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

JOINT LEGISLATIVE HEARING

In the Matter of the
2017-2018 EXECUTIVE BUDGET
ON HEALTH AND MEDICAID

Hearing Room B
Legislative Office Building
Albany, New York

February 16, 2017
9:40 a.m.

PRESIDING:

Senator Catharine M. Young
Chair, Senate Finance Committee

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

PRESENT:

Senator Liz Krueger
Senate Finance Committee (RM)

Assemblyman Robert Oaks
Assembly Ways & Means Committee (RM)

Senator Kemp Hannon
Chair, Senate Committee on Health

Assemblyman Richard N. Gottfried
Chair, Assembly Health Committee

Senator David J. Valesky
Cochair, Senate Committee on Health

2017-2018 Executive Budget
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PRESENT: (Continued)

Senator James L. Seward
Chair, Senate Committee on Insurance

Assemblyman Kevin A. Cahill
Chair, Assembly Committee on Insurance

Senator Diane Savino
Vice Chair, Senate Finance Committee

Senator Gustavo Rivera

Assemblyman Andrew P. Raia

Assemblyman Phil Steck

Senator Neil Breslin

Assemblyman Andrew Garbarino

Assemblyman John McDonald

Senator Martin J. Golden

Assemblyman Edward P. Ra

Assemblywoman Ellen C. Jaffee

Assemblyman Kevin M. Byrne

Assemblywoman Shelley Mayer

Senator Leroy Comrie

Assemblywoman Patricia Fahy

Assemblywoman Yuh-Line Niou

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CHAIRWOMAN YOUNG: Good morning. I'm Senator Catharine Young, chair of the Senate Standing Committee on Finance, and I'm joined by my colleague from the Assembly, Assembly Ways and Means Chairman Denny Farrell.

And also we have several colleagues who I will introduce, and then let the Assembly introduce their members, and from there we will proceed.

So joining us today, just coming in, is Senator Liz Krueger, who is ranking member on the Finance Committee. We also have our chair of the Health Committee, Senator Kemp Hannon; we have Senator David Valesky, who is vice chair; we have Senator Jim Seward, Senator Marty Golden, Senator Gustavo Rivera, and just joining us is Senator Neil Breslin.

Good morning. Chairman?

CHAIRMAN FARRELL: Good morning. Thank you.

Assemblyman Dick Gottfried, chair. Assemblyman Kevin Cahill, chair also. Assemblyman Phil Steck, Assemblywoman Ellen Jaffee, Assemblyman John McDonald,

Assemblywoman Shelley Mayer, and Assemblyman Oaks, who will tell us his folks.

ASSEMBLYMAN OAKS: Yes, we are joined by Assemblyman Raia, Assemblyman Ra, and Assemblyman Garbarino.

CHAIRWOMAN YOUNG: Thank you.

If you look at the schedule today, we have more than 50 witnesses. Health is a hot topic this year -- it always is a hot topic, but this year especially so. I am going to ask all of the witnesses to stick to the time period. I know for the commissioners we will have extra time allotted for you, just because there's so many questions.

But for the following witnesses, I would ask that you give a summary of your testimony -- that we will have written testimony that you will submit so we will have that, we will look at it. But in the interests of time, we don't want to be here until tomorrow, because we have to have the Housing Committee meeting tomorrow. We don't want to run into that. So I'm going to ask all of the witnesses to be on message and

sticking within time limits. Of course we may have to ask you questions.

But also the members, I'm asking the members to watch the clock. Watch the clock. We have clocks all over the place, watch the clock. And I am going to be strict today about members. There will be leeway given to the chairs of the fiscal committees and chairs of the health committees, but other than that I'm asking the members to stick to the time period. Thank you.

Pursuant to the State Constitution and Legislative Law, the fiscal committees of the State Legislature are authorized to hold hearings on the Executive Budget. Today's hearing will be limited to a discussion of the Governor's proposed budget for the Department of Health and the Office of Medicaid Inspector General.

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

I would like first to welcome

Dr. Howard Zucker, commissioner of health. Following the presentation by Dr. Zucker will be Dennis Rosen, Medicaid inspector general. And also we have Jason Helgerson joining Dr. Zucker here today.

All testimony will be followed by a question-and-answer period by members of the Legislature. And after the final question-and-answer period, an opportunity will be provided for members of the public to briefly express their views on the budgets under discussion.

So Dr. Zucker, good morning. Welcome. We are delighted to have you here, and we look forward to your testimony.

COMMISSIONER ZUCKER: Thank you. And good morning, Chairpersons Young and Farrell, Hannon and Gottfried, and members of the New York State Senate and Assembly. I'm here today to discuss Governor Andrew Cuomo's 2017-2018 Executive Budget as it relates to health. And I am joined by Jason Helgerson, the state's Medicaid director.

In the last six years, New York has

made remarkable progress improving the health of New Yorkers and, at the same time, controlling costs. We are transforming the healthcare delivery system; improving the quality of care provided; expanding access to health insurance through the success of the New York State of Health; promoting the state's Prevention Agenda; and all the while, responding to emerging priorities such as infectious diseases, weather emergencies, water quality, and the devastating effects of opioid abuse and heroin and synthetic cannabinoid use.

In a healthcare environment that is ever challenged to maintain spending within sustainable limits, the Governor is proposing to confront one of the biggest drivers of premium rate increases for New York's commercial health insurance market -- soaring prescription drug prices. Not only do these rising prices drive up commercial health insurance premiums, but there are implications for New York taxpayers who have subsidized a $1.7 billion drug-related cost

increase in the Medicaid program over the last three years.

The Governor's budget proposes a three-point plan to protect consumers and taxpayers from the consequences of the rapidly rising cost of prescription drugs. The plan insulates taxpayers by preventing prescription drug price-gouging in the Medicaid program; imposes a surcharge on drug manufacturers that charge exorbitant prices and reallocates that money to insurers and businesses to lower premiums for the following year; and protects ratepayers from abusive business practices by intermediaries that drive up drug prices.

The Governor's Budget also proposes significant actions to promote and improve public health. The Executive Budget proposes a comprehensive tobacco control and prevention strategy by incorporating the use of electronic cigarettes into the definition of "smoking," thereby including electronic cigarettes within the Clean Indoor Air Act and the Adolescent Tobacco Use Prevention

Act. This will prevent the use of electronic cigarettes in most public places and allow the Department of Health to regulate electronic cigarettes in the same way as other tobacco products.

Also, vapor products used in electronic cigarettes, or e-cigarettes, will be taxed along with other tobacco products. This proposal is significant because tobacco use remains the number-one cause of preventable disease and death in New York State.

A report released by the Office of the Surgeon General at the end of 2016 states that "E-cigarette use among U.S. youth and young adults is now a major public health concern." E-cigarette use among youth and young adults is associated with the use of other tobacco products. In New York State, the rate of high-school-age youth e-cigarette use has doubled in just the years between 2014 and 2016, increasing from 10.5 percent to 20.6 percent.

Because most tobacco use is

established during adolescence, actions to prevent our young people -- who are sensitive to price increases -- from the potential of a lifetime of smoking and addiction are critical.

In order to support ongoing public health programs or achieve flexibility to support new investments to meet emerging public health priorities, the Executive Budget proposes to consolidate some of the many public health appropriations into pools, and to reduce the overall funding for each of the pools. This action achieves savings, but will also allow the Department of Health to coordinate, streamline, and prioritize our public health spending.

Governor Cuomo's Executive Budget seeks to establish New York's Capital Region as a hub for life sciences innovation. This economic development proposal will complement the Governor's $650 million Life Sciences Initiative announced in December of 2016. The $150 million appropriation and authority to build, using more efficient approaches,

represents the first step in the development of a new modern public health laboratory facility in the Capital Region that is designed to enhance partnerships and encourage growth in the life sciences and health data sectors.

The Wadsworth Center Laboratory is a tremendous asset with an international reputation and a robust history of collaboration with private business, academic institutions, healthcare providers, and research facilities. Through the efforts of the department, the Empire State Development Corporation and the Dormitory Authority of the State of New York, we will improve our readiness to respond to public health priorities and to position the lab as a core element in the development of a life sciences cluster in the Capital Region.

New York, along with states across the country, is working to confront emerging contaminants in our drinking water. Governor Cuomo is taking an aggressive approach to this issue by proposing the Clean Water

Infrastructure Act of 2017, an investment of $2 billion in critical water infrastructure across New York State. These funds will support drinking water infrastructure, wastewater infrastructure, and source water protection actions.

There are an estimated 1.1 million private wells in New York State, providing drinking water to as many as 4 million residents, yet there is no requirement to test that water. The Executive Budget proposes to require the testing of private-well drinking water upon the sale of a residential property and the construction of a new well. In addition, the Governor proposes to require landlords to conduct periodic testing of private well water and notify tenants of the results. We will work with our partner agencies to ensure the testing includes contaminants of local or regional concern, and we will make hardship funding available for low-income homeowners and seniors.

The Governor has taken decisive action

towards ensuring New Yorkers have access to clean drinking water, and addressing unregulated contaminants is one of our top priorities. The Water Quality Rapid Response Team has been working to identify and address drinking water quality issues across the state. To enhance the effort, the Executive Budget proposes to require the testing of additional public water supplies for unregulated contaminants. Fewer than 200 of the over 9,000 public water supplies in New York are required to test for unregulated contaminants.

The state will use the model of the emerging contaminant testing required by the federal EPA for large public water supplies to require testing for smaller public water supplies, but consideration will be given to specific issues affecting localities when establishing the requirements. As with the private-well testing proposal, the Governor will make funding available for small community water systems with financial hardship.

From clean water to healthcare providers, the Governor proposes investments to support essential activities. The Executive Budget provides $500 million in additional capital support for essential healthcare providers, including a minimum of $30 million directed to community-based providers. These funds will be used for capital projects, debt retirement, working capital, and other non-capital projects that facilitate healthcare transformation. The total amount of capital support provided to healthcare providers for transformation efforts, between the current and the last two state budgets, will now be $3.3 billion.

It is not enough, however, to provide investment. We must continue to reimagine the structure in which care is delivered. New York has made great progress with Medicaid redesign and with the State Health Innovation Plan, or the SHIP, and now it is time to take a comprehensive approach to modernize the regulations that serve the core purposes of ensuring access and protecting

safety. The department will undertake a stakeholder engagement process to review existing healthcare regulatory structures and recommend appropriate changes.

With the uncertainty that now exists in federal healthcare policy, Governor Cuomo is taking decisive action in New York to ensure access to high-quality, cost-effective healthcare for all New Yorkers.

Thank you, and I'm glad to answer any of your questions.

CHAIRWOMAN YOUNG: Thank you very much.

Our first speaker will be Senator Kemp Hannon, who is chair of the Health Committee. Senator?

SENATOR HANNON: Commissioner, you raise a number of interesting questions, which at some point during the course of this morning I'm going to have a dialogue with you.

But the first topic that I want to discuss is the provision that's in the health proposal in regard to the powers of your

department and the Executive in the event there is a revenue shortfall from that which is projected in the adopted budget. I'm just thinking that this is an extraordinary request for powers that have hitherto not been seen in the Executive, even with the strong executive Division of Budget that we have in the state. And I'm wondering in what events that you envision that you're going to do this, and do you have alternatives? Because I frankly don't see that that's a proposal that's something I agree with.

COMMISSIONER ZUCKER: So the budget provides for an opportunity, in the event of emergencies, to make sure that there's a way for us to address that, not at the -- not by increasing the budget, but to redirect resources as necessary. And I think that that's the -- it gives us a little latitude in case that were to occur. And we've seen situations where there have been emergencies that surface.

SENATOR HANNON: Well, I think this goes beyond a latitude that's ever been seen

for allocating and suballocating and moving funds in a budget. So I would just suggest that there be some -- you may want to consider some alternative.

Obviously there are dramatic proposals in Washington, there are budgeting -- they're talking about doing two or three budgets by reconciliation during the course of the calendar year. Their fiscal year doesn't begin until October 1, so there's a lot of mismatch in regard to calendar years. But I think there needs to be a practical proposal, not a pie-in-the-sky proposal in regard to dealing with that situation.

COMMISSIONER ZUCKER: Thank you.

SENATOR HANNON: You mentioned the Wadsworth Lab, and I know this is something that you as commissioner are especially passionate about. My difficulty with that is I would look through the budget and I don't see any location proposed for a new Wadsworth Lab to the tune of $150 million. Has the Executive and yourselves come up with a finer tuning to where it might be located?

COMMISSIONER ZUCKER: So thank you for that question. So we are looking at -- the $150 million will work towards looking at, number one, engaging stakeholders, looking at site evaluations, trying to design the lab. And we are trying to identify the right place for this to make sure there's an opportunity for both a public/private partnership but also to engage those in academic communities and others to be able to utilize the unbelievable services that the lab has.

And this is all the first stage of what we're planning to do.

SENATOR HANNON: So it may be appropriate for us, in response, to say this is something to look at and to evaluate and to see where the request for proposals should be made and where the site selection should be. Because I know the lab is nationally, internationally renowned, yet could still be improved, but still this is a major undertaking for a fairly tight-knit region of the state.

COMMISSIONER ZUCKER: Right. And I

think, as you mentioned, it's a gem in our department, and what the Wadsworth Lab has achieved over the course of the past three years that I've been in the department, including the issues of Legionnaires' disease and Ebola and Zika and water testing.

So we want to be sure when we move forward with a new lab, the location, the site, the design, the partnerships are addressed, and that's where the first step of that $150 million -- or the $150 million will go.

SENATOR HANNON: The -- you mentioned water, which we have spent a considerable amount of time on, for good reason. And I noticed that yesterday the department mailed out to residents of the Newburgh area, the Hudson Valley, the results of their own blood tests.

One of the things I went looking for is whether or not your department has progressed in regard to levels of standards of safety for the contaminant that was tested in Newburgh, also in Hoosick Falls, the PFOA.

Now, since we began all the hearings, I know the federal government has come up with a standard that's 70 parts. But I was wondering, has the department adopted that? Has the department looked at the fact that that's -- you call the EPA standard an advisory, as opposed to a rigorous standard? And so if we don't have this adopted in this state as a standard, I'm wondering what's the use of mailing out the blood tests to people. Will they say it's safe, it's not safe. Do we --

COMMISSIONER ZUCKER: So thank you for that question. We've spent a lot of time on water.

The advisory put forth by the federal government was 70, as we know. However, we recognize that we've been working with -- trying to work with the EPA in the last administration. However, as of today, or maybe perhaps it's tomorrow, that there will be a new EPA administrator that will be confirmed, or it goes up for confirmation. And the department wants to work with the

federal government on identifying the steps for MCLs for these unregulated contaminants.

We need to give them a little bit of an opportunity to move forward in identifying an MCL. If they do not identify one -- or set one, I should say, then we as the state will do that.

SENATOR HANNON: Well, you could do that now, is that not the case?

COMMISSIONER ZUCKER: Right, we could do that. However, because the issue of water is such a national issue, it's in the best interests of everyone, whether New York or neighboring states or other states across the nation, to have a national standard. When the issues of PFOA were addressed upstate here in this area and I had an opportunity to speak with my colleagues in neighboring states, we all recognized that the best thing is for the federal government to set that.

And so again, we will ask the federal government. We hope that they do the right thing and set a standard. But if they don't, this state, New York and the Governor and the

department, will set one.

SENATOR HANNON: I've proposed legislation in regard to setting up in the state a Water Institute that would do testing, that would have standards, that would issue those. And I think in light of the fact that we don't have one for PFOA, the fact that the other day you and the Governor signed a letter to the EPA asking for testing of another contaminant, dioxin -- at the end of your statement you said, If the EPA won't do it, we will convey a group of experts and try to come up with our own standard -- I think that it's really incumbent upon this state to act.

If in eight years of an Obama administration, arguably an environmentally friendly administration, they could not come up with standards -- they don't even have the standard for chromium, which is Erin Brockovich's thing. So if they couldn't come up with a standard, the expectations are not high, and I think we should move forward having our own standard-making system

automatically, continually -- not ad hoc -- in this state.

COMMISSIONER ZUCKER: I appreciate that. And I had an opportunity to read the report that you provided to us regarding -- and the recommendations. I think that we -- yes, and I have it here too, thank you. And I appreciate the recommendations.

The -- and so the question that I raise is, okay, what are some of the things that putting together a committee would do that we are already looking at? So the Department of Environmental Conservation, my department, the Department of Transportation, all of us are working together and using our experts -- and we just mentioned Wadsworth, the experts there -- to come up with how do we move forward on these issues of water quality. And so I am with you on this and would love to work with you further on getting this done.

SENATOR HANNON: Well, thank you. I know there's a lot of good work that's been done, but I think there's a lot more that

needs to be done.

Madam Chair, I'll cede my time. At the end of my colleagues' time, I'd like to come back for questions, but I know people are anxious.

CHAIRWOMAN YOUNG: Certainly. Certainly.

SENATOR HANNON: And I didn't even ask anything of the Medicaid director.

(Laughter.)

CHAIRWOMAN YOUNG: That's coming.

(Laughter.)

CHAIRWOMAN YOUNG: We've been joined by Senator Diane Savino.

And also I want to point out -- I didn't announce it at the beginning, but we also will be hearing from Maria T. Vullo, superintendent of the New York State Department of Financial Services. She's up next after the two esteemed witnesses that we have now.

Chairman?

CHAIRMAN FARRELL: Assemblyman Gottfried, chairman of the Health Committee.

ASSEMBLYMAN GOTTFRIED: Thank you. I don't know whether this question is better directed to Dr. Zucker or Jason Helgerson, but you can divide it up. And I'm going to read through it, because it's kind of long.

So my first question is about prescription drug pricing. The proposals for dealing with high-priced prescription drugs suggest that DOH believes it can do a better job of bringing down those prices than individual insurance companies can. If that is correct, why limit it to those drugs? Why not provide the same benefit for antibiotics and all other drugs?

In the past, DOH has objected to restoring the role of the Preferred Drug Program to negotiate price or rebates for drugs for the whole Medicaid program. DOH has said individually Medicaid managed care plans get better prices than the PDP could, because they work through giant PBMs. But now DOH says it can do a better job bringing down prices than the managed care plans can. And the proposal to regulate PBMs suggests

that the Executive thinks PBMs are actually ripping off their health plan clients.

Please explain.

COMMISSIONER ZUCKER: So I think there's two parts there. One is the issue of the prescription drug prices. And as we all know, we've seen this, the price of prescriptions on some medications are just astronomical. And this is not -- not acceptable in -- it's just not acceptable for the high-quality care we're trying to provide. The commitment of Governor Cuomo is to not allow that to continue.

The -- we all have gone to pharmacies and have looked at filled prescriptions, we've all heard from -- you've heard from your constituents, and I've heard from them as well about the price of medicines. I personally have heard of patients when I was practicing medicine who cut --

ASSEMBLYMAN GOTTFRIED: Excuse me. Dr. Zucker?

COMMISSIONER ZUCKER: Yup.

ASSEMBLYMAN GOTTFRIED: Could you

focus on my question?

COMMISSIONER ZUCKER: On the prescription benefit?

ASSEMBLYMAN GOTTFRIED: On why the state can do a better job negotiating prices than drug companies, which I believe -- than insurance companies, which I believe it can, but which was -- which is the opposite of what the department has said in the past.

COMMISSIONER ZUCKER: So -- well, one part is that with regards to these prices, it's a -- as the Governor has put forth, it's not all medications, it's a small pool of medications.

There are three areas. One are new medicines that come onto the market that are markedly elevated in price. Another are medicines that are -- and for example, some of the hep C, hepatitis C medicines that were put out there. A second one are medicines that come into the marketplace that were there and then they have a dramatic increase in the price. So that's like the EpiPen, where it went from $100 and up by

500 percent. And others are medicines that are brought into the marketplace that have a very narrow area of diseases or a specific area of disease that has a markedly elevated price.

So the -- what you're saying is that the state addressing all medicines -- that's not the plan of what the Governor has put forth.

Regarding the Medicaid component, which is set, some of the prices -- Jason, did you want to add anything about the Medicaid?

MEDICAID DIR. HELGERSON: Sure. So, Assemblyman, I think that generally speaking both the state through the Preferred Drug List, as well as managed care plans through their contracts with PBMs, have an ability in the case of most drugs and most drug classes to create competition and, with that, to help bring down prices.

But what we have seen in the last few years is a relatively new phenomenon, which is manufacturers in a select set -- actually,

a relatively small set -- of specific drugs and specific classes, in which there is no competition, in which there really is just one drug available for a period of time, and during that period of time, during that period of patent protection, a manufacturer is using in essence their monopoly power to charge an outrageous price, a price that simply is not affordable.

And so in response to that, the Governor has proposed very aggressive action designed to target only those drugs where that's an issue. His proposal is not unique to Medicaid, it is an all-payer approach to basically provide a strong financial penalty to any manufacturer who brings such a drug to market or attempts to increase a drug's price, you know, during that period in which there is really no competition. Whether it's PBMs nationally or locally or whether it's state Medicaid programs, whether they negotiate as a whole or through their managed care partners, if there is no competition, there is no competition.

And what the Governor is acknowledging in his proposal is in those extraordinary circumstances -- and it's a limited number of drugs -- that if a manufacturer abuses the rights that they have under their patent protection and attempts to charge outrageous prices that no one can afford, that could in fact cost taxpayers in New York State billions of dollars, that in those rare circumstances the extraordinary all-payer initiative is necessary. And that's where his surcharge proposal comes in.

That's why, in our view, it's really two separate issues. And we think at the end of the day an all-payer surcharge penalty upon those limited number of drugs -- which we hope actually we don't have to use, but if we have to, is a very strong stick to discourage the kind of behavior that we've seen in the past few years.

ASSEMBLYMAN GOTTFRIED: Well, before I ask my second question, which may focus this point a little more, I'll just note that in the past you've said that PBMs with

90 million covered lives have more bargaining clout than the Medicaid program, even if under the PDP it was bargaining for 6.5 million lives, and therefore going through a PBM has more clout, presumably, to deal even with these big bad super-drugs.

But let me read my second question.

On January 13th, I wrote to you saying: "The Health Department has asserted that the current system saves Medicaid money because the managed care plans, by using the services of national pharmacy benefit managers, negotiate lower prices than the PDP, Preferred Drug Program, could.

"I assume that with hundreds of millions if not billions of dollars at stake, the department has evidence to support this assertion. For example, there ought to be evidence comparing the rebates negotiated by the PDP when it was at full strength, comparing that to the rebates by or for the various Medicaid managed care plans after the carve-in.

"I would appreciate it if you would

provide me this evidence before the budget hearing."

Now, I had asked this same question at previous budget hearings, got no evidence in response. In the intervening weeks since my letter, the department assured me that I would get that information prior to today's hearing. At 11:27 p.m. on Tuesday, DOH emailed my office saying: "Staff have been working on this issue, but the analysis is complicated and requires a bit more of a deeper dive to ensure that they have a full understanding."

So considering DOH's lack of understanding, wouldn't it be prudent and helpful to the department, to delete the drug pricing and PBM provisions from the Article VII bill until DOH can develop a full understanding and explain it all to the Legislature? We could then consider that in a departmental program bill after the budget.

MEDICAID DIR. HELGERSON: So in terms of the -- we are completing the analysis per your request. The issue is just -- what

we're trying to do is go back and basically try to replicate what the world would have looked like back to 2010. We're now in 2017, so the drug carve-ins now have been in place for five, six years. So it is a bit of a challenge to go back and try to replicate what the world would have looked like, considering how much has changed.

I think the bottom line is that the supplemental rebates that the managed care organizations are able to generate compared to what we were able to generate as a percent of total spend before the drug carve-in is basically comparable. It's about 5 percent of total drug spend comes from supplemental rebate revenue. That is about what it was back in 2010. That's about what the plans are able to generate. In fact, the plans generate slightly more than what we were able to do in 2010.

Now, obviously 2010 was 2010. We're now in 2017. So we're trying to see and update that to 2017, which is what is the complexity and a bit of a challenge working

with our actuaries as well as the state's contracted pharmacy benefit manager.

So that's what's taking a little bit of time. Apologize for it. But I do think that one fact which is known is that one of the things that carving the drug benefit into the managed care contracts did, and did very clearly -- and it is very clearly something that we can demonstrate -- is that they were very successful increasing the generic dispensing rate. And the vast majority of what is hundreds of millions of dollars in savings that was generated as a result of the drug carve-in had nothing to do with negotiations with manufacturers on brand-name medications. It rather was the fact that we have significantly increased the number of patients who are utilizing generics when the generic equivalent is available. In fact, prior to the carve-in we had a generic fill rate of 73 percent. We now have a generic fill rate of 86 percent. And that has generated significant savings, hundreds of millions of dollars in savings to taxpayers

as a result. And that's -- that is a key part of why we believe at the end of the day the drug carve-in has been a successful policy for the State of New York.

ASSEMBLYMAN GOTTFRIED: Well, I have two problems with that answer. One is that the reason the generic fill rate went up is not because of any magical powers of PBMs or Medicaid managed care plans. Isn't it because we enacted a statute that mandates generic substitution in Medicaid, whether the prescriber wrote "dispense as written" or not? Isn't that what bumped up the generic fill rate?

And secondly, you have said at these hearings and elsewhere, several times, that you know that the managed care plans have been more effective than the PDP was or could be. You've put specific dollar amounts on that increased effectiveness, both at this hearing and in budget negotiations. Now you're telling me that you really do not have a factual basis for those statements because you don't know what the rebates were in 2007.

And I find it hard to believe that the department wipes out those records. But you're saying you don't know what the rebates were in 2011 and are therefore having a hard time comparing it to the rebates, let's say, in 2013, when the carve-in was fully effective.

So how can you be so adamant that all along when I've been asking this question, I was wrong and you had a specific price tag to put on that answer?

MEDICAID DIR. HELGERSON: No, we do know exactly how much rebate revenue we collected in 2010 prior to the carve-in. We know how much rebate revenue is collected by the managed care organizations. They report that to us each and every year.

The issue is that what you had asked us to do was to try to replicate -- and we do this each year, but we wanted to do a deeper dive, per your request, because a lot has changed since 2010. That's part of the reason why we're here. Part of the reason why the Governor has proposed such aggressive

action in his budget is that in 2010, we did not have the kinds of treatments that we now have for the treatment of hepatitis C. In my time --

ASSEMBLYMAN GOTTFRIED: Well, no, wait a minute. First of all --

MEDICAID DIR. HELGERSON: -- as a Medicaid director, I've never seen anything that was more disruptive to the Medicaid program nationally than the new drug agents that came in for the treatment. Very exciting in so many ways, but so high cost that -- it's such a significant game changer that it made sense for us to sort of take a little bit more time because we knew at the end of the day whatever number we put on your proposal would be one that we would want to have the maximum ability to defend.

And we thought it made sense, with our actuaries and with the pharmacy benefit manager, to take that time to do that analysis. And that's what we're doing. And we will get your analysis shortly.

ASSEMBLYMAN GOTTFRIED: Well, first of

all, I never asked you to create a hypothetical scenario for 2016. I asked to know what the rebates were for 2011, the last year when the carve-out was in full effect, with what I guess would be 2012 or 2013, the first year when the carve-in was fully effective.

I can't believe that you couldn't get that number by dinnertime tonight, if you wanted it, from a member of your staff. And when I first started asking you this question, it was long before Sovaldi or any of these other things were on the market, it was long before the sevenfold increase in the price of an EpiPen. And I think I've been asking a pretty simple question and not getting an answer. And I believe at this point that the reason that evidence has not been presented is that that evidence, like the dog that didn't bark, does not prove your point. I believe it will prove my point.

And the fact that you think for these high-priced drugs you are more powerful than a 90-million-covered-lives PBM -- I agree

with you that I think you are more powerful for negotiating about Sovaldi, but I think you are also more powerful when negotiating about Crestor or amoxicillin.

MEDICAID DIR. HELGERSON: So I guess, in a sense -- I mean, we will get you the information. I think what we were -- maybe we were reading more into this in terms of your questions. But we were anticipating, as has been the case last year and in past years, that you would be needing this information for the preparation for a budget proposal, and that what you'd want us to do is to say if we changed our policy, what would be the fiscal implications of that and provide you with sufficient evidence to support our conclusion.

So that's the core of what we were doing. And obviously in order to do that, you have to take into account the current state of pharmaceutical prices and the current state of utilization. So that's -- so I apologize, but that was what we were anticipating, so that's a key reason for why

we are taking a bit more time to do that. But we definitely will get you what it is that you need.

I would say, however, the Governor's proposal really isn't about negotiation. The Governor's proposal is about situations in which negotiation doesn't work. It's about situations like we had with Sovaldi, where you had a drug come to market when there was no alternative -- and this was a drug that cured a horrific disease, a cure that many, many people have been waiting for for a long time. And it came in at a price tag that when you look at the potential cost to taxpayers, was in the billions, with a B.

And it shook the healthcare industry and shook the payer community and shook the Medicaid and Medicare programs like nothing I'm seen in my 10 years as a Medicaid director. And it has scared a lot of people about the future of healthcare costs in this state. And we have seen in the last couple of years a growth in our costs on drugs that we have not seen in the past.

And this isn't a general trend. This is a trend that is occurring with a select number of specialty medications and a select number of manufacturers who are using this small window in which they have patent protection and no other competitor -- you can't have a competition if there's only one player on the field. And that's the challenge, that's where the Governor's proposal is, is the only drugs that will go into, under his proposal, into the penalty box that is this surcharge are those in which the practice -- in which there is no opportunity for competition, where they use that unique window to drive inappropriate prices. That's the only time we plan to use it.

In fact, in a lot of ways we hope not to use it because we hope this will have a chilling effect on bad practice, on bad behavior, and as a result we'll see a more affordable drug benefit moving forward.

CHAIRMAN FARRELL: Thank you.

CHAIRWOMAN YOUNG: Thank you.

ASSEMBLYMAN GOTTFRIED: I'll come back with a couple of other questions later.

CHAIRWOMAN YOUNG: Thank you.

I have a few questions, and I would like to start with the Governor's proposal. In his Executive proposal he has a provision about avoidable emergency room visits and that people could basically be turned away if it's deemed somehow that they are not rising to the level of an emergency situation.

I'd like to point your attention to a law that was enacted in 1986. It's a federal law. It's the Emergency Medical Treatment and Active Labor Act that requires anyone coming to an emergency department to be stabilized and treated regardless of their ability to pay or their insurance status. And it applies when an individual comes to an emergency department.

So how does what the Governor is proposing interface with this federal law?

COMMISSIONER ZUCKER: So EMTALA obviously serves a very critical purpose for anyone to show up in an emergency room and

get the necessary care, at least for stabilization or, obviously, for labor.

And the commitment is to continue to provide that kind of care. The issues that we have in transformation of care is to make sure it's a seamless process of care. But I'm not clear as to where you're saying that we would be not following the EMTALA law.

CHAIRWOMAN YOUNG: Well, if somebody shows up to an emergency department and they're deemed somehow -- I guess it's up to the hospital? How would that even work? Who's responsible for deeming whether somebody is having an actual medical emergency or not?

COMMISSIONER ZUCKER: Right, so if someone shows up in the ER -- and having worked in these emergency rooms, if someone walks in that door, they are stabilized and the necessary care would be provided.

At some point after they are stabilized -- and this is the case for those who may be transported to another facility for one of many reasons, including care that

may not be provided at the hospital where they walked into the emergency room -- but that is the decision made at that point, after the patient has been -- their condition has been basically stabilized.

CHAIRWOMAN YOUNG: So -- but what if somebody is having a heart attack? Sometimes the -- I mean, you know better than anyone else, if somebody is having a heart attack sometimes the symptoms aren't as obvious in some people as others. So what if somebody is basically told, "You're stable, go home," and then they die? I mean, that could happen; right?

COMMISSIONER ZUCKER: Well, we do have -- number one, I mean, I hope that doesn't happen.

Number two, I think that the department is responsible for a lot of the obviously regulations that -- we monitor very closely hospital emergency rooms, and if there's ever a problem brought to our attention, we will investigate it.

The judgment call, it should not be

based on anything more than potentially a physician's or other healthcare provider's judgment call at that point. We hope that the judgment call is correct and that the decision to send somebody home was not based on anything more than their belief that the patient was doing better.

CHAIRWOMAN YOUNG: Doesn't the proposal penalize hospitals if they treat somebody and the condition is found to be not that serious?

COMMISSIONER ZUCKER: I would check on that, but I don't think that we would penalize a facility. I mean, do you --

MEDICAID DIR. HELGERSON: Right. So what the proposal is is to basically reduce the payment through Medicaid to hospitals for non-emergent ER visits. It's a specific set, we worked with clinicians to identify specific instances where there -- really this was a service that should not have been provided in the emergency room but rather should have been provided in an outpatient or primary care setting.

We subsequently increase reimbursements to outpatient services, to hospitals, to basically incentivize them to work with patients, work with others to redirect.

And I do think it's important to point out that the emergency room is not the appropriate place for someone with the flu. It is not the appropriate place for someone who does not have an emergent condition. Last year roughly a half a million visits to emergency rooms occurred in New York State that were for things that were not truly emergencies. A core function of the Delivery System Reform Incentive Program is to actually begin to help reconnect patients back to primary care, which is the most appropriate place for those services to be provided, not in the emergency room.

And I would also say one of the challenges are --

CHAIRWOMAN YOUNG: But what you're saying is somebody shows up at the emergency room and they are required to be seen and

stabilized, under federal law. And if the hospital does that, and then they have the flu, which you don't think is that serious, then the hospital will be penalized financially if they treat that person. I don't understand how this could even work.

And on top of that, in rural areas you know there is a dire shortage of primary care providers. In many cases, doctors have caseloads of 10,000, 15,000 patients, and there's not access. So if they have to go to the emergency room, that might be the only option that a person has.

So I don't understand how the hospitals could be penalized for this. They're required under federal law to provide the service, and then you would determine, no, you shouldn't have provided the service. And I think the hospitals are at risk of being sued if they don't treat someone and they go home and they die. I just think this is a really bad, bad proposal.

I understand the overutilization of emergency rooms. I understand the costs.

But I don't think this is the right direction to take.

Just switching gears, I want to talk about the Medicaid global cap. And there are a few questions regarding that, because the current fiscal year estimates emerging pressures on the global cap due to higher-than-expected enrollment with the managed long term care. Is the global cap on track to remain balanced through the conclusion of this year after accounting for higher projected deficits?

MEDICAID DIR. HELGERSON: So the answer is yes, we are on track this year to finish the year with the global cap in balance. As has been the case in past years, it is not without its challenges, but we anticipate finishing the year in balance.

CHAIRWOMAN YOUNG: What's the total amount of accrued Medicaid liabilities moving forward from the current year into fiscal year 2018?

MEDICAID DIR. HELGERSON: So we're in the midst of closeouts. So at that point, as

we come to the end of any fiscal year, we are looking at potential liabilities that may drag into the next year. And we always strive to make sure we have sufficient credits that we too can move into the next year so we do not create a structural deficit.

We've never created a structural deficit in the Medicaid program from one year to the next in terms of our management of the global cap. At this point we do not anticipate having that occur this year.

CHAIRWOMAN YOUNG: Is the growth in the global cap -- or I guess I'll reframe that. Does the growth in the cap increase the minimum wage? Is that included in it?

MEDICAID DIR. HELGERSON: So there is actually a fund that's been set aside, I believe it's $255 million, that's actually outside of the global spending cap that is administered jointly by the Division of Budget and the Department of Health. That is monies that are set aside, that's state share funding that is available to basically

support costs of implementing the minimum wage. The Governor made the commitment, and the Legislature in the last budget agreed, that the global cap would not bear the cost to the Medicaid program of the minimum wage. And the Governor's budget fulfills that commitment.

CHAIRWOMAN YOUNG: But isn't that fund, isn't that still Medicaid? Aren't those still Medicaid dollars?

MEDICAID DIR. HELGERSON: It is a -- in addition to the global cap itself, which grows at its historic rate of the 10-year rolling average of the medical portion of CPI, there is this separate fund, which in essence will be allocated on an as-needed basis to the global cap to cover those costs.

CHAIRWOMAN YOUNG: But the separate fund is still Medicaid.

MEDICAID DIR. HELGERSON: I mean, it only becomes Medicaid when it's transferred into that global cap for that purpose.

CHAIRWOMAN YOUNG: Okay, so it's still Medicaid.

(Laughter.)

CHAIRWOMAN YOUNG: What percentage of DOH State Medicaid global cap funds are used for funding purposes outside the Medicaid global cap?

MEDICAID DIR. HELGERSON: So off the top of my head, I don't know the percentage. There are a couple of transfers that occur. One of those transfers is associated with -- if people remember from a few years ago, we had to fundamentally change how we reimbursed or provided federal reimbursement to services within the OPWDD system. It was a loss of federal money, a very substantial loss of federal money, about a billion dollars per year loss of federal money.

The global cap helped contribute to that, and to the tune of about $700 million in the initial loss. And phasing out that contribution, that -- the last increment to that contribution is continuing, in the sense that it goes into the General Fund. Off the top of my head, I think it's about $260 million that is transferred out.

There's an additional transfer out of the global spending cap this year of $115 million that is also going to the General Fund. Obviously those dollars are supporting overall healthcare expenditures, including other expenditures in Medicaid. Medicaid doesn't cover the entire -- or the global cap doesn't cover all of Medicaid, there are other parts of the program that are outside. As well as obviously the rest of the Department of Health budget is outside.

CHAIRWOMAN YOUNG: So does the Executive proposal reduce funding for the supportive housing program?

MEDICAID DIR. HELGERSON: It does in this year. Although the good news is next year there will be a return of some capital funds that have been temporarily, in last year's budget, reduced. And so while we have a slowdown in the program this year, we anticipate ramping back up in terms of our supportive housing program beginning in the next fiscal year.

CHAIRWOMAN YOUNG: Okay, thank you.

My time is up, so I'll come back.

CHAIRMAN FARRELL: Thank you.

Assemblyman Cahill, chair of the Insurance Committee.

ASSEMBLYMAN CAHILL: Thank you, Mr. Chairman.

Dr. Zucker, good to see you. Thank you for the many times that I've called your office and you've been very responsive. I really do appreciate it.

I want to focus on two areas, as much as we can fit into the time we have allotted, and that would be early childhood intervention programs and the Essential Health Benefit Plan increases that are proposed in the budget.

So with regard to Early Intervention programs, the state several years ago took an initiative to remove the responsibility of the counties to seek reimbursement from insurance companies and place that responsibility directly with the providers, and put in place a fiscal agent. The fiscal agent, it was proposed at the time and

several times since, was to increase participation by insurance companies from their slightly under 2 percent to some significantly higher number. And over the course of the several years since this program has been initiated, we've spent about three-quarters of the $45 million that we promised to give the fiscal agent.

So can you give us a thumbnail report on the progress that the fiscal agent has made in increasing insurer participation?

COMMISSIONER ZUCKER: Sure. So Early Intervention, we have 68,000 newborns and toddlers, or infants and toddlers in it. We've got 16,000 or more Early Intervention providers. The state fiscal agent was put in place to help recover some of the insurance -- the reimbursement for these services.

However, of the 68,000 infants and toddlers, about 40 percent of them are covered by commercial insurance. And the reimbursement for that, it's only been about 2 percent that's come back. And the budget

is proposing to modify that work to create a system so that they can get more reimbursement. Because otherwise it ends up falling on -- obviously, on the state.

So the goal here is to increase the third-party reimbursement. It's also to expand the access to the commercial insurance as well. So we would like to see this be better reimbursement than what we see right now, and the goal here in the Executive Budget is to get that more in line.

ASSEMBLYMAN CAHILL: So this is the fourth year of the program, right?

COMMISSIONER ZUCKER: This is the fourth year, I think, yes.

ASSEMBLYMAN CAHILL: What has been the success for the first years of the program from the fiscal agent? Have they actually improved it over the course of the last several years?

COMMISSIONER ZUCKER: I'd have to check about how much of the changes, but I do know that we are not where we want to be at this point.

ASSEMBLYMAN CAHILL: I can tell you I've checked, and there's been no progress.

COMMISSIONER ZUCKER: So this is why the modifications, yeah.

ASSEMBLYMAN CAHILL: We spent several tens of millions of dollars for a fiscal agent, we've placed a lot more administrative burdens on providers, so that providers have been leaving the system. These are folks who are making, you know, sometimes $20 an hour and then are required to take one-third of their time to go out and secure billing, where in the past they got reimbursed directly from the counties.

Has there been any thought of abandoning this modification that has proven to be a failure over the past three years and returning to the old system where the counties sought out the reimbursement and the providers were directly reimbursed?

COMMISSIONER ZUCKER: So we think that with the proposal we have now, that may help facilitate the role of the state fiscal agent. So let's see how that works at this

point.

ASSEMBLYMAN CAHILL: Well, if I understand the proposal, it is to expand the range that insurers would be required to cover to add essentially new benefits, but also to deny those plans some of their administrative tools that they currently use. In other words, right now a plan can say that's not a covered benefit and therefore we're not going to cover it, and under the rule that's being proposed in the budget, the plan would no longer have that authority if there's been a doctor's diagnosis or something of that sort.

That seems to be just increasing the rates. Couldn't that also be done without a fiscal agent, couldn't the money that we're spending on the fiscal agent be better spent on reimbursing providers at a more responsible level?

COMMISSIONER ZUCKER: Well, we think that the role of the fiscal agent -- and it may not be as efficient as we want it to be right now, but we think that it serves a

role, and that's why these modifications, to help facilitate that role.

I hear what your concerns are. Let's -- so I would ask that we see where we are a year from now on this.

ASSEMBLYMAN CAHILL: Dr. Zucker, several years ago some of our colleagues, some of whom are on this panel -- Senator Hannon, Senator Seward and myself, Assemblyman Barclay, Senator Breslin -- visited the premises of the fiscal agent, and they were basically a start-up at the time. And great promises were made of success.

When do we decide that it was a failure? Do we wait till we've spent the entire $45 million to decide that it's a failure? Because we've spent a significant amount of that money already.

COMMISSIONER ZUCKER: So we've examined this -- and I hear your concerns. We've examined it, this is why we think these modifications that we've put in would help expedite the process of getting more reimbursement for this.

So I recognize that, you know, there's a period of time, several years have gone by, but this is sort of a complex process and we'd like to see if this works.

ASSEMBLYMAN CAHILL: I would suggest to you that there is no value added from the fiscal agent. I didn't reach that conclusion when I walked out of their offices -- that had xeroxed signs on the door, no artwork on the walls, no kids' pictures on the desks, that looked like something from The Sting that was set up just for our visit. I didn't make that conclusion at the time, but I said let's see what they produce and let's judge them on their product. And now it's time to judge them on their product, and they have no product.

All the changes you're proposing could go directly to the benefit of the providers themselves. If we were to continue with those changes without the need for the intervention, it would provide another maybe $10 million -- I don't know, have they been paid any bonuses over this time? I know

their contract called for bonuses. Have they been paid any?

COMMISSIONER ZUCKER: I couldn't hear the last part.

ASSEMBLYMAN CAHILL: I said, has the fiscal agent been paid any bonuses over the course of these four years?

COMMISSIONER ZUCKER: I don't know that answer. I'd have to find out.

ASSEMBLYMAN CAHILL: If you could provide that answer, I would really appreciate it.

The other question that I have is about the Essential Health Benefits Plan and the proposal on the part of the Governor to impose a $20 premium on people whose income ranges from 138 to 150 percent of the poverty level. This is probably for you, Mr. Helgerson. What is 138 percent of the poverty level? What's that family income in New York?

MEDICAID DIR. HELGERSON: It varies based on family size. So off the top of my head, a family of two -- I can get that for

you before the end of the hearing.

ASSEMBLYMAN CAHILL: It's not much, right?

MEDICAID DIR. HELGERSON: What's that?

ASSEMBLYMAN CAHILL: It's not much.

MEDICAID DIR. HELGERSON: It's not much. It is -- it is incomes above, obviously, the Medicaid level. We already have a premium for individuals whose incomes are between 150 and 200 percent of federal poverty. And so this program -- or this proposal extends that.

Now, it does cap total out-of-pocket expenses. But I hear your concern. I think, though, that we feel at the end of the day this is still a very affordable form of insurance. If these individuals -- if we didn't offer the Essential Plan, these individuals would be in qualified health plans through the exchange, and they'd be paying considerably more.

And so in a sense, because at the end of the day this is a program that is subsidized by state taxpayers, in addition to

the federal government, we still are offering a very, very affordable insurance that is actually better than anything you'd find anywhere in the country, with the possible exception of Minnesota.

ASSEMBLYMAN CAHILL: So there's a savings represented in the budget of approximately $15 million as a result of this $20 copay. Is that just the income from the $240 a year you're going to receive from these families between 138 and 150 percent of the poverty level? Or is there a component in there where there's anticipating that people will be leaving the system?

MEDICAID DIR. HELGERSON: So we work with our actuaries, so we basically estimate what our reductions will be in the premiums. I don't know if we have any estimates for reductions in actual enrollment as a result. I mean --

ASSEMBLYMAN CAHILL: So that $15 million just reflects the actual premium cost?

MEDICAID DIR. HELGERSON: Honestly,

off the top of my head, I'd have to go back and check to see whether there's any premium.

But what I can say is this program has been amazingly successful and popular. There are almost 700,000 people enrolled in it, far in excess of what the earlier estimates were. I don't think at the end of the day this is going to deter too many people, because compared to what they might find in other means, this is still exceptionally affordable insurance.

ASSEMBLYMAN CAHILL: So you said you'll have to go back and get that information. I'd appreciate it if you could get it for us before we have to actually decide on the Governor's budget proposal. I think it's information we need.

Are there any other changes for those people in 138 to 150 percent of the poverty level to the plan that they would get under the Essential Health Benefits Plan?

MEDICAID DIR. HELGERSON: Yes. So there are changes to the other forms of out-of-pocket expense that individuals will

be facing, not only in that 138 to 150 range but also the 150 to 200 range. So they are the institution of what I would consider fairly modest copays that -- but as I say, they're capped.

ASSEMBLYMAN CAHILL: What is the change in the copay? Because what you might consider fairly modest at a state employee's salary might be something different than what somebody at 138 percent of the poverty level might think is modest.

MEDICAID DIR. HELGERSON: So they range from say $5 for a copay for a visit to your primary care provider to an outpatient surgery procedure where the copay would be about $20. So that just gives you the range.

ASSEMBLYMAN CAHILL: So I would appreciate if you could provide us with any information that your actuaries have determined would result in people leaving the plan and, if so, what we expect those folks to do for their healthcare and what you expect us to do for their healthcare.

MEDICAID DIR. HELGERSON: Understood.

ASSEMBLYMAN CAHILL: Thank you.

CHAIRWOMAN YOUNG: Thank you.

CHAIRMAN FARRELL: Thank you.

CHAIRWOMAN YOUNG: Senator Marty Golden.

SENATOR GOLDEN: Good morning, gentlemen. Commissioner, I'm going to change the tone a little bit, going over to ambulances and ambulance service.

The good Governor has authorized you to take over the responsibility of the managed long term care transportation. You're going to select the contractors for this transportation system. Do localities have any input into that?

COMMISSIONER ZUCKER: The localities what?

SENATOR GOLDEN: That they're going to have these transportation systems in.

COMMISSIONER ZUCKER: Have we identified them? We're working on that. We're working on it.

SENATOR GOLDEN: Will the localities have some input into that?

COMMISSIONER ZUCKER: Yes. Yes.

SENATOR GOLDEN: The Governor has suggested -- not suggested, he's proposed repealing the standards. So since there's no standards in the bill, aren't we sort of like jeopardizing the transportation system for our --

COMMISSIONER ZUCKER: I don't follow why you're saying that, that we're jeopardizing it.

SENATOR GOLDEN: Because there are no standards, they're not in statute once we repeal them. So therefore when you have a service now, a transportation system taking people back and forth for the medically necessary appointments, what assurances do we have for safety?

MEDICAID DIR. HELGERSON: So I think you're referring to our proposals to carve certain -- in the case of certain managed care products, to carve those services, those transportation services out of those managed care contracts and manage it through our transportation manager.

So for the vast majority of individuals on the Medicaid program, they receive their services -- their transportation services are managed by a state vendor who manages the benefit with a 1-800 number that allows them access to the transportation services they need. Very successful initiative, saved tens of millions of dollars over the last several years.

As we proposed last year, we're proposing some additional moves to basically leverage that transportation manager. And we think at the end of the day it will lead to greater access, which is what we saw in the case of the transportation manager with the populations that already are affected, as well as some additional cost savings.

SENATOR GOLDEN: What are the safety standards, sir?

MEDICAID DIR. HELGERSON: I'm sorry, the safety standards? So the safety standards that apply in transportation are not being changed by this. All that's being changed is that the managed long term care

plans will no longer be paying for those services and the state will be paying for it and managing it with its vendor.

SENATOR GOLDEN: The supplemental ambulance payments that are now -- should be going to the ambulance providers, will that money go to the ambulance providers while you are choosing these contractors?

MEDICAID DIR. HELGERSON: So I think there's sort of two issues here.

There is a proposal in the budget relative to ambulance services, which is there's an existing appropriation for $6 million that the Governor's proposal is to basically continue to use those payments, use those dollars, but use them more efficiently to fund ambulance services. And that, in essence, will begin a process of adopting some rate reforms that will be recommended by a report which will be coming out very shortly on ambulance services in Medicaid.

And so that proposal is a little bit different than the carve-out services for managed long term care, which is --

SENATOR GOLDEN: With the money that's going to be used, are the ambulances going to get that supplemental payment while you are waiting to design and get this off the ground?

MEDICAID DIR. HELGERSON: Yes, they will receive those funds.

SENATOR GOLDEN: Thank you.

You know, you pointed out to us several million dollars in savings over the past couple of years by lowering the generic drug CPI penalty threshold by 225 percent, estimated to save the state about $17 million. Since the CPI penalty was enacted last year, the state has saved less than $2 million. The estimate was much higher. How can we be sure that the savings achieved will be even close to the estimate?

MEDICAID DIR. HELGERSON: So in terms of the -- and actually I take that the project or the proposal that was enacted, which put basically a cap on the rate of increase for generics -- and so we've spent earlier talking about brand-name medications.

But a recent trend, recent in the last few years, that's been very disturbing is generic manufacturers using windows of opportunity to greatly increase prices for generics.

So last year we enacted a policy specific to the Medicaid program where we would in essence require a mandatory rebate for any generic where the price grew by more than, I believe, 300 percent. And in fact, after a couple of years in which we saw increases of that level, in the last year since this proposal went into effect we have seen no generic manufacturer attempt to raise prices above that 300 percent threshold. And we think that is a direct result of the state's policy.

And as a result, we are proposing this year --

SENATOR GOLDEN: Thank you, sir, but I do not see the savings. And maybe we'll sit down at a later date and you'll show me these savings.

MEDICAID DIR. HELGERSON: Sure.

SENATOR GOLDEN: Brooklyn I. That's

obviously a corporation that we're setting up in Brooklyn, New York. It's similar to HHC -- which is losing about a billion-eight today -- but we're going to try something that we've already tried before.

We want to -- I appreciate that the legislators are at the table, and hopefully we continue to be at the table as we move forward on this. I don't see any money, though, going toward the implementation of this Brooklyn I, and I don't see -- I guess there's a proposal going out shortly, if it hasn't gone out already. And I don't see the -- this is going to cost a couple of billion dollars over a five-year period, probably, and I don't see that money in the budget for that to take place.

COMMISSIONER ZUCKER: So the $700 million is going -- will be going to Brooklyn. This is a major transformational approach to healthcare. The issues in Brooklyn, as you know and we all know --

SENATOR GOLDEN: Ground zero.

COMMISSIONER ZUCKER: -- have been

quite concerning, and we need to move this forward.

I believe, as I've said -- and I've been out to Brooklyn over a dozen times on this issue -- is that we will set the model in Brooklyn for how urban healthcare is delivered, not just in New York State but across the nation.

The RFA will go out soon on this. The Governor is committed to all the issues of not just the health component of this, but all of the social determinants of health, which we have all learned is as important as just the hospitals and other areas of delivery of care.

So please realize that we are committed to this, and I am confident that you'll see the changes that --

SENATOR GOLDEN: I know you're committed and you have $700 million going in for capital. But there's no money to implement the program that you are now going to implement in the next couple of months. That's my concern.

COMMISSIONER ZUCKER: Well, I understand but part of the -- the problem that we have -- with healthcare is that it has been divided up into different areas, and we need to see this more as a seamless process. So -- and I understand that you're saying it's capital and there's also the issues of program. But part of it is you have to fix some of the infrastructure right there to start with. And we will also address some of the issues of the program development as we move forward.

SENATOR GOLDEN: If the chair of Health here in the Senate could please get a copy of what your plans are to implement this program. When the dollars are needed, how it's going to be done, who's going to lead this process. We would like to see that happen and have a hearing, probably in the future, on how this is going to be implemented in Brooklyn. Because so goes Brooklyn, so goes the State of New York, and we want to make sure we do it correctly.

COMMISSIONER ZUCKER: Absolutely.

We'll get that information to you. And as I said, there are a lot of programs that we are looking at that address all the social determinants that will move this forward.

CHAIRWOMAN YOUNG: Thank you.

SENATOR GOLDEN: Since they reduced our time, we don't have the ability to go on. So if you can note generic drug pricing right now and pharmaceutical medical redesign, we'll get back to them later. Thank you very much.

CHAIRWOMAN YOUNG: Thank you, Senator.

Chairman.

CHAIRMAN FARRELL: Thank you.

We've been joined by Assemblywoman Fahy.

Mr. Oaks.

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

CHAIRMAN FARRELL: Next to question, Mr. Raia.

ASSEMBLYMAN RAIA: Thank you, Mr. Chairman. As the ranking member on the Health Committee, I've got a bunch of

questions. I'll try to move them along as quickly as possible, so we'll call this the lightning round.

Licensed home care service agencies, licensing issues. A couple of years ago we talked about the backlog, about getting assisted living facilities licensed and opened. And that was about three years. We seem to have been moving pretty well on that now. But the LTCSAs are complaining that it's anywhere from three to three and a half years to move along.

We all know it costs less to take care of somebody in their home than moving them to a nursing home. So how big is the backlog, and what are we doing to address it?

COMMISSIONER ZUCKER: So we'd have to look at the backlog on that, but we are trying to move this quick. And I agree with you that it is better to have someone cared for at home and we're trying to make sure that we provide the services that --

ASSEMBLYMAN RAIA: And we get that tax revenue too.

COMMISSIONER ZUCKER: I get it.

ASSEMBLYMAN RAIA: Thank you.

With respect to hospitals, ER was mentioned. The $195 million from last year's capital money, a lot of it hasn't been released yet. When can the hospitals expect to get that?

COMMISSIONER ZUCKER: We should be seeing it shortly. Within the quarter.

ASSEMBLYMAN RAIA: Okay. Elimination of the nursing home beds obviously is raising some concern, the hold.

COMMISSIONER ZUCKER: Right.

ASSEMBLYMAN RAIA: Do you foresee any problems with that, or do we think we just have a lot of open beds that somebody could be slid into?

COMMISSIONER ZUCKER: So I'll start and then I'm going to turn this to Jason.

The issue with the nursing bed hold is that clearly -- you know, we recognize that when someone goes into the hospital, they may need to go back to a facility. But there's been a lot of money that that person is going

into the hospital and that bed is sitting there, and they get reimbursed that money for that bed, and the amount that they need to cover that bed is not that much. And so we're trying to streamline this a little bit more.

But do you want to add there?

MEDICAID DIR. HELGERSON: Yeah. So we reduced the payment a few years ago because it creates a perverse incentive, which is that a nursing home can reduce its staffing as a result of having a regular churn of patients being churned out of the nursing home into other settings, because they only have to staff for the actual census of the day.

And that kind of incentive we are strongly trying to avoid, and that's why you see this proposal, which is at the end of the day we want to reduce the number of individuals who have to go into hospitals. And we think there's opportunities and projects, including those funded through DSRIP, that are available to help get better

connections between nursing homes and other providers to reduce the need for that kind of churn.

