman.

Jason, I thought I would just pick up where Chairman Gottfried left off on the capital pool, the $1.4 billion capital pool, specifically the upstate monies there. The $400 million, can you tell me the definition of "rural" that you will be using for which that would apply to?

MEDICAID DIRECTOR HELGERSON: I still think that the definition is a little bit to be determined. We want to be inclusive, but at the same time it is about $400 million. So it sounds like a lot of money, but given the scale of some of the indebtedness of some

of these institutions, that money could go quite quickly. And it's a one-time source, so once it's spent, it's gone.

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But I do think that that's something that's still in development, is how do you really define rural. Because obviously it's something that -- lots of different possible definitions of it. But really what we're really targeting are those providers who are in sort of smaller urban or nonurban areas who have had -- you know, have significant debt overhang that is basically putting their very financial existence at risk.

I think priority would be given, first and foremost, to the providers who received Interim Access Assurance Funds. These were waiver funds available on a one-time basis to sort of help keep the lights on. There's 27 facilities across the state, some of which are in rural settings, who would probably get priority. But we are aware of other institutions that are also out there that haven't yet gotten to the point of needing that kind of assistance to keep the lights on but really would benefit from this kind of debt relief.

SENATOR VALESKY: What is the nature

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of the situation in Oneida County such that a

proposal -- my understanding from your answer to a previous question is a proposal was brought to the Health Department speaking to antiquated facilities, of which, as you know, there are many all across the State of New York. But something about Oneida County in this budget has pulled $300 million of the $700 million out of that pool and is being targeted specifically for one particular county.

That appears to be relatively unusual, from my perspective, and I'm just wondering if you could speak to some of the additional circumstances behind why that was done.

MEDICAID DIRECTOR HELGERSON: Sure. So in the case of Oneida County we have, after many years of -- or multiple years, I should say, of efforts to try to consolidate multiple hospitals into a single system, they were able to achieve that and now basically came to us with a proposal that was interesting in the sense that it was highly consistent with our DSRIP objectives, which

was to try to better align the delivery system with what the needs are in the community.

One of the challenges that we have is healthcare, as time has gone on and science has advanced and payers, including Medicaid, are changing their policies to encourage more

community-based care and less institutional care, communities, you're correct, across the state are stuck with infrastructure that reflects the old way of providing healthcare, not the new way.

But in this case, one of the facilities in question is over a hundred years old, the other one also antiquated, and you have a provider who's willing, in essence, to take inpatient capacity out of the system. Not everyone is willing to necessarily do that. I still think that some people feel that inpatient capacity is a way to economic success. I would question that philosophy moving forward. But it is still a view that many have. But a provider willing to potentially do this was very intriguing to

us.

That said, we think that there's other projects of similar ilk that will get funded out of the $1.2 billion as well as out of the $400 million that's been set aside for the rural -- which won't be so much of a capital component, but with some of these providers it's less about capital infrastructure, building new facilities, and more about we just have a lot of outstanding debt that prevents us, makes it impossible for us to go out and borrow, you know.

So we think at the end of the day when

you look cumulatively at all the resources, we think that, as I say, we'll be able to meet much of the needs that are already out there in the community. And so we're excited about the resources that are available.

SENATOR VALESKY: Thank you.

Two issues. First, I want to follow up on Senator Hannon's comment regarding public health. And I certainly agree with him and want to commend the department in regard to your Ebola response.

News reports from across the country appear to indicate that we have a measles issue in a number of states, and perhaps here as well. In fact, I just heard on the news this morning something about an Amtrak train, someone on a New York to Niagara Falls Amtrak train with measles. I don't know that this particular issue was addressed in this budget in the public health portion of the budget. Is the state prepared for whatever reality may develop as a result of the situation? And if so, how? How will that take place?

EX. DEP. COMMISSIONER DRESLIN: Thank you. Yes, the State Department has actually been actively engaged in that particular case that you mention. We've been working very closely with the local Health Department and the college to identify unvaccinated students and to make vaccination available to any of

those students who wish to avail themselves of it.

We have comprehensive immunization programs. We actually have quite high immunization rates, childhood immunization

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rates as well as going into college and professional schools. We continue to do outreach with providers, we continue to do outreach to children and families to encourage vaccination.

SENATOR VALESKY: Okay, thank you.

And the third issue, I have been hearing from a number of doctors and pharmacists in my district -- I'm sure many of my colleagues have as well -- in regard to the e-prescribing mandate. We're coming up on the deadline I believe in another month, month and a half or so.

Senator Hannon and I are cosponsoring legislation that we're prepared to move from the Health Committee tomorrow to postpone that deadline for a year. My understanding is that the federal DEA has not been as timely with certification of vendors. So does the Health Department have a position on this issue moving forward?

EX. DEP. COMMISSIONER DRESLIN: Yes, we have been hearing from stakeholders about the implementation of e-prescribing, and

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we're aware of the concerns. And we know that providers have been working hard to try to come into compliance with the implementation date.

We believe in the value of the e-prescribing initiative as part of our I-STOP initiative a couple of years ago. And we will be listening and working with the stakeholders. We're aware of the bills in both houses to delay the implementation, and we're confident we can come to an agreement that will meet all of our goals.

SENATOR VALESKY: Okay, very good. Thank you.

SENATOR HANNON: Was that a yes or a no?

CHAIRMAN FARRELL: Assemblyman Raia.

CHAIRMAN DeFRANCISCO: Wait. That's a good point. Was that a yes or a no?

EX. DEP. COMMISSIONER DRESLIN: We're happy to continue to discuss the issue.

CHAIRMAN DeFRANCISCO: What's complicated about it? I mean, you either agree with postponing it for a year or you

don't. What's to discuss? Just -- just for the heck of it.

SENATOR HANNON: Begging your indulgence, the bill only talks about delaying. It does not address the myriad of other questions that are legitimately raised

about going to e-prescribing, moving this state forward, keeping good records, et cetera.

Many large hospitals are moving at different directions. There's a lot of doctors who have already adopted it. The problem is that there is a statutory deadline. And in order to deal with that, you have to change it ahead of time. Otherwise, people are caught short.

So I would expect you're going to be facing that bill relatively soon, and you should have a yes or a no relatively soon.

EX. DEP. COMMISSIONER DRESLIN: Understood.

CHAIRMAN FARRELL: Mr. Raia.

ASSEMBLYMAN RAIA: Thank you, Chairman.

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I'd like to follow up on Chairman Gottfried's -- some of his questions regarding the average wholesale price with respect to pharmacies.

The final budget last year required the department to consult with pharmacy stakeholders to develop a new methodology of Medicaid reimbursement that is transparent and adequate.

Is the Executive Budget proposal to change the reimbursement for brand drugs to an AWP minus 24 percent based on these

discussions? And it seems to me that that's a $36 million gross cut over last year.

MEDICAID DIRECTOR HELGERSON: Certainly, I can answer that. We did work in good faith with the pharmacist community around a variety of different issues, met repeatedly. I think at the end of the day we had to agree to disagree in terms of what the state's policy should be relative to pharmacy reimbursement.

We had done an exhaustive study looking at actual costs, both in terms of

ingredient acquisition by the pharmacies as well as costs of dispensing. And what that study found -- and it was based on data presented to us by the pharmacies themselves -- was that we were overpaying from a fee-for-service standpoint on the ingredient side. That's why you see the adjustment in the AWP discount from 17 to 24. But we also were underpaying with regards to dispensing. We had a dispensing fee of $3.50; it's being increased to $8 to compensate for the cost of the pharmacy of actually dispensing the medication to Medicaid members.

These reductions are changes which does lead to a net savings. It only occurs in fee-for-service, which is about 25 percent of the total Medicaid pharmacy benefit. The

75 percent is in our managed-care plans, and so we aren't adjusting those managed-care reimbursements. But we feel that this policy is consistent with federal law, which says that no Medicaid pharmacy program should reimburse above cost on the ingredient side

and should pay pharmacists a reasonable dispensing fee, which we feel is what our policy accomplishes.

ASSEMBLYMAN RAIA: So essentially it is a $36 million cut.

MEDICAID DIRECTOR HELGERSON: It is a $36 million reduction in reimbursement, yes.

ASSEMBLYMAN RAIA: Now, is it correct that the proposed -- that the reduction is based on the average acquisition cost surveys that the department conducted in 2012?

MEDICAID DIRECTOR HELGERSON: That is correct.

ASSEMBLYMAN RAIA: It was my understanding that was right around Hurricane Sandy, that you had a number of pharmacies that were, quite honestly, underwater. A number of them didn't respond, particularly in areas that were in New York City and Long Island, where you tend to have the higher costs.

So are we still basing your decisions on a flawed survey?

MEDICAID DIRECTOR HELGERSON: We don't

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feel the survey was flawed. We felt that pharmacies generally participated at a very high rate.

We gave pharmacies extended amounts of time to provide us with answers to the questions and provide us with the data as part of this. So it was an exhaustive process, took over a year. So I think that at the end of the day the data and the information that was garnered through it is still valid and helpful, and that's why we think it should inform the state's decision-making process relative to what should be appropriate reimbursement for pharmacists.

ASSEMBLYMAN RAIA: So are you going to continue using that survey? You met with the pharmacies, but you didn't come to a conclusion or an agreement with them, so the state just essentially went ahead and did what they wanted to do anyway. I would hope that in the future we would at least try to update that survey.

And I have no further questions.

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CHAIRMAN DeFRANCISCO: Thank you.

Senator Krueger.

SENATOR KRUEGER: Thank you.

Good morning.

I guess this is for you, Mr. Helgerson. So recently it was announced that the organization FEGS in New York City was going under due to I think a $20 million shortfall on a $250 million budget. I think those were the approximate numbers.

Now, FEGS is a large, multipronged health and human services organization, but many of its functions do seem to fall under Medicaid, particularly its services to the developmentally disabled, OMH -- they do housing for the mentally ill and developmentally disabled as well as direct healthcare.

I believe they were part of one of the larger home health -- home health? No.

MEDICAID DIRECTOR HELGERSON: Supportive housing?

SENATOR KRUEGER: Health home. Health home, thank you --

MEDICAID DIRECTOR HELGERSON: Oh, health home, yes.

SENATOR KRUEGER: -- models that you were moving everyone into.

One, what does it mean when an organization that large collapses very suddenly and it provides services to a huge number of people both -- specifically for that population?

And two, what is it signaling or is it

signaling that we have a continuing problem moving forward with a larger number of organizations where potentially we've asked people to do too much with too little or to take on too large a new set of assignments within Medicaid redesign?

Because I'm not an auditor and I'm not an operator of these programs, but FEGS was quite a surprise to see them suddenly collapse overnight. It's not that this was some tiny fringe provider that you might have even imagined was likely not to survive the evolution of where you were going with Medicaid redesign.

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So what are we going to do both immediately for all those people who will have their services gone, and how do you see it impacting our making the right decisions going forward?

MEDICAID DIRECTOR HELGERSON: Right. Yes, it's very unfortunate what's happened with FEGS. FEGS has been a significant provider of services to a wide array of programs cutting across multiple state as well as city agencies.

We have, in coordination with OMH, OASAS, OPWDD as well as the City, have been -- two things -- one, trying to find out what happened, why does an agency of this type all of a sudden have this kind of

financial stress, and then secondly, how do we recover from this to ensure we don't have a lack of continuity of care, and how do some of these programs which are really vital and have been operating with FEGS, how would those programs continue.

And I think that the bottom line with regard to FEGS is that we don't feel that

it's the result of something systemic, but a whole series of events that occurred actually over multiple years, although we I don't think ever had our sight lines into it, that negatively affected and sort of culminated in the problems that they have.

We could go into it in depth, but it's a whole series of events that sort of went against them, unfortunately that led to it -- so it's not just one specific thing you could sort of point to, but a series of things.

That said, you know, we've been working closely with FEGS and I think where we are now is trying to work to transfer these programs that they've had oversight from to other providers, so that we ensure that there is sustainability. One important area is supportive housing. They're a very important supportive housing provider, which is a strategy we have strongly embraced as part of Medicaid redesign, so we do not want there to be a decline in that service.

Obviously they're important within OPWDD as well.

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So, you know, we are committed to making sure and I would say right now we feel pretty good about our ability to transition and make sure we don't have a lack of continuity.

But I do think it does point to a broader issue, which is not so much in the case of FEGS, but maybe some of the other providers, I think we're going to need to see some further consolidation, organizations coming together in common cause to provide greater institutional capacity to weather the storm if things do occur.

But in the case of FEGS, I think it is somewhat of a unique circumstance, as I say, from a whole series of events actually over several years. There's no sort of single smoking gun that basically accounts for what happened with FEGS.

SENATOR KRUEGER: Do you feel that your agency would have the ability to do almost -- I don't mean the term forensic in a bad way, but a forensic audit to make sure you catch these kinds of problems earlier?

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Because you're describing that you actually after the fact saw that it was a series of things taking place over a number of years

that led to what appeared to be an overnight "good-bye, huge agency."

MEDICAID DIRECTOR HELGERSON: Yeah.

SENATOR KRUEGER: So is there a way to help protect both the agencies themselves from not literally going underwater but also, of course, from the state perspective making sure that we are not leaving incredibly vulnerable people high and dry? I mean, something like this happened with another supportive housing provider about six to eight months ago, which mostly had, I think, OMH contracts.

And so I do worry that literally overnight we can watch whole sections of our health and human services umbrella collapse.

MEDICAID DIRECTOR HELGERSON: Right, Senator, you make an excellent point. And yes, we are going through a process of, in essence, a forensic accounting, which is the right term to use, that -- and that's why

we've done enough of that analysis now to have a decent sense of the fact that it was caused by multiple things. Because we were as surprised as anyone when we were notified.

I do think, though, that there's also a couple of lessons to be learned from this experience. I think, one, we the state agencies have to up our game in terms of oversight of these entities.

But also I think it's up to the boards of these organizations, these not-for-profit entities who have their boards of directors and -- because one of the challenges we have is that these entities like FEGS, they hold multiple contracts, not just with us but with the City and other organizations. They receive grant funds and -- so sometimes it's a little hard to see. One of the issues was a performance problem that FEGS had with regards to a City-based contract.

And so we need to do a better job of coordinating with our colleagues in the City, because that's not something that we would necessarily have direct sight line into that

we've got to get our arms around.

But I do think it's an important wake-up call for all involved to be even more vigilant in monitoring these important organizations.

SENATOR KRUEGER: I do too.

My time is up. I may come back afterwards. Thank you.

CHAIRMAN FARRELL: Thank you.

Assemblyman Goodell.

ASSEMBLYMAN GOODELL: Thank you very much. Thank you for being here.

I know a few weeks ago that the Commissioner of Health mentioned that he -- it was on a fracking issue -- would not want

his children to go to school near a fracked well. In my county we have several school districts that have put in natural gas wells to provide low-cost utility -- you know, heating for their system.

Do you have any empirical data that quantifies whether any of those children are facing any measurable or ascertainable increase in health risks by going to those

school districts?

EX. DEP. COMMISSIONER DRESLIN: I'm sorry, could you clarify that question for me?

ASSEMBLYMAN GOODELL: Yes. I mean, the commissioner said he wouldn't want any of his children going to a school that's near a fracked well. I have several school districts in my county that have fracked wells right next to the school. My question is -- it's a two-part question, really.

First, do you have any empirical data indicating a statistical increase in health risks for any of those children? And secondly, is there any additional funding in this budget to address those risks?

EX. DEP. COMMISSIONER DRESLIN: Thank you. Sorry.

The commissioner's ultimate decision on the public health impacts related -- potential public health impacts related to

high-volume hydraulic fracturing, the methodology by which they arrived at that decision are included in the report. And I

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think one of the main conclusions was that the data is not sufficient. And at this time the department does not have plans to conduct any further study. We will continue to monitor the scientific literature related to high-volume hydraulic fracturing.

ASSEMBLYMAN GOODELL: And as it relates to all the existing school districts that are next to existing fracked wells, is there any funding in this budget to address any actual or perceived health risks attributable to those fracked wells?

EX. DEP. COMMISSIONER DRESLIN: No, there is not.

ASSEMBLYMAN GOODELL: I noted that the Rural Health Access program and the Rural Health Network were combined with several other programs, and then there was a 15 percent across-the-board cut. In our county those programs play an incredibly important role. In my county, as I mentioned with my opening remarks, we have about 5,000 fracked wells. Obviously that's a program that might be relevant if those are serious

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health issues.

Can you explain why we would want to cut the funding significantly for Rural Health Access or Rural Health Network?

EX. DEP. COMMISSIONER DRESLIN: Yes, thank you. The Rural Health Networks was included in one of the consolidations. And the department pursued the consolidations because it actually provides some administrative efficiency for the department. It does allow us to look at our programs to identify the high-performing programs and the ones that can have the greatest impact.

As Jason mentioned earlier, there are also opportunities for Rural Health Networks in other areas of the budget.

ASSEMBLYMAN GOODELL: And so is overall available funding still going down significantly for the Rural Health Access or the Rural Health Networks, or would the other funding -- is it stationary or going up?

EX. DEP. COMMISSIONER DRESLIN: As far as the consolidations, the individual programs are not lined out. It is, as you

mention, an overall for the consolidation.

But as I mentioned, it allows us the administrative flexibility to look at the various high-performing programs and to allocate the funds as needed in the area for emerging problems or new problems or for programs that are performing well.

ASSEMBLYMAN GOODELL: Thank you.

On a different subject, you mentioned the Basic Health Plan that's going into effect. Will the Basic Health Plan change the amount of copays or deductibles that currently apply in the subsidized health exchange?

MEDICAID DIRECTOR HELGERSON: Yes, actually we anticipate that the Basic Health Plan's cost-sharing for individuals will actually be less than what is currently experienced within qualified health plans. So in essence what it will mean is that individuals who are transitioning from qualified health plans to the BPH will be better off.

ASSEMBLYMAN GOODELL: One of the

concerns that I've had is there's thresholds in the current health exchange -- for example, in the subsidized plan -- where if you're just below 200 percent poverty, as an example, it's a $250 annual out-of-pocket cost. You go a dollar above, it's $1750. Which means that if you earn an extra dollar, you have to work several extra weeks to make up for the loss in health coverage.

Will the Basic Health Plan reduce or eliminate or phase out those changes in a more helpful manner, if you will, if you're trying to get out of poverty?

MEDICAID DIRECTOR HELGERSON: Sure. So I think definitely the BHP creates an opportunity to smooth the transition from Medicaid, where there's virtually -- or very little cost-sharing, to the QHPs, where they see cost-sharing more akin to what folks see in the commercial markets.

Now, there are various elements within the program designed to subsidize some of those even in a QHP environment. But that said, what the BHP does, it benefits

individuals between 138 percent of poverty and 200 percent of poverty, which is a real sensitive population in terms of cost-sharing, that we would -- through BHP, we're going to bring that cost-sharing down. So we think at the end of the day it will create what you suggest, which is a smoother transition as your income rises and less of a sort of a cliff effect where you trip from virtually no cost-sharing in Medicaid to something more akin to commercial insurance.

ASSEMBLYMAN GOODELL: And are those proposed changes available for our review?

MEDICAID DIRECTOR HELGERSON: I'm sorry?

ASSEMBLYMAN GOODELL: Are those proposed changes available now for our review and comment?

MEDICAID DIRECTOR HELGERSON:

Certainly there's a blueprint that has been presented to CMS, and we'd be happy to make a copy of that blueprint available to you.

ASSEMBLYMAN GOODELL: Thank you very much.

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MEDICAID DIRECTOR HELGERSON: No problem.

CHAIRMAN DeFRANCISCO: Senator Savino.

SENATOR SAVINO: Thank you, Mr. Chairman.

Good morning. I just have two quick changes.

One, I noticed in the budget I didn't see any allocation or any budget appropriation for the implementation of the medical marijuana program. Is that an oversight, or is it going to happen cost-free?

And if it's in there and I missed it, I apologize. I just would like an update on it, if you could give us an idea of --

EX. DEP. COMMISSIONER DRESLIN: There is, in state operations, $6.7 million for the medical marijuana program.

SENATOR SAVINO: And that $2.7 million, is that for the --

EX. DEP. COMMISSIONER DRESLIN: Six. Six-point-seven.

SENATOR SAVINO: Oh, 6.7. Okay, thank

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you.

And the second question, I notice that we have this -- as you know, in Brooklyn there's been an upheaval in our healthcare delivery system. And I know that the Governor has proposed that there be the creation of a $700 million fund to allow for the restructure of healthcare or to help facilities, but it doesn't really give us much explanation as to how those facilities will be determined, what would that money be utilized for, and how can we advise our healthcare operators in Brooklyn as to what they can expect from this pot of money.

MEDICAID DIRECTOR HELGERSON: Sure. So the $700 million is capital, so that's really bricks and mortar designed to either replace or modify physical plant in order to make sure that the physical plant of the delivery system matches the needs of the community. And so that's really what that money is for.

That said, in addition to that, the department -- or the Medicaid budget this

year also assumes a $250 million state share of operating funds that are potentially matchable, if we can find a way -- that if you match it, it turns it into $500 million -- that would be available to provide operational subsidies during a period

of transition.

And it's not just for Brooklyn, it's statewide, but we would be focusing on the IAF providers. The 27 facilities that received funds would be at the top of the list of priority, but other potential providers receiving funds as well.

But that's significant for Brooklyn as well because Brooklyn has some of the largest IAF recipients today. So we didn't want to have, when the IAF funds are over on March 31st, to have these funds in essence go away and then we have an immediate crisis. So we have addressed that short-term crisis, which now gives us the opportunity, working with the community and working with those providers, to develop a comprehensive and we hope a permanent solution for the community.

I think that's the big difference about where we are today, is that the Governor's budget actually puts sufficient resources into addressing it so that we can get ourselves out of this, you know, constant crisis that we're in in terms of facilities. And I think everyone probably knows which facilities have been the most challenged.

But I think you have a community there in Central and Eastern Brooklyn with over a million individuals, residents -- many are on Medicaid -- who without these funds would

face imminent collapse of their delivery system. And our goal is to use these funds to transition to a much more sustainable plane. And we think we now, for the first time, really have the resources to make that happen.

SENATOR SAVINO: On the capital program, though, I mean it's probably fairly well known to your department which hospitals have capital needs and what those capital needs are.

So what I'm trying to figure out is

how -- will -- are you just going to look at what the requests have been over the years for assistance, for new emergency rooms, new operating facilities, and just kind of parcel out the money? Or is there going to be some sort of a decision-making process as to who's qualified and why they would get money?

MEDICAID DIRECTOR HELGERSON: Yes, there will be a decision-making process. The department does have information that was presented by providers within the context of DSRIP not that long ago, earlier this year -- or in 2014 -- about the capital needs of providers.

Now, that information was submitted as part of the DSRIP planning grant applications, and so it gave us certainly a flavor of the magnitude and size of what the

potential needs were out there, which was very helpful in terms of what we needed to set aside in the budget. But there's still more that needs to be done in terms of stakeholder engagement. There's already been a lot. So Interfaith Medical Center, which

is one of the facilities, tremendous amount of activity, a community-based process of really looking at what's the future of that facility. There have been other processes that have been done at some of the other challenged facilities.

So, you know, what we're saying is that we think we have the resources, now it's really time for everybody to roll up their sleeves and put together a plan that can be implemented. To be honest, the plan is not a plan that will be overnight implemented. Some of this is going to take years to transition. But we actually think we have the funds now available within the confines of the global cap to facilitate what would be a multiyear transition to a sustainable high-performing healthcare delivery system for all Brooklyn residents.

SENATOR SAVINO: And finally, one last question. Is the HHC eligible for any of these capital funds?

MEDICAID DIRECTOR HELGERSON: Yes. In fact, HHC is a facility that is definitely

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central to this discussion. They're across the street from SUNY Downstate, which is one of our more challenged facilities in the borough.

I think a very positive development within DSRIP has been a partnership that has been formed between SUNY Downstate and HHC, really for the first time discussions going about how they can come together and work together. And they share a lot of patients. Possibilities of clinical integration are now being discussed, which I think is very positive and hopefully sets us up for a path of sustainability and even improved health outcomes for residents.

SENATOR SAVINO: Thank you.

CHAIRMAN FARRELL: Assemblyman Garbarino.

ASSEMBLYMAN GARBARINO: Thank you, Chairman.

I have a few questions. To follow up on Assemblyman Raia's questions before, how do you guys expect the proposed cut in the average wholesale prices minus 24 percent to

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affect people's access to prescription drugs or pharmacy employment? You know, if you're going to pay them less than what it costs them to get it through Medicaid, or the

pharmacies less than, you know, what it costs them, how do you expect that to affect people on Long Island and New York City and all throughout New York State?

MEDICAID DIRECTOR HELGERSON: Sure. So in terms of the AWP minus 24 percent, we still think, as I say, based on the survey that that's basically the average acquisition cost for pharmacies all across the state.

That said, on a drug by drug basis -- and we have a process for this -- if we do come across situations in which the price as set by the state is insufficient and the provider can provide us with documentation that shows that the price is not sufficient, we can and we do modify that price.

It's a fluid marketplace in the sense that prices rise and prices decline. Pharmacies are negotiating various agreements on a regular basis. So we have the

flexibility built into the current system that if we do come across situations where the ingredient price is more than what we're currently paying, that we have the ability to adjust upwards the price. And not just for that one pharmacy, but we systemically adjust that price up in terms of what is paid to all pharmacies.

ASSEMBLYMAN GARBARINO: So if it turns out that you're paying them less than what it

costs them, you'll raise the reimbursement or you'll raise it up to what the cost is to them or --

MEDICAID DIRECTOR HELGERSON: That's correct.

ASSEMBLYMAN GARBARINO: All right. Because I know you have your study or your survey, but I've been speaking to a lot of pharmacists in my district, and all I hear is they get paid -- you know, it doesn't make sense they get paid less than what -- I'm from Long Island -- they get paid less than, you know, what it costs them.

So as long as you guys can do that,

you know, I hope that happens.

On a separate note, since nobody from DFS is coming today, I have a question about there's a regulation that's changing at the end of this year about self-funded plans. You know, employers that, you know -- right now if you have 50 employees or more, you can buy stop-loss insurance. At the beginning of 2016, that regulation is going to change to only people with a hundred employees or more.

Why are you guys taking away that option for -- especially on Long Island, there's a lot of businesses that have between 50 and 100 employees. Why are you taking away that self-funding option?

MEDICAID DIRECTOR HELGERSON: I think

the good news is that we are unable to answer that question --

(Laughter.)

MEDICAID DIRECTOR HELGERSON: -- being that we are not from the Department of Financial Services. But we'll be happy, I think, to take that back and get you an answer from our colleagues at DFS.

ASSEMBLYMAN GARBARINO: All right. Well, if they're listening, what concerns me is if those -- I have employers in my district that have, you know, between 50 and 100 employees. And if they have to go to fully insured plans and lose the self-funding option, you know, they're going to be spending about $170 a month more for these plans.

And my question is, for them, you know, is the reason behind this because these self-funded plans are not taxed and these fully insured plans are taxed? And if that's the case, is there a budget projection for how much money this is going to bring in in 2016?

EX. DEP. COMMISSIONER DRESLIN: Right. So we'll be sure to have staff get back to you on that from DFS.

ASSEMBLYMAN GARBARINO: All right. I appreciate that.

EX. DEP. COMMISSIONER DRESLIN:

Absolutely.

CHAIRMAN DeFRANCISCO: Senator

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Bonacic.

SENATOR BONACIC: Good morning. Thank you both for being here this morning.

I guess my question is directed to the executive deputy commissioner, Ms. Dreslin. I was reading that you want to implement the Basic Health Plan under the Affordable Healthcare Act.

Now, in the spring there's going to be a Supreme Court decision on whether the subsidies to support the health exchanges are constitutional or not. And there's speculation that that guts Obamacare in the event the Congress does not want to correct language and keep Obamacare as a foundation, and they move to another health plan delivery system.

Now, having said that, do you have -- are you anticipating how that would play out as a Plan B if that was ruled unconstitutional? I'd like you to react to that question, if you would.

Thank you.

EX. DEP. COMMISSIONER DRESLIN: Thank

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you.

MEDICAID DIRECTOR HELGERSON: Yes, I can answer it. So in the spring, the Supreme

Court decision that you are -- or the potential Supreme Court decision that you're referencing really relates to whether or not it is legal for the federal government, operating the exchange in a majority of the states -- not New York, but in other states where it's the federal government administering the exchange -- whether or not tax credits are available to help subsidize insurance in the federal exchange.

So here in New York we have our state-based exchange. And so no one is challenging whether or not, under the very strict reading of the law, whether or not states who administer their own exchanges will be able to continue to see the flow of tax credits for anyone who is eligible to receive those tax credits on the state-based exchange.

So in a sense, that Supreme Court decision, while challenging in states other

than New York that have not done their own state-based exchange, is not really a problem for us. And so therefore it doesn't put at risk the state's proposal to implement the Basic Health Plan.

SENATOR BONACIC: Thank you.

CHAIRMAN FARRELL: Assemblyman Oaks.

ASSEMBLYMAN OAKS: Thank you, Chairman.

Just going back, the DSRIP dollars, $6.4 billion over five years, the target is 25 percent reduction of hospitalization, or avoiding that many. What is the starting point on that? Are we using a date certain, or how is that starting point of how are we going to know we've made the 25 percent reduction?

MEDICAID DIRECTOR HELGERSON: Sure. So it's 25 percent reduction in avoidable hospital use, just to be clear that it's not just a 25 percent reduction in all hospital use. Most hospital use is appropriate, people are using care. But what we're really trying to do is target when someone is going

into an emergency room, going into a hospital either on an initial admission or a readmission when, if the delivery system had done a better job, that would not have occurred. It's usually as a result of an overall failure of the delivery system to meet the needs of the person in the most appropriate setting. And so that's really what we're targeting.

So in terms of 25 percent reduction, what does that mean, so each of the 25 performing provider systems will have its current performance established and establish a baseline. And then the goal is that each and every year we want to see a reduction in

avoidable hospital use.

Now, payments to the performing provider systems that will be impacted upon their success or failure in those measures really start to make a meaningful difference starting in Year 3, so in Years 3, 4, and 5. So it gives each performing provider system an opportunity to stand up the infrastructure in order to implement their projects so that

they can actually achieve the results.

But it's basically each performing provider system is held accountable based on making improvements compared to where they start, which is where they are today.

ASSEMBLYMAN OAKS: And so the targeted time for the 25 percent is?

MEDICAID DIRECTOR HELGERSON: The full five years.

ASSEMBLYMAN OAKS: The full five years.

Back to a point that you had made earlier, 1.9 million people have signed up through the exchange, 1.4 million you said were on Medicaid. You also said how many had not enrolled before or not been in healthcare before. I missed that number that you gave.

EX. DEP. COMMISSIONER DRESLIN: Eighty percent of the 1.9-plus-million had reported no coverage at the time of enrollment.

ASSEMBLYMAN OAKS: Eighty percent,

thank you.

So just following up with a few of those numbers, do we know how many people had

had insurance but then with a nonqualifying plan who -- you know, then have been picked up? Do we know those numbers?

EX. DEP. COMMISSIONER DRESLIN: I can get back to you with those numbers.

ASSEMBLYMAN OAKS: My sense would be as we look at the overall success, maybe they ought to be pulled out of that. In other words, they had insurance, then they didn't because of the action we took. But -- and so we wouldn't know, then, if we don't know exactly how many we had, we don't know what percent of those went to private plans versus Medicaid. I would appreciate, as you look at that, too, enrolled before.

Do we know -- again, a few questions about this, employer-paid healthcare today versus pre-Affordable Care Act. So do we have more people getting private healthcare or fewer today? Do we know those numbers?

MEDICAID DIRECTOR HELGERSON: Right. So we do track, and nationally it's tracked, the percent of total health insurance that is employer-based, so people who receive it

through their employer.

We have been in a pretty steady decline nationally, and here in New York as well, in terms of employer-sponsored insurance. That accelerated with the Great Recession. A lot of jobs were lost, obviously, and not all the jobs that were created offered the same kind of health insurance benefits of the past.

So it's a -- you know, trying to separate out the impact of the Affordable Care Act from what is otherwise a general decline in employer-sponsored insurance is a challenge to do. But I think what makes us feel that we're doing a pretty good job of making sure that we're targeting who needs to get targeted is that 80 percent number, that the vast majority of people who are coming to the exchange really don't have a health insurance product. Maybe they did prior to job change, you know. And unfortunately they're manufacturing jobs and others that have often provided health insurance benefits.

But it is one of those things that we look at, because we certainly do not want to have the exchange crowd out good employer-sponsored insurance. And I think we'll have to watch particularly the small-group market over time to see how it performs. We're hopeful that with the SHOP, that we will

create a more robust small-group market than what was the case prior to the Affordable Care Act.

ASSEMBLYMAN OAKS: The next thing I guess I'd like to -- we're getting pretty close, we're under the cap this year that we've imposed for the state on Medicaid spending, but we're getting perilously close, I think, to that. And there's a concern that we're going to see some significant increases in the future. Do we have projections on that? Are we confident we can stay within the cap that we've self-imposed in the state?

MEDICAID DIRECTOR HELGERSON: Well, we've been living under the global cap for four years, so we -- and we've spent a tremendous amount of time and energy trying

to project how we will spend money. It is a very large and complex program with lots of puts and takes in it. But we know a lot more today about how the program functions than we did four years ago, and we apply that knowledge and understanding every day to honing our efforts and feel --

ASSEMBLYMAN OAKS: And any other -- I'm sorry, are there any Medicaid cost-saving measures that we're proposing now or looking at that are going to help in that process?

MEDICAID DIRECTOR HELGERSON: Absolutely. So in this budget, as in past

budgets, we are proposing a balanced score card, meaning that we propose investments, things like some of the things we talked about, but also savings initiatives that are designed to generate a rate of return and help control costs in the program.

So we feel next year that we have presented to the Legislature a balanced Medicaid program and one that will lead to greater efficiencies.

To give you a sense of the success to

date, we have reduced per-recipient spending in New York State Medicaid down to 2003 levels. That is a 10 percent reduction on a per-recipient basis. So in an era where costs in healthcare generally tend to grow in some years at double-digit percent rates, or certainly in single-digit rates, we have actually been to reduce overall Medicaid spending.

If you look at total spending in Medicaid, basically it's been flat throughout the MRT period, yet at the same time we've increased enrollment by 1.1 million people.

So we feel that we have a strong track record but we have to continue to be vigilant in terms of managing this big program. We're a third of the state budget, and if we have a budgetary problem, it's a budgetary problem for the entire state, so -- but we feel that

the budget that's proposed lives within its means and the amount that the global cap would otherwise have given us under state statute.

ASSEMBLYMAN OAKS: Thank you.

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CHAIRMAN FARRELL: Thank you.

CHAIRMAN DeFRANCISCO: That's an incredible record as far as keeping Medicaid costs under control that were strangling us in the past, and you should be commended for that.

With respect to the issue that the Assemblyman just asked you about, you gave us the percentage of people that have enrolled in the healthcare system. And how much of those people, what percentage of the total enrollment is people that were previously on Medicaid?

MEDICAID DIRECTOR HELGERSON: Sure. Well, what is true is that some of the population that we're seeing migrate to the exchange are individuals who normally would and were encouraged to go through the renewal process at the county level, but for one reason or another did not do that and came to the exchange.

Reasons for that could be that they saw the advertising, they thought they might be eligible for a qualified health plan, but

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they came to us through the New York State of Health and applied and found out they were deemed to be eligible for Medicaid again if they were renewing.

So it's a little hard to sort of ferret out how many of the Medicaid 1.4 million were previously on Medicaid, but many of them -- in fact, most of them are. And so it's somewhat of a migration that's naturally occurring. We anticipate eventually the counties will no longer be in the business of determining Medicaid eligibility. Right now, they're doing renewals. We do new starts for what's called the MAGI population.

But we can certainly pull together some additional statistics for you if that would be helpful.

CHAIRMAN DeFRANCISCO: Well, you can see the importance of the question. If someone is getting healthcare from Medicaid and then they're one of the 1.2 million or whatever it is that have gotten a policy -- but we're still paying, the same people are

just in a different program. And the real question is, you know, what is the real advantage of this program if you're just changing the title of where their insurance is coming from.

MEDICAID DIRECTOR HELGERSON: Right.

I mean as I think we said, though, there was -- roughly 1.4 of the almost now 2 million people who have been enrolled were enrolled in Medicaid. Of those, a portion weren't eligible for Medicaid in the past or were what we call the woodwork effect, which is individuals who weren't on Medicaid, didn't have any insurance, were eligible for Medicaid but they just didn't know it.

And so now with all the publicity, folks are coming to the exchange, finding out they're Medicaid-eligible, and therefore getting enrolled. So we think that's a real benefit. We think the woodwork effect is beneficial to reducing the uninsured rate.

But then also you have 600,000 people who are in qualified health plans on the exchange. And that's, you know, over half a

million people, New Yorkers who are now commercially insured that weren't before the Affordable Care Act.

And then the last benefit, obviously, is reductions of premiums in the individual market, which has been quite substantial.

CHAIRMAN DeFRANCISCO: Okay. My understanding of one of the theories of this whole healthcare act would be that the concept would be the younger, healthier people start enrolling, and it helps pay for the cost of those that are unable to -- that

have to be subsidized in some way.

Now, do you have any idea what the age range of these people are?

MEDICAID DIRECTOR HELGERSON: Yes. We do have it, we have that information. I don't have it in front of me right now, but we can certainly get it for you to give you a flavor of -- within the various age ranges.

What I can tell you is, to date, the sign-up that we've seen has pretty much stayed within original projections. So --

CHAIRMAN DeFRANCISCO: Age

projections?

MEDICAID DIRECTOR HELGERSON: Yes. So it was projections done as part of the estimates that helped us to sort of anticipate what the impacts would be.

And one of the things that -- one of the key policy questions which you're raising is are we attracting a mix of patients, including the younger population who may think they're healthy and don't really need insurance and don't want to pull money out of their own pockets to buy it.

And we made some projections in terms of what those percentages would be. And we felt that so far, at least, we've stayed within our projections. But we have that data that we can make available for you.

CHAIRMAN DeFRANCISCO: I'd appreciate

it. Because it just seems to me if you're 25 years old, you don't have a spouse or children, and you're fined -- I don't know, what do you get fined?

MEDICAID DIRECTOR HELGERSON: It's very small in the first couple of years.

CHAIRMAN DeFRANCISCO: Very small. And you can't prohibit someone from joining for preexisting health conditions. So it would seem very -- much more of an incentive for those people not to get in the system, and therefore not have the additional cash to deal with everybody else.