ASSEMBLYMAN RAIA: Okay. Thanks.

Moving on to pharmacy, developing the new pharmacy dispensing professional fees to offset the new benchmark, which I think you're saying is about $55 million that we're going to save. What surveys are we relying on? Are we still relying on that 2012 -- I call it the Superstorm Sandy survey -- to come up with those prices?

MEDICAID DIR. HELGERSON: The answer is I'm aware of the -- we don't internally refer to it as that, Assemblyman. But I would say that that is not the survey. Actually with the benchmarks that are going to be set, as I said earlier, the focus here is on a very small subset of drugs that have extremely high costs. And the idea there is to say, across all payers, what really is the appropriate cost? And that looks at a variety of different sorts of information, including information from the nonprofit,

very respected Institute for Clinical and Economic Review, which does specific analysis looking at the relative effectiveness of drugs and basically helps states and other purchasers to really understand what's the economic value of a new drug and what should be an appropriate price for that.

We have been using those sources -- lots of payers have -- but the Governor's proposal allows us in essence to utilize that information with even more strength.

I would point out that nothing about this policy is going to impact pharmacists. This is really about ensuring that -- it's really about the state and manufacturers.

ASSEMBLYMAN RAIA: Okay. Now, but there's a pharmacy professional fee in there?

MEDICAID DIR. HELGERSON: So there's a separate proposal, which is a requirement that we're just complying with, which is to in essence comply with federal rules relative to pharmacy payments at the point of sale. And it's requirements around us moving to really a cost-based system, and there's some

new sources of information that states and other payers can use for reimbursing pharmacies both on the ingredient side as well as on the dispensing side.

And what you see in the proposal is a change in both of those. I believe there's actually a net increase in the amount -- maybe it's a small net decrease, but it's an increase in the dispensing rate as well as some savings that somewhat offset that on the ingredient side, thanks to the use of a different measure of prices, not AWP.

CHAIRWOMAN YOUNG: Thank you.

ASSEMBLYMAN RAIA: But it seems, from what I've seen with respect to southern and midwestern states that are $11, $12, $13 -- our price is less than that, but yet quite clearly it costs more to do business in New York State.

MEDICAID DIR. HELGERSON: We looked at a number of comparable states. I believe our proposal is $10 on the dispensing, which obviously is considerably higher than it is today. But I'd be happy to work with you and

provide you more information on the sources and information we used.

CHAIRWOMAN YOUNG: Thank you.

Our next speaker is Senator David Valesky, who's vice chair of the Senate Health Committee.

SENATOR VALESKY: Thank you, Senator.

Commissioner, Director Helgerson, I just want to touch on two general areas. But before I do that, the way the calendar works, my understanding is that today happens to be the day that the Governor will submit 30-day amendments to his budget. I'm curious as to whether either of you can speak to, at this point in time, any potential changes that may be coming to the Legislature at some point today in regard to the health budget.

COMMISSIONER ZUCKER: I can't speak to that at this point. No, I don't know.

SENATOR VALESKY: We will actually anxiously await that document, then.

I want to first talk about safety net hospitals, and particularly DSH payment reductions. And I know there's a global

issue here that has to do with the Affordable Care Act, obviously. There's also a specific issue in regards to specific payments -- and I'm referring especially to the academic medical centers -- Upstate, particularly in my part of the state, but all three academic medical centers.

My understanding is that there was a midyear -- I'm not sure it was a reduction, but a withholding of a payment that the centers expected to receive in October, I believe. Could you speak specifically to where we are with those DSH payments to the academic medical centers?

MEDICAID DIR. HELGERSON: Certainly.

So the issue, Senator, is that of all the public hospitals -- and we have a separate DSH pool specifically for public hospitals in the state, of which there's the three SUNY hospitals, you could include in that Westchester Medical Center, also Erie County Medical Center, and obviously the Health and Hospital Corp. of New York City, and lastly NUMC, Nassau University Medical

Center. And so that's a fixed pot of money that in essence is available to those facilities, and we historically have and continue to utilize that entire pool.

What happened a couple of years ago is that we saw an increase in losses within the SUNY campuses, driven mostly by losses associated with the LICH facility that affected the SUNY Downstate facility. Obviously those losses have now been mitigated because of the disposition of the LICH facility.

That said, it takes a couple of years before those losses materialize into increased DSH payments. As the SUNY DSH payments went up, the Health and Hospital Corp. DSH payments went down. That created a global cap issue, because historically the global cap paid the state share for DSH payments to the SUNY campuses, whereas all the other publics were responsible for putting up intergovernmental transfer revenue to draw down the federal funds in DSH for their own facilities.

We agreed to cover, in the first year that that increase occurred, to -- for the global cap to come up with those funds. But what we told the SUNY campuses, from that point forward they would have to do -- for that increment, for that increase, that they would be responsible for putting up intergovernmental transfer revenues just like any of the other facilities, to pull down that additional increment. We would retain our historic level of investment, but for the increase they'd be responsible for that state/local salary.

We've said also, however, that we will continue to monitor the financial situation of the SUNY campuses, and if it's deemed that they are unable to afford to put up those dollars, that we would look to take steps to remediate. So we'll continue to monitor the situation, and if something happens relative to their financial state, we'd be prepared to adjust course.

SENATOR VALESKY: I appreciate that, particularly your last point.

The second issue I just want to touch on has to do with capital. So my understanding is the Governor's proposing another $500 million in capital.

COMMISSIONER ZUCKER: Correct.

SENATOR VALESKY: If you could summarize for us the status of last year's capital. Has that gone out the door? I believe it was $195 million. Has that gone out the door? With this -- assuming legislative appropriation, would this new round of capital fund projects that were proposed last year but we didn't have enough money to pay for those? If you could just talk us through that, please.

COMMISSIONER ZUCKER: So we have the $1.2 billion in capital, the capital restructuring, which we're getting those dollars out. We have -- just to give you an overview, we have the $700 million for Brooklyn, we have $300 million for Oneida. And then we have the $500 million, which is around, too, the statewide healthcare transportation dollars, and the $300 million

is for construction projects, the $200 million is for noncapital projects.

And as we move forward, clearly we will -- if someone puts a proposal together and then they're not accepting that, they can reapply and we will look at that proposal again. The goal is probably not to have to have them put the -- you know, work on the whole proposal and submit -- they can submit the same proposal and we can evaluate at that point in time.

So I recognize that your concern is that that's a lot of money that -- a lot of places that are looking for a pool of money, and that there's a lot of need out there.

SENATOR VALESKY: There is a lot of need, yes. Thank you.

CHAIRWOMAN YOUNG: Thank you.

CHAIRMAN FARRELL: Thank you. Mr. McDonald.

ASSEMBLYMAN McDONALD: Good morning, Doc. Good morning, Jason.

A comment first. In the budget there's actually comprehensive medication

management, which is an outcome of your workgroups. I think it's a good thing. I'm not saying it because I'm a pharmacist, I'm saying it because it gets to the larger goal, which is -- putting aside the cost of this medication -- if the right patient actually takes the right medication, we might get the right outcome. And that's what it should be all about, particularly in regards to preventing these very costly and unnecessary hospital readmissions.

In regards to the prescription drug proposal -- and I get it. As I tell people quite often, I pay for the drug before most people do. I see some great drugs coming on the market that are making significant impacts on the market. And in the absence of federal action, the state is in a very difficult position.

I guess my question -- and this is the one I had last year, so I need to have an updated answer -- is what you're proposing, particularly with the high cost of medications, is it legal? Is it going to

actually hold challenges in court? Because there's a heavy price tag of $55 million tied to this. Are we going to see that savings?

COMMISSIONER ZUCKER: So we will -- I think that, you know, with the proposal we put forth two things. We will see the savings. That's the first part.

And the second part is these prices that are so high, we believe that the Governor's proposal, as Jason mentioned before, may work as a -- create an environment where it will be -- prevent them from having the motivation to actually raise their prices. And I think that's what's going to happen, and we've seen some stories about that even in the news as recently as the other day.

MEDICAID DIR. HELGERSON: Right. I would also add on that, on the legal question, we considered and worked on this project, on this proposal, for a good long time, because we are well aware that other states have had proposals challenged in courts. And we are confident that the

Governor's proposal will stand up to any legal scrutiny because -- and we took that into account, that concern into account in the development of it and worked very hard cross-agency, with our colleagues in the Department of Financial Services as well as our colleagues in the Department of Tax and Finance, to develop this proposal in a way that we believe can in fact hold up in court.

ASSEMBLYMAN McDONALD: I agree with you, particularly -- the interesting part is we've spent a lot of time on the Sovaldis of this world, but I can tell you firsthand the generic drug marketplace has gone haywire. Now, the good news is yes, 86 percent of all meds are now -- because patents have basically expired -- they've gone off-patent. But we've seen some aggregation of companies, and basically they've taken full opportunity to really gouge the taxpayer, for lack of a better term. So I don't disagree with that at all.

I guess one question, though, is in this day and society, is it possible legally

to actually have outcomes-based reimbursement with the manufacturer? Is that really -- I mean, Sovaldi is a good example. If we can avoid the $175,000 liver transplant, maybe it's worth paying $60,000 or $70,000 for the drug, if it's taken properly and we get the 98 percent success rate.

COMMISSIONER ZUCKER: This is an interesting question. I've actually spoken to colleagues about this, because they raised this question with me about, well, if $80,000 could save you from $180,000. And I think that -- those prices are just exorbitant to start with. And I think that not -- I'm all in favor of medicine that can cure you of an illness, but I think, you know, when you look at -- let's pick $180,000. There's a whole system. That money doesn't go to just one person, it goes to many -- you know, a healthcare system. It involves a lot more -- those $180,000 go to a lot of providers and people and part of the system.

And I think that a $80,000 price tag or whatever for one drug to cure something is

sort of exorbitant. And I think that it's our responsibility -- and I've raised this before, in the sense that I think when you have a company that is making a product that is a lifesaving product or is making something that can affect someone's health, I believe that they stand on a higher rung on the ladder of corporate social responsibility. And I think that we need to -- and the Governor's plan will -- hold them to that step, to make sure that they do the right thing.

ASSEMBLYMAN McDONALD: On the PBM regulation, I get it. I understand it, actually. Because quite honestly, pharmacies, wholesalers, they're required to provide all their cost of goods. It only makes sense.

What I don't understand with the PBM regulation is that I believe in the managed care Medicaid program, the PBMs are not required -- they're not covered under the Governor's proposal. Is that correct? And is there a reason why?

MEDICAID DIR. HELGERSON: Right. So we're going to look at and ensure transparency, and we want to begin to better understand how PBMs operate. And the PBMs that the managed care plans in Medicaid contract with are the same ones that you see in the commercial space. It's a highly consolidated market.

So at the end of the day I think the benefits -- the question is is that if we actually begin to go beyond transparency, the one concern we had was not to have some sort of knock-on effect that led to an increase in the spend within the global spending cap. So I think we are just trying to be a little careful as we begin. We've never regulated PBMs before. You know, there's a debate between whether or not PBMs are a force for the good or a part of the problem.

ASSEMBLYMAN McDONALD: Serve a purpose.

MEDICAID DIR. HELGERSON: Which is that -- and so, you know, in the case of a force for the good, we don't want to weaken

in any way, shape or form our ability of our managed care partners to control expenses while we attempt to begin to shine some light on the practices, to make sure that we have confidence moving forward that overall, pharmacy benefit managers are doing what we would hope they would do.

ASSEMBLYMAN McDONALD: Thank you.

CHAIRMAN FARRELL: Thank you.

Senator?

CHAIRWOMAN YOUNG: Thank you.

Senator Gustavo Rivera.

SENATOR RIVERA: Thank you, Madam Chairwoman.

Good morning, folks. Since -- considering I probably will have a couple of parts, so let's start at the top and work our way down.

Considering what the federal situation -- which I call the Orange Madness -- might cause us in the next couple of months or years, I wanted you to talk briefly about some of the preparations that we're making as a state, considering we might

not know exactly what's coming but we have a pretty good idea of some of the worst parts.

So if you could tell us a little bit about that before we get to anything else.

COMMISSIONER ZUCKER: Sure. So the Governor has committed to the highest-quality healthcare in the State of New York. And we recognize that -- and that involves a lot of healthcare transformation. We recognize much is happening in Washington. We hear, as all obviously you hear from your constituents, I'm sure, calls about what will happen with the Affordable Care Act.

In New York, the Governor's New York State of Health program has provided 3.6 million New Yorkers with healthcare coverage. We recognize that if this ACA were repealed, that would be a major concern, with millions of people potentially losing healthcare.

I've been in contact with the Governor's team in Washington on a regular basis to try to see where we are. We read the news, I read the news, it's changing

every day as to where we are. But I can assure you that the Governor is committed to making sure that healthcare for New Yorkers will be not only the best in -- best in the nation, and we will guarantee that.

SENATOR RIVERA: That actually leads me to my second question, because it seems that as part of that preparation, I figure that that's the reason why this language, which was referred to earlier by my colleague Kemp Hannon, was injected in there. And while I certainly share the concerns that you expressed, and certainly everyone in this room has, I also share the concerns that my colleague has, as far as it being -- I need you to explain to us a little bit more about why do you think that it's necessary for you to have the authority, in the middle of a budget year -- or, I'm sorry, in the middle of the year, period.

I understand there might be some crises. But to take the Legislature completely out of that process, and basically we're giving you carte blanche, I don't get

it. So could you explain it to me?

COMMISSIONER ZUCKER: So this goes back to sort of the issue of the budget, as you mentioned before, about the budget -- making adjustments to the budget in the middle of the year for emergency -- for any situation that potentially is an emergency.

Now, I -- I know you're sort of tying this to the ACA or potential repeal of the ACA, but let's see where we are on that in the coming months on that. But I think in the bigger picture, if there is an emergency, there should be an opportunity and an avenue by which the changes -- the budget can be adjusted appropriately to meet that without increasing the overall budget as well.

And on the issue of the ACA, you know, I look forward to working with you and to working with all of the Legislature, because this is -- we're in this together on what's going to happen with the ACA.

MEDICAID DIR. HELGERSON: And, Senator, if I could just add something. The language that you see in the health budget is

language you see elsewhere in the budget.

SENATOR RIVERA: Oh, yeah, I know. I know.

MEDICAID DIR. HELGERSON: So it's -- and I understand the concern. I will just give you like -- the administration rationale for it is that we don't know where reductions in federal funding could come from, and we don't know what the magnitude is. But I think that the theory was that if we did see a reduction in federal funding in, say, Medicaid and there were extra funds elsewhere in the budget, that a transfer within the confines of the overall budget amount could be made so as to preserve services in the Medicaid program.

The idea would be not to use the money to launch new initiatives, but simply to preserve the programs as approved, in essence, by the Legislature. I understand -- I'm not discounting your concern, I --

SENATOR RIVERA: You do acknowledge that -- my time is short, and again, we're going to have another part. But you do

acknowledge that the language is broad enough so that it -- although you explained the rationale, the language doesn't state that. It is broad enough -- I mean, correct me if I'm wrong, but it is broad enough for you to make these decisions without coming back to us, which is my key here. We all recognize what our responsibility is. As you see, we're here on a Thursday, and look at how crowded this place is, and over here.

So if we have an issue in the middle of the year, certainly if there was something that the federal government turned a spigot, it would not go from Monday to Tuesday we have no funding. So if from Monday to Tuesday there's an issue, on Wednesday the Governor could call a special session and we'd be back here talking about what do we need to do to deal with the crisis.

MEDICAID DIR. HELGERSON: Sure.

SENATOR RIVERA: So I have many other things, so I will just ask one more in this turn and then we might need to get back to that. But on the issue of there's Article VI

language that reduces reimbursement to New York City on some public health programs, 36 percent to 29 percent, which amounts to an $11 million hit. And it deals specifically with some HIV-related issues or just that type of -- those types of diseases.

So wouldn't it be -- why would you do that, and isn't that going completely against what we're trying to do as far as ending the epidemic in the State of New York?

COMMISSIONER ZUCKER: So New York City is a unique situation here because, first of all, per capita they're getting more money than other parts of the state. And the other key thing about New York is they have the opportunity, because they are a large city, to get federal funds directly from CDC and from other federal agencies. So we felt that it is important that given that they have that opportunity to get another source of funds, that we would cut that back.

SENATOR RIVERA: We'll come back to some other stuff.

Thank you, Madam Chairwoman.

CHAIRWOMAN YOUNG: Thank you.

Mr. Chair?

CHAIRMAN FARRELL: Thank you.

Assemblywoman Jaffee.

ASSEMBLYWOMAN JAFFEE: Thank you.

Thank you, Commissioner.

I wanted to go back to the question about Early Intervention programs. I'm pleased that the Governor is recognizing that this has become a major problem in terms of the reimbursement for the Early Intervention providers.

About a year and a half ago, I think it is, when I chaired at that time the Oversight Committee, I held a roundtable discussion with our Early Intervention providers as well as the fiscal agent and some insurers, because there were very major concerns in the community. We were losing our Early Intervention providers, they could not sustain their programs because they were not being reimbursed. And the situation was -- is really quite serious, and so I'm pleased that the Governor is recognizing

that.

What we heard during that discussion was that there just -- the fiscal agent that was chosen really was not providing any kind of support or assistance for the Early Intervention providers to be able to get their insurance coverage, the insurance response to their needs. And it was becoming a very serious issue because they could not financially sustain programs.

So the Governor is proposing revisions to improve the insurance collections for the programs. The question I have is that how will this move forward and assist the Early Intervention providers, because the fiscal agent at this point, you know, this outside corporation, really wasn't of any assistance at all. So I'm hoping that there was some language within the revisions that give them much more requirements and are firmer in those provisions to assure that the providers are getting the funding.

And the second question I had was, when was the last rate increase for the Early

Intervention providers, and is there any discussion about improving that and increasing that at this time?

COMMISSIONER ZUCKER: So on the first question, so we believe, as I mentioned before, we do believe that the budget proposals will help facilitate the role of the state fiscal agent. I will gladly, after the hearing, sit down with the team and discuss some of the details and making sure that will actually be achieved, and I believe it will. And we have experts in our department who have looked at this issue of Early Intervention.

On the second one, I am not sure about the answer about a raise, but I will find out for you.

ASSEMBLYWOMAN JAFFEE: I did pass some legislation to have the fiscal agent be part of their board discussions, because one of the things that the fiscal agent noted in that hearing, that roundtable, was that they were not included. Now they are included, and so they need to be in part of that

discussion and very active in involving themselves with the providers so that they can move forward in a much stronger way.

And, you know, there are quite a number of providers that we've lost during this time. I think the number is maybe 25 percent, generally. So I'm hopeful that this will be a way to assure that the funding that they are required to be provided comes forward in a timely manner as well.

COMMISSIONER ZUCKER: I'm all in favor of communication, so if that will help move it forward, I'm glad to do that.

ASSEMBLYWOMAN JAFFEE: Because it is -- you know, as a former special education teacher, I can tell you how essential it is for us to have Early Intervention programs in our communities that can sustain the opportunities for these children to be able to get the needs that they have addressed in order for them to become much more productive as they move forward, and capable.

COMMISSIONER ZUCKER: And I will say, as a pediatrician, I believe in Early

Intervention programs, and I have seen the success that it has. So we need to make sure we do whatever we can to keep moving it forward.

ASSEMBLYWOMAN JAFFEE: So I'm hopeful that as we move forward that the fiscal agent will be much more engaged and assisting in this process.

COMMISSIONER ZUCKER: We will -- okay.

ASSEMBLYWOMAN JAFFEE: I also just have -- just briefly want to thank the Governor for his discussion regarding testing and monitoring drinking water. As you know, I had the well testing legislation I passed in Rockland County many years ago, and it really has made a difference, especially when you purchase a home, knowing, if there is a private well, that the water is safe for you to drink. And so I'm glad that the Governor is doing that as well as expanding it to the public water systems. I think that is essential, especially given at this time that so much has happened with regard to water quality and water supply.

COMMISSIONER ZUCKER: We thank you for your foresight in seeing this a decade ago, and appreciate that.

ASSEMBLYWOMAN JAFFEE: In fact we passed it a number of years in the state -- the Assembly has passed it every time. But I'm glad the Governor has picked this up, because I think it will make a huge difference when people purchase homes, knowing that if it's a private well that it's safe and the quality of water is significant.

Thank you very much.

COMMISSIONER ZUCKER: Thank you.

SENATOR KRUEGER: Thank you.

Senator Jim Seward.

SENATOR SEWARD: Thank you.

And thank you, Commissioner Zucker and Mr. Helgerson.

I wanted to return to a discussion on ambulance service in the state. As a matter of fact, right behind you I see seated a number of ambulance providers that are with us today, and I recognize some faces. There's some right from my own area.

As you know, the Governor's budget proposal in effect includes language that eliminates the supplemental Medicaid payments that have been included in the last number of budgets. These are supplemental Medicaid payments to our ambulance providers. And, you know, as I look at the situation, our ambulance services are an integral part of our healthcare delivery system in the state. Very often the ambulance is the gateway to healthcare delivery in our state, and what happens in that ambulance on the way to the hospital or any other medical provider is critical to improve patient outcomes and by doing that, of course, also help to lower the ultimate costs of healthcare.

The problem is in terms of the Medicaid rates paid to our ambulance providers. The Medicaid rate has been dramatically below the costs of providing the service. And with the number of people who -- the increased number of people who have signed up for Medicaid through the exchange, the trend is the actual Medicaid

usage of ambulance services is up. And we have a very inadequate Medicaid rate being paid to the ambulance providers.

And so this is exactly why we have inserted supplemental Medicaid payments in the last number of budgets, and of course that is matched by federal payments as well. I've always viewed this as a Band-Aid or at least a lifeline to our ambulance providers, but critically important to them.

So I'm very concerned about the proposal to eliminate the supplemental ambulance payments, or there's language about reprogramming those dollars, but we really don't know what that means.

So I have a three-part question. Number one, do you recognize that we do in fact have a problem here? And number two, where is the report that was due to us on December 31st in terms of a study of Medicaid rate adequacy as it relates to ambulance services, where is that report? And what is your recommendation for ambulance Medicaid rates going forward?

MEDICAID DIR. HELGERSON: Sure, so I can answer that. So the report is near complete. It took us a little bit more time than anticipated, primarily because the providers -- we had to gather cost information from providers, but there was some hesitancy, some concern that once the data was submitted to us that it would potentially be made public. And many of these entities are competitors, and there was a fear that this information would be seen as proprietary. Now, I argue that the information we were asking for is very similar to what we see in terms of information from almost any other provider that submits a cost report to the state.

But that said, we tried to be respectful of some of those concerns, but it did take us a little bit more time to gather the data to drive the report. But the report is near final.

Our intent with our budget proposal is that that $6 million will be invested within ambulance services, and it will be basically

invested in ways consistent with the findings of the report. So as soon as the report is disclosed or finalized, we will put it out for everyone to see, and that will show you exactly where we think investment should be made.

I think what the report will show -- and as I say, we haven't quite finalized it. But I think we anticipate that over the next several years we'll be looking to make targeted investments in the area, because I think overall we do conclude that there are some rate issues embedded within ambulance services.

I would say you are right, Medicaid enrollment has grown because of the Affordable Care Act, but the uninsured rate has also declined precipitously. In fact, we've cut the uninsured rate in half in New York because of the Affordable Care Act. So there's some benefit and some challenge there in terms of for ambulance providers, along with anyone else.

But that said, I think that the

report -- which will be out very shortly, in the next week or so -- will provide a lot more clarity in terms of our intention. And happy to answer any questions from the Legislature on it, and apologies for it not being with you sooner.

SENATOR SEWARD: So you say in the next week or so.

MEDICAID DIR. HELGERSON: Yes.

SENATOR SEWARD: That's critically important, because at this point it's impossible for us to make a judgment regarding, you know, how we will go forward in this budget.

I have concerns with the lack of that report and that information. I have very grave concerns about, you know, the elimination of the -- what we have done in the past in terms of the supplemental Medicaid payments. But we'll have to make a judgment in terms of what you're recommending in that report. But you're not sharing -- you can't share it with us, your recommendations, today?

MEDICAID DIR. HELGERSON: So as I say, the recommendations really are a product of that report. So -- but as I say, those -- and I apologize, I wish we would have gotten it done quicker. Some of the issues I described made it a little challenging. But it will be coming out shortly, and I think we'll have plenty of time to answer your questions in advance of -- before the budget gets finalized.

SENATOR SEWARD: Did you -- the first part of my question was do you recognize that there is a problem here.

MEDICAID DIR. HELGERSON: I think that -- and while we, as I say, haven't finished the report, I think the analysis that's been done to date does suggest that there are some issues embedded within ambulance reimbursement that need to be addressed. And I think one of the things we'd like to do over the next several years is to begin to address some of those imbalances.

This year's global spending cap, as

you'll see, is extremely tight. There literally are no new investments this year, and that's primarily a result of two factors. Factor number one is the prescription drug problem that we described earlier, and the second is growth in managed long-term care, which you also have seen some proposals in our budget to look at.

But because of that cost pressure, unfortunately we don't have a lot of flexibility this year. But we potentially will have more flexibility next year, pending what happens in Washington.

SENATOR SEWARD: Well, thank you. We'll have to make our judgments once we see that report in the next week or so.

ASSEMBLYMAN OAKS: Assemblyman Garbarino.

ASSEMBLYMAN GARBARINO: Thank you, Bob.

Just a follow-up. Under the drug price proposal, there's a proposed $55 million in savings. Where is that coming from? Is there a set list of drugs that

you're already looking at? Or, I mean, how did you come up with the number 55 million?

MEDICAID DIR. HELGERSON: So as mentioned by Dr. Zucker, the kinds of issues that we see where this proposal could be applied, or there's basically a subset of those issues, we looked at where those issues historically have occurred and what the rates of increase have been.

And working with our actuaries, we did some estimates in terms of what we thought could be done as a result of the power of this proposal. And so it was really looking at historic -- because in essence, the proposal is in essence prospective. We don't know in the next 12 calendar months what manufacturers will do relative to their pricing strategies. So as a result, it's hard -- what we've provided to legislative staff, happy to provide to members, are some examples of drug company practices in the past, to give you a sense of the magnitude.

But basically, in the case of the Medicaid savings, the 55 million, in essence

it's a combination of some supplemental, additional supplemental rebates that we will be generating, as well as some proceeds from the surcharge that would return back to Medicaid, as it would return back to any of the purchasers.

But as Dr. Zucker said, our goal with this proposal is not to actually put any manufacturer in the penalty box. Our goal is that they will change behavior, as they did in the case of generics, in response to our 300 percent ceiling on price increases. And as a result, we will generate savings not through surcharge revenue or through additional rebates, but simply lower prices and slower growth in pharmaceutical expenditures overall.

ASSEMBLYMAN GARBARINO: But doesn't the state already pay the cheapest -- under federal Medicaid law, don't we already pay the cheapest prices out there?

MEDICAID DIR. HELGERSON: That does not insulate us from the kind of practices that we have seen. We get federal rebates

designed to provide us with lower prices, but the phenomenon of things like hepatitis C and the rise in the cost of that have been the key factor that's driving billions of dollars of additional expense. And just because we get some additional things that allow us cheaper, doesn't mean that a bad practice by a manufacturer is prevented.

ASSEMBLYMAN GARBARINO: But, I mean if a drug is increased in price, you know, we are limited to only the CPI. So if it goes up 500 percent, like you said before, for a PBM but CPI is only 1 percent, the state only has to pay that additional 1 percent.

So if a PBM is willing to negotiate a 500 percent increase, who are we to tell them, you know, what they privately negotiated? Who are we to say, "No, you know what, you don't have to pay that, we're setting this price"?

MEDICAID DIR. HELGERSON: So what you're referring to is a federal change that is designed to slow the growth of drugs that have been already on the market, to allow

price growth of no more than CPI.

And that policy was an outgrowth of practices that -- and we could give you some examples of drugs where we saw, particularly as you approach the end of the patent life, all of a sudden spikes in prices, where it's the same molecule, the same exact drug that was available 10 years before, and now the price -- in the case of one example we looked at, over a decade the price of Abilify increased by 2.5 times, even though the drug Abilify was no different than it had been when first introduced into the market. And so those kind of practices, we believe, will begin to be hemmed in by the CPI policy.

That policy does not stop a manufacturer's first price out of the box being outrageous, and that is exactly the problem we saw with the hepatitis C agents, that that CPI policy does nothing to prevent that practice.

ASSEMBLYMAN GARBARINO: All right, I understand that. So you have this DURB board that's going to address those new drugs. Are

there any -- you know, does the DURB take into account the R&D? It's only 12 percent of drugs that go to trial, make it. So are they only looking at the R&D for that specific drug that made it, or are they taking into it the other costs of the manufacturers? Because based on the law, I don't think there's anybody from the manufacturers on the DURB board, under the increased numbers.

So are they looking at the other costs that the manufacturers have to spend? Because, you know, I'm afraid that what this is going to do is it's going -- you know, it's a dangerous proposal that might squash innovation. You know, if they can't make up the money that they spent on 88 percent of drugs that didn't make it, you know, what's going to happen here?

MEDICAID DIR. HELGERSON: Yeah, I would say that clearly our goal is not to squash innovation, our goal is to identify the outliers -- where there's a bad practice, where a manufacturer exploits their patent

period to charge a price that is completely beyond the pale. That is the goal. I mean, and as I'm saying, only a very small subset of drugs would ever be applicable for the surcharge in the Governor's proposal. The vast majority of drugs that come to market are not priced in these kind of ways, and therefore would not be impacted negatively in any way.

Obviously we will be pulling information from a wide variety of sources. We will include information that is provided directly by the manufacturer, who in essence will be given an absolute opportunity to justify their costs, including reflecting the R&D that they put into it.

I think the issue, and it's been well publicized -- there are many examples that you can look across in the last few years of where even when you take into account those R&D costs, even when you take into account other types of circumstances, you really can't -- and I think most rational people can't really justify or find a way to justify

some of these prices.

But as said, our hope at the end of the day is that there's a chilling effect from this policy and we don't actually ever have to enact this program, because practice will change from the recent times.

ASSEMBLYMAN OAKS: Thank you.

Senator?

CHAIRWOMAN YOUNG: Thank you.

Our next speaker is Senator Liz Krueger.

SENATOR KRUEGER: Good morning.

So I feel like I want to do lightning-rounds, because --

CHAIRWOMAN YOUNG: I'm sorry, Senator, before we do that, I'd like to announce that Senator Leroy Comrie has just joined us.

SENATOR KRUEGER: Thank you.

CHAIRWOMAN YOUNG: Thank you. Sorry about that.

SENATOR KRUEGER: Okay, now lightning-round.

So Assemblymember Cahill before raised the issue with you about the Essential Health

Plan and the $20 per month premium that you're expecting people to pay. I just want to highlight, the percentage amounts reflect incredibly low incomes. And these are working people, so assume incredibly low incomes minus 40 percent off for taxes. So that dollar amount can make a difference.

But you further propose in this budget that you're going to index the increases, based on the CPI --

MEDICAID DIR. HELGERSON: Correct.

SENATOR KRUEGER: -- that you use for other insurance packages. Well, this population is much more like a Medicaid population than the private insurance. So Medicaid's been a 3 percent increase, not a CPI of like 17 percent for the private insurance.

So I oppose the whole proposal. But I would urge you at least to, if you're looking at indexing, reflect a Medicaid reality, not a private insurance reality. Can I ask you to consider that?

MEDICAID DIR. HELGERSON: Always open

to further consideration as we move forward. Obviously the purpose of that policy -- that policy can be re-explored by the Legislature each and every year as we move forward.

You know, I think the broader point is that in every state other than New York and Minnesota, this program does not exist and people are buying insurance through the qualified health plans and are paying considerably more than even under the Governor's proposal. So we still think, at the end of the day, overall the essential plan remains very affordable, compared to virtually every other state in the country.

SENATOR KRUEGER: Well, we've had better success than most states, I think, because we were smart about it. So I don't want us to reverse our trend.

And there was discussions about what-if with other government funding decreasing during the year and ACA and all of that. But I'm particularly concerned about the loss of money for reproductive and women's health because it does appear that

Congress is fast-tracking trying to do away with funding for reproductive health, Planned Parenthood centers.

What is the state going to do to make sure these providers are kept whole in this budget year pending a loss of the federal money?

COMMISSIONER ZUCKER: Well, the Governor is committed to the issues of women's health. We've seen this with the issues of breast cancer, the Breast Cancer Initiative, we've seen this with --

SENATOR KRUEGER: I'm not challenging his commitment, I'm saying what are we doing with the money when they lose the federal money?

COMMISSIONER ZUCKER: Well, we will look -- we will look and see where the resources are and -- to be sure that all of what the women's health clinics and all that they serve will be -- those needs will be met, whether issues of sexual health, issues of Planned Parenthood and others.

SENATOR KRUEGER: So you know how much

money, right, because you have all that data. And they're actually testifying later, and they've broken it down also. So we're talking a decent chunk of money between the various funding streams and the matches with Medicaid and the Title XX. So --

COMMISSIONER ZUCKER: Sure.

SENATOR KRUEGER: So you are watching that and --

COMMISSIONER ZUCKER: We're watching.

SENATOR KRUEGER: Are you prepared to say you're committing to making sure we don't lose the dollars for these important programs this year?

COMMISSIONER ZUCKER: We will watch and take a look at those programs and see where we are.

SENATOR KRUEGER: The Governor's budget proposes a three-year extension of HCRA within the budget. HCRA is an enormous tax package for healthcare. There have been concerns raised that the money is not actually going for what it was intended to go for originally. I personally believe we

ought to do a separate evaluation of HCR in 2017, and where we're going. But let's just talk about two issues within it quickly.

One, the formula for bad-debt charity payments through HCRA doesn't actually seem to match which hospitals are actually providing the most care to the indigent bad-debt charity population. So is there any plan to reevaluate how that section of HCRA is distributed?

COMMISSIONER ZUCKER: I will go back and look at how the distribution is, although HCRA -- we're not decreasing anything on -- we're changing the program, the accounts of -- the HCRA program accounts at all. I mean, HCRA's been involved in Doctors Across New York and many other programs.

So -- but I will look and see where the numbers are and how that's being divided up.

SENATOR KRUEGER: No, I agree, you're not saying you're going to change it. I'm saying it's time that everybody, including the Legislature, ought to take a look at it.

Because how that money is spent is very different than the original commitments that were met -- that were offered to the public when we created and then later continued HCRA.

COMMISSIONER ZUCKER: There are some excellent services that HCRA is providing -- the school-based health clinics and many other areas. So no --

SENATOR KRUEGER: I don't disagree. I think there's really important programs in there. I'm saying for the sake of transparency and a dialogue between the Legislature, the public and the Executive, it's time to take a look at that. Because it's over --

COMMISSIONER ZUCKER: We will do that. Glad to do it.

SENATOR KRUEGER: -- I think it's over 6 billion or just below 6 billion a year.

COMMISSIONER ZUCKER: I'll have to check. I'll check.

SENATOR KRUEGER: All right, thank you. And then -- oh, zero. Damn. Maybe

I'll have Round 2. Thank you.

COMMISSIONER ZUCKER: Okay.

CHAIRWOMAN YOUNG: Thank you.

ASSEMBLYMAN OAKS: Assemblyman Ra.

ASSEMBLYMAN RA: Thank you.

I just wanted to go into the proposal for the Healthcare Regulation and Modernization Team. And I was just looking for some more specifics, because obviously, you know, regulation may in some instances here be a misnomer, because we're also talking about statutory or potential statutory changes that may be recommended, but in particular with these demonstration teams, actions that would normally be the purview of the Legislature.

So can you expand how you feel these demonstration teams would work?

COMMISSIONER ZUCKER: Sure.

So the issue here is that we have been living in an environment that is dramatically changing in how healthcare is being delivered. And we are living with regulations that have been put into place

in -- years ago. And it needs -- the whole system needs an upgrade. I mean, we upgrade -- we upgrade our phones, we upgrade information that's out there. And we feel that it is important -- and the Governor's commitment is -- that we need to look at all these regulations and get them up to the 21st century.

And that's what we're going to do. We will work with you, work with the Legislature on this. But I think that in an effort to make sure that we are providing 21st-century care, those regulations need to change, including everything from scope of practice, certificate of need -- and I can go down the list, but I'm sure you know them as well.

ASSEMBLYMAN RA: So going into something like the scope of practice, which in many ways can be a legislative issue, when you do one of these demonstration projects, though, I mean, it doesn't seem specific as to how long one of those could go on. Is there any, you know -- I guess this is some type of an experiment, I guess, for lack of a

better word, of a new technique or a new expansion of a scope of practice. How long would something like that go on before there would be, you know, work with the Legislature on a permanent change?

COMMISSIONER ZUCKER: So we will -- this is where we want to work with you on this. I think that we need to start to look at the regulations that are out there, figure out what is just literally outdated, what other new things need to be put in place.

And with regards to scope of practice, there has been a dramatic change. We -- 20 years ago nurse practitioners, physician's assistants were not doing the things that -- for instance, Assemblyman, they weren't as big a component of healthcare delivery. Today they are a significant component of healthcare delivery. We need to move these things forward. Pharmacists -- we've been talking a lot about drug prices, but pharmacists in general are an integral part of the system of healthcare delivery. And we need to change the scope of practice so that

they are more -- the critical roles that they play, the regulations match that.

We're glad to work with you on this.

ASSEMBLYMAN RA: Yeah, I mean I would certainly agree this is a field that's always changing. Technology changes rapidly, all these different things. So I think that's appropriate and putting together people that are dealing with these things, practically, in the field, is a great thing and we've done it in many other areas. But I think my concern and the concern of a lot of other people is the potential for, through these demonstration projects, things to be done that are normally the purview of the Legislature. So I think I -- I guess I'd rather see it in a way that, you know, they would come to us and say, We need to modernize this, this, this and this, which would be great, and then hopefully the Legislature would take appropriate action.

COMMISSIONER ZUCKER: So this is where we would sit down with legislators, other stakeholders, experts, the department, all of

us, sit down and have a meeting of the minds and say, Okay, what are some of the things that we need to do, what are some of the challenges that you have experienced, that you've heard from your constituents, some of the things that the hospitals have told us, some of the things that patients, obviously, who are your constituents, have told you, and our expertise from within the department.

So we will do this. We'll move forward.

MEDICAID DIR. HELGERSON: And I think we actually have, Assemblyman, a precedent for this. The Legislature granted to the Departments of Health, OMH, OASAS and OPWDD commissioners the ability to waive regulations on a case-by-case basis that stood in the way of DSRIP objectives. We've done that now a couple of hundred times. It's been very well received. In essence, it allows us to test some regulatory flexibility that eventually could help inform broader policy that we could bring back hopefully to the Legislature. In that case it's

time-limited to the DSRIP period, so it's basically until the end of the decade.

But I do think there's some really important lessons there that this team will be able to look at that -- and then obviously if there's more structural change to be made on a statewide basis, we'll have to bring that back to the Legislature.

ASSEMBLYMAN RA: And then I just wanted to ask about one other thing. The capital funding and Montefiore, is the criteria that that $50 million came from similar to that safety-net legislation that was passed by the Legislature and vetoed by the Governor? Or what was the methodology to come to that number?

COMMISSIONER ZUCKER: So the $50 million was given to Montefiore -- Montefiore serves a million lives in the area of the Bronx, and we felt that that -- in an effort for them to continue to move forward what they're doing in healthcare transformation, this would be an appropriate allocation of resources.

ASSEMBLYMAN OAKS: Thank you.

Senator?

CHAIRWOMAN YOUNG: Senator Savino.

SENATOR SAVINO: Thank you, Senator Young. Thank you, Commissioners.

I want to go back to the issue that Senator Seward brought up earlier about the ambulances. As you know, many of them are sitting behind you, and we'll be hearing from some of them later on today, so I'm not going to belabor the point. I understand the report is coming; we anticipate there will be some changes.

But I just want to make the point and stress it that we're going to hear from them later about there hasn't been an increase in ambulance rates to them since 2008. And with the looming minimum wage increases and the compression issue that it places on them, this is really placing many of these ambulance companies in an untenable situation.

And we're seeing the same effect on them that we're seeing across the human

service providers in the state, whether they be direct care professionals or they be home care providers or they be in our daycare centers, you know, where we have people who are highly skilled and qualified but because of this hard cap on Medicaid, they are stuck in a low-wage industry. And we're going to be losing people who we depend upon to take care of our most vulnerable people, whether they be the previously mentioned population or moving people who are sick -- we're going to be losing them to fast food work.

I mean, so I just think we really need to think about what we're saying as a state when we keep them under this hard cap. So I just want to make that statement clearly.

Now, with the limited time I have left, I would like to talk about my favorite subject, medical marijuana.

(Laughter.)

COMMISSIONER ZUCKER: How'd I know?

SENATOR SAVINO: No one else has brought it up, I will.

I do want to say thank you to the

department for rapidly making the changes that have been requested. You know, the program has only been up and running for two years. We would like to see it grow, we would -- no pun intended. But I do think that you have been responsive to changes that have been requested, and I want to thank you for that.

The one thing I would caution, though, is -- I know there seems to be some direction that you might be moving in about expanding the number of licenses. I would strongly caution against that at this point. Right now we have five registered organizations who are struggling financially because the entire burden is upon them. And we would not want to see one of them go under.

The reality is they have excess product. We don't have excess patients. And I know that you are working towards expanding the patient base, working with physicians, and we're doing the best we can there. I do think, though, that the way we can expand access to patients who are far-flung around

the state -- because we only have 20 dispensaries -- is the creation of a limited license for dispensary only. And I think that's something that you should consider. That, in my opinion, will do a lot more to get access to patients than expanding fully registered organizations.

And finally, I really, really think that you all should come out and see what you have created here in New York State. From an industry perspective, it is considered the best medical model in the country. And to my colleagues, if you have not had the opportunity to go and visit one of these grow houses, you really should go see what we are doing here in New York State. It is amazing. And quite frankly, you are largely responsible for the model that we have right here. So you should own it, be proud of it, and go take a look at it.

COMMISSIONER ZUCKER: Thank you.

CHAIRWOMAN YOUNG: Thank you, Senator.

ASSEMBLYMAN OAKS: Yes, I just had a couple of questions.

When you were speaking with Assemblyman Gottfried earlier, you talked some about pharmaceutical rebates. And you said you knew how much that it -- do we have the numbers for the recent year and what we anticipate in this budget for being the total amount of the rebates?

MEDICAID DIR. HELGERSON: Sure. So there's two kinds of rebates. There's what we call the over rebates, or the federal rebates referenced earlier, where the rebate's associated with we being, quote, unquote, guaranteed lowest price. That's the vast majority of the rebates. Those rebates account for roughly about 40 percent of total drug spend.

The remaining rebates, which are the supplemental rebates, which are either negotiated on behalf of the state or by the state for fee-for-service or by the Medicaid managed care plans, account for about 5 percent of total spend.

So doing the math off the top of my head, I think the drug spend is somewhere in

the 6-to-7-billion-dollar range, so that gives you a flavor. But I can get you the exact numbers. But just roughly, of our gross spend, about 45 percent is offset by rebate.

ASSEMBLYMAN OAKS: And do we anticipate that as a growing number in this year's budget?

MEDICAID DIR. HELGERSON: We anticipate that the percentage will stay about the same, but obviously as pharmacy spend grows, so do the rebates.

Now, unfortunately the rebates don't cover all the growth in total gross expenditure, but they obviously do offset. So rebate revenue goes up as pharmacy spend goes up.

ASSEMBLYMAN OAKS: With the Medicaid growth cap, is that applied to the full amount spent on pharmaceuticals, or is it on the rebate?

MEDICAID DIR. HELGERSON: So the Medicaid global spending cap applies to the state share of Medicaid expenditures. So

there are in essence, in New York, three forms of support for Medicaid. There's the federal share, which is the largest, there is the state share, and then there's the local share. And local share was capped a number of years ago, and in fact because of the Affordable Care Act has actually declined because enhanced federal monies because of the Affordable Care Act has reduced the local share.

The global cap applies to the state share -- specifically, about 90 percent of the state share, not all of it. Certain parts of the program, since the beginning of the global cap, have been outside. Most of that's within OPWDD. And so that -- the global cap itself applies just to that state share. So the local share has a separate cap and then federal share -- so with DSRIP or other things where we've got additional federal funds, those are not capped.

ASSEMBLYMAN OAKS: So when we get the rebates, does that come back to the Medicaid program or does it --

MEDICAID DIR. HELGERSON: Yes. Yes.

ASSEMBLYMAN OAKS: It does. Back to the General Fund?

MEDICAID DIR. HELGERSON: It basically offsets the state share.

ASSEMBLYMAN OAKS: Thank you.

When the commissioner of the Office for the Aging was here, they mentioned that the NY Connects program is now going to be funded under the cap. Do you know how much is being allocated for that?

MEDICAID DIR. HELGERSON: So off the top of my head, I can't remember the exact amount, but yes. Although you'll see on the global cap scorecard a little bit of savings. We anticipated this.

The initial funding source was Balancing Incentive Payment Program, which was a federal program, enhanced federal monies. We used those funds to help launch the statewide application of NY Connects. It's, as folks are aware, Aging Disability Resource Centers that we had in a number of counties, but was not a statewide program.

It is now a statewide program, and we're very excited about that. We used federal funds to launch it. But as those federal funds phase out, we need to replace that with state resources. And the global cap, a couple of years ago, agreed that eventually it would take on that responsibility. But we did get a short-term extension of the BIPP funds, so the fiscal impact for us is a little bit less than the global cap anticipated. That's why you see a little bit of savings.

But the amount we're going to absorb, I -- we can get it for you, I just can't remember it off the top of my head.

ASSEMBLYMAN OAKS: But we don't have a specific appropriation for NY Connects now?

MEDICAID DIR. HELGERSON: I don't know whether or not there is a -- I don't have the -- I don't understand -- I don't know what the appropriation structure is for it. But the idea is that the global cap would be the source of the local dollars necessary to keep -- because the thing about aging

disability resource centers are -- or NY Connects, as we call them -- is that they serve a more general population. They're the place that families can go if they have a member of their family who may now all of a sudden need some additional help at home but aren't Medicaid-eligible.

So they're providing counseling, support, connection to services that are beyond the Medicaid program. But the thought was since BIPP was the funding source to launch them -- and in fact a requirement of that program was that we had statewide access -- that it would make sense for the Medicaid global cap to pick up those expenses on a go-forward basis.

ASSEMBLYMAN OAKS: Thank you.

CHAIRWOMAN YOUNG: Thank you.

Senator Hannon.

SENATOR HANNON: A wide-ranging number of different things.

I just want to return, Commissioner, to the very first question I asked, because I got some notes from people and they said, oh,

Senator Rivera was the first who talked about the powers. Obviously they came late to the hearing, because my first question was the powers that you've asked for for making adjustments if there's a reduction in spending.

It's far too much. I don't think it's going to happen at all. The question will be, is there going to be a reasonable alternative? We do not intend to let people run the things the way they want. It's a consultive process. And as several leaders in the Legislature have said this year, this is a three-branch government. So I think we can continue, I'll just make the point again that I had made before.

A number of other things going forward. And in regard to powers, the whole transformation committee, it's a good idea. You're absolutely right about the need to modernize a lot of the standards that go into how we do approval of health entities, whether it's too elongated a process, too elaborate, has too many artificial rules that

are just archaic.

But I don't think it can be an MRT process. It's not going to be something where everybody meets, the gurus from your department go behind black doors and then come out with, you know, pronouncements: Of the 40,000 things submitted to this committee, we have come up with 80. So -- all due respect, Medicaid Director Helgerson, so it really has to be a collaborative process.

A couple of other -- lots of other things. The Washington action. It's not just the ACA. There were two things that were very crucial to New York when they passed it. One was the -- what we call the Essential Health Plan, they called it the Basic Health Plan. I'm very worried about it. It became something we were able to extend care to many people who didn't get it. But we're one of only two states in the entire nation that took advantage of it. And I think we're especially fragile, and there ought to be some type of consideration of

what will happen if that does not survive.

One other thing is the DSH payments themselves were reduced on the thought that ACA would have greater coverage, therefore hospitals would have more patients, therefore you didn't need the disproportionate share payments as much as possible. The question will be, what will they deal with? Will they repeal everything and therefore restore the DSH, or whether they just repeal everything and New York, which gets a high percentage of the total DSH in the nation, will get hurt.

And the same thing in another way with the graduate medical education, because we're one of a few states to get a lot of graduate medical education.

Construction. Your proposal is for $300 million bonding, $200 million appropriation, carving out about $50 million for Montefiore and $30 million for community health centers.

COMMISSIONER ZUCKER: Right.

SENATOR HANNON: I wonder if that's going to be sufficient. I wonder if there's

not going to be more proposals. There's several thoughts to it. It's not just the size of this, but it's the management of it. Included as part of that management will be knowing what the awards are from last year's budget for $195 million. I think it's essential to know what's happened with those awards so we can make an evaluation as to what more may be needed, whether -- and then, as we're setting the rules for the construction money this year, whether we should simply allow people who were eligible but did not win last year to be eligible this year, whether we should have all new bidding, or whether we should have a mixture of those two rules.

But getting those out would be really essential, and I don't see going along with the construction until we see what happened.

But there is an extraordinary amount of construction money that is out there. You have the Brooklyn, you have the Utica, you have the last year's 195, you have a revolving loan fund of 19.5 million, you have

10 million to behavioral health providers, you have 10 million for the all-payer database, and you have 30 million for the SHIN-NY.

Now, we have gone through a lot of different dialogue on the SHIN-NY. And I do believe the department has done excellent work, it's on the right course. But we always expected that the appropriation of 30 million for SHIN-NY, 10 million for all-payer database, would be a diminishing appropriation. It's not. In fact, I think it's the same number this year as it was last year, and it's projected it may be the same again next year.

I have asked for and the Senate has asked for the budgets of the SHIN-NY per se, the private organization called NYeC, and then the subsidiary -- they're not even a subsidiary, they're affiliate entities called RHIOs, regional health information organizations. The list of money from the 30 million that goes to the RHIOs is about 6 to 8 million each. I'd like to know what

it's going for, how it's going, so we can measure the progress and see where it is.

Going back to DSH, Senator Valesky made that the point that all of a sudden in October or November, SUNY Stony Brook, SUNY Syracuse got letters that said, We're not giving you the 30 million each you thought you were getting in DSH. Right in the middle of their budget year. Well, and you made the point, Mr. Helgerson, that, well, everybody else has a government entity that provides the nonmatching share and allows New York City, Nassau County, Westchester -- my point to you, and it's not necessarily your area, but SUNY is the state. SUNY should be putting that up. Just saying that they're different than the others and you don't have a local government to do it is not an answer. The state has that obligation. And especially the obligation of not pulling the rug out in the middle of a fiscal year. So I think that needs to be totally rethought.

Senator Seward rightfully, and Senator Savino, covered the report in regard to

ambulance and where we're going on that.

The PBMs. One of your big proposals is to have a disclosure piece for PBMs, pharmaceutical benefit managers. There's no fiscal attached to it, so it's really a quixotic type of proposal. When I started inquiring, the idea was, well, the state needs to find out what the information is.

Well, I would strongly disagree that you need to find out, because you have at hand that information. The State Civil Service Commission runs the Empire Program for the, I don't know, 200,000 state employees. They have a PBM. They got the PBM by going out and having a request for proposals. They formed the request for proposals by hiring a consultant. All of that is public information saying how these PBMs work and don't work.

Also, each one of the Medicaid managed care companies has a PBM. They're under your thumb. Now, I know your proposal does not deal with Medicaid PBMs, it only deals with commercial. But how they work -- they're the

same PBMs, and how they work is exactly the same.

So I'm really puzzled by this whole thing and don't know where we need to go, because I'm also challenged by the same thing as you are in regard to drugs. I mean, we do have to do something. We have screamed about different things like the EpiPens, which we helped create, and then when the -- Mylan put it up to $600, we got the Attorney General to say he'd do an antitrust investigation. It's starting to come down.

This week we saw Marathon Drug, in an outrageous thing, take a drug that was used and still available in Europe for $1200 a year, change a molecule, go through the FDA, say it's now on the market for $89,000 a year. Well, a lot of people screamed. And as last I read, they go -- they're rethinking that. Well, they ought to. It's for an orphan sickness, and it needs to be addressed.

But I don't know that we need to do -- I don't know, do we have the power to do what

you're suggesting, whether we have the constitutional power to tell a company: You must sell it to us, and you can only charge so much. They always have the right not to sell it to us. But can we go in and say, We can set the price for you? I don't know if we have that power. I don't know if that's a taking. We cannot do takings. I think there needs to be a way to entice them to do this and get these things to be reasonable, because not only you complain about the prices to your systems -- hospitals do, HMOs do. We know that it has to be addressed.

Long-term care. It is a growing crisis in the state, and it will lead me into comments on the global cap. When the MLTC, managed long-term care companies, are the ones that are the conduit to funds -- and perhaps management -- to home care and to certain patients in nursing homes, one would think that might be a system that would work.

Home care complains bitterly. Nursing homes for the patients that are under managed care complain bitterly. And when I've had

very fierce conversations with the managed long-term care plans, they complain bitterly about what you're doing to them.

And I said this last year during the budget conference committees, so it's not new. And it's gotten worse. What I'm afraid of, in the course of -- during the year, Medicaid Matters came out with a very thick report as to what is going on with managed long-term care and the number of denials that are happening to cases. And how those denials, when they go to fair hearing appeals, are overturned. A substantial percentage, over 90 percent, are overturned.

And now one of the legal services in New York City has gone to federal court. They're going to use that type of overturning high percentage as their proof. All of a sudden, we're going to be faced with the courts running it, we're going to be faced with the same type of problem we had with our overreimbursement in mental health or having the federal government run our jails. It needs to be addressed.

And we might as well say, look, it's being held down because we have to control the cost because of the global cap. The global cap has served a purpose of holding spending. But it's also a global cap that is far too flexible, has far too many leaks, doesn't cover the problem.

You said to Senator Young that there are other health expenditures that are not under the cap. We know you had to, as a matter of practicality, put the minimum wage outside the cap. We know in the cap there's a thing called the mental health improvement of $2 billion. That doesn't necessarily have to be in there. You moved something -- you just told us about you moved something else under the cap, something that I think -- NY Connects. Assemblyman Oaks questioned it.

This is not any longer more than a shibboleth and a facade. We have to go back. I know that you have done an admirable job of controlling the spending and doing a lot of delivery of care in a more efficient and economical manner. But the cap has outlived

its purpose and needs to be addressed. Whether you can do it for this budget or not, we just have to recognize we're not going there usefully in the future.

And lastly, I don't know why we need a two-year budget for Medicaid. If we're going to be that worried about Washington's action, I don't see you having a two-year budget whatsoever.

Those are my comments. We'll have a lot of negotiation between now and March 29th.

COMMISSIONER ZUCKER: Thank you.

CHAIRWOMAN YOUNG: Do you have any response?

(Laughter.)

COMMISSIONER ZUCKER: Well, a couple of things. A couple of quick things.

One is your comments about the capital and the 30 million for the community projects. And that's a minimum, because the people are just assuming it's just 30 million. It's a minimum.

The other issue is the SHIN-NY. And I

believe that the health information network is really the glue that is going to move us forward into this 21st century of healthcare and all the changes that we're doing. So I recognize that you feel we continue to put money into it. It's complicated. This whole system is quite complicated. But we are making great strides in this. And I anticipate that -- soon that it will be sort of a little more self-sufficient. But I recognize that --

SENATOR HANNON: I know it's complicated. And four years ago I said, we're not doing any of it. And then the compromise was, well, we'll give you a lot of information and we'll have a committee that will meet once. Well, that committee didn't meet once, it's met 10 times. I've been at each meeting. And it's useful. And as I say, that's why I know that the department did a very good job in information. And it's now functioning statewide, but it needs further growth. But it's not something we just do automatically.

COMMISSIONER ZUCKER: Right.

And on the issues of the federal government, we're watching and we're engaged to see where this goes. And I recognize that the changes are happening relatively quickly, and we need to see where we are on that.

The issues of the global cap, did you want to comment on that?

MEDICAID DIR. HELGERSON: Yeah, just a couple of things. One, per-recipient spending in New York Medicaid is now less than we spent in 2000. So we have in fact bent the cost curve quite substantially. We've narrowed the gap between the national average and what we spend on a per-recipient basis, and that's been verified by independent sources.

No question there are challenges, both right before us and essentially on the horizon, with changes in Washington. But that said, I do think that the global cap has provided a lot more transparency than this program ever had. And it's introduced a level of management oversight that didn't

exist before and a level of accountability that didn't exist before.

And lastly, although this year is not such a year, but in other years where we've been able to hold costs below the allowable trend, we've been able to make targeted investments. There are probably about 30 hospitals in this state that are open today in rural and in urban settings that would not be open if it were not for savings generated under the global cap.

There are people in supportive housing today -- we have the largest Medicaid-funded supportive housing program in the country. We would not have had that if it were not for the fact that we had the global cap allowable growth and the ability, when we beat that trend, to make investments, and now spend about $100 million in those kind of investments.

So I think overall the state has been well-served by it. That said, each and every year we should continue to revisit it and welcome the scrutiny the Legislature brings

to that process.

COMMISSIONER ZUCKER: And the last thing is also we do believe this is -- the pharmaceutical proposal is legal, and we will move forward with it.

ASSEMBLYMAN OAKS: Assemblyman Byrne.

SENATOR HANNON: Well, wait a minute, I got one more comment.

Global cap? No. We've kept the hospitals -- work with the hospitals has been extraordinary, whether it's been in inner-inner city or real rural, but we've had a VAP program, we have a VAPAP program, we've had a VBP QUIP program. This is -- this year, it's close to -- it's $300 million. That's money that's flowing. The other programs I read, that's not the global cap. The savings, the management you have, yes.

But we need a better structure to work this around. Maybe when we get a chance to look at HCRA -- and we're not making it permanent nor one year, the various proposals. When we look at HCRA, maybe we can structure it that way. But already,

think of it, MRT is five years old. It's time to renew it. And believe me, I haven't even mentioned DSRIP. So ...

MEDICAID DIR. HELGERSON: Yes. My point, Senator, was that those funds, which now are almost $500 million to provide that extraordinary assistance, are all confined within the confines of the global cap. So we were able to find savings generally in the program to help finance those programs.

If we had not had the savings -- in addition to that, we lost a billion dollars on a prospective basis in the middle of a budget year -- in the middle of budget negotiations, because of the changes in the OPWDD financing system mandated by the federal government. We absorbed that without having to make a single reduction in a benefit to any New Yorker or to raise taxes or do anything else. And that was a direct result of the fact that the global cap helped drive efficiency and drive efficiency in the sense we were reducing our per-recipient spending.

SENATOR HANNON: I'll let you have the last word.

(Laughter.)

CHAIRWOMAN YOUNG: Thank you.

ASSEMBLYMAN OAKS: Now, Assemblyman Byrne.

ASSEMBLYMAN BYRNE: All right, thank you.

I know some of the questions were asked and answered already, so thank you for that.

Something that I see in my community is the ever-growing rise of the heroin and opioid addiction. And I know that we've spent money on this in the past, and there's $200 million in funds dedicated to fight this crisis this year. My question is in regards to naloxone and funding for that. How much has been spend on funding Narcan in the past?

COMMISSIONER ZUCKER: So. On the naloxone, we've spent $7 million on that.

But I think it's important to recognize, 5200 lives have been saved as a result of that, and 186,000 people have been

trained in the use, including 9500 law enforcement. And this is one of the biggest issues that we are facing, not only in New York but right across the country. And we've got to tackle it. It is a public health crisis.

ASSEMBLYMAN BYRNE: I completely agree. I see this personally as a volunteer firefighter and EMT in my district. One of the things that we do see is an increase in costs for ambulance services because of this growing problem, particularly where I'm from in the Hudson Valley. Is there any funding available in the budget this year of that $200 million to help the ambulance services for Narcan?

MEDICAID DIR. HELGERSON: Right. On the ambulance services, I understand the concern and issue. In fact, in the Hudson Valley we have a great example within DSRIP of Ellenville Hospital, which is in the Catskill Mountains, a critical-access hospital that identified their superutilizers, the people who went to the

emergency room 10 or more times in a six-month period of time. And when they dove into the root cause, 85 percent of it was opioid addiction. And it actually galvanized that small community into a community-wide effort to really address the opioid crisis.

The other stat I would say -- which blew me away -- is the U.S. population makes up 5 percent of the world's population, yet 80 percent, today 80 percent of all the opioid scripts written worldwide are in the United States.

So you're absolutely right that opioid addiction is a massive public health challenge that faces us today, and we need to grapple with it in every way, shape or form.

As to ambulance services, you know, that's where that report comes out. We need to look and we have been looking, and look forward to the release of the report, and then working with the Legislature to potentially, over a period of years, implement the recommendations of that report.

ASSEMBLYMAN BYRNE: Thank you.

CHAIRWOMAN YOUNG: Thank you.

Senator Rivera.

SENATOR RIVERA: I'm baa-ack.

A couple of things. Let's start -- let's just go over one more as it relates to the potential cuts that might happen from the federal government. One in particular that I'd be interested in would be if you have been looking particularly at the services that are provided by Planned Parenthood in places of the state that are hard to access where they are the main providers of healthcare for women. Have you been thinking about what cuts could happen? Because that's something that could happen much quicker than changes to the ACA or something else. Have you all been thinking about that?

COMMISSIONER ZUCKER: Right. So we've been looking at this issue and trying to -- as I mentioned to Senator Krueger, we're trying to be sure that the women's health services will always be available across New York State.

SENATOR RIVERA: It will certainly be

important, and particularly in parts of the state where that is the only place where folks can access care.

Let's go quickly back to -- well, we were talking as far as the Article VI language. I know that that was related to the reductions in reimbursement rates for New York City, as opposed to other localities, that impacts public health programs. We dealt with it very, very quickly at the end of the -- you know, when I was trying to wrap up. So I want you to walk me through that again as far as why the choice was made to do that for the City of New York and not for any other locality, and what is the reasoning behind it?

COMMISSIONER ZUCKER: Well, that goes back to the -- you know, this is -- obviously we're looking at the budget closely, and as I mentioned before, that per capita -- it's only 42 percent of the -- I think it's 40, 43 percent of the population is in New York City, but they're receiving 63 percent of the funds.

So we -- and so we have cut it back. But we've also, as I mentioned before, the city has the advantage that they can still get federal funds coming from CDC, coming from HRSA, coming from other parts of the federal government --

SENATOR RIVERA: Under normal circumstances, of course. Remember, Orange Madness.

COMMISSIONER ZUCKER: Right. Right. But they do have the opportunity to access additional funds. And I feel that that would be a legitimate reason for moving from 36 percent to 29 percent for them.

SENATOR RIVERA: It certainly is -- you know I represent folks in the Bronx, and you know very well, because that's -- it's your old haunts.

COMMISSIONER ZUCKER: I know. I know.

SENATOR RIVERA: I represent the neighborhood where you grew up. And there are more than a few instances across the budget -- not just in health, but across the budget -- that seems to be a little, you

know, poke in the eye to the city where it's not necessarily necessary, pardon the oxymoron.

COMMISSIONER ZUCKER: So --

SENATOR RIVERA: And this seems one of them. And we're talking about $11 million. Which in the big scheme of things -- you know, $150-some-odd billion -- is not that much, but considering the type of programs that will be impacted, it is a big deal.

COMMISSIONER ZUCKER: We always -- I mean, the department is committed to providing the public health services to the city, and there's many things that we are trying to move forward to help in the bigger picture of public health for the city and some of the projects that they have.

SENATOR RIVERA: All right, a couple more things. Some of my colleagues expressed their concerns as it relates to ambulances generally. And you're referring -- you keep referring to a rate reform report that should be coming out imminently. Obviously, there's been seven or eight different ways that the

question has been asked; I figure that you're not really saying much of what's in the report until the report is public. That's -- I can -- you're saying yes.

MEDICAID DIR. HELGERSON: That's correct.

SENATOR RIVERA: Okay. So as it relates specifically, can you give us any -- I know that people hate spoilers, but any spoilers related to Medicaid rates as far as what is going to happen to ambulance companies and the fact they haven't changed in as long as they have? Anything you can spoil for us before the report comes out?

MEDICAID DIR. HELGERSON: I think that the budget proposal that's already on the table clearly suggests that we believe that embedded within an ambulance reimbursement, there are issues that need to be addressed. And the report will identify what some of those -- what those issues are. And we look forward to working with the Legislature to address these issues now and in the years to come.

SENATOR RIVERA: And you said that that report, its release is imminent?

MEDICAID DIR. HELGERSON: It's imminent. Yup, the next couple of weeks.

SENATOR RIVERA: All righty. We'll come back to you on that.

Lastly -- at least for now -- the $500 million in capital funding, we talked about -- a couple of my colleagues talked about it. There are $30 million that are for community-based providers. Was there a thought -- and that's correct, right?

COMMISSIONER ZUCKER: Yes.

SENATOR RIVERA: Was there a thought of making that a larger pool as it refers to community-based providers, considering the high need of those types of providers?

COMMISSIONER ZUCKER: All right, so two things there. One is the $30 million is a minimum. So it could be more than that. That's first.

And also, you know, the way we see this moving forward is that it's not just hospital versus ambulatory care, it's this is

a health system that needs to transform into a seamless process. And so a lot of the hospitals we're working to help be -- to basically oversee some of these community services that -- or community health systems that are in place. So I don't want it to be looked at like there's a fine line, that this money goes here and the other money goes there and that the services aren't going to come across.

So clearly, this is all a big transformation. But again, the 30 million is just a minimum.

SENATOR RIVERA: Thank you, Madam Chairwoman.

CHAIRWOMAN YOUNG: Thank you.

ASSEMBLYMAN OAKS: Chairman Gottfried.

ASSEMBLYMAN GOTTFRIED: I'm not sure the community-based providers are reassured to hear that you envision them becoming part of a seamless system under hospital domination. I know you didn't that word, but I think that's what they probably heard.

I was going to ask about the problems

with managed long-term care, but that's been talked about by several folks. But I do want to raise one issue in that area. The Article VII bill says (a) that no one may get more than 120 days of Medicaid home care except through an MLTC. But (b), if you are not "nursing home eligible" you may not enroll in an MLTC.

This means that if a patient needs more than 120 days of home care, but is not nursing-home eligible, there is no way for Medicaid to provide that needed home care. Right? You can only get it if you're nursing home-eligible, and if you're not, then you can only get it through an MLTC, but you can't join an MLTC.

Now, this language was in last year's budget. We asked the same question. I don't think we ever got an answer. And now the language is back.

So how are we going to accommodate, under this language, the patient who needs more than 120 days of home care but is not nursing home-ready? Or do they just not get

home care?

MEDICAID DIR. HELGERSON: So I can tell you the intent. And I am not a lawyer, so I -- we can certainly get you a definitive legal response to explain the manner in which that language was structured.

But the intent of the policy is to change the eligibility criteria for managed long-term care to actually a standard that I believe was the case prior to 2011, which is to basically say that in order to be eligible for managed long-term care, you have to be in need of a nursing home level of care.

We changed the policy to basically extend eligibility to individuals who don't meet that higher threshold but are deemed to be in need of 120 days of home and community-based care, a lower standard. The intent of the policy is that individuals not eligible for managed long-term care -- meaning that they have a need less than the nursing home certifiable standard -- that they would receive home care services through Medicaid fee-for-service. That is the way in

which individuals who need some level of home care that doesn't meet the standard today, the 120-day standard, is they get it through their local districts, who work with providers in their area to assign home care on an as-needed basis.

Now, the policy change doesn't affect the large number of people who are in managed long-term care. The vast majority of those who are eligible for the program have been deemed to be nursing home certifiable, so the policy will not change them.

But anyone who is affected, they do not lose their home care services, they simply will get them through fee-for-service.

ASSEMBLYMAN GOTTFRIED: So you think that the clause that says you cannot get more than 120 days of home care unless you get it through an MLTC, you think that clause means, oh, you can also get it through fee-for-service Medicaid, we were kidding about the MLTC part?

MEDICAID DIR. HELGERSON: So --

ASSEMBLYMAN GOTTFRIED: You don't have

to be a lawyer to know that those words are not in the statute.

MEDICAID DIR. HELGERSON: Right. So I guess all I can tell you is -- and I can refer back to counsel who drafted the language for the Article VII bill. But I can tell you our intent. And if there is something that the lawyers think in the writing and the drafting of it that is inconsistent with our intent, we are more than happy to look to provide greater clarity.

But in no way, shape or form is the Governor's proposal designed to restrict access to home care services. Under the Medicaid state plan, these are entitled services. And all we're saying is that we want to limit the participation in the managed long-term care program to those who are in need of a -- who are deemed in need of a nursing home level of care and to use local districts and the fee-for-service system for those who need a level of home care services that's less than that standard.

ASSEMBLYMAN GOTTFRIED: Okay. All I'll say on that point, I will eagerly await the legal explanation of that. You've still got a few hours to do a 30-day amendment to change the bill.

As I say, we raised this point a year ago. The discussions went round and round, and there was never really an answer.

On Early Intervention -- we talked about that earlier, but I want to go back to it. At a 2014 public hearing, in sworn testimony, DOH stated: "As part of the statement budget for state fiscal year 2012-2013, several reforms for the program were enacted. The two main goals of those reforms were to provide administrative and fiscal relief to municipalities and increase the amount paid by private insurers for EI services without mandating new coverage. To maximize insurance reimbursement, the 2013 statute included a requirement that providers submit claims directly to insurers using a new state fiscal agent, a contractor of the department, for fiscal management of claims."

Now, in '07-'08, before the fiscal agent took on the job of, quote, to maximize insurance reimbursement, the EI program got $13 million from insurance companies. In 2016, with the fiscal agent, we got $12 million from the insurance companies, a million dollars less. According to the 2012-2013 Executive Budget Briefing Book, these reforms were supposed to save localities $99 million over five years, but total EI payments by counties have actually risen almost $20 million since then.

How can we in good conscience continue to pay about $8 million a year to a fiscal agent that gets us less money?

COMMISSIONER ZUCKER: So we -- this is -- this goes back to what we were talking about a little bit before, that -- I understand your comments that you feel like the investment is not -- we're not getting reimbursement for the investment that we're putting in there.

But we would hope that the changes that we put into the budget will allow the

fiscal agent to be able to increase the amount of return that we're getting from these commercial payers.

I hear what you're saying. I'd be happy to sit down --

ASSEMBLYMAN GOTTFRIED: Okay, but most New Yorkers -- I think it's two-thirds of New Yorkers -- who have nonpublic health coverage get it through an employer-sponsored self-insured plan which is not subject at all to our regulations, so we're not going to get any more blood from that stone.

Insurance companies, when they reject EI claims, I think the most common grounds for rejection is "that the provider is not in our network." The language in the budget bill isn't going to change that. It's just going to require EI providers to keep banging their head against that brick wall, even though when they submitted their claim for last month's work and were told they weren't in network, when they submit the claim for next month's claim, they're again going to be told that they're not in network, they're

just going to be mandated to keep spinning wheels. How is that going to get any better?

COMMISSIONER ZUCKER: Well, part of it is to get parents also to provide more information. There's some issues, there's some administrative issues here --

ASSEMBLYMAN GOTTFRIED: Excuse me, information isn't going to make their coverage not subject to a risk of preemption, and more information isn't going to make their provider get included in the company's network.

COMMISSIONER ZUCKER: Right. But at times when information is not accurate, the insurers, whether it's in this situation or others, they just end up denying the coverage and saying that, well, we didn't have the right data. I have this personally, just saw this the other day with myself and some information. They said, we don't have the right information, we're not paying.

And so I think that that would help facilitate it, and I would think it would help facilitate the role of the state fiscal

agent to move this forward.

I will gladly sit down -- maybe we can sit down at another point and just, you know, work through some of these things and address it with some of the experts we have on the team regarding Early Intervention and see how we could move this forward.

ASSEMBLYMAN GOTTFRIED: Well, you know, we've had a lot of conversations with them over the last 10 years or so. I don't think we've ever gotten useful information from them. But we'll keep trying.

COMMISSIONER ZUCKER: I'll gladly sit down afterwards and work this through, figure out how we could do this. And the goal is obviously to provide, one, these children with Early Intervention and, two, to make sure that there's reimbursement for it. So ...

ASSEMBLYMAN GOTTFRIED: Okay, that's it.

CHAIRWOMAN YOUNG: Thank you, Chairman.

For a second round, Senator Golden.

SENATOR GOLDEN: Thank you, Madam Chair.

The -- simple questions and answers. This was already asked a couple of times, and it's been answered, but I just want to clarify. And it's on the supplemental ambulance cuts and the payments. You did say, Commissioner, that the ambulances that will be doing and providing this service will be paid the supplemental payment while this process is going on, correct?

COMMISSIONER ZUCKER: Correct, yes.

SENATOR GOLDEN: Thank you.

The $650 million for life sciences, we're obviously very thankful that it's coming out. I proposed one for $500 million last year, the Governor has upped it to $650 million. We look for the regional hubs. We think it's good that they're going to do this here in this Capital Region. But obviously we'd like to see what's going to happen across the state -- downstate, upstate -- and to make sure that there's a balance, and of course that there is an

opportunity for us to take a lead. California, Texas, Massachusetts are eating our lunch. New Jersey is stealing jobs left and right and companies left and right. We need to get ahead of the biotech and biomed field and the technology field, and this is the impetus and way to do that. Do you agree?

COMMISSIONER ZUCKER: This is a -- the issue of life sciences and the Governor's commitment to this is not just centered on one area of the state, this is across the state. And success in this arena requires partnerships throughout the state, public-private partnerships. The $650 million will move that forward. The $150 million to start moving forward with a state lab will be critical.

We bring that up and I mentioned that about the Capital Region because the lab is here, and it is tied to many other parts of government. And so that's one part. But the bigger picture of life sciences will be across the entire state on this. And this

requires public-private partnerships.

SENATOR GOLDEN: Excellent.

This is probably an expected question for me as well. SUNY Downstate, the hospital and of course the medical school, we do plan to keep that hospital operating and as a functioning hospital and part of the network here in the City and State of New York, correct?

COMMISSIONER ZUCKER: I couldn't catch which --

SENATOR GOLDEN: The hospital, I'm asking if there are any plans for any changes at SUNY Downstate.

COMMISSIONER ZUCKER: Downstate, yes. So we are committed to moving forward with -- obviously we recognize that they serve a community, and many people have asked about this. And we are looking at it as part of -- it was addressed in the plan that was provided to us by Northwell when we contracted with them about the issues with Downstate.

I would add also one other thing,

because you had mentioned this before and I didn't -- I was thinking about it afterwards, about the capital and about the other projects. We do have a lot of DSRIP projects out in Brooklyn and in other areas there, so that is separate from capital. And there's a lot of programs that are being supported by that as well. So I just -- you know, I forgot to mention that before.

SENATOR GOLDEN: Well, I was focusing on the actual development of this --

COMMISSIONER ZUCKER: Right. I know.

SENATOR GOLDEN: -- new corporation that there would be funding set aside in the budget that would allow this to happen. Because we're not talking about a few dollars, we're talking about probably, for this to take place, a couple of billion dollars over a period of time. So you need to obviously map that out, the strategy, over the next couple of years. I don't see that in the budget, and I think we need to have that in the budget.

There was one more good question I

believe -- oh, SUNY we asked about. I want to go back to generic drug pricing for a second. And this is another area that's been asked and answered, to a large degree; the Governor's proposal on the ceiling on the reimbursement for generic prescription drugs.

One of the areas is choosing the lowest price out of four different sources. And one of those sources is the MAC, the maximum acquisition cost. How do you do that? What data do you use to come up with that amount?

MEDICAID DIR. HELGERSON: Sure. So the typical way that state Medicaid programs reimburse pharmacies for generic drugs is what's called the SMAC, the state MAC price list. We use multiple data sources to compile that list. And the idea is just to make sure that list is updated in the state. And we have a contract with a pharmacy benefit manager, Magellan, who supports the state in updating and maintaining that list.

You know, generics are a fast-changing environment. Just because a drug is generic

does not mean it's cheap. So the example would be something that's just come off patent could still be just as expensive as the brand. But at some point, once it becomes what's called a multisource drug, the price can drop like a stone. So we have to be very nimble to adjust the price so that we are not overpaying at any point.

But also, as we've seen in recent years, prices can rise. And they can rise because of, you know, generic manufacturer bad behavior. And so that's why we also have a process in place where pharmacists can provide us with invoices and other information, so if our MAC price is too low, we could adjust upward to reflect what the market really is.

SENATOR GOLDEN: Both you and Senator Hannon pointed out extreme cases. I'm just concerned about those that, you know, get hit with ingredient shortages, which is going to cause the prices to go up, and changes in the MAC price. So that will be taken into consideration, obviously. And we're not

going to make a mistake here and somebody gets hurt, so there will be some exceptions to this that --

MEDICAID DIR. HELGERSON: Yes, absolutely. So what happens is that -- the idea here is that we will look at any drug and consider implementing the mandatory rebate. It's a mandatory rebate, just to be clear, on the manufacturer, and it has no impact on the pharmacist. The pharmacist will be paid whatever the MAC price is. But if we see a price go up by more than 75 percent -- so this is the same drug -- these are generic drugs, they were originally brands, in most cases they've been on the market for 15, 20 years. So the real question is why did the price go up by more than 75 percent. It could be that there's a temporary shortage, and that's appropriate. But what we've seen is a number of instances where we've seen these kind of price increases that really can't be explained by sort of temporary issues but more by sort of noncompetitive behavior.

SENATOR GOLDEN: Thank you, gentlemen. I don't know constitutionally how you get that done, but thank you for your testimony here today.

CHAIRWOMAN YOUNG: Thank you.

CHAIRMAN FARRELL: Thank you. Assemblyman Raia, for a second go-round.

ASSEMBLYMAN RAIA: I won't take that long. I just had a couple of quick questions.

With respect to inappropriate prescribing of opioids for doctors in the Medicaid program, it seems to be a little fuzzy as to whether or not there's due process for these doctors. Is there just going to -- you know, if something happens, someone makes a complaint, do they get a say in whether or not they are in the program or out?

MEDICAID DIRECTOR HELGERSON: Sure. So there's a proposal in the budget that basically allows the department -- and we have this authority to already, in consultation with OMIG and MFCU, to

potentially disenroll someone from the program based on cost. Now, once that determination is made, the provider has due process rights. This proposal doesn't change that.

However, we have detected bad behavior relative to this. And as I said, while the vast majority of prescribers in New York State and across the country have come to realize just how problematic this practice is, we still see that there are outliers in terms of practice. And while we are loath to want to kick anyone out of the program, we think this is just one additional deterrent that will exist for us to ensure that we aren't having the healthcare industry leading directly to people becoming addicted to opioids.

ASSEMBLYMAN RAIA: All right. And one last question.

How much do we spend on pharmaceuticals in the Medicaid program after we take out all of the rebates?

MEDICAID DIR. HELGERSON: Yes, so I

think the gross spend is like $6 billion or something like that, and then the rebate aggregate is about 45 percent.

ASSEMBLYMAN RAIA: Thank you.

CHAIRWOMAN YOUNG: Thank you.

Senator Comrie.

SENATOR COMRIE: Thank you, Madam Chair.

I wanted to ask you a couple of questions. The first question is you mentioned that there are about another $500 million in additional capital support for essential healthcare providers, including a minimum of $30 million for community-based providers.

I represent Queens, and it seems like everything is going to Brooklyn or the Bronx. Can you give me an idea on what's happening on the Queens level, and specifically in terms of --

COMMISSIONER ZUCKER: Sure. So first, and to clarify about the monies to the communities, and Assemblyman Gottfried's comment that I am sort of tying it to the

hospitals, we're not. We're supportive of all the community health programs that are out there, and the $30 million again is a minimum, it's not what the final amount is.

We are moving forward with a lot of projects within Queens, both -- whether it's the DSRIP projects for -- and the PPSs that we have out there, but also a lot of the other capital projects as well are there. There's a lot of hospitals that are -- from the hospital standpoint, a lot of hospitals that are tied to other hospitals, and they've become more of a network. But --

SENATOR COMRIE: Well, I'm specifically concerned about Jamaica Hospital, which is a Tier 1 trauma center.

COMMISSIONER ZUCKER: Sure. Right by JFK Airport.

SENATOR COMRIE: I know it's tied into all the -- everyone's consolidating networks now. But Jamaica Hospital, just to be focused, needs a lot of upgrading, modernization to be able to accommodate people. It's almost embarrassing when a

police officer or a firefighter has to go there and the facilities there -- much less the constituents that have to go there for Trauma 1.

St. John's, as you know, in the Rockaways, is seriously underbedded, underserved. And I haven't seen anything in the proposals about either of those.

COMMISSIONER ZUCKER: So I will look back at the -- and I'll have the team look at the monies that we have allocated to different facilities and see which ones are in Queens. I can't tell you off the top of my head. But there is as much a commitment there as to any of the other boroughs, and for that matter, anywhere else in the state, to make sure any of the safety-net hospitals are -- needs are available to them.

SENATOR COMRIE: Okay. I hope so, because it seems like that -- I haven't seen a detailed breakdown. I'd like to get a detailed breakdown. Hopefully Queens is in that balance and in that mix, and hopefully we can make sure that that happens as well.

COMMISSIONER ZUCKER: Sure. Sure.

SENATOR COMRIE: I'm concerned about the consolidation of the -- possible consolidation of the 39 public health programs into pools. And I hope that, you know, we can make sure that people don't drown in those pools and the public programs that traditionally get money and provide excellent service don't wind up losing opportunities to continue the level of service and/or get locked in at --

COMMISSIONER ZUCKER: Right. That's not the objective at all. We're trying to create some more efficiencies in the system. We recognize that, you know, with 39 of those programs, that it would fall in one of the four or five categories that we have.

We recognize that there has been concern by you and some of the other legislators, but we believe that this is a better way to provide more efficiencies, decrease some of the administrative burdens as well.

SENATOR COMRIE: Will these pools be

decided by -- who's going to sit in the pools to make the decision?

COMMISSIONER ZUCKER: Well, what I can do is get you the list of how we're looking at the pools. And mainly it is -- if a -- a pool that we have identified would clearly have the programs that sort of match what they are, if it's disease prevention or if it's the health promotion pool or if it's epidemiology. We'll look at the pools together that way.

SENATOR COMRIE: Okay. I only have a limited amount of time. I'm concerned about, as Senator Savino mentioned, the OPWDD staffing and the ability to make a decent living out of a difficult job, and the idea that people would rather go to the private sector than work in the public sector because of the salaries involved in it. And I hope we can make some corrections on that.

And also the safe staffing issues and how we can look at that across the state to make sure that both the staff and the patients are taken care of. I'm just going

to rant now because I only have 30 seconds left.

COMMISSIONER ZUCKER: That's okay.

SENATOR COMRIE: You know, I'm also just concerned and if you could get back to us about the update on childhood lead poisoning prevention.

COMMISSIONER ZUCKER: Sure. Sure. We put a report out about that. And down in the city, the schools have provided us information. We still haven't received all the information from all the schools in the state. We have about 86 percent upstate of lead -- reports about their lead pipes as well.

SENATOR COMRIE: Okay. And any type of redevelopment on Medicaid or the redevelopment of a healthcare regulation modernization, I would hope that the Legislature is involved with that as well and it's not just done from a level of -- where we can make sure that the community and all of the advocates can have a chance to be heard.

COMMISSIONER ZUCKER: Agreed.

SENATOR COMRIE: I understand the need for modernization, but I'm concerned that people may drown in the pool as they're not able to be heard or not able to give their suggestions as to what modernization should be.

COMMISSIONER ZUCKER: I'm a big believer in hearing everyone's opinions on these issues.

SENATOR COMRIE: Thank you.

CHAIRWOMAN YOUNG: Thank you, Senator.

CHAIRMAN FARRELL: Thank you.

CHAIRWOMAN YOUNG: You're in the home stretch, so that's good.

(Laughter.)

CHAIRWOMAN YOUNG: I just had a couple of follow-up questions. Senator Hannon and Senator Golden asked about the capital for hospitals. And I commend the Governor, I applaud him for the $500 million that's included in this proposal. The question I have, though, in light of the needs that hospitals have all over the state, is

$500 million enough?

COMMISSIONER ZUCKER: So, you know, having worked in the hospitals and seen the challenge in the infrastructure and the changes that need to be there, there's always more money that could be provided to help move this up to speed.

I think that we need to -- this is a major investment to start moving forward on some of those things and those projects. We have already put out -- and when you look at the amount, we've put $1.2 billion in capital, another $500 million, and we continue to invest. The Governor is committed to all the hospitals across the state, and particularly recognizes that some of the areas of the state where these safety-net hospitals are not only central to the community and the care that the community receives, but it's also central to jobs as well, because those hospitals often are where a lot of people are employed.

So we are working on this to try to move this forward. So a first step, but we

continue to deal with this and we're happy to deal with it in the budget negotiations.

CHAIRWOMAN YOUNG: Thank you.

When will the $195 million for the Health Care Facility Transformation Program be announced?

COMMISSIONER ZUCKER: That will be soon.

CHAIRWOMAN YOUNG: Very soon?

COMMISSIONER ZUCKER: Yes, within this quarter.

CHAIRWOMAN YOUNG: Within a month?

COMMISSIONER ZUCKER: Within the quarter.

CHAIRWOMAN YOUNG: Within the quarter, okay. Right, it has to be -- Senator Hannon is reminding me that it has to be done before we can do new funding. So okay. Thank you, Senator.

I wanted to follow up on HCRA, and I know Senator Krueger brought it up a little bit. But have all the recommendations of the HCRA modernization task force been implemented?

COMMISSIONER ZUCKER: I have to get more information and get back to you on some of those issues with the HCRA.

CHAIRWOMAN YOUNG: Okay. So is there a detailed accounting of all HCRA revenues that is available to the public?

COMMISSIONER ZUCKER: Sorry, I couldn't hear you.

CHAIRWOMAN YOUNG: So I know, Jason was talking to you at the same time, but that's okay. I have that up here all the time, by the way.

But is there a detailed accounting of all the HCRA revenues that is available to the public?

COMMISSIONER ZUCKER: I think there is.

You want to answer?

MEDICAID DIR. HELGERSON: We just published recently, actually, a report on HCRA, so that provided a lot of information. If there's a desire for more information beyond what's in that report, happy to provide it.

In terms of the modernization recommendations, I mean, I believe -- we believe that basically all those recommendations have in fact been implemented.

CHAIRWOMAN YOUNG: Okay, thank you.

Final question -- two more questions. The first has to do with the Medicaid minimum wage investments regarding home care workers and managed long-term care plans. And we've kind of talked about that today. But it's regarding direct salary costs and related fringe benefits. And currently MLTC enrollment is the second largest driver of increased spending under the Medicaid global cap.

The question I have is, how do -- so there's funding to take care of minimum wage increases for those workers. How do we ensure the minimum wage funding gets to the workers from the Medicaid managed-care plans? Because that could be a problem.

MEDICAID DIR. HELGERSON: Sure. It's a good question. So the monies, because it's

a managed care product -- and this is not just unique to -- although we're talking about mostly in the case of home care, because that's where the impact is felt initially. But obviously as we further phase in the minimum wage, impacts will begin to be felt in other sectors. And we are almost entirely a Medicaid managed care state.

So what we're doing in the case of home care is we're going to be collecting a lot of information, not only from the plans but actually one of the areas where we haven't had a good sight line in has been in the case of the LHCSAs, the licensed agencies, who have not been required to submit cost reports. So we are actually going to be collecting cost report information from them for the first time.

And in that cost report information we will see across all the LHCSAs -- and there are hundreds of them -- we will actually see how much money they're spending and where the dollars that were allocated are going and are they actually going into worker wages,

because that is absolutely our intent.

Our Division of Budget colleagues, who in essence control the purse strings relative to the funds -- you know, as I said, they are outside the global cap -- they will provide us the funds on as-needed basis. They've been very clear they want a detailed accounting. And I know the Legislature also expressed that desire in the legislation in the legislation that was passed last -- or in the budget last year. And so we take that responsibility very seriously. So we're going to be collecting that information from those agencies and making sure that the dollars that are allocated for this purpose are in fact going directly into wages for workers.

CHAIRWOMAN YOUNG: Thank you. I want to give a shout out to the ambulance folks here today, and I'm glad my colleagues asked some of the questions I was going to ask.

(Applause from audience.)

CHAIRWOMAN YOUNG: And finally, though, I did want to ask -- there seems to

be an issue, and I hear anecdotally and my colleagues do also, that there's an underreporting of heroin deaths in rural areas. And could you address that? Because it may be because of a stigma or, you know, somebody may die because they asphyxiated and that's the cause of death rather than an overdose. And I think that we need to figure out a way so that we have more accurate reporting.

COMMISSIONER ZUCKER: Right. So we get data quarterly, and we are looking at these reports. And I understand what your concern is, whether someone comes in and the cause of death is listed as one thing but in actual fact it may have been related to heroin. And we're trying to sort this out and trying to figure out a better system and to get more information and be sure it's accurate, because that has been brought to our attention before, I know.

CHAIRWOMAN YOUNG: Thank you.

So I want to sincerely thank both of you. You have such an incredible, awesome

responsibility in protecting the health of New Yorkers. And I know that you're very dedicated and devoted to that task. So I want to say thank you, thank you for all the time you've spent with you us today, and we look forward to continuing to work with you. So thank you very much for your testimony.

COMMISSIONER ZUCKER: Thank you very much.

MEDICAID DIR. HELGERSON: Thank you.

CHAIRMAN FARRELL: Thank you.

CHAIRWOMAN YOUNG: Our next speaker is Superintendent Maria T. Vullo, New York State Department of Financial Services.

(Pause in proceedings.)

CHAIRWOMAN YOUNG: Can we have some order, please. Please take your conversations outside. Could we have some order, please.

Welcome, Superintendent.

Could we have some order, please. Please take your conversations outside.

Welcome, Superintendent. We're so happy to have you here today.

SUPERINTENDENT VULLO: Hi. Thank you.

CHAIRWOMAN YOUNG: Glad to see you, and we look forward to your testimony.

SUPERINTENDENT VULLO: Thank you, Senator.

Has my written testimony been handed out? Just want to make sure.

ASSEMBLYMAN OAKS: Yes.

SENATOR KRUEGER: Yeah.

SUPERINTENDENT VULLO: Great. Great. Okay.

So good afternoon, Chairpersons Young and Farrell, Vice Chair Savino, Chairpersons Hannon, Gottfried, Seward and Cahill, ranking members, and all distinguished members of the State Senate and Assembly. Thank you for inviting me to be here today. This is my first appearance before the Legislature at budget hearings, and I am happy to provide my perspective and answer your questions.

I have now been the superintendent, or acting, of the Department of Financial Services for almost a year. It has been a very busy year, and I am privileged to work

for Governor Cuomo and serve all New Yorkers in this important role.

I understand from the invitation that this hearing is to address DFS's portion of the health budget, and I will therefore focus my comments accordingly, after some background about DFS's budget and our healthcare work this year.

As you all know, DFS's mission is to strengthen New York's financial services industries, safeguard our markets from fraud, and protect New York consumers. Under Section 206 of the Financial Services Law, DFS's operating expenses are assessed to industry. The Executive's budget for DFS proposes about $254 million in budget appropriation, a 1.7 percent increase from last year, due to contractual salary increases.

As DFS superintendent, I manage a staff of more than 1,350 individuals, supervising the activities of more than 1,400 insurance companies with assets of more than $4.3 trillion, and nearly 1,500 banking and

other financial institutions with assets of more than $2.6 trillion. DFS licensees include nearly 200 life insurance, 1,100 property/casualty insurance companies, approximately 100 health insurers and managed care organizations, and 300,000 individual insurance licensees. Our licensees also include approximately 250 state-chartered banks, approximately 1,200 other licensed financial services companies, and 7,600 mortgage loan originators and servicers.

As this is the joint budget hearing on health, it should come as no surprise that I have spent a substantial amount of my time this past year, and even more so since November, addressing New York's healthcare market. At DFS we have been working with our commercial health insurers and our colleagues at the Department of Health, the New York State of Health, and the Medicaid team, to be prepared for whatever happens at the federal level and to protect New Yorkers in their healthcare needs.

In the health field, this past year at

DFS we were privileged to help draft and issue guidance regarding the Governor's landmark legislation that mandates health insurance coverage with no cost-sharing for breast cancer screenings and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds, and magnetic resonance imaging covered under an insurance policy.

I was also privileged to serve as a member of the Governor's Heroin and Opioid Task Force, and thereafter to assist with the landmark legislation to increase access to addiction treatment, expand community prevention strategies, and combat the over-prescription of opioids. As New York's insurance regulator, I also protected women who suffer from maternal depression, are victims of domestic violence, and who seek reproductive healthcare, ensuring access to insurance when needed.

The strength and vibrancy of New York's commercial health insurance market has been a priority of DFS this year. The

process of setting the 2017 health insurance rates involved carefully examining the rates requested by insurers, applying sound actuarial principles, considering the insurer's financial condition, and taking into account the need for a competitive New York marketplace that supports consumer choice. Our final determinations permitted increases for individual policies offered through the New York State of Health exchange, and for small group commercial plans, due primarily to increasing costs of prescription drugs and other healthcare costs. Nonetheless, we reduced insurers' requested increases by more than 28 percent overall, which will save consumers more than $302 million in 2017.

It is important to note that since the Affordable Care Act, enrollment in the individual market went from approximately 20,000 members to over 300,000, and premiums dropped by more than 50 percent, not counting federal tax credits. In New York, our uninsured rate has declined from 10 percent

to 5 percent. Presently, we have 16 insurers participating in our individual market and 21 insurers in our small group market.

In addition, to further ensure market stability in New York's health insurance market, in June we issued an emergency regulation to address certain unintended consequences from the federal risk adjustment program in New York's small group market for the 2017 plan year, and we worked collaboratively with the federal Centers for Medicare & Medicaid Services in issuing that regulation.

Notably, CMS subsequently issued its rules for risk adjustment for the 2018 year, which included one of the factors that we had identified, resulting in a significant reduction of the statewide average premium to reflect the medical loss ratio, as risk adjustment should factor in medical expenses and not administrative costs or profit. DFS currently is reviewing, for the 2018 plan year, the continued impact of federal risk adjustment on both the individual and small

group markets in New York.

The Governor's Executive Budget proposes DFS initiatives as part of Article VIII legislation, and there are two that specifically involve health that I would like to discuss: prescription drug costs and pharmacy benefit manager reform.

First, for the New York State commercial market, prescription drug costs have been the biggest drivers of health insurance premium increases. In 2015, pharmacy expenses were 25 percent of the total premiums in New York State, significantly higher than the second largest category of premium expense, which was inpatient hospitalization, which was 18 percent. In 2015, New York sales of branded drugs exceeded $200 billion, and the cost of specialty drugs -- which is only 1 percent of the market, but such a greater cost, has skyrocketed.

Despite considerable efforts by the New York State Medicaid program to maintain affordability through formularies, preferred

drug lists, rebates, and utilization management, total drug costs have grown by over $1.7 billion over the past three years, or 38 percent.

Accordingly, the Governor's Executive Budget includes important proposals to maintain affordability of prescription drugs in New York. The first proposal, as you've heard from the Commissioner of Health, authorizes the Department of Health to collect cost and pricing information from drug manufacturers in order to establish state pricing benchmarks for certain drugs for the Medicaid program. The existing Drug Utilization Review Board will conduct those reviews for certain categories of drugs where the pricing is exorbitant relative to development costs and therapeutic value. That review will establish the benchmark for pricing in the Medicaid program.

Then turning to DFS's role in this proposal, the Governor's proposal would then require drug manufacturers and wholesalers to pay a 60 percent surcharge to the Department

of Tax and Finance applied to all first sales in New York State on gross receipts generated from drug costs in the commercial insurance market that exceed that DURB state pricing benchmark in the Medicaid program. That surcharge amount will be paid into a fund held at DFS, which DFS will distribute to health insurers and Medicaid in proportion to their relative costs with respect to those drugs that generate the surcharge.

Surcharge amounts paid to commercial insurers will be used to reduce premiums paid by consumers. In this way, the proposal would benefit New Yorkers by maintaining affordability of healthcare coverage.

The second proposal I'd like to discuss is the pharmacy benefit manager reform proposal. The Governor's Executive Budget includes a proposal for DFS to regulate pharmacy benefit managers servicing New York consumers. PBMs are involved in almost every aspect of prescription drug delivery, from the manufacturers to the insurance companies to employers, and of

course the individual pharmacies.

The proposed bill grants DFS regulatory authority over PBMs to provide us with the oversight necessary to reduce the cost of drugs and limit any abusive or unreasonable practices. As prescription drug costs have skyrocketed, PBM profits have doubled. We are aware of at least 18 states that regulate PBMs in some way, and we believe that New York should as well.

Under our proposal, DFS's authority over PBMs would come in two measured phases. First, PBMs would be required to register with DFS by June 1 of this year, and each PBM would be required to provide information requested by DFS. Any company-specific proprietary information will be confidential, just like DFS receives similar confidential information from its other regulated entities.

After conducting a thorough review through the registration and information-gathering process, DFS would license PBMs beginning January 1, 2019.

Based on the review of information obtained during the registration phase, DFS would develop a comprehensive set of regulations that could include requirements that PBMs disclose certain information to clients or to the public and, importantly, that conflicts of interest, deceptive practices, and unfair trade practices be eliminated.

The goal of this proposal is to either eliminate the significant conflicts of interest that exist in current PBM models, or manage the conflicts under tight regulation to ensure that the financial incentives of PBMs, insurers, employers and consumers are aligned and that every effort is made to manage the costs of prescription drugs.

The Governor's Executive Budget includes other proposals relevant to DFS, including proposals to regulate student loan servicers, to protect vulnerable adults, and to provide DFS with administrative supervision authority, as 31 other states have, in order to protect our insurance market and the guaranty funds in New York

from insurance company failures.

The Governor's budget also includes a proposal that DFS have the authority to ban bad actors from the business of banking, insurance, or financial services in New York if, after a hearing, the DFS superintendent determines that the individual has done something so severe as to have a direct bearing on his or her fitness or ability to continue participating in the industry.

I would think that everyone would be on the same page with this proposal. No one should want misconduct or malfeasance to persist in our financial services industry, and the disqualifying events set forth in the statute reflect this goal of addressing truly bad actors.

Indeed, the Financial Services Law expressly provides that one of DFS's obligations is to reduce or eliminate fraud or unethical conduct in the financial services industry. Since it is DFS that regulates the financial services industry in New York, it is appropriate that DFS have the

authority to disqualify persons working in the industries over which DFS -- and not any other state official -- has supervisory oversight every day.

Under this proposal, disqualifying events include acts of fraud, certain criminal convictions, the making of material misrepresentations to DFS or other regulators, or conduct constituting such gross misconduct, incompetence, or dereliction of responsibility as to compromise the banking, insurance, or financial services industries in New York. This proposal is similar to the statutory disqualification provisions existing in the federal securities laws that are enforced by the Securities and Exchange Commission and the Financial Industry Regulatory Authority, as well as the disqualification powers that the Federal Reserve -- which is the federal counterpart to DFS -- has for the banking industry.

Also, the administrative process in this bill is not materially different than

processes that lawyers, doctors, real estate agents, and other professionals must follow if a charge is brought against them for malfeasance. The proposal provides due process to those charged by DFS in a proceeding as well as the ability of the individual to seek redress in court if DFS determines that he or she should be disqualified.

New York sits at the financial center of the world. Giving DFS this ability protects our markets from recidivist bad actors and, equally importantly, communicates the message that we have zero tolerance in New York for those who seek to defraud consumers and undermine the fundamental ethics and fairness of our system.

Finally, I would like to update you on the Health Republic liquidation. On May 11, 2016, pursuant to an order of the Supreme Court in New York County, I was appointed liquidator of Health Republic, which as you know was a nonprofit corporation formed pursuant to the Federal Co-op Program. As

liquidator of Health Republic, my first priority has been to build a process for resolving policy-related claims in a fair and expeditious manner.

Prior to its liquidation, Health Republic paid all claims up to November 2015, and all members were transitioned to new plans. Currently there are approximately 700,000 remaining policy-related claims that require resolution. We believe the true valid claims are much less than this figure.

To ensure that the claims are accurately and properly determined in a liquidation of this size and claim complexity, we have engaged a court-approved claims auditor to determine those claims that are in compliance with plan designs, benefits, exclusions and eligibility requirements, and to remove what we believe are many duplicative claims. We expect the audit will be substantially complete by this May, and we will be then issuing claims determinations in the form of Explanations of Benefits/Allowances beginning in the second

quarter of 2017 and through year-end. Claimants will have the opportunity to appeal the EOBs under the court-approved claims adjudication procedures.

From the start, I have been committed to an honest and transparent process for Health Republic's liquidation. We publish on our website relevant events and court orders, as well as financial information. I have directed an audit of the company’s financial statements for year-end, which will be completed shortly. The unaudited September 30, 2016, financial statement contains an estimate of about $212 million in policy-related claims, which amount is not a determination of the actual amount of claims. As I mentioned, there is a claims audit underway that will determine the actual amount of claims.

That said, it is fair to say Health Republic's liabilities exceed its current assets. Presently we are assessing the merits of Health Republic's claims against the federal government, including

approximately $432 million due under the Risk Corridors Program and $51 million due under the Federal Reinsurance Program, as well as what we anticipate will be the federal government's claims of offset for start-up loans provided to Health Republic and amounts allegedly owed for risk adjustment, which we dispute.

As many other states with similar co-op failures have argued, congressional limits on funding these federal programs in 2014 caused significant solvency risk for the co-ops. Court actions are underway by many other states, and we are considering whether to join those actions, while seeking to be as efficient as possible in managing the liquidation process and steadily decreasing the expenses of the process. In addition, we are assessing other potential third-party claims, including against directors and officers, and the availability of a D&O policy.

Apart from potential action against the federal government, we do not believe

that there will be significant additional assets with which to pay claims. We will not know the amount of the liabilities until the end of this year at the earliest, and payments to claimants cannot be made until the dueling claims with the federal government are resolved. We will continue to provide updates throughout the year and will remain committed to a fair, efficient and transparent process.

During my confirmation hearings I promised candor and transparency and spoke about my belief in a fair process and a deliberative approach. Throughout the year, I have been consistent in my outreach to stakeholders and in my interactions with both industry and consumers, as well as the public at large. I have employed my authority based on substantive analysis and a deliberative process.

I have also been responsive to legislative inquiries, and my staff is ready and willing to assist all of your constituents. When you call or write, I

answer. Or, as today, I appear in person.

My team at DFS is working hard every day to build on our successes and make New York's financial services industries work better for both industry and consumers, and we are doing all of this effective work as efficiently as possible and within our budget.

Thank you. I look forward to your questions.

CHAIRWOMAN YOUNG: Thank you, Superintendent.

CHAIRMAN FARRELL: Thank you.

SUPERINTENDENT VULLO: Thank you.

CHAIRWOMAN YOUNG: That's great.

Our first speaker will be Senator James Seward, who is chair of the Senate Standing Committee on Insurance.

SUPERINTENDENT VULLO: Sure.

CHAIRWOMAN YOUNG: Senator?

SENATOR SEWARD: Thank you, Chair Young.

SUPERINTENDENT VULLO: Good afternoon, Senator.

SENATOR SEWARD: And to Superintendent Vullo, welcome back to the Legislature. It seems like yesterday you were before the Senate for the confirmation process.

And I must say, I note today you've brought along some very able staff members with you. But please tell your children I miss them, because they were right with you through the whole confirmation process.

SUPERINTENDENT VULLO: They were, thank you. But they didn't think it was particularly interesting. But that's okay.

(Laughter.)

SENATOR SEWARD: You know, I could tell by the look on their faces.

We appreciate the update on Health Republic and that whole liquidation process, as well as I know you recently responded to a letter from Senator Hannon --

SUPERINTENDENT VULLO: You had sent me a letter, I responded to it.

SENATOR SEWARD: -- and me, and we appreciate that information and ongoing.

You know, obviously we in the

Legislature are very concerned about the payment of the legitimate claims -- you know, that providers provided service and then, you know, were left unpaid. And we demonstrated that in last year's budget by setting up that Health Republic Insurance Fund. I mean, it's dry; there's no money in it at this point. But at some point, either through the liquidation process or, you know, funding this fund that was in last year's budget, we'd like to see these claims paid.

My question is I understand that there was a recent court decision which did hold the federal government responsible --

SUPERINTENDENT VULLO: Yes.

SENATOR SEWARD: -- for payment, I think it was over $200 million for a -- in terms of the Oregon --

SUPERINTENDENT VULLO: Oregon and Alaska, correct.

SENATOR SEWARD: Why haven't we moved forward with some sort of action against the federal government? Because as you point out in your testimony, there's a considerable

amount of federal monies that did not come to New York that obviously Health Republic was counting on, and that would provide substantial funding for the payment of the claims that I've outlined. I mean, why aren't we moving forward there?

SUPERINTENDENT VULLO: Well, Senator, there have been a number of actions filed across the country in different venues, and I have been monitoring it and watching it very closely. There is no statute of limitations, which is the first question I asked, having litigated for many, many years. And to monitor those actions in order to make what I believe would be the best and the most efficient determination as to where to file and how to do it.

In my mind right now, you know, we have a very favorable decision that came out of the federal Court of Claims on February 9th, which you alluded to, which was a determination of liability. Damages haven't yet been decided. And that has certainly prompted me to think now about -- I

have a draft complaint -- to think about going into the federal Court of Claims.

The alternative has been the district court, and I've been waiting to see, quite honestly, what has happened. There was another judge in the federal Court of Claims that came out with a decision a few months ago that denied the government's motion to dismiss but didn't come up with a substantive ruling. And so, you know, I've been watching that. There's also very extensive litigation costs that I've trying to avoid.

So for example, there's a case that is a class action with a plaintiff's law firm that's seeking a large contingency fee. I'm not seeking to join to give a contingency fee.

So I'm trying to do it in the most efficient manner as possible. And we weren't the first out there, because there were other co-ops that filed first for other reasons, and it just made the most sense to me to watch what's going on. And we now have a very favorable decision. But again, there's

no statute of limitations, so I'm being very protective of the expenses as well as the strategy of where might be the best approach to get the most effective result.

So I'm very pleased with that decision. It doesn't have an actual judgment attached. The other thing about the federal Court of Claims is that the federal Court of Claims can get a judgment issued against the government, which the district court can't. And so that's where we've been really doing the analysis.

I hope that helped.

SENATOR SEWARD: Well, thank you for that explanation. It strikes me that it's not a question of if, it's when. When appropriate, and timing.

SUPERINTENDENT VULLO: That is correct, certainly at this stage. You know --

SENATOR SEWARD: Depending on developments.

SUPERINTENDENT VULLO: -- the issues are a matter of first impression in many

respects. And if I would have jumped the gun and filed the lawsuit and gone through litigation expenses of a lawsuit only to have an unfavorable result, I don't think that would have been the best use of limited resources. And that's why I chose this approach. And I've been sitting on a complaint that's ready to go for that reason.

SENATOR SEWARD: Thank you.

Certainly a theme throughout the Governor's proposal -- and I'm sure others will address this as well -- is, you know, the pharmacy costs. And as we know in the health insurance area that, you know, this reflects -- you know, it's a driver in terms of health insurance premiums. And certainly no one can argue with an effort to try to control those costs of prescription drugs.

When it comes specifically to the PBM proposal, when I think of the PBMs and the health insurers, you know, there's that contractual agreement between the two. They're both what I would describe as pretty sophisticated entities. And, you know, they

reach an agreement and there's every incentive, it would seem to me, on the part of the PBM to deliver pharmacy cost savings to the health insurer as an effort to hold down costs.

You know, I know through the prior approval process that the department receives all kinds of detailed financial information from the health insurers as you go through your rate-setting process. When it comes to the drug cost, can you describe what type of information you receive and how that relates to the setting of premiums? And don't you have at that time, the department, have the opportunity to assess the performance of their contractual agreement with a PBM at that time? Rather than getting in the middle, having the department get in the middle of a contract between two pretty sophisticated entities. I'm not sure they need the consumer protection that the department may -- is talking about providing here.

SUPERINTENDENT VULLO: Okay. So,

Senator, the PBMs have a connection to pretty much every aspect of the delivery of prescription drugs to the consumer. They do have contractual arrangements with some health insurers. They do have arrangements with employers. They have relationships with the manufacturers. They have contracts with the individual pharmacies. And the large ones have their own mail-order pharmacies and the like.

So we think that the issue of who PBMs are acting for is one that's very, very open to question. Because they are getting the spread pricing between the manufacturers to the individual pharmacies. Yes, they are getting certain servicing fees from, for example, health insurance companies. But what about all the profit that they're getting in the mail-order pharmacies, which is not in any way something that we have the insight into?

So there are some very serious concerns about what we do see and the information we do have from the prior

approval process, as you mentioned, which is 25 percent of the increased costs of premiums are prescription drug costs. And at the same time, the major PBMs, their profits have doubled.

So there's something there. We don't know exactly what it is. But we have good reason to believe that there might be some very significant cost savings and, at a minimum, to identify where does the PBM have the obligation to. It's not necessarily the consumer here, because again, they have their own pharmacies, mail-order pharmacies. The individual pharmacies are not getting the full benefit, they're getting what is forced on them in terms of the amount that they get for their services, and then the spread pricing that the PBM gets.

So our proposal we think is actually quite measured. Some other states have tried this in different ways, where they have gone right at let's impose this requirement, that requirement. Instead, we have said have them register with us, have them provide us with

certain necessary information so we can understand and have the data as to what the prices are versus, frankly, what the obligations are, what the return to the consumer is, and why the costs are so high in the commercial insurance premiums.

And then after that, we would have very comprehensive regulations to identify what we think needs to be fixed in the PBM market and the licensing regime.

So I think our approach is very measured to really try to get at the crux of the problem. We don't have the information that we need to really manage this problem.

SENATOR SEWARD: I guess as a quick follow-up, following that logic, if DFS regulates these entities, why shouldn't DFS then regulate, you know, auto repair shops or hospitals -- you know, other entities that the health insurers have relationships with?

SUPERINTENDENT VULLO: Well, the prescription cost drug costs go to the heart of what we're dealing with every day in terms of premiums. I mean, I hear all the time the

costs of premiums, of healthcare costs. This is the largest. It's more than inpatient hospitalization as a cost contributor to premiums. So it is directly connected to what DFS does regulate. And as I said, 18 other states, mainly through their insurance departments, have done things to try to regulate PBMs in different ways.

Our proposal is different. Our proposal I think is more measured. But I think this goes directly to a real problem that impacts the regulatory that we have, the regulatory authority that we have and our ability to actually address what is such a driver that I can't do anything with right now.

SENATOR SEWARD: Okay, just one additional question and we'll turn it over to others.

I know through your confirmation process we had quite a discussion and I think we both share the belief that it's very important to balance the needs of both the consumers of insurance in our state and our

financial services industry -- you know, health insurers and the other insurers around the state. You know, when you know, take a look at all of the financial services industry as a whole, they employ thousands and thousands of New Yorkers and have a tremendous impact on our economy in a very positive way.

When I look at the Governor's proposal -- and I'd like your thoughts on this -- do you have any concerns about how this would impact the mission of DFS which also, in addition to being the regulator, is to also work to enhance and cultivate growth in our financial services industry in the state? When we created DFS back in 2011, we put that very plainly in your mission statement as one of your goals. And many of the proposals that I see in the Governor's proposed budget are items that were rejected by the Legislature at the time we established DFS back in 2011.

But do you have any concerns about, you know, kind of a dampening effect on those

hardworking men and women in the financial services industry, including our health insurers? Is there a dampening effect when there are proposals to increase fines by 10 times and have -- you know, increasing the powers of DFS in terms of managing certain insurers and -- you know, and then you mentioned the bad actors, so-called bad actors provisions, with a minimum of -- I would say a minimum of due process included there.