But if you can get me those, that would be helpful.

DSRIP, just -- well, not DSRIP. I don't know. I don't know what it is, there's so many RIPs and DISs and everything else. But you talked about the $700 million going to Brooklyn, $300 million going to Oneida County. Those areas, did they apply for this money?

MEDICAID DIRECTOR HELGERSON: So in the case of Brooklyn, I think we've been -- everybody has been well aware of the challenges that have existed there in the state, there's been multiple efforts around trying to put together --

CHAIRMAN DeFRANCISCO: I got it. I got it. Just did they apply for it?

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MEDICAID DIRECTOR HELGERSON: They have not. But before any money is allocated, they would have to apply.

CHAIRMAN DeFRANCISCO: All right. So some internal process took place where you're reserving that money. You mentioned in your testimony, unless I misheard you, that Oneida County, the system there did apply in their application, they --

MEDICAID DIRECTOR HELGERSON: They did not apply, they submitted to us a concept paper that was very attractive that -- but before any funds are actually allocated, they're going to have to go beyond a concept paper to a much more detailed application in order for the funds to be allocated.

CHAIRMAN DeFRANCISCO: I understand that. How about the rest of the systems throughout the state? Did they know they should -- had the opportunity to give you this information so they could be on the final list before they apply?

MEDICAID DIRECTOR HELGERSON: So we received the Oneida proposal, which was

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unique, and we decided to propose to fund a Oneida County proposal. But in the case of Brooklyn, it was just a long-standing, known problem that we've had that we knew we needed

to address at some point and no one else was prepared to do it.

But what I would say on that is that, you know, there's the $1.2 billion, which is a formalized procurement process which is ongoing.

CHAIRMAN DeFRANCISCO: Okay. But did the rest of the systems throughout the state know that they could make their situation known to you before you start carving out to other people?

MEDICAID DIRECTOR HELGERSON: No, they did not, Senator.

CHAIRMAN DeFRANCISCO: Well, that doesn't seem fair, does it?

MEDICAID DIRECTOR HELGERSON: Well, I mean, I think that the process here is -- this is the Governor's proposal, and obviously the Legislature has its opportunity to review that proposal before it becomes

law.

CHAIRMAN DeFRANCISCO: And lastly -- I'm beyond my time. The last category is $400,000 for rural health hospitals. Now, that works perfectly because it's upstate, downstate. But if we don't have a -- equal shares, right? But if we don't know what "rural" is, and it's up in the air, that "rural" could be used for something below the Mason-Dixon Line, as opposed to upstate. Is

that fair to say?

MEDICAID DIRECTOR HELGERSON: We definitely don't want to spend any money south of the Mason-Dixon Line, but --

(Laughter.)

CHAIRMAN DeFRANCISCO: I was trying to be humorous.

MEDICAID DIRECTOR HELGERSON: I hear you.

And so what I would say is that we'd be more than willing, I think, to work with all of you to define "rural" prior to the conclusion of the budget process.

CHAIRMAN DeFRANCISCO: Okay, thank

you.

CHAIRMAN FARRELL: Thank you.

Assemblyman Crouch.

ASSEMBLYMAN CROUCH: Thank you. Thank you, Mr. Chairman and Commissioner.

My understanding is if a person owns property or owns their home and they fall on hard times so they have to access some benefits, that there's a lien placed on their property, so once they come back into good financial times, you can, you know, get rid of that lien, you have to pay the money back. Or in other words, if you sold your house you'd have to reimburse Medicaid. Am I correct in that?

MEDICAID DIRECTOR HELGERSON: Right.

So I think what you're talking is that in the case of the need for long-term-care services, there are -- for certain services, long-term-care services, there are what are called asset tests, requirements that individuals must utilize some of their assets in order to cover their long-term-care expenses before Medicaid will become the

payor for those services.

And those rules take various forms, and they can take the form of liens.

ASSEMBLYMAN CROUCH: How about in the case of -- well, I'll be specific. I had a lady call my office, she had health insurance but it went away when the new healthcare came in. And so she tried to access healthcare on the website. And she owns some property. She said, "I'm not rich, but I'm paying my bills, I was paying for my health insurance. I'm property-rich and cash-poor."

But it kept kicking her over into the Medicaid benefit for the insurance. And she couldn't get an answer, I couldn't find an answer for her. After talking to some people, they couldn't answer it.

She said, "Will they attach a lien on my property?" She said, "I'd like to be able to give my property to my kids." And so she refused to -- it ended up she refused to sign up.

I was told that she should consult an attorney who is versed in elder care. And

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she said, "I've already talked to two of them, and they can't answer it either." So she went without insurance because she wasn't about to have a lien put on her property for accessing Medicaid while she was here, you know, working.

MEDICAID DIRECTOR HELGERSON: We would be happy to work with you and your office and help the woman that you describe.

I would say that generally speaking, with regards to Medicaid eligibility, outside of long-term-care services -- and so I don't know the exact circumstances of what services the woman is in need of. But for --

ASSEMBLYMAN CROUCH: Well, in purchasing health insurance --

MEDICAID DIRECTOR HELGERSON: Just regular insurance.

ASSEMBLYMAN CROUCH: Yeah. It put her over into the Medicaid.

MEDICAID DIRECTOR HELGERSON: But in Medicaid, unless you need long-term-care services or you're basically going to be determined disabled -- so if that's not an

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issue, that's not a need, then there are no asset tests. So there would be no threat of a lien, and that she should be able to enroll

based on her income. And in the case of Medicaid, there are no premiums and just very nominal cost-sharing.

So I apologize if somehow the system didn't work to help this woman access it effectively, and we'd be more than willing to try to get her enrolled, assuming that she's eligible.

ASSEMBLYMAN CROUCH: Okay. I will be in contact with her. Because she, you know, was past the sign-up time, and so she's due to pay a penalty this year. To my knowledge, she probably still doesn't have any healthcare -- I haven't talked to her in a while. But she's very upset she couldn't find an answer, nobody could answer that question if there was any assignment of lien on an asset, and so she just refused to be put in a box like that.

So I would appreciate maybe something confirming that to my office, please.

MEDICAID DIRECTOR HELGERSON: Sure.

EX. DEP. COMMISSIONER DRESLIN: Absolutely.

ASSEMBLYMAN CROUCH: Thank you.

CHAIRMAN DeFRANCISCO: We have been joined by Senator Murphy, and he would like to ask some questions.

SENATOR MURPHY: Good afternoon. And a few quick questions.

You have the proposal of the $1 billion bond capital. Do you have any idea what the interest rate is on that?

MEDICAID DIRECTOR HELGERSON: I think we have to direct you to the State Budget Office, who could probably answer that. But I can tell you that obviously we're functioning in a very low interest environment right now. And considering it's double-tax-exempt debt issued by a governmental entity, the interest rates are going to be very low.

SENATOR MURPHY: Okay. You mentioned that you have approximately 2 million people enrolled. Do you have any type of analysis

of how many doctors are leaving New York State because they --

MEDICAID DIRECTOR HELGERSON: As a result of the Affordable Care Act?

SENATOR MURPHY: Not specifically as a result of the Affordable Care Act, but just in general. Inevitably, someone's got to take care of these people.

MEDICAID DIRECTOR HELGERSON: Right. I don't think there's any evidence to suggest that we're seeing a flight of physicians out of New York State.

SENATOR MURPHY: I'll tell you firsthand, there are, as one. I have a number of my colleagues that can no longer

afford to stay here in New York State.

MEDICAID DIRECTOR HELGERSON: I think we'd be happy to look into the situation. As I say, we don't have any statistics to suggest that that's a systemic issue. But obviously we're very interested in doing whatever we can to retain and recruit physicians and all other healthcare providers in order to ensure that we have the best and

most efficient healthcare delivery system in the nation.

SENATOR MURPHY: I know, as a healthcare provider, we want to make sure we can take care of everybody. But it comes at a cost one way or another.

The second prong of that question is, do you have any -- I know you have roughly around 5200, you know, employees and you have roughly about another 325 new employees. Are any of those being dedicated to the fraud department?

EX. DEP. COMMISSIONER DRESLIN: We do work with the Office of the Medicaid Inspector General closely. And we do, on a continuous basis, review the performance of our, you know, recipients of funding.

But also back to your workforce question, we do have a number of initiatives to help develop the physician workforce, rural residency programs and rural physician

recruitment programs as well. And we'd be glad to work with you if you have additional ideas.

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SENATOR MURPHY: That would be great, if you could get me some statistics on that. I'm kind of numbers guy.

But, you know, it really boils down to money. And one way or another, we want to keep good physicians here in New York State. We have to make it affordable for them to stay here and obviously giving people, you know, some healthcare. So, you know, these are things that need to be looked at.

But the fraud is a big one I'd like to have some statistics on of how many dedicated employees and where you go with that, if you don't mind.

EX. DEP. COMMISSIONER DRESLIN: Absolutely.

MEDICAID DIRECTOR HELGERSON: And OMIG, after we are done here, the Office of Medicaid Inspector General will be testifying after us. And so they're the main entity within Medicaid that's responsible for detecting fraud and abuse in the Medicaid program.

SENATOR MURPHY: Thank you.

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CHAIRMAN FARRELL: Thank you.

Assemblywoman Gunther.

We've also been joined by Assemblyman McDonald, Assemblyman Steck, and Assemblyman Weprin.

ASSEMBLYWOMAN GUNTHER: The first thing I want to ask about is the $700 million that is going to go to Brooklyn. Now, I remember a few years back that we bailed out that hospital in Brooklyn, that we had a lot of things going on and we bailed them out. And $700 million is an awful lot of money.

So is there a plan? What's going on now that they're broke again? And if you couldn't fix it with the money that you invested, what's going to change at this point? It's a lot of money.

MEDICAID DIRECTOR HELGERSON: Absolutely it's a lot of money. I mean, the $700 million specifically is for capital improvements, so -- we have some very antiquated facilities out in that part of Brooklyn, some of which leads to very poor health outcomes. One of the poorest-

performing hospitals in the entire nation is in that --

ASSEMBLYWOMAN GUNTHER: And I ask, like, give me an example of a piece of equipment that would -- you know, I mean we've had healthcare outcomes with antiquated equipment all throughout upstate New York.

So tell me what creates -- is it an infection rate? What's going on? Length of stay?

MEDICAID DIRECTOR HELGERSON: Yes, I would say in some of these facilities they suffer from all the ills that one would imagine that a healthcare provider would suffer from. In at least one of the facilities, for instance, you are 10 times more likely than the national average to have a hospital-acquired bedsore, just to give you one statistic for one particular provider. And the quality of care there is just not what anyone would deem to be acceptable.

But the issue is is that we haven't really had the resources available. We've sort of done sort of fits and starts or little Band-Aids, if necessary, but what we

haven't done is have sufficient resources, both on the capital and operating side, to really transform delivery so that the state can get out of this business of having to constantly be directly subsidizing.

And that's what we think the Governor's budget does, is it really creates for us, for the first time, really, a systematic opportunity to change the direction.

ASSEMBLYWOMAN GUNTHER: So do they have a new Quality Improvement Plan? The joint commission has been in there,

obviously, the Department of Health has been in there. So, you know, an acquired infection is -- there must be a reason why. In other words, if you're going to throw all that money into some -- a system, and I believe that in that Cobble Hill area where they are, that they need that healthcare.

But I don't understand like -- they didn't request the money. And the money is put in the budget. But I don't understand why we don't have a plan of improvement.

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Because what's going to change is the age of the population. There's got to be a reason why. And, you know, normally you can drill down and find a reason, you know that. There are all kinds of systems in place.

So, you know, I question why $700 million. Why not $500 million or $200 million and give the rest to upstate New York and another hospital that needs some improvements or, you know, equipment, because that's an issue in all the poor rural areas.

The other thing I want to talk about is, you know, in the news lately, 60 Minutes, they've been talking about the cost of procedures and how they vary from one part of the state to the other for a CAT scan in one place or a colonoscopy -- and now how people are going on diagnostic tourism, they're actually going to other countries to get a

colonoscopy, a knee replacement, a hip replacement because of the cost.

And it's so much different from Iowa to New York to New Jersey. And, you know, certainly we can't do anything about other

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states, but what are we doing to look at cost and --

MEDICAID DIRECTOR HELGERSON: Sure. So I'm glad you asked that question because at its core you're pointing out one of the major challenges of healthcare generally in the United States, but particularly here in New York, which is there's a tremendous lack of transparency when it comes to cost and quality. It's very difficult for a healthcare consumer to be able to weigh their choices and make the most informed one in terms of what's going to lead to the best outcome and what's the most cost-effective solution for them.

It's also even difficult for payors, Medicaid being the largest payor in the state, or insurers, when they come down to trying to figure out how they can creatively contract, and there's tremendous variation in price.

I would say that the more interesting variation isn't so much price, but when you look at for a procedure or a population, you

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look at the variation in total cost of care, which takes into account both the price for the service as well as the total amount of utilization across an episode.

And right now we have data within Medicaid where we're looking right now to try to better understand why variation exists and then encourage providers and insurance companies to contract more creatively to try to reduce the bad variation, improve outcomes, and lower costs.

But in terms of within the context of multipayer, we're also excited about the possibility of having more comprehensive data that looks across all insurance sources to see what kind of variation exists. Not in any way to try to point fingers or to demonize, but rather to create opportunities. Because we think at the end of the day if better information is in the hands of providers and insurers, together they can come up with creative -- and many already are -- creative ways to change the incentives within the delivery that really rewards better outcomes.

Which I think at the end of the day is what we want out of our healthcare system. We want it to be based on how do we provide more value to patients. As opposed to the current set of incentives, which is the more services you provide, whether they add value or not, the more

money you get paid as a healthcare provider.

ASSEMBLYWOMAN GUNTHER: My fear is that the joint commission has been doing this for a really long time. We're computerized, we're gathering information, we computerize all the nosocomial infections in hospitals, we've targeted ones that are very costly and -- but we have that information. I mean, you've been collecting it -- not you, but generally across the country and of course in New York State. We have quality improvement programs.

So I think that is tangible information. And I don't know what we're doing with it. And if we put good money into somebody that can't improve the quality of care, and we have that information -- I don't get it. I don't get it. And you know what,

it's not rocket science to look at the age of a person, all that, and just say, you know, what the heck went wrong? How many days did they stay in the hospital?

MEDICAID DIRECTOR HELGERSON: Yes. You're absolutely right. I mean, the issue is that we've had a lot of data but we haven't made it actionable, in the sense that we have not been willing to really change the dynamic in healthcare --

ASSEMBLYWOMAN GUNTHER: That's exactly my point. You're exactly right. It's been

there, we're spending boatloads of money in the hospital. We pay people to come and get us ready for the joint commission, we pay boatloads of money. They pay boatloads of money when you come in, the Department of Health. You've got this information, and it's been around a long time. You know, I'm not telling you anything you don't know.

But it's very frustrating to me as a taxpayer, as representing 130,000 taxpayers, having so many people that can't afford healthcare. Now we have the Affordable Care

Act, and the premiums are going up. And why are they going up? Because we don't have the right controls, in my opinion, my humble opinion.

And I just think that if we don't use the information we can, we can come here, you can throw as much money as we want to, but it's the same thing every year. Somebody is going under, and we're going to put some money there.

MEDICAID DIRECTOR HELGERSON: Yeah, we need to change the dynamic. Which is we need to move away from a system where you see an ever-diminishing margin of providers, providers stretched, providers making it more and more difficult to provide quality care. We need to move to a reimbursement system for healthcare that actually pays people when

they're successful.

When the community is healthier, the providers do better financially. And in fact the reverse is the case, which is that as they get sicker, reimbursement -- total reimbursement goes up. And I think that

that's the dynamic we have to break out of, because otherwise we won't have a delivery system that, you know, is generating the outcomes that all citizens in New York should expect.

ASSEMBLYWOMAN GUNTHER: And I also think in New York State sometimes we have to look at flexibility and creativity, and sometimes we don't allow that for the people that are in the trenches that really are in the know. And that's not you, I just think in general.

CHAIRMAN FARRELL: Thank you.

Senator?

CHAIRMAN DeFRANCISCO: Senator Krueger for a second round.

SENATOR KRUEGER: Thank you.

Okay, so this time for Executive Deputy Commissioner Dreslin.

There is a cut through Article 7 language to the New York Physician Profile program. I believe it's about $1.2 million. How big is the state budget for the Department of Health? How large is your

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state budget allocation?

EX. DEP. COMMISSIONER DRESLIN: Over $130 billion.

SENATO0R KRUEGER: So this is a program that ensures that all New Yorkers can look up information about their doctor's records, whether they have had violations, complaints. I mean, it's a fundamental consumer protection, as I see it. It provides some level of transparency to those of us who might want to know something about the physician that we are using prior to making the decision that they are the right one for us.

Whose idea was it to cut this program out?

EX. DEP. COMMISSIONER DRESLIN: The Physician Profile website was -- when it started, it was an innovative website. The department does feel that much of the information that the physicians provide on their own to the website is available in other locations. But we are committed to having appropriate information for consumers

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to make educated and informed choices about their providers available. And, you know, we will work to ensure that that necessary information is available.

SENATOR KRUEGER: Where else would I get that information as a consumer if not the state website?

EX. DEP. COMMISSIONER DRESLIN: There are some other websites. There's some -- WebMD and some other additional sites that are available for information about physicians.

SENATOR KRUEGER: Are physicians required to put the information up there?

EX. DEP. COMMISSIONER DRESLIN: They are not.

SENATOR KRUEGER: Does the state have any vetting process for those websites to make sure that they are complete and accurate?

EX. DEP. COMMISSIONER DRESLIN: We do not. The physicians provide their own information for the New York State website as well.

SENATOR KRUEGER: But in theory there's a vetting process or a penalty if they were to put fake information up?

EX. DEP. COMMISSIONER DRESLIN: We do attempt to make sure that the information is present, yes.

SENATOR KRUEGER: I would urge the department and the Governor to revisit their decision to cut this program. If there are ways to improve it -- because it's 2015, not

the year 2008 -- if there are ways to make it easier to access, because it still assumes we all have computer accessibility and know how to go through a series of web pages to find the information.

But the concept that the State of New York would do away with this service instead of improving it I personally find disturbing. And I certainly hope the state will recognize that for a whopping sum of $1.2 million on a Department of Health budget, or even a full state budget, is the wrong direction for the state to go.

Changing topic, the HPNAP program for

emergency food that is funded through the Department of Health -- I don't know if it's still called the Food Nutrition Division or a different name. So you have an increase in that budget this year; is that correct?

EX. DEP. COMMISSIONER DRESLIN: Correct.

SENATOR KRUEGER: How much is the increase?

EX. DEP. COMMISSIONER DRESLIN: Four-point-five million dollars.

SENATOR KRUEGER: Is the increase or the -- that's 4.5, okay. I thought it was 2.5.

EX. DEP. COMMISSIONER DRESLIN: Four-point-five is the increase.

SENATOR KRUEGER: Is the increase. And do you know that in a different section of the state budget, TANF funding through OTDA, they cut funding for the same type of service?

EX. DEP. COMMISSIONER DRESLIN: Yes.

SENATOR KRUEGER: Yes. So do you think that the increase minus -- I think they

cut $2 million or $2.5 million out of the TANF funding. Do you think that's adequate to meet the needs of emergency food providers from throughout the state based on the demands that you've been getting?

EX. DEP. COMMISSIONER DRESLIN: We are funding in the amounts that we have available, in every effort to ensure that these who have food insecurity have access to food.

SENATOR KRUEGER: Do you hear from providers that they are desperate for additional resources for emergency food?

EX. DEP. COMMISSIONER DRESLIN: We have been working with a variety of stakeholders with the Governor's Anti-Hunger Task Force and trying to ensure that we have some creative ways of providing access to food and nutrition for children and adults as well as families and the elderly. So we are working very hard on sort of a multipronged creative approach, yes.

SENATOR KRUEGER: Again, more of, I guess, an editorial comment than another

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question. I'm glad to see the increase in the Department of Health budget. I do think that food and nutrition are direct health issues. And obviously when people get inadequate food and nutrition, we are paying the price through other, much more expensive health interventions.

But I wish that the Governor in totality would understand that cutting it out of one agency and putting it into another is not necessarily the path of growth that the providers unfortunately find themselves needing government to help them with. Because the demands for emergency food through the food banks, food pantries and soup kitchen system throughout the state are all documenting massive growth in demand despite the pickup in the economy compared to a few years ago.

So I hope that Department of Budget, I guess, in totality understands that when you say you're increasing a program over here by X but you cut out other funds for the same purpose over here, we the public really need

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to understand what the dollars and cents actually translate to.

Thank you.

CHAIRMAN FARRELL: Thank you.

Assemblyman Ra.

ASSEMBLYMAN RA: Thank you, Chairman.

Just a quick question on the proposal to combine a number of the funds for the chronic diseases. And I understand they're, you know, putting together a number of programs that are already existing into that. And then there's a, I guess, 15 percent cut off the top; is that correct?

EX. DEP. COMMISSIONER DRESLIN: Correct.

ASSEMBLYMAN RA: Can you just elaborate a little bit on that proposal and what is hoped to be achieved by it?

EX. DEP. COMMISSIONER DRESLIN: Absolutely. So this is a proposal that the department feels would add to its ability to be agile in the face of changing public health needs. We do, on a continual basis, review the performance of our programs, and

many of the recipients of funding in some of the buckets are the same. And so this will provide some opportunity to improve our administration and to be able to respond to emerging and new initiatives as they come forth.

ASSEMBLYMAN RA: And in terms of administration of that kind of new combined program, is there anything being put into

place that might kind of ensure like -- for instance, cystic fibrosis. There's a -- the over-21 program is only about $800,000 in last year's budget, and I think the previous year as well; it serves a relatively pretty small population.

Are there any controls in place to ensure that something like that, now that it's combined with the others, still will have adequate funding for that program?

EX. DEP. COMMISSIONER DRESLIN: Right. Yes, as I mentioned, we will be looking at the particular programs, how they're performing, the needs that they're serving. And as the department dispenses the funds,

those programs that are high-impact will be funded.

ASSEMBLYMAN RA: Okay, great. Thank you.

CHAIRMAN DeFRANCISCO: All right, a couple more questions.

On that malpractice website, what's the thought behind getting rid of it? The cost, period?

EX. DEP. COMMISSIONER DRESLIN: It is part of the savings plan that we are looking at. And again, we felt that much of the information was available in other locations.

We are committed to data transparency, and we will work to ensure that the

particular consumer information regarding malpractice will be available.

CHAIRMAN DeFRANCISCO: Well, rather than inventing the wheel, you've got something that works, number one.

And number two, there is no other place you can get it in such a concise way, rather than from going to site to site to site to site, so.

Number two, 2 percent across-the-board restoration of Medicaid rates. It was supposed to happen April 1 last year. Why has it not happened, and where are you with it?

MEDICAID DIRECTOR HELGERSON: It's currently pending with CMS for approval. Unfortunately, it's one of a long list of items. We have over a hundred state plan amendments that are currently pending with CMS.

So we're working diligently to get it restored. The good news is is that when the restoration occurs, it will be retroactive back to April 1 of 2014. So while there's a delay, the providers will see the full restoration.

CHAIRMAN DeFRANCISCO: Okay. And how long ago was your proposal submitted to CMS?

MEDICAID DIRECTOR HELGERSON: So we did the public notification in advance of

April 1, so that we were able to lock in that date. I'd have to go back and check to see when -- there's multiple state plan

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amendments that are associated with it. I'd have to go back and check to see when they were submitted. But we've been going at it with CMS, back and forth, for quite a while. There's a number of SPAs that have languished now for a couple of years with them, and it's associated with upper payment limit calculations that are still being worked through.

CHAIRMAN DeFRANCISCO: All right. Could you let me know, once you've checked it out, when it was submitted?

MEDICAID DIRECTOR HELGERSON: Sure.

CHAIRMAN DeFRANCISCO: Okay. And universal settlement. I've been informed that there's over 9,000 nursing home rate appeals for the last 25 years. Now, you're not responsible for the full 25. But what is -- I understand there's settlement discussions going on right now; is that correct?

MEDICAID DIRECTOR HELGERSON: That's correct.

CHAIRMAN DeFRANCISCO: And could you

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tell me where the settlement negotiations are

at this point?

MEDICAID DIRECTOR HELGERSON: So I can say they're ongoing, and we remain optimistic that we'll be able to reach agreements.

Because of the nature that not only are there rate appeals, but there's also outstanding litigation that's also part of the settlement discussions, I have -- there's limits in terms of what we can say at this time.

CHAIRMAN DeFRANCISCO: Okay. Now, I heard a rumor -- now, this can't be true, it just can't be true -- that some of the money that might go towards -- if the settlement actually happens, the monies that would be due to some of the recipients of these funds, there's some discussion or some thought that the state may want to use some of those settlement funds to pay towards the 2 percent -- the retroactive rate adjustment.

MEDICAID DIRECTOR HELGERSON: At this point, I don't think we can comment on the specifics of the negotiations.

CHAIRMAN DeFRANCISCO: Now, just for my two cents, you settle a case that's -- cases that have been going on for 25 years, you agree to pay the amount of money that these people are owed, whatever the settlement negotiation says, but part of those discussions is, Well, we also want to

use some of the money that we owe you after we've knocked you down in the negotiations, to pay what the Legislature said you have to provide. That doesn't seem too fair, does it?

MEDICAID DIRECTOR HELGERSON: It's -- it's a multiparty negotiation that's been ongoing I think now for over two years, maybe even closer to three. But, you know, as I say, it's very difficult for us to comment, but I think we hear your concern.

CHAIRMAN DeFRANCISCO: Okay. And there's a proposal for the increase in the minimum wage that's been given a lot of -- that's been talked about for some time, and I think it's in the Governor's budget. Now, since -- is the state going to give the

nursing homes and all the individuals involved in these funds, are you going to give them a deferment for a couple of years in having to pay the minimum wage until you get them the money that they're --

MEDICAID DIRECTOR HELGERSON: Right, so --

CHAIRMAN DeFRANCISCO: Because they have to pay their wages whether you get them the money in time or not.

MEDICAID DIRECTOR HELGERSON: Right. So we really don't anticipate there being the kind of impact that would require any sort of

rate increase above and beyond what the budget already assumes. There's some nursing home enhancements already included in the budget, so at this point we do not anticipate there to be a need for further. But obviously it's one of those things we'll have to monitor. And if at any time it appears that the rates are insufficient given the cost structure, and that the nursing homes are unable to manage the additional costs, we will have to take steps as

necessary to ensure access.

CHAIRMAN DeFRANCISCO: Just pay them what they're entitled to. I mean, that would help.

Number two, a totally different topic. Administratively, the Health Department enacted -- or not enacted, but put into effect a youth sexual health plan; is that correct? Do you remember when that happened, about May of last year?

EX. DEP. COMMISSIONER DRESLIN: Okay.

CHAIRMAN DeFRANCISCO: I mean, if you don't know, I'll go to another area.

EX. DEP. COMMISSIONER DRESLIN: I would probably have to get back to you, I'm just not familiar with --

CHAIRMAN DeFRANCISCO: Okay, I'm just trying to figure out -- I know there's been legislation for something like that for

years, and it's never passed both houses. I'm just trying to figure out why the Health Department would just make it part of the requirements of the State of New York. That's basically where I'm going. So if you

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get back to me, I'd appreciate that.

EX. DEP. COMMISSIONER DRESLIN: Absolutely.

CHAIRMAN DeFRANCISCO: And Mr. Helgerson, you were talking about the DSRIP earlier, and I just have one question about that that I haven't asked yet. Jim Introne, does that name ring a bell?

MEDICAID DIRECTOR HELGERSON: Yes, he does.

CHAIRMAN DeFRANCISCO: Can you tell me what role he has to play in the selection process of who's going to get some of the $8 billion and who's not.

MEDICAID DIRECTOR HELGERSON: Jim plays no role in that selection process. So Jim's role -- I mean, I think everyone -- or many of you are aware that Jim was deputy secretary for health and healthcare redesign for Governor Cuomo for almost -- basically the first three years of the administration.

He agreed, at the request of the commissioner, to come back on a part-time basis to assist us during the DSRIP

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implementation. Particularly as we were working with groups of providers all across the state, Jim played a key role in helping bring together groups of providers around the table.

But in terms of the decision-making process for the allocation of funds, we have a very formalized process. There is a consulting firm that's been required for us to hire, called the independent assessor. It's required under the terms and conditions of the waiver. That entity is the first entity that basically scores the applications.

Those scores are then brought to an oversight and review panel, which is a nonconflicted group of stakeholders and health policy experts who have basically review oversight responsibilities for basically reviewing the work of the assessor. And then they provide further recommendations on to the commissioner, who can then forward on recommendations to CMS for final approval.

CHAIRMAN DeFRANCISCO: All right. Has

the consultant that's going to score these things, have they been named yet?

MEDICAID DIRECTOR HELGERSON: Yes, they have.

CHAIRMAN DeFRANCISCO: And who is it?

MEDICAID DIRECTOR HELGERSON: It's

Public Consulting Group.

CHAIRMAN DeFRANCISCO: All right. And Jim Introne is a consultant as well, right?

MEDICAID DIRECTOR HELGERSON: He works -- actually has been working as a part-time state employee.

CHAIRMAN DeFRANCISCO: Was he ever a consultant on this project?

MEDICAID DIRECTOR HELGERSON: No, he was never a consultant on that project.

CHAIRMAN DeFRANCISCO: And do you know, does he work for any particular firm?

MEDICAID DIRECTOR HELGERSON: He does not. He was working -- when he came to work for us, he was working just for us.

CHAIRMAN DeFRANCISCO: Okay.

Next? Go ahead.

CHAIRMAN FARRELL: Mr. McDonald.

ASSEMBLYMAN McDONALD: Thank you.

Good morning. I don't know who to direct this question to, but I'm sure you'll pick up on it. And it deals with the pharmacy reimbursement. I know there was a little bit of questioning about it earlier, but I want to just expand about it a little bit more because I think the comments were mostly geared towards independent pharmacies.

But as you know, last year there was a lot of discussion about the generic methodology, and I know that there were

several meetings held between the Department of Health and all the shareholders in pharmacy. And I don't believe they ever really got to a resolution. I think there were some very constructive meetings, a lot of give and take. And as you know, my other day job is I am a pharmacist, so I do have an idea of what drugs cost and how to purchase them.

This AWP minus 24 percent that's being proposed -- and I understand there's a little bit of a way to adjust it by having an

increase in fee. In talking to not only independents but mostly to chains and the long-term-care pharmacies, we're having a very difficult time trying to find anybody who's able to purchase at that dollar amount. So I'm kind of curious -- or that discount amount, excuse me. So I'm kind of curious how you arrived at that.

I know there was an acquisition-cost study done in 2012, which is dated now. What was the basis on how you arrived at that dollar amount?

MEDICAID DIRECTOR HELGERSON: Yes, so that survey process, which was very extensive, that pulled in a tremendous amount of data from pharmacies all across the state, both community pharmacies as well as chains, and was really designed to look at what's the

actual acquisition cost for the pharmacy. And then the idea then also was to do a study that looked at what's the actual cost for dispensing, with the idea being that we would migrate to a system in which that would be the basis of reimbursement.

So there were concerns about that methodology and the updating that would be necessary as a result of having to regularly do this comprehensive survey.

And while we had proposed and actually the state law allowed the department to move ahead with AAC's methodology, which dates back to the beginning of MRT in our 2011-2012 budget, I think the decision was made not to proceed forward with the AAC in last year's budget.

But what we still felt was that we had this data, this information available to us, it suggested what the actual acquisition costs were, and we used that to calculate what would be the discount off AWP, which is the traditional price indices that's used in pharmacy reimbursement. Everybody has always known that average wholesale, you know, was problematic; that's why we always provide some discount off of it. But, you know, it's often challenging for any payor to really understand what's happening between the pharmacist and the wholesaler in terms of

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actual acquisition.

But I would say that we felt -- we still stand by the validity of the data. And as I say, if we come across examples of drugs where the price is inadequate, we can adjust systematically. But we think overall that AWP minus 24 is appropriate.

ASSEMBLYMAN McDONALD: I would not -- in my understanding it's AWP minus 24 on brand-name drugs only; is that correct?

MEDICAID DIRECTOR HELGERSON: That's correct.

ASSEMBLYMAN McDONALD: Okay. I would probably argue that that needs to be reviewed. Because I don't think in the marketplace that's attainable unless we're allowed to purchase from Canada. That's the only way I could see that ever happening.

I do agree with you, I've always been a fan of moving away from the AWP minus, particularly in the generic drug market, you're absolutely correct on that. And I can only hope that we get to some kind of constructive decision on that.

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Through the course of those discussions, I also understand there was also discussions about trying to get away from the annual exercise. And I've been in pharmacy

for 30 years now. So we would come in and -- is it a quarter-percent here, is it a fee here, whatever we can do. And trust me, I understand the pressure the department's under, particularly with the Medicaid budget as well.

Where are we at in regards -- I know some programs are suggested, you know, what's now called medication therapy management. In other words, instead of focusing on how much more can we squeeze off the provider, how can we get towards better outcomes? Which is really where we want to be.

MEDICAID DIRECTOR HELGERSON: Yup.

ASSEMBLYMAN McDONALD: And my understanding is a couple of months ago there were some suggestions made. Are we looking deeper into that? Because my belief, and I can speak from firsthand experience, we've seen, with various health plans in the

Capital Region, significant reductions in hospital readmissions and also misutilization of drugs. Are we looking at that as an opportunity? Because we still have some pharmacies out there that are anxious to be participatory in that.

MEDICAID DIRECTOR HELGERSON: Yeah, absolutely. In fact, two things. One, we've been encouraging pharmacies to join performing provider systems and become part

of those collective efforts to improve outcomes and then, as a result of that, opportunities to benefit financially from participation.

But secondly, I think more sort of fundamentally, is we've established what's called the value-based payment group, which is really to look at, you know, a restructuring of how Medicaid reimburses providers, who are -- most of our Medicaid businesses now are managed care. How do the managed-care entities reimburse providers, and how do we migrate away from systems of reimbursement that are volume-based -- so the

more you do, the more you get paid -- to value-based, so the more effective you are as a provider or group of providers in improving patient outcomes and lowering total cost of care, that you see increased reimbursement from that. And the pharmacist community has a representative on that group, and we anticipate further dialogue with pharmacists around what value-based payment means in the pharmacy world.

ASSEMBLYMAN McDONALD: I appreciate that. I think truly that is the direction we should have been headed years ago. And I know, as we discussed a couple of months ago at one of the conferences, that's the way things should be.

I really would caution, though, that we really take another look at that discount percentage, because I don't think it's going to be attainable. And the reality is if we're relying on having some providers out there in the community provide that value-based care, we might be stretched on that aspect.

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On a different topic, and I'll be really quick, Doctors Across New York. I know it's a program that I have met with the constituencies a few times. Is the program successful, is it failing, are we looking to expand it? Where are we at with that?

EX. DEP. COMMISSIONER DRESLIN: We've been very supportive of Doctors Across New York, and it is vitally important to have high-quality providers in rural areas and areas that have not as many, in general, healthcare providers as we need.

And we are committed to working on workforce issues. There are a number of different initiatives that include workforce initiatives, including the SHIP and DSRIP and also the Doctors Across New York program. We continue to put out grants to fund those.

ASSEMBLYMAN McDONALD: Thank you. Thank you.

EX. DEP. COMMISSIONER DRESLIN: You're welcome.

CHAIRMAN DeFRANCISCO: Senator Hannon.
SENATOR HANNON: Many different

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things.
First, to the department. There were at least three initiatives during last year's budget that I'm curious as to what happened.
The first one was in regard to Rape Crisis Center funding, where there was a transfer under suballocation to the Office of Victim Services. Apparently without any type of legislative input, the criteria for who the awards would go to were changed, monies allocated were changed, and what we had was a large series of complaints that the population that ought to be served is not served.
So that the whole -- I would like to get some type of review of that, why it was done, what was accomplished, and frankly an accounting for what was not accomplished.
EX. DEP. COMMISSIONER DRESLIN: Right. So there's actually two pieces to the answer to that. One is that the Department of Health received two different types of funding for rape crisis. And some of that came from the CDC, and the CDC changed the

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way that it allowed states to spend the money.
And so what the department did in the

first instance was to transfer $1.8 million of victim services funding to the Office of Victim Services. In many cases it was the same provider who was receiving funding from two different agencies, so it actually made -- it made efficiencies for that particular provider so they didn't have to contract with two separate agencies. And the funding was for actual services to victims.

And then as far as the money from CDC, since the parameters of that were changed, the department -- it was necessary for the department to go to a more regional approach. And those fundings are for prevention services. So it sort of -- it went to different pots, and the transfer over to Office of Victim Services was done actually to help out the recipients of the funding so that they didn't have to have multiple contracts with state agencies.

SENATOR HANNON: And by going to the

regional services from the county, you took people who were experienced and knew what to do, and you were creating a whole new entity. Without a transition, so that there was no real notice that this was going on.

EX. DEP. COMMISSIONER DRESLIN: There was the transition that with the help of the legislative add, the contracts were made whole through April. And it was seen as the

best opportunity to make the best use of the funding that we now had available.

SENATOR HANNON: I would simply suggest, when we had that suballocation -- a practice that I look very askance about -- that we have a far more collaborative model going forward.

Let me talk about two other things. During last year's budget we developed a whole process dealing with organ transplantation and set up a whole process so that the state's unused funds, which predate a couple of administrations -- and which were not being done -- were tried to be employed so we would increase the amount of organ

donation in the state.

During the course of the subsequent year, there was an RFP released in August. That RFP said that the deadline for responses was sometime in October, I think it was extended to December 1. To date there's been no awarding of anything. To date we are still in the same situation with regard to organ transplants in this state, which has within the past 18 months resulted in CMS giving a warning to this state about penalties that might be enforced.

And I view the inaction of the department to be horrible. And when I looked at the RFP, I noticed that a whole extra set

of layers of duties were now imposed on the people who would get the RFP, duties that the department itself didn't carry out when it was doing it. So there's several layers here of inaction and misguidance that I think needs to be corrected.

More importantly, I think healthcare is being endangered because we're not acting on it. And we'll be speaking about that even

more forcefully as we go forward.

EX. DEP. COMMISSIONER DRESLIN: The registry does continue to be operated by the state, and we are actively in the procurement process for that RFP.

SENATOR HANNON: What happened to the deadline for responding to the RFP? What happened to the people who -- and I don't know, because it's an RFP and I'm not about to inquire about the procurement process. But I think this is a major black eye.

EX. DEP. COMMISSIONER DRESLIN: Understood.

SENATOR HANNON: Something else that the Legislature had worked on, specifically the Senate, and that was in regard to Lyme disease.

Now, the fact is we did pass the statute codifying what the Office of Professional Conduct had been doing for seven to 10 years, but that was only a little part

of what our action was. We appropriated money, we appropriated money for a conference, we appropriate money for data

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mining, several other things where the Health Department is doing a good job about Lyme, we're going to help other county departments that were not.

We inquired, we received a response back in the beginning of December -- oh, the conference about bringing all the researchers in the state together so we might start to have a center point for a lot of very talented people and maybe we can go forward with tick-borne disease, we haven't heard a thing in the subsequent two months as to what's happened.

And I really view that, once again, healthcare is not being served. There was no more popular topic about what we were doing than trying to move forward with Lyme disease. And all of a sudden the state, which has a number of very good people involved in it in its Public Health Department, has not been able to move forward. So --

EX. DEP. COMMISSIONER DRESLIN: We're actually very appreciative of the task

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force's work. And this February is the first

conference. That one will be for healthcare providers, bringing them together. And there will then be a subsequent conference working with the local health departments.

SENATOR HANNON: This February? We're in February.

EX. DEP. COMMISSIONER DRESLIN: I think it's at the end of the month.

SENATOR HANNON: We've received no notice of it.

EX. DEP. COMMISSIONER DRESLIN: We'll make sure that you receive the information.

SENATOR HANNON: We worked very hard to develop the guidelines and the outline of that conference. So you can't run this thing alone.

EX. DEP. COMMISSIONER DRESLIN: Absolutely. We'll make sure that we reach out to your office and coordinate.

SENATOR HANNON: A couple of other things in regard to the department.

I echo Assemblyman McDonald's thoughts about Doctors Across New York, the funding,

the flat funding, and the delay in awarding the monies to the people who have gotten the grants is just not helping. Rural hospitals throughout the state talk about that program being a key to their moving forward. And as you're looking at all of the other requests, that program becomes a key that we ought to

increase the funding for.

WebMD. I don't know if you know this, but WebMD is not necessarily a reliable alternative. If you look at its site and you say "sources of funding for WebMD," grants from all the major pharmaceutical companies. So if we've held them at bay for academic profiling, I would think we would also hold them at bay for providing the information about the physicians.

Nothing could be more reliable than information from government. And that site probably hasn't been updated in 15 years and ought to be rethought so it's even more consumer-friendly.

The last thought for the department -- because I have a few for you,

Mr. Helgerson -- is the thing called State Health Information Network, SHIN-NY. Last year the proposal was to give them, on an annual basis, between $70 million to $100 million of ongoing HCRA funding on a permanent basis. The Legislature said no. We said we'll give you money, but we want to have a work group. Because there are a lot of unanswered questions.

I believe the department has been consulted and has made some real progress on that. But then again, I find in the budget they want permanentization and they want

continuation of that funding. So we're going to be looking for detail as to where the money went, how it was spent, and what kind of progress can be made as we go forward with it.

Still, in other words, there's been actual -- I commend you for this -- progress, but there's further steps to go.

Mr. Helgerson -- oh, one last thing for the department. I look askance at the request for 300 non-civil service jobs just

to be picked by the department. It's in there, it's in the middle of the budget, 300 jobs not subject to civil service. I commend you for your boldness, but not necessarily for the process.

MEDICAID DIRECTOR HELGERSON: I can explain that, if that's helpful, what that proposal is.

So that's what we call an in-sourcing initiative. So throughout Medicaid redesign, we've used some consultants to assist us in launching projects, like our Health Home and things like that. The Legislature has been extremely helpful in granting us some flexibility to allow us to be able to implement things that are designed to save money and implement them quickly, because particularly in our first year we were under such tremendous time pressure to generate a

very, very large sum of money in terms of savings, $4 billion.

So what we're proposing now is to basically create an opportunity for some of those contractors to actually move into state

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positions. Now they'll basically -- it creates a pathway for them. But they still will have to take exams, they'll still have to go through a process to become permanent employees. But the process that we're proposing, which we worked with civil service on, is akin to what was done for ITS and how they in-sourced some of their employees -- or contractors.

It was also for the state takeover of Medicaid administration, we pursued a somewhat similar approach for county employees. Because as the state was taking on responsibilities from the counties, we wanted to give the workers who live in counties who do the job today to have opportunities to continue that work if they so chose.

So it is ground that we have crossed before. But that's in essence the rationale for that proposal.

SENATOR HANNON: It's still 300.

MEDICAID DIRECTOR HELGERSON: Up to 300.

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CHAIRMAN FARRELL: Assemblyman Weprin.

SENATOR HANNON: No, no, no, I'm not finished.

CHAIRMAN FARRELL: I'm sorry.

SENATOR HANNON: I'm not finished. I have some more for Mr. Helgerson.

The construction monies. I find that the multiple streams of the construction monies lead to confusion. And unlike Senator DeFrancisco's point of did people know about it, ever since we've had HEAL grants in this state, starting in 2007, people who run hospitals or nursing homes or any community-based clinics or anything like that know there are grants available and, if they are serious and creative and have proposals, they can -- it can be done.

But you've proposed the DSRIP with reduction of hospital admissions. That's a different whole conceptual thought than what we did with the HEAL grants and the hundreds of millions of dollars that went with the HEAL grants. And I think there needs to be an articulated conceptual progress as to

what's different now. I don't necessarily find the $700 million and the $300 million Brooklyn/Oneida as conceptually different. It looks like it's business as usual. And what are we going to do that's different? And I think that's what needs to be

articulated.

And the second part of it is, does it have to be pure cash for everything? Can it be something that leverages other monies, leverages private financing, leverages paying off debts so there can be mergers? There's a number of different things that need to be done. And I think it needs to be put together, it needs to be articulated so people know what's happening. Otherwise, you know, we hear, Well, so-and-so wants a new hospital. That's not supposed to be the direction you're going in.

MEDICAID DIRECTOR HELGERSON: Correct.

SENATOR HANNON: So that really just -- I think we have to learn better than what we did. And learn better than what we did during the HEAL grants.

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A couple of other things. Basic Health Plan, that's an enormous expansion. I know that the up-front money allows the state to capture payment for people who are, by the courts, to be covered in the state. And that's $600 million the first year. I worry about what happens the second, third, fourth year. I worry about what happens if the Congress pulls the rug out from under it, because that's a very likely thing when they discover the rest of the things about healthcare and Obamacare.

I wonder about how the exact functioning is going to work. We call them the Aliessa population. How will they be different under Basic Health Plan versus non-Aliessa population under Basic Health Plan? Are we going to have two classes? Are we going to have different cards? I don't think this has been well thought out.

Last year we talked about Basic Health Plan, if it was in the financial interests of the state. Well, the financial interests are not just 12 months of the budget, but an

ongoing basis. We've already increased the amount of people in New York State under Medicaid, so almost one-third of the population of this state is under Medicaid, maybe even more. Within a percentage point or two. So the question of expansion really needs to be thought out as to where we're going and how much we're doing.

Just a couple of the other things. And I think the question of the exchange itself. Basic Health Plan would be part of the exchange. Increased Medicaid administration, part of the exchange. This tax, part of the exchange. And I think it's going to all become much more heightened.

If you read through Robert Pear's story in yesterday's New York Times about the immense complications that people who have

received subsidies for health care insurance will have to go through when they file their income tax -- one is people who have to pay a penalty. But two, the form that people will have to fill out is incredible. It's something like 16 boxes, you have to tell how

much your income was per month, whether you're eligible per month. It's going to have a major adverse reaction.

And I think we really have to think out where we're going with this exchange. Successful as it might have been under certain terms, the question is how much are we paying per person covered subsidized by the people of New York State. And that's what's going to happen if you want to go ahead with that tax.

And just on the last part, you have a list combining all of the competitive block grants and then saving 15 percent. I don't think we're going to go through that exercise again. This is the third year in a row, it hasn't happened. There are a number of major worthy programs. If there are problems with those programs, they ought to be cured. If those programs ought to be combined, they ought to be combined. But simply going across-the-board cut is not something that's very acceptable.

And with that, Mr. Farrell, I'll cease

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asking questions.

CHAIRMAN FARRELL: Thank you very much. And I really mean it.

(Laughter.)

CHAIRMAN FARRELL: Mr. Weprin.

ASSEMBLYMAN WEPRIN: Thank you, Mr. Chairman.

Commissioner, you didn't make any reference in your testimony to anything related to Early Intervention, an area I've been very involved in, and reimbursement on Early Intervention. I know in past budgets there were significant cuts to reimbursement for Early Intervention, and there was a partial restoration. Where are we now as far as the reimbursement levels? Have we caught up to the levels of four or five years ago?

EX. DEP. COMMISSIONER DRESLIN: We are actually making very good progress with Early Intervention, and we do appreciate the hard work of the providers in the Early Intervention program.

We have seen the number of children that are receiving services in EI increase

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this year, as well as an increase in the number of providers and in the number of rendering therapists as well.

And we've also made great strides with

reducing the number of unadjudicated claims and increasing the rate with which commercial claims are being made, so I think we're doing a tremendous job. And I think that the services are getting to the children that need them.

ASSEMBLYMAN WEPRIN: Okay. So there are no cuts in this particular budget year?

EX. DEP. COMMISSIONER DRESLIN: There are no plans for this year for any changes in the rates.

ASSEMBLYMAN WEPRIN: And on another issue, you made reference in your testimony to the AIDS epidemic and the Governor making it a priority to solve the AIDS epidemic. I know he appointed a task force; I commend his efforts in that regard. But I notice there's only about $5 million in the proposed budget to deal with the very ambitious goal of eliminating the AIDS epidemic and identifying

people, you know, who are HIV-positive and getting them the necessary services.

Obviously, we've come a tremendous way in being able to end the former death sentence and providing medication. Is $5 million enough? And is there an amount that was recommended by the task force?

EX. DEP. COMMISSIONER DRESLIN: The $5 million is in the context of a $110 million AIDS Institute budget.

And actually, the AIDS Institute is one of the examples of -- a couple of years ago there were consolidations of appropriations that enabled the AIDS Institute to be somewhat more agile and to redirect funds as necessary to high-performing, high-impact areas and to areas that were emerging.

So we're confident that within the funds that we have in the AIDS Institute and the additional funding for some of the recommendations for the end of AIDS, that we can accomplish this mission.

ASSEMBLYMAN WEPRIN: Okay. Thank you,

Commissioner.

EX. DEP. COMMISSIONER DRESLIN: Thank you.

CHAIRMAN FARRELL: Thank you.

Assemblyman Gottfried.

ASSEMBLYMAN GOTTFRIED: Thank you.

On the buckets issue that Senator Hannon just mentioned and that I talked about earlier, one of my questions earlier was about what the criteria would be for -- if by some chance the buckets idea gets enacted, has the department developed criteria for how it will carve up that reduced pot of money? And if there is a set of criteria, can you send that to us?

EX. DEP. COMMISSIONER DRESLIN: As I

mentioned, we do look at all of our programs. We follow almost a state procurement-like process when we disburse the funds. So we can -- we can let you know those different criterias that we look at to identify the high-performing programs and the programs that are meeting the deliverables of the contracts.

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ASSEMBLYMAN GOTTFRIED: I'm sorry, so --

EX. DEP. COMMISSIONER DRESLIN: I'm sorry, I misspoke.

ASSEMBLYMAN GOTTFRIED: -- does that mean yes, you have criteria that you can send me, or no, you don't?

EX. DEP. COMMISSIONER DRESLIN: Yes, we can send you the ways in which we evaluate our programs.

ASSEMBLYMAN GOTTFRIED: And that will be applied specifically to this bucket concept if it is adopted?

EX. DEP. COMMISSIONER DRESLIN: Correct.

ASSEMBLYMAN GOTTFRIED: And those criteria will be specific enough so that someone won't look at it and say, "Who are they kidding, if the commissioner wants to give this one money, these criteria are squishy enough that he can justify it"?

EX. DEP. COMMISSIONER DRESLIN: I

can't speak to how they'll be interpreted, but we can provide the information.

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ASSEMBLYMAN GOTTFRIED: Okay. So I will look forward to getting those criteria.

On the electronic prescription question that was touched on earlier, the question of whether to postpone the mandatory effective date, we've got about, what, 55 days to go before that takes effect? If it's going to be postponed, it would certainly be at least polite to let people know that sometime before March 27th.

I'm sure someone in the department has been thinking about this and whether some providers have been able to get up and running on e-prescribing. And if others haven't, how come? And is it because they've chosen not to, or is there some obstacle beyond their control that's keeping them from doing it? What's the story?

EX. DEP. COMMISSIONER DRESLIN: We have been reached out to by a number of different stakeholders. The challenges with meeting the deadline seem to vary across different industries. Some from private providers have a different set of challenges.

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Nursing homes have another set of challenges. The hospitals, some have a different, yet again, set of challenges.

So we have been listening to all the information coming in. And yes, there are people in the department who are working on the issue and we will, as expeditiously as we can, come out with a decision.

ASSEMBLYMAN GOTTFRIED: I'm just wondering why -- here we are February 2nd, and we're still discussing that in the future tense. I mean, people have been raising this issue for some time now.

EX. DEP. COMMISSIONER DRESLIN: The department has been working with the stakeholder community for almost two years now, providing education and input on the impending implementation date. There's been information up on our websites. We've been working with the community in an effort to help the stakeholder community become ready to implement on the date.

And we have seen a groundswell of outreach to the department in recent weeks.

And so we are again taking a look.

ASSEMBLYMAN GOTTFRIED: Who in the department is working on this that I could talk to?

EX. DEP. COMMISSIONER DRESLIN: We can reach out to your office.

ASSEMBLYMAN GOTTFRIED: Excuse me?

EX. DEP. COMMISSIONER DRESLIN: We can reach out to your office with an update on

where we are, if you wish.

ASSEMBLYMAN GOTTFRIED: Okay. But I assume there's somebody with a deputy or assistant commissioner title who's most responsible for this?

EX. DEP. COMMISSIONER DRESLIN: This falls within the Office of Primary Care and Health Systems Management.

ASSEMBLYMAN GOTTFRIED: And that would be who?

EX. DEP. COMMISSIONER DRESLIN: That would be Dan Sheppard, deputy commissioner.

ASSEMBLYMAN GOTTFRIED: I'm sorry, could you say that again?

EX. DEP. COMMISSIONER DRESLIN: Dan

Sheppard is the deputy commissioner for the Office of Primary Care and Health Systems Management.

ASSEMBLYMAN GOTTFRIED: Okay. Thank you.

CHAIRMAN FARRELL: Mr. Goodell.

ASSEMBLYMAN GOODELL: Thank you, Mr. Speaker.

One of my great concerns, I'm sure it's a concern of yours, is that the high cost of insurance is causing a lot of employers to look at high-deductible insurance. And of course with a high-deductible insurance, it really means no insurance until you meet the deductible. And

some of those deductibles are $2,500, maybe even $5,000, which takes a lot of primary care right out of the insurance field.

So when I looked at the cost of health insurance, I realized that over $4 billion in New York State is attributable to state taxes or assessments -- the covered lives assessment, gross receipts tax, the hospital sick tax, you know, the 9-point-whatever that

we've imposed.

Is there any effort on the part of the department to reduce the taxes, fees and assessments that apply to the healthcare industry in an effort to reduce the cost of healthcare in New York State?

MEDICAID DIRECTOR HELGERSON: Sure. So yes, the State of New York has a long history of relying on a variety of funding sources to fund the New York -- most of those funds that you described are funding the New York Medicaid program.

So the challenge is -- another revenue source that helps fund and has historically helped fund -- more so, actually, than in any other state -- has been the local property tax. Which particularly four years ago, three or four years ago, was a major hot topic and lots of concern amongst county executives and others about the burden that that was creating in terms of ever-increasing

burden.

And we made a lot of progress there. I mean, one of the sort of untold stories of

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Medicaid redesign was that we capped the county contribution and actually, with the Affordable Care Act, received increased federal funding that has offset the county's contribution.

But that said, I think that as we look to the future, we have to do whatever is in our power to try to make insurance more cost-effective. I do think that the SHOP offers affordable products, particularly to small businesses. But I do hear you in terms of -- and what you're suggesting is not just unique to New York, but a trend across the country, which is the growth of high-deductible health insurance products.

Now, not all high-deductible insurance products have the problem that you suggest about not being able to afford primary care. You know, there are ways that businesses can structure those high-deductible plans that makes certain preventative care services free or very low cost.

But you're right, it's that increased cost-sharing generally in healthcare is a

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concern in terms of what it means for real

affordability. And just because you have a card that says "insurance" on it doesn't necessarily mean that that's going to get you access in an affordable fashion.

And I think, you know, particularly as relates to the exchange, we've strived very hard to make sure that the products are not only affordable from a premium standpoint but are affordable from a cost-sharing standpoint. I mean, you have to have both components.

ASSEMBLYMAN GOODELL: In terms of the cost structure that's imposed on the healthcare industry by the state -- that is, the taxes, fees and assessments -- this budget, if I'm not mistaken, doesn't reduce those costs but actually increases them by imposing a new, I think you call it an assessment of 0.375 percent on qualified health insurance plans; correct?

MEDICAID DIRECTOR HELGERSON: Correct. It's --

ASSEMBLYMAN GOODELL: So we're

actually increasing the costs by a new assessment?

MEDICAID DIRECTOR HELGERSON: Yes and no. I mean, in the sense that you are increasing the assessment. However, that assessment is going to fund the day-to-day operations of the health insurance exchange,

which --
ASSEMBLYMAN GOODELL: And is that resulting in a reduction in cost somewhere else in the system?
MEDICAID DIRECTOR HELGERSON: Yes. It actually reduced premiums in its first year in the individual market by 50 percent. So at the end of the day, we think it's a wise investment to maintain the health insurance exchange, because it's been very successful at lowering premiums for individual and small group -- and so we believe that as a result, it's a wise use of funds.
ASSEMBLYMAN GOODELL: Earlier you said this is an assessment, not a tax increase. From the payor's point of view, what's the difference between an assessment of

0.375 percent and a sales tax, say, of 0.375 percent?
MEDICAID DIRECTOR HELGERSON: This is a revenue tax, revenue assessment. You can use the words that you choose. But we think it's an appropriate source. The Department of Financial Services has assessments of this type.
ASSEMBLYMAN GOODELL: But from a payor's point of view, is there any difference?
MEDICAID DIRECTOR HELGERSON: I mean, I wouldn't want to speak for the payors in

terms of how they would perceive the assessment.

ASSEMBLYMAN GOODELL: Now, we've spent several hundred million for GME, am I correct, graduate medical education support?

MEDICAID DIRECTOR HELGERSON: Correct.

ASSEMBLYMAN GOODELL: The Governor recently announced a proposal to provide funding assistance for teachers in return for a commitment to stay in New York and teach for five years.

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Is there any discussion about taking some of our GME funding and adding a commitment from the physician's side that they also stay in New York and also provide patient care for a number of years?

MEDICAID DIRECTOR HELGERSON: It's something that can be looked at.

I mean, I think New York is actually pretty well positioned. We train a tremendous number of physicians. I'm pretty sure that we're number one in the country in terms of training physicians. And so that's a great strength, because if we could find a way, since they're already here in our state, to keep them, that's -- you know, would be a tremendous success and benefit all 19.5 million New Yorkers.

So in terms of GME itself, you know, like all our other programs, we are always

looking at it to see if we can't get more out of it. But it has been an extremely important funding source for a lot of those teaching institutions.

ASSEMBLYMAN GOODELL: As you can

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appreciate, while I take great pride in the fact that we're number one in training doctors, my concern is that once they get their medical degree, they leave New York State so they don't have to pay all the taxes, fees and assessments.

So my question is, are we working on a financial strategy in connection with our training programs to help keep docs here?

MEDICAID DIRECTOR HELGERSON: Yes. In fact, it was mentioned earlier, Doctors Across New York.

But one other thing I would mention is that within the Delivery System Reform Incentive Payment program, within DSRIP, each of the performing provider systems was asked to come up with a workforce investment strategy, how they were going to use money through the initiative to actually hire or retain or retrain workers so that they can have the healthcare workforce that they need well into the future.

And in their applications, if you add up the total amount that those 25 performing

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provider systems are proposing to spend on workforce, it totals over $500 million over the five years. So we think that's a tremendous opportunity to make wise investments. Some of those funds will be spent directly on recruiting and retaining physicians. So, you know, I think that's a very exciting development as part of the waiver.

CHAIRMAN DeFRANCISCO: You're done?

ASSEMBLYMAN GOODELL: I had a quick question on spousal --

CHAIRMAN DeFRANCISCO: No more quick questions. We've got 31 more speakers.

ASSEMBLYMAN GOODELL: I have a long, detailed question on spousal --

CHAIRMAN DeFRANCISCO: Then definitely not.

ASSEMBLYMAN GOODELL: I'll follow up later. Thank you.

CHAIRMAN DeFRANCISCO: Thank you for your testimony and your patience.

It's a long day, especially for the people out there. I've got some good news

for some of you, maybe not others.

But as we're talking, Thomas Meyer, acting Medicaid Inspector General, is next.

Thank you.

EX. DEP. COMMISSIONER DRESLIN: Thank you.

CHAIRMAN DeFRANCISCO: There have been some cancellations and some changes of names, but here are the cancellations. UNYEIP, towards the bottom of the second page, is canceled. And Hospice and Palliative Care Association is canceled. They've submitted testimony.

(Discussion off the record.)

CHAIRMAN DeFRANCISCO: All right, Acting Medicaid Inspector General Thomas Meyer. Whenever you're ready.

ACTING MEDICAID IG MEYER: Good morning, Chairman DeFrancisco, Chairman Farrell, and distinguished members of the Senate Finance and Assembly Ways and Means Committees, Health Committee chairs Senator Hannon and Assemblymember Gottfried. My name is Tom Meyer, and I'm the acting Medicaid

inspector general.

I want to thank you for the opportunity to discuss the 2015-2016 Executive Budget as it relates to the Office of the Medicaid Inspector General.

OMIG was created as part of an overall effort to reduce fraud, waste, and abuse within the state Medicaid program. The intent was to take a more proactive stance in fighting fraud and also to detect and prevent overbilling in the Medicaid program. New York's results in this regard have made

us the national leader.

OMIG identifies and pursues opportunities to save taxpayer dollars. Preliminary numbers show that New York's proactive cost-containment strategies have saved taxpayers more than $6.3 billion over the last three years. We expect that the coming year will present new opportunities to prevent Medicaid dollars from being wasted.

Preliminary estimates of our recoveries also reflect our success in fighting fraud and recouping payments from

improper Medicaid billings. Over the last three years, the administration's enforcement efforts have recovered over $1.7 billion, a 20 percent increase over the prior three-year period.

The Medicaid program is in the midst of a tremendous transition from the traditional fee-for-service model to care management for all. Our reviews of managed care and managed long term care have already begun and are showing results.

For example, OMIG is focusing on policing social adult daycare and managed long term care in concert with the Department of Health, the State Office for the Aging, and the Medicaid Fraud Control Unit of the Attorney General's office. OMIG's work in these areas has taken two paths -- an

investigative focus on social adult daycare, and an audit focus on managed long term care plans.

We have opened investigations related to social adult day care and conducted on-site inspections. Some of the issues

we've found relate to fire/safety concerns, mismatches between space and occupancy, entrance and egress access, and zoning violations. As a result, we have made referrals to appropriate government and law enforcement agencies.

OMIG is also conducting audits of managed long term care plans. These audits focus on whether individuals are eligible for long-term care and whether they are receiving appropriate care management. In last year's budget testimony it was stated that there would be substantial recoveries in this area. We can report today that the state has recovered tens of millions of dollars from plans that received overpayments, with additional millions identified for recovery in the future.

We have continued our efforts to educate providers about Medicaid compliance. We now have 23 active audit protocols that can help providers learn about Medicaid compliance. In addition, we have conducted webinars, at the request of providers, on

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topics including the Medicaid exclusion and reinstatement process as well as the self-disclosure process. We are very proud of this work because it has a positive effect on program integrity and enables providers to partner with the state and OMIG in these efforts.

New York's first-in-the-nation mandatory provider compliance program is a national model that was adopted at the federal level in the Affordable Care Act. In New York, our commitment to these efforts has resulted in increases every year in the number of providers that certify to having compliance programs that meet New York's requirements.

And today, New York is again a leader by creating concrete measurements that demonstrate how stronger compliance efforts help save money. Last year, OMIG's monitoring of providers under Corporate Integrity Agreements resulted in more than $59 million in cost avoidance. This is proof that oversight, coupled with appropriate

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educational effort, can yield positive results.

At OMIG, we recognize the importance of identifying areas for potential fraud or

abuse, and of working with providers to prevent improper conduct before it starts. One of the areas where we thought improved automated controls would help was home health services. In 2011 a new control, pre-claim verification, was enacted into law. Pre-claim verification provides assurances that claims are only submitted when caregivers are present to provide home health services. This control had the added benefit of saving hundreds of millions of taxpayer dollars.

Last year the pre-claim verification statute was amended to bring services transitioned into care management under the umbrella of the control. I am pleased to report today that this control is being implemented.

OMIG is the leading state Medicaid program integrity agency in the nation, and

the coming year is sure to present new opportunities. The Executive Budget represents a strong commitment to our office, and will improve OMIG's operations and enhance our ability to fight fraud and abuse in the Medicaid program.

Thank you for the opportunity to speak today. I am happy to answer any questions you may have.

CHAIRMAN DeFRANCISCO: Senator Hannon.

SENATOR HANNON: Mr. Meyer, thank you.

Two things. One was maybe you could just describe a little bit of your activities in regard to referrals to managed long term care plans. This had been an expanded mission for managed long term care plans under MRT, and there are many places where their patients have skyrocketed. And I just wondered what you're doing to measure that and how well is it going, et cetera.

I'm concerned not only about the dollars but also about the care, because they're new entities and in some cases I'm not sure they had a great deal of experience

in dealing with people who needed home care services.

ACTING MEDICAID IG MEYER: On the referrals, we actually have a mandatory requirement now for the managed care plans to have a recipient restriction program. That's an adjunct to a long-running program that we've had. We work very closely with the plans in monitoring their recipient restriction programs.

SENATOR HANNON: What's a recipient restriction program?

ACTING MEDICAID IG MEYER: It's where a given recipient who might be shopping for drugs or whatever, they're restricted to a certain physician.

So that's something that we work on very closely with the plans and their special investigation units.

Senator, I missed the second half to that question. I heard the skyrocketing --

SENATOR HANNON: Just in terms of the appropriateness of the referrals to the MLTCs from either a CHHA or from a home health care

agency. Is that -- you haven't viewed that as your scope of duties.

ACTING MEDICAID IG MEYER: Yes, we have well over a thousand referrals to the plans per year. So there's a very active amount of interchange and referrals from the OMIG to the plans as well as to local districts and local law enforcement and prosecution.

SENATOR HANNON: Just switching topics entirely, there was a recent report that the number of guardianships initiated for nursing home recipients had been conducted -- the petitions to the courts had been conducted by nursing homes.

And the story centered on the fact that these petitions to the courts for guardianships of the nursing home patients were sometimes done with the intent and actual action of getting monies that the patient owed for nursing home care. And so the guardian was the person who was owed the

money. And I thought that that was fairly outrageous.

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Now, it may also be there's a totally legitimate reason -- that it's an isolated patient, there's no one else to take care of that person and they really do need a guardian. So it wasn't something that was black and white.

But I would just commend to you that that whole arena is something that you may want to look into. I know the Attorney General has, through the MFCU, some direct responsibility for nursing home patients. But you might be in a position to investigate it earlier.

ACTING MEDICAID IG MEYER: Thank you, Senator. We will definitely look into that. I'm certainly aware of the NAMI, or net asset monthly income stream. But I had not heard of that, so we can certainly look into that. I appreciate that.

SENATOR HANNON: I'll send you the article. It was in the Times. Nina Bernstein.

Thank you.

ASSEMBLYMAN OAKS: Assemblyman

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Abinanti.

ASSEMBLYMAN ABINANTI: Thank you.

Thank you for joining us today. Is

your task to just save money, or do you look at the quality of care being provided as well?

ACTING MEDICAID IG MEYER: We also certainly look at the quality of care.

ASSEMBLYMAN ABINANTI: I'd like to follow up on something that Senator Hannon touched on. I hear anecdotal reports that Medicaid managed care for people with special needs requires that patients be taken care of by doctors who have no experience in dealing with people with special needs, because the managed care plans don't have the appropriate doctors and don't have the appropriate staff.

Have you looked into that at all?

ACTING MEDICAID IG MEYER: Not specifically, Member Abinanti.

ASSEMBLYMAN ABINANTI: Well, there's a shortage of adult special care doctors. I didn't get a chance to ask the Health Department, but I wanted to ask them what

they were doing to increase the number of doctors who are familiar with people with special needs above, you know, the child level.

And so how do we deal with that when someone gets forced into a Medicaid managed care plan and there's no doctor in the plan that's familiar with somebody with special needs? I mean, do you look at that? Have

you seen whether they're charging for inappropriate care? Because if they don't have a doctor who's familiar with somebody with special needs, then the care is inappropriate.

ACTING MEDICAID IG MEYER: Certainly. Obviously the plan is responsible for a treatment plan within managed long term care, and they are responsible for providing the appropriate treatment that corresponds with --

ASSEMBLYMAN ABINANTI: But you haven't done any studies or looked at the issue of whether the types of doctors they're assigning to people are in fact appropriate?

ACTING MEDICAID IG MEYER: It's certainly something that our clinicians could come across in the -- like, for instance, we are currently doing eligibility audits in managed long term care. And as a function of that, there is a quality-of-care component where we do review the plan of care and make sure that --

ASSEMBLYMAN ABINANTI: Well, I would just ask that across the board you be aware of the fact that there is a shortage of these doctors and people are being assigned to plans where they don't have doctors who are appropriate.

The second thing -- and that goes for

psychologists and psychiatrists as well, because there's a shortage of psychiatrists in managed care plans.

So I don't know how they're charging for these services if they don't have people who are appropriate.

The second piece of this is the doctors and insurance companies who make determinations on whether care should be paid

for -- so again, managed-care plans -- often have no experience in the field that they're being asked to judge. Have you taken a look at that at all?

ACTING MEDICAID IG MEYER: Again, a lot of the credentialing that you're referring to is certainly performed by the department.

But as we perform audits and reviews, we do review the care that's provided and that it's done by the proper level of physician or expertise.

ASSEMBLYMAN ABINANTI: Look, I know of a specific case where there's a specialty hospital that provides one-of-a-kind care in this country, and the doctors who at the insurance company were supposedly ruling on whether it was appropriate care and how much should be paid, et cetera, et cetera, had no experience at all. They weren't pediatricians; this is a children's hospital.

They weren't familiar with special needs. They had no experience in the special needs field; this is a special needs hospital.

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They were, you know, doctors who dealt with adults, senior citizens or whatever.

I mean, when I heard the story I couldn't check it out, but I think that's your job to check it out. And I'm wondering if you don't even have a program to look to see who the gatekeepers are at the insurance companies, then we may very well be paying a lot of money for inappropriate care because the insurance companies are shunting patients off to doctors who are not appropriate for those particular patients.

And this is one of the fears that people have with using Medicaid managed care for people with special needs. So I would hope your department would start to look at the appropriateness, and that may be one way we can spur insurance companies and managed care plans to hire appropriate doctors and medical providers.

ACTING MEDICAID IG MEYER: Thank you.

ASSEMBLYMAN ABINANTI: Thank you very much.

CHAIRMAN FARRELL: Thank you.

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Senator?

SENATOR KRUEGER: Senator Diane Savino.

SENATOR SAVINO: Thank you, Senator Krueger.

Good afternoon, Mr. Meyer. I will be brief. I just have a question on the social adult daycare program.

Three or four years ago, working with Jim Introne -- when he was still at the Department of Health -- and the department, we brought to light some concerns we had about this proliferation of social adult daycare programs that were popping up, particularly in communities where you had a high population of seniors for whom English was not their first language.

I represent Brighton Beach and Coney Island, and at the time Sunset Park. We were seeing them all over: Sunset Park, in the Chinese community, and in the Russian community in Coney Island and Brighton Beach.

Some efforts were made to crack down on it, and I worked with the City of

New York. And two of the City Council members passed companion legislation to provide greater oversight over these programs in the City of New York, because they were draining healthy seniors out of DFTA-licensed senior centers and enrolling them in these social adult daycare -- which really were,

for all intents and purposes, a senior center. They were not doing what they were intended to do under the law.

And there's been tremendous improvement, but I'm seeing them pop up again now -- two have recently opened in my district -- and I'm concerned that there's a lack of the necessary oversight. So the question I have is when I see one open up, who do I report it to? Do I go to DFTA in the City of New York? Should I contact your office? Should I speak to the Department of Health, SOFA? Where should I take my concern when I'm seeing healthy seniors going to a social adult daycare program, which really is nothing more than a senior center being paid for by Medicaid?

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ACTING MEDICAID IG MEYER: Thank you, Senator.

Any suspicion along the lines of improper practice or fraud, you can absolutely bring those to us at the OMIG.

SENATOR SAVINO: Thank you. That's it.

CHAIRMAN FARRELL: Assemblyman Goodell.

ASSEMBLYMAN GOODELL: Thank you.

As you know, over the last couple of years the state has reduced the Medicaid share or capped the Medicaid share for

counties, so now counties don't pay more each year, they're at a flat rate.

One of the side effects of that is that they don't get any advantage from participating in Medicaid fraud investigations. They could recover millions of dollars, and their fee is still the same.

Is there any attempt to provide an incentive to enhance the counties' participation in Medicaid fraud, and would you find that helpful?

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ACTING MEDICAID IG MEYER: Yes. Actually, we have a very active county demonstration program. You know, as I understand, it was actually begun in lieu of the very point that you raised, to keep a fraud incentive in place for the counties.

So the counties that participate in the program are essentially our agents. And as they pursue provider fraud, waste and abuse, they incur expenses as part of that. But then where they actually have recoveries, they get to keep a portion of the net proceeds of their activities.

ASSEMBLYMAN GOODELL: Based on your experience with the demonstration program, should we extend it statewide?

ACTING MEDICAID IG MEYER: I think it really -- you could certainly extend the invitation, which is essentially there. It

really comes down to the county's own sense of value for them and their ability to actually perform within the demonstration context.

Some counties do better than others,

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some have participants and essentially dropped out -- but there are a core set of counties that are very active.

ASSEMBLYMAN GOODELL: As you know, the state is taking over the process of evaluating Medicaid applications from potential patients, I guess, or participants. And that's the other side, presumably, of Medicaid fraud, provider on one side and the individual who's seeking it.

Are you developing protocols to be used by the State Health Department so that they can minimize the number of applicants who might have hidden assets or income?

ACTING MEDICAID IG MEYER: We definitely work with the Department of Health and their enrollment folks. There's, you know, a great deal of activity that occurs relative to recipients and enrollment.

We typically refer many of those cases to local law enforcement, local prosecution, in some cases, the local districts -- in particular, HRA in New York City. So we have a very active relationship with the

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Department of Health and the enrollment activities in pursuing improper enrollments.

ASSEMBLYMAN GOODELL: One of the proposals in this year's budget deals with spousal refusal. As you know, that's where one spouse refuses to cover the healthcare of a different spouse. What role does your office play in that area of spousal refusal, if any? And secondarily, if we eliminate that as an exemption, will we see problems cropping up in other areas, in your estimation?

ACTING MEDICAID IG MEYER: Well, we -- historically a state recovery was performed by the local districts, and it is transitioning to a centralized state role. That's an active in-process transition. You know, obviously we recover and set our activities consistent with whatever the laws are that are in place.

So, you know, obviously we would make an adjustment if that law were to be passed. You know, I really couldn't speak to any unintended consequences of the law being

passed.

ASSEMBLYMAN GOODELL: In terms of the percentage of time and resources that your office devotes to Medicaid fraud, what percentage, roughly, goes toward rooting out Medicaid fraud from providers and what

percent would you estimate goes to detecting and stopping Medicaid fraud from applicants?

ACTING MEDICAID IG MEYER: I don't have those specific statistics at hand, but we could certainly look at how our FTEs are apportioned and provide that number for you.

ASSEMBLYMAN GOODELL: Do you have a rough sense? I mean, is it more on provider side, more on recipient side? What's your rough sense?

ACTING MEDICAID IG MEYER: My rough sense is there's more toward the provider side. But you also have to take into account all of our partners at the local districts and local law enforcement. So, you know, to some degree it's not just about our own specific FTEs.

ASSEMBLYMAN GOODELL: If you could

send that to me, I'd appreciate it. Thank you very much for your responses.

SENATOR KRUEGER: Senator Kemp Hannon.

SENATOR HANNON: Mr. Meyer, two things.

In some of the charts that were submitted as part of the budget, they list a savings on an OMIG initiative, a savings of $2 million. Our inquiries as to what the OMIG initiative consisted of had the vague response of, well, furthering the mission of OMIG. I wonder if you could detail what the

$2 million of savings would be from your agency's activities.

ACTING MEDICAID IG MEYER: I -- I believe -- it's hard for me to know specifically the reference you're making, Senator, but I think it was estimated savings for some of the focused work we would perform in the next budget year. I would need to double-check exactly what those initiatives would be.

SENATOR HANNON: There's not a lot of mention of you, so that was -- I think it

would be relatively easy to find. And I would appreciate that.

ACTING MEDICAID IG MEYER: Absolutely.

SENATOR HANNON: There's a whole other discussion that I could have had, but I would have taken Assemblyman Farrell's patience and really pinned it against the wall, and that's in regard to the global cap.

CHAIRMAN FARRELL: (Laughing.) That's all right. Keep going.

SENATOR HANNON: But there is one aspect of the global cap that's really intriguing. Now, the global cap usually deals with a target that we set and try to stay within in regard to Medicaid spending. But in your budget it says you're going to move I think 20 or 26 members of your staff under the global cap.

And I'm wondering how is this keeping in harmony with the spirit of the global cap. Is this just taking money that otherwise would be in your budget and putting it under the global cap? I find little rationale for this whole thing.

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ACTING MEDICAID IG MEYER: Some of that came up through discussions between ourselves, OMIG and OHIP and Jason Helgerson. It's really in recognition of the fact that, you know, with the efforts to stay under the global cap, that OMIG's activities are part and parcel with the state's ability to do that.

So we've created new ways, you know, where they feel they need additional assistance with some of their new programs and directions. We've basically partnered to target some of our specific activities in those directions and align them.