Do you have any concerns that that could have a dampening effect on the financial services industry of our state?

SUPERINTENDENT VULLO: Senator, if I had those concerns I wouldn't have proposed those bills. So no, I don't.

And I don't think that any of the proposals that are relevant to DFS in the Governor's budget should impact any of the, you know, employment of good men and women in this state. The ones that you mentioned -- I mean, I spoke about the bad actors bill. I mean, that is something that regulators

across the country have the authority to do under administrative processes.

We saw, in the financial crisis of 2008, the problem with, you know, individuals not being held accountable. This is a very, very small segment of people that we're dealing with. And it is, I think, essential to be able to have the power -- and it is an administrative process, but it has the ability for due process in court -- to be able to, when we identify, we have -- you know, as the regulator we have great insight into companies. And again, it's a very small proportion of the overall industry, just like everything. I would never say -- this is a good, vibrant industry, but you can have bad actors in any industry. And actually to promote the growth of it and to maintain its stability, you need to make sure that we have zero tolerance for people who are not actually following the rules and engaging in ethical conduct. And that, I think, is the essence of that proposal.

On the fines, we have a proposal that

actually ties it to what the damages might be. Currently, if someone files a willingly false statement of material fact with the agency, and that's one violation, I can fine them a thousand dollars. That, to me, is not deterrence to prevent people from filing a materially false statement with a government agency.

So -- and again, this is not directed at any large group, but it is essential to the deterrent purpose and to maintain the stability of the markets, in my view.

SENATOR SEWARD: Well, thank you for sharing your thoughts.

SUPERINTENDENT VULLO: Sure.

SENATOR SEWARD: I -- my view is you -- and we'll have to think this through, obviously, through the process. But it strikes me that through the licensing, you know, producer licensing and the other -- there are plenty of hammers that you have at the department. No one wants, shall we say, bad actors out there defrauding the public.

SUPERINTENDENT VULLO: Exactly.

SENATOR SEWARD: And you have, it seems to me, plenty of powers to go after those bad actors.

And so we'll be evaluating this proposal.

SUPERINTENDENT VULLO: And I'd be happy to share more thoughts, you know, separately if you want.

Thank you.

SENATOR SEWARD: Thank you.

Thank you, Senator Young.

CHAIRWOMAN YOUNG: Thank you.

Chairman?

CHAIRMAN FARRELL: Thank you.

Assemblyman Cahill, chairman of the Insurance Committee.

ASSEMBLYMAN CAHILL: Thank you, Mr. Chairman.

Thank you, Superintendent, for being here today.

I'm glad we had a chance to have a little exchange before we got here so that you were aware that we would probably go beyond the issue of just the relationship of

the Department of Financial Services when it comes to health insurance.

And I'd like to start by going back to health insurance, and Health Republic in particular, and the discussion that was had with my friend Senator Seward. The question was whether you are going to pursue a federal legal action against the government for a claim regarding monies due the State of New York, and Health Republic in particular, consistent with those actions that are brought by other states.

Have you been in communication with the Attorney General on how to proceed with this suit? Because my recollection is you wouldn't be bringing it just by yourself, you'd be doing it with the Attorney General; correct?

SUPERINTENDENT VULLO: No, that is not correct. As liquidator, I'm actually not a state agent, I am a private entity that is the receiver of Health Republic. And that action, just like in any other liquidation proceeding, goes through the Liquidation

Bureau. So that's sort of separate from the state agency, which is DFS. I actually wear two hats in that regard. And the Liquidation Bureau commences those actions.

When we go into court initially, when it's DFS actually putting Health Republic into liquidation, that is something that we sometimes work with. But the Liquidation Bureau handles those actions and actually has private counsel many times doing that too. It's a different fund, and it's a different process.

ASSEMBLYMAN CAHILL: So you'd be going in as liquidator, not as the superintendent?

SUPERINTENDENT VULLO: It's the only role that I have for Health Republic, is to go in as liquidator, that is correct.

ASSEMBLYMAN CAHILL: So the budget proposal by the Governor -- not just in the area of DFS but in many areas of the budget, the Governor recommends significant changes in the powers and authorities and responsibilities of agencies, particularly when it comes to things like the

investigative powers or prosecutorial powers -- not to use the criminal prosecutorial word, but the prosecutor to execute even a civil action.

There has been some concern expressed by the Attorney General regarding the reach, particularly when it came to DFS. And the changes would include more supervision, more enforcement, expanding the ability to ban operators. It would include the ability to levy assessments and increase fines by a thousand percent. In each instance, the Attorney General has expressed a concern that this is -- he didn't use the word usurping the role of the Attorney General, but clearly the memorandum that we received from the Attorney General indicates that he believes that this is an overreach. You responded and you said no, it's not. Which is kind of what I expected you would say.

These things were considered when the Department of Financial Services was being authorized in the first instance back around 2011, and rejected by the Legislature. What

has changed since 2011 other than who the Attorney General is that would make it reasonable for the Legislature to revisit the powers, authorities, and duties of the Department of Financial Services in this regard?

SUPERINTENDENT VULLO: Thank you for that question, Assemblyman.

So I did respond to the Attorney General's letter last night. And I think it's actually quite unfortunate that we have this issue.

The proposals in the Governor's budget don't take away in any way, shape or form any of the power of Attorney General. They're actually quite limited in what the proposals are. And it was the same Attorney General in 2011, when DFS was created, as is the case today. So that hasn't changed.

And the issue in 2011 was the Martin Act, and we're not asking for the Martin Act.

What these provisions are are the -- so the fines, that's just increasing -- a proposal to increase what the fines are that

currently exist in the Insurance Law that we already enforce.

And as I set forth in my letter that I sent last night, the Financial Services Law, both in its introductory disposition as well as in specific provisions, gives me the enforcement authority over the banking and insurance industries, just like the Banking Department had before the merger and the Insurance Department had before the merger.

I already have enforcement authority that I utilize every day, just like any other regulator does. I'm also a law enforcement officer. The Attorney General is not a regulator. I regulate the banking and insurance industries, and if I see conduct in the course of the regulation of that -- I supervise, we do examinations every day of our industries. And if something comes up in that, we take action. Overwhelmingly, that action is by agreement, by consent order. We very rarely go to court.

The only thing that these provisions are seeking to do on bad actors is

to make it clear that in my supervisory regulatory role, I'm there with the company, if I identify a problematic -- someone who is, you know, engaged in malfeasance, I should be able to remove that person through the process that I have for other things.

So that wouldn't be something that the Attorney General would ever do anyway, because that information is not available to him because it's in my regulatory authority to do that. And in fact what we included in the proposed bill is an explicit statement that I can refer the matter to the Attorney General, because there are circumstances that we would want to do that.

So I actually -- I guess that's being turned into something different. It was including an explicit provision that I can refer matters to the Attorney General that somehow is making it suggest that I'm trying to take away powers. It's just not the case.

ASSEMBLYMAN CAHILL: So -- but --

SUPERINTENDENT VULLO: And again, it's unfortunate.

The student loan servicing is another thing. That is a -- you know, we have a huge debt crisis of students. There's 2.8 million New Yorkers that have student debt, and the average amount is over $32,000. We're trying to regulate those servicers.

ASSEMBLYMAN CAHILL: Excuse me. Before we use up the entire 10 minutes, isn't DFS already required to cooperate with the Attorney General? And why could not that mandate that's already written into the Financial Services Law to cooperate with the Attorney General accomplish exactly what you're suggesting needs to be done with additional legislation?

And secondly, if you already have the authority, why do you need to restate it here in the language of the budget?

SUPERINTENDENT VULLO: The specific authority that we're talking about is the authority to ban bad actors.

ASSEMBLYMAN CAHILL: Okay, there's -- well, there's actually --

SUPERINTENDENT VULLO: That's the

specific authority. I have enforcement authority --

ASSEMBLYMAN CAHILL: Excuse me. There's several different sections that seek to expand the authority, responsibility, and reach of the Department of Financial Services, not just the bad actors part. There's several different, so ...

SUPERINTENDENT VULLO: There's a provision that is also misunderstood on unlicensed lenders. So I have requirements, we have requirements in the existing Banking Law that people must come to us and obtain a license if they're going to be a lender, make loans to New Yorkers.

There are people that refuse to come to us, as they are legally required to do, to get a license. What I'm asking for in that provision is the ability to apply to people who are flagrantly violating the law and not coming for a license that I can go after them in the same way I can go after somebody who does comply with the law and get a license. That's all that provision is.

And in that provision I say "and we can refer the matter to the Attorney General."

ASSEMBLYMAN CAHILL: We're going to move on, because there's only a minute left in the time that I have allotted.

SUPERINTENDENT VULLO: Okay.

ASSEMBLYMAN CAHILL: The concern that has been existing and growing over the past several years, and particularly last year, on the -- in the area of long-term-care insurance is that premiums have become unaffordable, people who have invested in these plans are not being able to rely upon them the way that they thought they would, the way that it was represented they would by the State of New York, as a matter of fact.

What exactly is DFS doing to restore the faith and trust of people who want to invest in these plans, help them over this circumstance, and correct this situation for the future?

SUPERINTENDENT VULLO: Thank you, Assemblyman. I share the concerns of all

New Yorkers who are experiencing increases in long-term-care insurance premiums. This is an unfortunate national problem caused by 15, 20 years ago the development of products that were underpriced because of assumptions about lapse rates, because of low interest rates for a long period of time, and assumptions about longevity and morbidity as well.

So the reality that we face -- and we have a very thorough process at DFS. When an insurer seeks premium increases for long-term care, we evaluate their actuarial data, we look at what the assumptions are, what the benefits are, what the actuarial analysis is as to what those liabilities would be compared to the premiums that exist. And unfortunately in a number of circumstances we agree that certain increases are necessary.

We often reduce the amount that the insurer is requesting, but we do it on an actuarial basis. And what we have done is two other things, is that we've offered the consumer -- and this is not a perfect solution, but it's honestly the best that we

could do -- is we offer them a choice. You know, you could take the extra premium but we require the insurance company to give them a landing spot, such as a reduced inflation rate, which ultimately could be a reduction in benefit. But -- and to lay that out in full consumer disclosure that they have that choice.

What's interesting is that most consumers do continue the coverage. They don't lapse on it. But that's what we've done.

The other thing that we've done when we've approved rate increases is we've said you can't come back to us for three years with another rate increase.

My biggest concern is I don't want to raise prices and then have an insurance company come back and say, now I'm insolvent and I have to be put in liquidation. That's a real concern that I have, and so we carefully address this.

It's a -- it's a -- it's a problem in terms of developing products that will

provide what people believe that they are contractually getting, and providing it in an affordable way so that the insurance company can actually pay out the claims based upon the premiums that they're getting.

And I think that products such as -- you know, life insurance policy products that have, you know, early benefits for long-term care where you can actually get the benefit if you -- you know, are good products. I'm very open and I've talked to a number of insurance companies, what other kinds of products can we come -- because obviously it's an impact on the Medicaid system when people don't have, you know, the insurance policy.

I have attended, you know, many meetings with industry, working with the Federal Insurance Office to try to -- it's a -- it's a very difficult problem with not very easy solutions, unfortunately.

ASSEMBLYMAN CAHILL: Thank you.

Mr. Chairman, I'll have to come back after some of our colleagues have a chance to

talk.

Thank you, Superintendent.

SUPERINTENDENT VULLO: Sure.

CHAIRMAN FARRELL: Thank you.

CHAIRWOMAN YOUNG: Thank you.

Senator Hannon.

SENATOR HANNON: Madam Superintendent, addressing Health Republic -- and you gave us a pretty good explanation in a letter just recently, and then more in your testimony. You talk about, in your testimony, approximately $432 million due under the Risk Corridors Program. But there's actually three parts of risk corridor. There's risk corridor, there's risk adjustment, and then there's reinsurance.

So what of the 432 would be risk reduction? I mean, what -- because, as you set forth in the letter, in 2014 Congress appealed the risk reduction. And therefore I wonder what of the risk adjustment is still outstanding for Health Republic.

SUPERINTENDENT VULLO: Okay, there are -- so there are -- it's the three Rs:

Risk corridor, risk adjustment, and reinsurance. And the Risk Corridor Program was specific to these nonprofit co-ops, which were not nonprofits, so they required capital in order to get rolling. And the Risk Corridor Program was intended to actually address the circumstance where in the early phase of the development of the exchange, that the companies couldn't really estimate for sure what the population of the uninsured becoming insured would be, and the Risk Corridor Program was supposed to protect against that with additional funding from the federal government.

That's what Congress in 2014 -- they reduced the funding from what it would have been, a hundred percent, to under 20 percent. And that created very large receivables for all of the co-ops and certainly Health Republic. The one that we knew of immediately was I think about $130 million.

The $432 million amount that I mentioned is what we have estimated as of September 30. And big caveat, I've directed

an audit, we're going to look at it, we have actually additional information. That's just risk corridor.

The two other -- reinsurance was also cut. That was about a $51 million amount. Risk adjustment goes the other way. So risk adjustment was the program -- and still exists -- where insurance companies that have healthier lives pay into the program to be paid -- so that's insurance company to insurance company, it's not federal monies.

And under risk adjustment, we believe it's possible that the federal government will claim an offset. We would argue $400-something million, if say that number turns out to be the accurate number, that we are owed that we think that the federal government may claim in offset for risk adjustment, which we dispute, and potentially the start-up loans. And our position is that that set-off would not be appropriate.

So that's why this lawsuit issue, too, is complicated, because it's not necessarily just that one piece, it's is the government

going to claim these other things. And our position is the federal government, under our New York statute, is subordinate as a creditor to policyholders. That policyholders come first, it's an unsecured loan, and we don't think that Health Republic would have to pay it. That we can use -- but do I think that somebody in the federal government might disagree with that? Yes.

So we're evaluating it. It hasn't yet been litigated and decided.

SENATOR HANNON: Well, thank you for laying out why it's a complicated case. That's huge.

In regard to ACA -- and I'm not so sure I want an answer, but just the fact that you're looking at it, especially your department looking at the contingency in the in the event the ACA is repealed, in part or all. And the reason I don't want a full answer is I don't think it's prudent. But I hope you're doing that.

SUPERINTENDENT VULLO: We are actively engaged and monitoring it very, very

carefully every day.

SENATOR HANNON: And one of the things that we have, just an offset of all of that -- and we did adopt as a statute, but we still look to change it -- is changing the size of the small group. We went to 100, there's been a fair amount of I think valid complaints, and that we ought to go back to 50, and at least consider that as a lot of different changes are going around in the next couple of years.

SUPERINTENDENT VULLO: Senator, I think that there are so many various factors, all of them should be considered when we see what exactly happens in Washington. Because none of these things can really be looked at on its own.

Obviously, the funding that would come from the federal government, the Medicaid expansion, the Essential Health Plan -- there are so many different factors, and then figuring out what the commercial health insurance program would be.

You know, on the small group market,

just like the large group market -- which is not, you know, subject to prior approval -- you know, may actually have healthier lives. So the argument on the small group market expansion is that you get more healthier lives the more people in the pool, or at least it's spread out more. That's the argument. Again, we'd have to look at each individual piece depending upon what happens at the federal level and what laws we have on the books and might need modification to.

SENATOR HANNON: Almost on an individual basis, as opposed to a company or a broker basis, I've heard the complaints and feel that it would be better to go to the smaller group.

Let me just switch entirely to another topic that you brought out, and that was in regard to the powers of your agency or maybe the powers of the Executive in regard to the drugs.

Because I'm puzzled by -- we have, obviously -- we run Medicaid, we regulate Medicaid, we set the rules for Medicaid.

We've worked for the Drug Utilization Review Board for Medicaid. What we don't do is deal with the component parts of the policy, like auto insurance or things like that.

But the Governor's proposal, as you said in your testimony, requires drug manufacturers and wholesalers to pay a 60 percent surcharge applied to all first sales in New York and gross receipts generated from drug costs on the commercial insurance market that exceed the DURB state pricing benchmark.

I just look at that as -- well, that would be wonderful if we could wave a magic wand and we reduce drug prices. However, I just don't know where we would get the power in order to do that. And the next part of it would be, what would be the amount of money you people would think we could recover? Because it's going to be an extraordinary type of academic/accountant/economic analysis in order to determine excessive pricing. And what's the benefit at the end? Because it's not clear from our negotiations with the

Department of Budget what the benefit is to this whole proposal for commercial insurance.

SUPERINTENDENT VULLO: So, Senator, the DURB would be setting the benchmark state price for the Medicaid program. And the proposal also includes an expansion of DURB to include economists and actuaries and others on that review board -- which of course, as you said, already exists to address sort of pricing.

And there are only certain drugs -- not all drugs, there are only certain drugs that would qualify for even that benchmark pricing or then the 60 percent surcharge. And they're the exorbitant-priced drugs where you see the launch prices being way higher than what development costs, research and development costs would be, or the huge spikes that we've seen, for example, with the EpiPen and the like. So it's actually a narrow category of drugs.

But the DURB would set those prices for the Medicaid system. DFS would have a representative on the DURB, but we wouldn't

do anything with respect to the setting of those prices. The surcharge would be 60 percent for that excess above what the price is that's set by the DURB for Medicaid purposes. And if the pharmaceutical manufacturer, for purposes of the commercial market, was going to charge a price higher than that, the Department of Tax and Finance would have that 60 percent surcharge. And the fund would come to me for purposes of actually giving the benefit of that to the insurance companies so that premiums can be reduced or, the corollary in the Medicaid program, based on the proportion of drugs.

So that's what the proposal would be. So we wouldn't be involved in the setting of the prices or anything. That's a pure Medicaid function. We think that this is appropriate and legal. And so I hope that answers that, you know, in terms of what DFS's role in that is.

SENATOR HANNON: I'm looking for a -- I'm looking for -- I'm looking for a number.

SUPERINTENDENT VULLO: So -- I'm

sorry. So the scoring, I think, for the Medicaid program has -- I think it's $55 million for the first year is the scoring of that. And certainly the commercial market, you know, is probably 10 million.

SENATOR HANNON: We have that scoring, but we also have, in an answer from the Division of Budget as to what's the surcharge, and they said the $55 million doesn't deal with the surcharge, hence that's what --

SUPERINTENDENT VULLO: Correct. It's.

SENATOR HANNON: I have that in writing, so hence I'm asking the question what's the value of the surcharge.

SUPERINTENDENT VULLO: Yeah, I don't have -- I don't have a number. I don't -- you know, I can certainly work with the Division of the Budget on that if you'd like.

But I do know that it's been scored for the Medicaid savings over a two-year period. And certainly given the commercial insurance market and the size of the commercial insurance market that we regulate

at DFS, we certainly think that there are sufficient savings to maintain affordability of health insurance rates that could be -- that make this an appropriate Article VII legislation.

SENATOR HANNON: The last point would really be just a comment about the PBMs. One of the rationales that was given to us in discussions with Budget was "We want to find out what the PBMs are all about and what they do and how they do it." And in terms of moving forward in discussion of what's going on in this state with PBMs, we already find out that all of Medicaid managed-care plans have a PBM. We find out that the Civil Service Department, which administers the Empire Plan in this state, has a PBM and acquired the PBM by a request for proposals advice.

And then, after he finished testifying on that question, Medicaid Director Helgerson talked about getting a PBM for another function, for the, quote, MAC function in setting drug prices, so that the Department

of Health directly contracted with a PBM for advice.

I mean, the information is there. That's one thing. It's why we're further looking forward. And second, to the extent we're starting to come up with regulating these groups -- and I have no connection, no love for them. We don't -- we don't -- they're not anything warm and fuzzy. But what are we doing? If we contract with them, use them, now we're going to regulate them and try to squeeze them? And how are we going to make the judgments for that?

Why don't we use the information we have now in state government to figure out where we're going? End of comment.

SUPERINTENDENT VULLO: Would you like me to respond?

SENATOR HANNON: Sure.

SUPERINTENDENT VULLO: The -- you know, there are three very large PBMs that interact with the commercial market. And certainly in the Medicaid system they have contractual arrangements as well. There's

nothing wrong with the contractual relationships with any, you know, commercial or state entity with PBMs. But we know that in the commercial health insurance market -- and we don't have the information with respect to the contractual arrangements in the commercial health insurance market. We know that the drivers of that are very, very different than the drivers of contractual arrangements with a state Medicaid or state-federal Medicaid market.

And that's where we have some real concerns and why this proposal to license -- first register and then license the PBMs we think will help maintain the affordability, because of the multiple relationships that the PBMs have in the delivery of prescription drugs relevant to the commercial health insurance market -- the relationships between the individual pharmacies, the rebates from the manufacturers, the spread pricing from the manufacturers. Everything that I'm talking about is about the commercial health insurance market, where we don't have the

information about the contractual arrangements, the pricing and who -- most importantly, who's getting the benefit of whatever administrative -- you know, large contractual arrangements are supposed to make things more efficient. Who's getting the benefit of the arguably reduced costs? And that's really why we want to regulate them in the commercial market. Which has different incentives from the governmental --

SENATOR HANNON: A comment and my observation. As you're talking, I'm thinking you regulate these insurers, you look at their rate requests. In order to look at their rate requests, you're looking at the elements of their rates. You have an MLR that they have to adhere to. I would think that you have already the information needed to do this.

SUPERINTENDENT VULLO: We don't, Senator. We don't.

The insurance companies' relationship with some of the PBMs, the contract is like a servicing fee, you know, for sort of managing

the delivery process. We don't have the mail-order pharmacy information that the PBM has that's supplying them. We don't have the price or the cost structure of that. We don't have the information with respect to the manufacturer rebates that the PBM may get and how they're passed along. Are they truly passed along to the insurance companies? We don't have the relationship or the contractual information or the pricing information of the PBM contracts with the individual pharmacies, because that's divorced from the contract that the insurance company has with the PBM for a management fee or a servicing fee.

So there's a lot about PBMs that we do not have that type of information. And to my knowledge, nobody in the state does. And that's why, again, other states have sought to do it as well.

SENATOR HANNON: Well, if we contract with these folks -- the Civil Service Department does it for the Empire Plan, think of how many covered lives there are in the

Empire Plan -- we ought to have that. They were derelict in doing their contracting.

I just can't imagine that -- because I have -- I don't -- see, my problem is when we're launching a whole new regulatory scheme, I'm wondering -- we ought to be doing it correctly. And second, I'm not so sure we do regulatory schemes that well. So witness the rest of your requests.

So anyway, that's a dialogue we'll continue at some point.

SUPERINTENDENT VULLO: Okay, thank you.

SENATOR HANNON: But thank you very much for really solid thinking in your answers.

CHAIRWOMAN YOUNG: Thank you.

CHAIRMAN FARRELL: Richard Gottfried, chair, Health Department -- Health Committee.

ASSEMBLYMAN GOTTFRIED: Yeah, you wouldn't want me chairing the Health Department.

(Laughter.)

ASSEMBLYMAN GOTTFRIED: I have many

fine qualities. Running anything is probably not one of them.

(Laughter.)

ASSEMBLYMAN GOTTFRIED: So I have a question about something you said. I can certainly understand that a PBM would treat Aetna, for example, just -- and not to single them out -- which is a huge customer, that they would treat them a little better than they would treat a Medicaid managed-care plan that may have 100,000 or 200,000 covered lives. That's part of my concern.

But you referred -- you used the expression that the drivers are different on the commercial side than on the government insurance side. What did you mean by that?

SUPERINTENDENT VULLO: The for-profit motive of the commercial insurance industry. And the for-profit motive of the PBMs. And the contractual -- you know, the -- when you're addressing the -- as Senator Hannon's question was asking about, well, we have some information in the Medicaid system with PBMs, but we don't have in that all of the pieces

of the commercial health insurance market, which are also different players in that market than would be in just the contractual discussions between, say, Medicaid and the PBMs. Right? So the commercial market has many different players, mostly for-profit institutions, as are the PBMs.

ASSEMBLYMAN GOTTFRIED: But doesn't the for-profit insurance company -- that wants to send as much money to its stockholders as possible -- have the same desire for a lower price as the little not-for-profit Medicaid managed-care plan?

SUPERINTENDENT VULLO: Well, I think that -- you know, and this gets sort of -- gets complicated and involves, you know, thinking about who has the sort of contractual power in various negotiations. You know, so if I were to ask a commercial health insurer when they submit to me their premium request to increase premiums and they say, you know, we're asking for X percent increase and you say, well, you know, that's too much, and they say, well, prescription

drug costs are so high, and I can't do anything about that because I don't have -- I don't have the power over -- I need to provide these drugs, I don't have the power over that.

And you have the PBMs that are actually negotiating some of those and providing the delivery of the pharmaceuticals either within their own captured companies that are mail-order pharmacies -- which is kind of interesting where that profit motive is, in which direction does that profit motive go.

ASSEMBLYMAN GOTTFRIED: Sure.

SUPERINTENDENT VULLO: Same thing with the profit motive towards contracting with the individual pharmacies and the manufacturers. So where is the PBM in terms of helping with the reduction of the cost to the consumer?

And that's why we think PBMs really are something that requires much greater transparency at a minimum.

ASSEMBLYMAN GOTTFRIED: Okay. Thank

you.

CHAIRMAN FARRELL: Thank you.

Senator?

CHAIRWOMAN YOUNG: Senator Golden. Oh, I'm sorry, Senator Krueger first.

SENATOR KRUEGER: Hi. Thank you so much for your testimony today.

So something that I have raised with your office quite a bit over the last several years are the concerns I get from my constituents and also from doctors and hospitals, that we sign everybody up in our exchange in the options, and then there are not enough doctors to meet the demands of the number of people who have signed into the insurance companies. The doctors suddenly discover they're off the exchange by certain companies but were never told; others, they're on, but were never told. When you go to look things up for yourself about who are the providers and you then use the navigators to decide who you're going to sign up with -- and then once it's all done, you discover, nope, they're really not there, nope, really

can't use those hospitals.

I even have a situation -- my district has a hospital a few people have heard of, Memorial Sloan-Kettering. It's fairly famous for cancer care. There is not one insurance company on the exchange that will use Memorial Sloan-Kettering, even though we have talked to Memorial, they will take the same rate those companies are paying the other hospitals.

I don't understand what we're not doing right to ensure that once people get into these insurance vehicles that I'm very glad we have set up in New York State and hope, as Kemp said, we don't see the collapse of ACA and have to deal with all the things that that might mean. How do we make sure these insurance providers have robust networks, aren't doing bait-and-switches? And I really just don't understand how major hospital institutions offering to accept the same rates from these companies are shut out.

SUPERINTENDENT VULLO: So, Senator, this is unfortunately one of those questions

that I have to say that in large part I don't have the authority to do much about because I can't demand that an insurance company include certain doctors in the network.

The law does provide for the Department of Health, in consultation with DFS, to look at network adequacy and ensure that the network is adequate. And I think all of your points are very, very relevant to the need for ongoing oversight over network adequacy. But the individual contracting relationships between the insurance companies and providers is something that I don't have any authority to demand that you include certain -- but we can say your network is not adequate.

The other piece of this, of course, is the out-of-network coverage requirements. And of course the Legislature and the Governor did a lot in 2014 for out-of-network coverage to ensure that there wouldn't be surprise billing and the like. But we still have in various places in the state, and particularly downstate, more reduced

out-of-network coverage.

And certainly we just had a working group that did a report on that, and I think certainly we can think about more reforms in all of these areas.

SENATOR KRUEGER: So I'll play devil's advocate.

SUPERINTENDENT VULLO: Sure.

SENATOR KRUEGER: So much of today's testimony back and forth with colleagues is about does the state have the power to tell drug companies what their prices can be, does the state or should the state have the power to tell the pharmacy benefit managers to show us their books and prove to us that they're transferring the monies the right way.

There's nothing that we can -- oh, should you have the right to have more criminal authority over certain kinds of cases. What would you need to be given the authority to hold these companies accountable for the fundamental thing they're supposed to be providing? You're signing up for insurance to get healthcare; shouldn't they

have an obligation to ensure you actually get what you're signing up for?

SUPERINTENDENT VULLO: Well, certainly, if they have contracted -- when they contract with the policyholders, whether they be the employer or the individual on the exchange, and they promise certain coverage and they don't provide that coverage, we come in and we make sure they provide the coverage.

The question as to whether or not there's a particular provider for that coverage -- so long as they have what's called an adequate network, the insured doesn't necessarily, under current law, have the right to a specific provider for the coverage that the insurance plan provides.

But we certainly enforce the laws that say that you promised certain coverage, you must have that coverage with the copays or whatever. But it's the particular decisions as to what providers are in networks. And of course individual providers, many of them decide not to take insurance at all. And

so that's just something that we don't have.

I want to address your thing on the criminal penalties. I do not have and am not seeking criminal prosecution authority. So that's something also in answer to Assemblyman Cahill's question that is a misunderstanding. I have criminal investigatory authority, and if there's something that we learn about that's of a criminal nature, we refer it to district attorneys or to the Attorney General, as the case may be. So I am not seeking any criminal prosecutorial authority in any of these proposals, so that's an unfortunate misunderstanding.

SENATOR KRUEGER: So let's go back to the subexample for me. You sign up, you discover that doctors you believed were in the network are not, even though they were on the website. You go in search of a doctor -- even though it might not be the same one you had in the past -- and there is nobody who can see you in any reasonable time frame. What are the standards you can hold them to?

SUPERINTENDENT VULLO: Well, so then that, if there is a circumstance where a consumer was promised something and there's a plan where there's treatment that is covered but no provider in the consumer's geographic vicinity to do it, then yes, and in most cases the out-of-network coverage would allow that consumer to get the out-of-network coverage and not necessarily have to pay the additional differential.

So there are certainly things in individual cases. We get consumer complaints all the time, and many of these types of complaints we actually resolve. Some of it is, you know, unfortunate misunderstanding, but not for any fault on anyone. It's very complicated to understand, and I get it, what the policy provides.

So I would say, you know, we answer these complaints all the time, we manage those complaints, we contact and we make sure that the consumer gets coverage. So any of your constituents, send them our way and we'll try to address individual ones as well.

SENATOR KRUEGER: We do, but we continue -- it's almost -- I'd say it's almost ubiquitous. And I don't know whether it's something unique to Manhattan -- because ironically, Manhattan has more doctors and more hospital beds than statistically I think anywhere else in the state, and yet when I talk to other Manhattan electeds, it also seems to be one of the biggest problem areas.

I don't know if you measure by geography, because I would have actually assumed it might have been a bigger problem for Cathy Young in her district because rural New York State has so many fewer options than, say, the big City of New York. But it's a constant struggle.

SUPERINTENDENT VULLO: And I can tell you from personal experience, in Manhattan it is.

So I don't think -- you know, I think the number of providers who don't take health insurance, the limitations of out-of-network coverage in the individual market downstate is certainly a greater issue than it is in

other places of the state, that is true.

SENATOR KRUEGER: I'm out of time, thank you very much.

SUPERINTENDENT VULLO: Thanks.

CHAIRWOMAN YOUNG: Thank you.

Assembly?

CHAIRMAN FARRELL: Mr. Raia.

ASSEMBLYMAN RAIA: Thank you, Chairman. And thank you, Commissioner. It's good to see we both survived the snowstorm last Thursday.

Under the Governor's Executive proposal, DFS may request information including but not limited to PBM services disclosing any type of financial incentive or relationship.

Isn't that information already available out there for the most part, all the contractual relationships between the PBM and the insurance companies? Because I've heard some folks say that it is out there.

SUPERINTENDENT VULLO: Well, again, I mean there may be the contracts that an insurance company has with the PBM. But

that's not going to give us what the PBM's various other pieces of that puzzle are, and the PBM's pricing and the PBM's costs and the PBM's profit. We wouldn't have that. We would have the contract that the insurance company has. And we certainly see how pharmaceutical prices impact premiums. But again, we don't have the PBM side and the PBM's relationships with the pharmacies, the manufacturers, you know, their mail-order pharmacies and the like. So that piece we don't have.

ASSEMBLYMAN RAIA: I guess I'm a little concerned about the "not limited to" part. What type of things could you -- because I didn't even finish reading the whole thing. It covers a whole lot of aspects between the relationships between the PBM and the insurance companies. And what other types of things could you foresee that the department might want?

SUPERINTENDENT VULLO: Well, it would be anything relevant to the cost structure that leads to prescription drug costs not

being affordable to the consumer. I mean, in many ways this is not different than, you know, what DFS's authority is over its regulated entities, which is oversight over, you know, safety and soundness and financial condition. And so we get, you know, this type of information from all of our regulated entities all the time, so it would be really no different than that.

ASSEMBLYMAN RAIA: Okay. My next question, I don't know if it should have been directed to the health commissioner, but maybe you can help me out. With respect to the first sales of high-priced drugs, who is reporting the first purchase? Is it the wholesaler or is it the pharmacy? How do we come up with the first -- you know, the first sale in the state?

SUPERINTENDENT VULLO: Right. The idea is to ensure that, you know, we are getting the jurisdictional connection to New York State and the first sale in New York State, whatever that first sale might be.

ASSEMBLYMAN RAIA: Right. But is

it -- because most of the drugs go through a wholesaler. So is it going to be the wholesaler?

SUPERINTENDENT VULLO: Then it would be the wholesaler, if that's the first sale into New York State.

ASSEMBLYMAN RAIA: Now, neither the wholesaler or the pharmacy really have any control over the price of the drug, right, that's going to come from the manufacturer?

SUPERINTENDENT VULLO: I'd assume so.

ASSEMBLYMAN RAIA: Okay. And then how do we gather that information with respect to Internet sales?

SUPERINTENDENT VULLO: So that would -- that's an interesting question. I mean, you know, Internet is always an issue of when does it come into the state. The idea, you know, would be to track it and that way -- again, this is not something that I would do at DFS, this is something that would be done through Tax & Finance, which addresses these issues all the time in terms of ensuring that sales taxes and other types

of taxes are collected appropriately.

ASSEMBLYMAN RAIA: All right. Then I'd be a little bit worried about interstate commerce issues on that as well.

Thank you, Commissioner.

SUPERINTENDENT VULLO: Thank you.

CHAIRMAN FARRELL: Thank you.

Senator?

SENATOR KRUEGER: Senator Marty Golden.

SENATOR GOLDEN: Thank you, Madam Chair.

Thank you, Superintendent, for being here today and for your testimony. I'll be brief. Do you like that, Kemp?

The -- I too have some reservations as to the regulation of PBMs. But I'm going to tell you right now, you definitely raise the bar when it comes to talking about the mail-order pharmacies that are controlled by these PBMs and what it's cost us here in the State of New York. Since most of these pharmacies are outside the State of New York, we don't know what are the monies coming in

and the profits and how they're being taken, and we should. And we should be able -- this is at a disadvantage to our local pharmacies and to the employment here in the City and State of New York.

So you've definitely raised, I believe, a serious question here and hopefully we can assist you and work with you and hopefully get some answers.

I'm going to go to another issue which I don't think has been brought up, and that's the cybersecurity. We understand that you've taken over some areas of cybersecurity that we believe is very important. I don't think you go forward enough, I think, on the local end of it -- the actual grand larceny, the actual skimmer devices, those types of areas. But we need to give you the tools that you need, that you require to be able to make this great state safe and the leader in cybersecurity.

And your thoughts on what you may need and your thoughts on where you think the state can go in adding to that legislation.

SUPERINTENDENT VULLO: So thank you, Senator Golden.

Actually, that's a timely question. We actually this morning issued our final cybersecurity regulation and the DFS role in this, in our cybersecurity regulation, is a regulation that requires the financial services industry -- so the banks and the insurance companies -- to establish cybersecurity programs and policies so that they are protecting New Yorkers in their identities and their personal data and of course from terrorist activities. You know, for example, banks which actually not only have data, but they also have cash, that a cyberattack could get into that and could have some very serious consequences to our financial industry in New York. So that's DFS's role.

The Governor has certain proposals for cybersecurity that are different, they're sort of homeland security type of proposals. That's not my agency. I am focused on how do we protect our financial industry and

requiring them, by regulation, to develop risk-based programs to protect the institutions.

And what I would say on that is I wish the federal government would do something on this too, but that's -- you know, because we're first to actually do something about the financial services industry and requiring them to have programs.

Now, many of them have it already. But I think it's really important to require it and for us to be ever-vigilant, because an attack on the financial services industry is -- it's what keeps me up at night. And certainly kept me up at night before the Affordable Care Act problems came into play this year. But that's what really keeps me up.

SENATOR GOLDEN: Thank you very much, Superintendent.

SUPERINTENDENT VULLO: Sure.

CHAIRMAN FARRELL: Thank you.

Assemblyman Cahill.

ASSEMBLYMAN CAHILL: Thank you,

Mr. Chairman.

Superintendent, I'd like to just go back to the issues of the powers, duties and responsibilities again. Let's start with the penalty question, a little more specific. How much did DFS raise with penalties in 2016?

SUPERINTENDENT VULLO: So I don't have the exact number, but it's over a billion dollars.

ASSEMBLYMAN CAHILL: Over how much?

SUPERINTENDENT VULLO: A billion dollars.

ASSEMBLYMAN CAHILL: With a B, billion?

SUPERINTENDENT VULLO: B.

ASSEMBLYMAN CAHILL: Okay. And where does that money go? Does that go straight into the General Fund, or does it go elsewhere?

SUPERINTENDENT VULLO: Every penny that I collect goes into the General Fund, the operating fund.

ASSEMBLYMAN CAHILL: And with the

thousand-percent-increase proposal, how was that percentage arrived at, that multiplying fines by 10 times?

SUPERINTENDENT VULLO: The proposal on fines is specific to the Insurance Law. And it's moving 1,000 to 10,000 as the per-violation fine, or treble damages or the sort of economic gain, the greater of those things. So I don't know how the -- I don't think we're using that percentage thing. That's what the specific proposal is with respect to the Insurance Law.

ASSEMBLYMAN CAHILL: Why wasn't it decided to be 5,000 or 20,000? Why was it 10,000?

SUPERINTENDENT VULLO: You know, it used to be 500 and it went to a thousand. So we don't think a thousand is sufficient to deter for the types of things that we see at times. And so we thought 10,000, but we thought that the more important one was to have it be the greater of that amount or economic gain, which would work in both directions. So if you have a very large

benefit that a company has gotten from malfeasance, then you could look at the economic gain. If it's a very small company and that fine, you know, would be too much, then you can sort of take that into account as well.

As we do. I can tell you that when we impose any fines, we look at the size of the company and the ability to obviously pay the fine, but also the deterrent purpose, which is really what it's about. Separate and apart from we often get money back to consumers, you know, in restitution where warranted. That's the analysis.

ASSEMBLYMAN CAHILL: And what do you believe to be the fiscal of multiplying the fines times 10 and introducing these other conditions that would allow for significantly higher fines? Would it be 10 billion, to go from a billion?

SUPERINTENDENT VULLO: Yeah, I don't -- it's hard for me to -- I mean, it certainly would have a fiscal impact to it because it would increase fines that go in.

But again, we don't necessarily take that fine, we negotiate those fines. Almost everything that we do is through consent order, and we negotiate them. But it certainly would have a fiscal impact to, you know, add to that. And again, these fines are specific to -- the ones that I'm talking about -- the insurance industry.

Quite honestly, the $1 billion is more on the banking side, the $1 billion that I mentioned is more on the banking side. And I'm not -- what I'm seeking on the banking side is the lending authority. Because that's just a -- frankly, a gap. It's a gap that needs to be filled. And there's also a gap on that side for the small dollar loans that I believe very strongly needs to be filled to prevent predatory lending.

ASSEMBLYMAN CAHILL: I would be very interested in hearing what people believe to be the fiscal impact of raising the fines time 10.

I recognize that, you know, just like when we raise the cigarette taxes, some

people give up cigarettes, but -- and maybe some people will give up violating the rules if you --

SUPERINTENDENT VULLO: That's the hope.

ASSEMBLYMAN CAHILL: That's the hope. But certainly it would result in a significant change in revenue. And this is real money. I mean, when you're talking with B's, it's real money.

SUPERINTENDENT VULLO: Well, certainly if you're talking about economic gain, it's both real money and it's deterrence. And, you know, I just want to be clear here, I'm not proposing these things because I'm looking to sort of just collect more money. I am proposing it because I believe that it's really essential that there be an appropriate punishment that fits the malfeasance so that the conduct doesn't occur.

Obviously, there will people that violate the law, that's just the reality of society. But I really want to stop the behavior. And it's really difficult when you

have somebody filing a false statement and you can only say a thousand dollars.

And it's in those cases where I would say, well, what's the economic gain from that false statement? It's not even the $10,000, right, it's the economic gain that I would look for in those circumstances, because those are circumstances where someone is doing that -- and again, it's a narrow group -- doing that for personal profit, and not being forthcoming and candid with the regulator. And so that's really where I'm focused on these.

But it obviously has a fiscal impact. And of course in the insurance industry the fiscal impact to the state of any malfeasance, which is also relevant to the bad actors bill, is that, you know, what if there's another failure? We have a guarantee fund. The rest of the industry pays for that.

So there's lots of fiscal impacts that we would like to prevent by legislation that permits us to sort of address malfeasance in

an appropriate way.

ASSEMBLYMAN CAHILL: You're in the department that deals in probabilities and likelihoods and risks and returns and so on and so forth.

SUPERINTENDENT VULLO: All the time.

ASSEMBLYMAN CAHILL: So I would hope that you will be able to provide us with a snapshot of what would be anticipated to be raised in the budget. Since it goes to the General Fund and we're facing a $2.5 billion deficit, it's raising a billion dollars right now, being increased times 10 -- if it doubles or triples, it could erase the deficit. It would be good to know that. That's important budgetary information.

SUPERINTENDENT VULLO: Appreciate it.

ASSEMBLYMAN CAHILL: In terms of administrative supervision, you're seeking to expand the powers for administrative supervision. Can you -- you can do it now, can you not?

SUPERINTENDENT VULLO: No. And I'm glad you asked that question, because it's

quite important. Currently, for problematic insurance companies, I have two powers. I put them into liquidation, I can put them into rehabilitation. The rehabilitation route hasn't worked particularly well to actually rehabilitate the company, as opposed to it just being a transition into liquidation. And both of those processes are court processes.

The administrative supervision bill, which is a National Association of Insurance Commissioners, NAIC, model act that 31 states have, that statute would give me the authority to basically put an administrative supervisor into the insurance company to prevent something before it gets worse.

ASSEMBLYMAN CAHILL: So --

SUPERINTENDENT VULLO: Utilizing the same standards that I could use for liquidation and rehabilitation, but hopefully to prevent something before it gets too far.

And I can say that the reason for this, in my judgment, is there are circumstances where bad management leads to a

company not being managed as well as it could and could result in both a liquidation proceeding and a hit to the guarantee fund. And I think that's why this is a power that the NAIC believes insurance commissioners should have. There's a model act, and we can do it.

You know, this has been something that the department has wanted for a while. I've pushed it forward, quite frankly, because I think it's really important. Health Republic is not irrelevant to this issue. Health Republic cooperated, so they consented. If Health Republic didn't cooperate and consent and we had some, you know, blowup in a court proceeding, we wouldn't have been able to transition. It could have been worse.

ASSEMBLYMAN CAHILL: So I just want to --

SUPERINTENDENT VULLO: So I think, you know, there's -- but that's not the -- this is a bill that, again, the NAIC has had a model act.

ASSEMBLYMAN CAHILL: This is the same

as the NAIC act, it doesn't differ from the model act except to make it New York-specific? Or does it go beyond the model act?

SUPERINTENDENT VULLO: It's modeled on the model act. I don't want to say that there's no specific change, but it's intended to be modeled on -- for the administrative supervision.

Where it's modeled on, in addition to the NAIC, is Article 74 of our Insurance Law, which has the standards for liquidation and rehabilitation. Those same standards would apply. So if somebody refuses to provide information to us, refuses to testify under oath, I can insert a monitor in there to ensure that we get the information that we need, for example. So, you know, I'm told, Well, you have the authority to get all this information. What if the company fails to give me the information that I have the authority to get? Right? So this helps me to be able to impose a monitor to get that.

And again, it's for the malfeasance,

the ones that management is not cooperative.

ASSEMBLYMAN CAHILL: Understood.

SUPERINTENDENT VULLO: That's not a lot of not -- it's not a lot.

ASSEMBLYMAN CAHILL: So in each of these instances, that and for bad actors as well, these are authorities that you have but you have to have some level of court intervention before you can exercise that authority, and the authority that you have isn't as broad as you would like.

In addition, for the bad actors piece -- and this will be my last question -- there is -- one of the circumstances under which you can ban a bad actor is for an unsafe or unsound practice.

SUPERINTENDENT VULLO: Right.

ASSEMBLYMAN CAHILL: Is that term defined anywhere, unsafe or unsound practices?

SUPERINTENDENT VULLO: Not in it. But safety and soundness is what we do at DFS every day. Right? So that's the test of financial safety and soundness that we apply

in our supervision of the financial services industries that we supervise. And so there are a lot of unsafe and unsound business practices that, you know, would fall under that. So that's a --

ASSEMBLYMAN CAHILL: But the definition would be up to you. There's nothing in the statute, or you're not proposing any specific definition or parameters for what would be an unsafe or unsound practice, is that a correct understanding of what's being proposed?

SUPERINTENDENT VULLO: Well, under that particular one. There's lots of other provisions in terms of, you know, violation of orders and all of the like that we're also proposing this.

But again, what we would do in this circumstance, if we determine that there was an unsafe and unsound practice, we would bring a charge against the company, we'd lay out the facts and there would be a process that they have due process. And if they disagree, the individual that we say is

banned, disqualified, they can go to court and they can overturn it if they disagree with us and a judge were to agree.

ASSEMBLYMAN CAHILL: Thank you.

SUPERINTENDENT VULLO: So it does have due process and a court proceeding connected to it.

ASSEMBLYMAN CAHILL: Thank you.

CHAIRMAN FARRELL: Thank you.

SENATOR KRUEGER: Thank you.

Senator Diane Savino.

SENATOR SAVINO: Thank you, Senator Krueger.

Thank you, Superintendent. Nice to see you again. I just want to ask you about this issue of lending circles. I know the Governor has some language in his budget that would allow you to regulate lending circles in New York State. And I'm just curious if you could kind of tell us a little bit more about what lending circles are, how many there are in New York, any other states that regulate them, and do we have any evidence to suggest that there's some fraud in these

lending circles. What is a lending circle?

SUPERINTENDENT VULLO: No. This is actually -- this is actually a great positive. A lending circle, these are nonprofit organizations that provide no-interest, no-fee loans to consumers to help build credit.

So one of the biggest problems that we have in certain underserved communities is the inability of people to actually get a loan because they don't have credit, or to sort of have other types of financial services because they don't have credit. So these lending circles are nonprofit organizations that are providing no-interest and no-fee loans to consumers.

And all we are asking for in this bill is to allow them to do this. And all they have to do is register. It's not a big regulatory thing. And what the bill requires and mandates is -- to just ensure that this is no-interest, no-fee, is they can't have a profit motive in that. And it is purely to actually assist in the building of credit.

California has this program, and there are some nonprofits. And if we can pass this bill, then it allows them to actually, you know, do this. But it's regulation-light, if that. It's not intended to do anything to impact them, but to actually encourage that type of activity. And frankly, if we can get that information, we could help with some of the underbanked and the credit issues that we have. So that's why we're proposing it.

SENATOR SAVINO: Where do these nonprofits get access to the capital? Where do they get the money that they lend?

SUPERINTENDENT VULLO: Good philanthropists.

SENATOR SAVINO: Really.

SUPERINTENDENT VULLO: Yup.

SENATOR SAVINO: And so they have this model in California.

SUPERINTENDENT VULLO: Yes.

SENATOR SAVINO: Would this replace like the lending that's done by like the CDFIs, or would it supplement it? Would it be personal lending? Would it be for

business lending? Or does it -- would it be able to --

SUPERINTENDENT VULLO: Yeah, it's not intended to supplement anything else, it's just intended to bring these entities that are doing -- and there's, you know, one major one in particular in California -- to sort of try to encourage that here in New York as well, and others like it.

So it's a credit-building thing, it's not intended -- I mean, the CDFIs, they're all great too. But it's not intended -- I mean, this is -- again, it's no-fee, no-interest loans solely for the purpose of credit building. And, you know, they're nonprofits that have their financial backers, basically.

SENATOR SAVINO: So you wouldn't be regulating the product, you would just be regulating the lender, right? Because --

SUPERINTENDENT VULLO: Yes. Yes. And making sure that it really is nonprofit and there's not a -- that it's working for its intended purpose.

And I think it would help sort of grow credit for New Yorkers in a way that could help us in other things that we're trying to do, quite frankly, to sort of expand financial services to all communities in the state. Because it's -- it is a -- it's a concern of ours.

SENATOR SAVINO: And again, do we know of any lending circles that are operating in New York, and how many there are?

SUPERINTENDENT VULLO: No. We know that there's one operating in California.

SENATOR SAVINO: Interesting. Thank you.

SUPERINTENDENT VULLO: Sure.

SENATOR KRUEGER: Thank you.

CHAIRMAN FARRELL: Thank you.

SENATOR KRUEGER: And that's our last Senate question, so thank you very much for coming today to testify.

SUPERINTENDENT VULLO: Thank you. Thank you for having me.

SENATOR KRUEGER: And our next testifier is Dennis Rosen, the inspector

general, New York State Office of Medicaid Inspector General.

And for those keeping track, this is our 11:30 a.m. testifier. And so for those of you who are scheduled for 7:30 tonight, you know, go get the sleeping bags, get comfortable, and come back with your overnight material.

CHAIRMAN FARRELL: We've been joined by Assemblywoman Yuh-Line Niou.

SENATOR KRUEGER: Good afternoon, Dennis.

INSPECTOR GENERAL ROSEN: Good afternoon.

SENATOR KRUEGER: We have your testimony.

If everybody would take their conversations outside. Thank you.

INSPECTOR GENERAL ROSEN: Okay. Should I start?

I appreciate this opportunity to share with you the activities and initiatives of the Office of the Medicaid Inspector General.

OMIG’s efforts to protect the

integrity of the New York Medicaid program continue to serve as a national model. Our investigative work, partnerships with state and federal law enforcement agencies, innovative auditing techniques, and OMIG's extensive compliance initiatives and provider education efforts are projected to result in more than $2.3 billion in cash recoveries and cost savings for 2016.

A core function of OMIG is identifying and recovering Medicaid overpayments. Preliminary numbers indicate 1,724 audits were initiated and 1,707 were finalized in 2016. Cash recoveries for 2016 -- including audits, third-party liability, and investigations -- total more than $418 million, representing an increase of more than $79 million over our 2015 cash recovery.

In addition to pursuing cash recoveries, OMIG's cost-avoidance efforts prevent, up front, improper Medicaid costs and billings. Proactively eliminating improper payments in the first place is far

more cost-effective than later identifying and chasing after dollars that have been paid out inappropriately. According to preliminary data, OMIG's cost-avoidance initiatives for 2016 saved nearly $1.9 billion.

OMIG works both independently and in collaboration with partners at all levels, including local, state, and federal law enforcement, provider organizations, and managed care plan special investigation units. OMIG also plays a critical role in collaborative law enforcement actions that result in the takedown of major fraud schemes, enrollment fraud arrests, and drug diversion cases.

For example, OMIG's pharmacists and investigators worked with the Attorney General's Medicaid Fraud Control Unit to obtain the conviction and sentencing in 2016 of Long Island-based pharmacists Ira Gross and Glenn Schabel for their roles in a massive black-market HIV prescription drug ring. The scheme involved the sale of more

than $274 million worth of diverted, medically worthless medications from wholesalers in multiple states to Medicaid recipients in New York State. The pair were sentenced to lengthy prison terms and ordered to pay back more than $30 million to the Medicaid program.

As part of the fight against opioid abuse, OMIG has been very involved in drug diversion cases. For example, in 2016 OMIG investigators provided critical evidence that helped lead to the conviction of Brooklyn pharmacist Kian Gohari for illegally distributing more than 25,000 medically unnecessary oxycodone pills between 2012 and 2015. Gohari's accomplices bought prescriptions for oxycodone and other high-price medications from patients, filled them, and then sold them on the black market throughout the New York City metropolitan area. He was convicted in federal court in November of conspiracy to distribute narcotics and conspiracy to commit healthcare fraud, and he faces up to 30 years in prison.

Prescription opioid abuse is a recognized national healthcare crisis, and New York is not immune, as you all know. A key tool in OMIG's arsenal to address this epidemic is its Recipient Restriction Program, which prevents duplicate prescription fills through doctor or pharmacy shopping by restricting patients suspected of overuse or abuse to a single designated provider, pharmacy, or both.

Preliminary data for 2016 show that 1,961 of the 2,331 Medicaid recipients whose files were reviewed were recommended by us for restriction to the appropriate managed care plan, county agency, or New York State of Health. As a result, more than $58 million in cost savings to the Medicaid program was realized.

Also, OMIG is a member of the Federal Healthcare Fraud Prevention Partnership. Working with the Centers for Medicare and Medicaid Services, the Department of Justice, the FBI, and national insurance companies, OMIG helped identify practices and strategies

to address opioid abuse in general, and opioid prescription abuse in particular. On January 19th of this year, the Partnership released a white paper entitled Healthcare Payer Strategies to Reduce the Harms of Opioids, which arose out of this collaboration. It describes best practices to address the dangers of opioids while ensuring access to necessary therapies and reducing fraud, waste, and abuse.

Overall, OMIG's 2016 preliminary enforcement activity statistics are robust. OMIG opened 3,493 investigations, completed 4,418, and referred 1,079 cases to law enforcement and other agencies. Referrals include 155 to the New York State Attorney General's Medicaid Fraud Control Unit and 924 to the New York City Human Resources Administration and other federal, state and local agencies. In addition, preliminary 2016 data show OMIG issued 929 Medicaid exclusions.

OMIG’s Managed Care Investigation Unit meets regularly with, and receives complaints

from, managed care organizations relating to network provider fraud, and works with their special investigation units to develop comprehensive investigative plans. Preliminary data for 2016 show that referrals from MCOs to OMIG totaled 518, up from 344 referrals in 2015.

OMIG has also worked closely with the State Department of Health in developing amendments to the Managed Care Model Contract to enhance program integrity. These amendments include the creation of a clearance process to ensure that OMIG and MCOs are not duplicating audit and investigative efforts; the submission by each MCO of a quarterly report showing all Medicaid overpayments it has identified or recovered; a provision enabling OMIG to obtain MCO assistance in recovering overpayments made to network providers identified by the state; and provision allowing an MCO to share in recoveries made as a result of a referral to OMIG. The model contract is currently under federal review.

Lastly, OMIG continues to emphasize provider outreach and education, particularly in the area of compliance. Through a comprehensive array of webinars, guidance materials, self-assessment tools, protocols, and presentations, OMIG's oversight activities and educational efforts increase provider accountability, contribute to improved quality of care, and save taxpayers dollars.

In 2016, OMIG issued 15 compliance-related guidance materials and conducted more than a dozen educational presentations and seminars. The compliance section of the OMIG website is among the site's most active areas, with close to 40,000 visits to compliance webinars, over 30,000 visits to compliance publications, and more than 40,000 visits to compliance resources and FAQs. Many of our webinars are accredited for legal, accounting, or compliance continuing-education credits. In 2016, we had 439 participants receive credits, up from 428 in the prior year.

With the transformational changes occurring in the Medicaid program, OMIG's commitment to protecting the integrity of the program and ensuring a cost-effective, sustainable healthcare delivery system remains unwavering.

Thank you. I am certainly happy to address any questions. I'd ask you to speak up. If you remember last time, sitting down here, I had a little problem.

SENATOR KRUEGER: Thank you very much.

INSPECTOR GENERAL ROSEN: Let's try it. But if you could speak up, I'd appreciate it.

SENATOR VALESKY: We have extra chairs up here.

INSPECTOR GENERAL ROSEN: I will -- I'll be up there. In fact, I think that gentleman over there was one of the hardest for me to hear.

But if you have questions, I'm happy to answer them either here or up there.

SENATOR HANNON: I have no questions. Each time I had a question in my mind, you

answered it in the next paragraph of your testimony. Thank you.

SENATOR KRUEGER: I just have one question.