SENATOR HANNON: Are you taking on a new endeavor in regard to the Department of Health and your involvement in its Medicaid program?

ACTING MEDICAID IG MEYER: Well, I suppose -- you know, we -- obviously, where the program goes, we go.

We are certainly focusing on expanding the activities and the depth of the activities we perform in managed care. We've

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begun to actually do tangible tasks in support of DSRIP and the PPSs. We're vetting some of the provider networks for the PPSs, ensuring that the attestations for those network providers are in fact in place, and beginning to work with the PPSs on adequate compliance programs.

So we are specifically working with them on some of their new directions.

SENATOR HANNON: Last year's budget had increased the amount of recovery monies available to counties who were helping you, from 10 percent to 20 percent. Has there been any results of that change in the budget?

THE SPEAKER: It would be hard -- you mean -- each year the county demo tends to be unique. You know, I can report that we actually did just cut checks for two counties. So there are counties that are receiving monies based on the new percentages.

And, you know, we are looking, we feel we've made a tremendous amount of improvement

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in the county demonstration project, eliminated all the backlogs we had in terms of reviewing county work. So we feel that we have a clean slate, if you will, and we are

looking for, you know, increased productivity and activity by the counties. In fact, I think just the year past we actually had the highest recovery number to date for the county demonstration program.

SENATOR HANNON: Well, that's great. And the backlog I know had been a thorn in people's side. And so if you could continue that, that would be great.

ACTING MEDICAID IG MEYER: Thank you, Senator.

SENATOR HANNON: Thank you.

SENATOR KRUEGER: Assemblyman.

CHAIRMAN FARRELL: Questions?

SENATOR KRUEGER: I believe we're done with the questions for you. Thank you very much.

SENATOR HANNON: Thank you, Mr. Meyer.

SENATOR KRUEGER: And our next testifier is Dennis Whalen, president, HANYS.

MR. WHALEN: Good afternoon, and thank you for the opportunity to testify today. We've submitted our formal testimony, but I'm going to summarize its contents and make a few points.

The Governor proposes strong, positive investments in healthcare, and we support those investments because they are necessary to transform our system and to ensure that access to care is preserved across the state.

And in areas of great need, such as capital, arguments can be made to provide even more resources to meet the needs.

We are concerned with certain aspects of the budget, particularly those areas where there may be overreaching, such as in payment reform, and areas where there may be underreaching, such as in missed opportunities for regulatory relief.

As you review the Executive Budget and develop your proposed budgets, I ask that you consider the current state of healthcare and the best pathway to achieve the goals to which we all aspire. I want to make a few

comments in that regard.

The first is that the pace, the breadth, and the depth of the change that is underway in healthcare is intense and is creating the highest level of challenge that we have faced. Hospitals and health systems are eagerly embracing transformation. They're committed to achieving the "Triple Aim" -- to provide the best and safest care in the most efficient manner to improve population health.

I worry for some that the Triple Aim may imply there is a cookie-cutter, one-size-fits-all approach where all hospitals are large systems, or hospitals become or merge with insurers, or the need

for academic medicine is diminished, or smaller community hospitals are always converted to outpatient centers or other uses, or there's a reduced need for long-term-care resources.

But the fact is that in a state as diverse as New York, we need a diverse healthcare delivery system to ensure access

to high-quality care is available to meet the needs of our diverse communities and our diverse populations.

Our challenge is to ensure that while transforming, we create sustainable structures of care and models of delivery. And we must continually test to ensure whether adequate resources are applied to enable transformation and, importantly, to make certain that the degree of change underway is appropriate.

So I want to make some quick observations on the landscape in New York for hospitals and health systems.

Number one, our hospitals and health systems are extraordinarily dedicated and committed to high-quality care. We've just completed a three-year Partnership for Patients program, a federally sponsored program, and hospitals working in that program reduced preventable hospital-acquired conditions by 40 percent and preventable

readmissions by 20 percent.

New York's efforts, the efforts of

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New York's hospitals in this program, achieved national recognition from the Department of Health and Human Services. And our work to improve even further, of course, is continuing.

The second point is our hospitals and health systems are transforming themselves. We have committed to control costs and stay under the Medicaid cap. Virtually every hospital in the state is participating in the DSRIP program. Hospitals and health systems across New York are participating in the Medicaid shared-savings and pioneer ACO programs or Medicare bundling projects, and innovative payment approaches working with their own commercial payers.

And hospitals and health systems are innovating new models of care such as increased outpatient services, use of telehealth, development of freestanding departments and models of partnership and affiliation.

The third point is our hospitals and health systems are vital to New York State.

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We are ready 24/7/365 to respond to emergencies, disease, trauma and to new emerging threats to public health, such as

demonstrated by New York's striking response to Ebola. Our hospitals and health systems are expected to be ever-ready, and we are.

And we also are typically the largest employers in our regions, cities, and counties and are thus a keystone in our economic infrastructure.

And yet, fourth point, our healthcare system in New York is fragile. Our hospitals have the third-worst operating margins in the United States. We are far below the national average. I think about half of our hospitals have negative operating margins. We have 27 hospitals across the state that are receiving Interim Access Assurance Funding through the Medicaid waiver program to ensure that they can continue to provide services, and many more are borderline-eligible.

And then, importantly -- and it's an aspect I know that doesn't get commonly

viewed, but over the next 10 years there are already $27 billion in federal cuts that have been enacted and will be implemented during those 10 years, taking those monies out of New York hospitals and health systems.

So our challenge is really how to reconcile the current state with our goals so that we can chart the right path forward. Our testimony goes into details; I wanted to

make just four essential points.

First is that we strongly support the Governor's proposed investments in capital and the Vital Access program, the establishment of a quality pool allowing the expiration of Medicaid cuts from previous years and, importantly, ensuring that the promises made, the commitments made in last year's budget are fulfilled.

Second, given the intense capital needs throughout our entire state healthcare system in all sectors, a greater investment in capital is justified.

Third is we need a better understanding of a clear and comprehensive

plan that describes what all these initiatives are doing and what the overarching logic is. And in doing that, we have to pay attention to several points.

One is to make sure we are testing what the system's ability to process and absorb change is, and the degree of flexibility that is provided, because institutions are not all the same. They may have the same goals, but their ability to act on those is different.

I think we should recognize that there may be such a thing as a saturation point beyond which destabilization may occur with all of these changes that are underway.

We also have so many initiatives underway that interact and intersect in various ways. And when you look at these at some points, you can see where there are countervailing forces where it seems there are internal inconsistencies with what providers are being asked to do.

And there is a need for stability and predictability as change is undertaken.

And my fourth point is one that I have made previously, and that is change is not only for the hospitals and health systems but for the state as well. So at nearly every turn we are faced with 21st-century problems and challenges but with 20th-century regulations, policies, and agency practices.

So the degree of flexibility and the innovative approach needed as we transform requires serious attention. Rigid, one-size-fits-all mandatory approaches need to be changed. We need a level playing field with regulatory relief and flexible approaches to encourage, not to hinder, the transformation that's underway.

Thank you, and I'm happy to try to answer any questions you have.

SENATOR HANNON: Thank you, Mr. Whalen.

Your point about change, not only do I have some apprehension, major apprehension

about the changes that are being asked about those who deliver healthcare, but I am concerned that people outside of the arena of

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healthcare don't understand the incredible amount of change that's being asked to take place and don't understand what's going to happen.

I keep on reflecting on my fellow legislators' concerns whenever there's a change in a hospital or a clinic in their district, reacting as if everything is not going to work out. And yet we have a program that's going on that calls for its stated goal to reduce hospital admissions by 25 percent in five years -- now, actually, four years.

Well, if you reduce hospital admissions, you are going to have some places that are almost empty or more empty than they are now, if that could be a logical thing. Because when I say more empty, there are places that are 50 percent empty, 60 percent empty. Looking at the statistics, some hospitals -- good hospitals -- are only -- they have a vacancy rate of 25 percent.

So what will happen to the general public? Do you think that there is a

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capability for the hospitals and nursing

homes you represent to communicate what's happening to the public? Or are they just so energized with "Oh, my lord, if we don't do this, we're going to be left behind, we won't participate in the billions of dollars that are coming through the federal waiver"?

And so that's a -- it's a really conceptual problem, but it's I think real.

MR. WHALEN: Yeah. Look, I think that's a challenge. And, you know, I want to make it clear that it's not only reform that is being pushed by government that's creating change. You know, clinical advancements, use of technology is also changing, and that creates pressure on providers to change the way services are provided. And patients are becoming, you know, empowered with available data and information. You know, huge emphasis on the convenience associated with obtaining services.

And so you're seeing hospitals and health systems react to that in a variety of ways. Some of it is under the label of the

programs sponsored by the state, but every institution in New York understands that pursuit of quality and patient safety is job one and understands that that information will be measured, and reimbursement will be based on it, and there will be transparency making that information available.

That will occur over a period of time, but systems in pursuit of efficiency and those goals are changing on their own, aside from a DSRIP program or a PPS participation or what Medicare may be doing. That means that the way services are delivered change. And, you know, so you do often have these disruptive conversations in communities when the perception is that, you know, significant change in your institution means there will be less access to services -- when in fact it may mean there will be more convenient or better access to services and higher-quality services and more efficient services.

But my point really was that we are not having a conversation in those broad terms. It's very segmented, related to the

individual programs that government might be undertaking at the time. And we need a more cohesive statement of policy and explanation in terms of where the state is headed and what the goals are.

SENATOR HANNON: You heard my question for Mr. Helgerson about we need a conceptual approach to construction money. I mean, I would think that would be part of this overall approach that you're speaking about, so we have a set of expectations on healthcare providers and a set of opportunities. And they don't have to be

one-size-fits-all, but they have to be there that's transparent, and not just, well, someone submitted a good application and it looked fine and it was a need, and then the question is how does that fit into the rest of the checkerboard that's New York State with different needs.

MR. WHALEN: I think that's correct. I mean, in the instance of those two projects there's no doubt in my mind that there is a need in Central Brooklyn for investment on

the capital side. You know, I think New York has the ninth oldest infrastructure in healthcare in the United States. And, you know, some of this is a legacy of our rate-setting system where access to capital was very controlled. And, you know, investment is needed.

You know, you look at the situation in Oneida County where, as Jason explained, you have some aging infrastructure. But, you know, the important elements I think of what they were talking about there was, you know, not simply the replacement of aging facilities, but this is facilities coming together, downsizing -- so a smaller inpatient footprint, larger outpatient footprint, moving some services outside the hospital. So, you know, I think at their essence those projects are good ones.

The process of naming them in the budget is an uncommon event, and I'm sure there's a better way to do that.

SENATOR HANNON: Let me shift a lot. That was a very small mention by

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Mr. Helgerson about value-based purchasing. A concept which is new to some, because we always have paid based on a transaction basis, unless of course you're given they call capitation and giving so much of a per member per month for general healthcare.

But value-based purchasing has not been a foundation for reimbursing those who provide healthcare. Do you have an understanding what exactly it is? Do you have an understanding as to how we would progress on it? I thought it was perhaps just idealistic health policy planners who were thinking of a new system -- you know, we used to have DRGs and then we had ABGs, and now we have value-based purchasing.

But then I saw an article over the weekend that Anthem Health Insurance is endorsing it mightily. And I thought, wait a minute, okay, that's a whole different side of the coin for value-based purchasing.

And I just wondered if you think there's enough "there" there to find progress to go forward, or perhaps -- and my thought

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was maybe we should have pilots the way the federal government did before it started to propose value-based purchasing for Medicare.

MR. WHALEN: I think the underlying health policy approach is a sound one. So moving from a system that incentivizes production and the number of, you know, interactions with a patient that you might have -- so a volume-drive system, the more you do, the more reimbursement you receive -- to one where reimbursement is more based on outcome. You know, how appropriate was the service provided, was it of high quality, was it efficiently provided.

You know, how you get there -- there's a lot of value-based purchasing going on already. You mentioned the federal government approaches, and lots of institutions in New York are participating in those programs. Many are participating with their own insurers on the basis of negotiation between the hospital or health system and their local healthcare payor.

And I think this is an area for

development. You know, still if you looked at it, you know, we're probably still substantially volume-based. But it is this switch.

And, you know, part of your earlier question about how systems and hospitals are

responding to that includes a very big focus on moving to risk-based approaches. So hospitals going at risk -- you know, the old wording would be a capitation or a partial capitation approach to provide those services -- because they see that ability to manage care as significant. Which is clearly a form of value-based approach.

So our understanding is that the state on the Medicaid side, as part of the waiver needs to get substantially to value-based purchasing by the end of the five-year waiver.

And there's a workgroup, we had the first meeting a couple of weeks ago, where it's clear the department wants to do this in a consultative process and talk about the best models for doing this.

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Part of the concern are those that I stated: you know, how quickly does it happen, how flexible is the approach, is this mandatory, how will it work?

A greater concern is that a separate program -- the State Health Innovation Plan -- talks about wanting to do what has been done with DSRIP on the commercial insurance side. And there's a lot of concern about that on the part of providers and payors both. You know, what's the reason for that? You know, as everybody here knows, we

have a pretty delicately balanced system where, you know, Medicare and Medicaid underpay providers -- I mean, you can hear MedPAC talk about that every year. And so the way our balancing system works is that negotiations on the commercial side enable that to occur without people, you know, going bankrupt.

And that's a -- you know, that's part of my point about the great number of things underway and, you know, inconsistencies within each of these approaches, almost a

nonrecognition of the impact of what one approach will have on the basis of the other.

SENATOR HANNON: Thank you. I think my time has expired at the moment.

CHAIRMAN FARRELL: Assemblyman Abinanti.

ASSEMBLYMAN ABINANTI: Thank you, Mr. Chairman.

I'd like to talk just for a couple of minutes with you about a subject I've been raising with most of the presenters, and that's special-needs patients. I notice that you touch on it on page 11 of your presentation, and then again on page 15.

On page 11 you talk about CMS disallowance of OPWDD Medicaid costs. And am I understanding you correctly that you are concerned that a $1.26 billion federal

proposed reclaiming of monies could be shifted to the providers?

MR. WHALEN: That's correct.

ASSEMBLYMAN ABINANTI: And that the $850 million that's being set aside is nowhere near enough?

MR. WHALEN: Well, the state is currently undergoing its appeal process. So I think the first -- well, let me back up. So in the past we have made adjustments already under the Medicaid global cap when the federal government first challenged New York's approach for funding these services. In anticipation of a prospective decrease in that funding, dollars were withdrawn from the cap to provide a smoother pathway for agencies providing those services.

We now -- they then came back and did another set of audits, and the proposal in the budget is to, as part of that reserve set-aside, say that while we are going through the appeals process -- and there are, I think, three levels of that. We've gone through the first one, we're now in the second. You know, if that hits in the middle of a year, we'd like to have some plan to anticipate that reduction so it doesn't provide the need for extreme reductions in the middle a fiscal year.

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ASSEMBLYMAN ABINANTI: How is the clawback tied to the providers that you represent? Is there a claim that your providers overbilled?

MR. WHALEN: No, they're not our providers, they're providers under the Office of Persons With Developmental Disabilities. But all of these dollars come out of the Medicaid cap. So conceivably, any provider who receives reimbursement under the Medicaid cap, if there's a need for extreme solutions, would suffer that.

ASSEMBLYMAN ABINANTI: Now, under the Medicaid cap, were your providers consulted in setting that cap?

MR. WHALEN: It was a part of a negotiation that set up a formula that relies on the Consumer Price Index, the medical component of the Consumer Price Index, with a 10-year rolling average.

We have some concerns generally about the cap and how transparent the calculations are that demonstrate where those dollars are going.

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ASSEMBLYMAN ABINANTI: Well, now jumping to page 15, how does Medicare managed care reform fit in with the cap? It seems to me that we're pushing more and more people

into certain types of Medicaid services, if you would.

MR. WHALEN: Yes. Yeah, you'll hear the state talk about managed care for all. So populations and individuals who may previously have been exempt from Medicaid managed care no longer are, and they now must receive services through Medicaid managed care. Those aren't our providers.

ASSEMBLYMAN ABINANTI: Again. Well, aren't your providers going to have to provide coverage or services for people under managed care if they need the services at your facilities?

MR. WHALEN: Yes. In fact, most are at the moment.

But I think the concerns that you had raised earlier might best be raised with the Office of Mental Health or Office of Persons With Developmental Disabilities that offer

those specialized services for those populations. Those were populations that were previously exempt from managed care.

ASSEMBLYMAN ABINANTI: No, I'm aware of the issue, I'm just trying to see how it fits in with what you do.

I mean, if somebody with a -- let's say a special disability ends up in one of your hospitals and you don't have a physician who's experienced at dealing with an adult

with special needs, what do you do?

MR. WHALEN: Typically hospitals will handle that by ensuring that the patient gets referred to the appropriate provider that does have those specialty services.

ASSEMBLYMAN ABINANTI: Okay. Now, you talked about the -- you have some suggestions here under Medicaid managed care to provide coverage for court-ordered behavioral health, et cetera, et cetera.

MR. WHALEN: Yes.

ASSEMBLYMAN ABINANTI: These proposals would require legislation?

MR. WHALEN: They would.

ASSEMBLYMAN ABINANTI: Okay. And what about under the behavioral health area at the bottom of the page? Would that require legislation too?

MR. WHALEN: I'm sorry, Assemblyman?

ASSEMBLYMAN ABINANTI: You have some concerns that you express about behavioral health, and I would respectfully suggest that these are very vague. It looks like you're dancing around what might be a real problem and just trying to allude to it. How do we address your concerns there?

MR. WHALEN: Sure. We can provide you with more detail. We've done a couple of reports on the transition of behavioral health into Medicaid managed care. And some

of that is regulatory, so disconnects between different agencies that may be licensing or approving providers.

Some of it, as you noted, is the court-ordered situation where there have been disputes between the provider and the insurer over whether a court-ordered treatment is sufficient to ensure payment. You know, some

have taken the position we need a clinical assessment. So even if a court orders treatment to be provided, then there have been some disputes on the part of the payors to --

ASSEMBLYMAN ABINANTI: I would be very pleased to work with you on this if you can forward stuff to my office.

MR. WHALEN: Absolutely.

ASSEMBLYMAN ABINANTI: I'm very concerned that we're seeing a diminution of healthcare provided to people who are not getting sufficient healthcare already.

MR. WHALEN: Be happy to.

ASSEMBLYMAN ABINANTI: So thank you very much.

MR. WHALEN: Thank you.

CHAIRMAN DeFRANCISCO: Senator Krueger.

SENATOR KRUEGER: Thank you.

Nice to see you, Dennis.

MR. WHALEN: Good to see you, Senator.

SENATOR KRUEGER: A variation on that last question. I get complaints -- and

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again, I'm from the East Side of Manhattan and I know that doctor and hospital issues really vary geographically. I get complaints from Medicare patients -- not Medicaid, but Medicare patients that it's harder and harder to get doctors to see them as patients.

Now, granted, in-hospital is different than private patient. But I'm wondering if you're tracking any patterns of issues for use of Medicare utilization. And is there something the state could do, since that's a federal program?

MR. WHALEN: Senator, I have to go back and check to see if we have any specific information. I mean, generally there has been continuing concern among physicians and other providers about some of the changes underway in terms of limitations on reimbursement, new rules that have come out.

And, you know, when I referenced that $27 billion of cuts, for example, that hospitals will face over the next 10 years -- already on the books, so enacted by Congress -- you know, in some ways when the

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ACA was passed, you know, the theory was at the time that everybody knew what the all-in cost was, so what reductions are you going to

take as a result of providing increased insurance coverage. But, you know, then with each challenge that comes along, whether it's the debt ceiling or sequestration or the doc fix, you know, additional cuts are undertaken.

So you know, the doc fix, so-called, is a provision in federal law where physicians can face a 20 to 25 percent reduction in Medicare payments. The solution has been sought for a long time to permanently fix that, but instead it turns out to be a year-by-year battle. So I'm sure for some physicians it's that degree of uncertainty about what might happen that causes them to withdraw from the Medicare program. But I'll take a look to see if we have anything specific.

SENATOR KRUEGER: Thank you very much.

Thank you.

ASSEMBLYMAN OAKS: Assemblyman

Goodell.

ASSEMBLYMAN GOODELL: Thank you very much for your testimony.

I'm particularly concerned about the financial state of our hospitals. You testified that 75 percent of them are in fair to poor condition, and you said 26, is that correct, are getting direct financial state aid?

MR. WHALEN: That's correct.

ASSEMBLYMAN GOODELL: And you testified that Medicaid and Medicare pay less than actual cost for these hospitals.

MR. WHALEN: That's right.

ASSEMBLYMAN GOODELL: So Medicaid pays less than actual cost, we may cut it off by trying to get a premium, if you will, from private insurance.

MR. WHALEN: To some degree, yeah.

ASSEMBLYMAN GOODELL: That drives up the cost of private insurance, which causes employers to implement high-deductible plans, which results in higher bad debt and charities for the hospitals because people

can't make the deductible. And that is then reimbursed to hospitals indirectly through HCRA or through assessments.

MR. WHALEN: To some degree, correct.

ASSEMBLYMAN GOODELL: To some degree. And those HCRA assessments are paid for by higher taxes on the healthcare industry itself.

I mean, it seems to me we have kind of like a death spiral here for the insurance coverage industry as well as for hospitals.

Wouldn't it make more financial sense of, instead of using these convoluted mechanisms of paying for bad debt and charity that's resulting as a result of our

underpayment in the first place, simply to increase the Medicaid costs? And if we did that, could we do it on a zero-sum basis?

MR. WHALEN: Well, I think this is part of the challenge that's involved in the work that's underway at the moment. You know, part of this is a legacy of old systems and the way that healthcare payments developed in New York, our switchover from

the highly regulated system where for a number of years the state set reimbursement rates for not only Medicare but also for commercial insurance. Then we went to the negotiated system that, when that was created, also put into place a number of these provisions to try and ensure that certain types of services or certain supports, what were deemed to be public goods, continued to be supported.

But, you know, my point earlier to Senator Hannon I think applies. And that is as all of this transformation occurs, as we get new clinical approaches, as we get the ability to process data in real time to support treatment decisions, and all of these things change, we should be certain to be having the kind of overarching policy discussion that you're suggesting, rather than changing each little piece along the way. Because without the coherent policy, we

may end up in a place that's not any better than where we are.

ASSEMBLYMAN GOODELL: I'm particularly

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mindful of the fact that a number of years ago we went and implemented a time-consuming and complex CON process. And that made perfect logical sense at a time when we were on a cost-based system, because if you're getting cost-plus, obviously the state has a vested interest in controlling your base costs.

But we haven't been in a cost-plus system for decades, yet we still have a complex CON process. If we're no longer in a cost-based system, is there a public policy rationale for the CON process itself? Shouldn't we look at ways of streamlining hospital operations in an effort to make them more efficient and cost-effective? CON, perhaps, physician recruitment? I mean, gracious, I've seen where it takes nine months or a year to recruit a physician who's board-certified in another state.

And do you have a list, if you will, of areas that cost us tremendous amounts of money in time and cash that are the result of an old system that no longer makes sense?

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MR. WHALEN: Yes to all of those -- to

all of those points. We have a couple of publications, Tangled Up in Rules and Tangled Up in Rules Volume 2, that talk about rules that no longer make sense. There are some very modest streamlining of CON requirements that are proposed in the budget, but those are baby steps. I think greater regulatory relief can be provided to good effect.

You know, we are always concerned also, Assemblyman Goodell, about the un-level playing field. So that as there are new entrants into healthcare -- so, you know, the presence of retail and clinics that you may see at pharmacies and other places appear -- we want to ensure that hospitals are not held to some different set of rules about how you could essentially, you know, open and provide the same service.

But we will get your office that information.

ASSEMBLYMAN GOODELL: I appreciated your testimony earlier about supporting outcome-based funding. And conceptually I

find it very intriguing and very attractive. Here's my concern. If you have a hospital that has poor outcomes because it lacks the capital investment or the funds needed to provide higher outcomes, don't you then create a death spiral if you provide higher funding for hospitals that have all the

equipment and provide the best service, and less funding for those hospitals that may be the most desperate for funding?

And I am also mindful of the opposite, which is where we, you know, where we have that theory no good deed goes unpunished, and the flip side is we reward incompetency.

So can you just address how do we deal with those two dilemmas?

MR. WHALEN: I think it's through smart policymaking and implementation of programs.

So my point on the diversity of the system and then meeting the diverse needs of communities was exactly that. There are institutions in New York that don't have a problem accessing the capital market, and

then there are places that have an extreme difficulty in attracting capital investment. And we need to be smart about this and not thinking that necessarily the solution to a problem is automatically that a stronger institution takes over a weaker one. It may be the answer, but there may be, you know, unique community needs, the knowledge of that set of providers in serving that community over a longer period, that makes the better choice be to strengthen the community hospital that's there now.

You know, everyone will want to be at

the point where they are providing the highest-quality efficient services. And every hospital administrator knows that that information is now being measured by the federal government, by the state government, by other entities, whether it's Leapfrog or all the various scorecards that you might hear about. And, you know, absolutely making sure that we have a policy approach that understands and tries to figure out what the right solution is, and then having the

flexibility to provide the resources necessary to accomplish that, I think is the challenge.

ASSEMBLYMAN GOODELL: Thank you very much.

ASSEMBLYMAN OAKS: Thank you. We've been joined by Assemblywoman Wozniak.

CHAIRMAN DeFRANCISCO: Senator Hannon has a question.

SENATOR HANNON: What would the speed be that you would see us adopting value-based purchasing?

MR. WHALEN: Well, I think it's underway already. Now, the waiver talks about within five years making progress toward value-based purchasing --

SENATOR HANNON: Let me get a little more pointed. The budget proposes we give blanket authority to the administration to

determine it.

MR. WHALEN: You know, we've asked some questions about that to try and understand what's behind that request. And obviously the concern would be is that

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related to SHIP, is that related to this other process where we're underway with discussions amongst stakeholders now with the department to try and come up with the right approach?

Under the waiver, the department is required to provide a roadmap for approval to CMS sometime within the next several months where they lay out what their approach will be over the five-year period to reach, you know, toward moving to that 90 percent target of value-based purchasing. So I think, you know, we -- and I'm sure you as well -- want to sort of understand how does all this fit in in terms of the need for the authority. That's just a question we've asked.

SENATOR HANNON: Well, we're going to be looking for input. But in the old days, some parts of roadmaps used to have an area marked as "Terra Incognita."

(Laughter.)

CHAIRMAN DeFRANCISCO: All right, I'll close very quickly. You mentioned the examples of Brooklyn getting $700 million and

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Utica 400, I think --

SENATOR HANNON: Three hundred.

CHAIRMAN DeFRANCISCO: -- 300, and then this rural undefined area. It almost seems like healthcare is becoming a competition. If you can get somebody's attention with a unique program, you can even get under the wire before the wire is taken down.

And the whole DSRIP situation, it seems like people are going around trying to come up with what they believe the state is looking for. Sometimes they're right, sometimes they're wrong, sometimes they have to jump from one group to another group to be more -- I mean, and it's almost like you go through all your consultants and they can do their weighing, but it's a competition. And somebody, usually one person, is the one who's going to make the decision.

Now, when you were in the state government, how were these type of operations -- you know, what was the scenario when things like this money had to be

distributed for capital or whatever, how was it determined who gets what without competition? Or maybe there was then, too. I was here, but I didn't know what I was doing then.

MR. WHALEN: Yeah. I mean, there were

a number of approaches over the years. I can remember programs that established a set of criteria, and then there was a process by which institutions that met that criteria could come in and file a simple application. And if you met the criteria, you received an award.

Others were competitive. And the usual process of trying to figure out, okay, what was the more deserving or worthy. Some were regionally based. And so I think there was a wide variety of approaches.

You know, the need -- the need for capital is intense because, you know, as I say, we have aging facilities. They are asked to reinvent themselves and to innovate and to change the way services are delivered from inpatient to start to focus on

outpatient. But, you know, if you have a facility you have an overhead. That's part of your obligation. And if you're not able to get to the capital market, then that's a problem.

So Senator Hannon I think may have made points earlier about what's the right use of capital. Is it just -- if it's just hard capital dollars, you're pretty constrained in how you can use those. But, you know, in the past the state used innovative means to maybe find insurance for

capital deals to work through SONYMA and DASNY to try to figure out how to leverage a dollar so that the private capital market became more attracted to healthcare deals.

Also, you know, balance-sheet relief. So if a smaller, weaker institution in fact wants a partner, oftentimes the rate-limiting step is a poor balance sheet. And the stronger institution is worried about their own balance sheet and doesn't want to, you know, mess that up.

So, you know, solving some of those

balance-sheet problems so it's a more equitable sort of partnership I think would also be a good way to think about using some of these dollars.

CHAIRMAN DeFRANCISCO: Thank you.

MR. WHALEN: Thank you.

CHAIRMAN DeFRANCISCO: David Rich, senior vice president of the Greater New York Hospital Association.

MR. RICH: Good afternoon. Thank you so much for allowing me to testify today. As was mentioned, I'm David Rich with the Greater New York Hospital Association.

You have our detailed written testimony, and I'm just really going to go over a few points. But I did want to point at the end we have a table that goes through many of the different Executive Budget

provisions that apply to hospitals and all of our positions on them. So hopefully you will find that helpful as you go through your budget deliberations.

You've heard a lot already today about all of the huge changes going on in the

hospital community, all of the reforms that are happening, all the challenges that they're taking on to transform, to reform. So I won't belabor any of that, because I'm sure you would appreciate me being as brief as I can.

But I would like to say and point out -- and some of the last interaction between Dennis Whalen and members of the committee referenced this -- New York hospitals are in critical need of financial support. Numerous hospitals across the state are on a watch list for closure. The reason for hospitals' financial distress are many and will likely persist for some time. While these include the obvious, such as the changing healthcare environment, all the different reforms we've been talking today, the government has also played a large role in the hospital sector's declining financial stability.

The federal government, for example, as Dennis mentioned, has cut Medicare reimbursement rates repeatedly since 2010.

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At the state level, the previous administration slashed Medicaid rates for many safety-net hospitals, which directly resulted in some of the closures that we've seen in the inner city in particular.

Medicaid rates were cut by 2 percent until they were restored in last year's budget. Thank you for doing that. But as Senator DeFrancisco correctly pointed out, unfortunately none of us have felt that yet because the federal government hasn't approved it.

There's been no inflation update provided for seven years.

And so the cumulative effect of these actions is that aggregate Medicaid payments cover only 72 percent of hospital costs of caring for Medicaid patients. What that means is for every dollar of cost that a hospital incurs taking care of a Medicaid patient, they only receive 72 cents. Now, on the inpatient side it's 91 cents, but on the outpatient side it's only 61 cents.

So because of that, we have

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considerable concern about the long-term viability of safety-net providers whose Medicaid reimbursement rates have eroded in value so significantly over the years.

Safety-net providers who rely on Medicaid and Medicare for the vast majority of their funding cannot continue to lose money on each and every Medicaid and Medicare patient and expect to survive, much less reinvest surpluses into their operations, as Dennis was just mentioning.

For all of these reasons, we are very pleased that Governor Cuomo's budget proposal includes some financial relief for hospitals. The Governor clearly understands that hospitals need to be strengthened and has proposed a number of steps to help safety-net institutions in particular.

First, the Executive Budget allows two Medicaid cuts from past years to expire. One is related to hospital rates of readmissions in 2007 and hospital complication rates in 2009. This cut is antiquated and has no relationship to the quality of care

hospitals are currently providing. Allowing it to expire will increase Medicaid rates by $51 million statewide.

The other cut was supposed to be related to early elective deliveries and to provide a disincentive to perform them. In reality, though, it was just an across-the-board Medicaid cut to all hospitals, even hospitals that don't provide maternity services. So eliminating that cut

will increase rates by $19 million statewide, and we certainly support that restoration.

Second, the Executive Budget creates a quality pool to incentivize hospitals to further improve quality, similar to pools that already exist for health plans and for nursing homes. This will provide hospitals with $91 million annually specifically related to the quality of care that they are providing.

Third, the Executive would reduce the tax maternity hospitals pay on their inpatient obstetrical services revenue. The tax would be reduced by $15 million and

provide critical relief to hospitals that provide obstetrical services. And we would urge you to approve that provision.

There are three other important healthcare investments in the Executive Budget I would like to mention and urge the Legislature to support.

As Jason and Dennis before me discussed, the first would increase state spending on the Vital Access Provider program by $290 million. This is critical funding for severely financially distressed safety-net hospitals. Dennis mentioned the 27 that are receiving Interim Access Assurance Funds. You have to be severely financially distressed to receive those

funds. They will expire at the end of March. And so the idea, we believe, behind this increase in the VAP funding is to try and provide a further bridge for those hospitals until restructuring can really take root.

The second investment is the $1.4 billion of capital funding which has been discussed a lot today, so I won't

belabor that. We do share your questions about the allocation and exactly what the criteria will be for providers to participate in that funding. Certainly, as was mentioned before, we certainly know the need that is there in Central Brooklyn and other parts of Brooklyn as well, but we'd like to get more detail on exactly how that funding will be allocated over time.

The third investment is the Indigent Care Pool, which provides funding to help cover the costs of hospital charity care. Without further action, the pool allocation methodology would expire at the end of this calendar year. The Executive reauthorizes the methodology for three more years, with stop-loss protection for hospitals. We urge the Legislature to support this as well.

Now, unfortunately this wouldn't be an Executive Budget -- and I wouldn't be from Greater New York -- if we didn't have a couple of problems with the budget. So I'd

like to mention two.

To ensure access for low-income

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Medicare beneficiaries to physician services and other outpatient services, the Medicaid program pays the Medicare copayments on behalf of many low-income Medicare beneficiaries. Under current state law, those copayments that Medicaid pays on behalf of these senior citizens is based on Medicare rates, which are almost always higher than Medicaid rates.

The Executive Budget proposes to instead base the copayments on Medicaid rates, which in some cases would mean that no copayment would be made at all, reducing the amounts a physician or other outpatient provider would receive by as much as 20 percent, because that's usually what the Medicare copay is under Part B of Medicare.

DOB projects that this would reduce payments to providers by $92 million a year. We strongly oppose this provision and urge the Legislature to reject it. We've got a lot of concerns about access to care for low-income Medicare beneficiaries. And Senator Krueger was mentioning earlier a lot

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of doctors are not even taking Medicare patients anymore. If they're also not getting the other 20 percent of their

payment, that will probably exacerbate that problem. So we would like you to look at that and reject it.

This provision is actually made even worse by the fact that the state is greatly reducing Medicaid primary care reimbursement rates this year. As you might know, under the Affordable Care Act the federal government mandated that states increase Medicaid rates for primary care services to the usually higher Medicare reimbursement rates for the same services. This provision expired on December 31st. And unlike many other states, New York State has not exercised its option to continue to pay Medicare rates for these services.

This means that reimbursement rates are plummeting for primary care services. And on top of that, due to the Executive Budget provision I just described, reimbursement rates for Medicare outpatient

services will plummet as well. Consequently, in addition to opposing the Executive Budget provision I just described, Greater New York supports adding a provision to keep primary care reimbursement rates at Medicare levels.

I understand in the President's budget that he came out with today, he would continue 100 percent federal financing for that. Of course, we can't be sure that the

Congress would actually pass that. But what we would like to see is for the state to continue to keep those rates at Medicare levels with the usual 50 percent Medicaid matching rate from the feds.

As I mentioned, we discuss many other provisions in the Executive Budget in our written testimony and on the table attached to it, so I will end there. But I would be happy to take any questions you might have.

CHAIRMAN DeFRANCISCO: Senator Krueger.

SENATOR KRUEGER: Hi. Thank you. Your testimony and Dennis Whalen's do have many commonalities, which I also appreciate.

But I just wanted to say thank you for the charts, because some of us actually think healthcare financing is the brain surgery of government and we're not all brain surgeons. So it's very helpful to see it laid out in this format.

And I also appreciate your highlighting what I was going to ask you as the question, which is do the issues with QMV likely exacerbate the problems at least my district is already seeing with private physicians literally opting out of Medicare because they say it's not even worth the paperwork time frame to try to get any of the funding?

MR. RICH: Yes, we would be very concerned that this would lead to fewer physicians accepting -- in particular, this applies to low-income Medicare beneficiaries, of course, so we would be very concerned about that.

You know, there's a whole trend not just for physicians not to accept Medicare, but some are not accepting any type of

insurance at all anymore, as you might have found -- I know in your district that is definitely the case -- due to paperwork headaches, due to low reimbursements, a variety of things.

And I think part of that has also contributed to the growing trend of physicians becoming hospital employees and of hospitals actually taking over whole physician practices. Because there's a lot that physicians have to deal with and a lot of costs that they have, a lot of paperwork that they have to deal with, and I think they'd rather be part of a larger organization that can sort of take all of that away from them.

Having said that, that also means that this particular reimbursement rate cut will affect hospital finances too, if they are employing the physicians who are then seeing the low-income Medicare beneficiaries, they

will suffer the cut in the copayment from this provision.

SENATOR KRUEGER: Thank you.

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MR. RICH: Thank you.

CHAIRMAN DeFRANCISCO: Assemblywoman Wozniak.

ASSEMBLYWOMAN WOZNIAK: Can you please explain the cap on losses under the Indigent Care Pool?

MR. RICH: Sure. So starting in 2013 --

CHAIRMAN DeFRANCISCO: Could you repeat the question, please?

MR. RICH: The question was could I explain the cap on losses in the Indigent Care Pool that I mentioned before.

In 2013 the state reformed the methodology that it uses to allocate funding for what we used to call the bad debt and charity care pool and now is called the Indigent Care Pool. They did that because, under the Affordable Care Act, there was a provision that appeared to say that the federal government would not reimburse anymore for bad debt. And because bad debt was a large part of the calculation for our pool, they needed to reform the state pool

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and take bad debt out of it.

That methodology was put into place for three years, but there was concern -- and we had a very strong concern at the time that because moving to the new methodology would mean that some hospitals would lose a lot of their funding under the Indigent Care Pool, that there would be a floor put under their losses, if you will, or a cap on their losses. So in the first year, it was 2.5 percent, the second year, 5 percent, and then the third, 7.5 percent.

What the Executive Budget does is extend the provision for another three years. It lets those caps increase. So it would go to 10 percent, 12.5 percent and 15 percent. Just as a way of making sure that no one hospital, you know, has a huge loss based on what they used to get out of the old methodology.

So the methodology is completely in place, there's just a cap on how much each hospital could lose under it.