INSPECTOR GENERAL ROSEN: Yup.

SENATOR KRUEGER: So I believe it's Erie County, it might have been a couple other counties of the state -- maybe I'm wrong on Erie County. One of them, at least -- one of our counties has started a lawsuit against some of the opioid drug makers for their falsifying and -- basically falsifying information and basically marketing their drugs even when they knew what was going wrong, and that they are attempting to challenge -- that this violated the law.

Is there any parallel role for you in that kind of work?

INSPECTOR GENERAL ROSEN: We're aware of that, and I've had discussions. But in terms of a lawsuit of that nature, there is no role for us.

I think the largest role we have that

is often not fully realized by the public or even you folks is that we work extensively, as I touched on in the statement, with other law enforcement agencies on drug diversion cases, opioid abuse, and other related kinds of cases.

And what will happen is you will read about a major case brought by the Department of Justice or, say, MFCU, or even a local district attorney, particularly in New York City -- and you very often might not see our name in it, because they will issue a press release talking about the case where they will thank us for having worked the case up and then coming to them to prosecute it.

But when they release the information to the public, it's somebody's just been indicted, that's the focus of the story, and that's about the DOJ or the AG's office or the district attorney. But you can bet that in most cases where there's a major drug prosecution, we've been involved.

And we have put a lot of work into it. Usually we'll testify in the grand jury, but

it will be released by the prosecutor, the story. And again, their press releases are usually very grateful to us. They might even have a quote from me, but it's not that likely to make it into the press.

But again, our major efforts are focused on the undercover stings. I mentioned our Recipient Restriction Program -- the folks that do that do a wonderful job, too, of tracking prescribing patterns by doctors or prescription filling patterns by recipients. So we'll see, for example, patterns where you've got doctors in Queens who have a clientele that consists of people 300 miles upstate that are coming down there for prescriptions for dangerous medications. And our folks will spot that, they will see those patterns, they will look at recipients' patterns, for example, in the examples that I gave with respect to putting people on restricted programs.

They do a wonderful job of tracking what medications Dennis Rosen is taking, how many of them he's taking in a month, and is

it off the charts. And we really have been emphasizing that, because when I first came to the agency, frankly, I got a phone call that my secretary put through from a guy who turned out to be the father of a 20-something-year-old son who had just had his third emergency admission because of an opioid abuse. And again, this kid was going to two or three pharmacies, getting the same prescription filled.

So we have really put an emphasis on that, and that's where our focus has been in these kinds of situations.

SENATOR KRUEGER: Thank you very much.

Assembly?

CHAIRMAN FARRELL: Thank you.

Assemblyman Gottfried.

ASSEMBLYMAN GOTTFRIED: Yeah, I actually don't have a question, I just wanted to say you and I have met several times and talked through a lot of interesting issues. And I just wanted to say, as far as I can tell, you're doing a very good job. You bring in money, you're helping to reshape

behavior, and nobody has complained to me about anything you've ever done.

INSPECTOR GENERAL ROSEN: You haven't even gotten a call from my wife?

(Laughter.)

ASSEMBLYMAN GOTTFRIED: So keep it up.

INSPECTOR GENERAL ROSEN: Now, I do want to say that, you know, we're in a tough role because we -- I want to do good law enforcement, and I want to bring in money that's been improperly collected so that we can put it back into the program for good providers and for recipients to get services that they need. And particularly with the global cap, that's very important.

But what is also important to me as a regulator -- and I've always exercised this kind of policy in other places that I've been -- is that we do the reach-out to the people that we're regulating and the people that sometimes we might even do an audit of, or go after in some fashion. And that's why, frankly, I think our numbers are very good with respect to enforcement and what we are

bringing in.

But on a personal level, the numbers that also appeal to me as much are the ones at the end that some people may think are a little superfluous, but about the kinds of outreaches that we do. And that's a reflection of conversations that people such as myself and other folks at the agency have with the industry, where we try to be engaged.

And I think if you are going to regulate people, you had better know what their issues are and you also better indicate to them what your perspective is, and what you think is important and what you don't think is important, and what their safe harbors are.

So again, I appreciate the conversations with you, because you help to clue me into what's going out there in the world. Because the last thing I want to do is regulate a significant industry like this that impacts the public so importantly and not have a good sense of what's going on out

there.

So again, I appreciate -- with a number of you -- the conversations that we've had.

CHAIRWOMAN YOUNG: Thank you.

CHAIRMAN FARRELL: Thank you.

CHAIRWOMAN YOUNG: Inspector General, I had a few questions.

INSPECTOR GENERAL ROSEN: Yes. And again, please speak up so I don't have to sit next to you.

CHAIRWOMAN YOUNG: Okay. Yeah, I remember that from last year, that you were actually -- you actually joined us on the dais.

So can you hear me now?

INSPECTOR GENERAL ROSEN: I'm sorry?

(Laughter.)

CHAIRWOMAN YOUNG: You've had so many titles, it's hard to keep track of. But I'm glad you're "Inspector General" now.

INSPECTOR GENERAL ROSEN: See, I'm starting to get an echo with you now. So if -- can I come up? Or can you repeat it a

little slower?

CHAIRWOMAN YOUNG: Okay. Well, I'll ask -- how about this. I'll ask my first question. Is OMIG currently on track to meet its audit recovery target for the current fiscal year?

INSPECTOR GENERAL ROSEN: An audit target for the fiscal year, did you say?

CHAIRWOMAN YOUNG: For the current -- so the current -- the recovery targets for this year are $1.16 billion, correct?

INSPECTOR GENERAL ROSEN: Let me -- I've got to come up there. I'm just having trouble hearing you.

I could hear fine in the audience. I'll just -- I'll get your question and then I'll sit down.

CHAIRWOMAN YOUNG: Okay, I guess we can do --

INSPECTOR GENERAL ROSEN: I'll sit down.

CHAIRWOMAN YOUNG: Okay. Well, I was asking about the $1.16 billion target for the recovery this year for OMIG. And are you on

track for that?

INSPECTOR GENERAL ROSEN: Yes, we are.

CHAIRWOMAN YOUNG: Okay. We need a mic.

SENATOR KRUEGER: The answer was yes, they are.

CHAIRWOMAN YOUNG: How about this. Why don't we --

INSPECTOR GENERAL ROSEN: Yes.

CHAIRWOMAN YOUNG: Okay. Does that work?

INSPECTOR GENERAL ROSEN: Yes.

CHAIRWOMAN YOUNG: Okay, great.

So you are on track for the recoveries this year. What new auditing strategies and technological innovations is OMIG now using or considering adopting in the future to improve Medicaid fraud recoveries?

INSPECTOR GENERAL ROSEN: We are constantly upgrading our software. We're constantly interfacing with ITS, we have private vendors that we deal with. And what we've done in terms of dealing with an industry that's really, as you all know,

incredibly transformational at this time is we form project teams from all different units, so you've got people representing every aspect of the agency where they focus on specific issues that have to do with what's happening in healthcare today.

So, for example, you were talking about PBMs earlier and some of those issues. We have a pharmacy team. We have a managed care team that looks at counter data, and how it can be improved, and looks at -- is starting to look at the data that network providers -- that is, providers within a managed care plan, at their data regarding their expenses and what they should get paid and comparing that to the MCO's data that's paying them, in counter data. So we are getting educated with respect to that.

We've got a project team that deals just with data issues to make sure they are always, as best we can, within physical constraints on the cutting edge of the kind of software that we need to do the kinds of things that I was talking about earlier. And

to keep those numbers up and hopefully to keep those rising.

So those are examples of how we are trying to stay current. And, I mean, I have been in a number of positions with the state, leadership positions, and I have never been in a position such as this with as many challenges, frankly, as we have because of the incredibly transformational changes that are going on within this industry. Just to move from fee-for-service to managed care is incredible in terms of all the implications it has, not just for the delivery of care but even the metrics by which we measure whether or not the job is being done.

You know, we've attended countless meetings on value-based payments, which is a whole 180-degree difference from fee-for-service, where you're paid for service. Now you're going to be paid based on, is Dennis Rosen better for having gone to you for services? If he's not, you're at risk of not doing very well.

So those are the kinds of things that

we're trying to do.

CHAIRWOMAN YOUNG: That's one of the things that you didn't hear me say earlier, was I've called you many titles over the years --

INSPECTOR GENERAL ROSEN: Yeah.

CHAIRWOMAN YOUNG: So now "Inspector General."

But -- so it sounds to me like you're more focused on recoveries from providers than beneficiaries.

INSPECTOR GENERAL ROSEN: Generally, we are. But again, we will do recipient reviews, as I said, to see if, for example, somebody's getting the same prescription filled three times. Which, one, takes money out of the system improperly and, two, is very dangerous for the recipient.

But usually the strategies involve things like them going to, say, the managed care plan and saying okay, Rosen needs to be put on a restrictive program where he's got one doctor, one pharmacy, that sort of thing.

We have collaborated with numerous

prosecutorial agencies -- for example, there are a couple of prosecutions last year through the Manhattan DA's office that we were very involved in where there were folks living in houses that were worth over $1 million who were collecting Medicaid.

CHAIRWOMAN YOUNG: I saw those stories.

INSPECTOR GENERAL ROSEN: And we did a lot of the groundwork on that, put a package together and went to the -- we went to the Manhattan DA's office, where we worked collaboratively, and there were indictments as a result then.

CHAIRWOMAN YOUNG: Do you see any regional variations or trends?

INSPECTOR GENERAL ROSEN: Most of the major problems are throughout the state. For example, opioid abuse. Frankly, I think one reason why it's getting so much attention now is that it transcends all areas and all classes. It's just not a working-class or a poor person's dilemma now.

When I started out as a young lawyer,

I was with the Legal Aid Society of New York City for 10 years, in different positions, and I saw -- there was an opioid crisis then. But you didn't hear that much about it because it was mostly limited to poor people who needed Legal Aid lawyers when they got in trouble. Well, now it's not that way anymore.

So most of the trends that we see, frankly, tend to be statewide.

CHAIRWOMAN YOUNG: Thank you.

Has outreach to providers regarding compliance resulted in higher response rates?

INSPECTOR GENERAL ROSEN: I think that -- you know, people will say: How much fraud is there out there? The GAO, for example, recently said it's 10 percent; some say higher.

But I do think that everything I look at, and I've tried to -- I've been in this for almost two years now, and I've tried to get educated on what the trends have been over the years -- and I think in many areas there is better compliance now than there

was, say, five or 10 years ago.

And I think that has a lot to do with outreach efforts, with telling the industry -- I think there are a lot of folks out there who want to comply, but they don't have the right checks and balances, they don't have the right program-integrity program that they've established.

We've got a Bureau of Compliance that goes out and tells people how to put a program together, they'll audit people's programs -- not to recover money from them, but to explain to them how they can improve their program integrity to be more in compliance with federal or state standards so that they can avoid the money going out improperly. I think --

CHAIRWOMAN YOUNG: So it's not always a gotcha mentality.

INSPECTOR GENERAL ROSEN: Yeah. I think -- I mean, I've been dealing with fraud and waste in one facet or another my whole professional life, as an attorney and in other respects, and I think, in my view, the

majority of money that is improperly spent is done so out of somebody just not knowing how to do it right -- having the right checks and balances in place, so there isn't the waste.

Obviously there's, you know, other kinds of fraud too, and we're very involved with that with the prosecutors that I've mentioned. But a lot of the money that's wasted is wasted because people don't put the right checks and balances in place.

CHAIRWOMAN YOUNG: How do you --

INSPECTOR GENERAL ROSEN: And we do help with that. And that's why, again, I'm very pleased with the kinds of statistics we've got in terms of people going to the website and doing our webinars.

CHAIRWOMAN YOUNG: How do you work with the Attorney General in compliance issues?

INSPECTOR GENERAL ROSEN: We have a very good relationship with the Attorney General's office. We have a statutory obligation that if we find a level of wrongdoing that rises to fraud -- where, for

example, you might -- it might be appropriate to have a criminal prosecution -- we have a statutory obligation to refer that case to the Attorney General's office.

Sometimes they will look at a case and give it back to us. But we work very closely with them. And as I said earlier in my comments, very often we'll work up a case, we'll bring it to them, they'll bring an indictment, and we'll continue as -- our folks will be witnesses and provide sometimes auditing data throughout the prosecution. So we have regular meetings with them, and I think it's a very good relationship.

CHAIRWOMAN YOUNG: Thank you for the face to face. I appreciate it.

(Laughter.)

INSPECTOR GENERAL ROSEN: Yeah. You're very welcome.

CHAIRWOMAN YOUNG: Okay. Anyone else?

No? Senator Rivera?

(Unintelligible.)

CHAIRWOMAN YOUNG: Okay. Well, thank you. Thank you, Inspector General.

INSPECTOR GENERAL ROSEN: Okay.

CHAIRWOMAN YOUNG: Okay, now what I would ask -- I'll read off the next three witnesses. So if you're the person coming next, and that's Stephen Hanse, president and CEO from -- oh, I'm sorry, first we have Bea Grause, president of the Healthcare Association of New York State, HANYS. Following President Grause there will be Steve Hanse and Mark Olsen. And then following them, it will be Laura Haight and Claudia Hammar.

So I'd like to welcome President Grause. Thank you for being here, and thank you for waiting so long.

MS. GRAUSE: Oh, sure.

Thank you, Senator Young. Thank you, Chairman Farrell, and other distinguished members of the joint hearing.

My name is Bea Grause. I am the CEO of Healthcare Association of New York State. We represent about 500 not-for-profit hospitals, health systems, home health agencies, nursing homes, and other providers.

By way of background, I'm a registered nurse by training and also an attorney, and I've spent the last 25 years in the policy field in Washington D.C., in Vermont, and now in New York State.

On behalf of all of our members across the state, we thank you for your time today and thank you for your support on the many healthcare issues that we have been discussing today.

You have my written testimony, and I'm just going to focus on three topics.

CHAIRWOMAN YOUNG: Thank you. You are a great role model for the following witnesses, so thank you.

MS. GRAUSE: Well, I am certainly mindful of your long day and the 49 people behind me.

So the first topic is ACA repeal, and I think we've talked a lot about that today. It is something we are laser-focused on, it is something the U.S. House is considering today, coming up with an ACA repeal bill that would change Medicaid, so we are very

concerned about that.

Our top concern around that is loss of coverage for the 2.8 million New Yorkers who gained coverage under the Affordable Care Act, the economic impact to the State of New York to counties, and also to providers across the spectrum. In addition, as we have been talking about today, the impact on healthcare reform and all the progress that New York State has made prior to the Affordable Care Act and during the tenure of the Affordable Care Act is also at risk.

So turning to the budget, I'll just briefly talk about the issues that we support and the issues that we are watching. Again, as was raised today, we are supportive of the capital funding in the Governor's budget -- very important for that -- for healthcare reform efforts. We also are supportive of the concept of the regulatory modernization effort, have been speaking with Deputy Commissioner Shepherd about that, and also the other various flexible funding -- including value-based payment for the next

budget year. Again, taken together, those three initiatives are important for the multiyear effort of improving our healthcare system.

In addition, we urge you to consider additional funding for financially distressed hospitals. There are 27 on the watch list for the Department of Health currently. We're concerned -- and those hospitals are in rural and urban areas all across the state. We are concerned that that number will go up, and again urge you to pay particular attention to financially distressed hospitals.

And then, in addition, we support a number of other initiatives, but particularly the Doctors Across New York. You can't provide healthcare without healthcare workers, and recruiting and retaining healthcare physicians and other healthcare workers is critically important.

Turning as our third topic to issues that we are watching, again as has been discussed today, we do not support the budget

superpowers that have been discussed earlier.

We also don't -- Senator Young, as you raised, we have questions and do not support the potentially preventable emergency room visits for all the issues that you raised. In addition to that, it may disproportionately hurt areas where there is a significant number of Medicaid recipients, particularly in areas where there's not the primary care infrastructure in that community.

And then lastly, there are various other cuts I won't mention -- but again, that's in our written testimony -- that we are watching and will continue to work with you as you work through the details of the budget.

With that, I'm happy to take your questions and look forward to talking with all of you in the weeks to come.

SENATOR KRUEGER: Senator Savino, did you have a question?

CHAIRMAN FARRELL: Questions?

CHAIRWOMAN YOUNG: No? Okay.

CHAIRMAN FARRELL: Thank you.

CHAIRWOMAN YOUNG: Well, thank you very much.

MS. GRAUSE: You're welcome.

CHAIRWOMAN YOUNG: We appreciate you being here and everything that you do.

MS. GRAUSE: Thank you.

CHAIRWOMAN YOUNG: And we'll take your suggestions under serious review and consideration.

Our next speakers are from the New York State Health Facilities Association, and that's Stephen Hanse, president and CEO, and Mark Olsen, administrator for the Kingsway Community.

And following them, as I said, is New York State Association of Health Care Providers, and after that the Home Care Association of New York State.

So welcome, gentlemen.

MR. HANSE: Thank you very much. Good afternoon, Chairwoman Young, Chairman Farrell, members of the committee.

Again, I will follow the lead and

pretty much cut to the chase and get to -- since you have our testimony, get to our critical issues that we are facing in the 2017-2018 Executive Budget.

There are four issues that are of significant concern to the skilled nursing community here in the State of New York. Just as an aside, I'd like to mention the New York State Center for Assisted Living, whose executive director is Shelley Wagar, will be testifying later today about the important need for an increase in the SSI rate for assisted living providers.

From NYSHFA's position, NYSHFA strongly opposes the Executive's proposal to eliminate bed-hold payments for skilled nursing providers. NYSHFA would advocate for establishing a separate managed long-term-care rate cell for nursing home care within the 2017-'18 Executive Budget.

We also support the extension of the nursing home benchmark rate within the budget and the importance of funding healthcare infrastructure investments for skilled

nursing providers within the Health Care Facility Transformation Program proposed in the 2017-2018 Executive Budget.

The Governor's budget, as you heard earlier, proposes to eliminate Medicaid payments to skilled nursing providers to hold beds for residents who are temporarily hospitalized. Presently New York reimburses skilled nursing providers with at least 95 percent occupancy at 50 percent of their Medicaid daily rate for up to 14 days in a calendar year for residents who are admitted to a hospital.

A nursing home's costs do not decrease when a bed is vacant. Moreover, as a consequence of the 2011 MRT cuts to skilled nursing providers, Medicaid pays only half of the daily rate to reserve a bed for a resident who is hospitalized. The Executive Budget proposal would eliminate bed-hold reimbursement and would further reduce funding for nursing home providers in New York State by $22 million, all the while arguably extending resident hospital stays

and potentially disrupting the residents' ability to return to their same room or, even worse, the same healthcare facility.

While the state's current 50 percent reimbursement is insufficient -- and as Commissioner Zucker acknowledged earlier today, it's really not that much money -- New York's bed-hold requirements do provide an essential source of revenue to skilled nursing providers. These payments help offset fixed costs while ensuring a nursing home resident is able to come back from the hospital to their original room with their original clinical staff, so as to ensure both the continuity of their care and the normalcy of their life and living environment.

Second, we would respectfully request the Legislature to establish a separate nursing home rate cell within the budget. Medicaid beneficiaries aged 21 or older who enter a nursing home for long-term care and are also Medicare-eligible are required to join a managed long-term-care plan. New York currently utilizes a blended-rate methodology

to calculate premium payments to managed long-term-care plans to pay for care for these beneficiaries. This blended rate combines the generally lower cost of community care with the higher cost of nursing home care.

Faced with inadequate payments for the Medicaid nursing home benefit under this blended rate, coupled with growing numbers of nursing home enrollees, many managed long-term-care plans have reduced their provider networks and are under pressure to select network providers simply on price, rather than on quality or consumer preference. This is adversely affecting enrollee choice, limiting access, and is impairing the financial ability of nursing homes to provide needed care.

To ensure that there is sufficient funding to cover the cost of nursing home care, NYSHFA respectfully requests that the enacted 2017-2018 State Budget establish a structure whereby managed long-term-care plans receive funding based on a separate

single rate cell for individuals who are receiving nursing home care.

Turning now to the benchmark rate. In 2015, the state established a benchmark rate that would be paid by managed long-term-care plans to contracted skilled nursing facilities for each day of care provided for a three-year period.

Generally speaking, the benchmark rate is a provider's fee-for-service rate and is set to sunset in 2018. In establishing the benchmark rate, the state acknowledged that it will assess the impact of its long-term managed care policies and consider extending the benchmark rate beyond the three-year requirement.

The benchmark rate provides skilled nursing facilities with vital rate stabilization and has secured the capital rate component necessary to help fund needed facility renovations in order to optimize resident care. As such, the benchmark rate has served to provide a level of certainty to providers that will be necessary for the

state's managed long-term-care program to continue beyond the rate's sunset date. This certainty is essential, especially as many providers face delays in timely payments for care from long-term managed care companies.

Without an extension of this important rate protection in the 2017-2018 budget, nursing homes will face reductions to already inadequate Medicaid payment levels.

Finally, we would respectfully request -- and I'll just really cut to the end -- that the state include, within the Governor's proposed Health Care Facility Transformation Program, dedicating $200 million in funds for capital improvements for skilled nursing and assisted-living providers.

In conclusion, it is vital that the 2017-'18 enacted budget establish a separate single rate cell for nursing home care and extend the nursing home benchmark rate.

Moreover, it is essential for the state to dedicate funding for skilled nursing and assisted living infrastructure

investments within the Healthcare Facility Transformation program.

I would like to note NYSHFA's support for the Governor's 2017-'18 budget proposal to establish a multi-stakeholder Health Care Regulation Modernization Team. As stated, it would provide the state guidance on restructuring and streamlining statutes, regulations, and policies affecting healthcare providers and facilities.

In closing, I am certain that we'd all agree that to care for those who once cared for us is one of life's highest honors. And as such, the New York State Health Facilities Association will continue to work together with the Governor, the Legislature, and all affected constituencies to ensure the continued delivery of high-quality, cost-effective long-term healthcare services throughout New York.

Thank you.

CHAIRWOMAN YOUNG: Thank you.

Any questions?

CHAIRMAN FARRELL: Thank you.

MR. OLSEN: I'd like to just add a comment.

CHAIRWOMAN YOUNG: Oh, sure. Of course.

MR. OLSEN: Earlier this morning the Medicaid director made a comment relative to the bed-hold issue in nursing homes, in that we would be able to make simple operational adjustments to our operations when a nursing home resident may be in the hospital when we're churning our residents, so to speak, as the medical director put it.

That's simply not the case. In the 28 years I've been in this profession, we have never been able to make any operational adjustments relative to a few residents being in the hospital at any given point in time.

Case in point, if I have two residents on a certified nurse assistant's caseload that may be in the hospital, out of the eight residents that she may be taking care of, I can't simply send 25 percent of that caregiver home or decrease her pay by 25 percent. That person needs to stay, care

for the other residents. And that's just a simple example of the ways that simple operational adjustments cannot be made in our environment to deal with adjustments in a few folks being in the hospital. And that's generally what we're talking about.

CHAIRWOMAN YOUNG: Thank you for that.

Anyone else?

CHAIRMAN FARRELL: Thank you.

Mr. Raia.

ASSEMBLYMAN RAIA: Thank you.

Actually, I was one of the people that asked that question this morning.

What's the impact on a patient with dementia or Alzheimer's if they're forced to go to the hospital and come back to a different room that they don't know?

MR. OLSEN: It is dramatic, because they do remember their environment that they may have just been in three or four days ago. They do remember their staff members, for the most part. Sometimes they may not remember their own family members, but they do remember the staff member that cared for them

the day before.

Them not being able to return to the same bed, or even potentially the same facility, would have a dramatic effect on their well-being moving forward.

ASSEMBLYMAN RAIA: Thank you.

MR. HANSE: And just to follow up on that. As the statute and regulation read, it really comes down to an $11 million state savings for taking an individual who does go to a hospital and may or may not be able to go back to their room. You're going to end up with an individual who's going to actually stay -- potentially stay at a hospital longer and then be displaced.

CHAIRWOMAN YOUNG: Okay.

MR. OLSEN: Thank you very much, Senator.

CHAIRWOMAN YOUNG: Thank you so much.

MR. HANSE: Thank you.

CHAIRWOMAN YOUNG: Next we have Vice President for Public Policy Laura Haight and President Claudia Hammar, from the New York State Association of Health Care Providers.

Following them, we will have the Home Care Association of New York State. And following them, we'll have LeadingAge New York.

Welcome.

MS. HAMMAR: Good afternoon. Thank you.

CHAIRWOMAN YOUNG: Good afternoon.

MS. HAMMAR: Good afternoon, Senator Young, Assemblymember Farrell, distinguished members of the Senate Finance, Assembly Ways and Means, and Senate and Assembly Health and Aging Committees.

HCP is a trade association representing approximately 350 offices of licensed home care services agencies, certified home health agencies, and health-related organizations. On behalf of HCP's board of directors and our members, thank you for your continued support for home care and the industry.

Home and community-based care has been widely recognized as an important component for new models of healthcare delivery aimed

at achieving New York State's goals of improving care, improving health, and reducing costs within the Medicaid system. Home care is the patient-preferred option that allows individuals to receive essential healthcare and personal care services so that they can continue to live independently in their communities.

Aging baby boomers are reaching age 65 in record numbers, so the demand for home care services in New York is expected to grow. Fortunately, New York has a broad network of home care providers that can deliver a wide range of healthcare and personal care services.

Most of HCP's members are licensed agencies that provide long-term care services for the disabled, chronically ill, and elderly New Yorkers. Many serve as fiscal intermediaries for the state's Consumer Directed Personal Assistance Services program.

Long-term care provides value to the state's Medicaid system by helping people

remain in their homes and communities for as long as possible, instead of in more costly settings. Home care workers are often the first to identify changes in a patient's condition that can be quickly addressed to keep the patient stabilized and at home. Home care has already played a major role in achieving cost savings in the state's Medicaid program, and has the potential to provide even greater value with an appropriate investment in healthcare information technology and workforce development.

Over the past few years, home care providers have faced unprecedented challenges, with mounting labor costs, reimbursements that do not begin to cover agencies' real costs, and a rapidly changing regulatory environment. New York's minimum wage increase and recent changes to the federal overtime payment requirements for home care workers have added more than $1 million in labor costs just in the past year -- $100 million in labor costs just in

the past year, and these numbers will go up significantly as the minimum wage is continued to be phased in.

The Governor and Legislature recognized the financial impact of these changes and included funding last year in the state budget to support these costs. However, home care providers have had tremendous difficulty getting these funds from Medicaid managed care plans. Stronger mechanisms are needed to ensure these funds are actually passed through to the home care providers to support their workforce.

The implementation of HCP's recommendations will help ensure that New York's elderly and frail citizens will continue to have access to high-quality home care services.

Thank you.

MS. HAIGHT: I'm Laura Haight. Thank you for this opportunity today.

As with previous years, HCP's priorities for this year's budget are adequate reimbursement for home care

providers for performing reimbursed services, funding for recruitment and retention of a qualified home care workforce, and grants to support investment in healthcare information technology and other needs.

The Governor's budget proposal contains funding to address all of these needs. However, unless certain changes are made, it is unlikely that this funding will flow through to home care agencies as needed.

On the minimum wage funding, HCP greatly appreciates the continued commitment of the State Legislature and Governor Cuomo to include additional Medicaid funding in the state budget to support the minimum wage increase for healthcare workers.

The home care industry is by far the largest healthcare sector impacted by this increase. Home care agencies in New York employ more than 300,000 full and part-time home care workers across the state, most of whom are paid base wages at or near the minimum wage. Consequently, of the $44 million in state Medicaid funding

appropriated for the minimum wage increase this year, $41.2 million went to home care workers. And in the Governor's proposed 2018 budget, that includes $255.4 million for this purpose, of which $242.7 million is earmarked for home care. So we're a large section of the minimum wage cost.

While HCP continues to work with DOB and DOH to refine the state's cost projections, this amount does appear adequate in this year's state budget to meet the bare minimum cost of compliance with the state minimum wage mandates.

However, HCP has three important caveats. First, the money needs to come through to home care workers, home care providers, to pay our workers. And we discuss this in more detail in our written testimony -- we had enormous challenges getting managed care plans to commit to reimbursing us for these services even though the state went through a great deal of effort, great lengths, to ensure that this funding was in hand in advance of

December 31st.

Second, overall home care provider reimbursements continue to be inadequate, and even if we fix the minimum wage, that's not enough to achieve sustainability.

And third, as other groups have expressed in previous hearings, the minimum wage is not enough to support recruitment and retention of direct care workers.

Therefore, HCP is offering three main budget recommendations, and I'll keep my comments short.

One is we're recommending that the state has to include budget language to address this issue of reimbursing home care providers for the base costs of compliance with state and federal and local laws. Between 2015 and 2016, home care agencies saw their labor costs increase dramatically across the state due to a wide range of increases. Yet despite these escalating costs, our reimbursements in Medicaid managed care stayed static or went down in that year.

And prevailing managed care

reimbursement rates in New York City for that year, 2016, were between $18.50 and $19 an hour. And this is well below what either DOH or HCP calculates to be the actual cost of providing such services when you factor in all of the taxes and benefits that are required to be paid.

The state has recognized the precarious financial condition of the home care industry and included additional funding to support these increased costs, including not just the minimum wage but also the new federal Fair Labor Standard Act overtime rule, which significantly increased our overtime costs and other expenses. However, much of this funding has been delayed or never been passed through to home care agencies to pay their workers.

For example, when this FLSA rule change went into effect, the state and federal government approved $45 million in emergency pass-through funds and later amended the MLTC plan rates to support this compliance moving forward. Our providers

still have not received all the emergency payments. Those payments arrived, you know, starting six months after the new rule went into effect. And overwhelmingly, the plans have refused to pass on increased reimbursements to home care providers, even though the plans have been getting this money in their rates since April 1, 2016.

So while HCP really appreciates the significant effort undertaken over the past year by DOH and the Cuomo administration to help make these resources available to home care providers to meet these increased labor costs, there needs to be a better way.

Ultimately, this piecemeal approach taken by the state is not a sustainable solution, and we recommend that language be included in the budget requiring that managed care plans reimburse home care providers for the cost of compliance with these mandates. And we believe the state has an obligation to ensure this, that you can't just walk away and say, Let them negotiate with the managed care plans. We have to have our base

obligations met.

Secondly, there is money in the budget that could help us with this. There is the home care workforce recruitment and retention funding. Close to $300 million a year is put into the budget for workforce recruitment and retention in the home care sector. But in Medicaid managed care, we're not seeing where this money goes any longer. It used to be, you know, a separate item listed on your remittance under fee-for-service. Now providers don't know what they're receiving or if they're receiving it, and when they contact plans, they might be told it's in your -- it's embedded in your rates.

Well, our rates are too low, so it appears that this money is being used to backfill compensation. And it's not additive, as it's intended, to support recruitment training and retention of non-supervisory home care services workers. So we have recommended some language regarding transparency and oversight of this funding.

And lastly, we too really see an opportunity with the Health Care Facility Transformation Program funding. Billions of dollars have gone out in capital funds as well as all the money from DSRIP -- very little of that if any has gone to home care, and in fact last year was only the first year we could apply for the transformation program funds, which we appreciated. But even then, the constraints were very limiting.

This year's program is designed to address a broader range of purposes, including what's most important to us, is healthcare IT. This is essential for us to be able to participate in the new integrated models of healthcare delivery that the state is working on, and we've been sort of on the sidelines with this because we've lacked the resources to really invest and present the full value, as Claudia described, that we can to the system. We are in the homes of our clients, we can do a lot to help keep them well and prevent them from injury and entering into more expensive care settings.

So thank you very much. We believe that these are -- this is the time to invest in home care, to meet the growing demands, and we look forward to continuing to work with you.

Thank you very much.

CHAIRMAN FARRELL: Thank you.

CHAIRWOMAN YOUNG: Any questions?

Okay, I think we're all set. So thank you for your testimony.

MS. HAIGHT: Thank you.

CHAIRWOMAN YOUNG: Our next speaker is Al Cardillo, executive vice president of the Home Care Association of New York State.

Following him will be LeadingAge New York, and following them will be Hospice and Palliative Care Association of New York.

Hi, Al.

MR. CARDILLO: Thank you, Senator. Thank you, chairs, and all the members of the committee.

One of the main aspects of the Hippocratic oath is to do no harm. So today in my testimony I will forgo reading my

testimony to you, and the variety of our attachments, and mainly we'll focus on the four critical points that we really want to emphasize.

CHAIRWOMAN YOUNG: Great.

MR. CARDILLO: They are actually attached in a one-pager to the testimony. And my colleagues Claudia and Laura really, I think, set the table very well, presenting the breadth of the home care picture in the state and of course really reflecting the urgency of the needs.

So within the four areas -- let me tell you just a bit, certainly, about the Home Care Association. So the Home Care Association represents home health providers of all types across the state. We also have within our membership long-term-care plans, which you've heard a lot about during the testimony today, hospice providers, providers of waivered services, and other allied providers.

So the areas that I want to focus on are rate adequacy and payment adequacy for

both managed long-term-care plans and home care agencies, the home care and state regulatory structure, and the need for capacity support within the home care system and the home care infrastructure.

So starting on the issue with rates, you heard in the prior presentation and well-documented in the attachments is data from the certified cost reports of the plans and home care agencies that really paint a very concerning picture of the financial status of plans and providers. It was discussed earlier when the Commissioner of Health and the State Medicaid Director was here that the managed long-term-care home care partnership solution is a very critical one for the state. It's virtually where the state has invested all of its energies and currently its policies in providing care for individuals who are very, very needy in the long-term-care system.

In addition, separately in terms of home care, home care really crosses the entire expanse of the system, from maternal

and child health services to pediatric services to postsurgical services to public health services to palliative care. So home care on its own accord is really providing services across the continuum in partnership with physicians who write the orders for the services.

So as I say, the data -- that data that we have that speaks from the certified cost information really paints a very concerning picture with the majority of plans and providers struggling to meet margin, most below margin.

The last two years, the Legislature has incrementally improved the language in the statute that directs the department on the methodology that it uses to reimburse plans and providers. HCA is requesting that this year you further strengthen that language to ensure that the methodologies are actually on point with the real costs that are experienced by plans and providers in trying to care for New York's most vulnerable citizens.

We have provided language to the Legislature for your consideration that would strengthen that component of the statute and hopefully ensure a truer methodology in terms of payment.

The Governor's budget includes funding for minimum wage. There's $242 million in state year funding. There's certainly a great deal of concern that those funds be able to be made available sufficiently to managed care plans and to home care agencies to truly meet the wage needs associated with minimum wage and in fact decent wages for all workers statewide. The process that has been implemented thus far has been a very difficult one for both plans and providers, and it's really not been clear how those funds ultimately go from the state and then ultimately to the provider in order to ensure payment of the worker. And that really needs redress in this budget.

The other aspect about the funds is that those funds just cover the Medicaid side of the equation, and they also do not cover

costs for individuals that are compensated above the minimum wage and have long been compensated just above the minimum wage but now really are deserving of an adjustment as well.

So that's something we just want to make sure the Legislature and Governor are mindful of when determining your final number for an adjustment under this system.

And the last item I'd like to mention with respect to the wage -- the rate issue is related to managed long-term care specifically. The Governor's budget proposes a series of cuts in adverse financial actions that are pointed at managed long-term-care plans: A carve-out of the transportation reimbursement, a cut in the quality innovation fund for managed long-term-care plans, a change in eligibility, and a restriction on marketing.

All those were discussed earlier with this panel and the Medicaid director. I don't need to go into the details. But HCA would encourage you to revisit, reject, and

restore the funding associated with those adverse proposals. The system in its fragile state really can't take anything more.

On the regulatory side, with the state moving to new models of care -- ACOs, advanced primary care, DSRIP, managed Care -- there is a tremendous opportunity for home care's contribution to really maximize the benefit to patients and the cost effectiveness to the system. The regulatory structure for home care was created and largely functions around home care as a separate, sole-serving, independent, fully responsible model for the patient.

But in these new models, the state envisions a shared partnership between a diversity of providers -- behavioral health, physicians, hospitals, and other providers. And so within that model, your roles are distinctly different, and there's a capacity for a very nimble level of involvement that yields very, very significant returns in terms of the patients and the system.

Just one quick example. In New York

City, it's projected that something like 50 percent of asthma cases are environmentally related. If a physician had the ability to -- say, you know, a child has presented with exacerbating symptoms on asthma. I could send a home care agency to evaluate that patient, report to me on the environmental conditions, and then on that basis I could then determine next steps for treatment.

But whenever home care gets involved, it gets involved under the current rule of regulation which has a very, very broad set of requirements, again presuming that the home care agency is going to be fully responsible assessing and managing that case.

It's really a case of the doctor -- and it's a case where the doctor, if they partner with the home care agency, can achieve immeasurable results in terms of public health advancement, public health protection, and mitigating that disease situation for the patient.

So that's just one of many examples.

HCA has provided the Legislature with legislative language for Article VII that would create a separate section within Article 36 that would allow you to facilitate the regulatory environment for home care's participation in these new models. And we ask your careful review and consideration of that language.

At the same time, the Governor has a major regulatory modernization team in the budget. There were comments made today by the members of the committee with respect to concerns about the breadth of the model and perhaps the Legislature's prerogative in terms of deciding exactly how statutes and regulations would be changed.

We are in sync with the Legislature on those concerns. We support those concerns. We wholeheartedly support regulatory relief, but it's very, very important as we are -- what we are seeing under DSRIP already is that providers who are not licensed home care agencies, who are not licensed hospices, are actively moving into the licensed protected

sphere of those agencies.

So you have entities that are out there providing services and seeking to provide services in the home that really go beyond the scope of their current licensure and go straight into the licensure category of Article 36 and Article 40s.

We would have grave concerns that -- certainly that there be safeguards in any regulatory reform process that does not further escalate that activity within the system.

I'll talk to you about my last two items quickly. In terms of home care capacity, there is a tremendous need for there to be a comprehensive review of the needs of the home care system and really of communities and patients for home care in this state. It's a long overdue process. If you talk to hospitals in the North Country, if you talk to the Statewide Senior Action Council, if you look at areas whether they're urban or especially rural, what you see is that the shortage of capacity is impairing

the functioning of the system and really affecting the ability of patients to be able to access services quickly and nimbly.

We recommend that the Legislature -- we've provided language for the Legislature to really require a comprehensive policy for meeting the home care capacity needs across this state and especially in the rural areas.

And Assemblyman Gottfried, thank you for hosting the upcoming hearings that will really focus very, very closely on that issue.

And finally on the infrastructure. The Home Care Association applauds the proposal of $500 million in the state budget for infrastructure health facility transformation. We also applaud the fact that within the proposal last year the Legislature, when it was funded at $200 million, actually set aside a minimum level that should go for community-based care. In a situation where the state as a policy is looking to move 25 percent of the acute care system into the community, we

would urge that at least that proportional amount be considered on the $500 million program -- so at least a proportional amount of $125 million.

And I say that in the context of the fact that of the billions, the 7 to 8 billion dollars that have gone to DSRIP, less than 4 percent of those monies go into another category which applies to community providers. And in recent years --

CHAIRWOMAN YOUNG: Al -- excuse me, Al.

MR. CARDILLO: Yes.

CHAIRWOMAN YOUNG: Al, I'm sorry, but you're over your time.

MR. CARDILLO: Yes.

CHAIRWOMAN YOUNG: And just to be considerate of the people behind you --

MR. CARDILLO: Thank you, Senator.

CHAIRWOMAN YOUNG: -- I think you can wrap it up. You gave us great testimony --

MR. CARDILLO: Thank you, Senator.

CHAIRWOMAN YOUNG: -- in writing, so we really appreciate all that you do.

MR. CARDILLO: Thank you very much.

CHAIRWOMAN YOUNG: Thank you for being here today.

MR. CARDILLO: Thank you, Senator.

CHAIRWOMAN YOUNG: Thank you.

I remind the speakers to please stay within -- oh, we do have a question.

So go ahead, Assemblyman.

ASSEMBLYMAN GOTTFRIED: Earlier, when I was asking Jason Helgerson about the nursing-home-eligible language relating to MLTCs and I asked how would someone who needs 120 days of home care but isn't nursing home-eligible gets it from Medicaid -- because I think the language as written says you can't -- and he said, Well, you would just get it through fee-for-service Medicaid.

Setting aside the fact that the language doesn't say that, what is your assessment of the availability of an infrastructure and administrative structures in many communities for fee-for-service home care these days?

MR. CARDILLO: Well, Assemblyman, my

concern about the infrastructure would span whether it would be fee-for-service or under managed care, because it's the same infrastructure, basically. The managed care plan contracts with a network of providers, and that network of providers delivers the services. So I would be concerned either way.

But speaking specifically to your point about eligibility, we certainly have concerns with respect to the change, because that change is also likely to create instability in the MLTC structure, which has been rated in terms of its premium and its activity to service the population that's 120 days and longer, just as you've set the eligibility today. So we would be concerned, certainly, about that change.

In the fee-for-service structure, the way it would work now -- and we'd certainly take a look at the legal language, but the way it would work now is until you have reached a point of eligibility to go into managed long-term care, agencies within the

community -- so certified agencies and long-term home healthcare providers who would act like a certified agency -- would be in a position to or certainly would be eligible for the patient to go into for services.

But there's been changes since the MRT which have certainly changed, say, the scope of services for the long-term home healthcare programs so you don't have the waivered services in that program anymore like you used to. But the state has just gone to an episodic reimbursement system for the long-term home healthcare program, really similar to what you proposed several years in a row. But it's not for the same scope of services, it's a much narrower scope. If that were broadened, again, as it was, you would at least have a fee-for-service alternative.

ASSEMBLYMAN GOTTFRIED: Okay. Thank you.

MR. CARDILLO: Thank you very much.

Thank you, Senator.

CHAIRWOMAN YOUNG: Thank you.

CHAIRMAN FARRELL: Thank you.

CHAIRWOMAN YOUNG: Our next speakers are Ami Schnauber, vice president of advocacy and public policy, and James W. Clyne, Jr., president and CEO of LeadingAge New York.

Following them -- oh, it's just Ami.

MS. SCHNAUBER: It's just me today. I will try and --

CHAIRWOMAN YOUNG: Excuse me.

-- Hospice and Palliative Care of New York, and following that we would have the New York Health Plan Association.

So welcome.

MS. SCHNAUBER: Thank you. Thanks so much.

I am submitting formal testimony; I'm not reading that. I'm just going to provide a few highlights. But I would like you to open the first page, because on the first and second page we've provided some charts for you because we're very concerned about the sweeping cuts to long-term care in this budget.

We have a problem in this state and in

this country. The baby boomer generation has started reaching age 65. Ten thousand people a day reach age 65. That started many years ago; the first wave is now 71. We already have significant service gaps. We've been talking to the administration about the fact that they have to invest in long-term care because we're going to be unprepared.

And you heard from HANYS, NYSHFA, HCA, HCP -- they've gone over what some of the issues are, and we concur with them. But I just hope that you can appreciate that -- the why of why you should care. We have a big problem, and we have to start addressing it.

The yellow line is the long-term care cut. It's $168,000. And we think that the elderly and the people with disabilities in this state are shouldering the bulk of the cut in this year's budget, and we think that we need to be going in the other direction.

There have been some investments in long-term care, and on the second page you will see our pie chart that shows the DSRIP investments that have gone out. I shared

this chart last year; the difference here is this actually -- the first pie chart I showed was what was proposed to be spent. This is actually first-year spending.

And once again, you will see that the vast majority of that funding is going to primary and acute care. And nursing homes are the little tiny orange slice. And I'm not sure if you can see hospice, because that's the thread that connects the gray and the orange. I think it's pretty clear this is not an area that we're investing in, and it's a major problem.

The good news is that there is a capital investment proposal in the budget by the Governor. It's $500 million. We would suggest that $200 million of that ought to go to long-term-care providers. Long-term care is about 40 percent of the Medicaid budget, and so we would suggest they ought to get 40 percent of this healthcare spending.

We also suggest and ask that you add assisted living programs and hospice programs to the providers who can be eligible for this

funding, because once again they've been left out, and we think they're an important part of the continuum.

New York State doesn't do very well in terms of -- if you look at other states in terms of hospital deaths, we rank 50th in the states. We rank 48th for our use of hospice. We know we have a major problem in assisted living. We haven't had an SSI increase for assisted living since 2007, and costs -- a daily cost for assisted living is about $70 a day, and the state reimburses $40 a day.

We have a huge population of aging people, and if we don't start investing in these areas, they are going to be in nursing homes. Nursing homes, 85 percent of the cost of nursing home is borne by the Medicaid program. It is completely unsustainable. The state has to start investing in some of these areas.

MLTC rate adequacy. It's a big issue that several of the prior speakers talked about. We represent the provider-sponsored MLTCs. Half of our MLTCs in the state have

negative premium margins. Unfortunately, the premiums tend to be at least a year behind. We've been adding new wage mandates, we've added new populations such as nursing homes, and the reality is is that the rates simply have not kept up.

Managed long-term-care plans are struggling because the number of nursing home members that are moving to MLTCs has grown faster than the department expected, and what this has caused is some of the plans to start narrowing their nursing home networks. We have to figure out a way to make sure that enough money is going into the rates so that we can accommodate the nursing home component of the benefit.

NYSHFA mentioned the nursing home bed-hold cut. We are concerned about that. We don't believe that there is a churning that is happening. What our members know is that if you have to transfer a frail individual, there are always complications. They often come back worse than they were. You're not sending people to a hospital

unnecessarily. All this will mean is that people are not going to be able to return to the place that they call home, and we think it's a big problem.

The other area that we would like to see some investment in is in senior housing. We know the Governor has already recommended $125 million for senior housing. But we are suggesting that some amount of money -- we would suggest $10 million -- be funded for service coordinators so that we can keep seniors in the community longer. We know, through the HUD programs, this has been effective. We think it can save Medicaid dollars by allowing people to be connected to the services in the community.

We have a significant workforce shortage in this state. I've testified before about the fact that my younger brother, who has a traumatic brain injury, is in the dementia unit of a nursing home because after 15 years we could not sustain him in the community anymore. We would try and get home care providers -- there simply

was not enough home providers. And it just takes a toll on a family when parents have to be caring for people as they become older themselves.

We have to address this. The minimum wage has gone up. Our members had traditionally been paying people more than the minimum wage; now they're competing with people in retail. And recently we heard that a number of our providers in the Western New York region are losing staff because communities are busing people to casinos. So now people who are using transportation, people who are providing home care, are going to casinos to do work instead.

We're very concerned about the MLTC and the adult day healthcare transportation carve-out. We think using a state vendor is a poor idea. We see examples in Senator Young's area -- we had a member tell us that they had to transport one of their residents 15 minutes to a doctor's appointment, and the state vendor was going to send transportation from Schenectady, New York. We think this

should be local.

CHAIRWOMAN YOUNG: Could you get me more information on that?

MS. SCHNAUBER: I will.

CHAIRWOMAN YOUNG: I thought it was bad when they were bringing people from Buffalo to Cattaraugus County to pick somebody up, take them to the doctor, and then drive back to Buffalo.

MS. SCHNAUBER: Right.

CHAIRWOMAN YOUNG: That's far worse.

MS. SCHNAUBER: It is.

CHAIRWOMAN YOUNG: Because that's a four-and-a-half-hour drive each way.

MS. SCHNAUBER: Exactly. And our plans are saying we want to be able to manage the transportation.

We have one provider who was given a HEAL grant in Senator Valesky's district, he was given a HEAL grant to bill the transportation and then, a year later, told: We're going to take transportation out of your MLTC rate.

It doesn't make sense. They all seem

to be individual suggestions and ideas and proposals coming from the state that don't always work together.

So those are the main points I'd like to make. I do hope that we can continue to work together and figure out how we can address some of these issues and make sure that our seniors and individuals with disabilities are getting their fair share.

CHAIRWOMAN YOUNG: Thank you.

Any questions?

CHAIRMAN FARRELL: Thank you.

SENATOR KRUEGER: Thank you.

MS. SCHNAUBER: Thank you.

CHAIRMAN FARRELL: Any questions? No?

CHAIRWOMAN YOUNG: The next speaker is Kathy McMahon, consultant with the Hospice and Palliative Care Association of New York.

Following her will be Paul Macielak, president and CEO of New York Health Plan Association. And following him will be the Coalition of Managed Long Term Care.

So if you're in the queue, please move forward. We're not -- there's Paul -- we're

not as mean as we look. So we see all these empty seats in the front; if people want to fill them up, that would be great.

Welcome. And thank you for staying within the time frame.

MS. McMAHON: I want to thank you very, very much for giving me this opportunity to provide comments on the 2017-2018 proposed Executive Health Budget. I promise I'm going to be very, very brief and I will -- with my comments, that I'm only going to make one request. We have additional requests, but they're in the written testimony. I want to be very fast here.

I wanted to start with that we were very, very grateful when the Medicaid Redesign Team called for greater access to hospice and palliative care seven years ago, MRT #209 for hospice and MRT #109 for palliative care. And you know, here in New York State, hospice utilization and length of stay are extremely low. In fact, I would say abysmally low.

Ami had mentioned earlier that we're 48th nationally as far as hospice utilization. Our utilization rate in New York is 30.3 percent, versus 45.9 nationally. Our median length of stay is 16 days; nationally it's 23 days. And regarding the 16 days, when I talk to the hospice providers around the state, they're all telling me that the majority of their patients are two weeks or less, and within that cadre it's usually a week or less. So we're talking on hospice for three to five days.

So we really need to do something about that, and I would be asking for your support on making sure there are not any additional barriers for hospice access.

I think it's important to be aware of the data that I just mentioned in light of some of the language in the Governor's proposed budget. There's a proposal intended to clarify that Medicaid would not cover hospice-related services otherwise covered by Medicare. It's a $4.4 million reduction. It

still remains unclear to us how this proposal would be implemented.

We've been working since the budget was introduced to get some clarification, and we originally received two explanations. One was that it has to do with ancillary services, and the second was that the cut would be implemented as a cut to MLTC rates, based on the assumption that hospice programs are billing MLTC plans for services and supplies that should be properly billed to Medicare. Neither of these explanations makes sense.

First of all, room and board is fixed, the only thing -- the only service for which hospice bills MLTC. Room and board would be for hospice patients residing in nursing facilities or in a hospice residence who are also members of an MLTC. The hospice benefit is carved out of MLTC. For dual-eligible individuals, Medicare is billed. For non-duals, straight Medicaid is billed.

Hospice is an all-inclusive service billed at a per diem rate. That includes

physician, nursing, home health aide, social work, psychosocial support, spiritual care, therapies as well as durable medical equipment, and also medications that are related to the terminal illness.

Yesterday we did receive a third explanation. I was on the DOH Twitter Chat, and at that time we were told that the provision was for dual and FIDA fully integrated dual advantage program and MAP, Medicaid Advantage Program, and that Medicaid would no longer pay; providers would bill Medicare. I find this confusing, since this is already the case, and that billing is being done correctly. It simply requires education and communication, not a provision in the budget.

Therefore, we remain -- because of the kind of confusion over the explanations that we've received, we remain deeply concerned that hospice patients would be negatively impacted by the proposed $4.4 million cut. Therefore, we respectfully request that this section be struck from the proposed budget.

Thank you for your time, for your consideration. I would be very happy to respond to any questions you may have.

CHAIRWOMAN YOUNG: No questions.

MS. McMAHON: Thank you.

CHAIRWOMAN YOUNG: Thank you very much. We appreciate your participation.

SENATOR KRUEGER: Thank you.

CHAIRMAN FARRELL: Thank you.

CHAIRWOMAN YOUNG: The next speaker is Paul Macielak, president and CEO of New York Health Plan Association.

And as I said, following him will be the Coalition of Managed Long Term Care, and following them will be the Community Healthcare Association of New York State.

So welcome.

MR. MACIELAK: Thank you, Senator.

First I'd like to say thanks to all of you -- Senators, Assemblymen, chairs -- for staying here this long and certainly well into evening, as you'll be here quite a while.

CHAIRWOMAN YOUNG: The fun is just

beginning.

(Laughter.)

MR. MACIELAK: I'm just going to summarize the testimony which is being handed out to you now. I want to cover about a half a dozen issues and try and keep time short.

First, today I just want to make the point -- it got raised earlier, certainly when the commissioner spoke, and Superintendent Vullo as well -- that government, consumers, and health plans are all concerned about stability of the health insurance market. Anticipated federal action is fueling a lot of turmoil, as you might guess -- rumors, press statements, committee actions in Washington, executive orders about repealing and replacing or repairing the ACA, all creating that instability.

I point that out as a backdrop for all of you and urge caution as you address some of the budget as well as pieces of legislation during the balance of this session. Please don't add cost in terms of legislation, in the budget, or in the balance

of the session. Costs go to affordability, and affordability is key in terms of stability for the market. And that is also key whether it is the Medicaid budget, whether it's a consumer's checkbook in terms of what they can afford or pay out-of-pocket, and for health plans in terms of what they can offer and what kind of losses they might be able to incur in the market.

So with that as the backdrop, I'd just like to say that HPA strongly supports the Governor's effort in terms of creating a pharmacy price cap and a surcharge proposal. I know there's a lot of concern about it, and I know there's a lot of questions, but I would just urge some action be done in the pharmacy arena. Something has to be done.

You heard statements earlier today about how much the Medicaid budget has increased. I know there were a couple of years where it went up, in pharmacy, a billion dollars a year. And that's certainly when Harvoni, Sovaldi -- when those came out, as well as some changes in terms of practice

protocols like prescriber prevails. But by our numbers, the cost of pharmacy has increased over 54 percent in the last four to five years. And that's net of rebates.

That is unsustainable. As you have heard earlier, pharmacy exceeds inpatient hospitalization. And for those of us who have worked in healthcare, that's a staggering fact.

Pharmacy is making for scarce dollars under the global cap. So whether it's the Brooklyn solution, whether it's behavioral health, financial support, whether it's payments for different providers throughout the system, all of those are competing against pharmacy for scarce dollars. And I would point that out, that we have to keep that in mind while we're also waiting for federal action which may decrease, certainly, federal support for our government programs like Medicaid.

Second point. We oppose the superintendent's discretionary powers. I know there was a lot of questions -- and

Assemblyman Cahill, you asked a number of them. And I would just make the point that there is no budget impact cited in the Executive proposal regarding certainly the increased fines or some of the other discretionary powers. So without a budget impact, I would just urge that you delete it from the budget. It could be a policy discussion we can have in April or May or something like that, as opposed to trying to do it in today's budget.

Our concern really has to do with the superintendent's discretion. And you asked some questions, Assemblyman, of the superintendent about the definition of unsound, unsafe, you know, whether they were defined in statute or if they were really her interpretation of it.

And we've lived with, as an example, the prior approval rate process, which is subject to the superintendent's discretion in terms of rate-making decisions. And we've experienced rate suppression, which we think runs counter to actuarially sound rates in a

number of occasions, and those decisions contribute to that instability in the marketplace that I talked about.

Now. We can't forget Health Republic's experience, which in part tracks back to rate decisions that were made under that discretionary power. I'd also point out in the discretionary power that the increase in fines from 1,000 to 10,000 -- that's per violation -- the superintendent clearly framed it in terms of bad actors and clearly a malfeasance and the ability just to fine somebody $1,000 versus $10,000 as a key factor.

But I would hasten to say that the experience of health plans has been, today -- on market conduct surveys, we've had a number of plans where you will have a paper violation and it might have been repeated over a hundred cases or a thousand cases, and you're facing fines in that situation running now into the hundreds of thousands of dollars and up to -- even out at a million dollars, for what are technical paper violations where

there's not a significant consumer harm.

So we would say that -- take it out of the budget. If you don't, at a minimum put in some guardrails and safeguards. Put in a framework to define, you know, repeat offenders, degree of harm, types of violations, number of violations, et cetera.

We also -- third point -- we oppose extending HCRA for three years without some reform. The Legislature adopted a HCRA modernization task force, some recommendations came out of them -- not startling recommendations, but they're not reflected in this extension. Those recommendations should be built in at a minimum.

We would also agree -- I know Senator Hannon raised it earlier -- whether there's a need for perhaps a modernization task force number 2 to look at really some of what HCRA is doing today versus what it was originally intended to do. You know, it started out, in terms of the public good funding, to fund GME and bad debt charities. Those were the

historic roots.

Today, more than two-thirds of the HCRA money goes to fund the General Fund and in fact Medicaid. So it's becoming a cost subsidy built on the backs of health insurance premiums to fund the Medicaid system.

The HCRA fund, just on health insurers today, are up at about $4.7 billion, far exceeding the millionaire's tax that I know a lot of people spent time talking about. That translates into 5 to 6 percent of a family's premium that they have to pay.

Finally, we would propose that with the churn in Washington, the uncertainty there in the Medicaid arena, take a look at perhaps adopting a moratorium on the carve-in of new services and new populations into the Medicaid managed care system. There's a lot of concern that, you know, some of what's occurring is because it was incorporated in the MRT plan six to seven years ago, and a lot has changed during that time period.

And we think with what's happening in

Washington, and the uncertainty that exists there, we ought to take a pause before we add clotting factor for hemophiliacs, certain behavioral health for children or certain children populations into the Medicaid managed care system. And should there be significant changes at the federal level, those will then be state decisions you'll have to make in terms of future funding.

Finally, we would just point out there is an administrative quality of care cut for the MLTC program of $30 million and Medicaid managed care of $40 million. Both of those cuts, if you think about it, are contrary to the goal of improving the quality of the system and certainly run counter to the whole value-based purchasing effort that's intended to improve efficiency and quality in the whole healthcare system.

And then I couldn't leave without raising the EI program, for which I know there have been a number of questions raised. And I would just say that I share certainly the feelings of a number of you that the

fiscal agent model that the state has adopted has been basically problematic for not only health plans but providers and in part for families as well.

The proposal advocated now, I think, is to solve some of the problems for the fiscal agent, but it will create a whole host of problems both for plans and for providers in trying to comply. So we would say that that likewise should be deleted from this budget proposal.

And it's another example where legislation was adopted last year for the Early Intervention Coordinating Council. And we would say, get that thing staffed up and have it meet regularly. Since it's been in existence, it never had a health plan participate on it to try and put forth what the problems were with some of the proposals. You adopted legislation to add health plans to that council. We need to get them appointed, get that group meeting.

And that's what I have for my testimony. Thank you very much.

CHAIRWOMAN YOUNG: Questions? Any questions?

Thank you, Paul.

CHAIRMAN FARRELL: Thank you.

SENATOR KRUEGER: Thank you.

CHAIRWOMAN YOUNG: Our next speaker is James Lytle, counsel for the Coalition of Managed Long Term Care.

Following him will be the Community Health Care Association of New York State, and then following that group will be the Medical Society of the State of New York.

Welcome.

MR. LYTLE: Thank you very much.

CHAIRMAN YOUNG: Great to see you.

MR. LYTLE: I'm here on behalf, actually, of two coalitions, but I promise not to take any additional time as a result.

CHAIRWOMAN YOUNG: Thank you.

MR. LYTLE: We represent the Coalition of New York State Public Health Plans as well as the New York State Coalition of Managed Long Term Care and PACE Plans.

Just by way of background, in the

first of these coalitions, known as the plans that are devoted to the mainstream Medicaid managed care program, we represent eight plans, about 3.6 million New Yorkers who are enrolled in them. Around $21 billion is spent in total on mainstream Medicaid managed care coverage. These are programs now that provide Medicaid coverage, HARP coverage for persons with serious mental illness. They also offer qualified health plans under the exchange and offer the Essential Plan, the newest of these products.

On the managed long-term-care front, we represent 22 plans. About 130,000 of the 190,000 enrollees statewide are part of our coalition. Overall, the MLTC and PACE program account for about $9 billion in the state's Medicaid budget.

So between the two programs, the mainstream Medicaid managed care program and the managed long-term care program, they together account for about half of all Medicaid spending in New York.

The members of our coalition are all

not-for-profit mission-directed plans, some of whom have been devoted in one way or another to the healthcare system literally for centuries, and who bring that mission focus to the work that they do on behalf of the folks who enroll in the programs.

Let me just touch on a couple of the issues that affect either one of these coalitions or both of them.

First of all, there are proposals, as you know, in this budget that would give the Governor and the executive branch extraordinary power in the event of significant changes at the federal level, reductions in federal support. We are as concerned as everyone is about what the future holds with respect to the Medicaid program in particular. But we very strongly support the Legislature remaining very much engaged in the process of overseeing this important program and are fearful that allowing that delegation of authority to the executive branch would not be a step in the right direction.

On the mainstream side, we have a number of concerns just on how the process is working. We are, after all, providing coverage to individuals who need to access care in an efficient way. And while the New York State of Health has been very successful in some respects, the enrollment process has not worked as smoothly as it should, particularly with respect to enrolling people within the specialized program, the HARP program for the seriously mentally ill.

It has not occurred as smoothly as it should have, and we describe in our testimony in greater detail why that may be. Individuals who sign up for Medicaid managed care are not able to pick a primary care physician on the exchange when they sign up for coverage, which creates enormous challenges for the enrollee when they try to actually access care and are told when they show up to their traditional primary care provider that they're not listed as their PCP.

One of the other proposals that the Governor has advanced is to cut facilitated enrollment, a set of navigators hired by the plans to help people navigate their way through this complicated process, and we believe that would be a very unfortunate result that would leave more people unable to access care successfully.

There's been a lot of conversation about the pharmacy issues. And as Mr. Macielak just said, it does account for an extraordinarily large growth of cost on the managed care side. We appreciate the controversy around some of the proposals that have been advanced, but we absolutely share the conviction of the administration that something needs to be done to bring pharmacy costs in line. And if that's not successful, we have to at least pay for those pharmacy costs. And the rates that are being paid to the plans now underfund pharmacy benefits by literally hundreds of millions of dollars, leaving the plans in the financial predicament that other speakers have

mentioned.

On the managed long-term-care side, a number of folks have shared this view. Carving out the transportation benefit from managed long-term care is not a step in the right direction. It adds to discontinuity of care. The majority of our clients who are part of our managed long-term-care coalition would oppose that proposal.

Mr. Gottfried has raised some good questions about the nursing home eligibility change that has been proposed that would require people to be nursing home-eligible to enroll in MLTC. If there is something about the eligibility that needs to be changed, we'd be more than happy to work with the administration around that proposal. I think the questions that Mr. Gottfried has raised, and some that we have raised about being clear about what this change would actually mean, would need to be resolved.

The department has also proposed a ban on marketing by managed long-term-care plans. Not a very significant part of their

activity, I might add. But apart from the question of whether it's constitutional to ban a private organization from letting the world know of its existence, we think the concern that may have given rise to this may have a somewhat more of a nuanced response that we are prepared to work with the department to address. If there are some marketing practices and policies that need to be addressed, we'd be happy to address those.

Finally, the fundamental issue from a perspective of managed care organizations is the adequacy of rates that are paid to provide the coverage that they require. Over the last several years, the plans have been required to make sure that issues like wage parity, compliance with various changes in the Fair Labor Standards Act, minimum wage, adequate payments to nursing homes are transmitted through the system, none of which is possible unless the rates given to those plans are adequate.

As I mentioned, pharmacy costs have been very substantially underreimbursed for

the mainstream plans. On top of the inadequacy of the rates currently, it's also been mentioned both kinds of plans have been singled out for a cut in the quality payments that they receive. I should point out that these are quality payments that they essentially pay for, that come from their rates and then are redistributed based on their quality of results.

We're proud of the fact that plans who are members of our coalition receive a substantial amount of those quality dollars, and it is those dollars that actually, for some of these plans, have allowed them to stay above water. It makes very little sense to punish the high-quality performers through these cuts, and we have strongly advocated for a different way to save $70 million in a $62 billion program.

Finally -- and we've had a substantial amount of conversations with Mr. Gottfried's office and Senator Hannon's office around proposals to enhance the actuarial soundness of these rates, to strengthen the current

standards in law that require these rates to actually cover the costs of care consistent with federal law and regulation. And we proposed some specific language to do that and to establish special rate cells for some of the high-cost and most needy categories of patients that are covered.

And we're very pleased by the level of interest and consideration being given in both of their offices and to this proposal and we look forward to working with them, hopefully including something along those lines in the state budget.

CHAIRWOMAN YOUNG: Questions?

SENATOR KRUEGER: Just one? Thank you.

So it's pages and pages of technical -- but the one proposal on page 7, at the top, that -- HARP enrollment in the marketplace, that's actually an issue that's been coming up in my office.

Is there a way to streamline this?

MR. LYTLE: We think so. We've been having conversations with the department

about this. It is really a maze that individuals with serious mental illness are required to go through now to actually find themselves in the program that was designed to meet their unique needs.

The consequence for the plans has been -- and the consequences for the individuals can be tragic -- chaotic. These are individuals who are sometimes difficult to engage in the health care system at all, and to put these barriers in place makes things so much worse.

For those who actually somehow find their way into a HARP program, the plan actually gets an enhanced premium to provide all the additional services that they require. For a number of these individuals, they're remaining in a kind of limbo in a regular managed care plan who is obligated to provide all those same services anyway at a cost that far exceeds the premium that they receive.

So we've been working with the department. We believe that there is still a

great deal of work to be done to make that easier, and we'd be happy to work with your office on it.

SENATOR KRUEGER: Thank you.

CHAIRWOMAN YOUNG: Thank you, Mr. Lytle.

MR. LYTLE: Thank you.

CHAIRWOMAN YOUNG: Our next speaker is Assistant Director of Policy Lacey Clarke, from the Community Health Care Association of New York State.

The Medical Society is following Ms. Clarke, and following the Medical Society is New York State Public Employees Federation.

Welcome.

MS. CLARKE: Hi. Thanks for the opportunity to provide testimony today.

My name is Lacey Clarke, and I am the assistant policy director of the Community Health Care Association of New York State, CHCANYS, the state's primary care association for federally qualified health centers. We work closely with the more than 65 federally

qualified health centers that operate over 650 sites statewide and serve more than 2 million patients annually.

FQHCs are nonprofit community-run centers located in medically underserved areas that provide high-quality, cost-effective primary care to anyone seeking it, regardless of their insurance status or ability to pay.

New York's stated priority is to transform the healthcare system by providing access to high-quality coordinated care through the integration of primary care and other community-based care. However, FQHCs and other downstream providers have received less than 7 percent of DSRIP funds expended by PPS Leads to date, and since 2014 these community-based providers have received approximately 6 percent of the nearly $2.8 billion in Healthcare Transformation funding.

New York State is relying on the work of the community-based healthcare providers to transform the state's healthcare system,

yet has not made an equitable investment in the sector to support this work. CHCANYS urges the Legislature to ensure that FQHCs and other community-based providers receive proportional resources to ensure the successful transformation of the healthcare delivery system and continued access to high-quality, cost-efficient primary care services to all New Yorkers by increasing funding to indigent care services by $20 million and allocating 25 percent of the Healthcare Facility Transformation funds to community-based providers.

I'll talk about the indigent care funds first. For many years, the Diagnostic and Treatment Center Indigent Care Fund was comprised of $54.4 million in state funding and an equal federal match, for a total of $108 million. These funds are available to comprehensive D&TCs with more than 5 percent uninsured visits. Eighty-five percent of these providers are FQHCs. Although this funding does not fully reimburse FQHCs for the cost of providing care for the uninsured,

it's essential to ensuring that FQHCs are able to do so, a cornerstone of the federal mandate.

The authorization for the federal match expired at the end of 2014, and as a result, FQHCs and other safety-net providers did not receive any federal indigent care funds for 2015, a loss of $54 million.

CHCANYS worked closely with the Department of Health and CMS to restore the federal match, and in 2016 CMS approved a state plan amendment authorizing federal matching indigent care funds for FQHCs. However, the SPA changed the distribution methodology for the funds, disproportionately disadvantaging those providers who have high percentages of uninsured visits and comparatively low percentages of Medicaid visits.

To address this disparity, in 2016 the state created a one-time mitigation pool comprised solely of state dollars to ensure that those providers who saw the highest percentages of uninsured patients were not

unduly harmed. The state was also able to draw down additional federal dollars in 2016 to increase the total indigent care funds for all eligible providers.

CHCANYS is now asking the Legislature to maintain these 2016 indigent care levels by adding $10 million to the D&TC indigent care pool, a portion of which would be eligible for a federal match, and allocating $10 million for a mitigation pool, which would be a total investment of $20 million.

CHCANYS estimates that without this additional funding, health centers will potentially face a deficit of $100 million in uncompensated care costs in 2017 that they would have to cover from other funds. As a result, many FHQCs may be forced to reduce staff, eliminate expansion plans, or limit access to care for all of their patients. A decrease in indigent care funding may also unnecessarily increase reliance on more costly forms of care precisely at a time when many people are at risk for losing coverage due to potential federal actions.

Increasing funding for the indigent care by $20 million will ensure continued access to quality, cost-effective primary care for all New Yorkers, including those without insurance coverage.

CHCANYS was pleased that the Executive Budget proposal includes $500 million in new funding for the Healthcare Transformation Facility Fund, but we are dismayed that only $30 million, or 6 percent of those funds, are allocated to community-based healthcare providers. We are pleased that last year's budget allocated a minimum of $30 million, or 15 percent of the $195 million, to community-based providers, which is a very promising start.

In response to that RFA that was released in September, 163 community-based provider applicants requested $436 million in funding -- nearly 15 times the $30 million set aside. This overwhelming response makes clear that there is an enormous need from the community-based sector for resources in support of their participation in

transformation initiatives.

As the state continues to transform its healthcare system, FQHCs need access to resources to support an increased integration of services, expansion and reimagination of peer-coordination models in preparation for valued-based payments, modernization, expansion of facilities, and support and solidifying new and existing community partnerships to continue to address social determinants of health.

To ensure the state resizes its investments and makes the necessary investments needed to support successful delivery system transformation, a minimum of 25 percent or $125 million of the Health Care Facility Transformation funding must be allocated solely to community healthcare providers, including FQHCs, behavioral health, substance abuse, and home health providers, to support their ongoing participation and transformation efforts.

And then we just have a few other items that we also support, including adding

$20 million to the Community Healthcare Revolving Capital Loan funds, fully restoring funding to health centers that serve migrant and seasonal farmworkers, supporting Doctors Across New York, and rejecting the consolidation of public health program funding and restoring funding to school-based health centers.

In conclusion, CHCANYS supports New York's healthcare transformation efforts and is pleased that the state has recognized the importance of expanding access to comprehensive, community-based care. However, meaningful, sustainable delivery system transformation will only be achieved if the state provides appropriate financial investment directly to the community healthcare providers whose work is at the center of the reimagined care delivery system.

CHCANYS stands ready to work with the Governor and the Legislature to support New York's ambitious health care agenda.

Thanks for the opportunity to present

my testimony, and I'm happy to answer any questions.

CHAIRWOMAN YOUNG: Thank you.

SENATOR KRUEGER: Thank you very much.

MS. CLARKE: Thank you.

CHAIRMAN FARRELL: Thank you.

CHAIRWOMAN YOUNG: Our next speaker is Morris Auster, senior vice president and chief legislative counsel of the Medical Society of New York State.

And following that is PEF, and following PEF is the New York State Nurses Association.

Great to see you.

MR. AUSTER: Good afternoon. Thank you very much.

To be sensitive to the three dozen or so people behind me, I will try to be extremely brief. I do have written testimony before you right now, but we want to say, on behalf of the over 20,000 physician, student, and resident members of the Medical Society of the State of New York, thank you for the opportunity to testify.

Just to begin, we just want to note that we view the state budget in the context of a number of changes that are occurring in our healthcare system, which I hear daily from our physicians about it threatening the viability of their practices. Those that actually remain -- so many have actually been forced out -- feel they had to sell out to their local hospitals because they've been unable to keep their practices open as a result.

This has been a result of all the overhead costs in the practice continuing to rise every year, while seeing a continuing huge increase in patient cost-sharing responsibilities and a significant narrowing of insurance networks that's been demonstrated through our data that we've collected.

There's also a continuing push for value-based payment programs that require huge electronic health record and other infrastructure investments in order to avoid large cuts, such as the new Medicare

incentive payment program that got implemented -- that is being implemented this year, as enacted by Congress a couple of years ago, which is going to require huge administrative expenses in order to prevent Medicare payments from being cut.

Not surprisingly, there's all kinds of studies right now that actually demonstrate the huge costs of the burdensome prior authorization procedures. One shocking study -- I was amazed myself, but I guess it made sense -- was in the Annals of Internal Medicine last year that reported that for every hour a physician spends delivering care, two more hours are spent on paperwork.

And like everyone else, we are very concerned about proposals that will repeal the ACA without a suitable replacement, because certainly that could cause a lot of people to become uninsured, and frankly it would have a huge impact upon our state budget.

Given all these concerns, we actually thank the Governor for sustaining funding at

past levels for the Excess Medical Malpractice Insurance Program and urge that that funding remain at that level in the state budget. However, we're very concerned about a proposal that would require physicians otherwise eligible to receive a tax clearance before they attain this coverage. Our concern is that this requirement would be cumbersome to implement and could interfere with the timely issuance of an access policy.

And particularly we're concerned whether a good faith dispute over an alleged tax liability or a mistaken identity could cause someone to lose coverage accidentally or be unfairly dropped from the coverage. For example, there are five physicians in New York State with the name of "Thomas Smith"; there are five physicians with the name of "Michael Smith." So there could be all kinds of mistaken identities which could cause the policy to not become issued.

Again, the continued severity of liability exposure faced by physicians and

hospitals in New York, and the continued exorbitant cost of liability insurance borne by the physician and the hospital community, make continued excess coverage essential. The Legislature has rejected this proposal in past years, and we urge you to do so again.

Also on the subject of other proposals that have come up in past years, we're also very concerned with proposals that would eliminate the prescriber-prevails protections in Medicaid and Medicaid managed care. As we mentioned, physicians are already drowning in administrative burdens seeking to make sure their patients receive the medications that they need. We appreciate the Legislature has rejected this proposal in past years and urge that you do so again.

We're also very concerned with aspects of the proposed Healthcare Regulation Modernization team. While certainly examination of ways to improve our patient care delivery system is always appropriate, we are very concerned with the provision that would seem to permit workgroup

recommendations to be implemented without approval from the Legislature, even if it might overlap with an existing law that does not allow that specific area.

There are many good reasons why the Legislature chooses not to pass a particular piece of legislation, such as the change to a scope of practice of a particular healthcare profession. MSSNY has been working with several other medical specialty societies in opposition to this proposal, and we urge at least that that piece be taken out of the budget.

We also have strong concerns with the proposal that would create a parallel collaborative drug management program across New York State. We certainly -- certainly many physicians believe that the existing program has been positive, and we're certainly willing to talk about ways in which we can improve that program and maybe even expand the settings in which that program can be used, but we're concerned that the proposal in the Governor's budget does not

necessarily have the same guardrails as exist in the current law, such as seemingly giving greater ability to change medication, than what is currently allowed under the existing statute.

We're also concerned with expanding the program to permit it to also include nurse practitioners. When the program was enacted, the state actually did an extensive study of the physician-pharmacist collaborative drug therapy program and found some positive aspects to it which caused the program to be extended. However, there has not been a similar study involving nurse practitioners, so we are very concerned about extending that without further study.

And frankly, since the program has been extended through legislative activity -- it was extended last year from 2015 to 2018 -- we think it actually may be premature to even bring it up, so we prefer to actually have conversations about that issue in the context of next year rather than as far as this year's legislative cycle.

Finally, we appreciate the discussion that the superintendent brought up, the Superintendent of Financial Services brought up earlier regarding Health Republic. Last year many of you were involved in helping to create that fund. Unfortunately, as Senator Seward referenced, it was -- no money was applied to it. Senator Valesky, Assemblyman Gottfried we know actually proposed putting forth a guarantee fund to address issues like -- to help provide -- pay these outstanding claims as well as to address concerns like this in the future.

We know that there are disputes over the outstanding liabilities. I know Superintendent Vullo mentioned $212 million in potential claims; we have read somewhere that it was as much as $460 million, and that they have less than $100 million in assets. In any event, there is a significant gap in the amounts between what the company has to pay the claims and what liabilities they have. Clearly what's going to happen is that most healthcare providers are going to get

paid pennies on the dollar.

Last year we had a very strong debate over whether to provide some kind of funding to pay these claims in the future. While we know the liquidation process is going to continue throughout the year, we felt it's very important that the state step up and provide funding for this Health Republic fund, because probably not a week goes by without hearing from several physicians.

And I see Assemblyman Raia shaking his head, because he's probably heard from Dr. Harvey Miller enough times about what happens about the concerns about claims not being paid from Health Republic, but comments like that we receive all the time.

And it's unfair, from our standpoint, that physicians in good faith delivered care to these patients and may not be paid for the care that they've delivered. In this regard, we hope that you find some way in which to allocate some of the remaining settlement money, knowing that various settlement monies have probably been spent about 10 or 11

different ways. But we urge you to make funding for the Health Republic fund a priority as you try to work towards a final budget.

And with that -- we have certainly many other issues that we've raised in our written testimony, but with that I will answer any questions that you may have.

CHAIRWOMAN YOUNG: Any questions?

CHAIRMAN FARRELL: Thank you.

CHAIRWOMAN YOUNG: Yes. Assemblyman.

ASSEMBLYMAN GOTTFRIED: Just one comment.

I was interested in your reference to the amount of time and effort and whatnot that doctors put into things like prior authorization. As we've occasionally discussed, I do have a bill that would solve that and innumerable other problems, and at some point your members will rise up and insist that we enact it.

MR. AUSTER: Certainly many physicians agree with the concerns. I should say at this point probably not a majority of our

membership, but I think that many physicians do agree with where you are going.

CHAIRWOMAN YOUNG: Thanks, Moe.

MR. AUSTER: Thank you.

SENATOR KRUEGER: Thank you.

CHAIRMAN FARRELL: Thank you.

CHAIRWOMAN YOUNG: Our next speakers are Nora Higgins, RN, SN, Region 12 coordinator, and Kenneth Ferro, associate healthcare fiscal analyst, from the New York State Public Employees Federation, PEF.

Welcome.

MS. HIGGINS: Thank you very much.

Again, my name is Nora Margaret Higgins, and I thank you for the time allotted today for the concerns of healthcare workers throughout the very blessed state of New York. I say and mean the very blessed, because those of us in the healthcare profession have had the privilege of touching, and in some cases saving, thousands of lives.

I myself have worked as a nurse for 30 years, 27 of those I'm proud to say at

SUNY Stony Brook University Hospital, and I currently work in the neonatal intensive care unit.

Through the years the song for the state worker has remained the same: "Do more with less." Watching people leave and never get replaced, salaries stagnating, more limitations to the newly hired employee, and the downright despair and frustration one feels when wanting to provide the best care for your patients but are limited by time, inadequate resources, and insufficient qualified staff members.

The shortage of nurses and other healthcare professionals in New York State is not discriminatory, it is everywhere, most severely in the hospitals and the New York State facility settings. To a great deal this is caused by two opposing ends of the spectrum. First are the new nurses who are not willing to come or stay in New York State, and the other is caused by the multitude of nurses leaving the state due to retirement for fear of losing their license.

Enter the Justice Center. The exodus of registered nurses working in New York State is directly attributed to the difficult working conditions, including inadequate staffing, as evidenced by the preponderance of Protest of Assignment sheets we receive daily and weekly; mandatory overtime, even though there is a No Mandatory Overtime law -- state agencies continue to violate it without any penalty; insufficient compensation in comparison to the private sector that pays, on average, $10,000 to $15,000 more in annual salary.

Again, a personal note. Stony Brook Hospital is losing the nurses in droves going to the Northwell System -- they're providing education and finances beyond anything that we are even near.

PEF nurses are already wrestling with the chronic understaffing and the ramifications it causes facilities throughout New York. The compensation for nurses employed by New York State is not competitive with the private sector. Combine that with

the poor working conditions found in many of the state institutions, and this is the perfect storm in New York State to form a massive nursing shortage.

Examples of the poor working conditions faced by many of the PEF nurses include increased incidents of physical injuries to nurses working in state psychiatric hospitals and developmental centers -- assault; frequently being required by their agency to cover two floors of patients ranging from 22 to 24, and even being responsible for patients physically located in other buildings; license is in jeopardy; not being able to take meal or restroom breaks -- fatigue leads to a lot of mistakes; being mandated to work double shifts, in some cases being pre-mandated to work on their days off or on other off shifts, even though there is a No Mandatory Overtime law. The New York State Department of Labor thus far has done nothing to enforce this law in the state facilities, and there is no fiscal penalty.

The New York State Department of Corrections and Community Service is charged with the care and custody of people who violate the law in New York State, and yet they are the lead violators of the No Mandatory Overtime law. Since 2009, there have been 4,000 incidents reported of mandatory overtime involving DOCCS nurses. And this is as reported in the DOCCS Monthly Health Services Report dated November of 2016.

The Justice Center activity has not resulted in improved quality of care for vulnerable citizens but has in fact had an adverse impact by draining resources, limiting staffing options, and creating a negative atmosphere.

Think of how a seasoned psychological resident feels when he or she is now being cared for by entirely different faces when several people are pulled from a shift or a unit during an investigation.

Nurses are often put out for insignificant accusations that take months to

investigate, all while that nurse's caseload is then dispersed among the already overloaded coworkers. In many instances, the nurse was pulled out because of a lapse in best practice resulting from an unrealistic caseload and additional responsibilities. This then creates a more stressful and dangerous situation for fellow nurses and patients when the residual workload must be absorbed.

The nursing staff shortages generally force nurses on duty to work longer shifts and get less sleep, which can lead to life-threatening mistakes and illness. Studies cite that many nurses have left the profession as a result of emotional exhaustion due to inadequate staffing ratios and excessive hours. Many of these same studies indicate that nurses could be persuaded to stay in the profession if regulations were implemented that address staffing ratios. In the case --

CHAIRWOMAN YOUNG: I just want to -- so you're going to give testimony too?

MR. FERRO: Yup.

CHAIRWOMAN YOUNG: Okay. Could you kind of summarize?

MS. HIGGINS: Wrap it up?

CHAIRWOMAN YOUNG: Because we don't want him to lose his time.

MS. HIGGINS: Okay. All righty.

CHAIRWOMAN YOUNG: Okay.

MS. HIGGINS: So again, I just want to point out that a newly hired nurse is faced with six weeks of lag payroll, Tier 6 retirement package, significant risks to their nursing license, and little time off due to operational needs related to short staffing. What new nurse in New York State would want to be employed by the State of New York?

I will jump to the ask, okay, and I thank you for your time.

Respectfully I ask that the New York State Legislature pass staffing legislation which will include state institutions and hospitals. Leaving this as an option and not a mandate is truly not working out very well

for the patients or the nurses.

Include a fiscal penalty to the No Mandatory Overtime law that also includes state agencies.

Support increased compensation for state nurses working in direct care titles, in order to recruit and retain more nurses into state service.

Revise the Justice Center's approach of "shoot, ready, aim."

In closing, again, I thank you for your time and consideration. The life you save may be your own. Thank you.

CHAIRMAN FARRELL: Thank you.

MR. FERRO: Thank you.

My name is Kenneth Ferro. I'm the labor management chair for the Department of Health and OMIG since 2005.

PEF realizes that the Medicaid delivery system is changing. But what is baffling to us is PEF and CSEA do not have a seat at any of these tables. We see the public workforce as a major stakeholder with no voice. Being public employees, we work

for the taxpayers of New York State and so we are accountable to them. We deliver and protect the health and safety needs of the residents of New York State -- it is cost effective and productive.

The workforce in some health and Medicaid areas has been decreased substantially, through attrition and a hard hiring freeze causing staffing shortages in many bureaus. However, areas that were affected by the Affordable Care Act and the Medicaid takeover program have grown. This does not help address the issues caused by the shortages. In the short term, these short staffing levels could possibly save the state money, but in the long term it sets us up for the failure both financially and for patient care as well.

We strongly advocate that the state give the agency the resources to increase staffing levels to do the job properly and protect the taxpayers of New York State.

When we look at the health and Medicaid budget, there seems to be a common

theme: Streamline processes, elimination of functions, contract out, closures of facilities, consolidations of facilities as well. Audit and/or inspections. We again see the streamlining CON process is back. Although the efforts to streamline will help spend grant money on time, won't the lack of reviews and inspections have a negative effect? We understand the reasoning; the process became bogged down with the decrease in staff, and the applications are not being completed in a timely manner. Hence, shortage of staff.

DOH started streamlining health and safety reviews and inspections with the self-certification process around 2005 to allow a licensed professional certification as an alternative to project review by the department. Currently the self-cert is up to 25 million for a non-hospital and 50 million for a hospital.

This is a regulatory exception that the department has used for over a decade. It is now the primary approval method used to

oversee health and safety of all New York State hospital patients and nursing home residents. Self-certification projects were supposed to be audited; to date, we don't believe any projects have been audited.

In 2011 there was a bill, Assembly 7665 and Senate Bill 4992-A, Chapter 174, the notification process: Unlimited cost, eliminates review of non-clinical projects, no health and safety review of CON approval needed, the decision to provide a profession certification of code compliance is left up to the provider. It only requires an email to DOH advising that the project is in process.

List of nonclinical projects with no health and safety review from the department: Ventilation systems for operating rooms; ventilation systems for infection and disease control; ICUs; nurse call and Code Blue systems; sprinkler systems; emergency electrical power distribution systems and emergency generators. I know --

CHAIRWOMAN YOUNG: Sir, could you kind

of summarize and -- the reason is, you're out of time. And I'm not trying to be difficult, but we have 32 more people testifying.

MR. FERRO: Oh, got you. I got you.

CHAIRWOMAN YOUNG: We have your written --

MR. FERRO: You want me to summarize, okay. Okay.

CHAIRWOMAN YOUNG: And in the best case, with 32 more, that's at least five and a half hours. So if you could summarize, that would be helpful.

MR. FERRO: Okay, I got you. All right. All right. All right.

Best case scenario -- I'll skip that.

There was just a couple more I want to -- on the lab issue, we're for the lab. We're in desperate need of a lab. We would want more details on the lab. Again, we -- the budget says to audit -- you know, we heard testimony from Dennis Rosen, but there's a different story. I hear from the members.

And the members -- a full-blown audit

is, on the facilities, done every five or 10 years. We don't believe that the audits are really being done. We decreased the staffing level of -- we've decreased OMIG staffing by 6 percent, then we threatened the Medicaid provider that we're going to have OMIG audited. So we're doing one thing and -- we say one thing and do another.

All right, in conclusion, thank you for giving PEF the opportunity to work for -- we look forward to working together with you. We want to leave you with a few things in summary. We want to reemphasize that the public workforce is accountable to the public, transparent, and we are well-educated and have to meet minimum standards.

Please give all state agencies the funding to increase the workforce, but not decrease. When we decrease the budgets, you force the agencies to contract out. We have to train them, and in a lot of instances we continue to do the work. It's not cost-effective, and contractors are held accountable to their company, not the public.

When making a major purchase such as an automobile, my wife and I discuss whether we can afford it. In the Legislature, over the last few years, there have been bills introduced for a cost/benefit analysis. We would encourage you to pass this legislation, as we owe it to the taxpayers of New York State. It is their money, and we need to spend it wisely.

Again, thank you for the opportunity to testify.

CHAIRWOMAN YOUNG: Thank you.

MR. FERRO: And I apologize that I --

CHAIRWOMAN YOUNG: No, we appreciate and value our workforce, so we appreciate you being here.

(Inaudible; laughter.)

ASSEMBLYMAN OAKS: Thank you.

CHAIRWOMAN YOUNG: I think we're good. Thank you.

Our next speaker is Jill Furillo, RN, executive director of the New York State Nurses Association.

Following her will be the New York

State Association of County Health Officials, and following them will be the United Ambulette Coalition.

Welcome.

MS. FURILLO: Thank you. Good afternoon, everyone. I'm Jill Furillo. I'm the executive director of the New York State Nurses Association.

I will be brief. I have submitted remarks in writing, and I know you eagerly await perusing those remarks later this evening.

CHAIRWOMAN YOUNG: We will read them.

(Laughter.)

MS. FURILLO: Okay. So --

CHAIRWOMAN YOUNG: No, we will read those.

You know, as a matter of fact, all this written testimony is very valuable because we use it during budget deliberations. Because that's why you're here: You're on the front lines, and we want to hear from you.

MS. FURILLO: Absolutely.

We do represent -- we're the largest organization representing registered nurses in the State of New York. We have 40,000 members, and we do believe that healthcare is a right for all, and our nurses are committed to equal care for all New Yorkers.

We believe that our healthcare system is entering a period of acute crisis here in New York State, but not just in this state. There are multiple threats to the financial viability of our entire system, and that's coming from all different sectors. What we're seeing is restriction of access to care now, but it could even expand with these attacks on the financial viability.

There are continued efforts to undermine regulation of the publicly funded but largely privately operated healthcare system and that is a problem. And most importantly, the watering down of the professional scope of practice standards for nurses and other caregivers like our physician colleagues could affect the delivery of patient care.

With the issue of the ACA, we know that millions gained health coverage under the Medicaid expansion, and we know that without a viable alternative that we could see millions of people losing their access to healthcare. But even with the Affordable Care Act in its current form, we still have problems that face our system with the Disproportionate Share Hospital funding that would be cut in years going forward.

And so these cuts alone are going to cost our hospitals in New York State more than $24 billion over the next ten years, and that is a problem. We have to take immediate action to preserve and expand the rural and urban safety net hospital system that we have in our state.

Last year, the Legislature unanimously passed the Enhanced Safety Net Hospital bill -- unanimous. And we thank you, thank all of the legislators for the support of that legislation. That bill unfortunately was vetoed by the Governor, and we are here now in this budget process to talk about

that. It would have created a new category of super-safety-net hospitals that are eligible for enhanced reimbursement rates in order to maintain and expand services to the medically underserved rural and urban communities.

The Executive Budget also includes a proposal to provide $500 million in new funding for a Healthcare Facility Transformation Program, and that would be aimed at strengthening and protecting continued access to healthcare services in communities. This could provide funding for capital projects, debt retirement, working capital, or other noncapital projects to care or preserve or expand essential healthcare services.

This proposal allocates $50 million directly to the Montefiore Hospital System to allow it to expand the availability of affordable healthcare. That would amount to -- what we've done is we've been able to actually look at that formula, and we see that it equals about $166 for every Medicaid

and uninsured person that was seen on an inpatient and outpatient basis last year.

We support this proposal, and we believe that the funding should be distributed to these other hospitals that qualify under the enhanced safety net proposal, and this formula that would track the numbers of Medicaid and uninsured patients that would be served by each qualifying hospital. We also believe that the $50 million should be allocated to the direct care of patients in the Montefiore system.

We call upon the Legislature to amend the Executive Budget proposal target to the funding to support vital rural and urban safety-net hospitals using the definitions established in the Enhanced Safety Net legislation that was unanimously supported here. This would result in the distribution of funds to 15 public hospitals in Erie, Westchester and New York City, 18 federally designated critical access and rural hospitals, 16 federally designated sole

community rural hospitals, and approximately 25 voluntary hospitals that have the highest proportions of Medicaid and uninsured patients.

Secondly, we want to state for the record that we are in opposition to the proposal to create a Health Care Regulation Modernization Team. We believe this proposal could be dangerous, and it needs to be rejected because it would undermine standards and undercut public input. And again, we would agree with what our colleagues from MSSNY said about the process takes the decision-making away from the Legislature.

On a more positive note, we would support the inclusion in the budget of $225 million to assist healthcare providers in implementing state minimum wage increases, and the provision of $334 million in funding to support Essential Health Care Providers. And we also support the renewal and extension of most of the provisions of HCRA that was due to expire in 2017. We also support price controls on pharmaceuticals.

And lastly and ultimately, we urge you to pass the New York Health Act, which would guarantee equal access to care for all New Yorkers.

Thank you.

CHAIRWOMAN YOUNG: Thank you.

Any questions?

SENATOR HANNON: No. Good summary, though. Thank you.

CHAIRWOMAN YOUNG: Yes, wonderful. Thank you.

MS. FURILLO: Thank you.

CHAIRWOMAN YOUNG: Our next speakers are Frank Kruppa, president, New York State Association of County Health Officials, Tompkins County public health director and commissioner of mental health, and -- are you solo?

MR. KRUPPA: I am.

CHAIRWOMAN YOUNG: Oh, okay. Well, thank you for being here.

MR. KRUPPA: Thank you for having me, Senators, Assemblymembers.

My name is Frank Kruppa, and I am the

public health director and mental health commissioner for Tompkins County. I am also the president of the New York State Association of County Health officials.

The reason that I'm here today representing our 57 county members and the New York City Department of Health and Mental Hygiene is we are the boots on the ground for public health in your communities. Much of what you've heard this morning and will hear throughout the rest of this evening -- we touch, partner, or support in our communities locally. We are the foundation of public health, and we are here to ask for some consideration on concerns that we have -- both things that we support, as well as concerns that we have in the Executive Budget proposal.

To summarize those issues, we had hoped to see in the Executive Budget an increase in state aid to local health departments in order to help us shore up the foundation of public health services, things that you all are aware of that we've been

dealing with on an emerging basis. Legionella, mumps, Zika, water contamination are all things that we are there and prepared to respond to, and we need that foundation in order to be able to meet the needs.

Besides not seeing an increase, we were very disappointed to see that there is a proposed cut to our members in New York City, and we would hope that the Legislature would be able to work to restore that funding as well as consider our proposals.

I am also, as the public health director, the Early Intervention Official for my county. But my most important role is I am the parent of an Early Intervention child. And I can tell you that the fiscal agent is not working as it was planned to work. It has not decreased the administrative burden to municipalities, it has not increased the insurance amounts being collected, and I can tell you from personal experience that my physical therapist for my daughter went 10 months without getting paid, and it was only because I found out late last year that

that was occurring and I knew who the right people were to call.

Probably the most concerning part of that -- we know there are issues, but I was thanked profusely for bringing it to the attention of the Bureau of Early Intervention that the providers were not being paid.

I am not unique. We have several families who are part of nonregulated insurance programs that are having these same issues with their providers in Early Intervention. We support the Executive's proposals to improve Early Intervention, but we would suggest that there is more work to be done.

We want to be clear that the local municipalities are not in a position to take back the responsibility. Funding was removed from us as part of the transition to the fiscal agent, and many counties have dismantled the support personnel and others necessary to administer that fiscal function. It would be extremely difficult in an era of tax caps and consolidation to rebuild that

infrastructure quickly.

We are opposed to the pooling of the discrete funding lines for chronic disease and maternal child health, as well as the 20 percent reduction associated with that.

We would also be opposed, as many others are, to the broad authority for the Executive to make budgetary changes without the input of the Legislature. So we would encourage you all to address that issue.

We applaud the Governor's initiatives to invest in water infrastructure and water quality and to include e-cigarettes under the Clean Indoor Air Act. We at the county health departments stand ready to support those initiatives, but we want to make sure that there are associated resources so that they are able to do that effectively for you and for our communities. We want safer water, we want cleaner air, and we want to be able to do that for our citizens.

So I will get to our most specific ask related to state aid in the budget. We have brought this to you before because we do feel

very strongly that we did need to increase the foundation of public health in our communities. And so right now we receive a base grant which pays for a hundred percent of court-eligible public health services in our counties, and then we are also compensated on a percentage basis for every dollar over that base grant.

We are proposing that for partial-service counties, those that to do not do environmental health services, that the base grant be increased from $500,000 to $550,000, and for full-service counties that it be increased from $650,000 to $750,000.

And for our counties that are larger that receive a per capita amount that if it is larger than the base grant, we are proposing an increase to $1.30 per capita from the current 65 cents. And our goal with this is to build up the infrastructure as a partnership between the state and our counties to be prepared for public health issues that we are faced with every day.

We do have a budget-neutral request

that we have as well. We are required to show maintenance of effort, essentially ensuring that the counties are supporting at the same level the core public health services that the state also supports. And so we report those on a quarterly basis, and we are required to show maintenance of effort in each single line of service we provide as a core public health.

We would like to see that combined to give us the opportunity locally to ensure that we are continuing to fund public health and core public health services at the same level, but doing it in a manner that's most effective to our communities. So we would like to see the opportunity to have more flexibility with that as well as having annual reporting rather than doing it quarterly.

So those are our asks and some of the concerns that we have. As I said, we feel like we are ready to serve in any fashion that we can as your local public health workforce and we're just asking for your

support we so we can do that effectively.

With that, I'd be happy to answer any questions.

SENATOR KRUEGER: Thank you.

CHAIRWOMAN YOUNG: Thank you for being here.

SENATOR HANNON: Thanks for shortening it.

CHAIRWOMAN YOUNG: Next we have Neal Kalish, codirector of the United Ambulette Coalition.

Following Mr. Kalish will be the Upstate Transportation Association, and following them will be the Pharmacists Society of New York State.

So we have Mr. Kalish, and who do you have with you?

MR. KALISH: Good afternoon -- or evening, as it might be at this point. I am Neal Kalish. I am a director of the United Ambulette Coalition. I have my colleague Wayne Soifer with me. Wayne is also a codirector of the United Ambulette Coalition. He's here to help me answer any questions,

but more importantly, Wayne will kick me under the table if I go and on, so --

CHAIRWOMAN YOUNG: The clock is ticking.

MR. KALISH: I'll try to keep it brief. You have copies of my written testimony. I've tried to skinny this down to a few key points to talk through.

But again, thank you so much for your time, and we really do appreciate it.

We are seeking your help and support on two items in the Executive Budget, and I will go over them momentarily -- minimum wage rate relief, which is dramatically underfunded, along with adult day care reimbursement methodology.

Before I get into that, I know this morning I was listening to some of the testimony and there was a -- the Ambulance Coalition was here, the ambulance group that was talking about minimum wage and their impact on that group as well. And I thought I would give you just some very brief background on the Ambulette Association we

represent in New York City.

We'll talk briefly about the service that we provide and how critical it really is to the Medicaid population. Obviously it's a -- I also own a company. As a company owner, we want to do well, but it's all about service. It's about providing quality access to the Medicaid population.

What we really serve is the hardest to serve of the Medicaid population. It's the sick, the elderly, the infirm. They are often wheelchair-bound, or they have difficulty ambulating on their own, often weak, often suffering with side effects of a treatment like dialysis, chemo, or radiation treatment. It frequently leaves them in a frail condition post-treatment following the side effects.

Without the access we provide, I believe it's a fair assumption that many amongst this population would require a far more costly ambulance transport. So by virtue of what we are doing, by providing access, we are keeping a population that

needs preventive care -- enabling them to access that care and treatment.

If, as an example, a dialysis patient could not access dialysis treatments based on the service we are providing, it's a fair assumption they would be calling 911, that they would need an ambulance transport at a far more burdensome cost to the healthcare system. They would be transported not to a dialysis facility, but to a hospital emergency room, potentially for an extended stay at thousands of dollars per night. I believe that makes a $34 ride, which is our reimbursement rate on the Medicaid side of the program in New York City for transport in New York City, a relative value to the healthcare system.

We provide access -- some of the other things we do -- to adult day treatment programs. These are programs that often are keeping the elderly from requiring far more costly nursing home stays or nursing home admissions.

We keep the New York City hospitals --

and if you talk to the New York City Health and Hospitals group, I think they would validate this in many respects -- operational as it comes to the Medicaid side of the program. We are responsible for the smooth transfer of patients that are going in and out of hospitals, emergency rooms, and the clinics that they operate, and I believe we are instrumental. The service we provide is a door-to-door service -- this is not curb to curb, it's door to door. It's helping Medicaid recipients in and out of their residence and in and out of the medical facility where they're receiving treatment.

We go up and down flights of steps in non-elevator buildings, so we are carrying wheelchair-bound Medicaid recipients up and down flights of steps with two-man trucks. We have a helper on board those vehicles. We move in and out of some of the most challenging and dangerous of housing projects in the nation. Beyond that, we sit snarled in traffic in New York City.

I don't know, a couple of months ago

the New York Post had an article talking about New York City being slowed down to an 8-mile-per-hour crawl -- it's great for pedestrians, but we're living that as company owners. It's very, very difficult to move around New York City right now.

I'll talk about our issues momentarily, but just a couple of things that I'm very proud of. I got into this industry right before 9/11, it was August 2001. And on 9/11 the city was traumatized, obviously -- the city was shut down. We were out there as ambulette providers, as an industry continuing to provide access. We did the same following Hurricane Sandy. We were sending vehicles out to Floyd Bennett Field, to the far reaches of Brooklyn, to get gasoline to continue to service the Medicaid recipients particularly going to dialysis. And during these storms of the century that we have every year, our blizzards and so forth, we're out there and we're running to ensure access.

The first issue I'd like to address,

and I'll touch on it, is minimum wage not being adequately funded in the Executive Budget. We employ thousands of predominantly minority employees, including drivers, matrons, and helpers on board our vehicles, along with clerical, admin staff, and mechanics. Many of these employees, particularly a helper or a matron on board the vehicle, they're at minimum wage. So they're earning -- they were earning $9 an hour. That just went to $11. There is a knock-on effect. Nobody wants to talk about the wage scale, but we have drivers who are earning $11 per hour, and now they're demanding increases as well. So it is having a dramatic impact on our payroll.

Overtime in our industry is excessive, and it's not because we generously want to give out overtime. It's really to meet the demands of dialysis facilities and the hospitals that are running 24/7 to bring patients in and out of treatments and in and out of their ER rooms. So if you look at what we're doing, we're dependent on the

Medicaid program to pass along to us on rate. We're not McDonald's, we're not Starbucks where we can take up the price of our product. Obviously it's about proper, fair rate setting.

Minimum wage in New York City going up 66.6 percent in two short years, by December of 2018. Recently the Department of Health was quite helpful, they put through a 4 percent rate increase that went into effect -- unfortunately, that was only on a small segment of the transports that we're running. The MLTC plans -- and what I mean by that is they only put their own increase on transports that are under five miles. So the rest of the work that we're doing, which is taking people out of borough, going from Manhattan out to Brooklyn, or doing longer-distance transports -- that's about 40 percent of our work -- was not included.

The MLTC plans and their broker network did not pass anything along to us as yet. The OMRDD program has not passed further. So when you look at the percent of

work we're doing, it's about 60 percent Medicaid fee-for-service, about 40 percent on the MLTC and OMRDD side. And when you look at the rate increase we've received so far, it probably adjusts about 20 percent of our transport. It simply doesn't go far enough. We're seeking your help on that issue.

As we get into next year, we're estimating approximately $11 million is required in funding, and that's Medicaid only. It's Medicaid as well as MLTC transports, not including OMRDD. Again, we are dependent on the Medicaid program to do the right thing. That enables us to continue and provide access.

The second issue is adult day healthcare. We oppose the Executive Budget initiative that would preclude adult day health programs from administering transportation directly for enrollees in their programs. Presently ADHC programs have flexibility, they can contract directly with a transportation provider. In so doing, they can have their own quality control metrics in

place so they can credential and have metrics for on-time performance, for safety, they can have insurance requirements that if we were billing directly to the Medicaid program, we would not necessarily -- the facilities would lose that flexibility.

So the Adult Day Health Care Association is looking to maintain that ability to bill Medicaid directly. We're supportive.

And with that, if you have any questions -- otherwise, I again thank you very much for your time and attention this afternoon.

CHAIRWOMAN YOUNG: I don't believe we have any questions, but we certainly appreciate your patience today and your input.

MR. KALISH: Thank you so much. I know it's been a long day for all of you.

CHAIRWOMAN YOUNG: Thank you.

SENATOR KRUEGER: Thank you.

CHAIRMAN FARRELL: Thank you.

CHAIRWOMAN YOUNG: The next speaker is

John Tomassi, president of the Upstate Transportation Association.

Following Mr. Tomassi will be the Pharmacists Society of New York State, and following them will be the Chain Pharmacy Association of New York State.

Welcome.

MR. TOMASSI: Thank you. My name is John Tomassi. I represent the Upstate Transportation Association.

CHAIRMAN FARRELL: And you came yesterday?

MR. TOMASSI: I'm sorry? I was here yesterday, yes. Probably about the same time, too.

(Laughter.)

SENATOR KRUEGER: That's what I was thinking.

SENATOR HANNON: They thought they were having a flashback.

MR. TOMASSI: I planned it better and came later. I didn't come at my appointed time.

As I said yesterday, the Upstate

Transportation Association is a not-for-profit trade association representing for-hire transportation companies. While our members were initially limited to upstate providers including taxi, livery, and medical transportation providers, we have been expanding our membership to all areas of New York State, not just upstate.

The budget issue we would like to address today is the Governor's proposed carve-out of the Medical Transportation Benefit, which would shift the funding for this benefit from managed long term care, MLTC plans, over to the Medicaid fee-for-service transportation manager.

We are overwhelmingly in support of the Governor's proposal to implement this proposed carve-out. The MLTC program as currently operating is unnecessarily increasing the cost of Medicaid-funded transportation while at the same time providing a less-than-satisfactory level of service to the Medicaid population.

As currently structured, MLTC

providers are funded on a capitated basis. As part of their funding, they receive a portion to be allocated to the transportation provider. The MLTC plans are fighting to hold onto the funds for Medicaid transportation, when the vast majority are turning around and outsourcing this program to brokers. The brokers are then retaining a healthy portion of the rate initially dedicated to the transportation providers, resulting in an MLTC rate structure that at times can be as little as half the Medicaid published rate for identical transportation provided to a non-MLTC Medicaid patient.

The original intent of having the MLTC providers manage their transportation needs was based on the premise that they can best serve their Medicaid clients when they control the entire process including transportation.

Presently, 22 of the 28 MLTC programs reviewed have abdicated their responsibility for transportation and farmed it out to a transportation broker. Please refer to

Exhibit A for a list of these MLTC programs. The brokers are then responsible for coordinating the transportation and establishing a transportation rate structure. It makes little sense to have 28 separate MLTC transportation programs when this can be consolidated in one more efficient program that is already established on the traditional Medicaid side. Why have 28 MLTC plans, with each plan having a medical transportation program, when a single program can manage all Medicaid recipients included under one cost-effective, more efficient umbrella?

Furthermore, these transportation brokers are not licensed or vetted by Medicaid but operate under their own authority. All MLTC program providers and Medicaid transporters of fee-for-service programs are required to have a Medicaid provider number assigned by Medicaid after meeting the Department of Health's requirements. They are also subject to routine Medicaid inspections by the Office of

Medicaid Inspector General to verify they are in compliance with Medicaid rules.

Under the MLTC program, no Medicaid approval is required of the transportation broker or the transport companies operating under the MLTC framework. Yet despite an estimated 40 percent of the total Medicaid transportation dollars flowing through these unregulated transportation brokers and in many cases unregulated transporters, these brokers are neither bonded nor required to provide audited financials.

As has happened in the past, if one of these transportation brokers files for bankruptcy or simply closes down the operation, our transporters would be left with a significant loss of revenue for all trips that have been completed and billed but no payment received. In 2002, the transportation broker Rainbow Transportation Services filed for bankruptcy with unsecured claims of over $3,300,000 -- a majority of which were completed trips provided by Medicaid transporters that went unpaid by

Rainbow despite Rainbow receiving the funds from Medicaid.

The potential for a repeat of this scenario still exists today. I have included a recent article from Crain's highlighting a critical payment issue with the largest of the MLTC transportation brokers. Many transportation companies are facing serious financial hardships due to the lack of timely payments, and in many cases no payments at all, for trips provided to Medicaid patients under the direction of the MLTC transportation broker. The members of our association are owed millions of dollars for trips completed over three months ago, and there are a significant number of members of our association who are owed in excess of $300,000 apiece and in many cases are due funds from 2005 that have not been paid.

It is important to understand that none of these trips have been challenged by the transportation broker, they have just not been paid. This doesn't happen under the traditional Medicaid model currently in

place.

Just to review the Medicaid fee-for-service issues and how the process works, Medicaid fee-for-service issues an authorization almost immediately when a transportation service is ordered, and upon documenting completion of the transport, the transportation provider is able to bill at the established Medicaid rate for a fee for service.

If a transport -- the Medicaid fee-for-service reimburses on a three-week cycle. If a transport request is from a broker or directly from an MLTC plan, the broker is typically paying a lower rate versus the established fee-for-service rate. And now there's a third-party middleman, the broker, taking an average of $5 or $6 off the top from every trip, leaving the provider with zero profit or a loss on that broker's assigned transport.

The MLTC plans, unlike the three-week cycle of the fee-for-service, pay off in 60 to 90 days after service, again owing

millions of dollars for services rendered but never paid. As was mentioned previously, the increase for the minimum wage allowed by Medicaid earlier this year did not get passed through the MLTCs to the transportation, it was only in the fee-for-service.

In summary, while the MLTC plans and their brokers lobby to keep this funding and not have it carved out, they in effect are taking advantage of the provider network -- shortchanging them on rate, not passing any relief on minimum wage, not paying timely, and sometimes not paying at all. The vast majority of the plans are acknowledging they cannot run transportation efficiently in house and are outsourcing transportation to brokers.

As has been well established in many markets across the country, when the transportation program is run by a broker, the broker often works in his own financial best interest. And this is not consistent with what is in the best interests of the Medicaid recipient, who requires quality

transportation, access to medically necessary care and treatment, and often at the expense of the transportation provider who is working diligently to ensure safe and timely service to Medicaid.

The Department of Health came to this realization a few years ago when they hired Logisticare and Medical Answering Service to handle the fee-for-service side of the program in a gatekeeper or management role, not running a brokered model in New York State. The Department of Health is now acknowledging that this system is flawed -- the MLTC system is flawed -- and therefore is proposing to carve out the transportation dollars from MLTC. Anything less is to the detriment of the Medicaid recipient in need of quality care and service and to the detriment of the transportation provider handling the work.

Thank you for your time.

CHAIRWOMAN YOUNG: Thank you.

MR. TOMASSI: Any questions?

SENATOR HANNON: Cathy?

CHAIRMAN FARRELL: Thank you very much.

CHAIRWOMAN YOUNG: Yes.

SENATOR HANNON: I just want to tell you, sir, you've cited instances from 2002 and 2005 about MLTCs?

MR. TOMASSI: I --

SENATOR HANNON: We just established MLTCs about 2002 --

MR. TOMASSI: No, I'm sorry, I was citing a transportation broker.

SENATOR HANNON: This is your written -- your written presentation infers that those things were because of MLTCs. And it's just not the case.

MR. TOMASSI: Right. I'm sorry. I didn't mean -- I meant for there -- become -- transportation brokers. Not because of MLTC.

SENATOR HANNON: Thank you.

CHAIRWOMAN YOUNG: Thank you.

MR. TOMASSI: You're welcome.

CHAIRWOMAN YOUNG: Anyone else?

Thank you. Our next speakers are President Russell Gellis, from the

Pharmacists Society of New York State, and Kathy Febraio, who is executive director.

Following them is the Chain Pharmacy Association of New York State, and following them is the Empire Center for Public Policy.

Thank you for being here.

MS. FEBRAIO: Thank you for the opportunity.

I'm Kathy Febraio, executive director of the Pharmacists Society of the State of New York. We are a statewide organization that represents the licensed pharmacists, there's over 25,000 in the state. Most of our members work in community pharmacy and many of them are independent pharmacy owners.

I will now turn it over to Russell Gellis, our president.

MR. GELLIS: Thank you very much. My name is Russell Gellis. I'm an independent pharmacist. I own a pharmacy in the Upper West Side of Manhattan. I'm the current president of the Pharmacists Society.

I'll try to keep this brief, but this is very important stuff. The Medicaid

proposal on the fee-for-service in the budget came about because of CMS's final rule, which required that state Medicaid fee-for-service programs adopt an actual acquisition cost methodology plus a new professional dispensing fee. Okay? Basically, it also stated that the reimbursement should be fair, should be consistent with efficiency, quality of care, and assured access.

Nothing in the requirement from CMS of the realigning of the reimbursement formula means there needs be a reduction in the payment levels to pharmacy. Pharmacy cannot sustain any more reductions in payments.