ASSEMBLYWOMAN WOZNIAK: Okay, thank

you. And I know oftentimes the Indigent --

CHAIRMAN DeFRANCISCO: Excuse me, can you speak closer -- pull the mic closer?

ASSEMBLYWOMAN WOZNIAK: Is it on?

CHAIRMAN DeFRANCISCO: There you go.

ASSEMBLYWOMAN WOZNIAK: Okay, sorry. Oftentimes the indigent do go to the hospital

as they need services, and the hospitals struggle to pay for the services they need. And there's definitely concern out there that the indigent don't get the services that they really should be getting.

Can you address that a little bit and just explain what you believe needs to happen to make sure that we are providing services and that we're not failing the indigent?

MR. RICH: I think -- that's an excellent question, and I think that there's a huge amount of work that's going on right now to try and make sure that people are getting the services that they need.

When we were talking earlier about the DSRIP program under the federal waiver, a huge amount of that, as well as a lot of

incentives in the Medicare program are to try and reduce preventable hospitalizations. In order to do that -- the only way to do that is to make sure that people are getting services in their community before they become sick enough to need to go to the hospital, or that they're getting, you know, primary care services in the community so they don't have to rely on the hospital emergency room to get that.

So what's happening is hospitals are working with a lot of different types of providers -- physicians, home health care

agencies, nursing homes, just the whole gamut of different providers -- to try and work together to reach out to people before they need to come into the hospital.

Hospitals are actually penalized under the Medicare program if they don't do this kind of work successfully, and so there are a lot of incentives out there already to try and make sure that people are getting care in the right place at the right time by the right provider. And I think only more of

that will happen in the future as we implement the DSRIP program and a lot of other incentives that payors are putting out there for providers to do a better job to make sure that needs really are taken care of.

ASSEMBLYWOMAN WOZNIAK: Okay. And can you also explain a little bit about what happens when the indigent go to the hospital and they're homeless and the hospitals then are in a position where they have to decide to either care for them, discharge them, keep them, try to find a place for them? And I know that oftentimes when they don't have coverage, they're just simply turned away. Can you just explain a little bit more about that?

MR. RICH: Sure. Well, first of all, just to your final point, hospitals cannot

turn away people from the emergency room. Partly because it's their mission, but also under federal law there are requirements that anyone who comes to the emergency room has to be treated and stabilized and admitted if

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necessary.

But the difficulties of caring for the homeless are many. And you're absolutely right, if they come into the emergency room and need to be admitted, they will be. Normally what a hospital can do at that point in time is get them signed up for Medicaid. But that's not always so easy, particularly when they don't have a home address. And so often homeless people do stay in the hospital a lot longer than their medical needs would seem to dictate.

There are some efforts at the state level to do more about supportive housing to provide housing for the homeless -- but not only just housing, but housing that would bring along with it behavioral health services, other types of health services, to try and help the homeless get healthier, keep from being homeless, but also stay out of the hospital and get the care that they need in the community. But so much more needs to be done on that front. And it's a huge challenge for hospitals.

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ASSEMBLYWOMAN WOZNIAK: Do you think there's any particular funding that the hospitals are in need of that would help make sure that they're providing the services that they need to to the homeless and indigent?

MR. RICH: Absolutely. We're always in need of funding for all kinds of different initiatives that the state and the federal government and the hospitals themselves feel are important to engage in.

As I mentioned before, one of the difficulties that especially safety-net providers have, who mainly treat Medicaid and Medicare and uninsured patients and don't have very many private-paying patients that they can, as was being discussed with Assemblyman Goodell before, cost-shift their losses from Medicaid and Medicare to, they just don't have the ability to cost-shift, to get the funding that they need out of people who are paying for their services. And that's why you see so much financial distress, why you see extremely busy and crowded emergency departments.

So yeah, we'd love to talk to you more about different funding streams that could be created to help the hospitals in that way.

ASSEMBLYWOMAN WOZNIAK: Okay, thank you.

MR. RICH: Thank you.

CHAIRMAN DeFRANCISCO: Senator Hannon.

SENATOR HANNON: I'll pass. I was going to ask you about how your membership is dealing with interacting with the number of PPSs, but -- it's a very softball question, but it would be interesting to see, especially in the geographically intensive regions of Manhattan and Brooklyn.

MR. RICH: Yeah. The activities around creating the PPSs and participating in them are ongoing and I think are extremely challenging.

And how exactly it will all work out in terms of, you know, Medicaid lives being allocated to one PPS versus another -- those could be lives that one hospital or healthcare provider has been dealing with but then, for whatever reason, they get sort of

allocated to -- for the funding to another provider in the area. Very, very complicated.

And it's not just in the City but especially in the City, given how many providers there are, the size of the Medicaid population, and how many different providers portions of the Medicaid population actually use. It's been eye-opening to see, when they've tried to do this allocation under the PPS methodology, how many different providers and how much traveling around, particularly

in the City, many Medicaid patients engage in because of the different needs that they have, the different services different providers provide.

So it's not really an answer to your question; I think it's a work in progress, and I think it's very, very challenging.

SENATOR HANNON: I don't know if there is an answer, but it is just illustrating that it's not -- it's not just easy to do.

MR. RICH: No, it's not.

SENATOR HANNON: Thanks.

CHAIRMAN DeFRANCISCO: I forgot what I was going to say. No, I see Mr. Whalen is still here, and maybe I can ask this jointly.

If you had the authority to do this -- and I'm serious, if you can think about it just so we can talk at a later date, I'm not looking for anything now -- and you could scrap the entire system that is not incomprehensible, it seems to have to need retooling every few years and we're still not any closer -- I don't think, anyway -- of a good solution for healthcare, over a beer or something, nothing official, what would you get rid of, what would you put in its place? And I would love to know that. Okay?

MR. RICH: That sounds like a great beer conversation to have.

(Laughter.)

CHAIRMAN DeFRANCISCO: Well, it might take two or three, but it's something that ought to be done. Thank you.

SENATOR KRUEGER: I think Senator DeFrancisco is endorsing universal healthcare.

(Laughter.)

SENATOR RIVERA: And I believe he did it on the record, ma'am. Let the record show.

(Laughter.)

CHAIRMAN DeFRANCISCO: I didn't do anything, I'm asking their opinion. I've got my own. Thank you.

MR. RICH: Sure. Thank you.

CHAIRMAN DeFRANCISCO: All right, the next speaker is Beverly Grossman, senior policy director, Community Healthcare Association of New York State. Oh, wait a minute, that's who I was -- wait. Time out. Time out.

Claudia Hammar, New York State Association of Healthcare Providers. And Beverly Grossman, you're on deck.

For those keeping track, there were a couple of other cancellations. New York State Association of Speech-Language-Hearing. That's the last page, Kathy Febraio. They submitted testimony. And also the New York State Council on Behavioral Health Care, they

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cancelled and submitted.

Whenever you're ready.

MS. HAMMAR: Thank you.

Good afternoon, Senator DeFrancisco and distinguished members of the Senate Finance, Assembly Ways and Means, and Senate and Assembly Health and Aging Committees. My name is Claudia Hammar, and I am interim president of the New York State Association of Healthcare Providers, HCP. With me today is Megan Tangjerd, HCP's senior associate for public policy.

HCP is a trade association that represents approximately 400 licensed home care services agencies, certified home health agencies, long term home health care programs, and other health-related organizations throughout New York State.

Thank you for the opportunity today to comment on Governor Cuomo's 2015-2016 Executive Budget proposal and its impact on home and community based care. Today we would like to highlight some of the issues detailed in our written testimony.

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Home- and community-based care play a vital role in the communities across this state. It is a patient-preferred method of care allowing those of all ages facing

illness, disability and aging to maintain their dignity, independence and privacy in the safety and comfort of their own homes.

Home care also delivers great value to the state. According to the U.S. Department of Health and Human Services, the average daily rate for home care services in New York State in 2012 was $130 per day, two and a half times less than the average daily rate for nursing home services. Looking to the future, HHS only expects this disparity to grow.

Over the past several years, New York State has introduced a series of large-scale initiatives aimed at restructuring the healthcare delivery system into one that is more patient-focused, providing better, more integrated care in the least restrictive setting, and at a lower cost. Whether it's the transition to managed long-term care, the

DSRIP program, the FIDA program, money follows the person -- whichever program it is, a fundamental aspect of these initiatives is keeping patients at home, in their communities, and out of more costly institutional-care settings by providing services through home- and community-based care.

Despite this paradigm shift, there has been an overwhelming lack of support and

investment in home care. To ensure the industry's future viability, we need funding to support costs related to unfunded wage and benefit mandates, including minimum-wage increases and wage parity, the establishment of a new Advanced Home Health Aide designation, and the ongoing transition to managed long-term care. HCP's members from all areas of the state contact us on a daily basis about their significant challenges operating under inadequate reimbursement levels; burdensome, costly and duplicative regulations; and massive system changes that lack financial support or recognition of the

impact of these issues on the delivery of high-quality care.

Since 2012, the state has been working to transition Medicaid beneficiaries in need of long-term services from fee-for-service Medicaid to managed-care models. This year providers upstate, where the transition is just beginning in many counties, and downstate, where the transition has been well underway for two years, face significant challenges. Providers are struggling with unstable cash flows stemming from delayed or nonexistent payments from managed-care plans, resulting in millions of dollars in receivables for providers. Limited cash flow for home-care providers translates into

workforce shortages, unstable businesses, and compromised access to care for patients.

A lack of standardization among managed-care plans' service authorization and billing processes continue to drain home-care resources and contributes to delays in payments.

Overall, there is a critical need for

New York to ensure that the integrity of the Medicaid program is upheld as the transition progresses. All entities involved in the coordination and delivery of care to Medicaid beneficiaries that use state dollars must be held to strict accountability standards and measures. Safeguards must be in place to ensure that the monies move through the system as intended and that provisions are in place to address ongoing obstacles and ensure patient continuity of quality home-care services.

The state should invest in home care and support providers through this transition and other similar programs that are being rolled out. Whether through grant funding or no-interest loans, the development of uniform billing codes or electronic funds transfer for payments, the home care industry needs your help to ensure that well-intentioned state policies translate successfully in implementation -- and, most importantly,

ensure that the thousands of New Yorkers who are in need of this care continue to receive

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the care they need at home and in their communities.

MS. TANGJERD: Good afternoon, Senators and Assemblymembers.

As Claudia mentioned, home care providers continue to face many challenges in the managed-care transition, all of which are exacerbated by inadequate reimbursement rates combined with mounting unfunded wage and benefit mandates. Whether we're talking about minimum-wage increases, wage parity or living wage requirements, home care in New York State is struggling to absorb rising costs while adapting to new ways of doing business and maintaining high quality of care for patients.

HCP and home-care providers have long maintained that home-care workers should be compensated for their hard work with fair and adequate wages and benefits. However, as home-care agencies are overwhelmingly funded by the Medicaid program in New York State, it is critical that Medicaid reimbursement, whether through a managed-care contract or

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through fee-for-service Medicaid, match the state mandates that are being imposed.

Last year HCP applauded the Executive

and the Legislature for beginning to address the fiscal challenges stemming from wage-parity rate increases by including a $350 million appropriation in the budget. While the funding did not go far enough to cover the full cost of the increases and did not address the increases going into effect outside of New York City, it was a critical step in the right direction.

Additional appropriations are necessary to ensure the mandate is adequately funded to address the current rates and future increases. This year there are no such funds included in the Executive Budget proposal. We expect at least $300 million in funding is needed to meet this year's rate increases, along with a mechanism to ensure that adequate rates are paid in a timely manner to the employers of workers, who are most often licensed home care services agencies.

The need for funding extends well beyond New York City. Wage-parity increases are happening in Nassau, Suffolk and Westchester counties and will continue to increase in coming years. And statewide, minimum-wage increases and other mandates, along with similar managed-care transition costs, are challenging providers in all areas of the state. Funds must be available to

support the delivery of care throughout New York, and it is currently not being made available.

The budget proposes to establish a new Advanced Home Health Aide designation, which would enable home health aides to perform advanced tasks in home care and hospice settings with the appropriate training and nurse supervision. HCP is supportive of this proposal, which takes a more cautious and prescribed approach than similar proposals advanced in past years. In concept, the new aide designation represents a career ladder for home-care workers and a vehicle for the state to lower service-delivery costs without

compromising care.

Concerns exist, however, as there does not appear to be any funding in the budget to support the initiative as it moves forward. We urge the Legislature to consider the increased costs participating providers will incur, including those related to higher hourly pay rates, staff development, and on-the-job training for Advanced Home Health Aides, and additional intensive oversight and supervision by RNs, among other costs, all of which must be addressed if the initiative is to be successful.

Before we conclude, it is important to also comment on the large-scale

health-related state policy initiatives that are currently underway and that Claudia mentioned in her testimony, and these signify more massive system changes for home care and the healthcare delivery system as a whole.

In addition to managed care, home care is closely connected to programs such as DSRIP, FIDA, BIP, MFP, CFCO, to name a few. These initiatives emphasize the importance

and value of keeping individuals in the community as long as possible. And moving forward, we must not lose sight of the value and expertise that home- and community-based care providers offer, as well as the need to ensure that necessary funds and support are available to aid the industry during this time of immense transition and systems changes.

New York State's home care industry is overwhelmingly comprised of agencies that go above and beyond to care for their clients and invest in their workforce. Their commitment and dedication to the work they do is unwavering.

As you work on the budget for the upcoming fiscal year, we urge you to consider the crucial role of home- and community-based care in caring for the state's most vulnerable populations, and the potentially devastating impact on patient access and

continuity of care, the stability of home care worker jobs, and the financial viability of home care businesses if critically needed

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state support continues to elude the industry.

We thank you for your time today and consideration of our testimony, and we are happy to answer any questions.

CHAIRMAN DeFRANCISCO: Any questions? Don't feel compelled.

(Laughter.)

CHAIRMAN DeFRANCISCO: Assemblywoman Wozniak.

ASSEMBLYWOMAN WOZNIAK: Thank you.

Regarding the unfunded wage and benefit mandates, what ends up happening then because you have these? Do you have to rely on cost-shifting from those with health insurance?

MS. TANGJERD: Well, the majority of our members serve Medicaid beneficiaries throughout the state, and so their reimbursement rates are largely set through fee-for-service Medicaid rates, in which they will submit annual cost reports. And there's a two-year lag, actually, in those rates, so costs that are reported on in 2013 reflect

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the reimbursement rates that providers will

receive in 2015.

As we move to managed care, providers are negotiating rates on an individual basis, and they're under contract with managed-care providers. And what we have found are that those rates have been inadequate on both the fee-for-service and the managed-care side. And as the costs for providers grow, their ability to renegotiate or get higher rates, they have not been successful.

ASSEMBLYWOMAN WOZNIAK: Okay. Thank you.

MS. TANGJERD: Thank you.

CHAIRMAN DeFRANCISCO: Could you just state your name for the record? I don't know if you mentioned who you were when you sat.

MS. TANGJERD: My name is Megan Tangjerd.

CHAIRMAN DeFRANCISCO: Okay, thank you.

Senator Hannon.

SENATOR HANNON: I'm not going to ask any questions. As you know, we have spent

hours dealing with the various amount of intricate and complicated challenges healthcare providers doing home care have had to do -- including, in the middle of it, the administration changing how you relate to MLTCs and CHHAs.

But I just want to tell you, we

continue to look forward to working with you. I believe you're an integrated part of the healthcare delivery system. I know a year ago I challenged your folks in Long Island, get involved with PPSs. This year -- they didn't all do it, but when we met again, they said "Are you crazy?"

But I think it is essential because you have more of control over who's going to be readmitted, who's going to be admitted than any other part of the healthcare system. So we look forward to working with you.

MS. TANGJERD: Thank you so much, Senator.

MS. HAMMAR: Thank you, Senator.

CHAIRMAN DeFRANCISCO: Thank you very much.

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MS. TANGJERD: Thank you.

MS. HAMMAR: Thank you.

CHAIRMAN DeFRANCISCO: Beverly Grossman, Community Health Care Association of New York State.

On deck is Stephen Hanse, New York State Health Facilities Association.

You're on.

MS. GROSSMAN: Okay. My name is Beverly Grossman, and I am the senior policy director of the Community Health Care Association of New York State, CHCANYS.

SENATOR HANNON: And you're going to

summarize, right?

MS. GROSSMAN: Look (indicating). Yeah.

(Laughter.)

SENATOR HANNON: Great.

MS. GROSSMAN: I knew you would say that, Senator.

I'm representing the federally qualified health centers in New York's primary care safety-net community. Thank you for the opportunity to provide testimony on

the Governor's proposed 2015-2016 budget.

CHCANYS is the voice of community health centers, which are located in medically underserved areas, providing high-quality cost-effective care to anyone seeking care regardless of their insurance status or ability to pay. We are the front line in providing community-based access to quality primary care to Medicaid and uninsured populations and reducing avoidable and unnecessary hospital admissions.

CHCANYS has been extremely supportive of the state's efforts towards healthcare delivery transformation and the goals outlined in DSRIP, including reducing avoidable hospital admissions by 25 percent over five years. This goal will only be achieved by strengthening community-based care models of primary care and behavioral

health.

Accordingly, we were profoundly disappointed that the Governor's budget indicates no investment in community-based safety-net providers.

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In contrast, the proposal includes $1 billion in capital funding for the development and expansion of healthcare systems focused on hospitals in Oneida County and Brooklyn, and another $400 million only for upstate hospital capital and noncapital costs in debt restructuring. That is $1.4 billion for hospital systems. And I think we heard earlier today from the Department of Health that they're planning on aligning the eligibility with the IAAF, which is also exclusively for hospitals.

New York's stated priority is to transform the healthcare system by providing access to high-quality coordinated care in every region of the state, by integrating primary care services with other community-based providers. However, investing $1.4 billion in capital dollars in hospital development and restructuring seems to directly contradict this priority and otherwise further entrench the existing hospital-focused delivery system.

While we appreciate that

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transformation funding is included in the Executive Budget, we have significant concerns based on our repeated past experiences that this money will not flow beyond hospital walls to community-based safety-net providers. Why is the presumption always that we have to fight for any dollars because the hospitals get first touch?

To bring equity to the budget proposal, CHCANYS respectfully requests that a minimum of 25 percent of the $1.4 billion, or $350 million in capital funding, be earmarked for community-based safety-net care providers, including FQHCs. This amount is equal to the 25 percent reduction in avoidable hospital use that DSRIP seeks to achieve.

Another budget provision that is misaligned with the administration's stated goals is the proposed revenue cut to 340B providers. The 340B drug pricing program enables healthcare organizations that care for underserved people to purchase outpatient drugs at discounted prices. The net result

of the Governor's proposed change to the program is that the state and/or the managed care organization will reap the 340B benefit -- and not the covered safety-net provider.

340B revenue is used by FQHCs to cover

precisely the kind of innovative programs to improve patient care and reduced system costs that are being promoted in DSRIP and the state's other delivery transformation initiatives. Cutting 340B revenue while relying on FQHCs to implement large-scale new programs for which they have yet to receive any funding is shortsighted and contrary to the goals of the system transformation.

These are two areas of significant importance to FQHCs, but there are numerous other items we have submitted in written comments, including restoring funding for school-based health centers, maintaining funding for the D&TC uncompensated care pool, and investing in a primary care workforce.

Meaningful, sustainable delivery system transformation will only be achieved

if the state provides appropriate financial and capital investment directly to the community-based safety-net providers whose work is at the center of the reimagined care delivery system.

We look forward to working with the administration and the legislature to develop a budget policy that furthers the administration's DSRIP goals and improves the healthcare delivery system for all New Yorkers.

I'm happy to answer any questions.

CHAIRMAN DeFRANCISCO: Senator Hannon.

SENATOR HANNON: I first think you're very calm when you talk about what they propose to do to your participation in the federal 340B drug program. By attempting to recapture whatever savings you might effect in the delivery of care through your participation, they remove any incentive for you to participate, which is not without administrative cost.

And so I think it's very counterproductive, and I think you're on the

right course on that.

Earlier Mr. Helgerson seemed to indicate, or at least there was a little bit of a softness to his language, that your participation in capital programs would be possible. I think that needs to be pursued.

In any event, your participation in the PPSs, I presume -- I don't know -- is going forward, and that should allow you to get funds through that process. Is that correct?

MS. GROSSMAN: Yes. I think the FQHCs in particular -- we've surveyed -- have been immensely engaged with PPS leads. There is only one PPS lead that is an FQHC, which is fantastic, but the rest are all large hospital systems.

And we have spent an immense amount of

money being good partners through our own consultants, our own planning, own project leads, own lawyers, the amount of contracting and negotiation that's happening. So yes, we like to think that there's something at the end of the rainbow, but so far nothing has

shown.

SENATOR HANNON: I do think that your growth in numbers and in individual entities of what you do has been fairly rapid, and I don't believe legislators are sufficiently aware of that growth in either case, and I would encourage you to individually have them talk to their legislators. Because I think, just like home care is really close to who needs, you're the next closest to who needs to be part of the system to prevent readmissions and admissions. So more power.

MS. GROSSMAN: Thank you.

CHAIRMAN DeFRANCISCO: Thank you.

We're now going to call on the last speaker on page 1, Stephen Hanse, vice president and counsel, governmental affairs, New York State Health Facilities Association.

On deck is Ami Schnauber, VP of public policy, LeadingAge New York. And if Ami would start coming down to the front, we can keep things moving.

MR. HANSE: Good morning -- or good afternoon. You have my testimony; I will

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abbreviate it.

My name is Stephen Hanse, and I have the privilege of serving as vice president of governmental affairs and counsel for the New York State Health Facilities Association and the New York State Center for Assisted Living.

NYSHFA and NYSCAL represent 57,000 employees who provide essential care to over 44,000 elderly, frail, and physically challenged women, men and children at over 300 skilled nursing and assisted living facilities throughout New York State.

As our providers enter into their seventh year without a trend factor, New York's long term care and assisted living providers face significant challenges and, as was stated earlier, changes as we navigate both the state's transition to managed long-term care and the state's ever-evolving delivery system reform initiative, or DSRIP, payment program, economic pressures from minimum wage and other staff and salary increases, recent state budget constraints,

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and certain initiatives proposed in the 2015-2016 Executive Budget.

Moreover, at $44.88 per patient per day, New York unfortunately leads the nation

with the largest shortfall between Medicaid payment rates and the cost of providing necessary patient care. Recognizing these constraints, it is important to note, as raised by Senator DeFrancisco earlier, that last year's 2014-2015 enacted budget eliminated the MRT imposed 2 percent across-the-board provider rate cut for nursing homes effective April 2014. This initiative would restore $140 million to long-term care providers throughout New York State.

However, as we heard earlier, the state has yet to enact the approved restoration of these needed monies, and to the best of our knowledge, the state plan amendment has not been submitted.

You have our testimony, so I'll briefly touch on certain issues that could benefit long-term care and assisted living

providers in the budget, those issues that adversely impact long-term care and assisted living providers, and those we would respectfully request be included within the 2015-2016 budget.

NYSHFA and NYSCAL support the Executive's proposal to provide $1.4 billion in funding for capital investments to make infrastructure improvements and provide necessary funding to stabilize healthcare

providers to advance the state's healthcare transformation goals.

While NYSHFA and NYSCAL support this initiative, we encourage the inclusion of language in the enacted budget to protect New York's long-term care and assisted-living residents by allocating specific funds to such providers.

Additionally, NYSHFA and NYSCAL support the Executive Budget allocation of $400 million to support debt restructuring and other capital projects to help transform the provision of healthcare in rural communities. Again, we encourage the

inclusion of language in the enacted budget to ensure that these funds are accessible by skilled nursing and assisted living providers.

Additionally, we support the Executive's proposal to provide $1.3 million in funding to support the administration of criminal-history record checks for staff at adult care facilities to ensure that providers receive needed reimbursement for fingerprinting costs associated with each prospective direct care employee.

While these proposals are beneficial, unfortunately, there are two proposals included within the Executive Budget that adversely impact New York's long-term care

and assisted-living providers and the individuals we serve.

The Executive once again proposes the elimination of the ability to set inflationary trend factor adjustments for nursing homes, assisted-living program beds and other Medicaid sectors. Additionally, the Executive proposes to permanently

continue the exclusion of the 1996-1997 trend factor from nursing home and inpatient rates.

We oppose these proposals given that it has been seven years since the state has afforded a trend factor. Costs have increased above the CPI, and our providers strive to provide salary increases to ensure the retention of well-qualified and trained individuals.

Additionally, NYSHFA and NYSCAL oppose the elimination of EQUAL funding. The Executive Budget proposes to eliminate the approximately $6.5 million in funding that sustains the Enhancing the Quality of Adult Living, or EQUAL, Program and directs one-half of these funds for the purpose of moving adult home residents to community housing while saving $3.3 million for the state.

EQUAL funding is a formula-based grant program centered on the number of SSI residents served within an individual

facility. While $6.5 million may seem inconsequential in the context of a

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$141.6 billion budget, EQUAL funding is essential to enhancing the quality of care, services and life experience of residents in adult care facilities.

Small and mid-sized adult homes serving SSI residents throughout New York State rely on EQUAL funding to better meet resident needs and improve the physical environment of their home. Without this essential grant funding, the quality of life of residents will be directly impacted and small adult care facilities that rely on this funding to benefit their residents may be forced to close.

Lastly, I will turn now to three critical issues that we respectfully request be included within the enacted budget.

The first of these issues dates back to a 2011 MRT initiative and is referred to as "return on equity." In 2011, there were numerous initiatives included among the enacted MRT proposals that affected New York's long term care providers. Included among these initiatives were proposals

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affecting all long term care providers -- addressing statewide pricing, bed hold policies, and nursing home rate appeals.

However, only one initiative was enacted, the elimination of return on equity under Section 2808(20)(d) of the Public Health Law that was aimed exclusively at proprietary nursing homes.

This initiative was approved with little discussion or understanding. Whereas the state's Medicaid capital reimbursement system recognizes the cost of physical buildings in the case of not-for-profit nursing homes by allowing for the depreciation of their real property, proprietary long term care facilities received a comparable benefit through a return on equity.

However, the lack of return on equity inhibits the ability of providers to refinance their buildings, because return on equity is viewed as a key element of the underwriting. Consequently, in a time of historically low interest rates, as noted

earlier by Mr. Helgerson, the state continues to pay a higher Medicaid rate for capital.

The disparate impact has limited the ability of proprietary nursing home providers to fully reinvest in their facilities and provide optimum resident care. As such, NYSHFA and NYSCAL respectfully request that Section 2808(20)(d) of the Public Health Law sunset on March 31, 2015.

The second issue we respectfully request consideration of is an increase in the assisted living Medicaid rate. Assisted living facility Medicaid rates under the ALP are based on 1983 costs, receiving only minimum inflationary trend adjustments through 2007. Since 2007, like skilled nursing facilities, assisted living providers have not received any inflationary trend factor adjustments to their rates.

Moreover, most ALP facilities do not receive a capital component as part of their rate and are therefore not reimbursed for capital improvements, a necessary ongoing cost they must absorb.

Although initially designed to represent approximately 50 percent of a skilled nursing facility rate, reimbursement rates for ALPs have fallen below this level. Depending on the region, in some instances an ALP rate pays as little as $43 per patient per day.

Given this shortfall, NYSHFA and NYSCAL respectfully request an increase in ALP rates to ensure the continuation of necessary resources to care for our residents in a lower cost, more homelike setting.

Lastly, we respectfully request consideration of an increase in the Supplemental Security Income rate for adult

care facilities.

New York has not increased the state portion of the SSI rate for low-income elderly and disabled individuals in adult care facilities in seven years. The current $40 per day is clearly insufficient to provide room, board, meals, activities, case management, supervision and medication assistance for our SSI recipients. While the

state portion of the SSI rate has remained frozen for seven years, facility costs for food, labor, health insurance and utilities, among other things, have increased year after year.

Consequently, NYSHFA and NYSCAL respectfully request the Legislature to increase the state portion of the SSI rate to help increase the quality of care and services to low-income SSI recipients and prevent continuing closures of SSI facilities throughout our state.

In conclusion, it has been said that to care for those who once cared for us is one of life's highest honors. While the 2015-2016 Executive Budget contains several positive initiatives, it is vital that the enacted budget enhance the provision of necessary care to New York's long term care and assisted living residents.

As such, we respectfully request your

rejection of the Executive proposals to permanently eliminate inflationary trend factors and abolish the EQUAL grant funding

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program, and we respectfully request legislative support to sunset the discriminatory return-on-equity statute and direct increased state funding for assisted living providers and Supplemental Security Income adult care facilities.

As always, the New York State Health Facilities Association and the New York State Center for Assisted Living will continue to work together with the Governor, the Legislature and all affected constituencies to ensure the continued delivery of high-quality, cost-effective care and services throughout New York State.

Thank you.

CHAIRMAN DeFRANCISCO: Any questions?

Yes, Assemblywoman Wozniak.

ASSEMBLYWOMAN WOZNIAK: My understanding is that if someone is --

CHAIRMAN DeFRANCISCO: You've got to push the button.

ASSEMBLYWOMAN WOZNIAK: Hello? Okay.

My understanding is that if someone is in an assisted living home, they've been

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placed there because they were deemed by a

healthcare professional that they needed to be there. Is that correct?

MR. HANSE: That is correct in most instances.

ASSEMBLYWOMAN WOZNIAK: Okay. And if the Governor's proposed budget was passed and the $6.5 million of EQUAL funding was lost, how would it be determined who would end up going into community housing if they needed to be in the assisted living? Would they be then reevaluated, or what would happen?

MR. HANSE: The Executive Budget, as proposed, is silent on that issue. Basically they were going to direct half of the money out there. There's many individuals who are not able to move to the community, but the budget does not speak to how those individuals be evaluated, who would go.

In some instances, there's many facilities -- small facilities, 40-bed facilities -- that are primarily if not all SSI residents, and they may be forced to close under that provision.

ASSEMBLYWOMAN WOZNIAK: Okay, thank you.

CHAIRMAN DeFRANCISCO: I assume you heard my questions of Mr. Helgerson, and I want to just ask about that settlement issue. I asked him when the proposal for the State of New York was sent to CMA. Do you have any

idea?

MR. HANSE: That's with regard to last year's enacted budget proposal and the 2 percent?

CHAIRMAN DeFRANCISCO: No.

SENATOR HANNON: You're mixing them up.

CHAIRMAN DeFRANCISCO: Oh, yes, it is, I'm sorry. I'm sorry, that proposal, right.

MR. HANSE: We had inquired, and to the best of our knowledge we had asked if a state plan amendment was submitted to CMS. And to the best of our knowledge, it's our understanding that a state plan amendment has yet to be submitted on that issue to CMS.

CHAIRMAN DeFRANCISCO: Okay. And he said he wasn't sure when it was submitted and

we're waiting on CMA.

SENATOR HANNON: CMS.

CHAIRMAN DeFRANCISCO: CMS, I'm sorry.

MR. HANSE: CMS, yes.

CHAIRMAN DeFRANCISCO: Is that correct?

MR. HANSE: That's correct. I will follow up on my end --

CHAIRMAN DeFRANCISCO: Yeah, if you can find out, because --

MR. HANSE: Yeah, my understanding, which was relatively recent, was a state plan amendment had yet to be requested on that

2 percent from CMS.

CHAIRMAN DeFRANCISCO: The settlement of the appeals, does that require any federal approval, or is it the state only?

MR. HANSE: That would require, the universal settlement would require approval of CMS were it to go through.

CHAIRMAN DeFRANCISCO: Okay. And that hasn't been settled yet.

MR. HANSE: That has not been settled to this point in time. Again, respecting the

confidentialities of the settlement situation, nursing homes throughout New York State have been -- an informal poll was taken as to whether or not they would opt into the settlement. A majority, a vast majority, I would say it was almost 97 percent of the homes in New York State, on non-legally binding, said yes, they would opt into it.

I think that's a recognition that there's appeals that date back I'm told to the 1970s. There's over 9,000 appeals. There's over 260 litigations. The department does not have the staff to move forward on these. I think your question with regard to what will they do in the future, will they be able to handle these, is a very relevant question. And it's a good question, because I don't know how they will.

CHAIRMAN DeFRANCISCO: Okay, thank

you. Thank you very much.

The lack of questions has nothing to do with quality of the presentation, it has to do with the hour of the day.

MR. HANSE: Thank you, Senator.

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CHAIRMAN DeFRANCISCO: The next speaker, LeadingAge New York, Ami Schnauber. She's the VP, public policy.

On deck is Paul Macielak, New York Health Plan Association.

MS. SCHNAUBER: Thanks so much for having us today. As Senator DeFrancisco said, my name is Ami Schnauber. I'm the vice president of advocacy and public policy.

SENATOR HANNON: And you're not going to read this.

MS. SCHNAUBER: I am not reading that testimony.

SENATOR HANNON: It's in 8-point print.

(Laughter.)

MS. SCHNAUBER: I am not reading it. I actually wrote my own comments.

CHAIRMAN DeFRANCISCO: Okay. Those are much more relevant.

MS. SCHNAUBER: Less academic and a bit briefer.

That testimony really includes all of the provisions in the Executive Budget that

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pertain to long-term care.

And keep in mind that LeadingAge New York represents the full continuum of aging services providers. We represent not-for-profits all the way from independent senior housing, assisted living, home care, managed long term care, adult day healthcare, nursing homes. And because of that, our members have a really great perspective on how people move through the system and I think have for a long time been working vertically and in a way that DSRIP is trying to transform the system.

There are a number of proposals in this budget that we certainly are supportive of. There's some welcome investments in capital and for caregiver support. And the Advanced Home Health Aide legislation is something that we've actively been working on with the Governor's office and other associations, and we are certain that you'll move forward with that.

However, there are some significant cuts in the budget that we're really

concerned about. The fact is is that in the last few years when healthcare has been transforming, care in the community is struggling.

I have my own personal experience, because my brother has a TBI. And I'll tell

you that over the last 10 years, trying to pull together a network of services for him in the community is very, very hard. It is very taxing. We have moved him around the state so that we could try and keep him in the community and find the staffing that we needed. He's been in Cortland, he's been in Auburn, he's now up in Jefferson County.

We continue to struggle. And someone in their mid-thirties is -- now we're looking at options like nursing homes. Or maybe we can find a creative way to have him in assisted living, and perhaps we could put the TBI services on top of that.

But the fact is is that over many, many years -- Steve Hanse certainly spoke to this -- long-term care has not seen increases in funding. Things are starting to get very,

very tough. It is very hard to find skilled caregivers, particularly in upstate.

You know, I think there's been this sense in the department that there's so many home health agencies that it's okay if some of them close down. And maybe that's the case in New York City, maybe there's so many people in large metropolitan areas that seniors and people with significant disabilities aren't going to suffer.

But I'm telling you, in upstate New York that's not the case. In upstate

New York it's really hard to continue to put all these services together.

And through DSRIP and through FIDA and through this whole move to managed long term care, our goal is to keep people out of institutions, keep them in the most integrated setting. And if we don't start putting money in to help create that network, it's not going to be very successful. And this budget isn't helping in any way.

Our members are certainly being involved in DSRIPs. We're now reviewing the

25 PPSs. Many of our members have had discussions with these PPSs. But if you look at them, they're playing a very limited role. In some of the PPSs, they say the long term care partners are to be determined.

So we're going a long way down this road, and our members are really concerned that they're ultimately not going to get some of the capital money, it's never going to trickle down to them.

We did a survey of nursing homes, and what we found was that only about half of them actually have any sort of electronic medical records. And of those half, even less have an ability for health exchange. And as you can imagine, when you're going into DSRIP, when you're talking about e-prescribing, that's a really big problem.

You talked a little bit about the e-prescribing mandate earlier with the commissioner. You may know that that mandate is on the physician. It is not on nursing home providers, it's not on assisted living providers. But the real problem is that it's

going to impact the people that we care for. It's going to impact people in the community. because if that prescription goes to a pharmacy and that pharmacy is not open or that pharmacy gets a prescription for a controlled substance and they don't have it, it takes a long time to get the prescription back, get it sent to a different pharmacy.

So there's a lot of problems that are still there. We certainly have been working with DOH and suggested that there needs to be a delay in this. I think for nursing homes we need to see even a longer delay, because implementation is going to be hard. And physicians may get to a point where they're able to do e-prescribing for all the people they see in their practice. The question is for the 20 people that they see in a nursing home, will they still have the ability to do that in a timely manner.

And when you think about controlled substances, we're really concerned about the impact that might have on hospice and palliative care in ensuring people in the

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community or people in that setting are able to get the access to those drugs as they need them.

The nursing home population is going to go mandatory into managed long term care. It starts today. The managed long term care rates don't cover even half of what the cost of an average nursing home stay is. Between that and wage parity, these managed long term care plans and the premiums are not adequate, and we would suggest that they need to be increased.

But as the nursing home population goes into managed long term care, we really believe that assisted living has a great opportunity. Assisted living costs half the rate of what a nursing home stay is. That is statutorily how it's determined. It's essentially half the price of the nursing home rate.

We know that managed long term care plans will see this as a viable alternative. Yet as Steve mentioned, the rates that they've been getting have been not very good.

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They've been very low. We support all the things that NYSHFA and NYSCAL have suggested.

We would like to see an increase to the SSI rate. Unfortunately, in the

Governor's proposal he has completely eliminated the EQUAL program. That's the Enhancing Quality of Adult Living. This is just an added benefit for these homes to take care of very low-income people, so that if they can't be taken care of in assisted living, they will go to nursing homes.

So it doesn't really make a whole lot of sense when you have a nursing home population going mandatory into managed long term care, to suddenly say that you're not going to pay for this anymore.

The Enriched Housing Subsidy is part of that 41-public-health-programs pool that's cut 15 percent. We think that's a poor idea; we're pleased that you feel the same.

There's $1.4 billion in capital infrastructure improvements. We would request that some of that money be earmarked for long-term care. Again, as I said before,

long term care providers are not seeing enough of the money being trickled down through DSRIP. There are some real needs regarding their capital, their buildings, regarding electronic health records. They're not going to be able to be a valuable part of this transformation in healthcare if they don't have access to funding for that reason.

There is the $50 million allocated for the not-for-profit infrastructure capital

investment. We would suggest that that is an area that would work well for our members, and we hope that our members are able to take advantage of that money. All of our members are not-for-profit, and they're providing a lot of the direct care in the community.

Related to MLTC, as I said, we're a little bit concerned about the adequacy of the rates. There's a lot that is changing in terms of MLTCs. The long term care providers are really struggling during this change.

You talked a little bit about value-based purchasing -- or value-based payment, I'm sorry. Dennis Whalen talked

about the aggressive timeline that they're moving forward with that. We're very, very concerned about that. We are actively participating in a workgroup that's looking at that.