The methodology is changed. New York State Department of Health is going to adopt a survey done by CMS, it's called NADAC, it's a survey of invoice pricing voluntary throughout the country as the acquisition cost. A couple of brief things on that that is concerning. It is a survey, it's an average, a national average of invoice prices for pharmacies throughout the country.

Some pharmacy will buy below that

average. Okay? Those pharmacies are going to have a hard time filling prescriptions below cost. Okay?

The other thing is is that because it's a survey, there's a lag in the updates, so when prices go up there's going to be a situation where claims will be paid below cost. Okay? And to be clear, on the acquisition cost of the drugs, it's a steep reduction in payments to pharmacy. The Department of Health proposed a new fee of $10 that's not only unreasonable, it's inadequate, it's unsustainable.

Let's also not forget that on brand-name drugs there's a $2.50 copay, which I can tell you, it's -- certainly in the downstate area, it's very rarely if ever paid. Okay? And where this is, just to be clear, a problem, is there's many patients in the five boroughs of the city that require very expensive medications, whether it's HIV, other disease states, high-priced insulins, you're expecting the pharmacy to pay it -- actual acquisition cost -- when it can be up

to a $1,000 to $2,000 claim, plus $10, less the $2.50, for a net $7.50. That's the severity of this situation for pharmacy. Okay?

So the other thing is the dispensing-fee side. CMS's final rule required state Medicaid programs in their state plan amendment to be submitted to CMS for approval to either do their own statewide analysis of cost of dispensing in pharmacies or use recently approved surveys done by qualified firms that were approved by CMS and then adjust for the cost of doing business in New York State, which of course we know is probably one of the highest. Okay?

So we, PSSNY, in working -- and the Chain Association, with the Department of Health, had gotten some surveys to them that were recently approved by CMS. In North Dakota it was $12.46, in the state of Missouri it was $12.99. Okay? The department instead decided to use their own flawed survey that was rejected by the Legislature in 2012, with data that is by no

means current. Okay?

This is really, in our eyes, just unacceptable. Okay? By any reasonable standard, the fee in New York State should be higher than fees paid in other states, taking into account the cost of doing business -- particularly in the five boroughs of New York City, particularly as other people that have testified mentioned with the minimum wage -- that impacts pharmacies very significantly. Okay?

We're just very concerned about the independent pharmacies and the patients they serve that require high-cost medications. This is not only from a business standpoint -- for the pharmacies, a critical issue -- but for the patients that require our trying to fill those prescriptions. That is our concern on the issue.

And I just want reiterate that the Department of Health used their own flawed survey that was thrown out by the Legislature, rejected, that was done in 2012 of 2011 data. CMS, in my conversations with

CMS, required surveys that were done recently and adjusted by cost of doing business in New York State.

So basically, in closing on this issue, we are committed to work with the Legislature to determine a fair reimbursement rate for the pharmacies so they can remain to serve the communities that they're in and the patients can continue to get the vital medications that they need.

On the issue of PBM registration or licensing, I will say that we wholeheartedly support it. It's long overdue. I was also impressed by the Superintendent of the Department of Financial Services, of her knowledge of the issue. PBMs started as middlemen that basically processed the claims, okay, when they started. They've developed into a multi-billion-dollar industry. The three CEOs of the top three PBMs alone last year earned themselves almost $50 million, okay?

So the Governor is correct in wanting to be bring down the cost of drugs.

Registering and regulating PBMs is going to be a tremendous step forward in seeing where all the costs are. Many of those rebates are not shared, they're not shared completely with the payers, it's buyer beware, depending upon the contract.

I think the Governor and his experience when he was the Attorney General of the State of New York -- my recollection is one of the PBMs that was handling the benefits for the Empire Plan settled a $27 million lawsuit with the State of New York. It's clear that these entities have to be controlled. They have self-interest, they self-direct, they own the mail-order pharmacies that they force patients to go to, they don't comply with laws passed in the State of New York.

We had a law passed in 2012 overwhelmingly by this Legislature preventing mandatory mail order. It's been completely ineffective, due to the fact that the PBMs have found loopholes in how to avoid it. Okay? So I think it's clear that we strongly

support and will work with you if there's any further information you need around the PBMs.

The high-cost surcharge -- I would say that we're all in favor of reducing the cost of drugs, but that surcharge and whatever costs there are can only be on the manufacturers. The wholesalers and the pharmacies cannot afford one penny of additional tax. If you tax or surcharge the wholesalers, they're going to pass it on to the pharmacies. So I just want to be clear that while we -- the intention of it is good, we have to be clear that that part of it is absolutely unacceptable.

We also applaud the Governor for recognizing pharmacists with his -- the component of comprehensive medication management came out of the Value-Based Payment Workgroup to reduce care costs and improve care in the health system, and we support that.

Thank you.

CHAIRWOMAN YOUNG: Thank you.

Senator Hannon.

SENATOR HANNON: I just think I'd like some more information -- not now -- about NADAC. Okay?

MR. GELLIS: Absolutely. Yeah.

SENATOR HANNON: Thank you.

CHAIRWOMAN YOUNG: Thank you. Anyone else?

Thank you very much.

CHAIRMAN FARRELL: Thank you.

MR. GELLIS: Thank you.

CHAIRWOMAN YOUNG: Our next speaker is President Michael Duteau, Chain Pharmacy Association of New York State.

Following him will be the Empire Center for Public Policy, and following them will be the Associated Medical Schools of New York.

Thank you for being here.

MR. DUTEAU: Good evening. Thank you for the opportunity, Chairwoman Young and esteemed members of the committee.

CHAIRWOMAN YOUNG: Nice to see you here.

MR. DUTEAU: I certainly appreciate

your time this evening. I will be concise and to the point.

Again, my name is Mike Duteau. I am the vice president of business development and strategic relations for Kinney Drugs. I am also the president of the Chain Pharmacy Association of New York State.

The Chain Association and our member companies across the state are focused on protecting patient access to pharmacy care and strengthening the role that pharmacists can play in improving patient health outcomes while reducing cost.

In summary, there are four areas of the budget we would like to briefly discuss and share our position.

First and foremost, the proposal to change pharmacy reimbursement under Medicaid from fee-for-service to a cost-based reimbursement with a professional fee. I think Mr. Gellis and Ms. Febraio before us adequately discussed the benchmark and the methodology. I won't get into the details; we concur with their statements, we share

their concerns, and I would like to put a few things into perspective.

We recognize that NADAC is a national survey supported by CMS. We just want to acknowledge publicly that moving to NADAC is a $48 million reduction from today's reimbursement model. So it's certainly substantial for our community pharmacies.

Also putting into perspective is the $10 professional dispensing fee that has been proposed. From our perspective, again, there are other states that were previously mentioned that are much higher, that have a much lower cost of living as well as a cost of doing business, and we feel that that certainly should be reconsidered. Ten dollars is not a sustainable model for any of our community pharmacies located in any section of our state.

Finally, on the reimbursement model, where NADAC is not available -- so new drugs, potentially very expensive specialty drugs where there's not enough survey data -- the state has proposed to use another benchmark.

And I know that pharmacy and healthcare is a sea of acronyms; this is wholesale acquisition cost, or WAC. Most states that are implementing the CMS outpatient rule where there is no NADAC, they are either using WAC or in some cases -- like New Hampshire just announced today WAC plus 0.8 percent for brands. New York State models WAC minus 3.3 percent.

So on a specialty drug, which of course is an extreme example -- a $30,000 drug where you're losing WAC, you're being paid at WAC minus 3.3 percent -- that could result in a pharmacy being paid hundreds of dollars below cost. That's not sustainable. We certainly are concerned, and we oppose the reimbursement proposal because of that methodology.

SENATOR HANNON: This is the chains. They were the independents.

MR. DUTEAU: Secondly, I would like to discuss the surcharge on certain drugs deemed as high-cost on establishments making first sales of the drug in the state. We fully

support this proposal, with a concern that again we would like to bring public. The way the proposal is currently written, it could inadvertently -- and we do not believe this to be the intention, but it could inadvertently make pharmacies and in some cases even wholesalers responsible for that tax when it is the manufacturer that sets that price.

Some drugs are extremely expensive. We understand that. We support all efforts to make drugs more accessible and more affordable for not only the patients but also the healthcare providers that support them. Again, we do support this, but we ask that pharmacies not be included in the definition of "establishment."

Thirdly, we support the proposal to create a program for improved management of medications for patients with chronic diseases -- comprehensive medication management, as it's been called. This was really something that came out of recent MRT, the Medicaid Redesign Team conversations, on

how to better support patients and how better to achieve goals of significant programs such as DSRIP.

In conversation with industry stakeholders and provider groups, this was determined to be a potential program that, similar to what already exists in law with CDTM, would allow community pharmacies to work with patients who have chronic conditions. So a little bit more narrow in scope, these patients would already be diagnosed by the physician, it would be patients with chronic conditions, participation by all providers in -- also the patient is voluntarily -- and we feel that it is certainly a great way for the state, our patients, and our providers to all come together and improve patient health outcomes and reduce costs across the board.

Finally, again, I know that the Pharmacists Society before me spent a great deal of time on this, and I think they did an excellent job portraying some of the concerns. From the Chain Pharmacy

Association, we do support the proposal to regulate pharmacy benefit managers. We feel that registration and licensure is certainly a great first step. Right now, pharmacy manufacturers, pharmacy wholesalers, and of course pharmacies have to be registered and licensed to operate in New York State. It only makes sense that PBMs would also follow suit, so that we can have what I consider to be a strengthening of the integrity in not only the distribution system but also the patient care continuum.

Thank you for your time.

ASSEMBLYMAN OAKS: Thank you.

CHAIRWOMAN YOUNG: Thank you.

Questions?

CHAIRMAN FARRELL: Thank you.

SENATOR HANNON: I'd like to hear more about NADAC, which means that you would get less reimbursement than your acquisition cost.

MR. DUTEAU: In some cases, yes. Because it is an average.

SENATOR HANNON: And at that -- I

would not understand how anybody would stay in business or stay offering that product.

MR. DUTEAU: We are very concerned about it as well. And we certainly appreciate the attention.

CHAIRWOMAN YOUNG: Thank you, Mr. Duteau.

MR. DUTEAU: Thank you.

CHAIRWOMAN YOUNG: Our next speaker is Director of Health Policy Bill Hammond, from the Empire Center for Public Policy.

Following Mr. Hammond will be Associated Medical Schools of New York, and following them would be the New York Biotechnology Association.

Hey, Bill.

MR. HAMMOND: Good evening.

My name is Bill Hammond. I'm health policy director for the Empire Center.

I wanted to start by saying something nice, and that is that I think it's clear that New York's Medicaid program has gotten measurably more efficient in the last five or six years. The cost per recipient is going

down, and that's the right direction. It's partly a function of demographics. The enrollment going up made a big difference. But New York's rates are going down faster than the national average, and that's a credit to the reforms that the Legislature and the Governor have put in, at least partly.

But this is no time to take the foot off the pedal. We're still spending a lot more per recipient than most states. And we have significant uncertainty about funding from Washington. And that brings me to the main topic I wanted to talk about today, which is the Healthcare Reform Act.

It is being renewed for three years. It actually means that a three-year period will bring in more money than the extension of the millionaire's tax. This is a very large piece of our revenue structure in New York State. And I would also say it's a very -- the Governor is proposing to extend it for three years without any significant changes, and I think that would be a mistake,

because the way this law works is very flawed.

It has changed dramatically over the years, and I know I lost track of what -- how it worked and what it was doing. I just want to draw attention to a few things that have happened since it first passed in 1996.

First of all, it's now raising $5.6 billion dollars a year. That's three times the original number. It ranks as the state's third-largest tax, behind income and sales. It's a regressive tax. It doesn't adjust for ability to pay. The guy stocking shelves at Walmart pays -- if he has insurance, pays about the same as the guy trading stocks on Wall Street. It's hidden from the public. It's paid by the health plans, worked into the premiums that are then passed on to employers. Chances are most people in New York State aren't aware that they're paying this tax.

And yet as we heard before from Paul Macielak of the Health Plans, it adds about 5 or 6 percent to premiums for a family of four

in New York City. That's maybe a thousand dollars or more. That is -- it's one reason why New York State has the second-highest health premiums in the country. And this is at a time when we're trying to make health insurance more affordable, not less.

There's also one piece of it that's unfair regionally. The covered lives assessment costs different amounts in different parts of the state. It's $9 per individual in Utica, it's $185 per individual in New York City. This is a throwback to a time when the law was subsidizing graduate medical education. It hasn't been doing that in seven or eight years.

So that's the taxing side. The spending side has drifted considerably too. You might remember the big expansions of the early 2000s, when cigarette taxes were increased and surcharges were increased and they used part of the money to pay for coverage of the uninsured -- Family Health Plus, EPIC, Child Health Plus, Healthy New York.

With the advent of Medicare Part D and the Affordable Care Act, those programs became either entirely or partly redundant, and they have been scaled back or eliminated. They're no longer a major expenditure for the Healthcare Reform Act. Most of the money, two-thirds of it, goes to Medicaid. It's helping to balance the state budget, it's freeing up general funds for other purposes.

The other third, I would say, is spent on kind of a variety of programs, some of which I think are very questionable. An example I would give is that it's subsidizing malpractice insurance for some physicians. Whether you think high malpractice premiums are the result of sloppy doctoring or a broken tort system or profiteering by insurance companies, I don't see how having taxpayers pick up part of the cost does anything to fix that.

The single biggest thing that HCRA does other than financing Medicaid is the indigent care pool. This it goes back to the beginnings of the law. It's supposed to

subsidize hospitals for providing charity care to the poor and uninsured. It's a completely legitimate purpose. Hospitals provide about $2 billion worth of free care, and some of them really -- it's a major burden for safety-net hospitals, and reimbursing them is the right thing to do.

But the way this program works, the money doesn't go to the hospitals that need it. It's distributed in a very haphazard way. Some safety-net hospitals are getting as little as 14 percent of their charity care reimbursed, and other hospitals that aren't safety nets are getting as much as 300 percent of their charity care reimbursed. They're getting three times more back from this pool than they provided in charity care.

In fact, there's a small negative correlation between the percentage of Medicaid patients that a hospital has versus the amount -- the percentage of their reimbursement from the indigent care pool. That means the more poor patients you're serving, the less money you're getting. And

that doesn't make any sense to me.

So HCRA has become a burden on middle-class New Yorkers. They're paying these hidden taxes, and the money is not being used in the optimum way.

I'm not going to pretend that allowing this law to expire and giving up billions of dollars in revenue overnight is a realistic proposition, especially with the situation in Washington. But I do think the Legislature should be trying to optimize how it does use what money it has. That means getting rid of programs like the subsidies for malpractice insurance. It means finding a better way to distribute indigent care money.

I know there's proposals floating around to provide more money for safety nets, and undoubtedly some safety-net hospitals need more money. It seems to me if we have a billion dollars that we're spending on safety nets, we ought to spend that properly first.

And then I would also argue that we should try to start weaning ourselves off of taxes that make healthcare more expensive,

and the covered lives assessment, the one that varies so dramatically from Utica to New York City, that would be a good place to start in terms of winding this thing down.

That's all I had to say today. Thank you very much for listening. If you have questions -- I know you probably don't want to take time now -- but I'd be glad to talk on the phone later.

SENATOR HANNON: Thank you.

SENATOR KRUEGER: Just very quickly, because I think my asking whether you might testify at a previous hearing I think might have motivated you to come and testify today.

MR. HAMMOND: It certainly added to my motivation.

SENATOR KRUEGER: So ultimately, you and I might not even agree about the right way or wrong -- the right or wrong priorities for state spending. But what I thought was so important when I read your report when it came out was the recognition that this is just one more model of taxation in New York State that isn't necessarily justified in any

way.

We have a whole series of antiquated and bastardized tax streams that if we just sat down, took a hard look at our entire model of taxation, I think we could come up with a more progressive model that didn't necessarily starve the State of New York but dealt with a whole host of inequities that we see throughout our tax system.

So what I appreciated in your report and in your testimony was highlighting for us in the Legislature -- you know, we fight about property taxes, we fight about income taxes, we fight about every tax -- but that it's really important to think about HCRA as the third-largest tax in the State of New York and to understand better the winners and losers in this model. So that's why I appreciate your doing this work and being here tonight.

Thank you.

MR. HAMMOND: Well, thank you.

ASSEMBLYMAN GOTTFRIED: If I could just chime in.

My concern with the report you put out a few weeks ago and your testimony is that I wouldn't want someone reading the report or listening to your testimony to conclude that the remedy for the unfair HCRA tax is simply -- and for the maldistribution of indigent care money -- that the remedy is to get rid of the tax and get rid of the program.

The remedy is for the taxation to be based on ability to pay and for the support for indigent care to be equitably distributed based on the amount of indigent care that hospitals deliver.

You know, part of how we got here is there's a line in Confucius that says you cannot carve rotten wood. When you carve rotten wood, you get things that look like HCRA. Ultimately we need to replace the rotten wood with a sensible system of financing healthcare.

MR. HAMMOND: I would just point out that most -- maybe no other state has a system quite like this. I tried to verify

that in my research. It's kind of a large piece --

ASSEMBLYMAN GOTTFRIED: We're special here, yeah.

(Laughter.)

MR. HAMMOND: Yeah, so most other states manage to operate their healthcare systems without this source of income. And those other states, generally speaking, have lower tax burdens overall.

And if you were to bring New York State's Medicaid spending down to the national average, which would be a big achievement -- but that would be enough, more or less -- that would be about $12 billion worth of Medicaid spending, half of which would return to New York State. Which would be more or less the amount that you're getting from HCRA. So it's -- I mean, I would argue that we should phase out HCRA altogether, especially the taxes on health insurance. The taxes on cigarettes are another issue.

But like I say, I'm not pretending

that that can happen overnight.

Thank you.

SENATOR HANNON: Before you go, if you want to go back in the history of this, you have to look at the prior funding stream that we had, NYSPHRM. You have to look at the tradeoffs that were made. You have to look at the original destination of these monies. And then in the fiscal crises of '09 and '10, the Executive just combined everything, took a lot of money for the General Fund.

But just looking at the current analysis, and then I would simply say wanting to lower Medicaid spending by 12 billion, I have to think that if you wanted to change, you have to have realistic proposals and you have to have realistic history. And I would look forward to you thinking about that.

MR. HAMMOND: Yes, sir. Thank you.

CHAIRWOMAN YOUNG: Thank you.

Next up, President and CEO Jo Wiederhorn, and Richard Pacheco, who is a first-year medical student. And they are from the Associated Medical Schools of

New York.

Following them will be the New York Biotechnology Association, and following them will be the New York State Association of Ambulatory Surgery Centers.

Welcome.

MS. WIEDERHORN: Thank you. I'm Jo Wiederhorn, president of the Associated Medical Schools of New York.

ASSEMBLYMAN OAKS: Thank you.

MS. WIEDERHORN: Okay. I'm going to be very brief, because I think that Mr. Pacheco has a much more compelling story than I do.

I'm going to just talk about our asks. And we have one major ask which is pertinent to this committee, and that is the funds for our Diversity in Medicine program. This program was put this year into the Governor's Healthcare Workforce Pool, where he pooled together six programs and then cut the money by 20 percent.

So our first ask is that you remove us from this pool. I know that many of you have

already voiced support for that.

Associated with that is if we were to get a 20 percent cut, that would mean that we would have to either cut stipends to students, the students who are in these programs, or else cut programs. So what we're asking for is to be taken out of the pool and to be given our funding that we've had for the past three years, which is $1.6 million.

Our next ask is that -- when this program was put into the budget in 2008, we became a line item in the budget at almost $2 million. Because of the recession, we were cut 20 percent over the course of that time, meaning we had to cut three programs. And so my next request would be to make us whole again to 2008 levels, which would be another $400,000.

And finally, my last request is probably the one which I want to stress here, and it's the expansion of the Diversity in Medicine program to include a scholarship program. Students leave medical school now

with an average debt of $183,000. That's at the end of medical school. But they don't have to pay back their debt until they're done with residency, which is anywhere from three to seven years. During that residency time period, the interest on that debt accrues so that they actually end up, by the time they start paying it back, with anywhere between $200,000 and $225,000 worth of debt. This greatly impacts the type of specialty people want to go into, and it impacts the place where people decide they're going to practice.

So what we're asking is for scholarships for 10 people, we're just asking for 10 people who have gone through one of our four post-bacc programs and have successfully completed it. We look to peg the scholarship to SUNY Medical School tuition, which is about $40,000 a year. And ultimately there would be a commitment that had to be made for these funds where they would practice for one year in an underserved area for every year that they took the

scholarship, with a minimum of two years working in an underserved area.

The first year of this program would cost $400,000. By the time it reached full capacity, it would be a $1.6 million nut every year. Which, when you think about that and you think about the amount of debt it would alleviate for young physicians, I think it's a definite -- worth people's while.

So just to review: Taken out of the pools and left at our current amount; restore us to the 2008 amount; and please fund us for this scholarship. It's vitally important.

And with that, I'm going to turn it over to Richard Pacheco. He is a graduate of our postbaccalaureate program, which is housed at the University of Buffalo.

MR. PACHECO: Good evening. My name is Richard Pacheco. I'm a first-year medical student at Albany Medical College. In the interests of time, I'm going to give you the abridged version of my stories.

Have you ever wondered what makes a good doctor? Is it expert knowledge and

understanding of the human body? Or is it compassion and the sense of connectedness with your patients? When I am not pulling my hair out on an exam or a lab practical, I usually find myself thinking about the answer to this question: What makes a good doctor?

The answer I've come up with is all of the above. A physician is someone who embodies all of these characteristics -- knowledge, compassion, the desire to heal another person.

One of the deans at my school said that regardless of the student or where they came from, if they show potential, the institution has a duty to mold him or her into a doctor. A good doctor.

Having gone through the postbaccalaureate program at the University of Buffalo, I can say that this program and others just like it do just that. They make good doctors.

I am going to share with you three stories, three short stories. The first is about me -- what motivated me to go to

medical school, and the qualities that led to my success in Buffalo. The second is about the program and how it effectively prepared me for medical school. And the third is about how the program helped me grow as a person. Together, these highlight just how special the program is.

Thinking back, it is hard to say that one moment or experience influenced my decision to attend medical school, but rather it just made sense due to multiple qualities I displayed from an early age. I think it comes down to three main passions in my life that have led me to seek a career in medicine. They are a love of fixing things, serving others, and science. Any one of these qualities in isolation might have led me to a variety of other careers, but taken together these interests always pointed me towards medicine.

At Buffalo I was given an amazing opportunity to hone these interests and continue down the path to becoming a physician. My brother also attends Albany

Medical College, and before I started the post-bacc program he told me, "Those post-bacc students, they just seem to get it. It's as if they already know the material."

Well, he was right. The program is like a Swiss watch, a well-oiled machine that has clearly grown and improved with time. It just made sense. The curriculum was tailored to me as student. I took classes that were intended to strengthen my weaknesses and last year was introduced to many of the concepts I am currently learning right now. It's a training camp that consistently equips students with the tools they need for success as a medical student.

When I started this year, I was surprisingly calm, relatively speaking. I still had some anxieties that come with change -- adjusting to a new schedule, new professors, new classmates, a newfound sense of responsibility that comes with the Hippocratic oath. These are all things that caused me stress in August when I started.

However, one thing I did not have to

worry about was the material, because I already knew it. I'd seen it a few months ago when I left Buffalo. When I left Buffalo I was prepared, and that was an amazing feeling. The peace of mind that came with my preparedness and confidence was invaluable, something that I am extremely grateful for.

Next, I'm going to share a story about an experience at Buffalo that helped me grow as a person. Last summer, while I was at the six-week summer program, my father collapsed at work. Within minutes of receiving a hysterical call from my mom, I rushed over to Mr. Angevin, our advisor, frantically explaining what had happened. It was obvious I needed to go home. And without hesitation, he offered to drive me to the airport.

That seemingly simple gesture really had an impact on me. It was the first time I realized that this program was not just a stepping stone to medical school. Rather, it was comprised of people who genuinely cared about me, my well-being, and my development as a person.

We thought my father had a stroke. Unfortunately, he collapsed because of a brain tumor, a glioblastoma, one of the fastest-growing forms of cancer and a very grim prognosis.

I soon began one of the most challenging years of my life. However, I was able to find peace in a very unexpected place -- my academic advising meetings with Mr. Angevin.

The first meeting we talked about me, not my grades or plan for the future. We talked about my life and the grief I was going through. The conversations we had covered a wide range of topics and equal scope of emotions. We talked about a lot -- pain, the uncertainty of my father's deteriorating health, the relationship I had with my parents, what it meant to be a man in today's society, work-life balance, the future -- the list goes on.

The tragedy of my father's disease opened up a lot of thoughts and uncomfortable emotions. However, it was the compassion and

the contemplation from those meetings which allowed me to grow and mature as a person.

This program has done so much for me. As a member of the 25th cohort of the University of Buffalo Postbaccalaureate Program, I was given an opportunity to begin a journey I have dreamed about my entire life. The structure of the program armed me with the tools I have since used to succeed in medical school. The compassion I was shown strengthened me during a very difficult time in my life.

I learned many things last year, irreplaceable lessons that have given me a thorough understanding of the human body and a unique perspective on life and the human condition. I have no doubt these will allow me to be a successful scholar of science and a compassionate healer.

I am a product of the AMSNY's Diversity in Medicine Program, and I know there will be many more to come.

Thank you.

CHAIRWOMAN YOUNG: Thank you. Any

questions?

SENATOR HANNON: No.

CHAIRWOMAN YOUNG: Thank you for sharing your story, and we wish you the best in your career.

MR. PACHECO: Thank you.

CHAIRWOMAN YOUNG: And I also wish you safe travels back to Buffalo. Is it snowing there?

MR. PACHECO: Actually, I'm from New Jersey.

MS. WIEDERHORN: No, no. He's from Albany. He's at --

CHAIRWOMAN YOUNG: Oh, he's from Albany?

MR. PACHECO: Yeah, yeah.

CHAIRWOMAN YOUNG: Okay. Well, safe travels no matter what.

Okay, anybody else? Okay.

SENATOR KRUEGER: Thank you very much.

CHAIRWOMAN YOUNG: Well, good luck in your career, and thank you for being here. And thank you for waiting for so long. I know it's hard.

Our next speaker is Nathan Tinker, executive director of the New York Biotechnology Association.

Following Mr. Tinker will be the New York State Association of Ambulatory Surgery Centers. And following them will be the New York Chiropractic Council.

MR. TINKER: Good evening.

NewYorkBIO represents over 350 of New York's life science companies, patient advocacy groups, universities, other organizations, et cetera, and we strongly oppose Part D of the Health and Mental Hygiene Article VII budget proposal, which would allow the state to impose draconian price controls on all pharmaceuticals sold in New York and thereby disincentivize innovative drug makers from offering their products in the New York market.

Most importantly, it would stifle the development of innovative therapies that target some of the most challenging and debilitating -- that's a hard word to say -- debilitating diseases of our time. This

proposal would be especially burdensome on the engine of biotech innovation, the small emerging companies with few or no marketed products.

These companies must use their limited resources as efficiently as possible to speed the discovery of treatments that can improve the lives of patients, ensure patients maintain access to these therapies once available, and to reinvest in future innovation. Reporting requirements alone contained in the proposal would divert scarce resources to accounting and compliance activities that could be better used on developing therapies that patients need.

Ironically, the Executive Budget also includes a proposal to invest $650 million in a statewide life science economic development initiative focused on even further expanding this important industry by providing incentives and capital to grow the very organizations that the price control scheme attacks.

Now, harming the state's bioscience

sector is certainly ill-advised, but the group most harmed by a proposal such as this will be the patients who will face reduced access to innovative treatments. The U.S. marketplace fosters robust competition which helps to control costs while allowing for development of innovative new therapies. This ecosystem allows patients in the U.S. to enjoy more timely and robust access to innovative therapies than patients in countries that employ government-imposed price controls.

Artificial interventions like price controls have such a devastating impact because the innovation system for new treatments is relatively fragile. According to researchers at Tufts, bringing just one drug to market costs nearly $2.6 billion and takes 10 to 15 years. In fact, of that very small number of potential treatments that make it even into human trials, only about 12 percent ultimately win approval from the FDA.

Only two out of every 10 treatments on

the market ever earn back enough money to match the costs of R&D and the FDA approval process before their patent expires, and only one in 10 biotech companies ever makes any profit at all. The incremental costs of failed drugs come to many times the profits from any one successful therapy. These costs are not included in the state's proposed pricing analysis, and therefore imposing additional costs and setting artificial price controls will only worsen those figures.

I know there is great pressure to respond to passions temporarily inflamed by the recent actions of a tiny handful of bad actors in the industry, but such sweeping interventions into the marketplace can cause much more harm than good. And as I noted above, this proposal would specifically harm New York because we have fostered such a strong bioscience sector in this state.

Indeed, many of the advanced therapies that New Yorkers have access to have been discovered in New York academic institutions, commercialized by small New York companies

who take on the full investment weight of bringing these therapies to market, and dispensed by New York doctors and hospitals. Critically, it is the patients of New York that most benefit from a healthy and innovative bioscience marketplace.

Thank you. I'd be happy to take any questions.

CHAIRMAN FARRELL: Thank you.

CHAIRWOMAN YOUNG: Thank you very much. We appreciate you staying.

Our next speaker is President Thomas Faith, New York State Association of Ambulatory Surgery Centers.

Following President Faith we will have the New York Chiropractic Council, and following them will be the New York State Center for Assisted Living.

Thank you for being here.

MR. FAITH: Good afternoon. Senator Young, when I left Buffalo this morning it was snowing to beat the band.

CHAIRWOMAN YOUNG: That's what I thought.

MR. FAITH: Yes.

CHAIRWOMAN YOUNG: That's why I asked.

So I'm glad you got here. You left this morning -- did you just get here?

MR. FAITH: I got here around 2 o'clock, 3 o'clock.

CHAIRWOMAN YOUNG: Okay. Not so bad, then. Okay.

MR. FAITH: Thank you all for letting me approach this panel today. And I thank you, all of you who have seen me before personally in your offices, and your staff, on various matters affecting ambulatory surgery centers.

I represent New York's 134 ambulatory surgery centers. Last year, we reached a new goal of 900,000 surgical and diagnostic procedures focused around things like precancer screening, cataract surgery, and orthopedic surgery for New York State's injured workers.

We are licensed by the State of New York. We are Article 28 facilities that follow the same regulations and expectations

that you have for your hospitals.

Furthermore, before I forget, our ambulatory surgery centers have provided over $2 billion to the bad debt and charity pool to help New York State's safety-net hospitals.

The Governor's budget rightfully focuses on reducing the cost of healthcare for third-party payers, employers who pay their premiums, New York State, and for private citizens who face the high deductibles and copays associated with today's healthcare environment.

In reading through the Executive's proposal, we were heartened to see the mention of a task force that will focus on healthcare reform. Our hope, on the other hand, is that the inference that healthcare reform means the elimination of those things that are working well isn't what happens at the end of the day.

What's working well is the regulatory role that New York State's Health Department has played in both the safe and efficient

provision of care for elective surgery and elective care in this state. New York's healthcare system is best served by matching patients to the appropriate level of care, whether that's an ambulatory surgery center, a hospital, or an office-based surgery practice.

I'd like to be as clear as possible to those who have met before on the subject of office-based surgery. The Ambulatory Surgery Center Association supports office-based surgery. We are supporters of it, but we are also supporters of 50 years of experience that Medicare and Medicaid has put into a system recognizing what can be done safely, what appropriately reimbursed, and how those issues affect patient's out-of-pocket expenses as well as the system's reimbursement program.

It's critical that as you look at legislation down the road, or the Governor's budget, that you continue to match the safe provision of care to your cost-effectiveness issues and observations.

With that, I'll close my comments and ask that you accept my bold attempt to give you advice on how to approach the budget, and hope that when I see you again, we'll do the right thing.

CHAIRWOMAN YOUNG: Thank you.

Any questions?

CHAIRMAN FARRELL: Thank you.

CHAIRWOMAN YOUNG: Thank you for coming all this way, and certainly it's very valuable information.

ASSEMBLYMAN OAKS: Thank you.

CHAIRWOMAN YOUNG: Our next speaker is Dr. Bryan Ludwig, Albany District representative for the New York Chiropractic Council. Welcome.

After Dr. Ludwig will be the New York Center for Assisted Living, and following them will be the Empire State Association of Assisted Living.

DR. LUDWIG: Thank you.

CHAIRWOMAN YOUNG: Thank you for being here.

DR. LUDWIG: My name is Dr. Bryan

Ludwig, and I'm a chiropractor in Cobleskill, New York -- Schoharie County. And I'm happy to be here again.

I'm representing the New York Chiropractic Council. And their mission really is to direct people that healing comes from within each of us, and that promoting health and wellness is much more valuable and superior to waiting and waiting and then treating a disease. And this theme will come throughout my testimony today.

One thing I want you to keep an eye out for is we do have a bill, the Partnership Bill, once again this year. It normally passes one house and is stuck in committee in the other. So it has an ability to create a partnership of owning a business, both a medical doctor and a chiropractic doctor. And it has the ability to bring about more coordinated care, saving money.

I want to talk a little bit about what I do as a chiropractor, what is my job. I find this is partly a chiropractor's problem -- for many years, we have stuck

ourselves in a position of being known for something that we don't really do, that we are just back-pain doctors.

So a little background. We've got a brain and nervous system that runs through your back. If it was in your big toe, we'd be known as the big toe doctors, because we'd be working on it. So your nervous system controls everything in your body. If it doesn't work well, that's not good; you get sick.

We improve and correct health by restoring normal nervous system function. We look for a structural misalignment that interferes with the nervous system. They may happen as an infant, it may happen as a senior citizen, it may happen while you're pregnant.

So traditional healthcare strategies and practice does not necessarily create healthier people. From our perspective, from a chiropractic perspective, what is often promoted and accepted as health often is not. We talk about prevention, and usually you're

talking about early detection. And in my previous year, I talked about how a prostate test is not preventing prostate cancer, it's finding it early. So it's not making you healthier.

So we talk -- I heard earlier testimony that says, you know, we need more and more access to drugs and surgery. Well, in the United States we already have better access to drugs than any three countries combined in the rest of the world. The World Health Organization rates us between 75 and 79 out of 81 industrialized nations as far as how healthy we are. I'd say adding more drugs and more surgery isn't the answer.

So this quick fix, this mentality of treating symptoms without finding the underlying cause of disease, it leads to more chronic problems. And I liken it to getting on this escalator. Once you start getting on it, and you're not taking care of the problem, you're just treating symptoms, it leads to more costly interventions over time.

So I imagine -- you know, let's say

you have a baby, and that baby has a little bit of trauma to the neck. And then they start getting ear infections. And so you add antibiotics, which is actually -- there's several studies that say not effective, it actually kills the gut bio. And you're more likely to have an another ear infection, and then that child has a 100 percent increased chance of having asthma. So now you're treating asthma with drugs. It could have been prevented.

And later on, that same neck structural misalignment which is affecting the nerves, which reduces the immunity or reduces the amount of lymph flow from the neck -- so now you have a stagnant issue, and you're more likely to have infection. Now that nerve then, later on, develops into that person having migraines. And then that nerve issue starts to develop into degenerative disease --

CHAIRWOMAN YOUNG: I just wanted to remind you, we need to talk about the state budget. So if you could please get to that

part of your testimony.

DR. LUDWIG: Absolutely.

CHAIRWOMAN YOUNG: Thank you.

DR. LUDWIG: So we would like you to look at ways in which barriers can be removed so that the health budget can be used toward working toward actually saving the Medicare budget.

So in 2013 I brought you a study that showed how over seven years a health insurance company in Chicago changed how they did business, and it reduced things such as the use of drugs by 85 percent. And I gave you some statistics on how that might help your Medicaid system. I believe it was $4.5 billion it would have reduced out of the state Medicaid budget system.

So as you're negotiating the 2017-'18 health and Medicaid budget, please remember: We save money over conventional medical treatment for the same or similar conditions. In Medicaid and workers' comp, chiropractic care can substantially help many Medicaid-eligible New Yorkers, but it's not

currently a covered Medicaid benefit in New York. So Medicaid patients that are seeking chiropractic care, they pay 100 percent out of pocket.

We ask that these barriers to chiropractic care be removed, establish reasonable rates for compensation for chiropractic, whether it's Medicaid or workers' comp. Currently workers' comp is about $2 or $3 above the cost to provide care in my office. Yet both systems act as a disincentive to providing quality chiropractic care.

The escalator I was talking about for prescribed medications to opioids to recreational drugs, the statewide heroin crisis, is tragic and avoidable. So if you want to spend less on prescription drugs and needless surgery, if your goal is to have fewer heroin addicts in New York, then you've got to reach people before they become an addict, before they become sick, before they become diseased. And this way, it will influence your budget.

CHAIRWOMAN YOUNG: Thank you.

DR. LUDWIG: Thank you.

CHAIRWOMAN YOUNG: Any questions?

Okay, thank you.

Our next speaker will be Shelley Wagar, executive director of the New York State Center for Assisted Living. And also Jeff Edelman, a board member. Or is it just you?

MS. WAGAR: It is just me. Mr. Edelman had an emergency and was unable to stay.

CHAIRWOMAN YOUNG: Oh, I'm so sorry to hear that. Okay. Well, thank you for being here.

And following you will be the Empire State Association of Assisted Living. And following them will be the New York State Council for Community Behavior Healthcare.

So welcome.

MS. WAGAR: Thank you. Good evening.

My name is Shelley Wagar, and I'm the executive director of the New York State Center for Assisted Living. We are the

assisted living voice of the New York State Health Facilities Association, and I believe you heard from Stephen Hanse, our president and CEO, several hours ago.

We represent nearly 100 adult care and assisted living communities across the state of New York. Those members serve nearly 12,000 residents who are elderly, frail, disabled, and mentally ill. Our providers are committed to a high level of quality care and the enhancement of the residents' quality of life.

It is an honor and privilege for me to be here today and to represent the needs of our members, those assisted living operators. Our testimony will highlight needs in the reimbursement that directly impact service delivery to the residents we serve.

We appreciate Governor Cuomo's efforts for his multiple proposals to enhance the life of many New Yorkers, such as tuition for the middle class, embracing immigrants, and public safety initiatives. We also support the proposal to establish the Health Care

Regulation Modernization Team. However, not included in these major budget proposals are increases in reimbursement programs to assist the poorest of New Yorkers and those care providers who serve them, all the while meeting the new minimum wage requirements.

New York State has a substantial number of assisted living communities and adult care facilities that only serve residents who are sustained by SSI. Additionally, there are many adult care facilities that serve a portion of SSI residents, so this is a statewide situation, not just a New York City situation.

The current SSI rate is $1,429 for a single individual. After the personal needs allowance is provided to the resident, what remains to pay the provider is $1,235 per month, which translates roughly to $41 per day. I ask that you take a moment to think about this. Forty-one dollars a day to cover all aspects of the resident's care. Their rent, their meals, assistance with personal needs, housekeeping, medication management,

arrangements for transportation, and staffing 24 hours a day, seven days a week.

Again, I ask you what you might use $41 a day for. A haircut, a lunch out, cab fare in New York City. But yet the state expects adult care providers to use this small amount of money to take care of some of the neediest individuals -- those with mental illness, physical frailties, and those without family.

Now take that woeful amount of reimbursement we currently receive and add the burden of the new minimum wage increase. Disaster is imminent. The current $41 a day is clearly insufficient to provide rent, meals, activities, case management, supervision, and medication assistance for our SSI clients. Adult care communities face yearly increases for food, health insurance, utilities, rent or mortgage, and now increased minimum wage requirements, all without any significant increase in funding in many, many years.

To illustrate this on an operational

level, visualize an adult care community that has 100 SSI residents. They are paid $1,200 per month per resident, so at best their operating budget is $120,000 a month. And that is at best, meaning there are no vacancies and that everyone is paying full. Their monthly payroll is $84,000. Their monthly cost for food, supplies, and housekeeping is $12,000, they spend nearly $31,000 a month on utilities, telephone, heating, fuel, electric, water, cable, laundry, insurance. That leaves the community nearly $7,000 in the red every month.

And these numbers do not even address the rent or mortgage payments. These are necessary costs for the care of each and every resident. There are no frills, and there is no fluff. These are not imaginary numbers. These are real numbers from an actual adult home. As you can see, there is no excess for emergencies nor budget for capital repairs.

Consequently, NYSCAL respectfully

requests an increase to the state portion of SSI rate to help increase the level of care and services to our recipients and to prevent continuing closure of SSI communities. We are in agreement with our colleague associations -- LeadingAge New York, who you heard from earlier, and ESAAL, the Empire State Association of Assisted Living, who will speak shortly -- in that an increase of the state portion of the SSI payment of $20 per resident to $61 per resident a day is an adequate increase to meet the current costs and needs of the residents.

Our fear is that if the state does not increase the SSI rate, an overwhelming number of communities that serve these recipients will close their doors. And that would be a travesty to the residents. If this scenario plays through, those residents will either go back to being homeless, they will be sent to a hospital, or they will be transferred to a nursing home as a Medicaid resident, ultimately costing the state much more money.

Again, it is an honor to be here today

and to share our challenges with all of you. I hope that you will give our request its due consideration, and we thank you in advance for your cooperation in assisting us in helping us serve our residents better through obtaining a very desperately needed SSI increase.

SENATOR HANNON: Thank you very much.

CHAIRWOMAN YOUNG: Thank you.

MS. WAGAR: Thank you.

CHAIRWOMAN YOUNG: We do have a question.

MS. WAGAR: All right.

SENATOR KRUEGER: I'm not arguing your math, but isn't it also true that you should be able to get SNAP benefits for SSI institutionalized?

MS. WAGAR: The SNAP benefits are unavailable to the SSI recipients in an adult home because they provide --

SENATOR KRUEGER: I'm sorry, I can't hear you.

MS. WAGAR: I'm sorry. I believe the SNAP benefits are unavailable for the

recipients in an adult home because the food is also already a regulation and a requirement to provide to the residents, so the residents do not receive SNAP. As I understand it. But I can make sure of that.

SENATOR KRUEGER: Because there are certain kinds of facilities where if you're SSI and you're in an institutional setting, you absolutely can get SNAP. So it would be interesting to see if there's some language in our regs that are preventing your facilities from maximizing federal benefits.

It's not a magic formula, it's not going to save you, but it could add a significant amount of money to help with the food budget for people every month.

MS. WAGAR: I will certainly check that and get back to you.

SENATOR KRUEGER: Okay.

MS. WAGAR: Thank you very much for the suggestion.

SENATOR KRUEGER: Thank you.

CHAIRWOMAN YOUNG: Thank you.

Our next speakers are Jim Kane,

treasurer, and Jacob Reckess, board chair, of the Empire State Association of Assisted Living.

Following them will be the New York State Council for Community Behavioral Healthcare. And following them will be the Primary Care Development Corporation.

Welcome.

MR. KANE: Good afternoon. Thank you for allowing us to testify. I've been here testifying for the last three years on this issue, so it's an issue that's near and dear to my heart, and I appreciate the opportunity.

As you said, my name is Jim Kane. I am the past president and current treasurer of the Empire State Association of Assisted Living Facilities, commonly known as ESAAL. I'm going to try to speed through the testimony because it has been such a long day, and Shelley just kind of captured some of the issues as well.

As a way of background, ESAAL is the only association that exclusively represents

the assisted living provider community, serving more than 275 licensed facilities and more than 23,000 seniors. The issue today, of course, is the urgent need for an immediate increase in the SSI rate which is currently $41 per day.

As Shelley mentioned, we are providing room and board, housing, case management, housekeeping, laundry, and food service 24 hours a day, 365 days a year, for $41 a day. In the past years I've testified and I've talked about the fact that it cost about the same amount to board a dog in a kennel as the reimbursement we're getting. I can't say that this year, because I just found out recently that the costs have gone up and it costs more to board a dog now than it does for us to get the $41 a day.

The last time the state increased its share of the SSI rate was a decade ago in 2007, and the last increase before that was 17 years earlier. That is one rate increase in 25 years.

The current average cost per resident

for ACFs is approximately $70 per day, nearly twice the reimbursed rate. As a result, many of our members have been forced to close, and I expect more will soon follow. I can speak from experience here as well, because as an operator and owner of assisted living facilities, a company that's been in business since 1972 -- at our peak, we had 14 facilities. We now have eight facilities as of today. The other facilities have been forced to close, and as a result we have gone from a maximum census of over 500 residents to only 350 now. We've closed six of those facilities due to financial hardship. We are now at a point where we are trying to stay afloat given the current market.

For every displaced resident from an ACF to a skilled nursing facility, the cost increases dramatically for the State of New York, from approximately $41 a day to somewhere in the neighborhood of $150 to $250 a day if that person ends up in a nursing home.

We are here to ask you for the State

of New York to invest in maintaining a quality, cost-effective option, which is the SSI facility. As I said, SSI providers are facing enormous new fiscal pressures as a result of the mandates by the state. The $15 minimum wage passed in last year's budget has devastated SSI providers. ESAAL estimates that the cost of minimum wage alone to our industry is approximately $170 million annually. Without any additional funding, many of our members have been forced to close, and many more will soon follow.

For my eight facilities remaining in upstate New York, the direct impact of the minimum wage increase for 2017 is estimated at $500,000. And the total impact to our eight facilities of the proposed increase to $15 an hour would be $1.7 million annually. Without substantial funding from the state to offset these higher costs, I will be forced to close, at a minimum, two to three additional facilities this year, displacing another 70 to 100 residents. And the same is true of many assisted living facilities

across the state.

In fact, we have already seen the effects that rising healthcare costs and wages have had on our industry as approximately 10 facilities voluntarily closed over the past two years, mostly because of financial hardship.

Simply put, without a very overdue increase in funding, more facilities will close. And as a result, many of our low-income and high-need residents will either face homelessness or more expensive institutional care, such as a nursing home.

The simple reality is that SSI beds are, by far, the most affordable option the state has to care for low-income seniors and disabled individuals. With this in mind, we are asking for your support to raise the state supplement of the SSI payment $20, to $61 per day. Although the budget impact will be high, it will be far less than the closure of ACFs to low-income individuals. To be clear, without an immediate and meaningful increase to the SSI rate, adult care

facilities across the state will close, leading to higher costs of care to the state and the loss of hundreds if not thousands of jobs.

Thank you, and now I'm going to have Jacob say a couple things.

MR. RECKESS: Thank you, Jim.

And thank you for hearing us today. I will also condense my comments because I know it's late.

My name is Jacob Reckess, and I am a newly elected board member of the Empire State Association of Assisted Living. Like Jim, I'm proud to share that I am a second-generation family member in this industry. And I can share and answer a question that some of my friends have asked, which is: Why would you enter an industry which has such an issue?

I can share that I have been trained by my father and by my parents and it's something I truly believe in, that if you can earn a living and help people, you've hit the jackpot. We try desperately to do that in

our job, but our costs are increasing faster than our revenues, and that is simply becoming harder and harder to do.

I wanted to talk about a second element of the failure of what happens if we don't increase the SSI funds. Jim has talked about the obvious foreseeable or visual -- when a facility closes, what happens to those residents. I also want to talk about what happens when -- that if the SSI rate is not sufficient, other facilities simply stop taking SSI residents into their facilities.

I can speak, for example, of one facility that we run in Westchester County that is fortunately in a community that has members of the community that can afford to pay private. While we would love to serve the SSI population, we have now directed and shifted to take less and less of that population. So the impact is not only on those facilities that have closed, but also on the existing beds that are simply not able to take SSI residents any longer.

With that, I just want to echo what

Jim and NYSCAL and others have said, that the time we request is now for an increase. We know that we're afraid of sounding like a broken record, but the impact is real. The residents are real. The facilities provide a wonderful service in a capitated rate formula that we find it's hard for anybody to really match the costs of services that we can provide. I would invite all members of this council to come and visit one of my facilities. I'm sure that we can find others for you to come and see the real impact on a day-to-day level that it has.

And with that, we really ask that this year an increase gets into the budget. Thank you.

MR. KANE: Thank you for your time.

ASSEMBLYMAN OAKS: Just a quick question.

So the facilities that are staying in business are ones that they're a mix of private pay, are covering then your losses, and some of your facilities would be a hundred percent on SSI, perhaps, or --

MR. KANE: Yeah. I mean, all of those things that you just mentioned are true.

You know, some facilities have either converted to private pay if they're in areas where they are able to -- not by choice, but again by financial need. Some facilities may have other funding streams within their program and in other areas, not adult care facilities but within other areas.

In my case, I have several that are 100 percent SSI in small, poor communities. All of those are closed now except for the three I mentioned that are facing closure. I have been hanging in there and supplementing those facilities that are losing with the little bit I have in other facilities.

ASSEMBLYMAN OAKS: Thank you.

MR. KANE: Thank you.

CHAIRWOMAN YOUNG: Anyone else?

Thank you for being here.

MR. RECKESS: Thank you.

CHAIRWOMAN YOUNG: The next speaker is Lauri Cole, executive director of the New York State Council for Community

Behavioral Healthcare.

Are you a substitute?

MS. COHEN: No.

CHAIRWOMAN YOUNG: Okay. Then next we have Louise Cohen, CEO, Primary Care Development Corporation.

Following Ms. Cohen will be Bryan O'Malley, executive director of the Consumer Directed Personal Assistance Association.

Thank you for being here.

MS. COHEN: Thank you for the opportunity to briefly testify in front of the committees today.

I'm Louise Cohen, the chief executive officer of the Primary Care Development Corporation, or PCDC. We are a not-for-profit organization and community development financial institution providing services throughout New York State and around the country. We are dedicated to catalyzing excellence in primary care through community investment, practice transformation, and our policy work.

We believe that access to quality

primary care is transformational and is a cornerstone of healthy, thriving communities. Particularly in this moment of uncertainty for the future structure of our nation's healthcare system, we believe that investment in high-quality primary care for all New Yorkers is paramount. And yet today, primary care receives only approximately 5 cents on the healthcare dollar.

Since our founding in 1993, PCDC has created and leveraged investments of almost $850 million in 130 primary care health center projects, leveraging more than $5 of private investment for every $1 of public investment. We are encouraged that many primary care transformation efforts are being undertaken throughout New York State, but we are concerned that while these programs rely heavily on primary care, they do not provide the full and necessary support to insure success.

I'm only going to focus on one issue in my written testimony, which is that of the need to increase capital funding for

community healthcare providers. And we ask that you allocate $125 million of the $550 million Healthcare Facility Transformation funding, or 25 percent of the pool, to community healthcare providers, and allocate an additional $20 million in financing for the Community Healthcare Revolving Capital Fund that you have established.

In the past several years, community-based primary care providers have received disproportionately less of New York State's capital grants than other parts of the healthcare system. That being said, we are very proud to be the administrators of the new New York State Revolving Capital Fund created by the Legislature and designed to support New York State-licensed primary care and behavioral healthcare facilities. Thank you very much for that.

This new fund is just being launched, and we look forward to working with all of you as we reach out to providers throughout the state to let them know about this new

low-cost financing mechanism. And we are particularly enthusiastic about supporting the integration of primary care with behavioral health.

With the devastation of the opioid epidemic in our communities, there is a desperate need in New York State to incorporate the services of community health and diagnostic and treatment centers licensed under Article 28, the mental health clinics licensed under Article 31, and alcohol and substance abuse treatment clinics licensed under Article 32. However, making changes to support this enhanced service mix to a facility takes both time and capital investment.

While the current grant pool financing is a strong step forward on the part of the state, it is not proportionate to the financing provided to hospitals and other providers. And you've already heard that this demand was -- is apparent. Last year's $30 million in grant funding for community-based primary care was met with

15 times the applications that the funding could support.

Increasing the amount of the loan fund capital will enable us to better meet this need. Currently, there is $19.5 million in the Community Health Care Revolving Capital Fund, and PCDC is working closely with bank partners to leverage these public funds with private investment to increase the amount of capital, low-cost capital available for our community health partners through this loan fund.

But even considering this larger pool of loan capital, we recommend an additional $20 million allocation for this fiscal year, given the demand demonstrated recently for the Health Care Transformation Fund. And we believe further that coupling the capital grants with additional loan financing would increase primary care providers' access to capital in a way that could fully fund construction projects and accelerate the pace of development across the state to serve the need.

In addition, just briefly, we support the restoration of the $20 million for the Diagnostic and Treatment Center Uncompensated Care Pool. And I want to mention that as the federal landscape changes, particularly for the Medicaid program, we encourage a thoughtful and inclusive planning process that includes legislative oversight as well as the participation of effective communities and organizations as decisions are being made about what could be very substantial financial implications for our state.

I would also like to thank you for your historic support of our organization and ask that that support continue. We're asking for a small increase this year as well. We were able to in this past year serve many organizations throughout New York State; they're listed in our testimony. And we feel that that support has been critical to the success of the primary care network in this state.

Finally, I would just say that with overwhelming evidence of its positive impact

on improving healthcare quality and outcomes while lowering healthcare costs, primary care faces a growing responsibility for patient and community health outcomes. And to meet this responsibility, primary care must be supported with sound policies and adequate resources.

We look forward to working with you to ensure that this year's New York State budget supports these goals. Thank you for your consideration of PCDC's recommendations and for establishing the fund that we are now being able to be the administrator for.

SENATOR KRUEGER: Thank you.

CHAIRWOMAN YOUNG: Thank you.

Senator Krueger.

SENATOR KRUEGER: Hi.

MS. COHEN: Hi.

SENATOR KRUEGER: So I know I knew this morning, and at least 20 groups have testified on this today, so just help me remember what I was already supposed to know.

With the DSRIP money and the SHIP money and all the commitment -- that some of

it was supposed to go to the community-based providers that we were transferring so much responsibility to -- is it that it was supposed to go, but somebody is doing something wrong? Or everybody hypothesized that it was supposed to happen but the funding stream doesn't say it actually has to go there?

MS. COHEN: So I think there's two different parts. For the capital fund, there was never a distinction where money was going to go. So for the capital fund it was just capital to support the DSRIP goals. On the sort of operating side of DSRIP, what is true is that most of the DSRIP funding has not flowed down to primary care providers.

So, for example, if there was a goal in a particular performing provider system of increasing access to a certain kind of primary care provider, no money has flowed to really help that happen. Most of the money has stayed with the performing provider system's central organizations and has flowed to the hospitals.

There has been some project money that has flowed, but this need for funding for primary care providers to actually support the transformation of their offices to provide the enhanced services and to provide enhanced access -- a good example is that most -- the mid-point assessment of DSRIP, many of the recommendations were that there should be a plan to increase primary care providers, the number of primary care providers in a particular PPS.

I actually think that our recommendations to the DSRIP program is that the DSRIP program actually pay for those providers in the short run so that they can ramp up so that reimbursement then covers their costs in a sustainable way. So I think we would make a distinction between the capital pools and the operating pools.

SENATOR KRUEGER: But in neither was there actually statutory language of a certain formula for A, B, and C.

MS. COHEN: No, there was not. But I would argue that the vast majority of the

work that is expected to happen in DSRIP is to create these integrated systems of care that rely on primary care providers. And the money simply hasn't gone there.

SENATOR KRUEGER: I get that, and I agree. But --

MS. COHEN: No statutory requirement was made to do that.

SENATOR KRUEGER: -- it hasn't been for years, right? So it's not statutory. And so it seems like everybody had a handshake deal, except maybe not really a handshake deal, because the money doesn't seem to flow down, far less than a handshake deal.

MS. COHEN: I think that's correct. I think that there was an intention and a hope, but I also think that the realistic goal was to support some of the hospital systems, and that's what happened.

SENATOR KRUEGER: My second question is for Kemp Hannon. Can we write it into statute?

SENATOR HANNON: Probably not. Not at

this time. Because there's so much DSRIP going on, and there's 25 PPSs. You might want to spend a week looking at the evaluations. It's all online.

But with PCDC and administering the new pool, we look forward to working with you and to see what type of coordination should be done and where and how to supplement. Because it's always been a bit ambiguous -- not deliberately ambiguous, but it probably has been without borders as to where the community of community-based providers begins and ends.