But there's a lot of risk involved in this. This is probably the most significant change in reimbursement that we've ever seen, and I think that we need to take our time and make sure that we do it right. Dependent on how these payment arrangements work, risk is different based on the payor and the provider, based on the outcome that you would see.

There's one proposal in the budget we're particularly concerned about. The

Governor is recommending the carve-out of the transportation from the MLTC benefit package. Our members are very concerned about that. That's a $14.7 million cut in this year's budget, and it would double for next year. The proposal is sort of puzzling to us. We're not exactly sure why they're doing this. It's clearly not consistent with the

direction towards a more coordinated care, and our members would really, really like to see that maintained in the rate.

David Rich from Greater New York talked about the Medicare/Medicaid crossover payments. That's the amount that Medicaid will pay for those dual-eligibles, the ones that they pay for the coinsurance. This is a $91 million cut, and it's unclear exactly who's going to take the brunt of that cut. We think we need more information. We're going to be looking for it, and we hope that you will as well.

For home care, there's a $30 million cut to CHHAs based on the rebasing of the episodic rate. We're not sure why they want to do this. We're concerned about a $3 million cut to CHHAs, especially in a time when we're trying to be investing, we think we should be investing in home care and community-based care, not reducing our commitment.

We do applaud the proposed investment of $25 million to support increased funding

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for caregiver support. We just recently finished a project up in the eastern Adirondacks in which we created a demand model and we looked at what the challenges were in that area, and caregiving is one of the biggest problems. It's hard to get home-care workers long distances. Transportation is an issue. The caregivers are not there.

Anything we can do to help in caregiving is going to help the hospice and palliative care folks take care of people in the community, and it's going to help us in those more rural settings where it's hard to find services. It's really going to make a big -- it's going to help, and we certainly encourage that.

And finally, I would like to just talk a little bit about housing. Last year --

CHAIRMAN DeFRANCISCO: Excuse me. A very little bit. Because you know you've been --

MS. SCHNAUBER: Okay. This is my final thing.

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Commissioner Shah had said that housing is healthcare. And we would absolutely agree. We know that by providing

some basic services in housing that it can make a huge difference in people's lives. And when you create universal design, make sure they have access to transportation, make sure that they can afford medication, it's going to keep people out of the next level of care.

We know that people in affordable housing are Medicaid-eligible. They really are just one incident away from being high Medicaid users. And I think we really need to start thinking about how we can care for them in that setting.

And that's all I have. Thank you. Do you have questions?

CHAIRMAN DeFRANCISCO: Thank you very much.

ASSEMBLYMAN OAKS: We do have one.

Assemblywoman Wozniak.

ASSEMBLYWOMAN WOZNIAK: Thank you.

What would you most attribute to the

problem of a lack of assisted living facilities in upstate New York?

MS. SCHNAUBER: What do I attribute that to?

ASSEMBLYWOMAN WOZNIAK: What do you think is the main problem that's causing the lack of assisted living facilities in upstate New York?

MS. SCHNAUBER: What our members have

often -- there used to be a lot more assisted living facilities in the '80s, and then we just weren't using the model. I wasn't here at that time to know exactly what it was that changed that.

But for our members who are interested in this model, one of the biggest challenges is the capital needed to develop them. because there's not enough money in the rate. It doesn't always cover the full cost. So if we have -- our members have said that if they have some capital to pay for this, they would create more.

ASSEMBLYWOMAN WOZNIAK: And another question I have, since nursing homes are now

required to provide long-term care, do you believe this will fully help the problem or partially help the problem of providing more care for those in need? Or how do you feel it's going to end up turning out? Do you understand my question?

MS. SCHNAUBER: No, I don't understand it.

ASSEMBLYWOMAN WOZNIAK: Okay, so I know you mentioned that now it's going to be mandatory for nursing homes to provide long-term care. Is that correct?

MS. SCHNAUBER: No, I think what I was saying is that the managed long term care program, the nursing home population is going

to become mandatory. So if you're a Medicaid patient and you're in a nursing home, starting in New York City today you're going to have be enrolled in managed long term care.

When we made this transition to require all people in Medicaid -- well, most people in Medicaid to be in a managed long term care program, it was done in phases.

And so the next phase starts today in New York City for people in nursing homes. So managed long term care plans are now going to have the nursing home benefit in their package, and it's going to be within the rate that they're getting.

ASSEMBLYWOMAN WOZNIAK: Okay. Thank you.

CHAIRMAN DeFRANCISCO: Thank you very much.

Paul Macielak, is he here? Ah, he didn't listen, did he? He was supposed to come down. President and CEO of the New York Health Plan Association.

Al Cardillo on deck, Home Care Association of New York State.

All right, Paul, you can start now.

(Laughter.)

CHAIRMAN DeFRANCISCO: I see Al's coming down.

Okay, here we go. Whenever you're

comfortable.

MR. MACIELAK: We're set?

CHAIRMAN DeFRANCISCO: Yup.

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MR. MACIELAK: All right, I'm Paul Macielak, president and CEO of New York Health Plan Association. Thank you, Senators and Assemblyman, for the opportunity to comment on the budget.

HPA represents the full gamut of plans, and we are a partner with you and the state on the MRT reforms as well as on the state exchange.

We want to make, I think, three points here today. Number one, we want you to just say no to the exchange tax.

SENATOR HANNON: Speak up -- I can't hear you.

MR. MACIELAK: The exchange tax, the Governor's proposed exchange tax.

SENATOR HANNON: Put the mic close to your --

MR. MACIELAK: Closer. Thank you very much. Okay?

The $68 million tax we do not believe is appropriate today. New Yorkers already pay 5 percent of their health insurance premiums in New York State taxes,

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assessments, surcharges, HCRA fees, et

cetera.

The ACA, Obamacare, is phasing in new additional taxes as we sit here today. And our prior approval rate process is structured to try and guarantee affordability in premiums. Yet we've got federal and state governments adding taxes, making that insurance less affordable. The exchange sustainability tax would be one more nail in that coffin in terms of denying affordability.

You heard testimony earlier today, I know some of you asked Jason Helgerson about how many enrollees had entered into the exchange, how many were Medicaid, how many were privately insured, commercially insured. And I heard numbers bandied about of like 1.9 million, of which I think he said 80 percent had been previously uninsured. So our rough calculation is like about 1.2 million of new insured individuals in New York State. And we think that that really provides the basis to say no to the

new tax and just a segregation and dedication of revenue from the existing taxes to pay for the exchange.

One-point-two million people who didn't have insurance now get insurance. They are paying the existing HCRA taxes. It's a good chunk of change today that if it

were segregated and dedicated to pay for the exchange, there wouldn't be a need for a new tax.

We had talked with the state last year to use that as the funding stream and solution for the sustainability of the exchange. This year's budget, however, negated that thought and went down into a different road. That money from all those newly insured people has gone into the black hole of no idea of where it is, but instead we've got the new tax in front of us. So we would urge you to use the new HCRA dollars of the newly insured, as opposed to the existing tax.

Another alternative to that funding stream would be to really consider the fact

that both our state exchange and the ACA, the goal is to provide insurance to the insured. We've got a million-two newly insured individuals. Yet there's been no reduction in care for and funding for the Indigent Care Pool. So the state today is funding at almost a billion-dollar level the Indigent Care Pool.

And if we have that many newly insured individuals and a reduced uninsurance rate in the state, there should be less of a need for funding of the Indigent Care Pool. Massachusetts expanded their insurance,

reduced their indigent care pool. We think New York should consider doing the same.

A final alternative to the tax. There was some talk this morning about the Basic Health Plan. In the budget, it's to go into effect, I think, 4/1/15. And a key part of the program is to take what's called the Aliessa population -- these are legal immigrants that the state today is paying a hundred percent of their Medicaid premium -- move that population through the exchange and

Basic Health Plan, and pick up 50 percent federal participation.

The budget targets the savings from that at over $900 million. We would say a piece of that savings should go towards paying for the exchange because it's being generated by virtue of the fact that population is now going to run, if you will, through the exchange.

Finally, it really is bad policy, when you think about it, to impose a new tax to basically finance an executive order program. I'm not talking about a statutory program like some of the others that have been discussed earlier today, but we're talking about something created by executive order. We're not aware of any legislative audits of the exchange in terms of their financing and their spending.

We find it also strange that the exchange tax is actually imposed through the Insurance Law, with DFS being the principal administrator of the tax. And it's only imposed on New York domestic insurance

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companies. It's almost like the narrowest base you could tax to try and generate this money.

Now, I've heard a couple and I've seen a couple of statements from Division of the Budget or whatever saying, Well, it's a $68 million tax, and it's a, quote, modest tax. It's $68 million.

The real impact of the tax is going to come in the premiums. So we have a tax going into effect for 2015 -- it's not in the insurance premium rates today. It's going to be paid in 2016. That's the way this tax is structured.

So when the health plans go to file the rate applications this spring for 2016, we're going to build in $68 million to pay for 2015, we're going to build in $68 million to pay for the 2016, if you will, liability. And also the federal grant money that exists today as the last, I assume, plug is going to disappear, and we're going to have to make up that money as well. So we're going to be looking really at about $200 million of new

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taxes that will be in our rate applications for 2016.

Which leads me to my second point, the prior approval rate process, which you the legislature adopted in 2010, requires the superintendent of the Division of Financial Services to use actuarial assumptions and methodologies in reviewing the rates and giving written decisions to justify those rates. That was added, that language was added to prevent the suppression of rates, artificial political suppression of rates. And it was to set some parameters on the actions that could be taken.

This year we were profoundly disappointed to see the 2014 rate cycle come out, and there has been no disclosure of the actuarial assumptions and methodologies, and there's been no written decisions of the basis for the decisions.

We need transparency in this rate process. Consumers need it, businesses need it, health plans need it. We need to know that the rate is actuarially sound and that

the decision is justified. We need it not only for this new sustainability tax or the HCRA taxes or the ACA tax or other components of a premium rate, but we need it to guarantee the financial solvency of health plans.

I'm here to tell you, and you've heard how hospitals are all hurting financially, home care is hurting financially. Health plans are hurting financially as well. I'd say virtually all the health plans in the small-group market are losing money.

There have been a number of articles out recently, whether it's the local plans here of CDPHP, MVP, HealthNow, Independent Health, Excellus, Emblem, all of them, if you look at their third-quarter financials, they're all running in the red. These are warning signs that we all have to be aware of as we proceed. And we would urge you to ensure DFS compliance with the law in terms of the actuarial assumptions and methodologies and written rates decisions to prevent problems from occurring in the future

in terms of solvency of plans.

The third and final point I just want to make is that the budget contains a number of provisions that are, I'd say, vague, open-ended, need some legislative review and structure, and I just wanted to point out a couple of them.

The value-based purchasing provisions include some language for these PPS entities coming into existence that directly contract with the state to arrange for the delivery and provision of services. Now, that

phraseology is the same phraseology that's used to determine an entity becoming licensed as an insurance company and providing insurance coverage, insurance services. And it's slipped into the value-based purchasing language to permit a PPS to, in effect, become an insurance company without necessarily meeting all the requirements of DOH or DFS for an insurance company.

So consumer protections about notices and appeals, or reserves to protect providers and consumers and businesses, are not

mentioned at all. And we think that that's an area and issue that you need to look at as this proceeds going forward.

CHAIRMAN DeFRANCISCO: Paul, can you glance down in front of you?

MR. MACIELAK: Can I -- excuse me?

CHAIRMAN DeFRANCISCO: Could you glance down in front of you?

MR. MACIELAK: Yeah.

CHAIRMAN DeFRANCISCO: You see the clock there?

MR. MACIELAK: Zero. Well done.

(Laughter.)

CHAIRMAN DeFRANCISCO: It's been there for a little while.

MR. MACIELAK: It has?

CHAIRMAN DeFRANCISCO: Yeah. That's all right, but you --

MR. MACIELAK: I thought I was shorter than the other speakers.

CHAIRMAN DeFRANCISCO: It doesn't matter, you were very engaging.

MR. MACIELAK: So I'll finish. I'll say --

(Laughter.)

CHAIRMAN DeFRANCISCO: You are.

MR. MACIELAK: -- say no to the exchange tax. The prior-approval rate process, please ensure that it's followed. And third, try and close the loopholes that exist in some of the statutory language produced.

CHAIRMAN DeFRANCISCO: Thank you.

Any questions? Thank you very much.

MR. MACIELAK: Thank you.

CHAIRMAN DeFRANCISCO: Al Cardillo, executive vice president, Home Care Association of New York.

Elizabeth Dears-Kent, on deck.

MR. CARDILLO: Good afternoon, Mr. Chairman and members of the committee.

CHAIRMAN DeFRANCISCO: Good afternoon.

MR. CARDILLO: I think the clock already says zero to start. So I'm starting with that preference.

CHAIRMAN DeFRANCISCO: Give him two minutes, will you?

(Laughter.)

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MR. CARDILLO: Thanks.

Again, on behalf of the Home Care Association of New York, I'm very pleased to have the opportunity to provide some remarks to you today, not only about the budget but about the status of home care and some recommendations that we have related to the field.

For the purposes of the members, and in the audience, the Home Care Association represents the full complement of home care programs and services across the state. We have members that also manage long term care plans, hospices, and basically that run the gamut.

In the testimony today -- and I will just highlight points in the testimony. We have a lot of details in the written narrative. We also have two documents that I'm going to refer to that really are intended to assist afterwards as a reference to really walk through, in a very brief but I think clear form, the proposals that the Home Care Association would make relative to

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the budget, and also attached to that is a statistical financial condition report which analyzes the cost report, experience of home care agencies, managed long term care plans,

and other statistical information which really will help provide a foundation for the proposals that I'll talk about.

But I couldn't help but think of the synchronicity between what we found in our analyses and some of the things Paul Macielak just spoke about, and certainly our prior speakers and colleagues.

In presenting the testimony, what I really want to do is just start with reference, kind of a reminder reference to the broad changes that are occurring within the delivery system and the payment system in New York. It's very important because it cues up the rest of what we have to say.

So clearly there are major changes and new models that are being implemented in the state -- FIDA, DSRIP, value-based purchasing, mandatory enrollment, health homes, accountable care organizations, all of these

policies. The key aspect of these policies is that they are intended to try to maintain the health of patient in the community and largely at home -- that is a key focal point -- and working toward a reduction in utilization of high-cost services, particularly on the institutional side.

So the policies really cue up a very important role and charge for the home care system in the state. So really I think the

basis of what I want to present today really goes to that point. Home care is being asked to assume a major role in the state's health reform plans. Home care providers are eager to be responsive, but there are certain things that are necessary to help equip providers to fulfill the role that is being asked, and I think largely to enable the models to work. And I'd like to review some of those.

Just one other preface statement. Aside from the models, obviously the needs of the citizens are continuing to increase, and the preference of citizens to receive

services in the community are likewise, you know, increasing as the awareness to receive services at home also increases.

Home care's reach is not just in terms of providing the service in the home, but home care really works across the spectrum to provide resources for care transitions in the hospitals, for emergency room diversion, working with primary practices for medical management. Home care is really throughout the system. And so part of these proposals that I will offer relate both to supporting home care in its role in the models and to meet citizens' needs in New York.

So to go through them -- and again, they're laid out in the documents so I won't

go into a lot of detail with them, but there's six points. And then I also will talk quickly about some of the Governor's proposals.

So the first relates to financing and incentivizing health information technology in the home care setting. Health information technology and healthcare technology is a

core across all the sectors. It's something that's going to link, in the future, everything from quality to payment to accountability, best practices and so on.

Senator Hannon, you were very gracious in sponsoring legislation to actually add home care to the State Information Technology Workgroup that met over the fall. Both you and Assemblyman Gottfried were on that workgroup. I think that it goes without saying that home care really needs to be pulled into the financial support base for information technology. The federal government, state programs over the years have lent support to the hospital sector and other sectors, but home care has rarely been on the map for any general systems support. That's a very critical issue, and we would commend that to your attention.

The next issue has to do with coverages for services. And I'd like to point this out in this recommendation, to

look at the health insurance covered program in the state and to look toward modernizing

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that coverage as it relates to home care.

Just a quick background on it. The home care insurance law was basically written in 1972. The system was obviously very different then. When you went into the hospital, the hospital was paid per diem, you stayed there until you could walk yourself out to the car. When you got older and sicker, if you didn't have family, nursing homes were available to you.

The coverage parameters for home care are very, very narrow. They don't match the current environment that would be valuable to not only the health system, the hospitals and the other players in the system, but ultimately to consumers.

So we would commend to your attention the consideration of an update to those laws so that home care is allowed to function the way it would, say, in Medicaid, allowed to function that way in the general system. We believe that doing that not only again improves functionality but improves efficiency, provides an offset to Medicaid --

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because many people spend down because they don't have other sources of coverage. And again, it's something that works in

synchronicity with the way the system is going.

Next relates to the adequacy and efficiency of the payment process. And again, prior speakers spoke to this as well as Paul Macielak from the standpoint that the current payment mechanisms for managed care and for home care are very, very much inadequate to meet the actual service demands and the missions of these sectors. And the testimony and the material that we give you will go into detail in that regard, but the level of fragility in the health-plan system and in the home healthcare system is pretty extraordinary.

I'm not here today to say bail us out of everything, but what I am here to say is that if home care is going to be looked at to serve the role that the state wants it to serve, then both home care agencies and managed-care plans have to be compensated

adequately to meet that mission.

The other thing that I would point out is that -- and, Senator Hannon, this is something I'm sure is well-seared into your memory, is in all of the discussions of the change from the regulated rate system for hospitals to the negotiated system, one of the key points was how do you finance public goods once you go to a negotiated system.

And remember, we spent weeks, months, incredible amounts of time looking into the issue, researching options, and trying to ensure that when you go from state-set rates to a negotiated system, the public goods, the public health aspect of that is maintained.

That is dwindling in the managed-care environment, and certainly dwindling in the home care environment, as rates are changing from set rates to negotiated payments. And so we would again commend to your attention a series of improvements that could be made to the payment structure for home care and managed care to address some of these deep-seated issues.

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In the Executive Budget there is a proposal to rebase the certified home health agencies' payment system -- so this is direct state to home health agencies. In doing that, there is an anticipation of a pretty significant decrease in the amount of funds that will be available to home health agencies. We are concerned about the loss of funding and what that might do to stability.

But at the same time, if there's going to be a rebasing, there's no provisions within the current certified agency system for investing in some of those public goods that I was just talking about. So for example, information technology, quality,

local public health activity, responding to emergencies -- all those kinds of things could be looked at in the rebasing and the conversion of the system. We would commend that to your attention.

There are also a number of items in the Executive Budget that provide new sources of financing, and you've heard from the hospitals and you heard from the other

sectors about them. We support the actions certainly of the Executive to put $12 million of funds for sole community providers, for vital access for clinics, rural area funding, $1.4 billion in capital, and disaster preparedness funding for nursing homes. But nowhere in any of the investment initiatives does the word "home care" appear.

So on the basis of what I've been talking about all along in terms of home care's role and the role that we need home care to play to make these models work, we would ask you to look at these investment proposals that are in the Executive Budget and determine where home care could either be woven in or where a parallel initiative could be created for that. And we would be happy to work with you, you know, certainly in that regard.

One very large area of payment that's been talked about, I want to reference it for

30 seconds, is the value-based payment plan. We have the opportunity to also participate in the Health Department's workgroup looking

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at value-based payment. We certainly agree that there's a lot of opportunity to improve the payment system and to better align quality with payment, but it's a very, very complicated process. We are aligned with the Hospital Association, the Health Plans and others in terms of really arguing for more -- a better timeline and I think reasonable goals and flexibility into how to approach the value-based system.

I'll just touch on my last comment?

CHAIRMAN DeFRANCISCO: Go ahead.

MR. CARDILLO: So a last area that I would mention relates to quality enhancement. I would like to say that our association has been very, very active in pursuing quality initiatives and quality advancement. There is much opportunity for savings and for improvement of care in these quality initiatives, and I would really welcome the chance to talk to you about this in greater detail.

An example of one of the areas that we're looking at has to do with sepsis, which

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is one of the major causes of admission and

readmission in hospitals in New York State. Most of the focus is on either the ICU or somewhere after you get through the ER. There's a very strong line of thought that that should be pushed out into the community setting before you get to the hospital door, which would not only save life and limb but certainly save tremendously on expenses.

CHAIRMAN DeFRANCISCO: Al --

MR. CARDILLO: With that, I certainly will take my cue and conclude.

CHAIRMAN DeFRANCISCO: Yeah. Your preface was too long, that was the problem. The preface took longer than the whole substantive part. But I've got to be fair to everybody else, as they've been waiting.

MR. CARDILLO: Oh, sure. Of course, of course. So -- but the details of the other issues are in our testimony, and I thank you very, very much for the opportunity.

CHAIRMAN DeFRANCISCO: Thank you.

SENATOR HANNON: Thank you.

CHAIRMAN DeFRANCISCO: Any questions?

Okay, thank you.

Elizabeth Dears-Kent, Medical Society of the State of New York.

MS. DEARS-KENT: Good afternoon, everyone.

CHAIRMAN DeFRANCISCO: Good afternoon.

CHAIRMAN FARRELL: Good afternoon.

MS. DEARS-KENT: On behalf of our president, Dr. Andrew Kleinman, and the 25,000 physicians we represent, I want to thank you for giving us this opportunity to speak with you today on the proposed budget.

Like many of the individuals who preceded us here to this table, physicians are facing many challenges these days. They have an outrageous education debt load, they have very significant medical liability premium burdens. The cost of health information technology and the cost of intraoperability is also significant.

The cost of meaningful use or attaining meaningful use or attempting to attain meaningful use, the complexities

associated with all of the new business models, whether it's ACOs, patient-centered medical homes or other integrated care delivery models, and reduced medical fees -- we need your help to assure not only just the financial viability of physician practices but also patient access to physicians with whom they've had long-standing relationships.

With regard to the budget, first I want to thank Senator Hannon, Senator Valesky and 29 of your peers for introducing the bill to delay by one year the e-prescribing mandate. This is certainly an issue that

affects all prescribers, but it also affects patients.

And we really believe that in addition to the delay, we really need to work with the state in assuring that patients are educated as to what's coming, whether it's a chronically ill patient whose e-script arrives at a pharmacy that does not have a supply of their medication and that causes a delay in their access to that medication, or whether it's a patient who likes to shop

around for the best-priced drug, or if it's just educating patients that they need to tell their primary care practitioner that in addition to their normal pharmacy, "Oh, by the way, it's not open 24/7, and if I call you in the middle of the night, please scribe to the chain pharmacy at the corner of Route 20 and 155." These are all issues that we think need to be addressed, and how better to do it than through a patient education effort.

We also thank the Governor for continuing the Excess program. However, it's included this year in the revenue bill, and that's because it's linked to a tax obligation clearance. So physicians who would be eligible for the Excess program would have to obtain, from the Commissioner of Tax & Finance, a tax obligation clearance.

Now, ostensibly it's worded in such a way as to pertain to finally adjudicated tax claims. However, there's a two-part analysis here, and it allows the commissioner to look at the tax returns of each physician for the

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past three years. And if in the commissioner's view the physician hasn't complied with the applicable return filing, then they could withhold that tax obligation clearance and prevent the physician from availing themselves of the Excess coverage.

There are a couple of other proposals I'd like to highlight. A proposal with regard to urgent care practices we feel may adversely impact the ability of physicians as urgent care. First of all, we think the definition is overly broad and could pertain to any physician practice with after-hours or weekend availability. Also, they would impose an accreditation requirement which is quite costly to these practices, ranging anywhere from $10,000 to $30,000 per practice.

Physician urgent-care practices are well known in their communities and are relied upon by patients who need acute episodic care when their physicians are not available. If they can't sustain, patients will be relegated to the more costly ED unit.

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The proposal with regard to office-based surgical practices is also quite concerning. It would add a registration requirement, and it adds very significant data collection provisions. OBS practices were required by the Legislature in 2007 to be accredited, and that accreditation is quite rigorous and reoccurs on a regular basis.

The Quad-A, which is one of the accredited entities that reviews physician practices, already maintains a nationwide database with 12 million cases in it. And it demonstrates that intraoperative deaths in office-based practices occur at a very low rate -- one in every 478,000 -- and also show the very low infection rates, one in every 2400 procedures. Should procedures now occurring in OBS settings move to hospital-based settings, the complication rate would surely increase.

Another proposal, which would allow for corporately owned limited-service clinics in retail establishments, is also concerning

to us. At a time when the system is moving toward greater integration and care coordination, establishing additional competitive separate sites of care seems counterintuitive.

Lastly, I'd like to also concur with

Mr. Rich, who touched on the Medicaid crossover payment issue and on the loss of the primary care physician payment bump. Both are critical, we think, to continuing to allow physicians to continue to practice in primary care and serve the needs of the fragile, dual-eligible population.

With that being said, we'll of course take any questions, and we thank you again for your time.

CHAIRMAN DeFRANCISCO: Any questions?

SENATOR HANNON: What can we do to encourage physicians to take Medicare?

MS. DEARS-KENT: Well, this has been a historical problem. As you know, Medicaid really didn't pay physicians very well for the first 50 years of Medicaid. And --

SENATOR HANNON: Medicare.

MS. DEARS-KENT: Oh, Medicare.

SENATOR HANNON: Medicare.

MS. DEARS-KENT: Well, I'm going to turn this over to Mo Auster, my colleague, who touches on the federal issues.

CHAIRMAN DeFRANCISCO: Would you state your name first?

MR. AUSTER: Mo Auster, vice president for legislative and regulatory affairs of MSSNY.

And it's been touched upon by previous testifiers before, about part of the problem

is on a federal level there's this crazy formula called the Sustainable Growth Rate Formula that every year threatens to cut Medicare physician payments by 20 to 25 percent if Congress does not step in to intervene.

Now, each year Congress -- but it's the threat of the cut --

SENATOR HANNON: What can we do at the --

MR. AUSTER: It's the threat of the --

SENATOR HANNON: What can we do at the

state level?

MR. AUSTER: Well, what we can continue to do is frankly make sure our congressional delegation actually takes the action that we need. Part of the problem is that -- everyone agrees that we need to fix it, no one can find the revenue source to do it. So we actually need to find the money on a congressional level to do it over a long-term period of time.

Congress has to set out payment over a 10-year schedule, so certainly, again, the extent to which there can be, you know, monetary availability that can come from Congress to be able to make sure that we do not have this threat or dagger hanging over a physician's head every single year is essential.

SENATOR HANNON: No more.

CHAIRMAN DeFRANCISCO: I have a question on the Excess coverage. What does the doctor -- I know that you said the doctor would have to submit tax returns. What would they be looking for if tax returns

are provided?

MS. DEARS-KENT: Compliance with the tax law. So to assure that the returns have been prepared accurately and that the tax that's due is paid.

CHAIRMAN DeFRANCISCO: But that -- but that doesn't -- does that apply to any other profession or occupation?

MS. DEARS-KENT: It's going to -- it is established for everyone, but it is -- but they condition eligibility for the Excess program to tax -- this new tax clearance initiative.

CHAIRMAN DeFRANCISCO: Wouldn't they already have their tax returns filed and available through the Tax Department?

MS. DEARS-KENT: Yes.

CHAIRMAN DeFRANCISCO: So how do they determine whether it's a properly filed tax return?

MS. DEARS-KENT: It's up to the commissioner.

CHAIRMAN DeFRANCISCO: And how does one relate to the other?

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MS. DEARS-KENT: I don't believe that they do.

CHAIRMAN DeFRANCISCO: Okay. So you don't like it.

MS. DEARS-KENT: No. We would like to see that --

CHAIRMAN DeFRANCISCO: Neither do I. I think it's ridiculous. But that's number one.

There was a mention earlier, I think Senator Krueger brought it up first, about removing the online medical malpractice -- the website. And I would assume you don't mind that, that that would be okay. But the question is, did the Medical Society advocate for that, or is that simply a cost-cutting measure that was proposed?

MS. DEARS-KENT: I believe it -- we did not advocate for it. And I believe it is, as proposed, to be a cost savings to the ...

CHAIRMAN DeFRANCISCO: Okay, thank you.

Anyone else? Thank you very much.

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Sorry for the long wait.

MS. DEARS-KENT: Thank you.

CHAIRMAN DeFRANCISCO: James Kane, executive board member and treasurer of the

Empire State Association of Assisted Living, to be followed by Dr. Bryan Ludwig, who is on his way down now.

Thank you.

MR. KANE: Good afternoon, and thank you for taking the time to listen to our testimony.

As you said, my name is Jim Kane. I am the past president and currently the treasurer of the Empire State Association of Assisted Living facilities, and to my left is Lisa Newcomb, the executive director of the Empire State Association.

I want to limit my testimony today to two what we consider very critical areas for adult care facilities, facilities that care for our low-income seniors and disabled individuals who are on SSI. The first issue is the urgent need for an SSI increase. Our rate is currently $41 per day, and it's

obviously inadequate. The second issue is the equally important need to reject the Governor's proposed elimination of the EQUAL program and restore the program at $6.5 million for the coming year.

As a bit of background, ESAAL is a nonprofit organization that has been dedicated to strengthening New York State's assisted living network and promoting the best interests of assisted living providers

and residents since 1979.

ESAAL is the only association that exclusively represents the assisted living provider network, serving more than 275 licensed assisted living residences, adult homes and enriched housing programs throughout New York. These member residences are home to more than 23,000 seniors.

While ESAAL represents the entire assisted living industry, I am focusing my testimony today on those facilities that provide housing and care for our low-income SSI recipients.

The SSI rate must be increased so that

ACFs can continue delivering quality care and services to low-income SSI recipients. Currently, ACFs are paid $41 per day to provide housing and a wide array of care and services to SSI recipients, including three meals per day, housekeeping, activities, supervision, case management, medication assistance and hands-on personal care. Let me repeat that, $41 per day to provide housing, care and services to each SSI recipient. And we do that 24 hours per day, 365 days a year.

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 $41 a day. And I can tell you that I recently boarded my dog and it cost me just about the same $41 a day to board my dog as it does for what we get reimbursed.

The last time the state increased its share of the SSI rate was seven years ago, in 2007. And the last increase before that was

17 years earlier. That is one rate increase in approximately 25 years. With one rate increase in 2 decades and no state COLA, the SSI rate has fallen far behind the costs of providing care and services.

Since the last SSI rate increase in 2007, facility costs have continued to climb every year. Over the past 7 years health insurance costs are up 42 percent, the minimum wage has increased by 26 percent, and workers' compensation costs are up 15 percent. With these rising facility costs, it is becoming increasingly difficult to meet costs and deliver all the state-mandated care and services to SSI recipients.

In 2013, there were approximately 260 ACFs that housed and cared for SSI recipients. Many of these ACFS only accept a certain number of SSI recipients at any time, because it is impossible to meet these facility costs solely on the SSI rate.

Indeed, a significant number of ACFs that cater solely to this low-income population

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have been forced to close their doors and move their residents out of their homes.

Approximately seven facilities voluntarily closed in 2014, mostly because of financial hardship, and a total of 20 facilities have closed over the last five years.

And I can speak from experience here as well as anyone. My company is a family-owned business that started in the early 1970s in upstate New York, and at our peak we had 14 facilities serving 511 low-income residents. Over the past few years, we have closed six of our 14 facilities, all due to financial losses. We now have eight facilities remaining, serving 359 residents.

Over the past year and a half, we have closed three of those facilities, resulting in 88 low-income recipients having to leave their homes and find alternative housing. In many, many cases the alternative was a nursing home. And while it has been painful to have to close our facilities and move our

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residents, the part that is so unbelievably frustrating is the last part, watching our residents move into nursing homes prematurely

at a far greater cost to the state.

For every displaced SSI recipient upstate who ends up in a nursing home, the daily cost for the state of housing and caring increases dramatically, from $41 per day to approximately $150 and sometimes as much as $250 a day. And in some parts of the state, the nursing home rate is even greater.

I want to take just a minute to cite one of the most recent cases. Just five weeks ago, in Onondaga County, a very small SSI facility that had been caring for frail, low-income seniors since 1979 had to close. When that SSI facility closed, five out of the remaining 13 residents were moved into nursing homes. There was nowhere else for them to go.

The difference in daily cost to the state for those five residents are as follows -- and I listed all five of them in our testimony, but I'll just mention that out

of those five, each one went from $40.83 per day to between $160 and $205 per day. The total cost to the State of New York for those five residents in 2015 will be $267,000 in additional costs, and that's for five residents.

The simple reality is that SSI beds are, by far, the best bargain the state has to care for low-income seniors and disabled

individuals. 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 in most cases is for a few hours of care per day, as opposed to the 24 hours of care we provide.

It is important to note that most of the residents that we are talking about must live in a 24-hour supervised environment such as an ACF. They cannot live alone and receive services 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 recipients are now setting aside fewer and fewer beds for this 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 imperative that the state increase the SSI rate this year. ESAAL is respectfully asking the Legislature to increase the SSI rate by $15 per day, over a

three-year period, to $55 per day. And of course, on behalf of our residents, ESAAL likewise respectfully requests a commensurate 25 percent increase over a three-year period in the personal needs allowance provided directly to SSI recipients in ACFs.

My second point is around the EQUAL program. The Legislature should restore the EQUAL program and reject the Governor's

unjustifiable cut of this important program.

To further assist in the operations of those facilities serving primarily the needy, the Legislature created a program years ago to help SSI facilities. It's designed to make quality improvements each year. The program was originally called the Quality Incentive Payment Program, or QUIP. The legislatively championed QUIP program has been in existence since the early 1990s and, while relatively modest, has become a vital necessity for enhancing care and services at our homes. Just a few years ago the Executive renamed the program EQUAL, or Enhancing the Quality of Adult Living program.

Over the past few years, the Governor has recommended and the Legislature has accepted funding the EQUAL program at approximately $6 million to $7 million per year. ACFs receive a per-person amount based

on the number of SSI and safety-net residents in their facility, with an additional supplement for smaller facilities with

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100 beds or less.

And that's important to point out because the program is designed to put the money in those facilities that are the most needy, the smaller ones.

Importantly, these monies are only allocated with the approval of the ACF resident council. Thus, the residents themselves approve of the important use of these funds.

This past year, $5.7 million was distributed to 261 ACFs. The awards this year ranged from a low of approximately $700, in one very small facility, to as much as $70,000.

The EQUAL program provides critically important funding to ACFs to make real quality improvements that we would otherwise be unable to make for our residents.

In the past this funding has helped facilities purchase air conditioners, backup generators, computers, new furniture and other amenities, as well as offer upgrades to improve the physical environment. It also

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allows us make programmatic improvements to

improve residents' quality of life and help them live more independently, such as wellness and nutrition programs, independent living skills training, and falls prevention programs.

It is shocking that the Governor proposed the complete elimination of this critically important program in the Executive Budget. According to the budget materials, the Executive is proposing to take last year's appropriation of $6.5 million and to do two things with it: One, achieve a state-wide savings of $3.3 million; and, two, spend the remaining $3.2 million on the transition of individuals with severe mental illness who currently reside in ACFs into supported housing. And that's despite the fact that there is another appropriation of $38 million proposed in the OMH budget for this same purpose.

In our view, this is a draconian cut and shocking elimination of a beneficial program that has long delivered quality

improvements to the homes of low-income seniors and disabled individuals.

We respectfully request that the Legislature reject the Governor's proposed elimination of the EQUAL program and fully restore the program at $6.5 million for the coming fiscal year.

Thank you. I know I talk fast, but I was trying to hurry for the time. And I'll take any questions.

CHAIRMAN DeFRANCISCO: Just thank her. She's got to get your words down, the stenographer over here.

MR. KANE: I'm sorry, I couldn't hear you.

CHAIRMAN DeFRANCISCO: I'm sorry. I said thank her, she's got to get every word down, the stenographer. And her fingers are numb right now.

MR. KANE: That was probably a tough job.

CHAIRMAN DeFRANCISCO: Any questions?

I know we've talked before about this issue, and it just boggles my mind. And I'll

do what we can, but how -- in so many instances the higher-cost services keep rolling on and the lower-cost services, with your type of facility, home care and all of that, get the short end of the stick.

And when that happens, as you stated clearly and with evidence, why are we pushing people into a higher-cost setting? It just doesn't make any sense.

So hopefully -- and I know others in the Senate have talked about that, I'm sure in the Assembly as well. We'll see what we can do. But we appreciate you taking the

time to be here.

MR. KANE: Thank you. I appreciate it very much.

CHAIRMAN DeFRANCISCO: Okay.

Dr. Bryan Ludwig, to be followed by Mary Sienkiewicz.

DR. LUDWIG: Thank you. My name is Bryan Ludwig. I'm happy to represent the New York Chiropractic Council today.

Senator DeFrancisco, you asked what -- if we were to scrap the whole system, what

would we do. And I think you've come back to that a few times.

CHAIRMAN DeFRANCISCO: Okay.

DR. LUDWIG: So throughout my testimony today, over the next five to six minutes, perhaps we'll get some ideas with that.

Just to lay a small groundwork to that, I think higher-level-cost healthcare items tend to come when people are less healthy, so it tends to cost less to keep them healthy in the first place. And some of that I was trying to put in my testimony when I spoke to the proposed New York State Workers' Compensation fee changes just a couple of months ago.

But I want to say thank you to the Legislature for making September 2015 Chiropractic Health Month. That's very

important to us.

We have a lot to explain, there's a lot to explain. There's a lot of myths about what chiropractors do. We try to let people know that health comes from within, that we

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all have the inherent ability to heal, that our neural immune systems control this. And that's what I work with as a chiropractor.

I don't crack backs, I don't work on pain. They'll say, "Hey, here's my pain, work on this right there." You know, that's not what we do. It's a nice side effect; you feel better. Enough of that.

So the last couple of years I testified before you, and I hear a lot about the treatment of disease. Which I don't do, but it costs a lot of money.

And then I'm hearing Dr. Zucker from the New York State Health Department say, Hey, we got a lot of data collected, we haven't been willing to change the dynamic.

David Rich, of the Greater New York Hospital Association: Care needs to be provided so that people don't get sick enough so that they need to go to the hospital.

Some common themes here that are finally starting to come together. Well, as a chiropractor, there's starting to be evidence that what we do allows people to be

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healthy. I've known that for a long time.

When I adjust a child, it's not for pain. Maybe they have ear infections and they no longer have them. Did I treat the infections? No, I did not. But I also see the same trend when I do a health history on somebody, an adult, say, and I'll go all the way back to their childhood. I'll say hey, what was their birth history like. "Well, boy, they really had to pull on my neck. Then I had ear infections. Then I had asthma. Then I had headaches." All this stuff costs more and more as their health degenerated more and more.

So as you look through -- you'll see some studies I'd be happy to have you look at, but I'm not going to read them -- they talk about how the longer somebody is under care, not only do they feel better but their health improves.

So, for instance, it talks about hospital admissions decreased by over 60 percent when this one insurance company over seven years used chiropractic care as a

gatekeeper. So the longer they used it, the less they were in the hospital.

So you might say, Well, boy, there is going to be a problem with that, hospitals will go out of business. Well, maybe the same thing that happened in agriculture in

Schoharie County, where I live and where I work: A lot of the farms that only did dairy started to have problems. They had to diversify. They had to do other things, raise grass-fed beef, things like that.

Well, maybe they should start to get reimbursed -- say, the respiratory therapists in the hospital, instead of just for administering the medication to the person who has COPD, maybe the hospital should be reimbursed for having that same therapist spend time and teach that patient so they don't have to come back. Instead of just penalizing the hospital for them coming back.

So there's a lot of barriers to what we do, there are a lot of myths to what we do. We've been shown to be cost-effective but historically reimbursed really poorly.

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We would love to see that change. We would think that any New Yorker should have the right to seek out chiropractic care without interference. I shouldn't have to have a patient call my office and say, "Hey, Dr. Ludwig, do you take Medicaid?" And my answer is "Medicaid doesn't take chiropractic." I get this call all the time. It's not -- you're saying, hey, how do we get physicians to get into Medicare. That question was asked. Here, we can't even get in if we want to. So all these people are

not being taken care of. Or they pay in cash, which is usually more than what they can take care of.

So there are a few things that can improve our health and actually change our genetic potential. We know that if we exercise, certain genes are expressed and certain genes are no longer expressed. We know that if we change how we eat, the same thing happens. We also know that when your nervous system has interference to it, from your brain to a certain organ, that those

genes are affected and expressed differently.

So when I do a chiropractic adjustment on somebody, it is not to relieve pain, it is to allow them to be healthier on the inside. Over time, things heal, get better, tissue damage starts to go away. That is a time factor.

So I would like to ask the members of this joint committee just to recognize the proven cost benefits and effectiveness of chiropractic care.

Please acknowledge the historic unjustified bias against chiropractic in our State Workers' Compensation system, our Medicaid system and in our healthcare system.

You know, as we're contemplating a new fee schedule, as you're thinking about that, I ask you to remind the Workers' Compensation

board to be true to their mandate to protect the injured worker by recognizing their right to seek out appropriate quality healthcare in a system that respects both patients and all healthcare providers.

When healthy people stay healthy or

when sick people become healthy, they need less drugs, they need less surgery, and it costs less money.

I don't have a timer, so I don't know how long it took. It's not counting down.

CHAIRMAN DeFRANCISCO: It's been counting down. Are you asleep over there at the switch? No?

(Laughter.)

CHAIRMAN DeFRANCISCO: Thank you very much.

And you should know there's now a chiropractor as a member of the Senate, so you might want to talk to him. He'll definitely understand what you're saying.

Anyone else? Thank you very much, Doctor.

Mary Sienkiewicz, New York State Area Health Education Center System.

On deck, Tracy Russell, Executive Director of the Pharmacists Society of New York State.

MS. SIENKIEWICZ: Good afternoon.

CHAIRMAN DeFRANCISCO: Good afternoon.

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MS. SIENKIEWICZ: I appreciate the opportunity to provide testimony this afternoon. I have prepared a one-page testimony with four points. There are some additional pages after that, should you be interested in some more detail.

Our first point is to request that you retain $2,077,000 for the New York State AHEC system -- that's level funding from this year -- and that you reject the proposed process to pool AHEC with health workforce funds with other line-item programs.

These cuts would be devastating for our nine AHECs. We have -- the 15 percent reduction is over $300,000. That is about what two of our nine AHECs get this year in funding.

The pools, the impact that that would have were we not to know by April 1 what our funding level would be, we would have problems. We would not be able to conduct our summer programs for students that are experiencing health careers.

I included a graph on the one-pager so

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that you can see the impact of funding cuts over time. You can see that there were across-the-board cuts three different times. Those are the blue bars. That is

cumulatively a 17 percent cut, or nearly $450,000. The line at the top is the cumulative inflation over that same period which is about 13 percent. So a 30 percent reduction in what we've been able to do over that period of time.

And I have to say we have done more with less, we've done the same with less, but the proposed cuts will mean that we'll have to do less with less. And that's that red bar that you see at the end.

We did actually request an increase of Commissioner Zucker because we believe that the health workforce is critical to all of these initiatives that we've heard about today and others that we know are important. And we believe that we've been able to show proven results. From pipeline to practice, early on in a student's career trajectory, middle and high school students, as they're

experiencing health care careers for the first time as health profession students, when they're working in underserved communities and as healthcare providers, when they're monitoring new students and seeing patients.

We've documented our outcomes both in terms of short-term results, as students increase their knowledge and appreciation of health careers; intermediate outcomes, as

students -- we know our AHEC students are more apt to be in college and college training than state and national rates; and also as they become healthcare providers.

I would encourage you -- we have a legislative open house, as it turns out, Wednesday morning at 9 a.m. in the Legislative Office Building, Room 711A, and we have four AHEC participants coming to explain about their experiences. We have a Brooklyn high school student who has experienced a summer program, we have a nurse who has graduated nursing coming with her mentor, and we have a family nurse

practitioner who now is working at Hudson Headwaters who had an experience because of a Hudson Mohawk AHEC.

So that is the full from pipeline to practice, recruiting students from all ages in terms of introducing them to health careers, giving them experiences and training, and providing them with opportunities in practice.

The return on investment is about one-third, one-third, one-third, as you can see on that last bullet in Item Number 3. The state, on average, is about 30 percent or about one-third of our budget. We match that -- we leverage that funding with other federal funds and with grants and contracts.

And I would end with saying that we believe that workforce is the infrastructure for the healthcare system. There are already shortages, others have commented on that. There is also forecasted growth for the healthcare sector.

We have nine community-based centers, three regional offices, and a statewide

office. We work with over a thousand partners a year. And we're able to have that experience over a decade, serving as a neutral broker with all healthcare disciplines and organizations.

Currently the state is transforming healthcare with federal and state dollars, but without adequate support for the health career pipeline, those reform initiatives will be delayed because professionals are already in short supply.

I have attached overview pages for the annual report that we submitted to the Department of Health. We have additional documentation beyond those pages. However, I would conclude by saying that our grow-your-own program, because we know that practitioners are more likely to practice in an area when they've graduated from New York high schools and trained in New York communities -- that our programs are a long-term solution to primary care shortages

and increasing the diversity of the healthcare sector.

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Each year that AHEC has received less than adequate funding, our ability to recruit, mentor, help train and track prospective healthcare workers is diminished.

So I would respond to any questions. We certainly have a significant program. We are committed to developing the health workforce as the infrastructure for the healthcare system. And we would encourage you to retain the funding level that we've had and also to reject the pools.

CHAIRMAN DeFRANCISCO: Any questions?

Thank you very much.

MS. SIENKIEWICZ: Thank you.

CHAIRMAN DeFRANCISCO: And thank you for the one-sheet summary. That's very helpful.

MS. SIENKIEWICZ: You're very welcome.

CHAIRMAN DeFRANCISCO: Tracy Russell, Executive Director of the Pharmacists Society of the State of New York.

On deck, Michael Duteau, Chain Pharmacy Association of New York State. Is he here?

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MS. RUSSELL: We're actually going to present together.

CHAIRMAN DeFRANCISCO: Oh, excellent.

That's fabulous. Oh, I'm sorry. Okay, I didn't see you both.

MS. RUSSELL: First, I'd like to thank you for having us here today and allowing us to present our testimony.

And we are presenting together to show you that we are collaborating and we have been working together on these issues over the years.

My name is Tracy Russell, and I'm the executive director of the --

CHAIRMAN DeFRANCISCO: Tracy, slow down just a bit. Because she's just falling off the chair right now.

(Laughter.)

MS. RUSSELL: Sorry.

I'm the executive director of the Pharmacists Society of the State of New York. It's a 137-year-old organization representing pharmacists and pharmacies across the state in all settings. A majority of our members

do practice in community settings, and this is going to be the emphasis of my talk today.

As I have stated before, we have been working together with the Chain Association on the collaborative work with the Department of Health, as directed by the legislators last year, to come up with a transparent and adequate reimbursement model.

We very much appreciate your support

over the years as you've offered it to pharmacies, specifically last year, when you stopped the Health Department from putting into effect the results of the cost survey. You agreed with us then that the methodology was seriously flawed, and that the results from this flawed data would have been devastating, not only for pharmacies but for the patients that pharmacies serve.

It's unfortunate that we're back here today to have to go through this battle again, as the department did not follow through with the Legislature's directions.

As you know, surveys continue to find that people put a great deal of trust in

their community pharmacy and pharmacist. Pharmacists are on the front line every day earning that trust. Pharmacies and pharmacists play a vital role in the healthcare of every community member across our state.

For most, the community pharmacist is the most accessible healthcare professional around -- they're available without an appointment, they're available without a copay for their services, and they're available sometimes 24 hours a day. Pharmacists may not be the first group that you think of when it comes to healthcare delivery -- however, according to Gallup's

polls of honesty and ethics, pharmacists are consistently among the most highly regarded and trusted professionals, second only to nurses.

Pharmacists in community pharmacies represent almost 4,500 pharmacies throughout the state --

CHAIRMAN DeFRANCISCO: Tracy? I'm going to interrupt you a minute. This is in

microscopic type.

MS. RUSSELL: I'm not reading the whole thing, I promise you.

CHAIRMAN DeFRANCISCO: Okay. And secondly, I would think the most valuable use of your time -- because all of us know the value of pharmacies -- I just think is to get to the specific points you're against, in your favor, if anything. All right?

MS. RUSSELL: All right. I'll get right to it. Let me scroll down, then.

Well, we know that all of the time that pharmacists spend with their patients is not compensated. They're only compensated for the products that they serve. But it can be -- now I've totally lost my track. Let me skip over here.

At the Legislature's request last year, we were directed to work with the Department of Health to meet with the stakeholders to determine a new Medicaid

reimbursement model that would be both transparent and adequate. The mandate was clear -- after years of budget proposals and

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fighting and coming to you year after year to cut this, that we should come to a resolution.

We did try to work with the department on this. Unfortunately, we were not able to come to an agreement. The stakeholders -- we were surprised that this cut was in the budget.

As directed, we met in the summer. The department cancelled the meetings in September and October. And then at our November meeting, where we were prepared to talk about value-based payment, the department told us that there would be no changes in pharmacy reimbursement in fee-for-service because the population of fee-for-service was being shifted and that they were working on focusing on the DSRIP program.

This took us off-guard, because we were planning to work with that at that meeting. We took this to mean that we could move forward and have more substantial conversations about situations where we could

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have greater healthcare savings for the

state.

We met in January with the intent, again, to discuss value-based payment. But instead, when the budget came out, we had to go back and discuss these reimbursement issues. While Mr. Helgerson did indicate that we agreed to disagree, it was more that they stopped the conversation.

A few points to consider. Throughout the meetings in the summer, and up to January 23rd, the department continued to refer to the discredited cost survey information as justification for reimbursement cuts. It was also their reasoning for disagreeing with any of the options that we presented.

This year's proposed pharmacy cut is far worse than what was proposed last year. The Legislature understood then that it was unrealistic and unsustainable, and a deeper cut only adds emphasis to the same facts.

Stakeholders offered reimbursement models that have been proven across other

states for dialogue, that we could discuss to see if we could come to an agreement, but to no avail.

New York is already among the lowest of other states in the amount paid to pharmacies for brand-name drug reimbursement under fee-for-service, and at the same time

New York ranks third in the most expensive states to live and to work.

Again, we're calling on the Legislature to restore this cut, as it's unworkable and unsustainable for pharmacies and potentially harmful to their patients. There is no other profession in healthcare or otherwise that is asked to provide uncompensated services, while at the same time be reimbursed for the products delivered at below the cost of these products. It is very plain to see that no one could sustain a business model like this, and it is not fair to the business, to the healthcare partners, or to the patients that they serve.

As an alternative to the constant battle over reimbursement rates, we would

suggest that the department investigate avenues where pharmacies can assist in cutting overall health costs while improving patient outcomes. This would be a win for all involved.

Community pharmacies are uniquely set up to advance the department's goals in the move toward more integrated, patient-focused healthcare models that will avoid unnecessary hospital admissions and strengthen the financial viability of the state's healthcare delivery system. Increasingly, pharmacists are being called upon to provide targeted

interventions and enhanced services, comprehensive medication management, and a variety of items that help patients be more adherent.

When patients are adherent, they're healthier, and it saves money in other areas of healthcare. So by incentivizing pharmacists to work more closely with the patients, instead of providing a disincentive, patients will become healthier.

So we are asking that you reject this

cut in the budget, consider the enormous savings potential that pharmacists can offer by working within the Medicaid program if they're able to practice the profession to their full potential, and recognize the other value-based items that pharmacies can bring to the table.

And with that, I will turn it over to Mr. Duteau to talk about some of those value savings.

MR. DUTEAU: Thank you, Tracy.

Good afternoon, chairman and distinguished committee members. I am excited to say "good afternoon"; I was nervous that I would have to say "good evening." But I will try and keep it on track.

My name is Mike Duteau. I am a pharmacist. I am vice president of business

Development and strategic relations for Kinney Drugs, and also president of the Chain Pharmacy Association of New York State.

In order to protect access to critical pharmacy services, we respectfully request

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that the Senate and Assembly assist us in rejecting the very problematic and flawed pharmacy reimbursement proposed in the Executive Budget.

The budget proposes to cut pharmacy reimbursement under Medicaid fee-for-service by $36 million. The Department of Health hopes to accomplish this by reducing pharmacy payments for brand-name drugs from average wholesale price minus 17 percent plus a $3.50 dispensing fee, to average wholesale price minus 24 percent with an $8 dispensing fee.

Once again, DOH is proposing to set a level of reimbursement that would pay New York's pharmacies below cost to acquire these medications. And like last year, the basis for this devastating reduction is the highly flawed and inaccurate analysis of pharmacy acquisition cost surveys conducted in 2012.

Last year DOH admitted that less than 50 percent of pharmacies would be able to purchase medications at the proposed

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reimbursement levels. The overall financial impact of this year's proposal is an even deeper cut. If enacted, it would establish an unsustainable pharmacy reimbursement model.

Requiring businesses to provide products at below cost is not consistent with Governor Cuomo's statement that New York is open for business. Furthermore, below-cost reimbursement is on top of uncollectible copayments for one out of every two Medicaid prescriptions, on average. For New York State pharmacies today, uncollected Medicaid copays amount to a loss of millions of dollars each year.

Due to the efforts of the Senate and the Assembly, last year's final state budget rejected the Department of Health's proposed reimbursement based on their highly flawed analysis of AAC. Our association and others representing all sectors of pharmacy stakeholders were invited to participate in meetings over the summer and the fall with the Department of Health, to discuss

alternative methodologies that would meet the standards set forth in the law --

CHAIRMAN DeFRANCISCO: Excuse me. Didn't Tracy already talk about that?

MR. DUTEAU: We did. I was going to get into a little bit more detail. But I can

certainly paraphrase it.

CHAIRMAN DeFRANCISCO: See the clock? I've got to keep it moving.

MR. DUTEAU: Absolutely.

CHAIRMAN DeFRANCISCO: She didn't give you much time. She already covered some of your topics.

Is there anything else in the budget? If you gave -- pinpoint what you want us to look at, reject, or include or whatever.

MR. DUTEAU: I think at this time we are focused on the cuts to AWP. We did propose some additional ways for pharmacists to provide cost savings such as collaborative drug therapy management. I know that there's a bill that will potentially be introduced again this year. I can certainly provide a very high level of detail if the committee is

so interested.

CHAIRMAN DeFRANCISCO: That would be helpful. The specifics are a lot easier for us to follow and look for in the budget, or try to add to the budget.

MR. DUTEAU: Certainly. Thank you.

Pharmacists are trained and are well-qualified to provide limited and specific drug therapy management services --

CHAIRMAN DeFRANCISCO: Would you put that down to zero again? I don't want to give him any false hope. You brought it up

to seven.

(Laughter.)

CHAIRMAN DeFRANCISCO: Okay, go ahead. Quickly, please.

MR. DUTEAU: In nearly 50 states, pharmacists are generally permitted to modify drug therapy, conduct tests and screenings, and order lab work in accordance with written guidelines established by physicians. Unfortunately, in New York, such agreements are currently permitted only for teaching hospitals.

Collaborative practice agreements improve patient care in a variety of ways, including expanding access to quality healthcare, improvement of medication adherence, and reduction of overall treatment costs through the expansion of patient oversight and reduction of duplicate services.

Pharmacists should be permitted to practice to the fullest extent of their training. In order to permit this, we support language in the pharmacy practice acts that allow physicians and pharmacists to enter into collaborative practice agreements with one another for pharmacists to provide collaborative drug therapy management, or CDTM.

CHAIRMAN DeFRANCISCO: Do you have

written remarks?

MR. DUTEAU: I do. They have been submitted.

CHAIRMAN DeFRANCISCO: Oh, they have been submitted. I think I got just one of them.

But I'm sorry, I've really got to cut you off. I really -- if these are --it sounds more like what you're talking about now is something off-budget that we would be doing. Bring the stuff to everybody and just tell them this is the bill you want. You got a sponsor yet?

MR. DUTEAU: We do have. We've been working very closely with Assemblyman McDonald and a few others.

CHAIRMAN DeFRANCISCO: All right. If you want to bring it to somebody in the Senate, I'd be happy to listen to you about it, see what we can do.

MR. DUTEAU: We would greatly appreciate that.

CHAIRMAN DeFRANCISCO: Okay.

MS. RUSSELL: So just in Mike's comments that were submitted, you'll also find some supporting documentation to our meetings with the Department of Health that were directly --

CHAIRMAN DeFRANCISCO: Okay. Good. Good.

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Anyone have any questions?

CHAIRMAN FARRELL: Yes, sir. Mr. Raia.

ASSEMBLYMAN RAIA: Hi, Tracy.

I don't know if you were here six hours ago when I was quizzing the deputy commissioner. You helped shed some light on the fact that they were supposed to be having discussions with you, and I kind of had the feeling that they put brakes on it themselves.

Was there any areas that you agreed upon during those discussions?

MS. RUSSELL: I'll let Mike address that as well, because we were both in the meetings.

MR. DUTEAU: I would say that we did not really come to a consensus on any part of the reimbursement methodologies. So I know the statement was made that we agreed to disagree. I personally do not feel that that was accurate.

ASSEMBLYMAN RAIA: Okay.

MS. RUSSELL: If I could tell you his

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definition of transparency, that it -- well, it has nothing to do with anything in the dictionary. But transparency was defined as the cost of the medication, I believe. That

was it. The cost of medication is the definition of transparency.

ASSEMBLYMAN RAIA: All right.

The deputy commissioner took great pains to say, Well, if you have any instances in which you're not getting the cost for the medication, that, you know, you can submit that.

I'm encouraging you to get me a list from your pharmacies. I have a strong suspicion we will see certain drugs where they will come in and every single pharmacist will say they're not making any money -- and I know I and the other members of the Health Committee will have no problem wallpapering the commissioner's office with those.

And if we can't get him to do it the right way, then maybe we'll have to keep pressuring him.

MS. RUSSELL: We can get you enough to

wallpaper many rooms.

ASSEMBLYMAN RAIA: So get me that information. That would be hugely helpful.

MS. RUSSELL: Thank you.

MR. DUTEAU: Thank you.

ASSEMBLYMAN RAIA: Thank you.

CHAIRMAN DeFRANCISCO: And on the copays, you know, we have a bill in the Senate which we've passed. I don't know if you've got an Assembly sponsor yet, but it's

got to go through both houses.

MR. DUTEAU: Thank you. We appreciate the support.

CHAIRMAN DeFRANCISCO: Okay. Thank you very much.

The next speaker is Linda Wagner, executive director of the New York State Association of County Health Officials.

And on deck -- no, you don't have to come down, you've been there all day. Steven Sanders is next.

MS. WAGNER: I've got to get some water. I ran out before, and I'm dry.

CHAIRMAN DeFRANCISCO: Don't let those

cups block your view of the time clock, all right?

(Laughter.)

MS. WAGNER: I'll try to keep that in mind.

Well, as a native of Syracuse I appreciate the weather here in Albany today and around the state. I'm glad I was able to get here, and I want to extend regards from all of the state's county and city health officials.

My name is Linda Wagner. I serve them as their executive director of their association, and I want to thank you for the chance to provide this input today.

We've seen a lot of evidence this past

year that disease ignores state and international borders. Ebola, when we first heard of it, was a distant threat, and within just a few months the World Health Organization declared it an international public health emergency.

So at that time our city and county health officials were already dealing with

another emergency of an international nature. Central American children who were escaping from the poverty and violence and chaos in their homes were showing up in residential facilities in New York State.

These facilities called upon the local health officials to contain a measles outbreak, to test children with bad coughs for tuberculosis, and to provide supportive mental health services for them as victims of trauma. These young refugees carried no records of childhood immunizations; they often didn't care any records at all.

Recently we've seen the measles outbreak that's come from the Disneyland episode, and we had a case in New York State of someone who was riding an Amtrak train and may have exposed many others. The city and county budgets that help to support the local health departments for addressing problems like this didn't anticipate those children from Central America or that Ebola would come

to American shores.

With the measles, there may be some

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extensive federal resources deployed for immunization. However, in that case we're battling antivaccine misinformation.

So in Sierra Leone and Liberia we've seen up close, through our television sets, at least, what it looks like when there's no public health infrastructure. You have dying patients sharing dirt floors with dead bodies. No one is there to track down the family members and neighbors with whom those contagious patients have had contact.

But in our state, local health officials in New York City and 24 other counties have been monitoring hundreds of people who've traveled to West Africa. Partnering with their hospitals, our local health officials have spent weeks and months in training and exercises to ensure that they're there and ready to protect us. They've prepared us not only for Ebola but other infectious diseases that might come to our state, and right now some are tracking the contacts of that Amtrak passenger who came down with the measles.

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Compared to most other parts of the world -- at least many other parts -- we're certainly fortunate. We recognize the need

for stable and timely funding to support core public health services. And we're pleased to see in the Governor's budget proposal, at least in news accounts of it, that the Governor and the Legislature intend to work on including e-cigarettes under the Clean Indoor Air Act, to work on dedication to an end of the AIDS epidemic. And we try to remain optimistic that this will be more than just lip service.

As you know, Article 6 of the Public Health Law currently provides a base grant to local governments, then provides state reimbursement to them for 36 percent of their cost for mandated core public health services. But during the past two years, most of the county health officials have found that 36 percent of a declining set of allowable expenses is just not enough to do the job.

As combined results of the multiple

levels of fiscal pressures, we've seen claims for Article 6 public health spending decline. But why? The executive branch may point to lower claims as a reason to lower them even further. But remember, to get that 36 percent, they have to spend 100 percent of the costs of providing the service in the first place.

Counties have not had the money to

provide all that the local health departments are mandated to provide. They certainly cannot provide all the public health services that they know, through their community health assessments, that their communities need.

So please be clear, when you look at this, the decline in state aid claims does not mean that there is less need for a strong public health infrastructure in our state. The legacy of these reductions has had a big impact on the workforces in local health departments.

The national association that we're an affiliate of profiles local health

departments nationwide. Their 2013 profile of New York reports that 74 percent of our state's local health departments lost staff through layoffs and attrition; 24 percent reported reduced staff time in the form of reduced work hours or furloughs; 57 percent reported cuts to at least one program; and 26 percent reported cuts to three or more programs.

Despite these reductions, federal and state government repeatedly ask local health departments to help them meet a whole host of public health challenges: End the AIDS epidemic; prevent and control the spread of diseases like Ebola, pertussis, and measles;

respond to the heroin epidemic that affects so many young New Yorkers along with their mental health counterparts at the local level; do all the regular work ensuring the safety of the food, the water we drink, the air we breathe; the safety of New Yorkers in camps and beaches; prevent major causes of death from chronic diseases like heart disease, diabetes, asthma and cancer;

monitor and control insect-borne diseases like West Nile Virus, Triple E, Lyme disease; monitor an influx of those unaccompanied minors into the state; respond to severe weather events; prepare for climate change; start billing for services that local health departments used to provide without charge; meet the goals of the prevention agenda by assessing community health and planning for health improvement; and, what we've heard a lot about here today, help to implement that blizzard of healthcare system changes, the Affordable Care Act, as well as Medicaid redesign, electronic medical records, regional health system planning, we've got DSRIP, we've got FPP, we've got SHIP.

We're trying to keep up with all of it like all of the rest of the health sector. The local health departments are being asked to play a role in all of these initiatives. It takes a lot of time and energy for our

local health officials to do their assessments, to collect the data that they need, to gather input from all of their

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community partners, and then identify what are the needs that need to be met and figure out how to develop programs to meet those needs.

We've seen not only a reduction in the workforce but a loss of a lot of intellectual history. Our local health departments have seen a loss of a lot of experienced leaders in public health. It requires a lot of education and dedication to be in the jobs that our local health officials have. And of course those positions all cost the counties and the city money.

So to compensate for all of this series of cuts that we've seen, including an administrative cut over the past couple of years that the Legislature can't do anything about, we are asking you to do something that you can do, which is to increase the state aid formula by 2 percent, from 36 percent to 38 percent, in the Article 6 State Aid for General Public Health Work reimbursement. We estimate the dollar value of that increase to be about $10.4 million.

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And how can you go about finding that?

Well, I like wine, I like craft beer, I like a little bit of rum now and then, but I also like to have my public health intact in my state. So one example would be that you reject the Executive Budget's suggestion of expanding the wine-tasting sales and use tax exemption to other alcoholic beverages. That ties into public health, because half of our counties, in talking to their community stakeholders, have found that they view substance abuse and mental illness as a priority in their communities.

So it seems to be a real question whether your constituents think that we should encourage more alcohol consumption in our state. That's one idea, take a slice out of that $400 million that's going to essential health providers and give just $10 million of that $400 million to the local health departments in the form of state aid.

I am not sure where else there might be money. It's not that easy to get through the entire state budget with a small staff

like ours. But I would just like to say that local health departments really need your attention at this point.

We agree with CHCANYS that all of the initiatives are to some extent ignoring some of the foundation that will actually serve the goals of things like DSRIP that, you

know, primary investment in primary care and public health can help to keep people out of the hospital. And we hope that you'll consider that in your look at the state budget.

Any questions?

SENATOR KRUEGER: Thank you.

Assembly? Thank you very much for your time today.

Steven Sanders, Agencies for Children's Therapy Services.

CHAIRMAN FARRELL: And former?

SENATOR KRUEGER: And former Assemblymember and education chair, as I recall.

MR. SANDERS: You recall correctly, Senator. And also a former constituent of

yours for a couple of years.

Thank you very much, members of the joint committee, Chairman Farrell and Chairman Hannon, a good friend, and as I said, Senator Krueger, who I enjoyed serving with way back in the day.

You have my written statement. It's brief, but I'm not going to read it. I'm going to try to be even briefer than that. The day has been long.

I hate to tell you, but there's probably more than a foot of snow outside, more so than when you came in here at about

10 o'clock this morning. It's been snowing all day.

I'm going to cut to the chase. I'm the executive director of the Agencies for Children's Therapy Services. These are agencies that provide more than half of the early intervention services around the state each year. Over 65,000 infants and toddlers are served by early intervention each year. My association serves more than half of that.

Let me just tell you a couple of

things a few you know, a couple of things that maybe you don't, and then get to my request.

Early intervention saves $7 for every dollar invested. This isn't a number that I invented. This is a number that is part of the literature, part of the research, and has even been mentioned by the United States Secretary of Education. Just several weeks ago, Arne Duncan also referred to the fact that early intervention saves $7 for every dollar invested.

Why? It's through avoided costs. For every child that goes through early intervention successfully, they will not need the far more expensive cost of preschool special education and school-age special education, and the cost of those programs to the State of New York are enormous. That is

one of the biggest drivers of cost in the education/health system we have today. And early intervention avoids those costs.

Early intervention providers have received no COLA, no trend, no increases of

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any kind, especially in the home and community rates, in over a decade. And I think in the 22-year history of early intervention there has only been one, possibly a second, increase and they all occurred, again, over 10 years ago.

Early intervention is clearly the right thing to do for kids, but it is clearly the right thing to do for our budget. Because it's a budget saver, not a budget expense driver.

So the proposal that we are asking you to consider is to take a small portion of the 15 to 20 percent in cuts that early intervention had to absorb over the last five or six years, take a small portion of that, 4.8 percent, and restore that small portion of the cuts.

Why 4.8 percent? Well, it's interesting, because as I mentioned a moment ago, early intervention is a program that is intended to prepare kids for the rigors of public school programs. The Governor set aside a 4.8 percent increase in education for

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this year, if it is fully funded as the Governor has recommended. And early intervention is rooted in the Individuals with Disability Education Act, IDEA, and again, this would represent a very, very small restoration of the overall cuts that they have had to absorb over the last number of years.

Now, I just want to also make mention of a couple of statements that were made earlier today that bothered me, statements made by the deputy commissioner of the Department of Health. She said that everything is going fine, don't worry, early intervention is okay, there are more providers, there are more kids being served than ever before.

That would be great. It's not true. At least it's inaccurate. According to the department's own figures, there has not been an increase in the number of children served in early intervention. That number has remained static. These are their December figures -- that number has remained static

and has dropped from what early intervention served five, six, seven years ago. So there are not more kids being served.

As for providers, well, she gave you half the story. There's been a slight uptick, maybe 1 percent, in the number of

rendering providers in early intervention, but there's been a dramatic decline and exodus in the number of billing providers, a 14 percent drop. Why? Because we have made the delivery of services for early intervention so expensive for providers who do billing that they cannot any longer afford the costs. They are leaving the program, a 14 percent reduction in the past year alone.

And we've got to stem that tide. And the only way to stem that tide is to make a small down payment, a small restoration of the deep cuts that were exacted into early intervention over the last five or six years.

So that is the sum and substance of my testimony. I went over by a couple of minutes last year, Senator DeFrancisco. I'm

giving you back that time this year, so we're even. So next year when I come to speak again, we're all even. And maybe we can have that beer you talked about earlier.

CHAIRMAN DeFRANCISCO: No, we're not even. You get a credit of 3 minutes and 49 seconds.

MR. SANDERS: I'll put it in the bank and I'll be back next year, undoubtedly.

CHAIRMAN DeFRANCISCO: Thank you very much.

MR. SANDERS: Thank you all. Thank

you for your time.

CHAIRMAN FARRELL: Thank you, Steve.

CHAIRMAN DeFRANCISCO: Next, Daniel Lowenstein, Primary Care Development Corporation.

On deck is James Lytle, counsel of the New York State Coalition for Managed Long Term Care and PACE.

And for those who are waiting, I don't know if you're all up-to-date. Let me tell you on the next page who's not showing, so you'll be ready. Numbers one and two,

Hospice, New York State Counsel on Behavioral Health Care, they cancelled. And First Transit will not be last, since they cancelled.

Okay, you're on.

MR. LOWENSTEIN: Thank you.

Thank you, Chairman DeFrancisco, Chairman Farrell, Chairman Hannon and the ranking members of the committees and the members who are here tonight. I'm going to be brief tonight as well; you have my testimony. I'm just going to go over a few points.

First of all, I'm Dan Lowenstein, I'm senior director of public affairs for PCDC, the Primary Care Development Corporation. We're a nonprofit that works to expand access to primary care to underserved communities.

We do this through providing affordable capital, expert technical assistance to change the model of primary care, and then advocating for policies that support good primary care in underserved communities.

I think you've heard before that we do

have a crisis in New York when it comes to primary care. About 2.3 million people lack access to good primary care, and really this is driving, has long driven the high costs in our system, the inappropriate use of ER and hospitals and other higher-cost interventions.

And really, it's no surprise, because we don't spend more than about 6 percent of our $162 billion total spend on primary care, even though everybody needs it and everybody should get it. And that really drives, I think, a lot of what I'm talking about today.

There's a lot of very important and exciting initiatives going on in New York. DSRIP, the State Health Innovation Plan, a lot of the work -- really, I mean, we do support the state's effort to really drive the system towards a more accountable way of delivering healthcare and one that's more affordable and one that ultimately makes people healthier and communities healthier.

Now on to the budget. Because really that whole system, all these plans that are

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in play right now, they really do rely on investment in primary care.

So first on to the $1.4 billion that's been talked about. We support putting about 25 percent of that towards community-based providers. Again, recognizing that this is where the change is going to happen, and it's really not considered in this budget how that is going to -- where that investment really needs to be.

In addition, and I think this gets to Senator Hannon's point earlier, you know, we don't believe that New York State should be on the hook for all of the investment in the healthcare system. And, you know, we do need to encourage responsible investment in this system. This is why we exist.

We're a community development financial institution that's provided over half a billion dollars' worth of investment into this sector, leveraging about 5:1 when it comes to private-to-public money, and we think that New York can play a role. And it's really the state's role, is the state

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can play a role by designating a portion of funds -- not that much at all, really, we're proposing about $40 million -- that can really leverage private-sector capital and

provide a backstop that will bring more lenders, responsible lenders, into the sector to really develop the kind of capacity that's needed. So that's really on the capital.

We do support the regulation of retail and urgent care clinics. They're going to happen anyway, and we know this, and we think that they need to be integrated into the system. We need to support and collaborate with primary care, and they can be quite beneficial to bringing more access to good care to a lot of folks, but there has to be some kind of a good regulatory framework. And we support the good work that the Public Health and Health Planning Council has done, and that's what you see in the budget legislation.

In addition, we also support the proposal to eliminate Certificate of Need for primary care facilities. CON was really used

to -- really to guard against the over-proliferation of services, the over-utilization of services. We don't have that problem, though, in primary care. We don't have enough of it. It's largely acknowledged, and this tends to be a barrier and not a facilitator of primary care in underserved communities.

Value-based payments has been talked about a lot today. We support the

administration's push to have authority over this process. I know this is somewhat controversial. This is the way the world is moving, though. Last week Medicare announced that 85 percent of the payments it's going to be making to hospitals are going to be in a value-based arrangement by the end of 2016, less than two years from now.

This is the way a lot of the private payers are working. The problem is that you have -- sometimes -- you need some kind of standardization. Not to say you can't have innovation, and not to say you can't have competition, because you need that too. But

some kind of standardization when it comes to what you're measuring, how you're measuring, needs to be in place in order to make this value-based market really thrive.

The Medicaid and Medicare parity issue that was talked about, basically New York is one of the worst, the second-to-worst state in the country when it comes to the percentage of Medicare that we pay for Medicaid for primary care docs is about 41 percent. Docs have -- they got this bump in the last two years, they lost it.

Now, it wasn't as severe when it comes to Medicare to Medicaid managed care, it was about 70, 75 percent. But this year there is still a significant revenue loss for the type

of provider that we need more of and we need Medicaid to see more of.

And a recent study just came out last week in the New England Journal of Medicine that showed New Jersey, which is a similar program to New York's, a similar parity issue, they saw their appointments jump, Medicaid appointments jump from 70 percent to

81.5 percent over those two years. The fear is that we're going to go back to a lot of -- to longer waits and more docs that just won't see Medicaid patients.

We support the uncompensated care pool for community health centers. We don't have a comment on the 300 individuals that the Health Department is looking to hire, but we will say that department needs the capacity in order to execute on these very ambitious changes that are out front, and I think that anywhere that they can get good people in that department to support the talented folks that are there, that would be helpful to the state overall.

And then finally, there is an item that we would like restored for PCDC to help us continue our work supporting the primary care sector. We were very grateful to have gotten $400,000 last year. We're asking for an increase to $500,000, given the enormity of the changes that are going on here and the

work that we're trying to do to support primary care.

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Thank you very much.

CHAIRMAN FARRELL: Thank you.

Mr. Raia?

ASSEMBLYMAN RAIA: You're not done, Dan.

MR. LOWENSTEIN: No, no. I'm sorry.

ASSEMBLYMAN RAIA: Have a seat.

MR. LOWENSTEIN: I thought you were calling the next -- Sorry, Assemblyman.

ASSEMBLYMAN RAIA: I'm not going to keep you long.

You piqued my curiosity with one point, and that was with respect to the retail clinics versus, I guess, urgent care. Do you think it's appropriate that kids under 18 utilize retail clinics as their main source of doctor's visits? I know in a lot of states they're starting to put age restrictions on that.

MR. LOWENSTEIN: We don't have a position on the clinical protocols there. But somebody under 18 -- you don't want this to supplant them having a regular primary care provider.

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ASSEMBLYMAN RAIA: Thank you.

CHAIRMAN FARRELL: Thank you.

CHAIRMAN DeFRANCISCO: Thank you very

much.

The next speaker, the last on page 2, James Lytle, counsel, New York State Coalition for Managed Long Term Care and PACE Plans.

On deck is the Consumer Directed Personal Assistance Association, who are walking down as we speak.

You're on.

MR. LYTLE: Thank you very much.

I have a great proposition for you. I'm actually here on behalf of two coalitions who had registered separately, so I will give the testimony for two in less time you would have allocated to one.

CHAIRMAN DeFRANCISCO: What's the other one?

MR. LYTLE: It was on the list earlier but not on the one in front of you. It's for the -- the two coalitions are the Coalition of New York State Public Health Plans, which

is not listed there, and the Coalition of Managed Long Term Care and PACE plans.

Both coalitions are Medicaid health plans. All consist of not-for-profit, provider-sponsored health plans that provide the bulk of service in these two programs.

In the Public Health Plan Coalition there are eight plans, and they serve more than 3 million Medicaid beneficiaries all

across the state. And on the managed long-term care side there are 23 plans that are part of the coalition that account for 110,000 of the roughly 139,000 people who are enrolled in managed long-term care.

Both coalitions face many of the same issues, which is why we felt we could combine this testimony. And the most significant of those common issues is the adequacy of the rates they receive and the timeliness with which they're established.

Fundamental to the idea of being a managed-care plan that's enrolling individuals is that you receive, prospectively, a payment for the individuals

who are enrolled. That has just not been the case over the last several years, and there's increasing delays in actually getting approved rates from the department. While here, earlier today I got an email -- that I was happy to receive -- that the rates for the public health plans, the mainstream managed-care plans that enroll 3 or 4 million individuals in this state just got CMS approval for their April 2014 rate levels.