MS. COHEN: Yeah, I think that's right. It's just that the fund that you put together that we now administer is very specific. It's Article 28s, 31s and 32s. And what we hope to do with that is support the integration of care, since it's actually not that much money in the capital world. Even if we leverage it so that we have, say, $25 or $30 million of loan capital, it's still not that much money when you think about the need and the stakes.

SENATOR HANNON: The commissioner this morning said the $30 million is only a floor, not a ceiling.

MS. COHEN: And he's talking about that out of the new $500 million pool. It's a floor. But if you actually look at what happened in the last round, we can assume that it's probably more or less what the proportion is that they're current intending.

SENATOR HANNON: Well, thank you. Welcome aboard. Good first presentation to all of us. And I look forward to working with you.

MS. COHEN: Great. Thank you so very much.

SENATOR KRUEGER: Thank you very much.

CHAIRMAN FARRELL: Thank you.

CHAIRWOMAN YOUNG: Thank you.

Our next speaker is Bryan O'Malley, executive director of the Consumer Directed Personal Assistance Association of New York State.

And following him will be Julie Hart.

Thank you for being here.

MR. O'MALLEY: Thank you. And thank you for staying to such a late hour.

I have abridged, but I am going to read because I am prone to tangents.

The Consumer Directed Personal Association of New York State is the only organization in the state focused solely on Medicaid's Consumer Directed Personal Assistance Program, or CDPA. We include fiscal intermediaries that administer the program, the seniors and people with disabilities who use it, and the personal assistants who provide these critical services. On behalf of the over 55,000 New Yorkers who either use this program or are employed through it, we appreciate the opportunity to inform you of the impact of this budget proposal on CDPA and those who rely on it.

According to the Bureau of Labor Statistics, personal care is the fastest-growing industry in both the state and the country. And within personal care, CDPA is the fastest-growing sector in the

industry. We have experienced 20 percent program growth each of the last five years, and there is no expectation that this will slow. Consumers who utilize the program currently employ about 35,000 individuals around the state.

Fiscal intermediary agencies are some of the most effective stewards of taxpayer dollars, using on average $0.90 of every Medicaid dollar to pay for wages, benefits and associated fringe costs. This level of efficiency, combined with an exemption from the Nurse Practice Act for those who work in the program, means that the program saves taxpayers over $150 million per year over services delivered in more traditional personal care settings.

Governor Cuomo's proposed budget signifies the catch-22 that those who use consumer directed personal assistance face. As Medicaid funding has decreased over the years, wages have not kept pace with inflation, and in some cases have gone down. Last year, I sat here and told you that

several fiscal intermediaries in Long Island were responding to news that one managed-care plan would be cutting reimbursement by over $1 per hour. Since then, the continued lack of oversight has seen three managed-care plans reduce reimbursement by up to $3 an hour.

Because of the low administrative expenses fiscal intermediaries have, this meant that they were forced to cut wages by 20 percent, to the minimum wage. These stagnant and even falling wages have meant it is harder and harder for people to recruit and retain high-quality workers. In fact, it is apparent to anyone who works in the industry that we find ourselves in the midst of a workforce crisis. The fastest-growing industry in the state is so underfunded that those who rely on this to stay in the community -- to fulfill the state's obligation under the Supreme Court's Olmstead decision -- cannot find people to do the job because of a decade's worth of neglect.

Indeed, in 2006, the average worker in

consumer directed personal assistance earned 150 percent of the minimum wage, allowing consumers to recruit and retain a high-quality workforce. Gradually, while consumer directed workers' salaries have been stagnant or even decreased, we have seen many industries raise wages, either voluntarily or through required changes to the minimum wage. This has reached a point where the fast food industry currently makes over $1 per hour more than most people who take care of people with disabilities and seniors.

Wages in CDPA are so low that a single mother of two, working full-time in New York City, qualifies for WIC, SNAP, HEAP, and Medicaid. Yes, we are subsidizing Medicaid with Medicaid.

Last year, when promoting the minimum wage increase, Governor Cuomo rightly decried companies like McDonald's and Wal-Mart who relied on public benefits to lower their costs. He cited that it cost the state $6,800 per month, in the cost of public benefits, when people were employed at that

minimum wage. However, it is clear the state is accruing these costs on its own. But in the state's case, it makes no economic sense. The state is paying tens of thousands of dollars per person per year to insure employees through Medicaid and deliver other basics, instead of making sure that Medicaid reimburses enough money so that these individuals do not have to rely on public benefits to begin with.

This has led to a scenario where our parents and loved ones with disabilities are losing workers to McDonald's. Seniors are looking for staff, sometimes for longer than a year. The workers that are available, who will accept the insulting wages, are the most desperate in the workforce, meaning that quality suffers.

The Governor has invested $270 million in funding the minimum wage increase this year. This, to be clear, is the absolute minimum that he could have done. He has funded the law. It does not deal with the shortage, nor does it end the neglect. As

demonstrated, the minimum wage increases are necessary -- but this workforce needs additional money.

CDPA is integral to maintaining lower capitated payments to MLTCs, but we know it is not enough to say that to solve this problem, managed care should be paying higher reimbursement. We know that the capitated model is broken. It does not take an actuary to figure this out.

Plans that have a relatively low number of complex cases are doing well. They provide low hours of home care or CDPA, and they make a relatively decent amount of money. However, those plans that are particularly effective, those that specialize in helping those with complex needs, wind up with a disproportionate number of high-hour cases and members who need either live-in services or 24/7 home care. In these instances, the capitation model is broken.

Therefore, we call on the state to mandate that the Department of Health create a high-needs, community-based rate cell.

This will restructure funds to allow those plans who work with the highest-need individuals to receive the resources they need. This must then come with linkages that tie the reimbursement to plans and mandate adequate payments to providers, and that this money be passed on to workers.

To do this, we may have to reexamine the global cap. The cap served its purpose well. New York has finally gotten Medicaid spending under control. In doing so, it has relieved local governments of much of their obligation under the program. However, in a webinar last week, Jason Helgerson himself noted that we are seeing extremely rapid growth in enrollment in Medicaid -- likely from the baby boomer generation -- and that this is preventing the state from making new and necessary investments in the program.

This is an unacceptable outcome. When the global cap is an obstacle to providing benefits to those who legally qualify for Medicaid, it has lived its useful life. At the very least, we must examine its structure

to ensure that the basic obligations of the Medicaid program can be met.

I have a number of other concerns with the budget which I will quickly summarize.

We do oppose the Governor's proposal to require a nursing home level of care for enrollment in managed long-term care. This will place an undue burden on Medicaid recipients and counties, who have mostly dismantled their LDSS units that take care of these assessments and authorizations.

We also feel that the Legislature must include language in the budget that certifies fiscal intermediaries who administer CDPA. This language was passed unanimously by both houses of the Legislature two years ago and vetoed by the Governor because he said it must be included as part of the budget. He has yet to do so.

We know that the number of fiscal intermediaries has risen from 56 to over 450. Many of these do not even know the name of the service or their basic obligations under the law. Certification is a logical step

that would protect valuable Medicaid dollars.

Thank you very much, and I'll take any questions.

CHAIRMAN FARRELL: Thank you.

CHAIRWOMAN YOUNG: Any questions? Okay.

MR. O'MALLEY: Thank you.

CHAIRWOMAN YOUNG: You'll be pleased to know that we're on our last page of speakers.

Okay, our next speaker is Julie Hart, director of government relations for the American Cancer Society Cancer Action Network.

MS. HART: Hi.

CHAIRWOMAN YOUNG: Thank you for being here.

MR. O'MALLEY: I'm Julie Hart, legislative director of the American Cancer Society Cancer Action Network. Thank you for the opportunity to testify today.

You have my written testimony, so I'm just going to highlight a few of those key items and then feel free to ask me any

questions, either today or at another date.

In New York State, 107,000 people will be diagnosed this year with cancer. And almost 36,000 people will lose their battle to cancer this year. I do have listed on page 1 a breakdown of new cancer cases and deaths by the different types of cancer, that you can see.

So I just want to highlight a couple of quick items. The first is the consolidation of public health programs, which I know people have spoken about earlier. And we strongly urge you -- I see you shaking your head -- to reject consolidation of public health programs. It does include funding for the Cancer Services Program, it's lumped in there, which provides breast, cervical and colorectal cancer screenings for those who are low-income and uninsured. And it's a vital service. Over 25,000 New Yorkers received a free screening in the past year, thanks to that program, so there's still a great need there. So we urge you to reject that and to fully fund that at

$25 million.

Next I just want to talk real quickly about smoking and tobacco use in New York State. Thanks to the great work that you guys have done as lawmakers over the years, we've made some great progress when it comes to youth smoking rates, and we've actually decreased our rate down in the youth population to 7.3 percent. We have a great Clean Indoor Air Act, and we have a high cigarette tax, which really helped be those driving forces there.

Where we have seen some sort of troubling news is with the adult smoking rate, which has actually crept back up over the past year. And the adult smoking rate has increased for the first time in years; we're now at 15.2 percent, which is a little bit troubling. And there's also disparities in the adult smoking rate. If you look at the low-income and low-education populations -- I do have a chart in there on page 4 which shows that -- those smoking rates are also significantly higher. So

there's vulnerable populations that we're still not reaching.

Now, the CDC says for our tobacco control program, to fund an effective tobacco control program, we should fund it at $203 million. The Governor proposes flat funding at $39 million. We know that that's a big leap to go to $203 million, but we do feel that going to $52 million -- so about a quarter of the CDC recommendation -- will help us reach some of those vulnerable populations. So we urge you to look at increasing the tobacco control funding to $52 million.

I also want to talk about e-cigarette use and the problems of e-cigarette use, particularly among kids. More kids actually use electronic cigarettes than use combustible cigarettes right now, which is really troubling for us. And more kids use e-cigarettes than adults use e-cigarette products.

The Governor has a few different proposals related to e-cigarettes. One of

them, which is -- Senator Hannon, I want to thank you, because you've sponsored a bill to include e-cigarettes in the Clean Indoor Air Law for the past couple of years, which is a priority for us and which we feel is very good in terms of health protections and de-normalizing that type of use and the progress that we've made. So we strongly support including e-cigarettes in the Clean Indoor Air Law.

The Governor also does have a proposal to tax e-cigarettes. We do support this in concept, but we would like to see some changes. We feel that the tax rate is very low. The tax in there right now is based by weight -- it's 10 cents per fluid milliliter that is being proposed. This is sort of within the range of what some other states have done -- specifically, North Carolina, Louisiana, Kansas, West Virginia, states that do not rival New York when it comes to tobacco control. We certainly don't want to set the bar that low. We want to be -- we've always been a champion when it comes to

tobacco control, so we want to set the bar higher.

Pennsylvania taxes by wholesale price, along with Minnesota by wholesale price. One taxes at 40 percent of wholesale price, and another 95 percent of wholesale price. So we would urge you to look at changing that tax formulary to wholesale price.

In addition to that, when that wholesale price increases, that price increases, so that's an additional deterrent for kids. And it's also additional revenue for the state each year.

Now, we do know -- I have mentioned that the smoking rate for kids has gone down to 7.3 percent. But in terms of overall tobacco use, if you're looking at cigarettes, e-cigarettes and all tobacco products, the rate is still at about 28 percent. So they're certainly turning to other products. So we would also encourage, as you look at e-cigarettes, to look at the tax on other tobacco products. We do have the highest cigarette tax in the nation, at $4.35 per

pack. Now, the tax on other tobacco products is 75 percent of wholesale price. That tax hasn't been raised since 2010. So there's all these other products that kids are looking at now, versus just traditional cigarettes.

We do look to the Campaign for Tobacco-Free Kids in terms of expertise and doing some projecting, and they've said that in order to have tax parity with cigarettes, that that price should be 101 percent of wholesale price. And they estimate that that will increase revenues by $24 million. So there's certainly additional revenue there, and also a source of revenue that could be used for that Tobacco Control Program funding.

Lastly, there's a couple of recommendations in there related to obesity prevention and healthy eating, which are in my written testimony.

And I'd be happy to take any questions or follow up with you at any time.

CHAIRWOMAN YOUNG: Any questions?

ASSEMBLYMAN OAKS: No.

CHAIRWOMAN YOUNG: I don't believe there's any questions, so thank you so much for being here. Appreciate your participation.

Our next speaker is Executive Director Jane Ginsburg, from the Coalition of New York State Alzheimer's Association Chapters.

Thank you for joining us.

MS. GINSBURG: Thank you.

Good evening. Thank you again. It's a pleasure to be here. I appreciate you giving us this opportunity to testify today, and of course thank you for staying so late in the evening. I know it's been a long day.

As you said, I'm Jane Ginsburg. I'm the executive director of the Coalition of New York State Alzheimer's Association Chapters. The coalition is the leading statewide organization serving and advocating for all New Yorkers affected by Alzheimer's disease and dementia. There are 390,000 Empire State residents living with Alzheimer's disease right now, and

1.1 million caregivers.

Alzheimer's is a progressive and fatal disease. There is no cure, and no way to prevent or treat its progression. Within the next decade, we expect to see an approximate 20 percent increase in the number of New Yorkers living with Alzheimer's, in large part due to the aging baby boomer population, which we've spoken a lot about today. By 2025, we anticipate that as many as 460,000 New Yorkers will be living with Alzheimer's.

And the impact that Alzheimer's is having on our state's bottom line and our nation's bottom line honestly has created a true public health crisis. Those affected by Alzheimer's disease require assistance with all activities of daily living, and eventually they will need around-the-clock care. Medicaid costs for someone with Alzheimer's disease are 19 times higher than others.

The coalition shares the Alzheimer's Association's mission to eliminate Alzheimer's disease through the advancement

of research to provide enhanced care and support for all affected, and to reduce the risk of dementia through the promotion of brain health. We align with and promote the work of the association by increasing concern and awareness, advancing public policy, and enhancing care and support through robust advocacy, partnership, and programmatic initiatives.

Since 2015, the Executive Budget has included approximately $26.5 million for those facing Alzheimer's disease. This includes almost $5 million for the coalition's contract with the Department of Health, the Alzheimer's Community Assistance Program -- we call it AlzCAP -- and the rest going towards our partner programs, including the Centers for Excellence in Alzheimer's Disease and for grants to support caregiver support and respite, in addition to administrative and program evaluation costs. And we're very grateful for this attention and this appropriation.

AlzCAP, the coalition's sole-source

contract with the Department of Health, is the key to educating and empowering the thousands of New York Alzheimer's informal caregivers, to delay skilled nursing facility placement for their loved ones and to reduce the Medicaid burden. I've included in our written testimony some detailed figures on what the costs of nursing home placement are, and the cost burden that it has on Medicaid. Since the increase in 2015, programs and services to all affected by Alzheimer's and dementia through AlzCAP include -- and I'm just going to give you some highlights -- almost 7,000 care consultations, which are the in-depth, personal, in-person meetings for those facing the decisions and challenges pertaining to the diagnosis of Alzheimer's disease or a related dementia. So when someone is diagnosed or they believe they are diagnosed, they come to the Alzheimer's Association and have a long, in-depth care consultation to navigate the challenges facing Alzheimer's disease.

We have trained more than 29,000

attendees in various caregiver training sessions. There have been more than 2,700 support group meetings. We've fielded more than 34,000 calls to our free, 24 hour-a-day, seven-day-a-week helpline. More than 800 physicians have been educated by our staff. And we've reached nearly 48,000 people at conferences and health fairs.

And while we are very, very proud of these outcomes, we know that more needs to be done. Too often, studies show that people do not understand Alzheimer's disease and the importance of early diagnosis and care planning. According to the 2015 Behavioral Risk Factor Surveillance System survey data, 11 percent of New Yorkers -- that's one in 10 New Yorkers -- age 45 and older report confusion or memory loss but have not spoken to their doctor about it.

In 2016, last year, in coordination with the Department of Health, and pursuant to the New York State Alzheimer's Disease Plan to promote concern and awareness of Alzheimer's disease, we engaged in a very

limited public awareness effort. When we did so in these between-four-and-eight-week efforts, calls to our 24/7 helpline increased 42 percent, attendance at our education programs increased by 35 percent, and just over a month of digital promotion produced three times the typical click-throughs to our website than a typical promotion of such a kind would have.

To address this public health crisis, we must promote greater understanding of the early warning signs of Alzheimer's disease and the value of early diagnosis and planning -- the services that the Alzheimer's Association offers. But dedicated funding for public awareness does not exist in our current budget. We respectfully request an additional $10 million investment in public awareness through AlzCAP to launch a large scale, culturally competent statewide public awareness campaign in coordination with the Department of Health.

Further, to meet the needs associated with increased awareness and the increased

attention that those folks would need, we request an additional $3.5 million to grow our staff and program services statewide.

We've also been partnering with many of the statewide assisted living organizations on matters concerning those with Alzheimer's in assisted living programs. And I've detailed some of that for you in our written testimony, and echo much of what the providers offered today in their testimonies.

Through AlzCAP and our coordinated efforts, the coalition is helping to achieve New York's Triple Aim -- better care, better population health, and lower healthcare costs -- through collaborative community work. Last year, New York spent $4.2 billion in state Medicaid costs for caring for those with Alzheimer's. But our efforts to empower and enable caregivers and those with dementia to live at home longer helps reduce the Medicaid burden now and into the future, especially as the population of those with Alzheimer's continues to skyrocket.

We're grateful for the current

appropriation and look forward to working together to grow our resources and continue to improve the status quo for all New Yorkers facing Alzheimer's disease and dementia.

Thank you again for this opportunity.

CHAIRWOMAN YOUNG: Thank you.

Any questions?

CHAIRMAN FARRELL: Thank you.

CHAIRWOMAN YOUNG: Senator Krueger.

SENATOR KRUEGER: I'm intimately involved with Alzheimer's at this moment in my family's life.

MS. GINSBURG: I'm sorry to hear that.

SENATOR KRUEGER: But tell me where you got the number $4.2 billion of our Medicaid costs are for Alzheimer's. How's that math done?

MS. GINSBURG: Where is -- I do have that number. That comes from -- actually, it comes from our national association, and I can provide you with some backup documentation on that. We can bring it to your office.

Our national association helps to kind

of whittle down costs per state, and help us look at various costs. We believe it's actually more than 4.2, and that 4.2 is a very conservative number, especially when you look at the nursing home costs. But the 4.2 number comes from our national association, and I'll get you the backup documentation on that.

SENATOR KRUEGER: Thank you.

MS. GINSBURG: Sure.

CHAIRWOMAN YOUNG: Assemblyman?

ASSEMBLYMAN RAIA: Thank you.

I'll ask you the same question I asked the nursing home folks earlier with respect to the Governor's proposal to eliminate the hold on nursing home beds. Are you concerned that if a patient with Alzheimer's or dementia goes into the hospital for two weeks and comes back and doesn't have the same room or the same healthcare aide, that that presents a problem?

MS. GINSBURG: Yeah, absolutely. Keeping someone with Alzheimer's or dementia in the most familiar setting is critical to

really -- you know, every time that you change the setting, even just a hospitalization, it can completely throw them out of whack and exacerbate any other kinds of confusion that they're having. So absolutely, it's a concern to us.

ASSEMBLYMAN RAIA: Thank you very much.

CHAIRWOMAN YOUNG: Thank you.

CHAIRMAN FARRELL: Thank you.

CHAIRWOMAN YOUNG: All set, thank you.

MS. GINSBURG: Thank you.

CHAIRWOMAN YOUNG: Is Scott Amrhein here? We don't have any testimony. No?

Okay, then we will go to Andrea Smyth, executive director of the New York State Coalition for Children's Behavioral Health.

Following Ms. Smyth will be Prevent Child Abuse New York, and following that, Agencies for Children's Therapy Services.

Thank you for being here.

MS. SMYTH: Thank you. I'm Andrea Smyth, with the Coalition for Children's Behavioral Health. Thank you for a very well

run hearing and the opportunity to speak with you.

I have submitted written testimony. It covers more than the issue I want to talk about. But my sole purpose of speaking with you this evening is to ask that you not address the Medicaid global cap pressures by agreeing to the Executive's recommendation to save $250 million by reversing planned investments in children's behavioral health. Rather, accept the Executive recommendation to invest $5 million into transformation of residential treatment capacity so that we can expand community services, reject the $20 million savings, and then restore 17.5 of that so that we can expand capacity.

I've taken the opportunity to take stock of the contemporary array of children's behavioral health services. I hope you enjoy looking for services in your county, because they may not be there. In the entire state, there are eight -- eight -- crisis residences for kids, and six of them are state-operated on psychiatric center property. They are not

in your communities. And we want that service to be available to children and families all around the state.

There are 104 outpatient clinics. In 25 counties, there's one or none that provide services to children and adolescents.

So in 2011 the Medicaid Redesign Team -- not the behavioral health team, the major Medicaid redesign table -- said the children's behavioral health system lacks capacity and should be targeted for planned investments. That was in 2011.

In 2017, because there have been delays in implementation of Medicaid redesign for kids, there are planned reductions. I urge you not to agree to them, and I urge you to restore the children's behavioral health funding.

And I address workforce, DSRIP, and capital funding in the written testimony.

Thank you.

CHAIRWOMAN YOUNG: Thank you.

SENATOR KRUEGER: Thank you.

CHAIRWOMAN YOUNG: Any questions?

CHAIRMAN FARRELL: Thank you.

CHAIRWOMAN YOUNG: Okay. Our next speaker is Tim Hathaway, executive director of Prevent Child Abuse New York.

Look forward to your testimony. Thank you for being here.

MR. HATHAWAY: Good evening. Thank you for having me here this evening. Prevent Child Abuse New York is an organization, not for profit, that is working with over 6,000 professionals in the state --

SENATOR KRUEGER: Can you pull the mic up a little closer?

MR. HATHAWAY: Yes, absolutely.

SENATOR KRUEGER: Thank you.

MR. HATHAWAY: -- to provide and enhance prevention services.

This year, over 64,000 children will be impacted by the issue of child maltreatment. Those children are going to incur, along with their families, an increasing spiral of health-related costs. This evening I just want to share with you four different areas that are really pivotal

in terms of prevention work that fall under the purview of this committee and work that the Department of Health is ongoing with.

The first is the area of primary prevention. And what we know is that there are protective factors that, if they are in place for families, we greatly reduce the risk that children are at for child maltreatment. Related to that is the issue of childhood trauma and adverse childhood experiences.

The state last year included in the Behavioral Risk Factor Surveillance System, the BRFSS, the opportunity to surveil issues of adverse childhood experience. Our office believes that surveillance of these issues is a critical marker and helps us both sharpen prevention practice and points the way for increased work around prevention.

I would encourage this committee to maintain and strengthen its commitment to looking at and exploring and identifying adverse childhood experiences as they've been collected in the BRFSS.

The second issue I would like to address with you is the area of maternal, infant, and early childhood home visiting. Currently there are four evidence-based programs across the state serving families with very young children in this area -- my colleague with Parents as Teachers is going to address you in couple of moments -- the Healthy Families New York model, the Parent Child Home model, and then the Nurse-Family Partnership model, which is directly under the purview of this body.

We would encourage you to maintain the $3 million currently funded and expand that funding by an additional $3 million to both maintain services and expand services.

The third issue I'd like to address with you is preconception planning. We need to concentrate on a mother's health before she becomes pregnant. Vital time is lost when providers and communities fail to address the period prior to conception. When women are not healthy, physically or emotionally, maternal mortality, maternal

depression, and infant mortality all increase.

We support passage of the Comprehensive Contraceptive Care Act, the CCCA, and/or similar regulations that will encourage requiring health insurance policies to include coverage of all FDA-approved contraceptive drugs, devices and products as well as voluntary sterilization procedures, contraceptive education and counseling, and related follow-up services. We also support Family Planning Grant funds.

Finally, a word about Medicaid. In New York State, 47 percent of children under the age of six receive public health benefits, including Medicaid/CHIP. Overall, children account for the largest group of Medicaid beneficiaries.

There are rumors afoot that that coverage for children may be in danger. I encourage you to be vigilant as federal proposals are made that potentially change Medicaid. While more state flexibility sounds promising, there is a real danger that

it actually will result in cuts and the potential elimination of things like guarantees of coverage, cost-sharing limits, and early and periodic screening, diagnostic and treatment services.

These are all essential pieces in terms of ensuring the economic stability of families in our communities and ensuring that families have access to the kinds of services that provide for emotional well-being and for the sort of environments that are healthy and nurturing for young children. Ultimately, if we are not providing the sort of services that support families early, we will pay the cost for those services down the road.

Thank you very much. Happy to answer questions.

CHAIRWOMAN YOUNG: Any questions?

CHAIRMAN FARRELL: No.

CHAIRWOMAN YOUNG: No questions. So thank you so much for being here.

SENATOR KRUEGER: Thank you very much.

MR. HATHAWAY: Thank you.

CHAIRWOMAN YOUNG: Our next speaker is

Mr. Steven Sanders, executive director of Agencies for Children's Therapy Services.

Welcome, Steve.

SENATOR KRUEGER: Deja vu.

CHAIRWOMAN YOUNG: All over again.

MR. SANDERS: Thank you very much. It's good to be with you again, and thank you for being here so late.

Just for the record, I would observe that when I arrived here, my hair was dark.

(Laughter.)

MR. SANDERS: And Bob, you've been here so long today I would have to observe that you are in the majority.

(Laughter.)

ASSEMBLYMAN OAKS: Yes, we are.

MR. SANDERS: Although I think Assemblyman Farrell constitutes a majority of one, so --

(Laughter.)

MR. SANDERS: You have my brief written remarks. I'm not going to dare to read them. I'm going to very briefly summarize what those remarks contain.

The members of my association comprise 35 agencies that do primarily Early Intervention, and those 35 agencies are responsible for more than half of the services rendered to the Early Intervention population statewide.

There are essentially two parts to the Governor's Early Intervention proposal this year: One deals with amendments to Insurance Law, and one deals with amendments to the Public Health Law.

The amendments to the Insurance Law, in my judgment, are good and deserve your consideration, and I would endorse them. Why? Because those changes would actually speed up the commercial insurance adjudication process. It would probably result in more commercial insurance reimbursement to providers. You heard a lot about that this morning, discussions about the fiscal agent. And it appears to me that the Insurance Law changes are heading Early Intervention in the right direction -- speeding up the adjudication, probably

increasing commercial insurance reimbursement -- and as such, I think they deserve your consideration.

On the other side of coin, the Public Health Law amendments, while seemingly innocuous, are really not. Most of the changes in the Public Health Law will add additional responsibility to providers. And you heard plenty of testimony this morning about how providers have had to shoulder all of the billing responsibilities that used to be borne by the counties. The fiscal agent really doesn't do that much in terms of chasing claims that are not being paid or are tied up in adjudication.

And a lot of the proposals made by the Governor will simply add even more administrative responsibilities, taking away time from services, additional expenditures for this additional administrative work. And it's something that, given all of the new responsibilities providers have had to take on in the past three years, it just would be probably the straw that would break the

camel's back for many of those provider agencies.

The other Public Health Law change of note which I want to draw your attention to is, again, one that sounds fairly reasonable and innocuous. It says that the fiscal agent or the department may require providers to appeal commercial insurance denials. When Aetna or Prudential denies a claim, before that claim goes to escrow to be paid, what the Governor says is that the fiscal agent or the department may require providers to appeal that denial. The hope being that the denial will be overturned and it will save the state money and counties money because commercial insurance will pay.

Number one, the odds of commercial insurance changing their minds upon appeal is very remote. But the biggest problem is that based on current Insurance Law, this will add up to an additional three and a half months, 105 days, to the process of adjudication. These are days when providers will not get paid, it will affect their cash flow

mightily. It's something that is well-intentioned, but it's a very bad idea. It will hold up the whole process, it will hold up reimbursement, it will probably not result in any additional savings for the state or counties.

So I draw that to your attention. I hope that you will reject that particular proposal. I hope that you will give consideration to the Insurance Law proposals.

And again, I want to just thank you for waiting it out. It's a great effort on your part, and your interaction with the witnesses I think has been really, really good. And I just want to also thank the staff of Senator Hannon and Assemblyman Farrell, in particular Kristin and Sean, who are sitting in the back. You have terrific staff, and I know that they aid your efforts mightily.

So thank you.

CHAIRWOMAN YOUNG: Thanks, Steve. It's always great to see you.

MR. SANDERS: You need not ask me any

questions, unless you want to.

CHAIRWOMAN YOUNG: And I know tonight is like a flashback of the good old days in the Assembly when you're into the wee hours of the morning. So thank you.

MR. SANDERS: My pleasure. Thank you.

SENATOR KRUEGER: Thank you, Steve.

CHAIRMAN FARRELL: Thank you.

CHAIRWOMAN YOUNG: Next, we have Lisa Foehner, director of state advocacy for the Parents as Teachers National Center.

MS. FOEHNER: Good evening. I'd like to thank the chairs and the members of the committees for allowing me to provide testimony tonight on the New York State Budget.

My name is Lisa Foehner, and I am the director of state advocacy for Parents as Teachers National Center. And I'm also -- I also support programs here in New York. I sit on the New York State Home Visiting Workgroup as well. I will be brief and, for the record, have submitted detailed testimony.

Parents as Teachers is a nationally recognized evidence-based home visiting model that promotes the optimal early development learning and health of children by supporting and engaging parents and caregivers. Parents as teachers is the most widely replicated home visiting model in the United States. It serves families in all 50 states. In New York, 10 community-based providers provide Parents as Teachers to a little over a thousand families in nine communities. In fact, there is a program in Senator Young's district at the Jamestown Community Learning Council, and they serve families in several school districts.

Parents as Teachers programs have been operating in New York State for decades without designated state funding. It's actually the only model in the state that does not receive any state funding. Additional funding is needed for these vital programs to serve more families in key communities, and to reduce waiting lists.

This year we respectfully request

$491,000 in the '17-'18 budget to expand Parents as Teachers to families in Broome, Chautauqua, and Westchester counties, where programs currently have waiting lists and the majority of children who need these services do not have access. The additional funding would support services for 120 new families and also provide for a quasi-experimental study of local outcomes.

The premise of Parents as Teachers is simple. Trained professionals, referred to as parent educators, who are often early childhood educators, social workers, nurses, or other providers, work through school districts, hospitals and other agencies to strengthen families. The model includes four components: personal visits, child screenings, a resource network, and group connections.

Personal visits are individualized, and they're strength-based, where parent educators focus on child development, parent-child interaction, and empower parents to work with their children in a way that

facilitates healthy development.

The screening portion of the program helps identify possible developmental delays, vision and other health problems, so that children can be linked to appropriate services and therapies. In some cases, Parents as Teachers is the first link to the state's Early Intervention system. Last year we screened about 875 children in New York.

Sometimes our parent educators are detecting delays way before a pediatrician can, because they're in the home with families for sometimes two hours a month.

Every personal visit focuses on family well-being, so parent educators help parents set family goals, such as finding employment, getting health insurance, or getting a better education to help increase family self-sufficiency and independence.

Parents as Teachers has a core value of working with moms and dads, prenatally all the way through the first year of kindergarten, including families with multiple children. Enrollment can happen at

any time along this continuum. This is a unique quality to our model.

Parents as Teachers also addresses individual family needs and is adaptable to communities. For example, some of our programs focus on teen parents. Some of our programs, like the one in Mount Kisco, target immigrant families.

Seventy percent of families in Parents as Teachers have two to four high-needs characteristics, which is reflective of some of the things that Tim Hathaway from Prevent Child Abuse talked about, having ACES and other things. Eighty percent of our families are low-income families.

Parents as Teachers is a proven strategy that has been well-researched. We have randomized control trials, quasi-experimental studies that demonstrate that it reduces the need for remedial education, increases school readiness, reduces instances of child abuse and neglect, promotes economic self-sufficiency, improves a parent's care and education of their child,

and actually improves some parent health and child outcomes such as higher immunization rates and increased parental health literacy. A detailed list of outcomes by domain is included in my written testimony.

It's also a good investment. One state institute for public policy issued a list of evidence-based programs to policymakers and budget writers that are well-researched and that can, with a high degree of certainty, lead to better statewide outcomes coupled with a more efficient use of taxpayer dollars. Policy analysts found that Parents as Teachers has a cost-benefit ratio of $3.29 for every dollar invested. It saves taxpayers money.

Home visiting models vary in design, eligibility criteria, content and intensity, so a range of home visiting program models is more reflective of the broad spectrum of family needs in New York State. So in addition to the request for Parents as Teachers programs, we also support the request of the other evidence-based home

visiting models in New York, including Nurse Family Partnership, Healthy Families New York, and Parent Child Home Program, so that collectively we can serve more families who are at risk for poor outcomes. I ask that the state maintain the current $26.8 million investment in these programs and support their request for $9.5 million in additional funding. Details of their request are also in my testimony.

Evidence-based home visiting is a huge success in this states, and expanding it and enhancing it is a really strategic opportunity to strengthen our families and ensure that from birth to school, children can grow up healthy, safe, and ready to learn. I have attached two stories, from families in the Binghamton City School District and Mount Kisko, as well as a fact sheet entitled "Parents as Teachers' Impact on Health," which are also in my testimony.

Thank you.

CHAIRWOMAN YOUNG: Thank you.

Any questions?

SENATOR HANNON: Thank you. No.

SENATOR KRUEGER: Very wonderful program. Thank you.

CHAIRWOMAN YOUNG: Thank you.

SENATOR HANNON: Thanks for being here.

MS. FOEHNER: Thank you.

CHAIRWOMAN YOUNG: Our next speaker is Kim Atkins, family planning board chair, from Family Planning Advocates of New York State.

I'm sorry. Are you Kim?

MR. ATKINS: Yes, I'm Kim.

CHAIRWOMAN YOUNG: Oh, okay.

MR. ATKINS: Thank you. My name is Kim Atkins, and I'm the board chair for the organization that used to be known as Family Planning Advocates and is now known as Planned Parenthood Empire State Acts.

CHAIRWOMAN YOUNG: Could you get a little closer to the mic? We want to hear what you're saying. Thank you.

MR. ATKINS: Sure.

CHAIRWOMAN YOUNG: Great. That's better.

MR. ATKINS: Planned Parenthood Empire State Acts represents the state's nine Planned Parenthood affiliates that collectively represent an integral part of New York's healthcare safety net for the uninsured and underinsured. These nine health centers alone served nearly 180,000 patients just in 2015.

As many of you are well aware, this year has the potential to be filled with challenges for Planned Parenthood. Just today, the House of Representatives did vote to allow states to act to defund Planned Parenthood. It's the first step in some other actions that we expect to go forward.

Although we are being targeted for one service that we provide, it is very important that you understand Planned Parenthood provides an array of vital primary and preventive care services, including family planning and counseling, contraception, pregnancy testing, health education, treatment and counseling for sexually transmitted infections, including HIV,

behavioral health screening, drug therapy counseling, and support to transgender individuals as well as breast and cervical cancer screenings.

While we understand that congressional action is imminent, defunding cannot happen all at once, as there are several funding streams that support Planned Parenthood services. Some of those funding streams directly contribute to certain state programs that appear in the State Budget. Therefore, as you take a look to make decisions about the budget, it is important to understand what sources of funding could further be depleted as a result of federal action.

First, the Family Planning Grant pays for a range of services that are designed to offer a comprehensive approach to reducing the incidence of unintended pregnancy. These include direct medical care, community outreach, education, and patient counseling and programming that is designed to respond to the unique needs of each particular community we serve.

It is through the support of the Family Planning Grant that Planned Parenthood is able to keep family planning services affordable and accessible to all New Yorkers. The grant allows our providers to charge patients based on a sliding-fee scale depending on their level of income.

The rate of unintended pregnancy and abortion in the United States has been going down for 20 years. Our efforts to improve access to contraception and education are paying off. In addition to a decline in the these rates, the Family Planning Grant has had a direct role in contributing to this through providing better health and allowing women to plan better for their families.

With continued state support, we hope to proceed with this important work of increasing access to family planning services.

The federal Title X program provides about a third of funding for the Family Planning Grant. Without the same level of grant funding, it is hard to ascertain

whether Planned Parenthood would be able to offer the same level of services at reduced charges to patients.

Also, many of you are familiar with the Comprehensive Adolescent Pregnancy and Prevention Grant, which is the only statewide prevention initiative using evidence-based programming. The prevention agenda goals involve reducing the incidence of adolescent pregnancy, reducing the transmission of sexually transmitted infections, and engaging young people in preventative healthcare.

The 2017-2018 Executive Budget proposes the consolidation of 39 separate appropriations and reduction of all funding pools by 20 percent. We recommend that these vital programs, including CAPP, be restored and spared from any reductions in funding. For the last two decades, the teen pregnancy rate in New York has declined by 46 percent. This work must be allowed to continue.

Regarding the cost-of-living adjustments for public health programs, the Executive Budget would defer for one year the

cost of living for several certain health service providers, including Planned Parenthood. Planned Parenthoods are also employers who are facing their own challenges with respect to recruitment and retention, and we strongly urge the Legislature to restore the COLA for 2017.

The Executive Budget would also place new limitations on the prescriber-prevails policy under the state's Medicaid program. This important policy allows a provider the ultimate say on whether a drug will be covered for a Medicaid beneficiary. This could negatively impact transgender patients who typically rely on very high cost drugs that are unique and specific to their hormonal needs. Removing prescriber-prevail authority on those drugs could create additional complications for their therapy.

And this could also impact others who are either HIV-positive or who are attempting to prevent becoming HIV-positive through the use of high-cost antiretroviral drugs. Again, it should be what's right for the

patient.

So let me just return for a second to the looming defunding threat from the federal government. Today everything remains in place, but as I mentioned earlier, the House took the first action towards allowing states to defund Planned Parenthood. But we know that there have been promises to defund Planned Parenthood directly and repeal the ACA, affecting Planned Parenthood as well as other healthcare providers.

And at the same time, you know, there's been a ban on federal funding of abortion services for many years with the enactment of the Hyde Amendment. New York State stepped up to ensure that Medicaid beneficiaries are able to exercise their constitutional right to reproductive choice, by assuming responsibility for paying the federal share. But the defunding will deprive Planned Parenthoods of every other source of federal funding for the preventive and primary care services we provide.

Let us be clear. These actions will

hit hardest those areas of the state where Planned Parenthood is the sole or one of the few healthcare providers for Medicaid beneficiaries, particularly in the state's underserved rural and some inner-city communities. If the predictions are accurate, defunding could occur as early as late March or early spring. And we recognize that the timing of this action presents a serious challenge to your budgetary process.

So we are urging you to take the necessary steps at this time to protect New Yorkers who currently receive healthcare services at Planned Parenthood centers. We ask that you consider establishing a contingency fund only to be used if Planned Parenthood is defunded at the federal level. Just as New York stepped up when the federal government declined to support Medicaid funding for abortion, we urge New York to do the same to protect access to the full array of reproductive health, family planning, primary and preventive services that the federal action threatens.

New York has always served as a model for the rest of the nation, so we must send a powerful message that we will not accept federal policies that negatively impact our citizens and go against the values that we stand for.

Thank you.

CHAIRWOMAN YOUNG: Thank you.

CHAIRMAN FARRELL: Thank you.

CHAIRWOMAN YOUNG: Any questions?

SENATOR KRUEGER: Appreciate your work. It's going to get harder.

MR. ATKINS: I know. Thank you.

CHAIRWOMAN YOUNG: Thank you.

Our next speaker is Rebecca Novick, director of the Health Law Unit at the Legal Aid Society.

Following Ms. Novick will be the Campaign for New York Health.

Everybody is in the back again, so if you're going to be speaking, please come down toward the front.

CHAIRMAN FARRELL: All two of you.

MS. NOVICK: Yes, I was just going to

apologize for the long grand entrance. I didn't realize that the person before me wasn't here.

CHAIRMAN FARRELL: Come on down.

MS. NOVICK: Thank you for the opportunity to testify tonight and for still being here. My name is Rebecca Novick, and I'm the director of the Health Law Unit at the Legal Aid Society in New York City. The Legal Aid Society is a private, not-for-profit legal services organization, the oldest and largest in the nation, dedicated since 1876 to providing quality legal representation to low-income New Yorkers.

The Health Law Unit provides direct legal services to low-income healthcare consumers from all five boroughs of New York City. We also participate in state and federal advocacy efforts on a variety of health law and policy matters.

The Legal Aid Society applauds Governor Cuomo, the Legislature, and the Department of Health for another year of

successful implementation of the Affordable Care Act, and in particular the first year of the availability of the Essential Plan. The popularity of this program is a testament to the fact that working low-income New Yorkers have been desperate for a truly low-income insurance option. This coverage is crucial to ensuring that these hardworking individuals can access care in these unstable times.

This is a time of unprecedented uncertainty about the future of healthcare in this country. I am confident that New York will continue to be a leader in providing high-quality, comprehensive healthcare in the Medicaid program to needy New Yorkers. As New York's Medicaid program continues to implement its own sweeping changes, it's particularly important to protect low-income New Yorkers' access to quality healthcare benefits and services.

My written testimony includes comments on a number of proposals that we believe could have a significant impact on our

clients' health and well-being. And in the interests of time, I will touch on just a few of these now.

The Legal Aid Society strongly supports the $2.5 million appropriation for the Community Health Advocates, or CHA, program in the Executive Budget, and urges the Legislature to provide an additional $2.25 million to fortify this critical program. One of the remaining speakers will say more about this program, so I'll be extremely brief, and just to say that this statewide all-payer program of consumer assistance in all areas of healthcare helps people use their care, keep their care, and get needed health services and take care of crushing medical bills. And it couldn't be more important in these uncertain times in healthcare in this country.

I also want to comment on the proposed carve-out of the transportation benefit in managed long-term care. I understand the utility of aligning the transportation benefits across the managed care programs.

However, this change, if it goes forward, should only proceed in combination with provisions to more carefully evaluate the ability of the state's transportation vendors to provide appropriate services to MLTC enrollees.

Current law states that the commissioner should adopt quality assurance measures for the transportation vendor, quote, if appropriate. It is not only appropriate but essential that any transportation vendor with which the state contracts meets stringent quality measures and demonstrates expertise in serving this complex population.

We see incredibly big problems both in -- that unfortunately are common to both mainstream and MLTC in transportation. We had a mainstream managed care client who's serious disabled who recently waited for transportation home from a medical appointment for three hours, half of that time outside in the cold. And unfortunately we see these problems with our MLTC clients

as well, but not having the added step of having to go to an entity that's outside of the plan can at least provide an additional kind of lifeline for the people in that program.

We have an MLTC client who is blind, wheelchair-bound, and receives dialysis, and we had to do a lot of advocacy with her plan to have them acknowledge that she couldn't just be dropped off with her vendor and picked up at the end of her dialysis treatment, that her needs required somebody going back and forth with her. And when you're adding a layer of you're not even dealing with the plan, it just becomes more complicated, and it's becoming more complicated for an extremely vulnerable population.

And then I just wanted to briefly comment on consumer cost-sharing in a couple of areas. We are very concerned about the proposed $20 monthly premium for individuals in the Essential Plan between 138 and 150 percent of poverty. We represent

individuals for whom that amount of money really makes a difference. And I see how, when you're looking at that amount of money, it seems like such a reasonable amount. But our clients need to make incredibly tough choices about the money they spend. And the studies really have shown that these small increases in cost-sharing keep people from having insurance and from accessing services.

We're also concerned about the increase in prescription and nonprescription drug payments in the Medicaid program. The reality is that many of our clients don't have $1 or $2 to pay for a prescription and will miss out on taking needed medication because they lack the copayment.

It's particularly important that any increase in consumer cost-sharing should be accompanied by meaningful efforts by the state to remind providers and consumers about their rights with regard to accessing services. The rule is that no Medicaid beneficiary should walk out of a pharmacy without their medication if they can't afford

the copayment, but it happens all the time. And we saw a huge increase in this after the pharmacy benefit was carved into Medicaid managed care in 2011.

Department of Health staff were very helpful at the time in resolving individual cases and reminding individual pharmacies about their obligation, but it's inevitable that many more people who didn't get to us or another advocate were actually turned away without their medications.

This kind of change in copayments necessitates increased information to people to understand that if they can't afford this additional copayment, they should not be going without needed prescription drugs.

Thank you very much for the opportunity to testify today, and I look forward to working with the Legislature to help preserve a strong Medicaid program while protecting beneficiaries' rights.

CHAIRWOMAN YOUNG: Questions?

No questions, so thank you very much.

MS. NOVICK: Thank you.

SENATOR KRUEGER: Thank you very much.

CHAIRMAN FARRELL: Thank you.

CHAIRWOMAN YOUNG: Our next speaker is Maria Alvarez, board member and executive director of Statewide Senior Action Council, Campaign for New York Health.

Thank you for waiting so long.

MS. ALVAREZ: Thank you for holding these hearings and for making it this long so that all of us could get in.

My name is Maria Alvarez. I'm the executive director of New York Statewide Senior Action Council. And as you said, I'm testifying on behalf of the Campaign for New York Health, a statewide coalition of nurses, doctors, labor unions, healthcare workers, seniors, faith groups, businesses, immigrant rights organizations, and concerned individuals advocating for a universal, publicly financed healthcare system, as detailed in the New York Health Act, a bill that passed by a large majority in the Assembly in 2015 and 2016.

I'm going to read a statement.

However, some of the facts are -- you know, we refer to a report that is -- that you can find online, but I've also included with our testimony an overview of the report for your reference.

SENATOR HANNON: Can't you summarize?

MS. ALVAREZ: Excuse me?

SENATOR HANNON: Can you summarize instead of reading? It's 8 o'clock.

(Laughter.)

MS. ALVAREZ: Okay.

SENATOR RIVERA: It's only 7:48.

ASSEMBLYMAN RAIA: We can all read it.

MS. ALVAREZ: Okay. Well, my -- well, okay, fine.

So basically the testimony hinges on three things. The healthcare costs are an important matter for the state budget process to address. It's important because it would actually save New York State money in the long run -- taxes to the localities, businesses as well.

Second, the overwhelming need for improvements in our state healthcare. At

Statewide we run a patient's rights helpline and a Medicare consumer helpline. And one of the things that we do is -- you know, I just came from the office today -- finding, you know, patients who are saying I was just -- I don't know what happened to my healthcare, I've been -- I was told I don't have it anymore, and claiming that they never received any notice of being expelled from their insurance.

Well, one of the things that would resolve that issue is if we had a single-payer program where people would not have to worry what insurance they're on or not on, what benefits they have or don't have, because everybody would have it.

Coming from the aging field, I can tell you that we have Medicare, and Medicare seems to be a very good alternative to a single-payer -- you know, to be a good single-payer system. In original Medicare, you only have the 2 percent overhead versus 15 to 20 percent of overhead when we deal with all of the insurance companies that we

have in New York State. It would be a lot more cost-effective.

There are companies in New York State that cannot afford to pay for insurance for their employees, who are even considering leaving the state, something that would be detrimental to our state and to the revenues of our state.

In terms of the need, I just wanted to highlight that New Yorkers are panicking about their healthcare. You know, we are -- you know, this looming threat of block-granting Medicaid will definitely affect more people in New York State, and unfortunately probably the most vulnerable ones. And it's -- millions of New Yorkers are going to go without healthcare, more than the ones that already go without healthcare now because they can't afford it.

This is very affordable, prudent, and it makes sense from a budgetary standpoint.

So anyway, I know you want to go home. So if you have any questions, I'll be more than glad to answer them. If not, you can,

you could always reach us later.

ASSEMBLYMAN RAIA: One quick question.

CHAIRWOMAN YOUNG: Assemblyman.

CHAIRMAN FARRELL: Quick.

ASSEMBLYWOMAN RAIA: Yes, very quick. Thanks. I noticed you're citing a detailed study of this plan conducted by Professor Gerald Friedman. Is this the same Gerald Friedman that -- how do I phrase this -- basically came out and said, Well, I don't subscribe to normal views on things?

MS. ALVAREZ: Mm-hmm.

ASSEMBLYMAN RAIA: When we talk about this particular healthcare plan, every piece of data I've seen said it's going to cost twice as much than what Mr. Friedman is saying. I just want to point that out for the record.

CHAIRWOMAN YOUNG: Anybody else?

SENATOR KRUEGER: Just a clarification. Your proposal actually is the Dick Gottfried bill here in New York State; is that correct?

MS. ALVAREZ: Yes, it is. Yes.

SENATOR KRUEGER: So it's too bad that Assemblymember Gottfried isn't here, because he might be able to challenge those assumptions with his colleague from the Assembly, and perhaps will another day.

ASSEMBLYMAN RAIA: I'll challenge him on the floor when we do that.

SENATOR KRUEGER: I was about to say, on another day.

So thank you very much for your testimony.

CHAIRWOMAN YOUNG: Thank you. Thank you very much.

(Discussion off the record.)

CHAIRWOMAN YOUNG: Okay, let's move along here.

Next we have Bailey Acevedo, health attorney for Healthcare for All New York Coalition.

If you could give the salient points from your testimony, that would be very helpful.

MS. ACEVEDO: Hi. Good evening, and thank you for the opportunity to speak with

you this evening.

SENATOR KRUEGER: Could you speak up a little bit, into the mic? Thank you.

MS. ACEVEDO: Sure. My name is Bailey Acevedo, with Health Care for All New York.

Health Care for All New York, or HCFANY, is a statewide coalition of over 170 organizations dedicated to achieving quality, affordable healthcare for all New Yorkers. This testimony outlines HCFANY's position on five provisions within the Executive Budget.

First, HCFANY supports the proposed budget allocation of $2.5 million in funding for the Community Health Advocates, or CHA, the state's health consumer assistance program, and urges the Legislature to increase it for a total appropriation of $4.75 million.

CHA is a statewide network of community-based organizations that helps New York's consumers and small businesses obtain, use, and keep health insurance coverage. The CHA program is administered by the Community Service Society of New York, in

partnership with three specialist organizations -- the Empire State Justice Center, the Legal Aid Society, and the Medicare Rights Center.

Since 2010, CHA has handled over 280,000 cases and saved consumers over $21 million in medical expenses. CHA's services are available for free to consumers, regardless of how they get their insurance coverage, and they're available in person in every county in New York and through a toll-free helpline operated out of the Community Service Society of New York.

CHAIRWOMAN YOUNG: Maybe if you could -- you have several points, I think, that you want to make. So could you just go over each point briefly instead of reading all the testimony?

MS. ACEVEDO: Sure.

CHAIRWOMAN YOUNG: Thank you.

MS. ACEVEDO: So CHA services are needed now more than ever, with the looming changes in the federal programs. And we're already seeing at Community Health Advocates

an increased demand in services. Consumers are already very concerned that their insurance coverage may change, and they don't know what's going to happen in the future.

Second, HCFANY urges the state to increase the age limit for Child Health Plus to age 29 from its current age limit of 18. This would create a young adult option for people who are not eligible for subsidized health insurance because of immigration status.

Third, HCFANY opposes proposals that cut spending by increasing the financial burdens experienced by low-income New Yorkers. This includes higher premiums for Essential Plan enrollees and increased prescription drug copays for Medicaid enrollees.

Fourth, HCFANY opposes provisions that would make it more difficult for low-income New Yorkers to enroll in Medicaid and use their coverage to get the healthcare they need, including proposals to eliminate the right of spousal refusal and prescriber

prevails protections.

Last, HCFANY recommends changes to the composition and powers of the Governor's proposed Healthcare Regulation Modernization Team to ensure meaningful consumer engagement, improve transparency, and require legislative approval for any demonstration programs that would waive existing statutes or regulations.

Thank you.

SENATOR HANNON: Thank you. Thank you for listening to Senator Young.

SENATOR KRUEGER: Thank you for your testimony and for waiting all day.

MS. ACEVEDO: Thank you.

CHAIRWOMAN YOUNG: I just want to remind everybody, your written testimony is part of the record. So we do review that.

Our -- I think it's our final speaker, is Coverage 4 All, Claudia Calhoon, director for health advocacy.

SENATOR HANNON: No pressure.

CHAIRWOMAN YOUNG: Thank you for being here.

MS. CALHOON: Good evening. I did a very short version, so that is the one I will read from, since I'm the very last one in between you and going home. Thank you for staying here so late.

My name is Claudia Calhoon. I'm the health advocacy director at the New York Immigration Coalition, and I'm here representing the Coverage 4 All Campaign, which is actually a campaign of Health Care for All New York. I'm going to talk a little bit more about the Child Health Plus proposal.

As we prepare this budget, immigrants in New York face an ever-deepening period of stress and vulnerability from changes at the federal level. I give some examples of some of the things that have been going on, but I'll just say today I was back up there fielding rumors about ICE being in Kings County Hospital all day, and what to do about it. We don't think that happened, but people's use of healthcare is going to be drastically affected by changes at the

federal level.

New York State elected officials, led by Governor Cuomo, have publicly and passionately committed to protecting and supporting immigrant communities under attack in Washington. Access to coverage and healthcare must be part of that response.

Undocumented immigrants in New York State have been shown to contribute more than $1,108,625,000 annually in state and local taxes. And investing in coverage expansions for this population -- it's not only for the immigrant community, and it's not only good for the families it will serve, it's also critical for strengthening our workforce and our tax base.

So we urge New York to include $81 million in its budget to increase the upper age limit of the Child Health Plus program from 18 to 29. As you heard just a second ago, that would create a young adult option. It would -- there are probably about 90,000 people that would be eligible for it, and it's estimated last year, in 2016, under

the last administration, it was estimated that just about 28,000 would likely enroll. I think probably some of those assumptions might be a little bit different now.

The people that would benefit from this proposal, they're young adults, many of them came here as children, they have grown up in this country, they know no other home, many of them -- and they contribute to the strength of the New York State economy and the workforce through their labor and by paying taxes. Many of them are parents with young children, and this proposal strengthening their access to coverage, the parents, also strengthens the children's access to coverage and improves health outcomes for them.

Child Health Plus is a model program that New York has had for many years. It is the reason why New York has a 3 percent child uninsurance rate. That's one of the lowest in the nation.

And this question has come up in some of my legislative visits. The reason that 29

is the proposed age, as opposed to 26, which matches the ACA -- 29 is actually the age of the program that extends coverage to young adults whose parents have private coverage. And that initiative predated the ACA. The ACA sort of borrowed from that in its coverage of people up to age 26 -- or its facilitating coverage for people up to age 26.

Benefits of increased coverage and better health access are well-documented. There's a few citations in the Community Service Society report, which we quote. But people without insurance are more likely to delay seeking care, they're more likely to incur medical debt and bankruptcy. When that happens, hospitals don't get paid for the care they provide. It's not good for hospitals, it's not good for the communities they serve. It is inevitable that people are sometimes going to get sick and need healthcare services, and the losses experienced by the healthcare system when that happens are passed on to everyone

through higher prices.

And then the other thing that this would do is this would address publicly funded uncompensated care, which is sort of what I just laid out.

The times in which we find ourselves require staunch and ambitious and in some cases big commitments to ensure the security of health of all communities that contribute to the New York State economy. With efforts underway to repeal the Affordable Care Act, and with this new raft of very intense and terrifying -- for the communities that are affected -- immigration enforcement that is taking place, New York has an opportunity to act on the national stage to further cement its leadership to other states by making a firm commitment to supporting young adults' ability to stay healthy for years to come.

Thank you so much for the opportunity to share testimony.

CHAIRMAN FARRELL: Thank you.

CHAIRWOMAN YOUNG: Thank you.

Any questions?

CHAIRMAN FARRELL: Thank you very much.

CHAIRWOMAN YOUNG: Okay, I think we're all set. Thank you again for being a trooper and sticking it out.

MS. CALHOON: Thank you.

SENATOR KRUEGER: Thank you.

CHAIRWOMAN YOUNG: That concludes the New York State Legislature 2017 Joint Budget Hearing on Health and Medicaid. And we have one final budget hearing tomorrow, Mr. Chairman, and that will be on housing.

CHAIRMAN FARRELL: 9:30.

CHAIRWOMAN YOUNG: 9:30 a.m. Be there or be square. Thank you.

CHAIRMAN FARRELL: And we will see the sun at the end of it.

CHAIRWOMAN YOUNG: Yes. Thank you, everyone.

SENATOR KRUEGER: Good night.

CHAIRMAN FARRELL: Thank you.

(Whereupon, the budget hearing concluded at 8:01 p.m.)