Now again, that wasn't entirely the Department of Health's fault, obviously, because the federal government took that long. But receiving in February the April of 2014 rates is not a good way to do business.

With the managed long term care plans, it's even worse. They still do not have their 2014 rates and, to make matters significantly more problematic, the rates that they have received are inadequate.

The challenge for the Legislature is that there's nothing in this budget or in legislation that says anything about this rate process. And we intend to present to

you some proposals that would, for the first time, provide the Legislature with a little bit more authority or at least set some standards for the manner in which the Department of Health meets its rate-setting obligation.

SENATOR HANNON: Is this because we gave them blanket authority through the Medicaid redesign process?

MR. LYTLE: I think it actually even predates that. But I think in large part, Senator, I take your point. I think engaging the Legislature more directly in a lot of the redesign activities was certainly -- I think being --

SENATOR HANNON: Up until Medicaid redesign there was less than 5,000 people in managed long term care. Now you're talking about, what is it, 139,000?

MR. LYTLE: Yes.

SENATOR HANNON: So it's a horse of a

different character.

MR. LYTLE: Yes. So turning first to some of the issues that face the Managed Long

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Term Care Coalition -- where, again, rates are a particular concern -- the challenge has been that simultaneously the Department of Health has required health plans to meet various payment obligations through the wage-parity requirements. Minimum-wage issues will -- if they were to be increased, could potentially exacerbate this even further. And while the plans are prepared to do whatever they need to do to make sure that they meet their legal obligations under these requirements, the rates have not adequately supported that obligation.

An issue of particular concern, Senator DeFrancisco, to one of the plans in your area that Mary Kate Rolf operates, known as VNA Homecare Options, is that on the managed long term care side they've taken the transportation -- they're proposing to take the transportation component out of the rate.

And for many upstate plans who are serving frail and disabled elderly individuals who need to get access to primary

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care services, to a range of other social and

healthcare related purposes, transportation is a very critical component. Relying on the Medicaid transportation system to meet the needs of this population is not sufficient, from her perspective, and from many other plans' perspectives, especially upstate.

On the mainstream side, for the public health plans that we represent, I should note that, first of all, several of the plans are actually offering plans on the exchange. Some of the most popular plans on the New York State of Health exchange have been offered by not-for-profit, provider-sponsored previously managed Medicaid plans, and there are issues with respect to the exchange that need to be addressed.

Most significantly, there's been a challenge in allowing individuals who enroll to pick their primary care physician when they're on the exchange. That failure of functionality on the exchange has created confusion and a considerable amount of consumer dismay when they end up with some

primary care physician who's been assigned to them. It's an important issue to address. The technology is taking a while to address it.

There's a proposal that the Health Plan Association spoke to, about taxing the plans to pay for the exchange, and we would

share their recommendations with respect to that matter.

And finally, there was a proposal to place a cap on profits within the Medicaid managed-care program. Now, for our plans, they're not-for-profit plans. Any surplus that they generate is going to be reinvested in the plan. I can assure you that there are very few profits to be realized in this context in any event. Already their rates are very carefully regulated, and we're not sure that this proposal has merit.

Finally, just on the DSRIP program, for which there's been quite a bit of conversation, I'd only point out that the mainstream managed-care plans that have been part of New York State's Medicaid program

since the 1980s have been engaged in trying to move the system towards a value-based purchasing system and are particularly interested in being part of that discussion going forward.

The $5 billion available in DSRIP came thanks to the work that the health plans have done in reducing Medicaid expenditures over these years, so we're happy that it has had that result. What we're hoping is that the input that the plans have and the experience that the plans have had in effectively managing care and paying for that care will

be brought to bear as we put together the value-based payment approach.

That's it for me. If there are any questions, I'd be happy to answer.

CHAIRMAN DeFRANCISCO: Thank you very much.

Bryan O'Malley and Anthony Caputo, Consumer Directed Personal Assistance Association, on deck.

Alzheimer's Association, I believe it's Elaine Sproat. Is she here? Okay,

thank you.

Are you Anthony Caputo?

MR. CAPUTO: Yes, I am.

CHAIRMAN DeFRANCISCO: What happened to Bryan O'Malley?

MR. CAPUTO: He's back there.

CHAIRMAN DeFRANCISCO: Oh, you're back here? Okay.

So you have the Italian gentleman doing the speaking?

MR. CAPUTO: That's Brian, yes.

CHAIRMAN DeFRANCISCO: Smart move.

MR. CAPUTO: I do want to thank -- it's late, it's approaching 5:00. All of us, I assume, to some extent saw the game last night -- so whether you enjoyed or didn't enjoy it, you probably spent some time with it. So I'm going to try to be brief. And as in the past, I'll try to keep my speech at a

reasonable --

CHAIRMAN DeFRANCISCO: Very good.

MR. CAPUTO: Okay. So I don't have to get stopped.

I do want to thank you, Chairman

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DeFrancisco, and all the other members of the State Senate and Assembly, for having me here today. I'm Anthony Caputo, I'm the president of the Consumer Directed Personal Assistance Association of New York State. We represent 17 of the fiscal intermediaries that operate the Personal Assistance Program. We have approximately 14,000 consumers and growing. And those consumers hire approximately 25,000 home care workers that we refer to as personal assistants.

As you know, the program allows consumers to hire, fire and train the worker of their choice, either the individual that is in need or a family member-designated representative. Because of that, there have been significant savings in our program as opposed to the traditional model. The estimates are that, based on the fact that consumers do take on the responsibility that a traditional agency does not have to, which we don't have to provide, that saves about $52 million a year.

In addition, the other beauty of our

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program -- and this is just getting into the background of how cost-effective we've been -- but in addition, because there's an exemption to the Nurse Practice Act that the personal assistants can perform skilled services, we believe that there's another approximately $50 million a year that is saved in the programs.

I just want to make clear -- did I say 52,000 or 52 million in the first part? Fifty-two million is probably saved with regard to the fact that consumers take on the responsibility that a licensed aide does not have to; another 50 million in that the workers perform skilled services.

Those workers, some of them perform high-skill services like an RN or an LPN, but they're paid at a relatively low amount. Basically, they're paid at the same rate as personal care workers. And also they're not even part of wage parity, so in some regions they're paid even less than personal care workers though they are doing skilled services.

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And the issue that we'd like to bring up is that, you know, the Consumer Directed Personal Assistance Program has satisfied the state's three main goals of high quality of care at a fraction of traditional providers cost while keeping consumers safe and in the

community. Cost-effective, better outcomes, and that's proven by the fact that some of us -- I run one of the fiscal intermediaries, Concepts of Independence -- we have consumers with us 30 and 35 years. We have workers with those consumers for 25 and 30 years.

Continuity of care results in quality of care results in significant savings to Medicaid, as I just mentioned before.

However, the success of the model, both in outcomes and cost-effectiveness, is based on the stable workforce of personal assistants that are trained in the specific needs of their respective consumers. We find that workers may be with consumers, as I said before, for 20 and even 30 years. However, due to virtually little or no wage increase over the past several years, personal

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assistants are being forced to leave for higher-paying jobs, which is resulting in the erosion of the consumer-directed program. Which may mean that the millions of dollars of savings may not be there in the future unless an investment is put back in the way of wages to those workers.

Further, reimbursements have failed to reflect significant cost increases in the cost of doing business over the course of a decade that has resulted in stagnant wages that have not kept pace with other

industries. This has lead to an inability of consumers to recruit and retain a high-quality workforce, as they are competing with jobs and other opportunities in other industries such as McDonald's and Walmart.

We have analyzed Governor Cuomo's proposed budget for 2015-2016's fiscal year based on the impact on consumer-directed services, and we would like to highlight two particular areas: One, how it will affect the program's ability to continue to effectively meet the needs of those seniors

and people with disabilities who rely on it; and two, how it will affect the state, who has continued to rely more and more on the significant savings the program offers over traditional services.

We would like to acknowledge that the state supports our cost-effective model. It's been encouraged and it's been the first option for many of those entering managed care, and even the managed-care plans have embraced us. We continue to grow, but we're concerned that if there is no reinvestment of some of those savings, workers will not be there to perform the skilled services and other tasks that are required by our model.

Okay. Particularly there's no recognition in the health budget of the effect that the minimum wage increase, both

those previously enacted as well as those proposed this year, will have on health providers such as fiscal intermediaries.

To reverse this trend, the Legislature must finally pass language that makes sure the long-term viability of consumer directed

personal assistance is protected. We must make sure that reimbursement meets the rising costs brought about by minimum-wage increases, both addressing the insufficient wage base to ensure that a living wage is provided to these workers, and that there's sufficient reimbursement for overtime costs.

To do this, we must require managed-care companies and fee-for-service Medicaid to pay at reimbursement rates that will allow for a living wage to be paid to the workers, while addressing associated labor costs such as increases in worker's compensation and unemployment. And two, to attract and retain high-quality workers, CDPAANYS recommends that this wage be pegged at 150 percent of the minimum wage.

That's basically our main concern for this year, is wages for the workers, overtime costs. And even though the FLSA has been put on hold regarding overtime pay based on a base wage -- for example, if minimum wage is $8.75 and workers are getting paid $10 an hour -- there was going to be a new law put

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in place by the Department of Labor to remove the exemption of overtime to workers, which would have required someone getting $10 an hour to receive overtime at $15 an hour.

Presently these workers do not get any overtime at all. That's been on hold, there's been a lawsuit at the federal level. However, New York State still has a requirement that a worker that works over 40 hours a week receive time and a half of the state's minimum wage. As it goes up, that worker does have to get -- it's $8.75 now. That worker does have to get time and a half, $13.13, when they do work over 40 hours a week.

And in the testimony you'll see bar charts to show that the reimbursement we have will not be able to compensate workers at the state's minimum wage for overtime. And that's the purpose of why a big chunk of our testimony here today -- in addition to three other budgetary issues we'd like to bring up, and I should be able to do this in less than two minutes.

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The state is still awaiting approval from the federal government on Community First Choice, a program that will allow the state to receive an extra 6 percent in

federal matching funds for a collection of services aimed at keeping people out of institutions.

The Governor has proposed requiring that the increased reimbursement be reinvested in services implementing the state's Olmstead Plan. CDPAANYS strongly supports this as a stream of revenue that can help support salaries in the future, and thinks that it should be strengthened to create a dedicated account to be restricted to that purpose.

Number two, the Governor has proposed creating a workgroup that looks at how transportation is delivered to Medicaid recipients with disabilities and other special needs.

CDPAANYS has long maintained that those who use consumer-directed services should be allowed to have their worker drive

them to and from medical appointments and not have to rely on ambulettes and other costly and time-consuming services. We support this process, with the caveat that stakeholders such as consumers and people who use consumer-directed services be included in the workgroup, a stipulation not currently present in the language.

Third, Governor Cuomo has proposed a new Office for Community Living. CDPAANYS

supports it and looks forward to working with the administration and the Legislature as it develops.

Thank you very much. Any questions?

CHAIRMAN FARRELL: Thank you.

CHAIRMAN DeFRANCISCO: Thank you very much.

The next speaker is Elaine Sproat, Alzheimer's Association, followed by Bill Sherman.

And so you know, we had another cancellation, and that's the Medicaid Matters New York, the former second-to-last speaker.

Whenever you're ready.

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MS. SPROAT: Very well.

Good afternoon, chairs and members of the committee. My name is Elaine Sproat, and I'm the president and CEO of the Hudson Valley/Rockland/Westchester/New York Chapter of the Alzheimer's Association, and I'm here today as cochair of the Coalition of New York State Alzheimer's Association Chapters.

The Coalition of New York State Alzheimer's Association Chapters advocates on behalf of the 380,000 Empire State residents who are living with Alzheimer's disease and the caregivers who support them. For over 25 years, the seven chapters of the coalition have provided care consultations, consumer and professional education programs,

a 24-hour Helpline, safety services and support groups. These services are available in all regions of New York and provide family caregivers with the support that they need to avoid premature placement of individuals with Alzheimer's disease in nursing homes or other institutional settings.

The Alzheimer's Association is the

recognized leader in Alzheimer's disease, and the coalition is the only statewide organization in New York that has the capacity to meet the needs of individuals with Alzheimer's disease and related dementias and those who care for them.

This year, Governor Cuomo included an additional $25 million for Alzheimer's disease and respite care services. This includes $4 million for the Alzheimer's Community Assistance Program, known as AlzCAP, $4 million for Alzheimer's Disease Assistance Centers, known as ADACs, and $16.5 million for grants to support respite and caregiver support, with the remainder going to administrative costs.

The association strongly believes that this significant expansion of the AlzCAP funding will allow its chapters to reach many more New Yorkers suffering with Alzheimer's disease.

Alzheimer's is, as many of you know, a

progressive and fatal disease. There is no way to cure, prevent or truly slow its

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progression. The increase in funding is a great first step that will position New York to be a leader in the nation when it comes to funding and addressing the problem of Alzheimer's disease. With these funds, the coalition will be able to expand our regional approach and will be able to provide more resources for evidence-based training, education, and support programs, as well as offering more one-on-one care consultations that provide individualized education and support.

Additionally, with more staff, the coalition will be able to better serve individuals in the rural areas of the state and address the unique challenges of New York's increasingly diverse populations.

Currently, AlzCAP is funded through the Department of Health, and it supports the delivery of community-based services to help individuals and families who are struggling with Alzheimer's disease. The coalition receives this funding through AlzCAP to support a variety of educational initiatives

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and caregiver support programs.

Specifically, coalition chapters provide training for volunteers and family

members to enable them to deliver proper care to individuals with Alzheimer's disease who live at home, respite programs for caregivers, educational programs for individuals with Alzheimer's disease, care consultations for individuals and families with a member suffering from Alzheimer's disease, and support groups for both individuals with Alzheimer's and their family members.

Services provided by coalition chapters are critical in addressing the public health crisis of Alzheimer's. Those affected by Alzheimer's disease require increasing assistance with basic activities such as eating, bathing, dressing, and toileting. Individuals essentially need around-the-clock care.

The cost of Medicaid for an individual with Alzheimer's disease is 19 times higher than for someone without the disease.

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Delaying the need for institutional care for those with the disease can reduce these costs to the Medicaid system. There is strong evidence that community-based services, like those that the coalition chapters provide through AlzCAP, delay nursing home placement and reduce the state's Medicaid burden.

A research study by Dr. Mary Mittelman of NYU's Langone Medical Center concludes

that, with the use of community-based caregiver services such as support groups, education seminars, counseling sessions and telephone support, the median delay in skilled nursing facility placement is 557 days. The state sees an average potential Medicaid savings per person of $138,136 in that time period, or $90,520 per person annually.

The savings to the Medicaid system would more than offset the costs of increased funding for community-based programs to support individuals and families facing the challenges of Alzheimer's disease and related disorders.

The role informal caregivers play in helping to delay institutionalization of an individual with Alzheimer's disease is critical. In New York State, over a million caregivers spend over 1.15 billion hours annually caring for people with dementia. On average, caregivers for individuals with Alzheimer's and other dementias spend 23 hours per week providing care, and one in six spends 40 hours or more per week. This is longer than the average 16 hours per week spent by caregivers of those with other conditions.

While caregivers often take on these tasks willingly, the demands of caregiving

can take a toll on their health, compromising their ability to care for themselves and their family members. Those who care for someone with Alzheimer's disease or another dementia are 3.5 times more likely than caregivers of people with other conditions to say that the greatest difficulty associated with caregiving is that it creates or aggravates their own health problems. That's

according to the latest Behavioral Risk Factors Surveillance System survey.

For 31 percent of Alzheimer's and dementia caregivers, stress is the biggest problem with caregiving, compared with 23.7 percent of caregivers of those with other conditions. Ensuring that caregivers have access to necessary support is crucial to help prevent caregiver burnout.

Part of the coalition's work is making sure that caregivers receive the support they need from the Alzheimer Association's local chapters. Every chapter offers a variety of support groups and other services to help caregivers cope with the stress of their undertaking. Ensuring that caregivers receive the services they need to continue providing quality care to a family member is another way to keep individuals with Alzheimer's disease out of institutional settings and reduce Medicaid costs.

Keeping individuals with Alzheimer's disease connected to appropriate community-based services can also help to

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avoid unnecessary hospitalizations. Not only do such hospitalizations place a burden on the already financially strapped Medicaid system, they also exact a toll on the individuals with Alzheimer's disease. Indeed, there is new evidence that, for a person with Alzheimer's disease, a stay in the hospital can lead to accelerated mental decline and increase the risk of going into a nursing home or dying.

A recent study from Harvard researchers entitled "Adverse Outcomes After Hospitalization and Delirium in Persons with Alzheimer Disease" demonstrated that 41 percent of the patients who were hospitalized with dementia experienced accelerated mental decline during the year following hospitalization.

The coalition believes that the increased state funding will appropriately support community-based services that can help to keep more individuals with Alzheimer's disease at home for as long as possible.

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New York State has traditionally been

a follower in state funding initiatives to support individuals with Alzheimer's disease. This budget presents an opportunity for the Empire State to be a leader among its peers. The Coalition of New York State Alzheimer's Association Chapters looks forward to accepting the state's challenge to positively impact the lives of more families than we previously have been able to reach.

Thank you for the opportunity to speak with you today, and I'm happy to take any of your questions.

CHAIRMAN DeFRANCISCO: Let me see if I get this. The Governor put $25 million more in the budget for the Alzheimer's Association?

MS. SPROAT: No, not just for the Alzheimer's Association. We would be one of the agencies that would benefit from that funding.

CHAIRMAN DeFRANCISCO: Okay. And you like that.

MS. SPROAT: Yes.

CHAIRMAN DeFRANCISCO: And you want to keep it in the budget.

MS. SPROAT: Yes.

CHAIRMAN DeFRANCISCO: Okay. Thank you.

MS. SPROAT: Are there any other questions?

CHAIRMAN FARRELL: No, thank you.

CHAIRMAN DeFRANCISCO: I don't think so.

Bill Sherman, the American Cancer Society, then we skip over to Kate Breslin from the Schuyler Center for Analysis and Advocacy.

MR. SHERMAN: Thank you, Mr. Chairman.

Chairman DeFrancisco, Chairman Farrell, and distinguished members of the Senate and Assembly, it's a pleasure to be here today. My name is Bill Sherman, I'm the vice President of government relations for the American Cancer Society Cancer Action Network, and today I'm here with Michael Burgess, our state director.

We will summarize our written

testimony.

I want you to know that I'm here on behalf of the over 908,000 cancer survivors in New York State, and that the American Cancer Society Cancer Action Network has over 100,000 devoted volunteers across this state, 250 of whom will be here next Tuesday to talk with each of you individually.

I will address three issues in the Governor's budget proposal that are important to our mission to eliminate cancer as a major health problem.

First I want to say thank you very

much for the support in the past that this Legislature has provided to these cancer programs and these life-saving programs. We appreciate greatly the support that you have provided in the past and we ask for your support again this year.

To start, it is crucial that you support full funding for the New York State Cancer Services Program. This is a program that supports lifesaving detection screenings and breast cancer wellness grants across the

state.

The CSP provides breast, cervical, and colorectal cancer screenings to low-income men and women who do not have health insurance, or who have health insurance that does not cover the cost of these cancer screenings. According to the Kaiser Family Foundation, there are approximately 1 million New Yorkers who still do not have health insurance, and untold thousands more who have insurance that either does not cover these screenings or they include excessively high copayments.

I want you to know that in 2013 the CSP program covered 107,000 screenings in New York. The Governor unfortunately has proposed a 15 percent cut of this program, or a $3 million price tag. If that were to be enacted, 16,000 people would be turned away

this next year from the cancer screenings.

Earlier, Senator Hannon expressed his support for rejecting the Governor's proposal to consolidate the funds, and we agree with him. We ask that you listen to Senator

Hannon, and that we believe that the Legislature should really make the determinations of where the funding goes, not going to a lump sum for the Department of Health to determine where those funds go.

The second program is the Tobacco Control Program. There are still over 2.5 million adults and over 100,000 high school students in New York who smoke. Every year 13,500 New York kids under 18 become new daily smokers. But what's important is that 70 percent of smokers want to quit, and last year 52 percent made an attempt to quit.

Since 2007, New York State has cut by 50 percent the program funding for this evidence-based program to help people quit. Seventy percent want to quit. We know that tobacco is a difficult drug to get off of. The Tobacco Control Program run by the Department of Health provides the necessary background and support for the smokers that want to quit. We ask that you give an additional $13 million this year for that, so New York can go back to becoming a leader in

the country in terms of tobacco control funding.

The last piece that I'm advocating for today is the Healthy Food and Healthy Communities Fund program. The American Cancer Society recommends consuming a healthy diet, with an emphasis on plant foods, in order to reduce cancer risk.

This program is a great public-private partnership. In 2009 it was started with $10 million in state funding. Goldman Sachs covered $20 million to make it a total of $30 million in a public/private partnership. This program provides much-needed grants and loans to supermarkets, grocery stores, farmers markets, and other healthy food retailers in underserved communities across the state. By providing this economic incentive, mobile markets and supermarkets across the state including in Buffalo, Rochester, Syracuse, Broome County, the Hudson Valley and New York City have greater access to healthy foods.

We're asking that you provide an

additional $15 million, because the funding is just about -- will be completed by the end of this current fiscal year.

Thank you, Senator.

CHAIRMAN FARRELL: Questions?

Mr. Raia.

ASSEMBLYMAN RAIA: Good to see you, Bill.

Is American Cancer Society taking a position on e-cigarettes?

MR. SHERMAN: We do. We are very supportive of the Governor's idea -- the Governor's concept to include e-cigarettes in the Clean Indoor Air Act. That's where we are in terms of this.

We know that there's a lot of research that needs to be done in terms of the long-term view of this and if it's in fact a cessation device to help people quit. But right now the reports and the research that we're seeing is that people who use electronic cigarettes become dual users, and so they're using e-cigarettes in places where they can't smoke traditional cigarettes.

And for that reason, and because of the unknown impact on the aerosol, we believe that it should be prohibited from being used in public.

ASSEMBLYMAN RAIA: Okay. As I chew a piece of Nicorette while I'm talking to you.

Are we seeing any studies with respect to the youth? Are they still preferring regular cigarettes versus electronic cigarettes, or are we starting to see some trends?

MR. SHERMAN: Yes, we are seeing some

troubling trends. So in the past, in a year-to-year comparison, the number of youth, middle schoolers and high schoolers, who are using electronic cigarettes more than tripled in one year. Out of that population, 75 percent of those youth attempted to use a traditional cigarette in that same year.

So for that reason I'm viewing it as a gateway for people, and particularly youth, to become traditional cigarette smokers. Which we want to make sure that we're, obviously, putting up as many barriers to as

possible.

ASSEMBLYMAN RAIA: And one last question. Medical marijuana, or eventually the possibility of legalizing it. Is the American Cancer Society taking a position on that?

MR. SHERMAN: We do not have a position on that.

ASSEMBLYMAN RAIA: Thank you, sir.

MR. SHERMAN: We met with the Senator last year on that as well.

CHAIRMAN FARRELL: Thank you.

CHAIRMAN DeFRANCISCO: First of all, thank you for summarizing your testimony.

He stole my thunder, okay, about the marijuana. It just boggles my mind. It boggles my mind that the Cancer Society doesn't have a position on marijuana.

Because what's going to end up happening -- and I asked this question for a couple of years before we passed the medicinal, medical marijuana bill. Because I would think that if there's a potential of health problems from somebody inhaling

something that provides smoke in their body, that it might be relevant to the debate.

Now, we're going to come in -- there's no question, it's just a matter of time until we'll be legalizing marijuana. And I just hope that at some point somebody in the Cancer Society decides this is something worth checking out before they expand things that people are ingesting.

MR. SHERMAN: I agree.

CHAIRMAN DeFRANCISCO: I don't think it's a healthy food.

MR. SHERMAN: I agree with you. We did not have a position on medical marijuana. We do have a position in that we are strongly opposed to smoking marijuana for whatever purpose. We're very much opposed to smoking marijuana.

CHAIRMAN DeFRANCISCO: Except medicinal.

MR. SHERMAN: No, including that. For any purposes at all.

Our position is evolving as we have the ability to conduct additional research

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and review research across the country. But, Senator, you're correct, and we are advocating within our organization to have a stronger position on that.

CHAIRMAN DeFRANCISCO: Okay, good. Because while you're evolving, there'll be a bill passed legalizing marijuana, and then you'll want more money to care for those people who have marijuana problems.

MR. SHERMAN: I understand your position.

CHAIRMAN DeFRANCISCO: So thank you very much.

Let's see. I lost my sheet. Does anybody know who's next? Oh, Kate Breslin. Definitely. How could I forget.

MS. BRESLIN: Hi. I'm Kate Breslin, from the Schuyler Center for Analysis and Advocacy. We're a 142-year-old statewide nonprofit organization that does policy analysis and advocacy on how our public systems meet the needs of people living in poverty.

You have my written testimony in front

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of you that covers a lot of hot topics that have already been covered, including payment reform. We're very involved in a lot of the activities going on with regard to

value-based payment, DSRIP, and we're participating in an advisory role.

But I'm going to be merciful and address only one topic that has not yet been addressed. What I'd like to talk to you about is the Healthy Teeth Amendment.

We would like to call your attention to a policy proposed by the Governor that will ensure public notice when a community considers eliminating community water fluoridation and will provide funding for communities that need to repair, upgrade or purchase fluoridation equipment. We're calling these provisions the Healthy Teeth Amendment for their potential to greatly improve the oral health of all New Yorkers.

Community water fluoridation is far and away the single most cost-effective way to improve oral health, especially for children in poverty. The American Academy of

Pediatrics, the Institution of Medicine, the Centers for Disease Control, surgeon generals of various stripes all agree. The Governor's proposal is a beautiful marriage of smart, cost-saving public health and good open government. The new policy will allow community residents to be informed if their government considers a policy change that will negatively affect their health.

The proposal continues local control

of water districts but improves the transparency and accountability of their decision-making, since it can have a significant impact on the public's health.

There are many preventive strategies to address the issue of tooth decay and save the state healthcare costs, but community water fluoridation is far and away the most effective and offers the largest return on investment of any public health effort. By reducing the need for fillings and tooth extractions, fluoridation saves money for taxpayers and families.

We urge you to enthusiastically

support the Executive Budget policy to improve children's and adults' oral health in a cost-effective way by requiring public notice when a community considers eliminating community water fluoridation, and authorizes $5 million for a fund for communities to upgrade their equipment. It's good public policy, smart public health, and saves public dollars.

And the rest of my testimony, please read.

CHAIRMAN DeFRANCISCO: Thank you very much.

CHAIRMAN FARRELL: Thank you.

CHAIRMAN DeFRANCISCO: I'm for healthy teeth.

Let's see. We're now at the last two speakers, Tracey Brooks, the New York State president and CEO of Family Planning Advocates, followed by Charles King.

Did Charles stick it out?

MS. CRUZ: Charles isn't here, but we will be speaking.

CHAIRMAN DeFRANCISCO: Okay, you're

on.

MS. BROOKS: Thank you so much. Thank you for having us today.

We just want to briefly talk about a few different issues in the budget. First and foremost, the most important part is the Family Planning Grant.

In 2013-2014 the Family Planning Grant received a $1.4 million cut. And we want just wanted to talk about why it's so important to restore that funding. In 2010 we saw, through the public funding of family planning health services, both in Medicaid and through grant services, a savings of over $600 million to the State of New York in that one year alone.

We have been a very good partner of the state during the fiscal downturn, taking grant money and reinvesting it into Medicaid to maximize the 90/10 match of family planning. You'll see in the Governor's budget that once again they're looking at

maximizing the 90/10 match on family planning by carving it out of the APG structure to

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access more of the 90/10 match.

What we're asking for at this point is the 90/10 leverage on family planning, we would ask for the reinvestment back into the Family Planning Grant. It's vital, it's important, it ensures greater access.

Folks are -- we do see more patients who have healthcare coverage, but we're also seeing them on higher-deductible plans. Those deductible plans, for people under 250 percent of the federal poverty level, they still have the ability to access the sliding-fee scale that the Family Planning Grant supports. So it's still really imperative to ensure that we have those funds for people to continue to get the healthcare services that really save the state so much money.

In New York, more than 87 percent of our Family Planning Program patients are below 200 percent of the federal poverty level, and two-thirds of them are below the 100 percent level. So you recognize that it's our patients that we're looking at.

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With the maximization of the 90/10 match, let's continue to move forward in looking at the, once again, bucketing. I

thank very much the Senate, in particular, and the Assembly for continuing to un-bucket grants that have been put together in bundles that then look at across-the-board cuts.

The CAPP, the Community Adolescent Pregnancy Prevention program, has been put into a bucket this year with a 15 percent slice off the top. That program is the only program and money that's used to support the prevention agenda to reduce unintended pregnancy. We've seen teen pregnancy rates continue to decrease across the state. We've seen the numbers come down in unintended pregnancies overall.

As we've said, it's $10.6 million. We would ask that bundled dollar figure to come out of that bucket and be reinvested in the Family Planning Grant. Over 50 percent or close to 50 percent of the grantees for the CAPP grant are family planning providers who are funded by the Family Planning Provider

grant as well, so what you would be doing is reducing the number of contracts that the state has -- beginning that goal of folks we're looking at by reducing the number of contracts -- by putting the two contracts that our providers and our membership have together in one.

Both of these grants, the Family Planning Grant and the CAPP grant, are slated

for their five-year contract to be renewed this year. The RFA will go out probably midyear, in the summer. They usually go out within 10 days of each other. So this is a really great pairing of funding as well as opportunity to streamline some of the state's interaction between state contractors.

We'd like to talk to you about the VAP grant as well as the capital. You heard a ton of testimony today. I'm just going to say, number one, ditto everything that HANYS said. The family planning providers stand in really very similar shoes to the hospitals in looking at the number of changes that are occurring to the healthcare system and really

how we have streamlined, our providers and members have streamlined their healthcare systems to react to those changes.

However, there hasn't been any state or public funding invested in the family planning providers. As folks have mentioned today when CHCANYS came up and testified, folks praised them on the proliferation of the federally qualified health centers across the State of New York. Well, that didn't happen without public investment.

And so we're asking that in the VAP grant $5 million of that be earmarked for the family planning providers, and $20 million of the capital monies be earmarked for family

planning providers, to allow us to just move that next step from where we've streamlined our providers, we've streamlined our health systems to now be able to grow those health systems.

Looking at the surplus, we have a few idea of what we could do with surplus dollars. There's a lot of innovation in healthcare services that you heard both

hospital associations talk about the fact that we can't take advantage of because we're missing the opportunity to really reduce some of the regulatory -- antiquated burdensome regs that are out there that prevent us from really moving forward with some of the great innovation in healthcare delivery, what healthcare delivery is looking at -- both the Internet, looking at telemedicine.

Really being able to take $5 million to invest in some of the great programs that Planned Parenthood Federation is piloting all over the nation, but is unable to bring into the State of New York because of (a) our regulatory system and (b) just the lack of investment that we'd be able to provide, would allow greater access to folks to basical family planning preventative healthcare services.

We are an entry point to the healthcare system. And Guttmacher has just

come out with the newest statistics that really shows that when -- even in situations and communities where people have an option

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between a comprehensive primary provider or a healthcare provider that's supported by the family planning grants, when looking at the fact that the number of health centers -- we're about a third of the health centers in the State of New York, 166 of the health centers -- folks at a greater perpetuation go to the family planning health centers for their healthcare services.

So really being able to invest in that capital to proliferate and grow the family planning providers, we'd love $5 million in innovation and then $5 million of the surplus monies to really look at education and outreach. We are doing a great job with our patient base, but there are a number of people who are not accessing healthcare services. And if we look at the difference -- and there's a chart in our written testimony that shows you what the disparity difference is in the reduction in teenage pregnancy across ethnicity.

And for us to really be able to do some better outreach into populations and

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communities that are not seeking access would

just increase exponentially the people who are coming to seek healthcare.

Also pulled down in one of those pink boxes we put for you a pilot program that one of our providers did that was supported by philanthropic giving and increased the number of patients of ethnic diversity who came in the first six months by 500 percent. And they've been able to maintain an increase of 130 percent of African-American women coming for regular primary preventative healthcare services for family planning.

And then the last piece we really want to look at is that 340B piece that Senator Kemp Hannon had already mentioned to CHCANYS. We have grave concern about this. We have asked the state a number of times, because of the 90/10 match, to really help us negotiate our contracts with the managed-care companies. And what we heard from the Medicaid director is, you know, we stand back, we don't do that.

Well, we've negotiated those contracts

with the Medicaid managed care companies, and now the state Medicaid director wants to step in and say that the providers have to pay the managed-care companies what our acquisition costs are after we've already negotiated our prices.

We would ask that if in fact you're

going to move forward with that -- which we think, number one, is going to be overly burdensome to comply with in its operationalization -- but secondarily, then we ask that the managed-care companies pay the APG rate for all family planning services that have a 90/10 match.

And other than that, I have a minute and 43 seconds.

CHAIRMAN DeFRANCISCO: Excellent.

Are there any questions?

CHAIRMAN FARRELL: Thank you.

MS. BROOKS: Thank you again.

CHAIRMAN DeFRANCISCO: Excuse me. You don't have any members of your organization here, do you, other than yourself?

MS. BROOKS: Not today. No, they

already left. I had quite a few with me earlier.

CHAIRMAN DeFRANCISCO: Okay, so now we're alone.

(Laughter.)

MS. BROOKS: I like your pink tie. Were you going to mention that?

CHAIRMAN DeFRANCISCO: Thank you. Thank you. No, we're alone, it's just between you and me.

MS. BROOKS: And everyone on the Internet.

CHAIRMAN DeFRANCISCO: Don't you think

it would be a great idea to pass the bill dealing with sex trafficking, equal pay for women and all of that, without holding the tenth point -- or ninth point now -- as hostage? Do you think?

MS. BROOKS: Senator, I think that there are 10 really great pieces of legislation that women of the State of New York need. And securing Roe v. Wade in a state that has 90 percent of people supporting it, including Republicans, they

just want you to grab that last piece of it.

CHAIRMAN DeFRANCISCO: Somehow I thought you'd answer that way. But thank you.

(Laughter.)

SENATOR KRUEGER: Thank you.

MS. BROOKS: Thank you.

CHAIRMAN DeFRANCISCO: All right. And the last and featured speaker is not Charlie King -- or is this Charlie King? No, okay. Who are you?

MR. ROGERS: My name is Ervin Rogers. With an E and no Gs. And no D in the Rogers.

MS. CRUZ: So neither of us are Charles King. My name is Carmelita Cruz. I'm the director for advocacy and organizing for Housing Works.

Charles was unfortunately unable to make it to Albany today. Ervin is here; he's

a client of Housing Works. He's actually going to share a statement on behalf of Housing Works.

Before he does, I just wanted to say Charles served as the cochair of the

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Governor's Task Force to End the AIDS Epidemic for the past few months. Some of the Ending the AIDS Epidemic initiatives were mentioned earlier by Assemblyman Weprin and Linda Wagner.

I also wanted to thank Senator Valesky's staff and Senator Hannon's staff; they served as members of the ad hoc elected committee to the task force.

And go ahead, Ervin.

MR. ROGERS: Good afternoon, Senators and Assemblymembers. As I said, my name is Ervin Rogers, and I am a person that's living with AIDS. And I've also dealt with drug addiction, I've dealt with homelessness. These are three challenges that are very serious, but they don't define me and they don't make up who I am.

I am a man who has much to offer, and who cares about the community, including people living with HIV and AIDS, people who experience mental health conditions, including addiction, and people who know what it is like to be without a place to live. I

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am a person who has found my voice and who is on a mission to use my voice to speak for those who cannot speak for themselves.

I live in supportive housing in East New York, Brooklyn -- one of the hardest neighborhoods in New York -- owned and operated by Housing Works. I've been there since 2012. And since moving in there, I saw a need to take the lead in advocacy.

One of my first advocacy trips up here to Albany was for the transgender population, who deserve civil rights and equal healthcare just like everybody else.

Today I am the chairperson of the East New York Residential Advisory Board. I have also went to school and gotten my CASAC certification. I'm studying at the Housing Works Peer Academy program to return to full-time work to help other people like myself.

I'm honored to be here today to offer testimony on behalf of the entire Housing Works community.

Last June, Governor Cuomo made an

amazing commitment. He promised to end the AIDS epidemic here in our state by 2020. As someone living with AIDS, you don't know how amazing that sounds to me. I know I will still be living with the virus until a cure or until the day I die, but I want to make

sure that no one else becomes infected with this horrible virus. And I am prepared to play my part to make that happen.

That is why I am a part of Housing Works' program, The Undetectables program, which helps people like me stay on our medication so that the HIV virus is suppressed. This not only helps me maintain my own health, but it ensures that I can’t pass the virus on to anyone else. I am blessed to have the housing support that I have, to be virally suppressed, and the possibility of going back to work one day.

People who are not infected, especially young transgender people, young gay men, and people who are addicted and getting medical care and access to nPeP and PrEP -- this is two programs that I am really

faithfully committed to, because I am a retired nurse and I became infected on the job.

And at that time the PrEP program, which is pre-exposure prophylactics, was in its infancy, and we didn't know that much about it when I was infected. So I went on the regimen, but it didn't remove the virus and I became infected. So that's something that I am really, really, really strong behind.

After Governor Cuomo made his

commitment to end the AIDS epidemic, he appointed a task force to develop a blueprint with recommendations for getting this goal done. I don't know everything that's in the blueprint, but I believe that it has a lot of recommendations that will help my friends and I -- help people who are not infected stay that way, and that will help people like me live our lives well. I hope the Governor will release it soon.

I know that Housing Works will be submitting detailed budget testimony in

writing, but I am here today to ask each and every one of you that you're not just passing a budget, you're basically saving lives. And if we can do that here in New York State by 2020, maybe the rest of the country will follow suit. And then, who knows, maybe one day, God willing, we can do it in Africa.

Now I'd like to thank you for your time and attention.

CHAIRMAN DeFRANCISCO: Thank you.

MS. CRUZ: So we did submit budget testimony. If anyone has any questions, we'd be happy to address them now.

CHAIRMAN DeFRANCISCO: Questions?

CHAIRMAN FARRELL: None. Thank you very much.

CHAIRMAN DeFRANCISCO: Thank you very much. And I appreciate -- Assemblyman Oaks

just mentioned thank you for your story and your personal reflections, and the rest of us do the same.

MR. ROGERS: Thank you.

CHAIRMAN DeFRANCISCO: Thank you for appearing.

The hearing is over, and we'll start again tomorrow at 9:30 with Education. Thank you.

(Whereupon, at 5:43 p.m., the budget hearing concluded.)

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